CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 514	**Date: May 2, 2014**
	Change Request 8682

SUBJECT: Update to CMS Publication 100-08, Chapter 15

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to update various sections of chapter 15 of the Program Integrity Manual (PIM). The changes largely, though not exclusively, address the "recommendation for approval" letters that Medicare Administrative Contractors send to the state agencies and CMS Regional Offices (ROs).

EFFECTIVE DATE: June 3, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 3, 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
R	15/15.4.1.4/Federally Qualified Health Centers (FQHCs)
R	15/15.4.2.6/Radiation Therapy Centers
R	15/15/5.4/Practice Location Information
R	15/15.5.15.2/Form CMS-855A and Form CMS-855B Signatories
R	15/15.5.16/Delegated Officials
R	15/15.7.9.2/Submission of Registration Applications
R	15/15.7.9.7/Registration Letters
R	15/15.9.2/Certified Providers and Certified Suppliers
R	15/15.19.3/Temporary Moratoria
R	15/15.24.6/Model Approval Recommended Letters
N	15/15.24.6.1/Initial Enrollments Requiring Referral to the State
N	15/15.24.6.2/Initial Enrollments Requiring Direct Referral to the Regional Office (Including Federally Qualified Health Centers)
N	15/15.24.6.3/Changes of Information
N	15/15.24.6.3.1/Changes of Information Requiring Referral to the State
N	15/15.24.6.3.2/Changes of Information Requiring Direct Referral to the Regional Office
N	15/15.24.6.4/Potential Changes of Ownership Under the Principles of § 489.18
N	15/15.24.6.4.1/Potential Changes of Ownership Under the Principles of § 489.18 - Referral to the State Required
N	15/15.24.6.4.2/Potential Changes of Ownership Under the Principles of § 489.18 – Direct Referral to the Regional Office Required

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 514	Date: May 2, 2014	Change Request: 8682

SUBJECT: Update to CMS Publication 100-08, Chapter 15

EFFECTIVE DATE: June 3, 2014
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IMPLEMENTATION DATE: June 3, 2014

I. GENERAL INFORMATION

A. Background: The purpose of this change request (CR) is to update various sections of chapter 15 of the Program Integrity Manual (PIM). The changes largely, though not exclusively, address the "recommendation for approval" letters that Medicare Administrative Contractors send to the state agencies and CMS Regional Offices (ROs).

B. Policy: This CR updates various sections of chapter 15 of the PIM to address certain various provider enrollment issues that have arisen.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8682.1	**NOTE**: The contractor shall observe the manual revisions.	X	X	X						

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

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).

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

ATTACHMENTS: 0

Medicare Program Integrity Manual
Chapter 15 - Medicare Enrollment

Table of Contents
(Rev.514, 5-2-14)

15.4.1.4 - Federally Qualified Health Centers (FQHCs)

(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

FQHCs furnish services such as those performed by physicians, nurse practitioners, physician assistants, clinical psychologists, and clinical social workers. This also includes certain preventive services like prenatal services, immunizations, blood pressure checks, hearing screenings and cholesterol screenings. (See CMS Publication 100-02, chapter 13, for more information). Even though they complete the Form CMS-855A application, FQHCs are considered Part B certified suppliers.

FQHCs are not required to obtain a State survey; there is no State agency involvement with FQHCs. As such, the contractor will either deny the application or make a recommendation for approval and forward it directly to the RO. The RO will then make the final decision as to whether the entity qualifies as a FQHC. Generally, in order to so qualify, the facility must be receiving, or be eligible to receive, certain types of Federal grants (sometimes referred to as "grant status"), or must be an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian organization. The Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services (DHHS) may assist the RO in determining whether a particular supplier meets FQHC standards, since HRSA maintains a list of suppliers that met certain grant requirements. (See CMS Pub. 100-07, chapter 2, sections 2825-2826D for more information.)

NOTE: Additional information about FQHCs:

- As stated above, there is no State agency involvement with FQHCs. However, FQHCs still must meet all applicable State and local requirements and submit all applicable licenses. Typically, HRSA will verify such State/local compliance by asking the FQHC to attest that it meets all State/local laws.

- FQHCs can be based in a rural or urban area that is designated as either a shortage area or an area that has a medically underserved population.

- To qualify as an FQHC, the facility must, among other things, either (1) furnish services to a medically underserved population or (2) be located in a medically underserved area.

- The FQHC must submit a signed and dated Attestation Statement for Federally Qualified Health Centers (Exhibit 177). This attestation serves as the Medicare FQHC benefit (or provider/supplier) agreement. (See Pub. 100-07, chapter 2, section 2826B.) The FQHC must also submit, as indicated above, a HRSA "Notice of Grant Award" or Look-Alike Status. A completed FQHC crucial data extract sheet (Exhibit 178), however, is no longer required.

- The contractor shall ensure that the attestation statement (Exhibit 177) contains the same legal business name and address as that which the FQHC provided in section 2 and section 4, respectively, of the Form CMS-855A. If the attestation contains a different name, the contractor shall develop for the correct name.

- An FQHC cannot have multiple sites or practice locations. Each location must be separately enrolled and will receive its own CMS Certification Number.

- *If an FQHC submits a change of information request to change its location, the contractor may wish to contact the RO to see whether the change (1) is such that an initial enrollment is required (i.e., the change constitutes the establishment of a new FQHC) or (2) makes the clinic no longer eligible for enrollment as an FQHC (i.e., the change is to a location that is neither a shortage area nor an area with a medically underserved population).*

When sending a recommendation for approval letter to the RO for an initial FQHC application, the contractor shall indicate in the letter the date on which the FQHC's application was complete. To illustrate, assume that the FQHC submitted an initial application on March 1. Two data elements were missing; the

contractor thus requested additional information. The two elements were submitted on March 30. The contractor shall therefore indicate the March 30 date in its letter as the date the application was complete.

See CMS Publication 100-07, chapter 2, section 2826F for information regarding the effective date of an FQHC's agreement with CMS.

For additional general information on FQHCs, refer to:

- Section 1861(aa)(3-4) of the Social Security Act
- 42 CFR Part 491 and 42 CFR Part 405.2400
- Pub. 100-07, chapter 2, sections 2825 – 2826H
- Pub. 100-07, Exhibit 179
- Pub. 100-04, chapter 9 (Claims Processing Manual)
- Pub. 100-02, chapter 13 (Benefit Policy Manual)

For information on the appropriate contractor jurisdictions for incoming FQHC enrollment applications, see:

- Pub. 100-04, chapter 1, section 20
- Pub. 100-04, chapter 9, section 10.*3*

15.4.2.6 - Radiation Therapy Centers

(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

Under 42 CFR § 410.35, Medicare Part B pays for X-ray therapy and other radiation therapy services, including radium therapy and radioactive isotope therapy, and materials and the services of technicians administering the treatment.

Radiation therapy centers (RTCs) may receive reassigned benefits. An RTC need not separately enroll as a group practice in order to receive them.

For additional background on radiation therapy services, see:

- Section 1861(s)(4) of the Social Security Act
- 42 CFR § 410.35
- Publication 100-04, chapter 13
- Publication 100-*02*, chapter 15, section 90

15.5.4 – Practice Location Information

(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

Unless specifically indicated otherwise, the instructions in this section 15.5.4 apply to the Form CMS-855A, the Form CMS-855B, and the Form CMS-855I.

The instructions in section 15.5.4.1 apply only to the Form CMS-855A; the instructions in section 15.5.4.2 apply only to the Form CMS-855B; and the instructions in section 15.5.4.3 only apply to the Form CMS-855I.

A. Practice Location Verification

The contractor shall verify that the practice locations listed on the application actually exist. *I*f a particular location cannot at first be verified, the contractor shall request clarifying information*; f*or instance, the contractor can request that the applicant furnish letterhead showing the appropriate address.)

The contractor shall also verify that the reported telephone number is operational and connects to the practice location/business listed on the application. (The telephone number must be one where patients and/or customers can reach the applicant to ask questions or register complaints.) The contractor shall match the applicant's telephone number with known, in-service telephone numbers - via, for instance, the Yellow Pages or the Internet - to correlate telephone numbers with addresses. If the applicant uses his/her/its cell phone for their business, the contractor shall verify that this is a telephone connected directly to the business. If the contractor cannot verify the telephone number, it shall request clarifying information from the applicant; the inability to confirm a telephone number may indicate that an onsite visit is necessary. In some instances, a 1-800 number or out-of-state number may be acceptable if the applicant's business location is in another State but his/her/its practice locations are within the contractor's jurisdiction.

In addition:

- If an individual practitioner or group practice: (1) is adding a practice location and (2) is normally required to complete a questionnaire in section 2 of the Form CMS-855I or Form CMS-855B specific to its supplier type (e.g., psychologists, physical therapists), the person or entity must submit an updated questionnaire to incorporate services rendered at the new location.

- Any provider submitting a Form CMS-855A, Form CMS-855B or Form CMS-855I application must submit the 9-digit ZIP Code for each practice location listed.

- *The practice location name entered into the Provider Enrollment, Chain and Ownership System shall be the legal business name.*

B. Do Not Forward (DNF)

Unless instructed otherwise in another CMS directive, the contractor shall follow the DNF initiative instructions in Pub. 100-04, chapter 1, section 80.5. Returned paper checks, remittance notices, or EFT payments shall be flagged if returned from the post office or banking institution, respectively, as this may indicate that the provider's "special payment" address (section 4 of the Form CMS-855) or EFT information has changed. The provider should submit a Form CMS-855 or Form CMS-588 request to change this address; if the provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System, it must complete an entire Form CMS-855 and Form CMS-588. The Durable Medical Equipment Medicare Administrative Contractors are responsible for obtaining, updating and processing Form CMS-588 changes.

In situations where a provider is closing his/her/its business and has a termination date (e.g., he/she is retiring), the contractor will likely need to make payments for prior services rendered. Since the practice location has been terminated, the contractor may encounter a DNF message. If so, the contractor should request the provider to complete the "special payment" address section of the Form CMS-855 and to sign the certification statement. The contractor, however, shall not collect any other information unless there is a need to do so.

C. Remittance Notices/Special Payments

For new enrollees, all payments must be made via EFT. The contractor shall thus ensure that the provider has completed and signed the Form CMS-588 and shall verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

If an enrolled provider that currently receives paper checks submits a Form CMS-855 change request – no matter what the change involves – the provider must also submit:

- A Form CMS-588 that switches its payment mechanism to EFT. (The change request cannot be processed until the Form CMS-588 is submitted.) All future payments (excluding special payments) must be made via EFT.

- An updated section 4 that identifies the provider's desired "special payments" address.

The contractor shall also verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

(Once a provider changes its method of payment from paper checks to EFT, it must continue using EFT. A provider cannot switch from EFT to paper checks.)

The "special payment" address may only be one of the following:

- One of the provider's practice locations

- A P.O. Box

- The provider's billing agent. The contractor shall request additional information if it has any reason to suspect that the arrangement – at least with respect to any special payments that might be made – may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.

- The chain home office address. Per Pub.100-04, chapter 1, section 30.2, a chain organization may have payments to its providers sent to the chain home office. The legal business name of the chain home office must be listed on the Form CMS-588. The TIN on the Form CMS-588 should be that of the provider.

- Correspondence address

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

(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

(The instructions in this section 15.5.15.2 apply unless another CMS directive states otherwise.)

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

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

contractor remains unconvinced that the individual qualifies as an authorized official, it shall notify the provider that the person cannot be an authorized official. If that person is the only authorized official listed and the provider refuses to use a different authorized official, the contractor shall deny the application.

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

In addition:

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

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

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

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

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

6. Social Security Number - To be an authorized official, the person must have and must submit his/her social security number (SSN). *An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.*

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

8. Certification Statement Development – When the contractor develops for missing or additional information and the provider must submit a newly-signed certification statement, only the actual signature page is required; the additional page containing the certification terms need not be submitted unless the contractor requests it. (This does not apply, however, to the provider's initial submission of a certification statement for a particular application; such instances require the submission of both the signature page and

the page containing the certification terms. To illustrate, suppose the provider submits an initial CMS-855 application with an undated certification statement. The provider must furnish a newly-dated (and signed) certification statement and the certification terms page; it does so on March 1. On March 15, the contractor determines that information on section 4 of the provider's application is incorrect and must be revised. When submitting the revised section 4 page, the provider need only furnish a newly-signed signature page; the certification terms page need not be submitted unless the contractor requests it.

15.5.16 – Delegated Officials

(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

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

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

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

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

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

The contractor shall note the following about delegated officials:

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

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

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

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

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

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

7. Social Security Number - To be a delegated official, the person must have and must submit his/her social security number. *An Individual Taxpayer Identification Number (ITIN) cannot be used in lieu of an SSN in this regard.*

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

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

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

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

12. Certification Statement Development – When the contractor develops for missing or additional information and the provider must submit a newly-signed certification statement, only the actual signature page is required; the additional page containing the certification terms need not be submitted unless the contractor requests it. (This does not apply, however, to the provider's initial submission of a certification statement for a particular application; such instances require the submission of both the signature page and the page containing the certification terms. To illustrate, suppose the provider submits an initial CMS-855 application with an undated certification statement. The provider must furnish a newly-dated (and signed) certification statement and the certification terms page; it does so on March 1. On March 15, the contractor determines that information on section 4 of the provider's application is incorrect and must be revised. When submitting the revised section 4 page, the provider need only furnish a newly-signed signature page; the certification terms page need not be submitted unless the contractor requests it.

15.7.9.2 - Submission of Registration Applications

(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

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) or carrier 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 or carriers 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 and carrier 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) *and resident agent address (if applicable)* as practice location*s*.

(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.

15.7.9.7 – Registration Letters

(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

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 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 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 21244-1850

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]

15.9.2 - Certified Providers and Certified Suppliers

(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

(This section only applies to: (1) initial Form CMS-855A applications or change of ownership (CHOW), acquisition/merger, or consolidation applications submitted by the new owner; and (2) initial ambulatory surgical center and portable x-ray supplier applications.)

If the contractor decides to recommend approval of the provider or supplier's application, the contractor shall send a recommendation letter to the applicable State agency, with a copy to the Regional Office's (RO) survey and certification unit. (For those provider*/supplier* types that do not require a State survey, such as federally qualified health centers, the letter can be sent directly to the RO.) The recommendation letter shall, at a minimum, contain the following information:

- Supplier/Provider NPI Number
- CMS Certification Number (if available)
- Type of enrollment transaction (CHOW, initial enrollment, branch addition, etc.)
- Contractor number
- Contractor contact name
- Contractor contact phone number
- Date application recommended for approval (and, for FQHCs, the date that the package is complete)
- An explanation of any special circumstances, findings, or other information that either the State or the RO should know about.
- Any other information that, under this chapter 15, must be included in the recommendation letter.

The letter can be sent to the State/RO via mail, fax, or e-mail.

The contractor shall also:

- Send *either a photocopy (not the original), faxed version, or e-mail* version of the final completed Form CMS-855 to the State agency *or RO (as applicable)*, along with all updated Form CMS-855 pages, explanatory data, documentation, correspondence, final sales agreements, etc. *(which can also be sent via mail, fax, or e-mail). If the CMS-855, associated documentation, and recommendation letter are mailed, they should be included* in the same package.
The contractor shall not send a copy of the Form CMS-855 to the RO unless the latter specifically requests it or if the transaction in question is one for which State involvement is unnecessary.
- Notify the applicant that the contractor has completed its initial review of the application. The notification can be furnished via e-mail, or via the letter identified in section 15.24.6 of this chapter, and shall advise the applicant of the next steps in the enrollment process (e.g., site visit, survey). The contractor may, but is not required to, send a copy of its recommendation letter to the provider as a means of satisfying this requirement. However, the contractor should not send a copy to the provider if the recommendation letter contains sensitive information.

- Inform initial applicants (including new owners that have rejected assignment of the provider's or supplier's provider agreement) that Medicare billing privileges will not begin before the date the survey and certification process has been completed and all Federal requirements have been met.

- Notify the applicant of the phone numbers and e-mail addresses of the applicable State agency and RO that will be handling the survey and certification process; the applicant shall also be instructed that all questions related to this process shall be directed to the State agency and/or RO.

15.19.3 – Temporary Moratoria

(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

Under § 424.570(a), CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area. *The announcement of a moratorium will be made via the Federal Register, though the contractor will be separately notified of the moratorium.*

The contractor shall abide by all CMS directives and instructions issued pursuant to the imposition or lifting of a particular moratorium.

15.24.6 – Model Approval Recommended Letters

(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

15.24.6.1 – Initial Enrollments Requiring Referral to the State
(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

[Contractor name] has assessed your Medicare enrollment application and has forwarded it to [Name of State Office]. A copy has also been sent to the [City] Regional Office of the Centers for Medicare & Medicaid Services (CMS). [If – and only if - a survey or accreditation is required, include the following language: "The next step will be a survey conducted by a State Survey Agency or a CMS approved deemed accrediting organization to ensure compliance with the required conditions of (insert "participation" or "coverage," as applicable.)] After the CMS Regional Office determines whether all conditions of (insert "participation" or "coverage," as applicable) are met, we will send you our decision.

If you have any questions concerning this letter, please contact [Name of State Office] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

15.24.6.2 – Initial Enrollments Requiring Direct Referral to the Regional Office (Including Federally Qualified Health Centers)

(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

[Contractor name] has assessed your Medicare enrollment application and has forwarded it to the [City] Regional Office of the Centers for Medicare & Medicaid Services (CMS). After the CMS Regional Office determines whether all conditions of (insert "participation" or "coverage," as applicable) are met, we will send you our decision.

If you have any questions concerning this letter, please contact [Name of Regional Office] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

15.24.6.3 – Changes of Information

(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

This letter shall be used for change requests that require a referral to the State and/or Regional Office (RO) (as applicable). See the appropriate sections of this chapter for information on changes that mandate referral to the State and/or RO.

15.24.6.3.1 – Changes of Information Requiring Referral to the State
(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

[Contractor name] has assessed your request to update your Medicare enrollment information and has forwarded it to [Name of State Office]. A copy has also been sent to the [City] Regional Office of the Centers for Medicare & Medicaid Services (CMS). Once the CMS Regional Office completes its final review of your request, we will send you our decision.

If you have any questions concerning this letter, please contact [Name of State Office] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

15.24.6.3.2 – Changes of Information Requiring Direct Referral to the Regional Office
(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

(This letter shall be used for change requests that require a referral to the RO but not the State because there is no State involvement with these provider/supplier types (e.g., federally qualified health centers))

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

[Contractor name] has assessed your request to update your Medicare enrollment information and has forwarded it to the [City] Regional Office of the Centers for Medicare & Medicaid Services (CMS). Once the CMS Regional Office completes its final review of your request, we will send you our decision.

If you have any questions concerning this letter, please contact [Name of State Office] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

15.24.6.4 – Potential Changes of Ownership Under the Principles of § 489.18
(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

(These letters shall be used for potential changes of ownership under the principles of § 489.18.)

15.24.6.4.1 – Potential Changes of Ownership Under the Principles of § 489.18 - Referral to the State Required
(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

[Contractor name] has assessed your change of ownership application and has forwarded it to [Name of State Office]. A copy has also been sent to the [City] Regional Office of the Centers for Medicare & Medicaid Services (CMS). Once the CMS Regional Office completes its final review of your application, we will send you our decision.

If you have any questions concerning this letter, please contact [Name of State Office] at [contact information].

Sincerely,

[Name]
[Title]
[Company]

15.24.6.4.2 – Potential Changes of Ownership Under the Principles of § 489.18 –Direct Referral to the Regional Office Required

(Rev.514; Issued: 5-2-14; Effective: 6-3-14; Implementation: 6-3-14)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (PTAN #, Enrollment #, Case #, etc.)

Dear [Provider/Supplier Name]:

[Contractor name] has assessed your change of ownership application and has forwarded it to the [City] Regional Office of the Centers for Medicare & Medicaid Services (CMS). Once the CMS Regional Office completes its final review of your application, we will send you our decision.

If you have any questions concerning this letter, please contact [Name of State Office] at [contact information].

Sincerely,

[Name]
[Title]
[Company]