CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 502	**Date: January 17, 2014**
	Change Request 8284

Transmittal 494, dated December 6, 2013, is being rescinded and replaced by Transmittal 502, dated January 17, 2014, to remove the "Sensitive/Controversial" label. In addition, as the extract analyses were implemented in the January 2014 Release, the analyses are not included in this correction. All other information remains the same.

SUBJECT: Registration of Entities Using the Indirect Payment Procedure (IPP)

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to outline the IPP registration process. Medicare Part B payment otherwise payable to an enrollee for the services of a physician or supplier who charges on a fee-for-service basis may be paid to an entity under the IPP.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

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
N	15/15.7.9/Indirect Payment Procedure
N	15/15.7.9.1/Indirect Payment Procedure – Background
N	15/15.7.9.2/Submission of Registration Applications
N	15/15.7.9.3/Processing of Registration Applications
N	15/15.7.9.4/Disposition of Registration Applications
N	15/15.7.9.5/Revocation of Registration
N	15/15.7.9.6/Changes of Information and Other Registration Transactions
N	15/15.7.9.7/Registration Letters

III. FUNDING:

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 Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 502	Date: January 17, 2014	Change Request: 8284

Transmittal 494, dated December 6, 2013, is being rescinded and replaced by Transmittal 502, dated January 17, 2014, to remove the "Sensitive/Controversial" label. In addition, as the extract analyses were implemented in the January 2014 Release, the analyses are not included in this correction. All other information remains the same.

SUBJECT: Registration of Entities Using the Indirect Payment Procedure (IPP)

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

I. GENERAL INFORMATION

A. Background: The purpose of this change request (CR) is to outline the IPP registration process. Medicare Part B payment otherwise payable to an enrollee for the services of a physician or supplier who charges on a fee-for-service basis may be paid to an entity under the IPP.

B. Policy: This CR is designed to outline the registration process for IPP entities.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility											
		A/B MAC			DME MAC				Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8284.1	Upon receipt of a Form CMS-855 registration application from an IPP entity, the contractor shall begin processing the application; this includes the steps outlined in Pub. 100-08, chapter 15, section 15.7.9.3(A).		X										NSC
8284.2	The Provider Enrollment, Chain and Ownership System (PECOS) shall load the Health Plan Identifier (HPID)/Other Entity Identifier (OEID) CSV formatted file from HPOES to automatically verify/validate the HPID/OEID issued.												PECOS
8284.3	If the contractor determines that one or more of the return reasons in section 15.8.1 of chapter 15 applies, the contractor shall return the registration application in accordance with the instructions outlined in that section.		X										NSC
8284.4	If, in response to a development request, the IPP entity indicates that it is unable to		X										NSC

Number	Requirement	Responsibility											
		A/B MAC			DME MAC				Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	furnish certain data elements because said elements do not apply to it, the contractor shall contact its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) for guidance.												
8284.5	The contractor shall process IPP initial applications and changes of information in accordance with the timeliness and accuracy standards in sections 15.6.1.1.3, 15.6.1.2, 15.6.2.1, and 15.6.2.2 of this chapter.		X										NSC
8284.5.1	If the contractor exceeds timeliness standards due to the requirements of sections 15.7.9.1 through 15.7.9.7 of chapter 15, the contractor shall note the provider file in accordance with section 15.7.3 of chapter 15.		X										NSC
8284.6	If the contractor determines that the IPP entity meets all requirements, it shall send an e-mail to its PEOG BFL that contains: (1) the entity's legal business name, "doing business as" name (if applicable), assigned PTAN or NSC number, and HPID or OEID; (2) a draft approval letter patterned after the applicable model letter in section 15.7.9.7; and (3) any issues the contractor encountered in its review.		X										NSC
8284.6.1	If PEOG authorizes the approval, the contractor shall (1) switch the PECOS record to "Approved," (2) establish an effective date that is the date on which the contractor approved the application, (3) assign a Provider Transaction Identification Number (PTAN) or National Supplier Clearinghouse number (as applicable), or (4) send the approval letter via regular mail or e-mail to the entity no later than 5 business days after the contractor received authorization of the approval from PEOG.		X										NSC
8284.7	If the contractor determines that the entity does not meet all requirements, it shall send an e-mail to its PEOG BFL that contains: (1) the entity's legal business name, "doing business as" name (if applicable), and HPID		X										NSC

Number	Requirement	Responsibility											
		A/B MAC			DME MAC				Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	or OEID; (2) a draft denial letter patterned after the applicable model letter in section 15.7.9.7; and (3) the contractor's rationale for proposing to deny the application.												
8284.7.1	If the contractor believes that a ground for denial other than those listed in section 15.7.9.4(B) exists, it shall include this in its e-mail to its PEOG BFL.		X										NSC
8284.7.2	If PEOG authorizes the denial, the contractor shall (1) switch the PECOS record to "Denied," and (2) send the denial letter via certified mail to the entity no later than 5 business days after the contractor received authorization of the denial from PEOG.		X										NSC
8284.8	The contractor shall reject the IPP entity's Form CMS-855 if (1) the entity fails to furnish all required information on the form within 30 calendar days of the contractor's request to do so, or (2) the entity fails to timely submit new or corrected information in the scenarios described in section 15.8.2 of this chapter; this includes situations in which information was submitted, but could not be verified. (The basis for rejection shall be 42 CFR § 424.525(a).)		X										NSC
8284.8.1	The rejection letter shall follow the format of the applicable letter in section 15.7.9.7 and shall be sent via regular mail no later than 5 business days after the contractor determines that the application shall be rejected.		X										NSC
8284.9	If the contractor determines that the entity no longer meets all necessary requirements, it shall send an e-mail to its PEOG BFL that contains: (1) the entity's legal business name, "doing business as" name (if applicable), and HPID or OEID; (2) a draft revocation letter patterned after the applicable model letter in section 15.7.9.7; and (3) the contractor's rationale for proposing to revoke the entity's registration.		X										NSC
8284.9.1	If the contractor believes that a ground for		X										NSC

Number	Requirement	Responsibility											
		A/B MAC			DME MAC				Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	revocation other than those listed in section 15.7.9.5 exists, it shall include this in its e-mail to its PEOG BFL.												
8284.9.2	If PEOG authorizes the revocation, the contractor shall (1) switch the PECOS record to "Revoked," and (2) send the revocation letter via certified mail to the entity no later than 5 business days after the contractor received authorization of the revocation from PEOG.		X										NSC
8284.10	The contractor shall process change of information requests in accordance with existing instructions.		X										NSC
8284.11	The contractor shall not deactivate an entity's IPP registration for any reason unless CMS instructs the contractor to do so.		X										NSC
8284.12	If an IPP entity submits a voluntary termination application, the contractor shall process it in accordance with existing instructions.		X										NSC
8284.13	The contractor shall use the applicable letter in section 15.7.9.7 when approving, denying, or rejecting an application, or when revoking an entity's registration.		X										NSC
8284.14	The contractor shall assign a specialty code of C2 to each IPP that is enrolled; the new C2 specialty code will be considered to be a non-physician specialty.		X								X		NSC
8284.15	PECOS shall add a new specialty code, "C2", for IPP entities.												PECOS
8284.15.1	The specialty code shall be housed in PECOS and flow down on the nightly extract to MCS and VMS.										X		PECOS
8284.16	PECOS shall ensure that all IPP registrations flow to the MCS and VMS via PECOS nightly extracts.										X		PECOS
8284.17	PECOS shall update the daily MCS and										X		PECOS

Number	Requirement	Responsibility											
		A/B MAC			DME MAC				Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	VMS extract to send the PTAN or NSC number along with the HPID and/or OEID for the IPP entity.												
8284.18	PECOS shall include the NSC-assigned IPP number and the HPID/OEID on the PECOS extract to the VMS.										X		PECOS
8284.19	PECOS shall include IPP entity registration data in the existing MCS and VMS nightly extract files along with Medicare Part B/DMEPOS enrollments.										X		PECOS
8284.20	The contractor shall ensure the information for IPP entities passed along on the PECOS nightly extracts are set up and mapped in the shared systems in the master provider and financial files or menus as any other Medicare entity for claims billing and payment purposes unless otherwise indicated in CR 8266.										X		
8284.21	PECOS, MCS, and VMS shall conduct regression testing of the current MCS and VMS extraction process prior to the implementation date of this change request.		X								X		PECOS
8284.21.1	EDC shall support the efforts identified in business requirement 8284.21 by executing the jobs to retrieve and process the files in UAT.												EDCs
8284.22	PECOS shall create two new fields for both the HPID and the OEID. It is an optional requirement to have both fields populated. The identifier field will be populated based on how the Plan is enumerated.												PECOS
8284.23	PECOS shall create a new Child Record for the HPID and OEID and provide its location on the updated nightly extract file to both MCS and VMS at least 3 weeks prior to the implementation of this change request; this new child record shall include the following information on the MCS/VMS extracts: (1) an indicator that notates either an HPID or an OEID, (2) effective date, and (3) end date.									X	X		PECOS

Number	Requirement	Responsibility											
		A/B MAC			DME MAC				Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8284.24	PECOS shall provide an updated file layout to MCS at least 3 weeks prior to the implementation of this change request. (VMS has already received the VMS extract layout.)												PECOS
8284.25	MCS and VMS shall be required to capture the HPID/OEID on the MCS and VMS Provider Master files and any other screen in VMS similar to where the NPI field is captured.									X	X		
8284.26	PECOS shall ensure IPP data validation is enforced centrally in PECOS.												PECOS
8284.27	PECOS shall ensure IPP data is searchable in the administrative interface (AI) as read-only or available for editing only at the contractor level.												PECOS
8284.28	The Rail Road Board (RRB) shall be exempt from these requirements since they do not process CMS 855 Medicare enrollment applications.												RRB
8284.29	PECOS and the contractors identified as responsible parties in this business requirement shall conduct coordinated testing.		X		X						X		PECOS
8284.30	PECOS shall implement a solution that collects a single/national IPP registration for an IPP biller and allows all contractors to add PTANs and NSC numbers whenever applicable.												PECOS
8284.31	PECOS shall be used to collect all the information on the CMS-855C for a particular IPP when an IPP Biller submits a CMS-855C to a contractor within a particular jurisdiction.		X										NSC, PECOS
8284.32	Instead of the contractor having to create 10 different registrations for that IPP biller for each state within that jurisdiction, PECOS shall allow any contractor to access that IPP												PECOS

Number	Requirement	Responsibility											
		A/B MAC			DME MAC				Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	registration and add as many PTANs as necessary for each state.												
8284.33	If the IPP entity intends to bill for DMEPOS under the IPP, PECOS shall allow the NSC to access the IPP registration and designate the IPP as a DME PART B in addition to it being a PART B; this will enable the NSC to enter as many NSC PTANs as it wishes on the enrollment.												PECOS
8284.34	PECOS shall collect the contractor IDs pertaining to each PTAN entered on the registration, and transmit the registration to the MCS and VMS system of each contractor that entered a PTAN.												PECOS
8284.34.1	PECOS shall capture the contractor that is adding the PTAN to the national IPP Registration.												PECOS
8284.34.2	PECOS shall make all the Part B and NSC contractor IDs available to the contractor in a drop down.												PECOS
8284.34.2.1	Pursuant to business requirement 8284.34.2, the contractor shall select the contractor ID and input the Medicare ID.		X										NSC
8284.34.3	For the NSC, PECOS shall utilize the existing logic to generate the PTAN (as PECOS does today).												NSC
8284.34.4	PECOS shall capture and store each Contractor ID that inputted a PTAN and transmit an iteration of the registration to the MCS system for that contractor ID (and to the NSC if the IPP registration is an NSC entity as well).									X			PECOS
8284.35	PECOS shall provide a solution that will stop the registration from locking when a single MAC has accessed it so that the registration does not have to be ‘finalized’ before another contractor may access it.												PECOS
8284.36	MCS and VMS shall be required to separate									X	X		

Number	Requirement	Responsibility											
		A/B MAC			DME MAC				Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	out data individually and support claims processing for IPP claims.												
8284.37	PECOS shall allow an IPP L&T to be tied to an existing IPP Registration.												PECOS
8284.37.1	Pursuant to business requirement 8284.37, the contractor shall be allowed to edit any IPP information on that registration and finalize the changes.		X										NSC
8284.37.1.1	The changes shall flow down to the claims systems belonging to all contractor IDs that have entered a PTAN to the registration.										X		PECOS
8284.38	Contractors shall search for IPP entities using the normal searches that exist in PECOS currently.		X										NSC
8284.39	PECOS shall include a base record for an IPP in the MCS and VMS files; the base record shall include the following information on the MCS/VMS extracts: 1. Legal Business Name 2. Tax ID Number 3. Correspondence Address The following information is not included: 1. Name of Health Plan 2. Adverse Legal Actions 3. Billing Agency 4. IRS Registration Information 5. Business Structure									X	X		PECOS
8284.40	PECOS shall include Child Record 13 on the nightly extract to MCS for the IPP; this record shall have the location key to the									X			PECOS

Number	Requirement	Responsibility											
		A/B MAC			DME MAC				Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	practice address.												
8284.40.1	Child record 13 shall include the following data elements: a. NPI will be blank b. PIN will be included c. Effective Date will be included d. Termination Date will be included e. PL Key will be included.									X			PECOS
8284.41	PECOS shall include a new Child Record 18 that shall only contain the HPID or OEID with an effective or end date.									X			PECOS
8284.42	The algorithm for the HPID/OEID is similar to that of the NPI in that it will be 10 digits in length and begin with either a "7" or "6", respectively.									X	X		PECOS

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC				Other
		A	B	HHH					
	None								

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Frank Whelan, 410-786-1302 or 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 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.502, Issued: 01-17-14)

15.7.9 – Indirect Payment Procedure
(Rev. 502, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-06-14)

Medicare Part B payment otherwise payable to an enrollee for the services of a physician or supplier who charges on a fee-for-service basis may be paid to an entity under the indirect payment procedure (IPP). Sections 15.7.9.1 through 15.7.9.7 below outline the IPP registration process.

15.7.9.1 – Indirect Payment Procedure - Background
(Rev. 502, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-06-14)

Per 42 CFR § 424.66(a), Medicare may pay an entity for Part B services furnished by a physician or other supplier if said entity meets all of the following requirements:

(1) Provides coverage of the service under a complementary health benefit plan (this is, the coverage that the plan provides is complementary to Medicare benefits and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan).

(2) Has paid the person who provided the service an amount (including the amount payable under the Medicare program) that the person accepts as full payment.

(3) Has the written authorization of the beneficiary (or of a person authorized to sign claims on his/her behalf under 42 CFR § 424.36) to receive the Part B payment for the services for which the entity pays.

(4) Relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, his/her survivors, or estate.

(5) Submits any information that CMS or the contractor may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.

(6) Identifies and excludes from its requests for payment all services for which Medicare is the secondary payer.

Entities that comply with § 424.66(a) and the registration procedures described in sections 15.7.9.1 through 15.7.9.7 of this chapter are hereinafter referred to as "IPP entities." An IPP entity is not a "provider" or "supplier" as those terms are defined in § 400.202; moreover, an IPP entity does not meet the definition of a "health care provider" under 45 CFR § 160.103 and, as such, is not eligible for a National Provider Identifier (NPI). Indeed, an IPP entity does not furnish Medicare services. Rather, it is an entity that provides supplementary coverage in the circumstances described in § 424.66(a). To illustrate, suppose an IPP entity furnishes complementary coverage for its retired union members and is a retiree drug subsidy plan sponsor. The entity may seek to (1) pay in full its retired members' drug benefits and other Part B services, (2) bill the Part B services to Medicare, and (3) receive payment for Medicare claims. Assuming, again, that all requirements are met, entities that may utilize the IPP could include:

- *Employers*
- *Unions*
- *Insurance companies*
- *Retirement homes*
- *Health care prepayment plans*
- *Health maintenance organizations*
- *Competitive medical plans*
- *Medicare Advantage plans*

As stated, an IPP entity is not a Medicare provider or supplier. It therefore cannot enroll in the Medicare program. It is crucial, nonetheless, that Medicare obtain sufficient background information on prospective

IPP entities to ensure the integrity, accuracy, and legitimacy of Medicare payments to said entities. Hence, CMS will apply the Form CMS-855 process to IPP entities consistent with our authority to request information under 42 CFR § 424.66(a)(5). For purposes of the IPP, this process is called IPP "registration," rather than enrollment. An entity must satisfy the requirements described in 42 CFR § 424.66 and successfully complete the Form CMS-855 registration process before it can bill Medicare under the IPP. Naturally, an IPP entity's status as a non-provider and non-supplier will result in procedures that differ in certain aspects from those associated with the enrollment of Medicare providers and suppliers.

15.7.9.2 - Submission of Registration Applications
(Rev. 502, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-06-14)

A. Jurisdiction

An IPP entity's registration application must be submitted to each Medicare claims administration contractor to which the IPP entity will be submitting claims. Claims for all Part B items and services – other than for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) – must be submitted to the A/B Medicare Administrative Contractor (MAC) based on where the service was performed or the item was furnished. Almost all claims for DMEPOS must be submitted to the DME MAC based on where the beneficiary resides. However, claims for Medicare-covered implantable devices, although classified as DME, are submitted to the A/B MACs based on where the implant surgery was performed. These jurisdictional rules for claim submission apply to submission of registration applications. As such, the IPP entity must complete and submit:

(1) The appropriate Form CMS-855 application and Form CMS-588 to each applicable A/B MAC to which the plan will be submitting its non-DMEPOS claims; and/or

(2) The appropriate Form CMS-855 application and Form CMS-588 to the National Supplier Clearinghouse (NSC).

With respect to (1) – and consistent with section 15.5.4.2(D) of this chapter - the IPP entity need only submit one Form CMS-855 application and one Form CMS-588 per contractor jurisdiction.

B. Form Completion

The IPP entity:

(1) Must use the paper version of the Form CMS-855 application.

(2) Must – in light of its ineligibility for an NPI - apply for and receive either a Health Plan Identifier (HPID) or an Other Entity Identifier (OEID) in accordance with 45 CFR § 162. This is to facilitate the entity's submission of claims under the IPP. The entity must furnish its HPID or OEID in the appropriate place on the Form CMS-855. It shall also list the HPID or OEID on the Form CMS-855 and Form CMS-588 and furnish documentation evidencing the issuance of the number (e.g., a notice from the HPID or OEID issuer identifying the number).

(3) Need not submit licensure or certification information.

(4) Shall list its main business address (e.g., its headquarters) as its practice location.

(5) Need not report medical record storage information.

(6) Need not pay an application fee (as it is not an "institutional provider" under 42 CFR § 424.502), although it must receive payments via electronic funds transfer (EFT).

(7) Need not submit a Form CMS-460. Because § 1842(h)(1) of the Social Security Act only permits "physicians and suppliers" to enter into participation agreements and because IPP entities do not meet the definition of a "supplier" at § 400.202, IPP entities cannot enter into a participation agreement (Form CMS-460) with Medicare. The IPP entity shall therefore be treated as "non-participating."

(8) Need not meet the applicable (a) supplier standards, (b) accreditation requirements, (c) surety bond requirements, and (d) liability insurance requirements if the IPP entity is a DMEPOS supplier. (The NSC may need to relax certain edits in the Provider Enrollment, Chain and Ownership System (PECOS).) Moreover, the contractor need not perform a site visit.

(9) Meet the attestation requirements in subsection (C) below.

C. Attestation

1. Contents

The IPP entity must submit with each registration application a signed attestation statement certifying that for each claim it submits, all of the following requirements in 42 CFR § 424.66 are met:

(1) The entity provides coverage of the service under a complementary health benefit plan and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan.

(2) The entity has paid the person (i.e., the physician or other supplier) who provided the service (including the amount payable under the Medicare program) an amount that the physician or other supplier accepts as full payment.

(3) The entity has the written authorization of the beneficiary (or other person authorized to sign claims on the beneficiary's behalf under 42 CFR § 424.36) to receive the Part B payment for the services paid by the entity.

(4) The entity relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, the beneficiary's survivors, or the beneficiary's estate.

(5) The entity agrees to submit any information requested by CMS or by a Medicare contractor, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.

(6) The entity agrees to identify and exclude from its requests for payment all services for which Medicare is the secondary payer.

This attestation is necessary to help ensure that the entity is in compliance with the provisions of § 424.66. As already stated, compliance with § 424.66 is a prerequisite for initial and continued registration as an IPP entity.

Since the IPP entity may be submitting applications in multiple jurisdictions, it is acceptable for the entity to submit a photocopy of a signed attestation rather than an originally signed attestation.

2. Signature

An "authorized official" - as that term is defined in 42 CFR § 424.502 – must sign all attestations, though the same authorized official need not sign all attestations.

The certification statement on the Form CMS-855 supplements - and does not supplant - the attestation referred to above. The IPP entity is bound by the terms of the certification statement to the same extent as it is bound by the attestation's terms.

15.7.9.3 – Processing of Registration Applications
(Rev. 502, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-06-14)

A. Basic Requirements

Upon receipt of a Form CMS-855 registration application from an IPP entity, the contractor shall begin processing the application. This includes:

- *Ensuring that the application is complete (see section D(1) below for additional information).*

- *Creating a logging & tracking (L & T) record and entering the IPP entity's information in the Provider Enrollment, Chain and Ownership System (PECOS).*

- *Verifying the information on the application in accordance with (1) the "limited" category of screening (see section 15.19.2.1(A) of this chapter for more information), and (2) existing processing guidelines (e.g., reviewing all entities and individuals listed on the Form CMS-855 against the Medicare Exclusion Database and General Services Administration Excluded Parties List System).*

- *Ensuring that the attestation identified in section 15.7.9.2 above is submitted, signed by an authorized official, and contains the required language.*

- *As needed, asking the entity for additional or clarifying information using the procedures outlined in this chapter and other applicable CMS directives; this may include information – beyond the attestation itself – that is necessary to determine whether the entity is indeed in compliance with the provisions of 42 CFR § 424.66.*

- *Assigning specialty code C2.*

- *Assigning a Provider Transaction Access Number (PTAN) (if the application is approved).*

B. Prescreening

The contractor need not "prescreen" (as that term is described in section 15.7.1.1 of this chapter) the registration application.

C. Returns

Section 15.8.1 of this chapter outlines the reasons for which the contractor may immediately return a Form CMS-855. If the contractor determines that one or more of these reasons applies, it shall return the registration application in accordance with the instructions outlined in that section.

D. Development Issues

If, in response to a development request, the IPP entity indicates that it is unable to furnish certain data elements because said elements do not apply to it, the contractor shall contact its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) for guidance.

E. Timeliness and Accuracy Standards

The timeliness and accuracy standards in sections 15.6.1.1.3, 15.6.1.2, 15.6.2.1, and 15.6.2.2 of this chapter apply to the processing of IPP initial applications and changes of information. Should the contractor exceed timeliness standards due to the requirements of sections 15.7.9.1 through 15.7.9.7, the contractor shall note the provider file in accordance with section 15.7.3 of this chapter.

F. HPID/OEID

The algorithm for the HPID/OEID is similar to that of the National Provider Identifier in that it will be 10 digits in length and will begin with either a "7" (HPID) or a "6" (OEID). The HPID/OEID will replace the placeholder NPI for IPP entities only.

15.7.9.4 – Disposition of Registration Applications
(Rev. 502, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-06-14)

A. Approval

If the contractor determines that the IPP entity meets all necessary requirements, it shall send an e-mail to its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) that contains: (1) the entity's legal business name, "doing business as" name (if applicable) and HPID or OEID; (2) a draft approval letter patterned after the applicable model letter in section 15.7.9.7; and (3) any issues the contractor encountered in its review. The PEOG BFL will review the matter and advise the contractor as to how to proceed.

If PEOG authorizes the approval, the contractor shall (1) switch the Provider Enrollment, Chain and Ownership System (PECOS) record to "Approved," (2) establish an effective date that is the date on which the contractor approved the application, (3) assign a Provider Transaction Access Number (PTAN) or National Supplier Clearinghouse number (as applicable), and (4) send the approval letter via regular mail or e-mail to the entity no later than 5 business days after the contractor received authorization of the approval from PEOG.

After the entity is registered, the contractor (consistent with § 424.66(a)(5)) may request additional information in order to confirm the entity's continued compliance with 42 CFR § 424.66.

B. Denial

If the contractor determines that the entity does not meet all necessary requirements, it shall send an e-mail to its PEOG BFL that contains: (1) the entity's legal business name, "doing business as" name (if applicable), and HPID or OEID; (2) a draft denial letter patterned after the applicable model letter in section 15.7.9.7; and (3) the contractor's rationale for proposing to deny the application. The PEOG BFL will review the matter and advise the contractor as to how to proceed.

Grounds for denial include, but are not limited to, the following:

(1) The entity does not comply with all applicable registration requirements.

(2) The entity does not satisfy all of the requirements described in 42 CFR § 424.66. (The contractor can contact its PEOG BFL for assistance on this issue.)

(3) The entity or any of its 5 percent or greater direct or indirect owners, managing employees, corporate officers, or corporate directors - or any entity or individual with a general partnership interest or a 10 percent or greater limited partnership interest in the entity - is excluded or debarred per the Medicare Exclusion Database (MED) and/or the General Services Administration Excluded Parties List System.

If the contractor believes that any other ground for denial exists, it shall include this in its e-mail to its PEOG BFL.

If PEOG authorizes the denial, the contractor shall (1) switch the PECOS record to "Denied," and (2) send the denial letter via certified mail to the entity no later than 5 business days after the contractor received authorization of the denial from PEOG.

As indicated in the model denial letter in section 15.7.9.7, an entity may appeal the denial of its IPP registration application. Although IPP entities are neither providers nor suppliers, the procedures in sections 15.25.2 through 15.25.2.3 of this chapter shall apply to IPP appeals.

C. Rejection

The Form CMS-855 shall be rejected if (1) the entity fails to furnish all required information on the form within 30 calendar days of the contractor's request to do so, or (2) the entity fails to timely submit new or corrected information in the scenarios described in section 15.8.2 of this chapter. (This includes situations in which information was submitted, but could not be verified.) The basis for rejection shall be 42 CFR § 424.525(a). The rejection letter shall follow the format of the applicable letter in section 15.7.9.7 and shall be sent via regular mail no later than 5 business days after the contractor determines that the application should be rejected.

Prior PEOG approval of the rejection is unnecessary. However, as stated earlier, if the entity indicates that it is unable to furnish certain data elements because said elements do not apply to it, the contractor shall contact its PEOG BFL for guidance.

15.7.9.5 – Revocation of Registration
(Rev. 502, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-06-14)

If the contractor determines that the entity no longer meets all necessary requirements, it shall send an e-mail to its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) that contains: (1) the entity's legal business name, "doing business as" name (if applicable), and HPID or OEID; (2) a draft revocation letter patterned after the applicable model letter in section 15.7.9.7 below; and (3) the contractor's rationale for proposing to revoke the entity's registration. The PEOG BFL will review the matter and advise the contractor as to how to proceed.

Grounds for revocation include, but are not limited to, the following:

(1) The entity no longer complies with all applicable registration requirements.

(2) The entity no longer appears to be in compliance with the provisions of 42 CFR § 424.66. (The contractor can contact its PEOG BFL for assistance regarding grounds (1) and (2).)

(3) The entity has not complied with the terms of its signed Form CMS-855 certification statement (e.g., has not timely submitted an update to its registration information).

(4) The entity or any of its 5 percent or greater direct or indirect owners, managing employees, corporate officers, or corporate directors - or any entity or individual with a general partnership interest or a 10 percent or greater limited partnership interest in the entity - is excluded or debarred per the Medicare Exclusion Database (MED) and/or the General Services Administration Excluded Parties List System.

If the contractor believes that any other ground for revocation exists, it shall include this in its e-mail to its PEOG BFL.

If PEOG authorizes the revocation, the contractor shall (1) switch the PECOS record to "Revoked," and (2) send the revocation letter via certified mail to the entity no later than 5 business days after the contractor received authorization of the revocation from PEOG.

As indicated in the model revocation letter in section 15.7.9.7 below, an entity may appeal the revocation of its IPP registration. Although IPP entities are neither providers nor suppliers, the procedures in sections 15.25.2 through 15.25.2.3 of this chapter shall apply to IPP appeals.

15.7.9.6 – Changes of Information and Other Registration Transactions (Rev. 502, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-06-14)

A. Changes of Information

An IPP entity is required to submit changes to its Form CMS-855 information in accordance with the terms of its signed Form CMS-855 certification statement. The contractor shall process such changes in accordance with existing instructions.

B. Other Transactions

1. Deactivations – The contractor shall not deactivate an entity's IPP registration for any reason unless CMS instructs the contractor to do so.

2. Voluntary Terminations – If an IPP entity submits a voluntary termination application, the contractor shall process it in accordance with existing instructions.

15.7.9.7 – Registration Letters (Rev. 502, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-06-14)

The contractor shall use the following letters when approving, denying, or rejecting an application, or when revoking an entity's registration.

A. Approval

CMS alpha representation
Contractor

[Month Day & Year]

[Entity Name]
[Address]
[City, State & zip code]

Dear [Entity name]:

We are pleased to inform you that your Medicare Form CMS-855 registration application as an Indirect Payment Procedure (IPP) entity has been approved. Listed below is the information reflected in your Medicare Form CMS-855 record, including your Provider Transaction Access Number (PTAN).

For more information on how to bill Medicare, please contact our XXXXXXXX department at [insert phone number].

Your PTAN is also activated for use and will be the required authentication element for all inquiries to customer service representatives (CSRs), written inquiry units and the interactive voice response (IVR) system for inquiries concerning claims status, beneficiary eligibility and to check status or other related transactions. Please keep your PTAN secure.

Medicare Information

Entity name:	*[Insert name]*
Business address:	*[Insert address]*
PTAN:	*[Insert PTAN]*
Status:	*IPP Entity*

Please verify the accuracy of this information. If you disagree with this initial determination or have any questions regarding the information above, call [insert applicable Medicare contractor name] at [insert Medicare contractor phone number] between the hours of [insert hours of operation].

Consistent with 42 CFR § 424.516, you must submit updates and changes to your Form CMS-855 information in accordance with specified timeframes. Reportable changes include, but are not limited to, changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) business address, and (3) payment information (such as changes in electronic funds transfer information). To download the CMS-855 applications, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll.

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

Sincerely,

[Your Name]
[Title]

B. Denial

CMS alpha representation
Contractor

[Month Day & Year]

[Entity name]
[Address]
[City, State & zip code]

RE: [insert decision]

Dear [Entity name]:

We have received and reviewed your Form CMS-855 registration application as an Indirect Payment Procedure (IPP) entity. Your application is denied. We have determined that you do not meet the conditions necessary to bill Medicare as an IPP entity.

FACTS: [Insert ALL the reason(s) for denial and cite the applicable regulatory authority]

(Repeat for multiple, if necessary)

If you believe that you are able to correct the deficiencies and establish your eligibility to bill Medicare as an IPP entity, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with the necessary registration requirements and must be signed and dated by an authorized official of the entity. CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment Operations Group
Mail Stop AR-18-50
7500 Security Boulevard
Baltimore, MD 21224-1850

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to the office listed below within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. The reconsideration request must be signed and dated by an authorized official of the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the denial involves exclusions or sanction: You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action]. The request for reconsideration should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment Operations Group
Mail Stop AR-18-50
7500 Security Boulevard

Baltimore, MD 21224-1850

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

C. Rejection

CMS alpha representation
Contractor

[Month Day & Year]

[Entity Name]
[Address]
[City, State & ZIP Code]

Dear [Entity name]:

We received your Medicare Form CMS-855 registration application on [insert date]. We are rejecting your application and returning it to you for the following reason(s):

FACTS: [Insert ALL rejection reason(s) and cite the applicable regulatory authority]

(Repeat for multiple, if necessary)

Consistent with 42 CFR § 424.525, prospective Indirect Payment Procedure (IPP) entities are required to submit a complete registration application and all necessary supporting documentation within 30 calendar days from the date of the contractor's request for missing/incomplete/clarifying information. If you would like to resubmit your registration application, please make sure to address the issues stated above and to sign and date the new certification statement page on your resubmitted application.

To submit a new registration application, you may download and complete the application from the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/MedicareProviderSupEnroll.

You should return the complete application to the address listed below:

[Insert contact address]

If you have any questions regarding this letter, please call [phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]

D. Revocation

CMS alpha representation
Contractor

[Month Day & Year]

[Entity name]
[Address]
[City, State & ZIP Code]

[RE:]

Dear [Entity name]:

This is to inform you that your Medicare registration as an Indirect Payment Procedure (IPP) entity is being revoked effective [insert effective date of revocation].

FACTS: [Insert ALL reason(s) for revocation and cite the applicable regulatory authority]

If you believe that you are able to correct the deficiencies and re-establish your eligibility to be registered as an IPP entity, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with all registration requirements. The CAP request must be signed and dated by an authorized official of the entity. . CAP requests should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment Operations Group
7500 Security Blvd.
Mailstop: AR-18-50
Baltimore, MD 21244-1850

If you believe that this determination is not correct, you may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to the office listed below within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. The reconsideration request must be signed and dated by an authorized official of the entity. . Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review. [The following statement should only be used if the revocation involves exclusions or sanction: You may not appeal through this process the merits of any exclusion by another Federal agency. Any further permissible administrative appeal involving the merits of such exclusion must be filed with the Federal agency that took the action.] The request for reconsideration should be sent to:

Centers for Medicare & Medicaid Services
Provider Enrollment Operations Group
7500 Security Blvd.
Mailstop: AR-18-50
Baltimore, MD 21244-1850

Consistent with 42 CFR § 424.535(c), [insert contractor name] is establishing a re-registration bar for a period of [insert amount of time]. This bar only applies to your registration in the Medicare program. In order to re-register, you must meet all registration requirements.

If you have any questions regarding this determination, please contact [insert contact name] at [insert phone number] between the hours of [insert office hours].

Sincerely,

[Your Name]
[Title]