CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 423	**June 1, 2012**
	Change Request 7839

SUBJECT: General Update to Chapter 15 of the Program Integrity Manual (PIM) - Part VII

I. SUMMARY OF CHANGES: The purpose of this CR is to continue the process of updating chapter 15 of the PIM.

EFFECTIVE DATE: July 2, 2012
IMPLEMENTATION DATE: July 2, 2012

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/15.5.3/Final Adverse Actions
R	15/15.5.5/Owning and Managing Organizations
R	15/15.5.6/Owning and Managing Individuals
R	15/15.5.7/Chain Organizations
R	15/15.5.8/Billing Agencies
R	15/15.5.12/Special Requirements for Home Health Agencies (HHAs)
R	15/15.5.15/Authorized Officials
N	15/15.5.15.1/Form CMS-855I Signatories
N	15/15.5.15.2/Form CMS-855A and Form CMS-855B Signatories
R	15/15.5.16/Delegated Officials
R	15/15.6/Timeliness and Accuracy Standards
R	15/15.6.1/Standards for Initial Applications
R	15/15.6.1.1.1/Form CMS-855A Applications
R	15/15.6.1.1.2/Form CMS-855I Applications
R	15/15.6.1.1.3/Form CMS-855B Applications Submitted by Suppliers Other Than Independent Diagnostic Testing Facilities (IDTFs)
R	15/15.6.1.1.4/Form CMS-855B Applications Submitted by Independent Diagnostic Testing Facilities (IDTFs)
R	15/15.6.2/Standards for Changes of Information
R	15/15.6.2.3/Web-Based Applications - Timeliness
R	15/15.7/Application Review and Verification Activities
R	15/15.7.6/Special Processing Guidelines for Form CMS-855B, Form CMS-855I and Form CMS-855R Applications
R	15/15.7.7/Special Processing Guidelines for Form CMS-855A Applications
R	15/15.7.7.1/Changes of Ownership (CHOWs)
R	15/15.7.7.1.1/Definitions
R	15/15.7.7.1.2/Examining Whether a CHOW May Have Occurred
R	15/15.7.7.1.3/Processing CHOW Applications
R	15/15.7.7.1.4/Intervening CHOWs
R	15/15.7.7.1.5/Electronic Funds Transfer (EFT) Payments and CHOWs
R	15/15.7.7.1.6/Pre-Approval Changes of Information
R	15/15.7.7.2/Tie-In/Tie-Out Notices and Referrals to the State/RO
R	15/15.7.7.3/Out-of-State Practice Locations for Certified Providers

R	15/15.7.7.4/State Surveys and the Form CMS-855A
R	15/15.7.7.5/Sole Proprietorships
R	15/15.7.7.6/Additional Form CMS-855A Processing Instructions
R	15/15.7.7.7/Contractor Jurisdiction Issues
R	15/15.7.8/Special Processing Guidelines for Independent CLIA Labs, Ambulatory Surgical Centers and Portable X-ray Suppliers
R	15/15.7.8.1/CLIA Labs
R	15/15.7.8.2/Ambulatory Surgical Centers (ASCs) and Portable X-ray Suppliers (PXRS) - Initial Enrollment
R	15/15.7.8.3/Ambulatory Surgical Center (ASC)/Portable X-ray Supplier (PXRS) Changes of Ownership (CHOWs)
R	15/15.7.8.3.1/Examining Whether a Change of Ownership (CHOW) May Have Occurred
N	15/15.7.8.3.2/Electronic Funds Transfer (EFT) Payments and CHOWs
R	15/15.7.8.4/Ambulatory Surgical Centers (ASCs)/Portable X-ray Suppliers (PXRS) Tie-In/Tie-Out Notices and Referrals to the State/RO
R	15/15.7.8.5/Out-of-State Practice Locations for Certified Suppliers
N	15/15.7.8.6/State Surveys and the Form CMS-855B
D	15/15.8.4.2/Adverse Legal Actions/Convictions
N	15/15.21.1.1/Compliance Standards for Pharmacy Accreditation
N	15/15.22/Customer Service/Outreach
N	15/15.22.1/Web Sites
N	15/15.22.2/Provider Enrollment Inquiries
N	15/15.23/Document Retention
N	15/15.23.1/Security
N	15/15.23.2/Release of Information
N	15/15.23.3/File Maintenance
R	15/15.26.3/Additional Home Health Agency (HHA) Review Activities
D	15/15.34/Customer Service/Outreach
D	15/15.34.1/Web Sites
D	15/15.34.2/Provider Enrollment Inquiries
D	15/15.36/Document Retention
D	15/15.36.1/Security
D	15/15.36.2/Release of Information

D	15/15.36.3/File Maintenance
D	15/15.38.6.1/Compliance Standards for Pharmacy Accreditation

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: 423	Date: June 1, 2012	Change Request: 7839

SUBJECT: General Update to Chapter 15 of the Program Integrity Manual (PIM) - Part VII

EFFECTIVE DATE: **July 2, 2012**
IMPLEMENTATION DATE: July 2, 2012

I. GENERAL INFORMATION

A. Background: This change request (CR) is the seventh in a series of transmittals designed to update chapter 15 of the PIM. The majority of the revisions in this CR will either (1) be editorial in nature, or (2) incorporate existing policies directly into chapter 15. Any new instructions will be reflected in the CR's business requirements.

B. Policy: The purpose of this CR is to continue the process of updating chapter 15 of the PIM.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7839.1	Per section 15.5.3 of chapter 15, if the provider discloses a final adverse action on the Form CMS-855 other than an exclusion or debarment, the contractor shall refer the matter to its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) for guidance.	X		X	X	X					
7839.2	If the contractor discovers that an entity listed in sections 7, 8, or 12 of the Form CMS- 855 has had a final adverse action imposed against it, the contractor shall contact its PEOG BFL for guidance.	X		X	X	X					
7839.3	If a brand new group with new practitioners is attempting to enroll but submits only the Form CMS-855Rs for its group members (i.e., neither the initial Form CMS-855B nor the initial Form CMS-855Is were submitted), the contractor shall develop for the other forms if they are not submitted within 15 calendar days after receipt of the Form CMS-855Rs.	X			X						
7839.4	If a brand new group wants to enroll but submits only the Form CMS-855B without including the Form CMS-855Is and Form CMS-855Rs for its	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	
	group members (i.e., the Form CMS-855B arrives alone, without the other forms), the contractor shall develop for the other forms if they are not submitted within 15 calendar days after receipt of the Form CMS-855B.										
7839.5	If a newly-enrolling individual (1) submits only the Form CMS-855I without including the Form CMS-855B and Form CMS-855R, and (2) indicates on the Form CMS-855I that he/she will be reassigning all or part of his/her benefits to the group practice, the contractor shall develop for the other forms if they are not submitted within 15 calendar days after receipt of the Form CMS-855B.	X			X						
7839.6	If a provider undergoing a change of ownership pursuant to 42 CFR § 489.18 is assigned to a new contractor jurisdiction because it is transitioning from freestanding to provider-based status, the contractor for the new jurisdiction (the "new contractor") shall process both the buyer's and seller's Form CMS-855A applications.	X		X		X					
7839.6.1	If, in the situation described in business requirement 7839.6, the "old" (or current) contractor receives the buyer's or seller's Form CMS-855A application, it shall (a) forward the application to the new contractor within 5 business days of receipt, and (b) notify the new contractor within that same timeframe that the application was sent.	X		X		X					
7839.7	If, under section 15.26.3 of chapter 15, a home health agency (HHA) – after the required contractor re-review - is still in compliance with enrollment requirements (e.g., no owners or managing employees are excluded, capitalization is met), the contractor shall notify the applicable CMS regional office of this via e-mail; the notice shall specify the date on which the contractor completed the aforementioned reviews.	X		X		X					
7839.8	If, under section 15.26.3 of chapter 15, an HHA – after the required contractor re-review - is no longer in compliance with enrollment requirements (e.g., capitalization is not met), the contractor shall notify the HHA of this via letter.	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

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

Post-Implementation Contact:
Contact your Contracting Officer's Representative (COR) 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),* 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 Provider/Supplier Enrollment

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15.5.3 – *Final Adverse Actions*

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

Unless stated otherwise, the instructions in this section 15.5.3 apply to the following sections of the Form CMS-855:

- *Section 3*
- *Section 4A of the CMS-855I*
- *Section 5*
- *Section 6*

A. Disclosure of Final Adverse Action

If a final adverse action is disclosed on the Form CMS-855, the provider must 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. The documentation must be furnished regardless of whether the adverse action occurred in a State different from that in which the provider seeks enrollment or is enrolled.

Note further:

1. *Reinstatements - If the person or entity in question was excluded or debarred but has since been reinstated, the contractor shall confirm the reinstatement through the Office of Inspector General (OIG) or, in the case of debarment, through the federal agency that took the action. It shall also ensure that the provider submits written proof of the reinstatement (e.g., reinstatement letter).*

2. *Revocation Reversals – Medicare revocations that were reversed on appeal need not be reported on the Form CMS-855.*

3. *Scope of Disclosure – All final adverse actions that occurred under the legal business name (LBN) and tax identification number (TIN) of the disclosing entity (e.g., applicant; Section 5 owner) must be reported. This includes Medicare revocations that: (1) were initiated by a different Medicare contractor in another contractor jurisdiction, and (2) involve a different provider or supplier type. Consider the following examples:*

   Example (a) - Smith Pharmacy, Inc. had 22 separately enrolled locations in 2009. Each location was under Smith's LBN and TIN. In 2010, two locations were revoked, leaving 20 locations. Smith submits a Form CMS-855S application for a new location on Jones Street. The two revocations in 2010 must be reported on the Jones Street application. Suppose, however, that each of Smith's locations had its own LBN and TIN. The Jones Street application need not disclose the two revocations from 2010.

Example (b) - A home health agency (HHA), hospice and hospital are enrolling under Corporation X's LBN and TIN. X is listed as the provider in section 2 of each applicant's Form CMS-855A. All three successfully enroll. Six months later, Company X's billing privileges for the HHA are revoked. Both the hospice and the hospital must report the revocation via a Form CMS-855A change request because the revocation occurred under the provider's LBN and TIN. Assume now that X seeks to enroll an ambulatory surgical center (ASC) under X's LBN and TIN. The HHA revocation would have to be reported in section 3 of the ASC's initial Form CMS-855B.

Example (c) – Company Y is listed as the provider/supplier for two HHAs and 2 suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). These 4 providers/suppliers are under Y's LBN and TIN. Each provider/supplier is located in a different State. All are enrolled. Y's billing privileges for one of the DMEPOS suppliers are revoked. Y now seeks to enroll an ASC in a fifth State. Y must disclose the DMEPOS revocation on the ASC's initial Form CMS-855, even though the revocation: (1) was done by a Medicare contractor other than that with which the ASC seeks enrollment, and (2) occurred in a State different from that in which the ASC is located.

Example (d) – Company Alpha is listed as an owner in section 5 of the Form CMS-855A. Alpha operates two health care providers – Y and Z - under its LBN and TIN. Y was subject to a General Services Administration debarment, which ended in 2009. The debarment would have to be reported in section 5, since it occurred under Z's LBN and TIN.

4. *Timeframe – With the exception of the felony convictions identified in #1 under "Convictions" in section 3 of the Form CMS-855, all final adverse actions must be reported regardless of when they occurred.*

5. *Corporate Integrity Agreements (CIAs) – CIAs need not be disclosed on the Form CMS-855.*

6. *Evidence to Indicate Adverse Action – There may be instances where the provider states in section 3, 4A of the CMS-855I, 5, and/or 6 that the person or entity has never had a final adverse action imposed against him/her/it, but the contractor finds evidence to indicate otherwise. In such cases, the contractor shall contact its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) for guidance.*

B. Prior Approval

If a current exclusion or debarment is disclosed on the Form CMS-855, the contractor shall deny the application in accordance with the instructions in this chapter. Prior approval from PEOG is not necessary. If any other final adverse action is listed, the contractor shall refer the matter to its PEOG BFL for guidance.

C. Review of the Provider Enrollment, Chain and Ownership System (PECOS)

If the contractor denies an application or revokes a provider based on a final adverse action, the contactor shall search PECOS (or, if the provider is not in PECOS, the contractor's internal system) to determine:

- *Whether the person/entity with the adverse action has any other associations (e.g., is listed in PECOS as an owner of three Medicare-enrolled providers), or*

- *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).

D. Chain Home Offices, Billing Agencies, and HHA Nursing Registries

If the contractor discovers that an entity listed in sections 7, 8, or 12 of the Form CMS-855 has had a final adverse action imposed against it, the contractor shall contact its PEOG BFL for guidance.

15.5.5 – Owning and Managing Organizations

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

(This section only applies to section 5 of the *Form* CMS-855A and *Form* CMS-855B. It does not apply to the *Form* CMS-855I.)

All organizations that have any of the following must be listed in section 5A of the *Form* CMS-855:

1. A 5 percent or greater direct or indirect ownership interest in the provider.

The following illustrates the difference between direct and indirect ownership:

EXAMPLE: The supplier listed in section 2 of the *Form* CMS-855B is an ambulance company that is wholly (100 percent) owned by Company A. Company A is considered to be a direct owner of the supplier (the ambulance company), in that it actually owns the assets of the business. Now assume that Company B owns 100 percent of Company A. Company B is considered an indirect owner - but an owner, nevertheless - of the supplier. In other words, a direct owner has an actual ownership interest in the supplier, whereas an indirect owner has an ownership interest in an organization that owns the supplier.

See the instructions for section 5 of the Form CMS-855 for additional information on indirect ownership.

2. Mortgage or security interest

For purposes of enrollment, ownership also includes "financial control." Financial control exists when:

(a) An organization or individual is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the provider or any of the property or assets of the provider, and

(b) The interest is equal to or exceeds 5 percent of the total property and assets of the provider.

All entities with at least a 5 percent mortgage, deed of trust or other security interest in the provider must be reported in section 5. This frequently will include banks, other financial institutions, and investment firms,

3. Any general partnership interest in the provider, regardless of the percentage. This includes: (1) all interests in a non-limited partnership, and (2) all general partnership interests in a limited partnership.

4. For limited partnerships, any limited partnership interest that is 10 percent or greater.

5. Managing control of the provider or supplier

A managing organization is one that exercises operational or managerial control over the provider, or conducts the day-to-day operations of the provider. The organization need not have an ownership interest in the provider in order to qualify as a managing organization. For instance, the entity could be a management services organization under contract with the provider to furnish management services for one of the provider's practice locations.

The organizations referred to above generally fall into one or more of the following categories:

- *Corporations*
- *Partnerships and limited partnerships*
- *Limited liability companies*
- *Charitable and religious organizations*
- *Governmental/tribal organizations*
- *Banks and financial institutions*
- *Investment firms*
- *Holding companies*
- *Trusts and trustees*
- *Medical providers/suppliers*
- *Consulting firms*
- *Management services companies*
- *Medical staffing companies*
- *Non-profit entities*

In section 5(A)(2) of the Form CMS-855, the provider must indicate the type(s) of organizational categories the reported entity falls into.

The contractor shall also note the following with respect to *section 5:*

a. Diagrams – In addition to completing section 5(A):

- *The provider must submit an organizational structure diagram/flowchart identifying all of the entities listed in section 5 and their relationships with the provider and each other. (This applies to the Form CMS-855A, CMS-855B and CMS-855S.)*

- *If the provider is a skilled nursing facility (SNF), it must submit a diagram/flowchart identifying the organizational structures of all of its owners, including those that were not required to be listed in section 5 or 6. This must be submitted in addition to the diagram/flowchart in the previous bullet.*

These diagrams/flowcharts must be submitted for initial enrollments, revalidations and reactivations, and upon any contractor requests.

b. Percentage of Interest (section 5(B)) – The provider need not:

- *Disclose a percentage of managerial control*

- *Submit documentation verifying the percentage of ownership, partnership interest or security/mortgage interest, unless the contractor requests it.*

c. Section 2 - Any entity listed as the *provider* in section 2 of the *Form* CMS-855 need not be reported in section 5A. The only *exception involves* governmental entities, which must be *identified* in section 5A even if they are already listed in section 2.

d. *Governmental Organization Letter* - *For* governmental organizations, the letter referred to in the *Form* CMS-855 instructions for section 5 must be signed by an appointed or elected official of the governmental entity who has the authority to legally and financially bind the government to the laws, regulations, and program instructions of Medicare. *This government official is not required to* be an authorized official, or vice versa.

e. *Non-Profit Organizations* - Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body *must* be listed in section 5A of the *Form* CMS-855. The *provider must* submit a copy of its 501(c)(3) approval notification for non-profit status. If it does not possess such documentation but nevertheless claims it is a non-profit entity, the *provider* may submit any other documentation that supports its claim *(e.g., written documentation from the State).*

f. *IRS CP-575* - Owning/managing organizations need not *furnish* an IRS CP-575 document unless requested by the contractor (e.g., the contractor discovers a potential discrepancy between the organization's *reported* legal business name and tax identification number.)

g. *Documentation – Proof of ownership, managerial control, security interest, etc., need not be submitted unless the contractor requests it. This also means that articles of incorporation, partnership agreements, etc., need not be submitted absent a contractor's request.*

15.5.6 – Owning and Managing Individuals

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

(This section applies to section 6 of the *Form* CMS-855A, the *Form* CMS-855B, and the *Form* CMS-855I.)

All individuals who have any of the following must be listed in section 6A:

1. A 5 percent or greater direct or indirect ownership interest in the provider.

2. A 5 percent or greater mortgage or security interest in the provider.

(See section 15.5.5 of this chapter for more information on direct and indirect ownership, and on mortgage and security interests.)

3. Any general partnership interest in the provider, regardless of the percentage. This includes: (1) all interests in a non-limited partnership, and (2) all general partnership interests in a limited partnership.

4. For limited partnerships, any limited partnership interest that is 10 percent or greater.

5. Managing control of the provider. (For purposes of enrollment, such a person is considered to be a "managing employee." A managing employee is any individual, including a general manager, business manager, office manager or administrator, who exercises operational or managerial control over the provider's business, or who conducts the day-to-day operations of the business. A managing employee also includes any individual who is not an actual W-2 employee but who, either under contract or through some other arrangement, manages the day-to-day operations of the business.)

6. Officers and directors, if the applicant is a corporation. (For-profit and non-profit corporations must list all of their officers and directors. If a non-profit corporation has "trustees" instead of officers or directors, these trustees must be listed in section 6 of the Form CMS-855.) Note that only officers and directors of the provider must be reported. Board members of the provider's indirect owners need not be disclosed to the extent they are not otherwise required to be reported (e.g., as an owner or managing employee) in section 6.

The contractor shall note the following:

- *The provider need not disclose a percentage of: (1) control as an officer or director, (2) W-2 or contracted managerial control, or (3) operational control. Also, the provider need not submit documentation verifying the percentage of ownership, partnership interest or security/mortgage interest, unless the contractor requests it.*

- Government entities need only list their managing employees in section 6 of the *Form* CMS-855, as they do not have owners, partners, corporate officers, or corporate directors.

- The applicant must list at least one managing employee in section 6 if it is completing the *Form* CMS-855A or the *Form* CMS-855B. *An individual* completing the *Form* CMS-855I need not list a managing employee if he/she does not have one.

- All managing employees at any of the practice locations listed in section 4C of the *Form* CMS-855I must be reported in section 6A. However, individuals who: (1) are employed by hospitals, health care facilities, or other organizations shown in section 4C (e.g., the *chief executive officer* of a hospital listed in section 4C), or (2) are managing employees of any group/organization to which the practitioner will be reassigning his/her benefits, need not be reported.

- The contractor *need not* request a copy of the individual's W-2 to confirm that he/she *is a* W-2 employee (as opposed to a contracted employee), *although it reserves the right to do so.*

- *Proof of ownership, managerial control, security interests, etc., need not be submitted unless the contractor requests it.*

15.5.7 – Chain Organizations

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

(This section only applies to the *Form CMS-855A.)*

All providers that are currently part of a chain organization *or are* joining a chain organization must complete *section 7* with information about the chain home office. *Under 42 CFR § 421.404, a "home office" means the entity that provides centralized management and administrative services to the providers or suppliers under common ownership and common control, such as centralized accounting, purchasing, personnel services, management direction and control, and other similar services. Other definitions relevant to chain organizations (and which are in § 421.404) include:*

- *Chain provider - A group of two or more providers under common ownership or control.*

- *Common control - Exists when an individual, a group of individuals, or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of the group of suppliers or eligible providers.*

- *Common ownership – Exists when an individual, a group of individuals, or an organization possesses significant equity in the group of suppliers or eligible providers.*

The contractor shall not *delay its* processing of the provider's application while awaiting the issuance of a chain home office number (i.e., a determination as to whether a set of entities qualifies as a chain organization). Such an issuance/determination is *not required for a* recommendation for approval.

In addition, the contractor shall ensure that:

- The chain home office is identified in section 5A and that *final adverse action* data is furnished in section 5B. (For purposes of provider enrollment, a chain home office automatically qualifies as an owning/managing organization.) Note that a *National Provider Identifier (NPI)* is typically not required for a chain home office.

- The chain home office administrator is identified in section 6A and that *final adverse action* data for the administrator is furnished in section 6B. (For purposes of provider enrollment, a chain home office administrator is automatically deemed to have managing control over the provider.)

For more information on chain organizations, refer to:

- Pub. 100-04, chapter 1, sections 20.3 through 20.3.*6*

- 42 CFR §421.404

- CMS change request 5720

15.5.8 – Billing Agencies

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

(Unless otherwise stated, this section applies to the Form CMS-855A, the Form CMS-855B, and the Form CMS-855I.)

A billing agency is an entity that furnishes billing and collection services on behalf of a provider or supplier. A billing agency is not enrolled in the Medicare program. A billing agency submits claims to Medicare in the name and billing number of the provider or supplier that furnished the service or services. In order to receive payment directly from Medicare on behalf of a provider or supplier, a billing agency must meet the conditions described in § 1842(b)(6)(D) of the Social Security Act.

The provider shall complete *section 8 of the Form CMS-855* with information about all billing agents *it utilizes.* As all Medicare payments must be made via electronic funds transfer, the contractor *need not* verify the provider's compliance with the "Payment to Agent" rules in CMS Publication 100-04, chapter 1, section 30.2. The only *exception is if* the contractor discovers that the "special payments" address in section 4 of the provider's Form CMS-855 application belongs to the billing agent or agency. In this situation, the contractor may obtain a copy of the billing agreement if it has reason to believe that the arrangement violates the "Payment to Agent" rules.

If the chain organization listed in section 7 of the Form CMS-855A also serves as the provider's billing agent, the chain must be listed in section 8 as well.

For further information on billing agencies, see CMS Publication 100-04, chapter 1, section 30.2.4.

15.5.12 – Special Requirements for Home Health Agencies (HHAs)

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

(This section only applies to the *Form* CMS-855A.)

A. Capitalization

For initial applications, the contractor shall verify that the HHA meets all of the capitalization requirements addressed in 42 CFR § 489.28. *(Note that capitalization need not be reviewed for revalidation or reactivation applications.)* The contractor may request from the provider any and all documentation deemed necessary to perform this task. Failure to meet the capitalization requirements shall result *in a denial or revocation, as appropriate.* For more information on HHA capitalization, *see §* 489.28 and section 15.26.2 of this chapter.

B. Nursing Registries

If the HHA checks “yes” in section 12B, the contractor *shall ensure* that the information furnished *about* the HHA nursing registry *is accurate.* (A nursing registry is akin to a staffing agency, whereby a private company furnishes nursing personnel to hospitals, clinics, and other medical providers.)

15.5.15 – *Authorized Officials*

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

Unless indicated otherwise below or in another CMS directive, the instructions in sections 15.5.15.1 and 15.5.15.2 apply to: (1) signatures on the paper Form CMS-855, (2) signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications, and (3) electronic signatures.

15.5.15.1 – Form CMS-855I Signatories

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

The enrolling or enrolled physician or non-physician practitioner is the only person who can sign the Form CMS-855I. (This applies to initial enrollments, changes of information, reactivations, etc.) This includes solely-owned entities listed in section 4A of the Form CMS-855I. A physician or non-physician practitioner may not delegate the authority to sign the Form CMS-855I on his/her behalf to any other person.

15.5.15.2 – Form CMS-855A and Form CMS-855B Signatories

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

For CMS-855A and CMS-855B initial and revalidation applications, the certification statement must be signed and dated by an authorized official of the provider. (See section 15.1.1 of this chapter for a definition of “authorized official.”) The provider can have an unlimited number of authorized officials, so long as each meets the definition of an authorized official. Section 6 of the Form CMS-855 must be completed for each authorized official.

If an authorized official is listed as a “Contracted Managing Employee” in section 6 of the Form CMS-855 and does not qualify as an authorized official under some other category in section 6, he/she cannot be an authorized official. The contractor shall notify the provider accordingly. If the person is not listed as a “Contracted Managing Employee” in section 6 and the contractor has no reason to suspect that the person does not qualify as an authorized official, no further investigation is required. Should the contractor have doubts that the individual qualifies as an authorized official, it shall contact the official or the applicant's contact person to obtain more information about the official's job title and/or authority to bind. If the contractor remains unconvinced that the individual qualifies as an authorized official, it shall notify the provider that the person cannot be an authorized official. If that person is the only authorized official listed and the provider refuses to use a different authorized official, the contractor shall deny the application.

An authorized official must be a 5 percent direct owner, chairman of the board, etc., of the enrolling provider. One cannot use his/her status as the chief executive officer, chief financial officer, etc., of the provider's parent company, management company, or chain home office as a basis for his/her role as the provider's authorized official.

In addition:

1. Original Signatures - For non-electronic signatures, the signature of an authorized official must be original. Faxed, stamped, or photocopied signatures cannot be accepted.

2. Deletion of Authorized Official - If an authorized official is being deleted, the contractor need not obtain: (1) that official's signature, or (2) documentation verifying that the person is no longer an authorized official.

3. Change in Authorized Officials - A change in authorized officials does not impact the authority of existing delegated officials to report changes and/or updates to the provider's enrollment data.

4. Authorized Official Not on File - If the provider submits a change of information (e.g., change of address) and the authorized official signing the form is not on file, the contractor shall ensure that: (1) the person meets the definition of an authorized official, and (2) section 6 of the Form CMS-855 is completed for that person. The signature of an existing authorized official is not needed in order to add a new authorized official. Note that the original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompassing two different actions) for purpose of enrollment processing and reporting.

5. Effective Date - The effective date in the Provider Enrollment, Chain and Ownership System for section 15 of the Form CMS-855 should be the date of signature.

6. Social Security Number - To be an authorized official, the person must have and must submit his/her social security number.

7. Identifying the Provider – As stated earlier, an authorized official must be an authorized official of the provider, not of an owning organization, parent company, chain home office, or management company. Identifying the provider is not - for purposes of determining an authorized official's qualifications - determined solely by the provider's tax identification number (TIN). Rather, the organizational structure is the central factor. For instance, suppose that a chain drug store, Company X, wants to enroll 100 of its pharmacies with the contractor. Each pharmacy has a separate TIN and must therefore enroll separately. Yet all of the pharmacies are part of a single corporate entity – Company X. In other words, there are not 100 separate corporations in our scenario, but merely one corporation whose individual locations have different TINs. Here, an authorized official for Pharmacy #76, can be someone at X's headquarters (assuming that the definition of authorized official is otherwise met), even though this main office might be operating under a TIN that is different from that

of #76. This is because headquarters and Pharmacy #76 are part of the same organization/corporation. Conversely, if #76 was a corporation that was separate and distinct from Company X, only individuals that were part of #76 could be authorized officials.

15.5.16 – Delegated Officials

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

(*Unless indicated otherwise below or in another CMS directive, the instructions in this section apply to: (1) signatures on the paper Form CMS-855, (2) signatures on the certification statement for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications, and (3) electronic signatures. Note also that t*his section only applies to the *Form* CMS-855A and the Form CMS-855B.)

A delegated official is an individual *to whom an authorized official listed in section 15 of the Form CMS-855 delegates the authority* to report changes and updates to the provider's enrollment record. The delegated official must be an individual with an *"*ownership or control interest*"* in (as that term is defined in *§* 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of the provider.

Section 1124(a)(3) defines an individual with an ownership or control interest as:

- A five percent direct or indirect owner of the provider,
- An officer or director of the provider (if the provider is a corporation), or
- *Someone with a partnership interest in the provider*, if the provider is a partnershi*p*

The delegated official must be a delegated official of the provider, not of an owning organization, parent company, chain home office, or management company. One cannot use his/her status as a W-2 managing employee of the provider's parent company, management company, or chain home office as a basis for his/her role as the provider's delegated official.

*T*he contractor shall note the following about delegated officials:

1. Authority - A delegated official has no authority to sign an *initial or revalidation application*. *However, the delegated official may sign off on changes/updates submitted in response to a contractor's request to clarify or submit information needed to continue processing the provider's initial or revalidation application.*

2. Section 6 – Section 6 *of the Form CMS-855 must be completed for all delegated officials.*

3. Managing Employees - For purposes of section 16 only, the term "managing employee" means any individual, including a general manager, business manager, or

administrator, who exercises operational or managerial control over the provider, or who conducts the day-to-day operations of the provider. However, this does not include persons who, either under contract or through some other arrangement, manage the day-to-day operations of the provider but who are not actual W-2 employees. For instance, suppose *the provider hires Joe Smith as an independent contractor to* run its day-to-day-operations. Under the definition of "managing employee" *in* section 6 of the *Form* CMS-855, Smith would have to be listed *in that section*. *Yet* under the section 16 definition (as described above), Smith cannot be a delegated official because he is not an actual W-2 employee of the provider. Independent contractors are not considered "managing employees" under section 16 of the *Form* CMS-855.

*4. W-2 Form – Unless the contractor requests it to do so, t*he provider is not required to submit a copy of the owning/managing individual's W-2 to verify an employment relationship.

5. Number of Delegated Officials - The provider can have as many delegated officials as it *chooses.* Conversely, the provider is not required to have any delegated official*s.* Should no delegated officials be listed, however, the authorized official(s) remains the only individual(s) who can *report* changes and/or updates to the provider's *enrollment data.*

6. Effective Date - The effective date in *PECOS* for section 16 of the *Form* CMS-855 should be the date of signature.

7. Social Security Number - *To* be a delegated official, the person must have and must submit his/her social security number.

8. Deletion - If a delegated official is being deleted, documentation verifying that the person no longer is or qualifies as a delegated official is not required. *Also,* the signature of the deleted official *is not* needed.

9. Further Delegation - Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the provider's Medicare *data.*

10. Delegated Official Not on File - If the provider *submits* a change of information *(e.g., change* of address*)* and the delegated official signing the form is not on file, the contractor shall ensure that: (1) the person meets the definition of a delegated official, (2) section 6 of the *Form* CMS-855 is completed for that person, and (3) an existing authorized official signs off on the addition of the delegated official. Note that the original change request and the addition of the new official shall be treated as a single change request (i.e., one change request encompass*ing* two different actions) for purpose of enrollment processing and reportin*g.*

11. Signature on Paper Application - If the provider submits a *paper Form* CMS-855 change *request*, the contractor may accept the signature of a delegated official in Section 15 or 16 of the *Form* CMS-855.

*15.*6 - Timeliness and Accuracy Standards

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

Sections *15.*6.1 through *15.*6.3 of this chapter address the timeliness and accuracy standards applicable to the processing of *Form* CMS-855 applications. Even though the provisions of 42 CFR § 405.874(h) contain processing timeframes that are longer than those in sections *15.*6.1 through *15.*6.3, the contractor shall adhere to the standards specified in sections *15.*6.1 through *15.*6.3.

The processing of an application generally includes, but is not limited to, the following activities:

- Receipt of the application in the contractor's mailroom and forwarding it to the appropriate office for review.

- Prescreening the *application.*

- Creating a *logging and tracking (L & T)* record and an enrollment record in *the Provider Enrollment, Chain and Ownership System (PECOS).*

- *Ensuring that the information on the application is verified.*

- Requesting and receiving clarifying information.

- Site visit (if necessary).

- Formal notification *to the SA and/or RO* of the contractor's *approval, denial or recommendation for approval of the application.*

15.6.1 – Standards for Initial Applications

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

For purposes of sections *15.*6.1.1 through *15.*6.1.4 of this chapter, the term "initial applications" also includes:

1. *Form CMS-855 change of ownership*, acquisition/merger, and consolidation applications submitted by the new owner.

2. "Complete" *Form* CMS-855 applications submitted by enrolled providers: (a) voluntarily, (b) as part of any change request if the provider does not have an established enrollment record in *the Provider Enrollment, Chain and Ownership System (PECOS)*, (c) *as a* reactivation, or (d) *as a* revalidation.

15.6.1.1.1 – *Form* CMS-855A Applications

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

The contractor shall process 80 percent of *all Form* CMS-855A initial applications within 60 calendar days of receipt, process 90 percent of *all Form* CMS-855A initial applications within 120 calendar days of receipt, and process 99 percent of *all Form* CMS-855A initial applications within 180 calendar days of receipt.

15.6.1.1.2 – *Form* CMS-855I Applications

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

The contractor shall process 80 percent of all initial *Form* CMS-855I applications where no contractor development is needed within 60 calendar days of receipt, and *process* 95 percent of *all* such applications within 90 calendar days of receipt.

The contractor shall process 80 percent of all initial *Form* CMS-855I applications where one developmental request is made by the contractor within 90 calendar days of receipt, *process* 90 percent of *all* such applications within 120 calendar days of receipt, and *process* 95 percent of *all* such applications within 180 calendar days of receipt.

The contractor shall process 70 percent of all initial *Form* CMS-855I applications where at least two developmental requests are made by the contractor within 90 calendar days of receipt, *process* 80 percent of *all* such applications within 120 calendar days of receipt, and *process* 90 percent of *all* such applications within 180 calendar days of receipt.

15.6.1.1.3 – *Form* CMS-855B Applications Submitted by Suppliers Other Than *Independent Diagnostic Testing Facilities (IDTFs)*

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

(This section *15.*6.1.1.3 applies only to initial *Form* CMS-855B applications submitted by suppliers other than IDTFs.)

The contractor shall process 80 percent of all initial *Form* CMS-855B applications where no contractor development is needed within 60 calendar days of receipt, and *process* 95 percent of *all* such applications within 90 calendar days of receipt.

The contractor shall process 80 percent of all initial *Form* CMS-855B applications where one developmental request is made by the contractor within 90 calendar days of receipt, *process* 90 percent of *all* such applications within 120 calendar days of receipt, and *process* 95 percent of *all* such applications within 180 calendar days of receipt.

The contractor shall process 70 percent of all initial *Form* CMS-855B applications where at least two developmental requests are made by the contractor within 90 calendar days of receipt, *process* 80 percent of *all* such applications within 120 calendar days of receipt, and *process* 90 percent of *all* such applications within 180 calendar days of receipt.

15.6.1.1.4 – *Form* CMS-855B Applications Submitted by *Independent Diagnostic Testing Facilities (IDTFs)*

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

The contractor shall process 70 percent of all initial IDTF *Form* CMS-855B applications where no contractor development is needed within 90 calendar days of receipt, *process* 80 percent of *all* such applications within 120 calendar days of receipt, and 95 percent of *all* such applications within 180 calendar days of receipt.

The contractor shall process 65 percent of all initial IDTF *Form* CMS-855B applications where one developmental request is made by the contractor within 90 calendar days of receipt, *process* 75 percent of *all* such applications within 120 calendar days of receipt, and *process* 90 percent of *all* such applications within 180 calendar days of receipt.

The contractor shall process 60 percent of all initial *Form* IDTF CMS-855B applications where two or more developmental requests are made by the contractor within 90 calendar days of receipt, *process* 70 percent of *all* such applications within 120 calendar days of receipt, and *process* 80 percent of *all* such applications within 180 calendar days of receipt.

15.6.2 – Standards for Changes of Information

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

For purposes of timeliness, the term “changes of information” also includes:

1. *Form CMS-855 change of ownership*, acquisition/merger, and consolidation applications submitted by the old owner

2. *Form* CMS-588 changes submitted without a need for an accompanying complete *Form* CMS-855 application

3. *Form* CMS-855R applications submitted independently (i.e., without being part of a *Form* CMS-855I or *Form* CMS-855B package)

4. *Form* CMS-855 voluntary terminations

15.6.2.3 - Web-Based Applications - Timeliness

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

The contractor shall process 90 percent of *all Form* CMS-855 Web-based chang*e* of information applications within 45 calendar days of receipt, process 95 percent of *all such* changes of information within 60 calendar days of receipt, and process 99 percent of *all such* changes of information within 90 calendar days of receipt. This process generally includes, but is not limited to:

- Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review. *(This obviously does not apply to applications submitted with an electronic signature.)*

- *Ensuring that the changed information has been verified*

- Requesting and receiving clarifying information

- Supplier site visit (if necessary)

- Formal notification to the *SA and/or RO* of the contractor's *approval, denial or recommendation for approval of the application*

15.7 – Application Review and Verification Activities

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

Unless stated otherwise in this *chapter,* the instructions in sections *15.*7 through *15.7.*3 apply to the *Form* CMS-855A, the *Form* CMS-855B and the *Form* CMS-855I. These instructions are in addition to, and not in lieu of, all other instructions in this *chapter.*

15.7.6 – Special *Processing Guidelines* for Form CMS-855B, Form CMS-855I and Form CMS-855R Applications

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

A. Reassignment Packages

In situations where an entity wants to simultaneously enroll a group practice, the individual practitioners therein, and to reassign benefits accordingly, the contractor shall adhere to the instructions contained in the scenarios below. During the pre-screening process, the contractor shall examine the incoming forms to see if a reassignment may be involved.

- Only the *Form* CMS-855Rs are submitted - If a brand new group with new practitioners is attempting to enroll but submits only the *Form* CMS-855Rs for its group members (i.e., neither the initial *Form* CMS-855B nor the initial *Form* CMS-855Is were submitted), the contractor *shall develop for the other forms if they are not submitted* within 15 calendar days after receipt of the *Form* CMS-855Rs.

- Only the *Form* CMS-855B is submitted - If a brand new group wants to enroll but submits only the *Form* CMS-855B without *including* the *Form* CMS-855Is and *Form* CMS-855Rs for its group members (i.e., the *Form* CMS-855B arrives alone, without the other forms), the contractor *shall develop for the other forms if they are not submitted* within 15 calendar days after receipt of the *Form* CMS-855B.

- Only the *Form* CMS-855I is submitted – Suppose an individual: (1) submits only the *Form* CMS-855I without *including* the *Form* CMS-855B and *Form* CMS-855R,

and (2) indicates on the *Form* CMS-855I that he/she will be reassigning all *or part* of his/her benefits to the group practice. *The contractor shall develop for the other forms if they are not submitted within 15 calendar days after receipt of the Form CMS-855B.*

B. Additional Instructions

The contractor shall note the following:

- If an individual is joining a group that was enrolled prior to the *Form* CMS-855B (i.e., the group never completed a *Form* CMS-855), the contractor shall obtain a *Form* CMS-855B from the group. During this timeframe, the contractor shall not withhold any payment from the group *solely on the grounds that a Form CMS-855B has not been completed.* Once the group's application is received, the contractor shall add the new reassignment; if the *Form* CMS-855R was not submitted, the contractor shall secure it from the supplier.

- If a supplier is changing its tax identification number *(TIN),* the transaction shall be treated as a brand new enrollment as opposed to a change of information. Consequently, the supplier must complete a full *Form* CMS-855 application and a new enrollment record must be created in *the Provider Enrollment, Chain and Ownership System (PECOS).* (This does not apply to ambulatory surgical centers and portable x-ray suppliers. These entities can submit a TIN change as a change of information unless a *change of ownership* is involved. If the latter is the case, the applicable instructions in sections 15.7.8.2.1 through 15.7.8.2.1.2 of this chapter should be followed.)

- If the supplier is adding or changing a practice location and the new location is in another State within the contractor's jurisdiction, the contractor shall ensure that *the supplier meets all the requirements necessary to practice in that State (e.g., licensure).* A complete *Form* CMS-*855 for* the new State is not required, though the contractor shall create a new enrollment record in PECOS for the new State.

- All members of a group practice must be entered into PECOS.

15.7.7 – Special *Processing Guidelines* for Form CMS-855A Applications

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

Unless otherwise stated, all references to the "RO" in sections 15.7.7.1 through 15.7.7.7 of this chapter refer to the RO's survey & certification staff.

15.7.7.1 - Changes of Ownership (CHOWs)

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

Changes of ownership (CHOWs) are officially defined *in* and governed by 42 CFR § 489.18 and Publication 100-07, chapter 3, sections 3210 through 3210.5(C). The RO *– not the contractor –* make*s* the determination as to whether a CHOW has occurred (unless this function has been delegated).

Unless specified otherwise, the term "CHOW" - as used in sections 15.7.7.1 through 15.7.7.1.6 of this chapter - includes CHOWs, acquisitions/mergers and consolidations. *Though section 2 of the Form CMS-855A separates the applicable transactions into CHOWs, acquisition/mergers and consolidations for ease of disclosing and reporting, they fall with the general CHOW category under 42 CFR § 489.18 (e.g., an acquisition/merger is a type of CHOW under § 489.18).*

15.7.7.1.1 - Definitions

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

For purposes of provider enrollment only, there are three main categories of CHOWs captured on the *Form* CMS-855A application:

- **"Standard" CHOW** – This occurs when *a provider's CMS Certification Number (CCN)* and provider *agreement are* transferred to another entity as a result of the latter's purchase of the provider. To illustrate, suppose Entity A is enrolled in Medicare, but Entity B is not. B acquires A. Assuming all regulatory requirements are met, A's provider agreement and CCN number will transfer to B.

This is the most frequently encountered change of ownership scenario. *As explained in section 15.7.7.1*, *e*ven though it is technically an acquisition (i.e., B bought/acquired A) under § 489.18, this situation falls under the "CHOW" category – as opposed to the "Acquisition/Merger" category – on the *Form* CMS-855A.

- **Acquisition/Merger** - In general, this occurs when two or more Medicare-enrolled entities combine, leaving only one remaining CCN number and provider agreement. For instance, Entity A and Entity B are both enrolled in Medicare, each with its own CCN number and provider agreement. The two entities decide to merge. *E*ntity B's CCN number and provider agreement will be eliminated (leaving only Entity A's CCN number and provider agreement).

If the acquisition results in an existing provider having new owners but keeping its existing provider number, the applicant should check the CHOW box in section 1A of the *Form* CMS-855A.

Unlike the new owner in a CHOW or consolidation, the new owner in an acquisition/merger need not complete the entire *Form* CMS-855A. This is because the new owner is already enrolled in Medicare. *A*s such, the provider being acquired *should be* reported as a practice location in section 4 of the new owner's *Form* CMS-855A.

- **Consolidations** - This occurs when the merger of two or more Medicare-enrolled entities results in the creation of a brand new entity. To illustrate, if Entities A and B decide to combine and, in the process, create a new entity (Entity C), the CCN numbers and provider agreements of both A and B will be eliminated. Entity C will have its own CCN number and provider agreement.

Note the difference between acquisitions/mergers and consolidations. In an acquisition/merger, when A and B combine there is one surviving entity. In a *consolidation, when* A and B combine there are no surviving entities. Rather, a new entity is created – Entity C.

*U*nder 42 CFR §489.18(a)(4), the lease of all or part of a provider facility constitutes a change of ownership of the leased portion. If only part of the provider is leased, the original provider agreement remains in effect only with respect to the un-leased portion. (See Pub*lication* 100-07, chapter 3, section 3210.1D (4) for more information.)

Note that a provider may undergo a financial or administrative change that it considers to be a CHOW, but does not meet the regulatory definition identified in §489.18.

15.7.7.1.2 - *Exa*mining Whether a CHOW *May Have* Occurred

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

As stressed in section 15.7.7.1, the RO – not the contractor – determines whether a CHOW has occurred (unless this function has been delegated). However, in processing the application, the contractor shall perform all necessary background research regarding whether: (1) a CHOW *may have* occurred, and/or (2) the new owner *is* accepting assignment of the Medicare assets and liabilities of the old owner. *Such research may include* reviewing the sales agreement or lease agreement, contacting the provider(s) to request clarification of the sales agreement, etc. *Note that an* RO CHOW determination is usually not required prior to the contractor making its recommendation.

While a CHOW is usually accompanied by *a tax identification number (TIN)* change, this is not always the case. There may be *isolated instances where* the TIN *remains* the same. Conversely, there may be cases where a provider is changing its TIN but not its ownership. In short, while a change of TIN (or lack thereof) is evidence that a CHOW *may or may not have* occurred, it is not the most important factor; rather, the change in the provider's ownership arrangement is. Hence, the *contractor should* review the sales/lease agreement closely, as this will help indicate whether a CHOW *may or may not have* occurred.

Note further:

- If the provider claims that the transaction in question is a stock transfer and not a CHOW, the contractor reserves the right to request any information from the provider to verify this (e.g., copy of the stock transfer agreement).

- *There may be instances where the contractor enters a particular transaction into the Provider Enrollment, Chain and Ownership System (PECOS) as a CHOW, but it turns out that the transaction was not a CHOW* (e.g., was a stock transfer; was an initial enrollment because the new owner refused to accept the Medicare liabilities). If the contractor cannot change the transaction type in PECOS, it can leave the record in a CHOW status; *however, it* should note in the provider's file that the transaction was not a CHOW.

15.7.7.1.3 - Processing CHOW Applications

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

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

A. Old Owners

The old owner's *Form* CMS-855A CHOW application does not require a recommendation for *approval. Any* recommendations will be based *on* the CHOW application received from the new owner.

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

If a certification statement is not on file for the old owner, the contractor shall request that section 6 be completed for the individual who is signing the certification *statement.*

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

B. New Owners

If a *Form* CMS-855A is not received from the new owner within 14 calendar days of receipt of the old owner's *Form* CMS-855A, the contractor shall contact the new owner. If the new owner fails to: (1) submit a *Form* CMS-855A and (2) indicate that it accepts assignment of the provider agreement, within 30 calendar days after the

contractor contacted it, the *contractor* shall stop payments unless the sale has not yet taken place per the terms of the sales agreement. Payments to the provider can resume once this information is received and the contractor ascertains that the provider accepts assignment.

C. Order of Processing

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

D. Sales and Lease Agreements

The contractor shall abide by the following:

- **Verification of Terms** - The contractor shall determine *whether: (1) the* information contained in the sales/lease agreement is consistent with that reported on the new owner's *Form* CMS-855A (e.g., same names), and *(2) the* terms of the contract indicate that the new owner will assume the provider agreement. In many cases, the sales/lease agreement will not specifically refer to the Medicare provider agreement. Clearly, if the box in section 2F is checked "*Y*es" and the sales/lease agreement either confirms that the new owner will assume the agreement or is relatively silent on the matter, the contractor can proceed as normal. Conversely, if the agreement indicates that the assets and liabilities will not be accepted, the contractor should *deny the application*.

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

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

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

*Unless specified otherwise in this chapter, b*oth the old and new owners must submit separate *Form* CMS-855A applications, as well as copies of the interim and final sales/lease agreements.

E. CHOWs Involving Subunits and Subtypes

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

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

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

F. Early Submission of CHOW Application

The contractor may accept Form CMS-855A CHOW applications *submitted up to 90 calendar days* prior to the anticipated date of *the ownership* change. Any application received more than 90 days *before* the projected sale date can be returned under section 15.8.1 of this chapter.

G. Unreported CHOW

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

If the contractor learns of the transaction via the receipt of a tie-in notice from the RO, it shall follow the instructions under "Receipt of Tie-In When CMS-855A Not Completed" in section 15.7.7.2 of this chapter.

H. Relocation of Entity

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

I. Transitioning to Provider-Based Status

Consistent with existing CMS policy, a provider undergoing a CHOW pursuant to 42 CFR § 489.18 may be assigned to a new contractor jurisdiction only if the provider is transitioning from freestanding to provider-based status. In such cases, the contractor for the new jurisdiction (the "new contractor") shall process both the buyer's and seller's Form CMS-855A applications. Should the "old" (or current) contractor receive the buyer's or seller's Form CMS-855A application, it shall: (a) forward the application to the new contractor within 5 business days of receipt, and (b) notify the new contractor within that same timeframe that the application was sent.

15.7.7.1.4 - Intervening CHOWs

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

In situations where: (1) the provider submits a *Form* CMS-855A initial application or CHOW application and (2) a *Form* CMS-855A CHOW application is later submitted but before the contractor has finished processing the first application, the contractor shall notify its Provider Enrollment Operations Group (PEOG) liaison immediately. To illustrate, suppose that the seller (X) and the buyer (Y) in a CHOW submit their respective *Form* CMS-855A applications on March 1. On March 30, Y and Z submit CHOW applications as the old and new owners, respectively, in a subsequent CHOW.

Assuming that it has not yet finished processing the March 1 applications, the contractor shall immediately refer the matter to its PEOG liaison.

15.7.7.1.5 – *Electronic Funds Transfer (EFT)* Payments and CHOWs

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

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

15.7.7.1.6 – Pre-Approval *Changes of Information*

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

A. Seller

If – prior to the issuance of the tie-in notice – the contractor receives from the seller a *Form* CMS-855 request to change any of the provider's enrollment data, the contractor *shall reject the change request* if the information in question involves changing the provider's:

1. Electronic funds transfer or special payment address information to that of the buyer (as described in section 15.7.7.1.5 of this chapter*)*

2. Practice location or base of operations to that of the buye*r*

3. Ownership or managing control to that of the buye*r*

4. *Legal business name, tax identification number, or "doing business as"* name to that of the buyer.

All other *"pre-tie-in notice" Form* CMS-855 change requests *from the seller* can be processed normally.

B. Buyer

If – prior to the issuance of the tie-in notice – the contractor receives from the buyer a *Form* CMS-855 request to change any of the provider's existing enrollment information, the contractor shall *reject the change request.* Until the tie-in *notice* is issued, the seller remains the owner of record. *H*ence, the buyer has no standing to submit *Form* CMS-855 changes on behalf of the provider.

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

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

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

A tie-in or tie-out notice (CMS-2007) *is* generally issued in the following circumstances:

1. Initial enrollments

2. CHOWs

3. Voluntary terminations

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

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

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

B. *Form* CMS-855 Changes of Information

1. Referrals to State/RO

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

- Addition of *outpatient physician therapy/outpatient speech pathology* extension sit*e*
- Addition of hospice satellite
- Addition of *home health agency* branch
- Change in type of *Prospective Payment System (PPS)*-exempt uni*t*
- Conversion of a hospital from one type to another (e.g., acute care to psychiatric*)*
- Change in practice location or subunit address in cases where a survey of the new site is require*d*

- Stock transfer

In these situations, the *Provider Enrollment, Chain and Ownership System (PECOS)* record should not be switched to "approved" until the contractor receives notice from the RO that the latter *has authorized* the change/addition.

2. Post-Approval RO Contact Required

*Form CMS-855A c*hanges that do not mandate a recommendation to the State/RO but do require post-approval correspondence with the RO include:

- Deletions/*v*oluntary *t*erminations of practice locations or *hospital* subunits
- *Legal business name, tax identification number, or "doing business as name"* changes that do not involve a CHOW
- Address changes that do not require a survey of the new locatio*n*
- Addition of hospital practice location

For these transactions, the contractor shall: *(1)* notify the provider via letter, *fax,* e-mail, or telephone that the change has been made, and *(2)* switch the PECOS record to "approved." The contractor shall also notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction. Such notice to the State/RO *shall* specify the type of information that is changing.

3. All Other Changes of Information

For all *Form* CMS-855A change requests not identified in (B)*(1)* or (B)*(2)* above, the contractor shall notify the provider via letter, *fax,* e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The State and RO need not be notified of the change.

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

In situations where the provider submits a: (1) *Form* CMS-855A reactivation, (2) *Form* CMS-855A revalidation, or (3) full *Form* CMS-855A as part of a change of information (i.e., the provider *has no* enrollment record in PECOS), the contractor shall make a recommendation to the State/RO and switch the PECOS record to "approval recommended" only if the application contains new/changed data falling *within one of the categories in* (B)(1) above. For instance, if a revalidation application reveals a new hospital psychiatric unit that *was never* reported to CMS via the *Form* CMS-855A, the contractor shall make a recommendation to the State/RO and await the RO's approval before switching the record to "approved." In this situation, the contractor should

forward *the application* to the State with a note explaining that the only matter the State/RO needs to consider is the new hospital unit.

If the application contains new/changed data falling within *one of the categories in (B)(2) above*, the contractor can switch the PECOS record to "approved." It shall also notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed processing the transaction.

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

If the contractor receives a tie-in notice *or approval letter from the RO* for a transaction/change regarding information that is not collected on the *Form* CMS-855*A,* the *contractor need* not *ask* the provider to submit a *Form* CMS-855*A* change of information.

D. Involuntary Termination Prompted by State/RO

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

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

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

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

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

4. Creation of New *Logging and Tracking (L & T)* Record Unnecessary - The contractor is not required to create a new L & T record in PECOS when the tie-in notice

arrives, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.

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

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

15.7.7.3 - Out-of-State Practice Locations for Certified Providers

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

*T*he question of whether a *Form* CMS-855A *must* be completed for each State in which the provider performs services depends on three things: (1) State law, (2) the contractor

jurisdictions involved, and (3) how the RO(s) wants to handle the *particular* situation. Consider the following scenarios:

A provider is enrolled in State X and now wants to perform services in State Y.

1. Assume that X & Y are in the same contractor jurisdiction. If State Y requires an entity performing services in Y to be surveyed or the RO says that the provider must sign a separate provider agreement and obtain a separate *CMS Certification Number (CCN)* for its State Y services, the provider must submit an initial *Form* CMS-855A application for State Y in order to be a provider in that *S*tate. If a separate enrollment is not required, the provider would simply submit a *Form* CMS-855A *change request* that adds the out-of-state location.

2. Assume that X & Y are not in the same contractor jurisdiction. *T*he provider must submit an initial *Form* CMS-855A application to the State Y contractor - regardless of whether a separate survey, *provider* agreement, or *CCN is* needed.

In short, if a provider in one State wishes to perform services in another State and the latter State is serviced by a different contractor, a new enrollment is required with that contractor. If both States are in the same contractor jurisdiction, a *Form* CMS-855*A* initial application *or change request* is necessary; whether an initial application or a change request is required will depend on State law and what the RO says. In either case, the contractor must create *separate* enrollment record*s* in *the Provider Enrollment, Chain and Ownership System* for each Stat*e.*

15.7.7.4 - State Surveys and the Form CMS-855A

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

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

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

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

NOTE: If the applicant is a *home health agency (HHA)*, it must resubmit capitalization data *per* section 12 of the *Form* CMS-855A *regardless* of whether any of the provider's other *Form* CMS-855A information has changed. To illustrate, if no *Form* CMS-855A data has changed, the HHA must submit the letter, capitalization data and the signed certification statement.

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

15.7.7.5 - Sole Proprietorships

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

If the provider indicates in section 2B1 of the *Form* CMS-855A that he/she is a sole proprietor, the contractor shall note the following:

- The *legal business name* in section 2B1 should list the person's (the sole proprietor's) legal name.
- The *tax identification number* in section 2B1 should list the person's *social security number.*

- Section 3 of the *Form* CMS-855A must be completed with information about the individual's *final adverse action* history.

- Section 5 of the *Form* CMS-855A will not apply unless the person has hired an entity to exercise managerial control over the business (i.e., no owners will be listed in section 5, as the sole owner has already reported his/her personal information in sections 2 and 3).

- No owners, partners, or directors/officers need *to* be reported in section 6. However, all managing employees (whether W-2 or not) must be listed.

- The sole proprietor may list multiple authorized or delegated officials in section*s* 15 and 16.

Since most sole proprietorships that complete the *Form* CMS-855A will also have *an employer identification number*, the contractor shall request from the provider a copy of its CP-575.

15.7.7.6 - Additional Form CMS-855A Processing Instructions

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

A. Non-Enrollment Functions

In some instances, the contractor cannot forward an application to the State until it performs certain non-enrollment functions pertaining to th*e* application (e.g., the reimbursement unit needs to examine patient listing data). The contractor may flip the *provider's* status *in the Provider Enrollment, Chain and Ownership System (PECOS)* to "approval recommended" prior to the conclusion of *the* non-enrollment *activity if: (1) all required enrollment actions have been completed, and (2) the non-enrollment action is the only remaining activity to be performed.*

B. Multiple Providers under a Single Tax Identification Number (TIN)

Multiple providers may have the same TIN. However, each provider must submit a separate *Form* CMS-855A *application and* the contractor must create a separate enrollment record for each.

C. Future Effective Dates

If the contractor cannot enter *an* effective *date* into PECOS because the provider, practice location, etc., is not yet established, the contractor may use the authorized official's date of signature as the temporary effective date. Once the actual effective date is established (e.g., the tie-in notice is received), the contractor *shall change the effective date in PECOS.*

15.7.7.7 – *Contractor* Jurisdiction Issues

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

A. Audit and Claims *Contractors*

1. Background

For purposes of enrollment *via the Form CMS-855A*, there are generally two categories of *contractors*: audit *contractors* and claims *contractors*. The audit contractor enrolls the provider, conducts audits, etc. The claims contractor pays the provider's claims. In most cases, the provider's audit contractor and claims contractor will be the same. On occasion, *though*, they will *differ*; this *can happen, for instance,* with provider-based entities, whereby the provider's enrollment application will be processed by the parent provider's contractor (audit contractor) and its claims will be paid by a different contractor (claims contractor).

Should the audit and claims *contractors* differ, the audit contractor shall process all changes of information, including all *Form CMS-588* changes. The audit contractor shall notify the applicant during the initial enrollment process that all future changes of information must be sent to the audit contractor, not the claims *contractor. If* the provider inadvertently sends *a change request to* the claims contractor, the latter shall return the application per section 15.8.1 of this chapter.

2. Process

Once the audit contractor finishes processing the *Form* CMS-855A initial enrollment application, *change request*, voluntary termination, *etc., it shall send an e-mail to the claims contractor identifying the specific Form CMS-855A transaction involved and confirming that the information has been updated in the Provider Enrollment, Chain and Ownership System (PECOS).* Pertinent identifying information*,* such as the *provider name, CMS Certification Number and National Provider Identifier,* should be included on the e-mail notification. Any supporting documentation that may contain *p*ersonal *h*ealth *i*nformation or *p*ersonally *i*dentifiable *i*nformation*,* such as *e*lectronic *f*unds *t*ransfer data*,* may still be faxed to the claims contractor.

Upon receipt of the e-mail notification, the claims contractor shall *access PECOS, review the enrollment record, and, as needed,* update its records accordingly.

The audit contractor *shall keep* the original copies *of the* Form CMS-855*A* paperwork and supporting documentation.

3. Tie-In/Tie-Out Notices and Approval Notices

If the provider's audit contractor and claims contractor are different, the audit contractor shall e-mail *or fax* a copy of all *tie-in/tie-out notices and approval letters* it receives to the claims *contractor. Thi*s is to ensure that the claims contractor is fully aware of the RO's action, as some ROs may only send copies of *tie-in/tie-out notices*

and approval letters to the audit contractor. If the audit contractor chooses, it can simply contact the claims contractor by phone or e-mail and ask if the latter received the tie-in notice.

Again, it is imperative that audit and claims *contractors* effectively communicate and coordinate with each other in all payment-related and program integrity matters involving the provider.

B. Provider Nomination

With respect *to provider* nomination and changes of *contractors*, the contractor shall *follow* the instructions in Pub. 100-04, chapter 1, sections 20 through 20.5.1.

If *the* contractor receives a request from a provider to change its existing contractor, it shall refer the provider to the RO contact person responsible for contractor assignments.

15.7.8 – Special *Processing Guidelines for* Independent CLIA Labs, Ambulatory Surgical *Centers and* Portable X-ray Suppliers

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

Unless otherwise stated, all references to the "RO" in sections 15.7.8.2 through 15.7.8.5 of this chapter refer to the RO's survey & certification staff.

15.7.8.1 - CLIA Labs

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

Labs that are "integrated" into an existing provider or supplier do not require a separate *Form* CMS-855B enrollment. "Integrated" labs *typically are* those that have exactly the same ownership and physical location as another enrolled supplier or provider. (Common examples include: (1) hospital labs and (2) a lab at a physician's office.) If a lab is *considered* "integrated," the parent provider shall identi*f*y the lab as a practice location in section 4 of its *Form* CMS-855.

If the lab is not "integrated," the lab must enroll as an independent CLIA lab via the *Form* CMS-855B application. The contractor shall advise the lab that it must contact the applicable CLIA office; the lab cannot be enrolled until it receives a CLIA number. The contractor shall also ensure that the lab *is CLIA-certified and, as applicable, State-licensed.*

Labs that do not plan to participate in the Medicare program must be directed to the applicable CLIA office.

For more information on the enrollment of CLIA labs, refer to section 15.4.2.2 of this chapter.

15.7.8.2 – *Ambulatory Surgical Centers (ASCs)* and Portable X-ray Suppliers (PXRS) - *Initial Enrollment*

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

Unlike other supplier types that enroll *via the Form CMS-855B*, ASCs and PXRSs must receive a State survey *and RO* approval before they *can enroll* in Medicare. *Accordingly,* once it finishes reviewing the supplier's application, the contractor *may* only make a recommendation for *approval to* the State. The contractor shall not enroll the *supplier until* it *receives a tie-in notice or approval letter from the RO and – in the case of PXRSs - a follow-up site visit is performed per section 15.4.2.5 of this chapter.*

When enrolling the ASC or PXRS, the contractor shall use the effective date that is indicated on the tie-in notice/approval letter. This is the date from which the supplier can bill for services.

15.7.8.*3* – *Ambulatory Surgical Centers (ASCs)/Portable X-ray Suppliers (PXRS)* Changes of Ownership (CHOWs)

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

Though ASCs and PXRSs are *not mentioned* in 42 CFR § 489.18, CMS generally applies the change of ownership (CHOW) provisions of § 489.18 to *them.* CHOWs involving ASCs and PXRSs are *thus* handled in accordance with the principles *in §* 489.18 and Publication 100-07, chapter 3, sections 3210 through 3210.5(C). Note that the *RO – not the contractor – determines whether a* CHOW has occurred (unless this function has been delegated).

As *discussed in* sections 15.4.2.1 and 15.4.2.5 of this chapter, an ASC must sign a supplier agreement with Medicare prior to *enrollment. PXRSs* have no such *requirement. However, the contractor shall* – unless *CMS instructs* otherwise – *process Form CMS-855B ASC CHOW applications* in the same manner as PXRS CHOW *applications.*

15.7.8.*3.1* - *Exam*ining Whether a *Change of Ownership (CHOW) May Have* Occurred

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

A. Review of Sales Agreement

As stated in section 15.7.8.3, the RO – not the contractor – determines whether a CHOW has occurred.

If the "Change of Ownership" box in section 1B of the *Form* CMS-855B is checked, the contractor shall ensure that the entire application is completed and that the supplier submits a copy of the sales agreement. The contractor shall review the sales agreement to *see* whether:

1. The ownership change *may qualify* as a CHOW under the principles *of §489.18* and *Publication* 100-07, chapter 3, section 3210.1D.

2. Its terms indicate that the new owner will be accepting assignment of the Medicare assets and liabilities of the old owner.

3. The information contained in the agreement is consistent with that reported on the new owner's *Form* CMS-855B (e.g., same names).

If the sales agreement is unclear as to issues 1 and 2 above, the contractor shall request clarifying information from the supplier. (Note that some sales agreements may *not* specifically refer to Medicare supplier agreements, assets, and/or liabilities; *hence, the agreement should be examined* in its totality.) The information shall be in the form of additional legal documentation or a letter. If the *clarification requires* an update to the supplier's *Form* CMS-855B application, the contractor shall *request this update*. In addition, if the contractor discovers discrepancies between the data in the sales agreement and that on the *Form* CMS-855B (issue 3 above); the contractor shall *request* clarifying information and, if necessary, obtain an updated *Form* CMS-855B.

In reviewing the application and the sales agreement, the contractor shall *note* the following:

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

- While a CHOW is usually accompanied *by a tax identification number (TIN)* change, this is not always the case. *T*here may *be isolated* instances *where* the TIN remains the same. Conversely, there may be cases where a supplier is changing its TIN but not its ownership. *Thus,* while a change of TIN (or lack thereof) is evidence that a CHOW *may or may not have* occurred, it is not the most important factor; rather, the change in the provider's ownership structure is.

- *The contractor may accept Form* CMS-855B CHOW applications *submitted up to 90 calendar days* prior to the anticipated date of *the ownership* change. Any application received more than 3 months *before* the projected sale date shall be returned under section 15.8.1 of this chapter.

- *A*n ASC or PXRS may submit a *Form* CMS-855B *change request* to report a large-scale stock transfer or other significant ownership change that the supplier does not believe qualifies as a CHOW. If the contractor *suspects* that the *transaction may* indeed be a CHOW, it shall request clarifying information (e.g., copy of the stock transfer agreement).

- *An RO CHOW determination is usually not required prior to the contractor making its recommendation.*

B. *Disposition*

As already indicated, the contractor shall perform all necessary background research to determine whether: (1) a CHOW may have occurred, and (2) the new owner is accepting assignment of the Medicare assets and liabilities of the old owner. Once this is completed, the contractor shall abide by the following:

1. Scenario 1

If the contractor believes that a CHOW *has likely* occurred but the new owner is not accepting the assets and liabilities of the old owner, the contractor shall treat the ASC/PXRS as a brand new supplier. It shall notify the ASC/PXRS that it must submit: (1) a *Form* CMS-855B *that voluntarily terminates* the "old" facility, and (2) a *Form* CMS-855B initial enrollment for the "new" facility.

2. Scenario 2

If the contractor believes that a CHOW has *likely occurred and the* new owner is accepting the old owner's assets and liabilities, it shall process the application normally and*, if warranted,* make a recommendation for *approval to* the State (with a cc: to the RO). If the *apparent CHOW was* accompanied by a change in TIN, the transaction must be treated as a CHOW notwithstanding the general rule *for Form CMS-855B submissions* that a TIN change constitutes an initial *enrollment.*

Under scenario 2, the contractor shall not forward a copy of the CHOW application to the State agency until it has received and reviewed the final sales agreement. (In some cases, the supplier may submit an interim sales agreement with its application. *Though this is acceptable, the supplier must still submit a final agreement.)* If the final sales agreement is not submitted within 90 days after the contractor's receipt of *the CHOW* application, the contractor shall reject the application. Though the contractor must wait until the 90th day to reject the application, the contractor may do so regardless of how many times it contacted the new owner or what type*s* of responses (short of the actual receipt of the sales agreement) were obtained.

3. Scenario 3

If the contractor believes that a CHOW has *likely* not occurred and that the transaction *is merely* an ownership change (e.g., minor stock transfer) that does not qualify as *a § 489.18*-type CHOW, the transaction must be reported as a change of information. The only *exception is if* the change of information was accompanied by a change of TIN, in which case the supplier must enroll as a new entity.

Note that it is not uncommon for a supplier to undergo a financial or administrative change that it considers to be a CHOW but does not *actually qualify as such.*

C. CHOWs and Address Changes

A new owner may propose to relocate the supplier concurrent with a CHOW. If the relocation is *to a* different geographic area serving different clients than previously served and employing different personnel to serve those clients, the contractor shall notify the RO immediately. Unless the RO dictates otherwise, the supplier shall - per Pub*lication* 100-7, chapter 3, section 3210.1(B)(5) - treat the transaction as an initial enrollment (and the supplier as a new applicant), rather than as an address change of the existing supplier.

15.7.8.3.2 – Electronic Funds Transfer (EFT) Payments and CHOWs

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

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

If – pursuant to the CHOW – the seller submits a Form CMS-855B voluntary termination application, the contractor shall contact and explain to the seller that the ambulatory surgical center/portable x-ray supplier will not receive any payments until the RO approves the CHOW. (This is because payments must be sent to the seller until the tie-in/approval letter is sent). If the seller insists that its application be processed, the contractor shall process it; however, it shall first notify the facility/new owner and explain that payments will cease once the seller's termination is effective.

15.7.8.*4* – *Ambulatory Surgical Centers (ASCs)/Portable X-ray Suppliers (PXRS) Tie-In/Tie-Out Notices and Referrals to the State/RO*

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

(For purposes of this section 15.7.8.*4*, the terms "tie-in notices" and approval letters will be collectively referred to as tie-in notices. "Tie-out notices" are notices from the RO to the contractor that, in effect, state that the *ASC's/PXRS's participation in Medicare* should be terminated.)

A. Issuance of Tie-*I*n/Tie-*O*ut *Notices*

A tie-in or tie-out notice is generally issued in the following circumstances:

1. Initial enrollment*s*
2. CHOW*s*

3. Voluntary terminations

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

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

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

B. *Form* CMS-855B Changes of Information

1. **Referrals to State/RO**

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

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

In these situations, the *Provider Enrollment, Chain and Ownership System (PECOS)* record should not be switched to "approved" until the contractor receives notice from the RO that the latter *has authorized* the change/addition.

2. **Post-Approval RO Contact Required**

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

- Deletions/voluntary terminations of practice locations or subunits
- *Legal business name, tax identification number or "doing business as"* name changes that do not involve a CHOW
- Address changes that do not require a survey of the new location

For these transactions, the contractor shall: *(1)* notify the supplier via letter, *fax,* e-mail, or telephone that the change has been made, and *(2)* switch the PECOS record to "approved." The contractor shall also notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 calendar days after it has completed

processing the transaction. *The* notice to the State/RO *shall* specify the type of information that is changing.

3. All Other Changes of Information

For all *Form* CMS-855B change requests not identified in *(B)*(1) or *(B)*(2) above, the contractor shall notify the supplier via letter, *fax,* e-mail, or telephone that the change has been made and shall switch the PECOS record to "approved." The State and RO need not be notified of the change.

4. Revalidations, Reactivations and Complete CMS-855 Applications

In situations where the provider submits a: (1) *Form* CMS-855B reactivation, (2) *Form* CMS-855B revalidation, or (3) full *Form* CMS-855B as part of a change of information (i.e., the supplier *has no* enrollment record in PECOS), the contractor shall make a recommendation to the State/RO and switch the record to "approval recommended" only if the application contains new/changed data falling *within one of the categories in (B)(1)* above. For instance, if a revalidation application reveals a new practice location that *was never reported* to CMS via the *Form* CMS-855B, the contractor shall make a recommendation to the State/RO and await the RO's approval before switching the record to "approved." In this situation, the contractor should forward *the application* to the State with a note explaining that the only matter the State/RO needs to consider is the new location.

If the application contains changed data falling *within one of the categories in (B)(2)* above, the contractor can switch the PECOS record to "approved." The contractor shall also notify the State and RO of the changed information (via any mechanism it chooses, including copying the State/RO on the notification letter or e-mail) no later than 10 days after it has completed processing the transaction.

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

If the contractor receives a tie-in notice *or approval letter* for a *transaction that concerns information not* collected on the *Form* CMS-855B application, *the contractor need not ask* the supplier to submit a *Form* CMS-855B change of information.

D. Involuntary Termination Prompted by State/RO

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

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

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

If the contractor receives a tie-in notice *or approval letter* from the RO but the supplier never completed the necessary *Form CMS-855B,* the contractor shall have the supplier complete and submit said *form.* This applies to initial applications, CHOWs, practice location additions, etc., but does not apply to the cases described in subsection C above.

2. Delegation to State Agency

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

3. Review for Consistency

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

4. Creation of New *Logging and Tracking (L & T)* Record Unnecessary

The contractor is not required to create a new L & T record in PECOS when the tie-in notice *or approval letter arrives*, as the existing record should not be in a final status and can therefore be modified. Simply changing the L & T status is sufficient.

5. *Supplier* Inquiries

Once the contractor *makes its* recommendation for approval to the State/RO, any inquiry the contractor receives from the *supplier* regarding the status of its request for Medicare participation shall be referred to the State or RO.

6. Timeframes

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

15.7.8.*5* - Out-of-State Practice Locations for Certified Suppliers

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

The question of whether a *Form* CMS-855B *must* be completed for each State in which *the supplier* performs services depends on three things: (1) State law, (2) the contractor jurisdictions involved, and (3) how the RO(s) wants to handle the *particular* situation. Consider the following scenario:

A supplier is enrolled in State X and now wants to perform services in State Y:

1. Assume that X & Y are in the same contractor jurisdiction. If State Y requires an entity performing services in Y to be surveyed or if the RO says that the supplier must sign a separate supplier agreement *and be separately certified*, the supplier must submit an initial *Form* CMS-855B application for State Y in order to be a *supplier* in that *S*tate. If a separate enrollment is not required, the supplier can simply submit a *Form* CMS-855B change *request that* adds the out-of-state location.

2. Assume that States X & Y are not in the same contractor jurisdiction. *T*he supplier must submit an initial *Form* CMS-855B application to the State Y contractor - irrespective of whether a separate survey, *agreement or certification* is needed.

In short, if *a supplier* wants to perform services in another State that is serviced by another contractor, a new enrollment with that contractor is required. If both States are in the same contractor jurisdiction, a *Form* CMS-855B initial application or a *Form* CMS-855B change *request is* necessary; whether an initial enrollment or a change request is required will depend on State law and what the RO says. In either case, the contractor must create *separate* enrollment record*s* in *the Provider Enrollment, Chain and Ownership System for each State.*

15.7.8.6 - State Surveys and the Form CMS-855B

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

A. Delay in State Survey

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

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

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

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

B. Future Effective Dates

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

15.21.1.1 – Compliance Standards for Pharmacy Accreditation

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

The National Supplier Clearinghouse (NSC) shall not require that a pharmacy be accredited as a condition of enrollment before January 1, 2011.

The NSC-Medicare Administrative Contractor (MAC) shall determine which enrolled suppliers are pharmacies that are not accredited and who will be enrolled for 5 calendar years prior to January 1 of the next calendar year. The NSC-MAC shall then send a notice of revocation by January 10, 2011, to all enrolled pharmacies that are not accredited and who will not be enrolled for 5 calendar years as of January 1, 2011.

The NSC-MAC shall prepare a letter which enables all individually enrolled practice locations of pharmacies who have been enrolled for 5 calendar years prior to January 1, 2011, to attest that they are exempt from the requirement to be accredited because their total durable medical equipment, prosthetics orthotics and supplies (DMEPOS) billings subject to accreditation are less than 5 percent of their total pharmacy sales, as determined based upon the total pharmacy sales of the pharmacy for the previous 3 calendar or fiscal years. The letter shall cite that the attestation requires the signature of the authorized or delegated official of the entity. The authorized and delegated officials are defined in Section 15, of the Medicare Enrollment Application (CMS-855S), and as described in the internet enrollment application version of the Provider Enrollment, Chain and Ownership System (PECOS). Before mailing the letters, the NSC-MAC shall obtain NSC project officer approval of the letter. The mailing shall be in the form of an endorsement letter with an enclosed stamped self addressed envelope. The mailing should be performed between October 1, 2010 and October 31, 2010. For pharmacies with more than one practice location, the letters shall cite the need for each individually enrolled practice location to attest that they are exempt from the accreditation requirements. New locations of enrolled chain pharmacies shall not be considered to have been enrolled for 5 calendar years. Pharmacies that have had a change of ownership in the prior 5 years which resulted in a change in their legal business entity, including a change in their tax identification number (TIN), shall not qualify for an attestation accreditation exemption and therefore shall not be sent the attestation letter.

The NSC-MAC shall review the attestations received from pharmacies. Pharmacies that properly signed the attestation letter shall be given an accreditation status of exempt. The NSC shall make attempts to assist and follow-up with pharmacy suppliers that have not submitted or properly completed their attestations. The NSC-MAC shall send a notice of revocation by January 10, 2011, to all enrolled pharmacies who were sent an attestation letter and have not properly completed it as of the date of the notice of revocation. The notice of revocation shall cite that the revocation is for a lack of required accreditation.

Between April 1, 2011 and April 30, 2011, the NSC-MAC shall compile a sample listing of at least 10 percent of the pharmacies that have submitted an NSC accepted attestation exempting them from accreditation. The NSC-MAC shall develop a letter to be sent to pharmacies that will be audited to determine if their accreditation exemption attestations are correct. The letter shall request submission of evidence substantiating that the validity of the pharmacy supplier's attestation. At a minimum, requested materials for this evidence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods. The NSC-MAC shall obtain NSC project officer approval of the letter. Within 45 days after project officer approval of the letter the NSC-MAC shall mail a copy of the letter to the random sample of pharmacies which claimed exemption through an attestation. The NSC-MAC shall determine the acceptability of the replies received in response to the audit verification random sample mailing. The NSC shall use DMEPOS billing data for only products and services requiring accreditation to assist in the determination. The NSC shall make attempts to assist and follow-up with pharmacy suppliers that have not submitted or properly completed their audit verifications. The NSC-MAC shall consult with the NSC project officer in cases where they are uncertain as to the acceptability of the supplier's response to the audit request. By June 30, 2011, the NSC-MAC shall send a notice of revocation to all enrolled pharmacies that were sent an audit verification letter who did not submit satisfactory evidence that they were in compliance with the requirements to obtain an accreditation exemption. The notice of revocation shall cite that the revocation is for a lack of required accreditation.

The NSC-MAC shall follow the procedures shown above concerning issuance of attestation letters and audit survey letters for all succeeding years after they have been performed for the first time.

15.22 – Customer Service/Outreach

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

15.22.1 – Web Sites

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

The contractor must provide a link to CMS' provider/supplier enrollment Web site located at http://www.cms.hhs.gov/MedicareProviderSupEnroll . The link shall: (1) be available on the contractor's existing provider outreach Web site (which should be an established sub-domain of the contractor's current commercial Web site), and (2)

comply with the guidelines stated in the Provider/Supplier Information and Education Web site section (Activity Code 14101) under the Provider Communications (PCOM) Budget and Performance Requirements (BPRs). Bulletins, newsletters, seminars/workshops and other information concerning provider enrollment issues shall also be made available on the existing provider outreach Web site. All contractor Web sites must comply with section 508 of the Rehabilitation Act of 1973 in accordance with, 36 CFR §1194, and must comply with CMS' Contractor Web site Standards and Guidelines posted on CMS's Web site.

The CMS Provider/Supplier Enrollment Web site, http://www.cms.hhs.gov/MedicareProviderSupEnroll, furnishes the user with access to provider/supplier enrollment forms, specific requirements for provider/supplier types, manual instructions, frequently asked questions (FAQs), contact information, hot topics, and other pertinent provider/supplier information. The contractor shall not duplicate content already provided at the CMS provider/supplier enrollment Web site, and shall not reproduce the forms or establish the contractor's own links to forms. It shall, however, have a link on its Web site that goes directly to the forms section of the CMS provider/supplier enrollment site.

On a quarterly basis, each contractor shall review and provide updates regarding its contact information shown at URL:

http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf

If the contractor services several States with a universal address and telephone number, the contractor shall report that information. In situations where no actions are required, a response from the contractor is still required (i.e., the contact information is accurate). In addition, only such information that pertains to provider enrollment activity for the contractor's jurisdiction is to be reported. All updates shall be sent directly via e-mail to the contractor's Provider Enrollment Operations Group Business Function Lead.

15.22.2 – Provider Enrollment Inquiries

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

The contractor's customer service unit may handle provider enrollment inquiries that do not involve complex enrollment issues. Examples of inquiries that can be processed by customer service units include:

- *Application status checks (e.g., "Has the contractor finished processing my application?") (The contractor may wish to establish electronic mechanisms by which providers can obtain updates on the status of their enrollment applications via the contractor's Web site or automated voice response (AVR).*

- *Furnishing information on where to access the Form CMS-855 applications (and other general enrollment information) on-line*

- *Explaining to providers/suppliers which Form CMS-855 applications should be completed.*

The contractor is strongly encouraged to establish e-mail "list serves" with the provider community to disseminate important information thereto, such as contractor address changes, new CMS enrollment policies or internal contractor procedures, reminders about existing policies, etc. By being proactive in distributing information to its providers and suppliers on a regular basis (e.g., weekly, bi-weekly), the contractor can reduce the number of policy inquiries it receives and help facilitate the submission of complete and accurate Form CMS-855 applications.

15.23 – Document Retention

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

15.23.1 - Security

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

The contractor shall ensure that the highest level of security is maintained for all systems and its physical and operational processes, in accordance with the CMS/Business Partners Systems Security Manual (BPSSM) and the Program Integrity Manual.

Applications shall never be removed from the controlled area to be worked on at home or in a non-secure location. Additionally, provider enrollment staff must control and monitor all applications accessed by other contractor personnel.

All contractor staff shall be trained on security procedures as well as relevant aspects of the Privacy Act and the Freedom of Information Act. This applies to all management, users, system owners/managers, system maintainers, system developers, operators and administrators - including contractors and third parties - of CMS information systems, facilities, communication networks and information.

Note that these instructions are in addition to, and not in lieu of, all other instructions issued by CMS regarding security.

15.23.2 – Release of Information

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

On October 13, 2006, CMS published System of Records Notice for the Provider Enrollment, Chain and Ownership System (PECOS) in the Federal Register. Consistent with this notice, once the provider has submitted an enrollment application (as well as after it has been enrolled), the contractor shall not release – either orally or in writing - provider-specific data to any other person or entity. This includes, but is not limited to, national or State medical associations or societies, clearinghouses, billing agents, provider associations, or any person within the provider's organization other than the provider's authorized official (section 15 of the CMS-855), delegated

official (section 16) or contact person (section 13). The only exceptions to this policy are:

- *A routine use found in the aforementioned System of Records applies.*

- *The provider (or, in the case of an organizational provider, an authorized or delegated official): (1) furnishes a signed written letter on the provider's letterhead stating that the release of the provider data is authorized, and (2) the contractor has no reason to question the authenticity of the person's signature.*

- *The release of the data is specifically authorized in some other CMS instruction or directive.*

(These provisions also apply in cases where the provider requests a copy of any Form CMS-855 paperwork the contractor has on file.)

It is recommended that the contractor notify the provider of the broad parameters of the aforementioned policy as early in the enrollment process as possible.

In addition:

- *When sending e-mails, the contractor shall not transmit sensitive data, such as social security numbers or employer identification numbers.*

- *The contractor may not send PECOS screen printouts to the provider.*

- *The contractor shall not send an individual's provider transaction access numbers (PTAN) to a group or organization (including the group's authorized or delegated official). If a group/organization needs to know an individual provider's PTAN, it must contact the provider directly for this information or have the individual provider request this information in writing from the contractor. If the individual provider requests his/her PTAN number, the contractor can mail it to the provider's practice location. The contractor should never give this information over the phone.*

15.23.3 – File Maintenance

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

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

Supporting documentation includes, but is not limited to:

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

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

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

- *Copies of CLIA certificates and FDA mammography certificates.*

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

1) Provider/Supplier and Durable Medical Equipment Supplier Application

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

Disposition: Destroy when 7 years old.

b. Approved applications of provider/supplier

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

c. Denied applications of provider/supplier.

Disposition: Destroy 15 years after the date of denial.

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

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

e. Voluntary deactivation of billing number

Disposition: Destroy 15 years after deactivation.

f. Provider/Supplier dies

Disposition: Destroy 7 years after date of death.

2) Electronic Mail and Word Processing System Copies

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

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

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

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

15.26.3 – Additional *Home Health Agency (HHA)* Review Activities

(Rev.423, Issued: 06-01-12, Effective: 07-02-12, Implementation: 07-02-12)

As stated in section 15.26.2(B)(3) of this chapter, the contractor must verify that a newly *enrolling 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 confirm that the HHA is still in compliance with Medicare enrollment requirements prior to the issuance of a provider agreement, the contractor shall *also* – during the post-RO review period *ensure that* each entity and individual listed in sections 2, 5 and 6 of the HHA's *Form* CMS-855A application *is again reviewed* 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: *(1)* regardless of whether the HHA is provider-based or freestanding, and *(2) o*nly to initial enrollments.

The capitalization *and* MED/GSA *re-reviews* described above shall be performed once the RO notifies the contractor *via e-mail* that the RO's review is complete. *(Per sections 15.4.1.6 and 15.19.2.2 of this chapter, a site visit will be performed after the contractor receives the tie-in/approval notice from the RO but before the contractor conveys Medicare billing privileges to the HHA.) If:*

a. The HHA is still in compliance *(e.g., no owners or managing employees are excluded, capitalization is met):*

1. *The contractor shall notify the RO of this via e-mail. The notice shall specify the date on which the contractor completed the aforementioned reviews.*

2. *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 Publication 100-08, chapter 10, section 5.5.3.1, the contractor shall complete its processing of the tie-in notice/approval letter within 45 calendar days of receipt (during which time a site visit will be performed).*

b. The HHA is not in compliance *(e.g., capitalization is not met):*

1. *The contractor shall notify the HHA of this via letter. This letter is not a formal*

denial, but merely alerts the HHA that (a) it has not met the capitalization or MED/GSA list requirements (as applicable) and (b) the matter is being referred to the RO.

2. *T*he 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 its capitalization and MED/GSA 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.

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