CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 462	**Date: May 16, 2013**
	Change Request 8155

NOTE: Transmittal 450, dated February 13, 2013, is being rescinded and replaced by Transmittal 462, dated May 16, 2013, to remove section 15.5.20. All other information remains the same.

SUBJECT: Update to Chapter 15 of the Program Integrity Manual (PIM)

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to address in Publication 100-08, chapter 15, various policy issues that have recently arisen.

EFFECTIVE DATE: March 18, 2013

IMPLEMENTATION DATE: March 18, 2013

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/Table of Contents
R	15/15.4/Provider and Supplier Types/Services
R	15/15.4.2.3/Mammography Screening Centers
R	15/15.5.5/Owning and Managing Organizations
R	15/15.5.6/Owning and Managing Individuals
R	15/15.7.5/Special Program Integrity Procedures
R	15/15.7.7.1.4/Intervening Change of Ownership (CHOW)
R	15/15.8.1/Returns
R	15/15.8.2/Rejections
R	15/15.9.1/Non-Certified Suppliers and Individual Practitioners
R	15/15.10.1/Changes of Information - General Procedures
R	15/15.11/Electronic Fund Transfers (EFT)
R	15/15.19.1/Application Fees
R	15/15.25.1.1/Corrective Action Plans (CAPs)
R	15/15.26.1/HHA Ownership Changes
R	15/15.27.1/Deactivations and Reactivations
R	15/15.27.3.1/Zone Program Integrity Contractor (ZPIC) Identified Revocations

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor's 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 obliged 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 Instructions

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-08	Transmittal: 462	Date: May 16, 2013	Change Request: 8155

NOTE: Transmittal 450, dated February 13, 2013, is being rescinded and replaced by Transmittal 462, dated May 16, 2013 to remove section 15.5.20. All other information remains the same.

SUBJECT: Update to Chapter 15 of the Program Integrity Manual (PIM)

EFFECTIVE DATE: March 18, 2013
IMPLEMENTATION DATE: March 18, 2013

I. GENERAL INFORMATION

A. Background: The purpose of this change request (CR) is to address in Publication 100-08, chapter 15, various provider enrollment policy issues that have arisen.

B. Policy: This CR updates Publication 100-08, chapter 15, to address various provider enrollment policy issues that have recently arisen.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8155.1	In the situations described in sections 15.7.5(B) and (C) of chapter 15, the contractor shall confirm the change with the contact person if it cannot reach, as applicable, the individual physician/practitioner or an authorized or delegated official.	X	X		X	X	X					
8155.2	Absent a CMS instruction or directive to the contrary, the contractor shall send a rejection letter to the provider or supplier no later than 5 business days after the contractor concludes that the provider or supplier's application should be rejected.	X	X		X	X	X					
8155.3	If the contractor rejects an application, it shall either (1) keep the original application and all supporting documents, or (2) make a copy or scan of the application and documents and return the originals to the provider; if the contractor chooses the former approach and the provider requests a copy of its application, the contractor may fax or	X	X		X	X	X					

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	mail it to the provider.											
8155.4	In conducting the verification activities described in section 15.7.5 of chapter 15, if the contractor believes that a case of identity theft or other fraudulent activity likely exists, the contractor shall notify its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) immediately.	X	X		X	X	X					
8155.5	Absent a CMS instruction or directive to the contrary, an approval letter under section 15.9.1 of chapter 15 shall be sent no later than 5 business days after the contractor concludes that the supplier meets all Medicare requirements and that his/her/its application can be approved.		X			X						
8155.6	The contractor shall process as a separate change request any new or changed information that a provider submits prior to the date the contractor finishes processing a previously submitted change request.	X	X		X	X	X					
8155.7	For HHA changes in majority ownership, if the contractor concludes that no exception to the 36-month rule applies, the contractor shall refer the case to its PEOG BFL for review.	X			X		X					
8155.8	Prior to deactivating an HHA's billing privileges for any reason (including under the 36-month rule), the contractor shall refer the matter to its PEOG BFL for review and approval.	X			X		X					
8155.9	If the contractor determines that the provider or supplier fell out of – yet came back into-compliance with enrollment requirements during a period of deactivation, it shall contact its PEOG BFL for guidance as to how the situation should be handled.	X	X		X	X	X					
8155.10	In situations where a provider with multiple PTANs is to be deactivated for non-billing, the contractor shall only deactivate the non-billing PTAN(s).		X			X						
8155.10.1	If a provider with multiple PTANs is to be	X	X		X	X	X					

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	deactivated for any reason other than (1) non-billing or (2) failing to respond to a revalidation request, the contractor shall contact its PEOG BFL for guidance as to the specific PTANs that should be deactivated.											
8155.11	If the contractor receives a direct request from a Zone Program Integrity Contractor (ZPIC) to revoke a provider or supplier's Medicare billing privileges, it shall refer the matter to its PEOG BFL if it is unsure whether the ZPIC received prior PEOG approval for the revocation.	X	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8155.12	MLN Article : A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X		X	X	X	

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
	NOTE: The contractor may reject an application that was signed more than 120 days prior to the date on which the contractor received the application - assuming the provider or supplier failed to furnish a new, appropriately-signed certification statement within 30 days of the contractor's request to do so.

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

V. CONTACTS

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

Post-Implementation Contact(s): 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's activities are to be carried out within their operating budgets.

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

Medicare Program Integrity Manual
Chapter 15 - Medicare Enrollment

Table of Contents

(Rev.462, Issued: 05-16-13)

15.4 – Provider and Supplier Types/Services

(Rev.462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

The contractor shall consult other Medicare manuals for more information on how these providers and suppliers bill Medicare, their conditions of coverage*, their* conditions of participation, etc.

Provider and supplier specialty codes can be found at Publication 100-04, chapter 26, sections 10.8 through 10.8.3.

15.4.2.3 - Mammography Screening Centers

(Rev.462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

As stated in 42 CFR §410.34(a)(2), a screening mammography is a radiological procedure "furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedure." All mammography centers must apply for and receive certification from the Food and Drug Administration (FDA), which is responsible for collecting certificate fees and surveying mammography facilities (screening and diagnostic).

The FDA provides CMS with a listing of all providers that have been issued certificates to perform mammography services. *The file contains the FDA Certification Numbers of active and terminated facilities. Typically, it is transmitted to the Multi-Carrier System (MCS) on a weekly basis; the contractor accesses the file from MCS.*

Prior to enrollment, the contractor shall require the center to submit a copy of its FDA certificate. *P*er 42 CFR §410.34 (a)(7)(i), the contractor may accept a "provisional" certificate.

For more information on mammography screening centers, refer to:

- §1834(c) of the Social Security Act
- 21 CFR Part 900
- 42 CFR §410.34
- Pub. 100-04, chapter 18, sections 20 through 20.8 (Claims Processing Manual)
- Pub. 100-02, chapter 15, section 280.3 (Benefit Policy Manual)

15.5.5 – Owning and Managing Organizations

(Rev.462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

(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 following principles also apply 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 *and Tribal* Organization Letter - For governmental *and tribal* 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 *or tribal* entity who has the authority to legally and financially bind the governmen*tal or tribal entity* to the laws, regulations, and program instructions of Medicare. This governmen*tal or tribal* 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).

Governmental and tribal entities need not submit a copy of a 501(c)(3) if it is otherwise obvious to the contractor that the entity is a governmental or tribal entity. The contractor can assume that the governmental or tribal entity is non-profit.

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.

h. Partnerships – Only partnership interests in the enrolling provider need be disclosed in section 5. Partnership interests in the provider's indirect owners need not be reported. However, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be disclosed in section 5.

15.5.6 – Owning and Managing Individuals

(Rev.462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

(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*/board members*, if *– and only 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.) *O*nly officers and directors of the *enrolling* 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. *However, there may be situations where the officers and directors/board members of the enrolling provider's corporate owner/parent also serve as the enrolling provider's officers and directors/board members. In such cases – and again assuming that the provider is a corporation – the indirect owner's officers and directors/board members would have to be disclosed as the provider's officers and directors/board members in section 6.*

With respect to corporations, the term "director" refers to members of the board of directors. If a corporation has, for instance, a Director of Finance who nonetheless is not a member of the board of directors, he/she would not need to be listed as a director/board member in section 6. However, he/she may need to be listed as a managing employee in section 6.

In addition:

- 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.

- *Only partnership interests in the enrolling provider need be disclosed. Partnership interests in the provider's indirect owners need not be reported. Of course, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be disclosed in section 6.*

15.7.5 – Special Program Integrity Procedures

(Rev.462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

This section contains additional verification procedures that the contractor shall utilize when processing the following transactions:

- Changes in the provider's practice location

- Changes in *the* provider's correspondence or special payment address

- On the *Form* CMS-588, changes in the provider's bank name, depository routing transit number, or depository account number

- Reactivations *and Revalidations*

*T*he instructions in this section 15.7.5 are in addition to, and not in lieu of, all other verification instructions contained in this chapter *and in other CMS directives.* Also, unless otherwise stated, section 15.7.5 applies to the *Form* CMS-855A, *Form* CMS-855B and *Form* CMS-855I.

The signature comparison requirements stated below are not necessary if the Form CMS-855 or Form CMS-588 change request, reactivation, or revalidation was submitted with an electronic signature.

A. Change in Practice Location Address

In cases where a provider submits a *Form* CMS-855 request to change its practice location address, the contractor shall undertake the following activities:

1. Compare the signature thereon with the same person's signature on file to ensure that the signatures match. If they do not, the contractor shall request additional information from the signatory to confirm his or her identity. Proper identification includes a photocopy of a current passport or a photocopy of a driver's license. If the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.

For *Form* CMS-855A and *Form* CMS-855B submissions *that were not signed electronically*, if the person's signature is not already on fil*e t*he contractor shall request that he/she *(1)* complete section 6 of the *Form* CMS-855 and *(2)* furnish his/her signature in section 15 or 16 of the *Form* CMS-855.

2. Contact the location currently associated with the provider in *the Provider Enrollment, Chain and Ownership System (PECOS)* or *the Multi-Carrier System (MCS)* to verify that the provider is no longer there and did in fact move.

3. Request that the provider fax to the contractor a copy of his/her driver's license or, if applicable, a copy of a phone bill/power bill containing the business's new *legal business name (LBN) or doing business as (DBA) name* and its new address.

B. Change in Correspondence or Special Payments Address

If the provider submits a change to its correspondence or special payments address, the contractor shall undertake the following activities:

1. Compare the signature thereon with the same person's signature on file to ensure that the signatures match. If they do not, the contractor shall request additional information from the signatory to confirm his or her identity. Proper identification includes a photocopy of a current passport or a photocopy of a driver's license. If the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.

For *Form* CMS-855A and *Form* CMS-855B *submissions that were not signed electronically,* if the person's signature is not already on file the contractor shall request that he/she *(1)* complete section 6 of the *Form* CMS-855 and *(2)* furnish his/her signature in section 15 or 16 of the *Form* CMS-855.

2. Contact the *individual physician/practitioner (for Form CMS-855I changes), an authorized or delegated official (for Form CMS-855A and Form CMS-855B changes), or the contact person listed in section 13 (for Form CMS-855A, Form CMS-855B, and Form CMS-855I changes) to verify the change. Hence, if the contractor cannot reach, as applicable, the individual physician/practitioner or an authorized or delegated official, it shall confirm the change with the contact person.*

C. Change of EFT Information

If the provider submits a *Form* CMS-588 request to change the bank name, depository routing transit number, or depository account number, the contractor shall undertake the following activities:

1. Compare the signature thereon with the same person's signature on file to ensure that the signatures match. If they do not, the contractor shall request additional information from the signatory to confirm his or her identity. Proper identification includes a photocopy of a current passport or a photocopy of a driver's license. If the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.

For organizational providers *whose submissions were not signed electronically,* if the person's signature is not already on file the contractor shall request that he/she *(1)* complete section 6 of the CMS-855 and *(2)* furnish his/her signature in section 15 or 16 of the *Form* CMS-855.

2. Contact the *individual physician/practitioner (for Form CMS-855I enrollees), an authorized or delegated official on record (for Form CMS-855A and Form CMS-855B enrollees), or the section 13 contact person on record (for Form CMS-855A, Form CMS-855B, and Form CMS-855I enrollees) to verify the change. Hence, if the contractor cannot reach, as applicable, the individual physician/practitioner or an authorized or delegated official, it shall confirm the change with the contact person.*

D. Reactivations and Revalidations

When processing a *Form* CMS-855 reactivation or revalidation application, the contractor shall *– unless instructed otherwise by another CMS directive -* undertake the following activities:

1. Compare the signature thereon with the same person's signature on file to ensure that the signatures match. If they do not, the contractor shall request additional information from the signatory to confirm his or her identity. Proper identification includes a photocopy of a current passport or a photocopy of a driver's license. If the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.

For *Form* CMS-855A and *Form* CMS-855B applications *that were not signed electronically,* if the person's signature is not already on file *t*he contractor shall request that he/she *(1)* complete section 6 of the *Form* CMS-855 and *(2)* furnish his/her signature in section 15 or 16 of the *Form* CMS-855.

2. If the (a) practice location address or (b) correspondence/special payment address on the application is different than that which is currently associated with the provider in PECOS or MCS, the contractor shall abide by the instructions in subsections A and B above, respectively.

3. (Reactivations only): Request that the provider furnish a copy of a claim that it plans to submit upon the reactivation of its billing privileges. Alternatively, the provider may submit on letterhead the following information regarding a beneficiary to whom the provider has furnished services and for whom it will submit a claim: (1) beneficiary name, (2) health insurance claim number (HICN), (3) date of service, and (4) phone number.

E. Reassignment of All Benefits

If a physician or non-physician practitioner who is currently reassigning all of his or her benefits attempts to enroll as a sole proprietorship or the sole owner of his or her professional corporation, *professional* association, or *limited liability company*, the contractor shall:

1. Compare the signature thereon with the same person's signature on file to ensure that the signatures match. If they do not, the contractor shall request additional information from the signatory to confirm his or her identity. Proper identification includes a photocopy of a current passport or a photocopy of a driver's license. If the individual fails to submit this information or if the contractor determines that the supporting documentation does not verify the person's identity, the contractor shall deny the application.

2. Call the old practice location to determine if the physician or non-physician practitioner is still employed there; if he or she is not, contact the practitioner to verify that he or she is indeed attempting to enroll as a sole proprietorship or sole owner and request that he/she fax to the contractor a copy of his/her driver's license.

F. *Potential Identity Theft or Other Fraudulent Activity*

In conducting the verification activities described in this section *15.7.5,* if the contractor believes that a case of identi*t*y theft or other fraudulent activity likely exists (e.g., physician or practitioner indicates that he or she is not establishing a new practice location or changing his or her EFT information, and that the application submitted in his/her name is false), *the contractor shall notify its Provider Enrollment Operations Group Business Function Lead immediately.*

15.7.7.1.4 - Intervening Change of Ownership (CHOW)

(Rev.462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

(This section does not apply to home health agencies)

In situations where (1) the provider submits a Form CMS-855A initial application or CHOW application and (2) a CMS-855A CHOW application is subsequently submitted but before the contractor has received the tie-in notice from the CMS Regional Office (RO), the contractor shall abide by the following:

- Situation 1 – The provider submitted an initial application followed by a CHOW application, and a recommendation for approval has not yet been made with respect to the initial application – The contractor shall *return* both applications and require the provider to re-submit an initial application with the new owner's information.

- Situation 2 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has not been made for the first application - The contractor shall process both applications – preferably in the order in which they were received – and shall, if recommendations for approval are warranted, refer both applications to the State/RO in the same package. The accompanying notice/letter to the State/RO shall explain the situation.

- Situation 3 - The provider submitted an initial application followed by a CHOW application, and a recommendation for approval of the initial application has been made – The contractor shall:

  - *Return* the CHOW application.

  - Notify the State/RO via letter (sent via mail or e-mail) that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information.

  - Request via letter that the provider submit a new initial CMS-855A application containing the new owner's information within 30 days of the date of the letter. If the provider fails to do so, the contractor shall *return* the initial application and notify the provider and the State/RO of this via letter. If the provider submits the application, the contractor shall process it as normal and, if a recommendation for approval is made, send the revised application package to the State/RO with an explanation of the situation; the initially submitted application becomes moot. If the newly submitted application is denied, however, the initially submitted application is denied as well; the contractor shall notify the provider and the State/RO accordingly.

- Situation 4 - The provider submitted a CHOW application followed by another CHOW application, and a recommendation for approval has been made for the first application - The contractor shall:

  - Notify the State/RO via e-mailed letter that there has been a change of ownership (the new owner should be identified) and that the contractor will be requiring the provider to resubmit a new initial application containing the new owner's information.

  - Process the new CHOW application as normal. If a recommendation for approval is made, the contractor shall send the revised CHOW package to the State/RO with an explanation of the situation; the first CHOW application becomes moot. If the newly submitted CHOW application is denied, the first application is denied as well; the contractor shall notify the provider and the State/RO accordingly.

15.8.1 – Returns

(Rev.462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

A. Reasons for Return

Unless stated otherwise in this chapter or in another CMS directive, the contractor (including the National Supplier Clearinghouse) may immediately return the enrollment application to the provider or supplier only in the instances described below. This policy – again, unless stated otherwise in this chapter or in another CMS directive - applies to all applications identified in this chapter (e.g., initial applications, change requests, Form CMS-855O applications, Form CMS-588 submissions, change of ownership (CHOW) applications, revalidations, reactivations):

- The applicant sent its paper Form CMS-855 to the wrong contractor (e.g., the application was sent to Contractor X instead of Contractor Y).

- The contractor received the application more than 60 days prior to the effective date listed on the application. (This does not apply to: (1) providers and suppliers submitting a Form CMS-855A application, (2) ambulatory surgical centers (ASCs), or (3) portable x-ray suppliers (PXRSs).

- The contractor received an initial application from (1) a provider or supplier submitting a Form CMS-855A application, (2) an ASC, or (3) a PXRS, more than 180 days prior to the effective date listed on the application.

- An old owner or new owner in a CHOW submitted its application more than 90 days prior to the anticipated date of the sale. (This only applies to Form CMS-855A applications.)

- The contractor can confirm that the provider or supplier submitted an initial enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application.

- The provider or supplier submitted an initial application prior to the expiration of a re-enrollment bar.

- *The application is to be returned per the instructions in section 15.7.7.1.4 of this chapter.*

- The application is not needed for the transaction in question. Two common examples include:

  - An enrolled physician wants to change his/her reassignment of benefits from one group to another group and submits a Form CMS-855I and a Form CMS-855R. As only the Form CMS-855R is needed, the Form CMS-855I shall be returned.

  - A physician who is already enrolled in Medicare submits a Form CMS-855O application, thinking that he must do so in order to refer services for Medicare beneficiaries. The Form CMS-855O can be returned, as the physician is already enrolled via the Form CMS-855I.

The contractor need not request additional information in any of these scenarios. For instance, if the application is not necessary for the particular transaction, the contractor can return the application immediately. If an application fee has already been submitted, the contractor shall follow existing instructions regarding the return of the fee.

The difference between a “rejected” application and a “returned” application is that the former is typically based on the provider’s failure to respond to the contractor’s request for missing or clarifying information. A “returned” application is effectively considered a non-application.

B. Procedures for Returning the Application

If the contractor returns the application:

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

- It shall <u>not</u> enter the application into PECOS. No logging & tracking (L & T) record shall be created.

- Any application resubmission must contain a brand new certification statement page containing a signature and date. The provider cannot simply add its signature to the original certification statement it submitted. (This does not apply to e-signature situations.)

It shall return all paper documents submitted with the paper or Internet-based PECOS application (e.g., Form CMS-588, Form CMS-460). The contractor shall, however, make and keep a photocopy or scanned version of the paper application (if applicable) and any paper documents (regardless of whether the application was submitted via paper or electronically) prior to returning them.

15.8.2 –Rejections

(Rev.462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

A. Background

In accordance with 42 CFR § 424.525(a)(1) and (2), the contractor (including the National Supplier Clearinghouse) may reject the provider's application if the provider fails to furnish complete information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation. For purposes of this policy, this includes situations in which the provider submitted an application that falls into one of the following categories and, upon the contractor's request to submit a new or corrected complete application, the provider failed to do so within 30 days of the request:

(1) The Form CMS-855 or Internet-based Provider Enrollment, Chain and Ownership System (PECOS) certification statement: (*a*) is unsigned; (*b*) is undated; (*c*) contains a copied or stamped signature; *(d) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application);* or (*e*) for paper Form CMS-855I and Form CMS-855O submissions, someone other than the physician or non-physician practitioner signed the form.

(2) The submitted paper application is an outdated version of the Form CMS-855.

(3) The applicant failed to submit all of the forms needed to process a reassignment package within 15 calendar days of receipt.

(4) The Form CMS-855 was completed in pencil.

(5) The wrong application was submitted (e.g., a Form CMS-855B was submitted for Part A enrollment).

(6) If a Web-generated application is submitted, it does not appear to have been downloaded from CMS' Web site.

(7) The provider sent in its application or Internet-based PECOS certification statement via fax or e-mail when it was not otherwise permitted to do so.

(8) The provider failed to submit an application fee (if applicable to the situation).

The applications described in (1) through (8) above shall be developed, rather than returned. For instance, if the provider submits an application completed in pencil, the contractor shall request the provider to submit a new application, either in ink or via Internet-based PECOS.

B. Timeframe

The 30-day clock identified in 42 CFR § 424.525(a) starts on the date that the contractor mails, faxes, or e-mails the pre-screening letter or other request for information to the provider. If the contractor makes a follow-up request for information, the 30-day clock does not start anew; rather, it keeps running from the date the pre-screening letter was sent. However, the contractor has the discretion to extend the 30-day time period if it determines that the provider or supplier is actively working with the contractor to resolve any outstanding issues.

C. Incomplete Responses

The provider must furnish all missing and clarifying data requested by the contractor within the applicable timeframe. If the provider furnishes some, but not all, of the requested data, the contractor is not required to contact the provider again to request the remaining data. It can simply reject the application at the expiration of the aforementioned 30-day period. Consider the following examples:

- The provider submits a Form CMS-855A in which section 3 is blank. On March 1, the contractor requests that section 3 be fully completed. On March 14, the provider submits a completed section 3A. However, section 3B remains blank. The contractor need not make a second request for section 3B to be completed. It can reject the application on March 31, or 30 days after its initial request was made.

- The provider submits an outdated version of the Form CMS-855B. On July 1, the contractor requests that the provider resubmit its application using the current version of the Form CMS-855B. On July 15, the provider submits the correct version, but section 4B is blank. The contractor is not required to make a follow-up request regarding section 4B. It can reject the application on July 31.

D. Creation of Logging & Tracking (L & T) Record

If the contractor cannot create an L & T record in PECOS because of missing data and the application is subsequently rejected, the contractor shall document the provider file accordingly. If the contractor is able to create an L & T record for a rejected application, it shall flip the status to "rejected" in PECOS.

E. Additional Rejection Policies

1. **Resubmission after Rejection** – If the provider's application is rejected, the provider must complete and submit a new Form CMS-855 (either via paper or Internet-based PECOS) and all necessary documentation.

2. **Applicability –** Unless stated otherwise in this chapter or in another CMS directive, this section 15.8.2 applies to all applications identified in this chapter (e.g., initial applications, change requests, Form CMS-855O applications, Form CMS-588 submissions, change of ownership (CHOW) applications, revalidations, reactivations).

3. **Physicians and Non-Physician Practitioners** – Prior CMS guidance instructed contractors to deny, rather than reject, incomplete applications submitted by physicians and certain non-physician practitioners. This policy no longer applies. Such applications shall be rejected if the physician or practitioner fails to provide the requested information within the designated timeframe.

4. **Notice** – If the contractor rejects an application, it shall notify the provider via letter (sent via mail or e-mail) that the application is being rejected, the reason(s) for the rejection, and how to reapply. *Absent a CMS instruction or directive to the contrary, the letter shall be sent to the provider or supplier no later than 5 business days after the contractor concludes that the provider or supplier's application should be rejected.*

*5. **Copy of Application** – If the contractor rejects an application, it shall either (1) keep the original application and all supporting documents, or (2) make a copy or scan of the application and documents and return the originals to the provider. If the contractor chooses the former approach and the provider requests a copy of its application, the contractor may fax or mail it to the provider.*

15.9.1 - Non-Certified Suppliers and Individual Practitioners

(Rev.462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

(This section does not apply to ambulatory surgical centers, portable x-ray suppliers, or providers and suppliers that complete the Form CMS-855A.)

If the contractor approves a supplier's enrollment, it shall notify the applicant via letter of the approval. The letter shall:

- Follow the content and format of the model letter in section 15.24.7 of this chapter;

- Include the National Provider Identifier (NPI) with which the supplier will bill Medicare and the Provider Transaction Access Number (PTAN) that has been assigned to the supplier as an identifier for inquiries.

- Provide instructions on how suppliers should use the assigned PTAN when they use the contractor interactive voice response (IVR) system for inquires concerning claims status, beneficiary eligibility, check status or other supplier-related IVR transactions.

- Include language reminding suppliers to update their NPPES record whenever their information changes.

Absent a CMS instruction or directive to the contrary, the letter shall be sent no later than 5 business days after the contractor concludes that the supplier meets all Medicare requirements and that his/her/its application can be approved.

For claims submitted by physicians and non-physicians prior to the date of enrollment, the contractor shall follow the instructions in Pub. 100-04, chapter 1, section 70, with respect to the claim filing limit. Payments cannot be made for services furnished prior to the date the applicant is appropriately licensed.

15.10.1 – Changes of Information - General Procedures

(Rev.462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

Unless otherwise specified in this chapter or another CMS directive, if an enrolled provider is adding, deleting, or changing information under its existing tax identification number, it must report the change using the applicable Form CMS-855. Letterhead is not permitted.

The provider shall (1) furnish the changed data in the applicable section(s) of the form, and (2) sign and date the certification statement. In accordance with 42 CFR §424.516(d) and (e), the timeframes for providers to report changes to their Form CMS-855 information are as follows:

A. Physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals; and organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph.): The following changes must be reported within 30 days:

- A change of ownership
- A final adverse action
- A change in practice location

All other informational changes involving the providers listed in this section 15.10.1(A) must be reported within 90 days.

B. All providers and suppliers other than (1) those listed in section 15.10.1(A); (2) suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS); and (3) independent diagnostic testing facilities (IDTFs): Any change of ownership, including a change in an authorized or delegated official, must be reported within 30 days. All other informational changes involving the providers listed in this section 15.10.1(B) must be reported within 90 days.

The reporting requirements for IDTFs can be found in 42 CFR §410.33(g)(2) and in section 15.5.19.1(A)(2) of this chapter. Reporting requirements for DMEPOS suppliers can be found in 42 CFR §424.57(c)(2)).

In addition:

- **Unsolicited Additional Information** - Any new or changed information that a provider submits prior to the date the contractor finishes processing a previously submitted change request is *no longer considered to be* an update to that change request. Rather, *it is considered to be and shall be processed as a separate change request. The contractor may process both changes simultaneously, but the change that was submitted first shall be processed to completion prior to the second one being processed to completion.*

- **Unavoidable Phone Number or Address Changes** – Unless CMS specifies otherwise, any change in the provider's phone number or address that the provider did not cause (i.e., area code change, municipality renames the provider's street) must still be updated via the Form CMS-855.

- **Application Signatures -** If the signer has never been reported in section 6 of the Form CMS-855, section 6 must be completed in full with information about the individual. (This policy applies regardless of whether the provider already has a Form CMS-855 on file.) The contractor shall ensure that all validation required to be performed with respect to the individual is conducted.

- **Notifications** – For changes of information that do not require Regional Office approval (e.g., Form CMS-855I changes; Form CMS-855B changes not involving ambulatory surgical centers or portable x-ray suppliers; minor Form CMS-855A changes), the contractor shall (1) furnish written, e-mail, or telephonic confirmation to the provider that the change has been made, and (2) document (per section 15.7.3 of this chapter) in the file the date and time the confirmation was made. If, however, the transaction only involves an area code/ZIP Code change, it is not necessary to send confirmation to the provider that the change has been processed.

15.11 – Electronic Fund Transfers (EFT)

(Rev.462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

A. General Information

If a provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) and wants to change any of its EFT information (e.g., bank routing number), it must submit a complete Form CMS-855 before the contractor can effectuate the change. With the exception of the situation described in section (B) below, it is immaterial whether the provider or the bank was responsible for triggering the changed data.

Under 42 CFR §424.510(d)(2)(iv) and §424.510(e):

- All providers (including Federal, State and local governments) enrolling in Medicare must use EFT in order to receive payments. Moreover, any provider not currently on EFT that (1) submits any change to its existing enrollment data or (2) submits a revalidation application must also submit a Form CMS-588 and thereafter receive payments via EFT.

- If a provider is already receiving payments via EFT and is located in a jurisdiction that is undergoing a change of Medicare contractors, the provider must: (1) continue to receive EFT payments and (2) submit a new Form CMS-588 for the new contractor.

B. Verification

Providers and suppliers may submit a Form CMS-588 via paper or through PECOS. In either case, the contractor shall ensure that:

- The information submitted on the Form CMS-588 is complete and accurate.

- The provider/supplier submitted (1) a voided check or (2) a letter from the bank verifying the account information.

- The routing number and account number matches what was provided on the Form CMS-588.

- The signature is valid. (**N*OTE*:** For electronic Form CMS-588 submissions, the provider can either e-sign the form or submit a written signature via the paper Form CMS-588)

Once the Form CMS-588 has been processed, the 588 form will be printed and delivered to the contractor's financial area along with the voided check and letter from the bank verifying account information, for proper processing of the EFT information. If this information cannot be verified and the provider fails to timely respond to a developmental request, the contractor shall reject the Form CMS-588 and, if applicable, the accompanying Form CMS-855.

C. Miscellaneous Policies

1. Banking Institutions - All payments must be made to a banking institution. EFT payments to non-banking institutions (e.g., brokerage houses, mutual fund families) are not permitted.

If the provider's bank of choice does not or will not participate in the provider's proposed EFT arrangement, the provider must select another financial institution.

2. Verification - The contractor shall ensure that all EFT arrangements comply with CMS Publication 100-04, chapter 1, section 30.2.5.

3. Sent to the Wrong Unit - If a provider submits an EFT change request to the contractor but not to the latter's enrollment unit, the recipient unit shall forward it to the enrollment staff, which shall then process the change. The enrollment unit is responsible for processing EFT changes. As such, while it may send the original EFT form back to the recipient unit, the enrollment unit shall keep a copy of the EFT form and append it to the provider's Form CMS-855 in the file.

4. Comparing Signatures - If the contractor receives an EFT change request, it shall compare the signature thereon with the same official's signature on file to ensure that it is the same person. If the person's signature is not on file, the contractor shall request that he/she complete section 6 of the Form CMS-855 and furnish his/her signature in section 15 or 16. (This shall be treated as part of the EFT change request for purposes of timeliness and reporting.)

5. Bankruptcies and Garnishments – If the contractor receives a copy of a court order to send payments to a party other than the provider, it shall contact the applicable RO's Office of General Counsel.

6. Closure of Bank Account – If a provider has closed its bank/EFT account but will remain enrolled in Medicare, the contractor shall place the provider on payment withhold until an EFT agreement (and Form CMS-855, if applicable) is submitted and approved by the contractor. If such an agreement is not submitted within 90 days after the contractor learned that the account was closed, the contractor shall commence revocation procedures in accordance with the instructions in this chapter. *The basis for revocation would be § 424.535(a) due to the provider's failure to comply with the EFT requirements outlined in § 424.510(e)(1) and (e)(2).*

7. Reassignments – If a physician or non-physician practitioner is reassigning all of his/her benefits to another supplier and the latter is not currently on EFT, neither the practitioner nor the reassignee needs to submit a Form CMS-588. This is because (1) the practitioner is not receiving payment directly, and (2) accepting a reassignment does not qualify as a change of information request. If, however, the group later submits a change of information request and is not on EFT, it must submit a Form CMS-588.

8. Final Payments – If a non-certified supplier (e.g., physician, ambulance company) voluntarily withdraws from Medicare and needs to obtain its final payments, the contractor shall send such payments to the provider's EFT account of record. If the account is defunct, the contractor can send payments to the provider's "special payments" address or, if none is on file, to any of the provider's practice locations on record. If neither the EFT account nor the aforementioned addresses are available, the provider shall submit a Form CMS-855 or Form CMS-588 request identifying where it wants payments to be sent.

9. Chain Organizations - Per CMS Publication 100-04, chapter 1, section 30.2, a chain organization may have payments to its providers be sent to the chain home office. However, any mass EFT changes (involving large numbers of chain providers) must be submitted and processed in the same fashion as any other change in EFT data. For instance, if a chain has 100 providers and each wants to change its EFT account to that of the chain home office, 100 separate Form CMS-588s must be submitted. If any of the chain providers have never completed a Form CMS-855 before, they must do so at that time.

15.19.1 – Application Fees

(Rev.462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

A. Background

Pursuant to 42 CFR §424.514 - and with the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices – institutional providers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information per 42 CFR §424.515, must submit with their application:

- An application fee in an amount prescribed by CMS, and/or
- A request for a hardship exception to the application fee.

This requirement applies to applications that the contractor receives on or after March 25, 2011.

For purposes of this requirement, the term "institutional provider," as defined in 42 CFR §424.502, means any provider or supplier that submits a paper Medicare enrollment application using the Form CMS-855A, Form CMS- 855B (not including physician and non-physician practitioner organizations), Form CMS-855S or associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment application. *A* physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) via the Form CMS-855S application must submit the required application fee with its Form CMS-855S form.

B. Fee

1. Amount

The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted. The fee for March 25, 2011 through December 31, 2011 *was* $505.00. The fee for January 1, 201*3* through December 31, 201*3* is $5*32*.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give the contractor and the public advance notice of any change in the fee amount for the coming calendar year.

2. Non-Refundable

Per 42 CFR §424.514(d)(2)(v), the application fee is non-refundable, except if it was submitted with one of the following:

a. A hardship exception request that is subsequently approved;

b. An application that was rejected prior to the contractor's initiation of the screening process, or

c. An application that is subsequently denied as a result of the imposition of a temporary moratorium under 42 CFR §424.570.

(For purposes of (B)(2)(b) above, the term "rejected" includes applications that are returned pursuant to section 15.8.1 of this Chapter.)

In addition, the fee should be refunded if:

- It was not required for the transaction in question (e.g., the provider submitted a fee with its application to report a change in phone number).

- It was not part of an application submission.

3. Format

The provider or supplier must submit the application fee electronically through Pay.gov, either via credit card, debit card, or check. *C*MS will send to the contractor on a regular basis a listing of providers and suppliers (the "Fee Submitter List") that have paid an application fee via Pay.gov.

*Also, w*ith respect to the application fee requirement:

- The fee is based on the Form CMS-855 application submission, not on how enrollment records are created in PECOS. For instance, suppose a hospital submits an initial Form CMS-855A. In section 2A2 of the application, the hospital indicates that it has a psychiatric unit and a rehabilitation unit. Separate PECOS enrollment records must be created for each unit. However, only one application fee is required because only one Form CMS-855A application was submitted.

- A physician/non-physician practitioner clinic or group practice enrolling via the Form CMS-855B is exempt from the fee even if it is: (1) Tribally-owned/operated, or (2) hospital-owned. However, if a hospital is adding a physician/non-physician practitioner clinic or group practice to its Form CMS-855A enrollment, a fee is required because the hospital is adding a practice location.

C. Hardship Exception

1. Background

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and any supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper Form CMS-855 application is submitted, the hardship exception letter must accompany the application; if the application is submitted via Internet-based PECOS, the hardship exception letter must accompany the certification statement. Hardship exception letters shall not be considered if they were submitted separately from the application or certification statement, as applicable. If the contractor receives a hardship exception request separately from the application or certification statement, it shall: (1) return it to the provider, and (2) notify the provider via letter, e-mail or telephone that it will not be considered.

2. Criteria for Determination

The application *fee generally* should not represent a significant burden for an adequately capitalized provider or supplier. Hardship exceptions should not be granted when the provider simply asserts that the

imposition of the application fee represents a financial hardship. The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that may suggest that a hardship exception is appropriate include the following:

(a) Considerable bad debt expenses,

(b) Significant amount of charity care/financial assistance furnished to patients,

(c) Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;

(d) Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or

(e) Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Upon receipt of a hardship exception request with the application or certification statement, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to its Provider Enrollment Operations Group Business Function Lead *(PEOG BFL).* PEOG has 60 calendar days from the date of the contractor's receipt of the hardship exception request to determine whether it should be approved; during this period, the contractor shall not commence processing the provider's application. PEOG will communicate its decision to the provider and the contractor via letter, after which the contractor shall carry out the applicable instructions in section 19.1(D) below.

If the provider fails to submit appropriate documentation to support its request, the contractor is not required to contact the provider to request it. The contractor can simply forward the request "as is" to its PEOG liaison. Ultimately, it is the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.

D. Receipt

Upon receipt of a paper application (or, if the application is submitted via Internet-based PECOS, upon receipt of a certification statement) from a provider or supplier that is otherwise required to submit an application fee, the contractor shall first determine whether the application is an initial enrollment, a revalidation, or involves the addition of a practice location. If the application does not fall within any of these categories, the contractor shall process the application as normal. If it does fall within one of these categories, the contractor shall undertake the following:

a. Determine whether the provider has: (1) paid the application fee via Pay.gov, and/or (2) included a hardship exception request with the application or certification *statement.*

b. If the provider:

i. Has neither paid the fee nor submitted the hardship exception request, the contractor shall send a letter to the provider notifying it that it has 30 days from the date of the letter to pay the application fee via Pay.gov, and that failure to do so will result in the rejection of the provider's application (for initial enrollments and new practice locations) or revocation of the provider's Medicare billing privileges (for revalidations). The letter shall also state that because a hardship exception request was not submitted with the original application, CMS will not consider granting a hardship exception in lieu of the fee.

During this 30-day period, the contractor shall review each updated Fee Submitter List to determine whether the fee has been paid via Pay.gov. If the fee is paid within the 30-day period, the contractor may begin processing the application as normal. If the fee is not paid within the 30-day period, the contractor shall reject the application (initial enrollments and new locations) under 42 CFR §424.525(a)(3) or revoke the provider's Medicare billing privileges under 42 CFR §424.535(a)(6) (revalidations).

If, at any time during this 30-day period, the provider submits a Pay.gov receipt as proof of payment, the contractor shall begin processing the application as normal.

ii. Has paid the fee but has not submitted a hardship exception request, the contractor shall begin processing the application as normal.

iii. Has submitted a hardship exception request but has not paid a fee, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to its PEOG liaison. If PEOG:

a. Denies the hardship exception request, it will notify the provider in the decision letter (on which the contractor will be copied) that the application fee must be paid within 30 calendar days from the date of the letter. During this 30-day period, the contractor shall review each updated Fee Submitter List to determine if the fee has been submitted via Pay.gov. If the fee is not paid within 30 calendar days, the contractor shall deny the application (initial enrollments and new locations) pursuant to 42 CFR §424.530(a)(9) or revoke the provider's Medicare billing privileges under 42 CFR §424.535(a)(6) (revalidations).

If, at any time during this 30-day period, the provider submits a Pay.gov receipt as proof of payment, the contractor shall begin processing the application as normal.

b. Approves the hardship exception request, it will notify the provider of such in the decision letter (on which the contractor will be copied). The contractor shall begin processing the application as normal.

iv. Has submitted a hardship exception request and has paid a fee, the contractor shall send the request and all documentation accompanying the request via regular mail, fax, or e-mail to its PEOG liaison. As the fee has been paid, the contractor shall begin processing the application as normal.

In all cases, the contractor shall not begin processing the provider's application until: (1) the fee has been paid, or (2) the hardship exception request has been approved.

E. Appeals of Hardship Determinations

A provider may appeal PEOG's denial of its hardship exception request via the procedures outlined below:

1. If the provider is dissatisfied with PEOG's decision to deny a hardship exception request, it may file a written reconsideration request with PEOG within 60 calendar days from receipt of the notice of initial determination (e.g., PEOG's denial letter). The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review.

The reconsideration request should be mailed to:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment Operations Group

7500 Security Boulevard
Mailstop: AR 18-50
Baltimore, MD 21244-1850

Notwithstanding the filing of a reconsideration request, the contractor shall still carry out the post-hardship exception request instructions in subsections (D)(b)(iii)(a) and (iv) above, as applicable. A reconsideration request, in other words, does not stay the execution of the instructions in section 19.1(D) above.

PEOG has 60 calendar days from the date of the reconsideration request to render a decision. The reconsideration shall be:

(a) Conducted by a PEOG staff person who was independent from the initial decision to deny the hardship exception request.

(b) Based on PEOG's review of the original letter and documentation submitted by the provider.

Upon receipt of the reconsideration, PEOG will send a letter to the provider or supplier to acknowledge receipt of its request. In its acknowledgment letter, PEOG will advise the requesting party that the reconsideration will be conducted and a determination issued within 60 days from the date of the request.

If PEOG denies the reconsideration, it will notify the provider of this via letter, with a copy to the contractor. If PEOG approves the reconsideration request, it will notify the provider of this via letter, with a copy to the contractor, after which the contractor shall process the application as normal, or, to the extent applicable:

i. If the application has already been rejected, request that the provider resubmit the application without the fee, or

ii. If Medicare billing privileges have already been revoked, reinstate said billing privileges in accordance with existing instructions and request that the provider resubmit the application without the fee.

*C*orrective Action Plans (CAPs) may not be submitted in lieu of or in addition to a request for reconsideration of a hardship exception request denial.

2. If the provider is dissatisfied with the reconsideration determination regarding the application fee, it may request a hearing before an Administrative Law Judge (ALJ). Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. ALJ requests should be sent to:

Department of Health and Human Services
Departmental Appeals Board (DAB)
Civil Remedies Division, Mail Stop 6132
330 Independence Avenue, S.W.
Cohen Bldg, Room G-644
Washington, D.C. 20201
ATTN: CMS Enrollment Appeal

Failure to timely request an ALJ hearing is deemed a waiver of all rights to further administrative review.

If the ALJ reverses PEOG's reconsideration decision and approves the hardship exception request, and the application has already been rejected, the contractor – once PEOG informs it of the ALJ's decision - shall notify the provider via letter, e-mail or telephone that it may resubmit the application without the fee. If the provider's Medicare billing privileges have already been revoked, the contractor shall reinstate said billing privileges in accordance with existing instructions and request that the provider resubmit the application without the fee.

3. If the provider is dissatisfied with the ALJ's decision, it may request Board review by the Departmental Appeals Board (DAB). Such request must be filed within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a review by the DAB is deemed a waiver of all rights to further administrative review.

If the DAB reverses the ALJ's decision and approves the hardship exception request, and the application has already been rejected, the contractor - once PEOG informs it of the DAB's decision - shall notify the provider via letter, e-mail or telephone that it may resubmit the application without the fee. If the provider's Medicare billing privileges have already been revoked, the contractor shall reinstate said billing privileges in accordance with existing instructions and request that the provider resubmit the application without the fee.

To the extent permitted by law, a provider or supplier dissatisfied with a DAB decision may seek judicial review by timely filing a civil action in a United States District Court. Such request shall be filed within 60 days from receipt of the notice of the DAB's decision.

F. Miscellaneous

The contractor shall abide by the following:

1. Paper Checks Submitted Outside of Pay.gov – As stated earlier, all payments must be made via Pay.gov. Should the provider submit an application with a paper check or any other hard copy form of payment (e.g., money order), the contractor shall not deposit the instrument. It shall instead treat the situation as a non-submission of the fee and follow the instructions in (D)(b)(i) or (iii) above (depending on whether a hardship exception request was submitted). When sending the applicable letter requesting payment within 30 days, the contractor shall explain that all payments must be made via.Pay.gov, stamp the submitted paper check "VOID," and include the voided paper check with the letter.

2. Practice Locations – DMEPOS suppliers, federally qualified health centers (FQHCs), and independent diagnostic testing facilities (IDTFs) must individually enroll each site. Consequently, the enrollment of each site requires a separate fee. For **all other providers and suppliers** (except physicians, non-physician practitioners, and physician and non-physician practitioner groups, none of which are required to submit the fee), a fee must accompany any application that adds a practice location. *(This includes the addition of a hospital unit – such as a psychiatric unit – in section 4 of the Form CMS-855A.)* If multiple locations are being added on a single application, however, only one fee is required. The fee for providers and suppliers other than DMEPOS suppliers, FQHCs, and IDTFs is based on the application submission, not the number of locations being added on a single application.

3. Other Application Submissions – A provider or supplier need not pay an application fee if the application is:

   - Reporting a change of ownership via the Form CMS-855B or Form CMS-855S. (For providers and suppliers reporting a change of ownership via the Form CMS-855A, the ownership change does not necessitate an application fee if the change does not require the provider or supplier to enroll as a new provider or supplier.)

   - Reporting a change in tax identification number (whether Part A, Part B, or DMEPOS)

   - Requesting a reactivation of the provider's Medicare billing privileges

   - Changing the physical location of an existing practice location (as opposed to reporting an additional/new practice location).

   The application fee requirement is separate and distinct from the site visit requirement and risk categories discussed below. Physicians, non-physician practitioners, physician groups and non-

physician practitioner groups are exempt from the application fee even if they fall within the "high" level of categorical screening per section 15.19.2.5 of this chapter. Similarly, physical therapists enrolling as individuals or group practices need not pay an application fee even though they fall within the "moderate" level of categorical screening and are subject to a site visit.

4. Non-Payment of the Fee - If the application is rejected or denied due to non-payment of the fee, the contractor shall:

- Enter the application into PECOS, with the receipt date being the date on which the contractor received the application in its mailroom.

- Indicate in PECOS that a developmental request was made.

- Switch the enrollment record to a "denied" or "rejected" status, as applicable per section 19.1(D).

- Notify the applicant of the rejection or denial in accordance with section 19.1(D).

15.25.1.1 - Corrective Action Plans (CAPs)

(Rev.462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

A. Requirements and Submission of CAPs

The CAP process gives a supplier an opportunity to correct the deficiencies (if possible) that resulted in the denial of its application or the revocation of its billing privileges. The CAP must:

(1) Contain, at a minimum, verifiable evidence that the supplier is in compliance with Medicare requirements;

(2) Be submitted within 30 days from the date of the denial or revocation notice;

(3) Be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative;

(4) For a revocation, be based on a revocation reason other than § 424.535(a)(2), (a)(3), or (a)(5). Per § 424.535(a)(1), CAPs for revocations based on § 424.535(a)(2), (a)(3), or (a)(5) shall not be accepted. If the supplier submits such a CAP, the contractor shall notify the supplier via letter or e-mail that it cannot be considered.

The contractor may create a standard CAP form to be sent with the denial or revocation letter to easily identify it as a CAP when it is returned. The contractor may also accept CAPs via fax or e-mail.

If the submitted CAP does not comply with (1) or (3) above, the contractor need not contact the supplier for the missing information or documentation. It can simply deny the CAP.

The contractor may make a good cause determination so as to accept any CAP that has been submitted beyond the 30-day filing period.

*T*he supplier's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a CAP.

B. Processing and Approval of CAPs

The contractor shall process a CAP within 60 days of receipt. During this period, the contractor shall not toll the filing requirements associated with a reconsideration request.

If the contractor approves a CAP, it shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. *For new or restored billing privileges – and unless stated otherwise in another CMS directive or instruction - the effective date* is based on the *date the* supplier came into compliance with all Medicare *requirements.* Consider the following examples:

1. Denials - A physician's initial enrollment application is denied on March 1. The physician submits a CAP showing that, as of March 20, the physician was in compliance with all Medicare requirements. The effective date of billing privileges should be March 20. The 30-day "backbilling rule" should not be applied in this situation because the rule assumes that the provider was in compliance with Medicare requirements during the 30-day period. This was not the case here. The physician was not in compliance with Medicare requirements until March 20.

2. Revocations – A site visit is conducted of a revalidating ambulance supplier. The supplier is found to be out of compliance with certain enrollment requirements. The supplier's billing privileges were therefore revoked effective April 1. The supplier submitted a CAP showing that – as of April 10 – it was in compliance with all enrollment requirements. The contractor shall apply a new effective date of April 10 to the supplier's Provider Transaction Access Number of April 10. Services furnished during the period when the supplier was out of compliance with Medicare requirements shall not be paid.

For an approved CAP, the contractor shall use the receipt date of the CAP request as the receipt date entered in the Provider Enrollment, Chain and Ownership System.

For DMEPOS suppliers, the effective date is the date it is awarded by the National Supplier Clearinghouse. CMS' approval is required prior to restoring DMEPOS billing privileges.

C. Concurrent Submission of CAP and Reconsideration Request

If a CAP and a reconsideration request (see section 15.25.1.2 below) are submitted concurrently, the contractor shall first process and make a determination on the CAP. The contractor and the reconsideration hearing officer (HO) shall coordinate with one another prior to acting on a CAP or reconsideration request to determine if the other party has received a request.

If the CAP is accepted, the standard approval letter (or, if applicable, a notice of rescission of the revocation) shall be sent to the supplier with a statement that the reconsideration request should be withdrawn.

If the CAP is denied:

- It cannot be appealed.
- The contractor shall notify the supplier of the denial via letter.
- The supplier may continue with the appeals process if it has filed a request for reconsideration or is preparing to submit such a request and has not exceeded the timeframe in which to do so.
- The reconsideration request, if submitted, shall be processed.

15.26.1 – HHA Ownership Changes

(Rev.462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

A. Background

Effective January 1, 2011, and in accordance with 42 CFR §424.550(b)(1) - if there is a change in majority ownership of an HHA by sale (including asset sales, stock transfers, mergers, and consolidations) within 36 months after the effective date of the HHA's initial enrollment in Medicare or within 36 months after the

HHA's most recent change in majority ownership, the provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of the HHA must instead:

- Enroll in the Medicare program as a new (initial) HHA under the provisions of §424.510, and

- Obtain a State survey or an accreditation from an approved accreditation organization.

For purposes of §424.550(b)(1), a "change in majority ownership" (as defined in 42 CFR §424.502) occurs when an individual or organization acquires more than a 50 percent direct ownership interest in an HHA during the 36 months following the HHA's initial enrollment into the Medicare program or the 36 months following the HHA's most recent change in majority ownership (including asset sales, stock transfers, mergers, or consolidations). This includes an individual or organization that acquires majority ownership in an HHA through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's most recent change in majority ownership.

B. Exceptions

There are several exceptions to §424.550(b)(1). Specifically, the requirements of §424.550(b)(1) do not apply if:

- The HHA has submitted 2 consecutive years of full cost reports. (For purposes of this exception, low utilization or no utilization cost reports do not quality as full cost reports.)

- The HHA's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.

- The HHA is changing its existing business structure – such as from a corporation, a partnership (general or limited), or an LLC to a corporation, a partnership (general or limited) or an LLC - and the owners remain the same.

- An individual owner of the HHA dies.

In addition, §424.550(b)(1) does not apply to "indirect" ownership changes.

C. Effective Date

As indicated earlier, the provisions of 42 CFR §424.550(b)(1) and (2) as enacted in "CMS-6010-F, Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices; Final Rule" – are effective January 1, 2011. This means that these provisions impact only those HHA ownership transactions whose effective date is on or after January 1, 2011. However, the provisions can apply irrespective of when the HHA first enrolled in Medicare. Consider the following illustrations:

- Example 1 – Smith HHA initially enrolls in Medicare effective July 1, 2009. Smith undergoes a change in majority ownership effective September 1, 2011. The provisions of §424.550(b)(1) apply to Smith because it underwent a change in majority ownership within 36 months of its initial enrollment.

- Example 2 – Jones HHA initially enrolls in Medicare effective July 1, 2007. Jones undergoes a change in majority ownership effective February 1, 2011. Section 424.550(b)(1) does not apply to this transaction because it occurred more than 36 months after Jones's initial enrollment. Suppose, however, than Jones undergoes another change in majority ownership effective February 1, 2012. Section 424.550(b)(1) would apply to this transaction because it took place within 36 months after Jones's most recent change in majority ownership (i.e., on February 1, 2011).

- Example 3- Johnson HHA initially enrolls in Medicare effective July 1, 2006. It undergoes a change in majority ownership effective October 1, 2010. This transaction is not affected by §424.550(b)(1) – as enacted in CMS-6010-F – because: (1) its effective date was prior to January 1, 2011, and (2) it occurred more than 36 months after the effective date of Johnson's initial enrollment. Johnson undergoes another change in majority ownership effective October 1, 2012. This change would be affected by §424.550(b)(1) because it occurred within 36 months of the HHA's most recent change in majority ownership (i.e., on October 1, 2010).

- Example 4 – Davis HHA initially enrolls in Medicare effective July 1, 1999. It undergoes its first change in majority ownership effective February 1, 2011. This change is not affected by §424.550(b)(1) because it occurred more than 36 months after Davis's initial enrollment. Davis undergoes another change in majority ownership effective July 1, 2014. This change, too, would be unaffected by §424.550(b)(1), as it occurred more than 36 months after the HHA's most recent change in majority ownership (i.e., on February 1, 2011). Davis undergoes another majority ownership change on July 1, 2016. This change would be impacted by §424.550(b)(1), since it occurred within 36 months of the HHA's most recent change in majority ownership (i.e., on July 1, 2014).

D. Section 424.550(b)(1)'s Applicability

If the contractor receives a CMS-855A application reporting an HHA ownership change, it shall undertake the following steps:

1. Step 1 – Change in Majority Ownership

The contractor shall determine whether a change in direct majority ownership has occurred. Through its review of the transfer agreement, sales agreement, bill of sale, etc., the contractor shall verify whether:

- The ownership change was a direct ownership change and not a mere indirect ownership change, and

- The change involves a party assuming a greater than 50 percent ownership interest in the HHA.

Assumption of a greater than 50 percent direct ownership interest can generally occur in one of two ways. First, an outside party that is currently not an owner can purchase more than 50 percent of the business in a single transaction. Second, an existing owner can purchase an additional interest that brings its total ownership stake in the business to greater than 50 percent. For instance, if a 40 percent owner purchased an additional 15 percent share of the HHA, this would constitute a change in majority ownership. This is consistent with the verbiage in the aforementioned definition of "change in majority ownership" regarding the "cumulative effect" of asset sales, transfers, etc.

If the transfer does not qualify as a change in majority ownership, the contractor can process the application normally. If it does qualify, the contractor shall proceed to Step 2:

2. Step 2 – 36-Month Period

The contractor shall determine whether the effective date of the transfer is within 36 months after the effective date of the HHA's: (1) initial enrollment in Medicare, or (2) most recent change in majority ownership. The contractor shall verify the effective date of the reported transfer by reviewing a copy of the transfer agreement, sales agreement, bill of sale, etc., rather than relying upon the date of the sale as listed on the application. It shall also review its records – and, if necessary, request additional information from the HHA – regarding the effective date of the HHA's most recent change in majority ownership, if applicable.

If the effective date of the transfer does not fall within either of the aforementioned 36-month periods, the contractor may process the application normally. If the transfer's effective date falls within one of these timeframes, the contractor shall proceed to Step 3.

3. Step 3 – Applicability of Exceptions

If the contractor determines that a change in majority ownership has occurred within either of the above-mentioned 36-month periods, the contractor shall also determine whether any of the exceptions in §424.550(b)(2) apply. As alluded to earlier, the exceptions are as follows:

a. The HHA has submitted 2 consecutive years of full cost reports.

- For purposes of this exception, low utilization or no utilization cost reports do not qualify as full cost reports. As stated in Pub. 15-2 (Provider Reimbursement Manual, Part 2), section 3204, refer to 42 CFR §413.24(h) for a definition of low Medicare utilization.

- The cost reports must have been: (1) consecutive, meaning that they were submitted in each of the 2 years preceding the effective date of the transfer, and (2) accepted by the contractor.

b. The HHA's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.

c. The HHA is changing its existing business structure – such as from a corporation, a partnership (general or limited), or an LLC to a corporation, a partnership (general or limited) or an LLC - and the owners remain the same.

- If the HHA is undergoing a change in business structure other than those which are specifically mentioned in this exemption (e.g., corporation to an LLC), the contractor shall contact its DPSE liaison for guidance.

- For the exemption to apply, the owners must remain the same.

d. An individual owner of the HHA dies – regardless of the percentage of ownership the person had in the HHA.

E. Determination

If the contractor concludes that one of the aforementioned exceptions applies, it may process the application normally. If no exception applies, the *contractor shall refer the case to its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) for review. Under no circumstances shall the contractor take action against the HHA without the prior approval of PEOG. If PEOG agrees with the contractor's determination,* the contractor shall send a letter to the HHA notifying it that, as a result of §424.550(b)(1), the HHA must:

- Enroll as an initial applicant; and

- Obtain a new State survey or accreditation after it has submitted its initial enrollment application and the contractor has made a recommendation for approval to the State/RO.

As the new owner must enroll as a new provider, the contractor shall also deactivate the HHA's billing privileges if the sale has already occurred. If the sale has not occurred, the contractor shall alert the HHA that it must submit a CMS-855A voluntary termination application.

F. Additional Notes

The contractor is advised of the following:

1. If the contractor learns of an HHA ownership change by means other than the submission of a CMS-855A application, it shall notify its DPSE liaison immediately.

2. If the contractor determines, under Step 3 above, that one of the §424.550(b)(2) exceptions applies, the ownership transfer still qualifies as a change in majority ownership for purposes of the 36-month clock. To illustrate, assume that an HHA initially enrolled in Medicare effective July 1, 2010. It undergoes a change in majority ownership effective February 1, 2012. The contractor determined that the transaction was exempt from §424.550(b)(1) because the HHA submitted full cost reports in the previous 2 years. On February 1, 2014, the HHA undergoes another change in majority ownership that did not qualify for an exception. The HHA must enroll as a new HHA under §424.550(b)(1) because the transaction occurred within 36 months of the HHA's most recent change in majority ownership - even though the February 2012 change was exempt from §424.550(b)(1).

15.27.1 – *Deactivations and Reactivations*

(Rev.462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

A. *Deactivation Reasons*

Unless indicated otherwise in this chapter or in another CMS instruction or directive, the contractor may deactivate a provider or supplier's Medicare billing privileges when:

- A provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12 month period begins on the 1st day of the 1st month without a claims submission through the last day of the 12th month without a submitted claim;

- A provider or supplier fails to report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services; or

- A provider or supplier fails to report a change in ownership or control within 30 calendar days.

The deactivation of Medicare billing privileges does not affect a supplier's participation agreement (CMS-460).

Providers and suppliers deactivated for non-submission of a claim are required to complete and submit a Medicare enrollment application to recertify that the enrollment information currently on file with Medicare is correct and must furnish any missing information as appropriate. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation.

Providers and suppliers that fail to promptly notify the contractor of a change (as described above) must submit a complete Medicare enrollment application to reactivate their Medicare billing privileges or, when deemed appropriate, recertify that the enrollment information currently on file with Medicare is correct. Reactivation of Medicare billing privileges does not require a new State survey or the establishment of a new provider agreement or participation agreement. However, per 42 CFR §424.540(b)(3)(i), and as described *in section 15.26.1 of this chapter,* a home health agency (HHA) whose billing privileges are deactivated must undergo a State survey or obtain accreditation prior to having its billing privileges reactivated. *Prior to deactivating an HHA's billing privileges for any reason (including under the "36-month rule"), the contractor shall refer the matter to its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) for review and approval.*

Each contractor shall forward a copy of the Deactivation Summary Report provided by the Multi-Carrier System (MCS) to its designated *PEOG BFL* no later than the last calendar day of each month.

B. *Deactivation Effective Dates*

The effective dates of a deactivation are as follows:

1. Non-Billing – The effective date is the date of the expiration of the applicable 12-month period.

2. Failure to Report Changed Information – The effective date is the date of the expiration of the application 30-day or 90-day reporting period. (See subsection A above.)

3. The "36-Month Rule" for HHAs – PEOG will determine the effective date during its review of the case.

C. Reactivation Effective Date

If the contractor approves a provider or supplier's reactivation application, the reactivation effective date shall be the provider or supplier's date of deactivation. (If the contractor determines that the provider or supplier fell out of – yet came back into- compliance with enrollment requirements during the period of deactivation, it shall contact its PEOG BFL for guidance as to how the situation should be handled.)

D. **Deactivation and Appeals Rights**

The Medicare contractor shall not afford a provider or supplier appeal rights when a deactivation determination is made.

E. Miscellaneous Policies

1. Multiple Provider Transaction Access Numbers (PTANs) - In situations where a provider with multiple PTANs is to be deactivated for non-billing, the contractor shall only deactivate the non-billing PTAN(s). If a provider with multiple PTANs is to be deactivated for any reason other than (1) non-billing or (2) failing to respond to a revalidation request, the contractor shall contact its PEOG BFL for guidance as to the specific PTANs that should be deactivated.

2. "No Payment" and "Demand" Bills – A "no payment" bill with a condition code 21 (billing for denial notice) is considered a Medicare claim for purposes of 42 CFR § 424.540. A "demand bill" (as described in Pub. 100-08, chapter 3, section 5.4 (Exhibit 1)) is considered a Medicare claim for purposes of 42 CFR § 424.540. Thus, for instance, if the provider only submitted "no payment" or "demand" bills over a 12-month period and furnished no claims for payment, the provider still submitted Medicare claims under § 424.540. Deactivation for non-billing would therefore be inappropriate.

15.27.3.1 - Zone Program Integrity Contractor (ZPIC) Identified Revocations

(Rev.462, Issued: 05-16-13 Effective: 03-18-13, Implementation: 03-18-13)

If, through its investigations, the ZPIC believes that a particular provider or supplier's Medicare billing privileges should be revoked, it will develop a case file - including the reason(s) for revocation - and submit the file and all supporting documentation to its respective *contracting officer's representative (COR).* The ZPIC will provide the *COR* with the name, all known identification numbers - including the National Provider Identifier and associated Provider Transaction Access Numbers - and locations of the provider or supplier, as well as detailed information to substantiate the revocation action.

The *COR* will review the ZPIC case file and:

- Return the case file to ZPIC for additional development, or
- Recommend that the Provider Enrollment Operations Group (PEOG) consider approv*ing* the ZPIC*'s* recommendation for revocation.

If PEOG concurs with the *COR's* revocation recommendation, PEOG will: (1) ensure that the applicable fee-for-service contractor is instructed to revoke the provider/supplier's Medicare billing privileges, and (2) notify the Division of Medicare Integrity Contractor Operations of the action taken.

If the contractor receives a direct request from a ZPIC to revoke a provider or supplier's Medicare billing privileges, it shall refer the matter to its PEOG Business Function Lead (BFL) if it is unsure whether the ZPIC received prior PEOG approval for the revocation.