

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 521	Date: June 13, 2014
	Change Request 8784

SUBJECT: Submission of Community Mental Health Center (CMHC) Certifications of Compliance with Section 485.918(b)(1)

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to instruct contractors on the processing of CMHC certifications of compliance with § 485.918(b)(1).

EFFECTIVE DATE: July 15, 2014

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

IMPLEMENTATION DATE: July 15, 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/revise 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	15/15.4.1.1/Community Mental Health Centers (CMHCs)
N	15/15.4.1.1.1/CMHC 40 Percent Rule
R	15/15.5.4.3/Section 4 of the Form CMS-855I
R	15/15.7.5.1/Special Procedures for Physicians and Non-Physician Practitioners
R	15/15.23.2/Release of Information

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 Instructions

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared- System Maintainers				Other
		A	B	H H H		F I S S	M C S S	V M S S	C W F	
8784.3	If the provider exceeds applicable timeliness standards due to the instructions in this section 15.4.1.1.1, the contractor shall accordingly document the provider file consistent with section 15.10 of this chapter.	X								
8784.4	The contractor shall include the certification in the recommendation package it sends to the State agency.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
8784.5	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

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@hotmail.com

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.521, 06-13-14)

15.4.1.1.1 – CMHC 40 Percent Rule

15.4.1.1 - Community Mental Health Centers (CMHCs)

(Rev.521, Issued: 06-13-14, Effective: 07-15-14, Implementation: 07-15-14)

A. General Background Information

A community mental health center (CMHC) is a facility that provides mental health services. A CMHC must perform certain “**core services.**” These are:

1. **Outpatient services** (This includes services for (1) children, (2) the elderly, (3) persons who are chronically mentally ill, and (4) certain persons who have been discharged from a mental health facility for inpatient treatment.)
2. **24-hour-a-day** emergency psychiatric services;
3. **Day treatment** or other **partial hospitalization (PH) services**, or psychosocial rehabilitation services; and
4. **Screening** for patients being considered for admission to State mental health facilities.

NOTE: Partial hospitalization is the only core service for which a CMHC can bill Medicare as a CMHC. Thus, while a facility must furnish certain “core” services in order to qualify as a CMHC, it can only get reimbursed for one of them – partial hospitalization. However, the facility may still be able to enroll in Medicare as a Part B clinic if it does not perform partial hospitalization services.

In some instances, these core services can be furnished under arrangement. This generally means that the facility can arrange for another facility to perform the service if, among other things, CMS determines that the following conditions are met:

- The CMHC arranging for the particular service is authorized by State law to perform the service itself;
- The arranging CMHC accepts full legal responsibility for the service; and
- There is a written agreement between the two entities.

While the CMHC generally has the option to furnish services under arrangement, there is actually an instance where the facility must do so. If the CMHC is located in a State that prohibits CMHCs from furnishing screening services (service #4 above), it must contract with another entity to have the latter perform the services. Any such arrangement must be approved by the regional office (RO). (See Pub. 100-07, State Operations Manual (SOM), chapter 2, section 2250, for additional information on core services and arrangements.)

A CMHC must provide mental health services principally to individuals who reside in a defined geographic area (service area); that is, it must service a distinct and definable community. A CMHC (or CMHC site) that operates outside of this specific community must – unless the RO holds otherwise - have a separate provider agreement/number and enrollment, and must individually meet all Medicare requirements.

B. Initial Enrollment and Certification

1. Policy through October 28, 2014

Unlike most certified providers and certified suppliers, CMHCs are not surveyed by the State agency to determine the CMHC’s compliance with Medicare laws (although the State may do a survey to verify compliance with State laws). Instead, the RO (or CMS-contracted personnel) will perform a site visit. The

RO will not approve the CMHC unless the latter demonstrates that it is furnishing the core services to a sufficient number of patients. In addition, CMS reserves the right to request at any time documentation from the CMHC verifying the provision of core services.

If the RO or CMS-contracted personnel plans to perform a site visit of an existing, enrolled CMHC, the contractor shall furnish all background information that the RO requests. All inquiries and correspondence relating to the site visit shall be directed to the RO.

Prior to making a recommendation for approval, the contractor shall ensure that the provider has submitted a completed and signed CMHC attestation statement. If the CMHC cannot submit one, the contractor shall deny the application. (The attestation requirement also applies to new owners in a CHOW.) The CMHC attestation statement typically serves as the provider agreement.

If the contractor issues a recommendation for approval, it shall send a copy of the Form CMS-855A to the State agency (or, for contractors in RO 9, the contractor's RO) with its recommendation. The contractor shall also contact the appropriate RO to initiate a site visit of the CMHC applicant; a copy of this request should be sent to the State agency.

2. Conditions of Participation

Effective October 29, 2014, CMHCs will be required to meet the conditions of participation outlined in 42 CFR Part 485, subpart J. CMHCs, like many other types of certified providers and certified suppliers, will therefore be required to undergo a State survey as part of the certification and enrollment process. The RO will no longer be performing the site visit discussed in section (B)(1) nor will be above-referenced attestation statement be required. Except as otherwise noted in this chapter 15 or in another CMS directive, CMHC initial applications shall – on and after October 29, 2014 - be processed in the same manner as those for all other certified providers.

C. Post-Tie-In Notice Site Visit

(The policies in this section (C) apply before, on, and after October 29, 2014)

The contractor shall order a site visit through the Provider Enrollment, Chain and Ownership System (PECOS) after the contractor receives the tie-in notice (or approval letter) from the RO but before the contractor conveys Medicare billing privileges to the CMHC. This is to ensure that the provider is still in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with section 15.19.2.2(B) of this chapter. The National Site Visit Contractor (NSVC) will perform the site visit. The contractor shall not convey Medicare billing privileges to the provider prior to the completion of the NSVC's site visit and the contractor's review of the results.

D. Revalidations

If the CMHC submits a Form CMS-855A revalidation application, the contractor shall order a site visit through PECOS. This is to ensure that the provider is still in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with section 15.19.2.2(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

E. Practice Locations/Alternative Sites

A CMHC must list in Section 4 of its Form CMS-855A all alternative sites where core services are provided (i.e., proposed alternative sites for initial applicants and actual alternative sites for those CMHCs already participating in Medicare). The RO will decide whether the site in question: (1) can be part of the CMHC's enrollment (i.e., a practice location), or (2) should be enrolled as a separate CMHC with a separate provider agreement. The practice location could be out-of-state if the RO determines that the location services the

same “defined geographic area” as the main location. In all cases, the RO makes the final determination as to whether a particular practice location qualifies as an alternative site or whether a separate enrollment, provider agreement, etc., is required. If the contractor is unsure as to whether the location requires a separate enrollment and provider agreement, it may contact the RO for clarification.

If a CMHC is (1) adding a new location or (2) changing the physical location of an existing location, the contractor shall order a site visit of the new/changed location through PECOS after the contractor receives notice of approval from the RO but before the contractor switches the provider’s enrollment record to “Approved.” This is to ensure that the new/changed location is in compliance with CMS’s enrollment requirements. The scope of the site visit will be consistent with section 15.19.2.2(B) of this chapter. The NSVC will perform the site visit. The contractor shall not switch the provider’s enrollment record to “Approved” prior to the completion of the NSVC’s site visit and the contractor’s review of the results.

The contractor may refer to Pub. 100-07, SOM, chapter 2, section 2252, for additional information on CMHC alternative sites. Particular attention should be paid to the following provisions in section 2252I, regarding alternative sites:

- If a CMHC operates a CMS-approved alternative site, the site is not required to provide all of the core services. However, a patient must be able to access and receive the services he/she needs at the approved primary site, or at an alternative site that is within the distinct and definable community served by the CMHC.
- RO approvals of such alternative sites should be very limited because (1) CMHCs must serve a distinct and definable community, and (2) CMS has not limited the number of CMHCs an entity may submit for Medicare approval as long as these proposed CMHCs serve different communities.
- The RO will inform the CMHC if it determines that the proposed alternative site must be separately approved because it is not a part of the community where the CMHC is located.

F. Additional Information

For more information on CMHCs, refer to:

- Section 1861(ff) of the Social Security Act
- 42 CFR Sections 410.2, 410.43, and 410.110
- Pub. 100-07, chapter 2, sections 2250 – 2252P

See sections 15.19.2.2 through 15.19.2.4 of this chapter for additional information on CMHC site visits.

15.4.1.1.1 – CMHC 40 Percent Rule

(Rev.521, Issued: 06-13-14, Effective: 07-15-14, Implementation: 07-15-14)

(The policies in this section 15.4.1.1.1 apply on and after October 29, 2014.)

A. Background

Effective October 29, 2014, under § 485.918(b)(1) a CMHC must provide at least 40 percent of its items and services to individuals who are not eligible for benefits under title XVIII of the Social Security Act, as measured by the total number of CMHC clients treated by the CMHC for whom services are not paid for by Medicare, divided by the total number of clients treated by the CMHC in the applicable timeframe.

Pursuant to this requirement, a CMHC is required to submit to CMS a certification statement provided by an independent entity (such as an accounting technician). The document must certify that:

- *The entity has reviewed the CMHC’s client care data*

- *For:*
 - *Initial enrollments: The CMHC meets the 40 percent requirement for the prior 3 months.*
 - *Revalidations: The CMHC meets the 40 percent requirement for each of the intervening 12-month periods between initial enrollment and revalidation.*

The statement must be submitted as part of any initial enrollment or revalidation (including off-cycle revalidations).

B. Processing

The contractor shall abide by the following:

1. *The contractor does not receive the certification with the CMS-855 form - The contractor shall develop for the certification as it would with any other form of required supporting documentation.*

If the CMHC fails to submit the certification within the applicable time period, the contractor shall notify its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) of this via e-mail. The BFL will notify the contractor as to how to proceed.

2. *The contractor receives the certification with the CMS-855 or timely receives the certification as part of a development request – The contractor shall forward the document to its PEOG BFL for review. The document shall be sent via fax or e-mail. Upon review/confirmation, the BFL will notify the contractor via e-mail as to how to proceed (e.g., develop for a revised certification). The contractor may continue processing the CMS-855 application during the PEOG review period.*

Sections (B)(1) and (2) above do not apply if the contractor determines that the CMS-855 form can be returned under section 15.8.1 of this chapter.

If the provider exceeds applicable timeliness standards due to the instructions in this section 15.4.1.1.1, the contractor shall accordingly document the provider file consistent with section 15.10 of this chapter.

C. Special Guidelines

1. *An appropriate official of the certifying entity must sign the document. (Notarization is not required unless CMS requests it.) Such persons may include accounting technicians, CEOs, officers, directors, etc.*
2. *The certification should be on the certifying entity's letterhead or should otherwise indicate that the document is clearly from the entity.*
3. *The contractor shall include the certification in the recommendation package it sends to the State agency.*
4. *Unless CMS instructs the contractor otherwise, the appropriate denial bases for failing to comply with § 485.918(b)(1) are §§ 424.530(a)(1) and 485.918(b)(1). The appropriate revocation bases are §§ 424.535(a)(1) and 485.918(b)(1). In cases involving the latter, CMS will determine the appropriate re-enrollment bar length under § 424.535(c) and will notify the contractor thereof.*

15.5.4.3 – Section 4 of the Form CMS-855I

(Rev.521, Issued: 06-13-14, Effective: 07-15-14, Implementation: 07-15-14)

A. Solely-Owned Organizations

The former practice of having solely-owned practitioner organizations (as explained and defined in section 4A of the CMS-855I) complete a CMS-855B, a CMS-855R, and a CMS-855I has been discontinued. All pertinent data for these organizations can be furnished via the CMS-855I alone. The contractor, however, shall require the supplier to submit a CMS-855B, CMS-855I and CMS-855R if, during the verification process, it discovers that the supplier is not a solely-owned organization. **(NOTE: A solely-owned supplier type that normally completes the CMS-855B to enroll in Medicare must still do so. For example, a solely-owned LLC that is an ambulance company must complete the CMS-855B, even though section 4A makes mention of solely-owned LLCs. Use of section 4A of CMS-855I is limited to suppliers that perform physician or practitioner services.)**

Sole proprietorships need not complete section 4A of the CMS-855I. By definition, a sole proprietorship is not a corporation, professional association, etc. Do not confuse a sole proprietor with a physician whose business is that of a corporation, LLC, etc., of which he/she is the sole owner.

In section 4A, the supplier may list a type of business organization other than a professional corporation, a professional association, or a limited liability company (e.g., closely-held corporation). This is acceptable so long as that business type is recognized by the State in which the supplier is located.

The contractor shall verify all data furnished in section 4A (e.g., legal business name, TIN, adverse legal actions). If section 4A is left blank, the contractor may assume that it does not pertain to the applicant.

A solely-owned physician or practitioner organization that utilizes section 4A to enroll in Medicare can generally submit change of information requests to Medicare via the CMS-855I. However, if the change involves data not captured on the CMS-855I, the change must be made on the applicable CMS form (i.e., CMS-855B, CMS-855R).

B. Individual Affiliations

If the applicant indicates that he/she intends to render all or part of his/her services in a group setting, the contractor shall ensure that the applicant (or the group) has submitted a CMS-855R for each group to which the individual plans to reassign benefits. The contractor shall also verify that the group is enrolled in Medicare. If it is not, the contractor shall enroll the group prior to approving the reassignment.

C. Practice Location Information

A practitioner who only renders services in patients' homes (i.e., house calls) must supply his/her home address in section 4C. In addition, if a practitioner renders services in a retirement or assisted living community, section 4C must include the name and address of that community. In either case, the contractor shall verify that the address is a physical address. Post office boxes and drop boxes are not acceptable.

D. Sole Proprietor Use of EIN

The practitioner must obtain a separate EIN if he/she wants to receive reassigned benefits as a sole proprietor.

E. NPI Information for Groups

If a supplier group/organization is already established in PECOS (i.e., status of "approved"), the physician or non-physician practitioner is not required to submit the NPI in 4B2 of the 855I. In short, if

group/organization is already established in PECOS, the group/organization does not need to include an NPI in section 4B2. The only NPI that the physician or non-physician practitioner must supply is the NPI found in section 4C.

NOTE: Physicians and non-physician practitioners are required to supply the NPI in section 4B2 of the CMS-855I for groups/organizations not established in PECOS with a status of "approved."

F. Out-of-State Practice Locations

If a supplier is adding a practice location in another State, *a separate, initial Form CMS-855I enrollment application is required for that location even if:*

- *The location is part of the same organization (e.g., a solely-owned corporation),*
- *The location has the same tax identification number (TIN) and legal business name (LBN), and*
- *The location is in the same contractor jurisdiction.*

To illustrate, suppose the contractor's jurisdiction consists of States X, Y and Z. Dr. Jones, a sole proprietor, is enrolled in State X with 2 locations. He wants to add a third location in State Y under his social security number and his sole proprietorship's employer identification number. *A separate, initial Form CMS-855I application is required for the State Y location.*

15.7.5.1 – Special Procedures for Physicians and Non-Physician Practitioners *(Rev.521, Issued: 06-13-14, Effective: 07-15-14, Implementation: 07-15-14)*

To help ensure that only qualified physicians and non-physician practitioners are enrolled in Medicare, the contractor shall undertake the activities described below.

For purposes of this section, the term "practitioner" includes both physicians and non-physician practitioners. In addition, the instructions in this section, apply only to these practitioners.

A. Monthly Reviews

No later than the 15th day of each month, the contractor shall review State licensing board information for each State within its jurisdiction to determine whether any of its currently enrolled practitioners have, within the previous 60 days:

1. Had their medical license revoked, suspended or inactivated (due to retirement, death, or voluntary surrender of license);
2. Otherwise lost their medical license or have had their licenses expire.

For those practitioners who no longer have a valid medical license, the contractor shall take the necessary steps to revoke the individual's billing privileges.

The mechanism by which the contractor shall perform these monthly licensure reviews lies within its discretion, though the most cost-effective method shall be used.

B. Relocation to a New State

1. Licensure Reviews

When a practitioner submits a CMS-855I application to either: (1) add a practice location in a new State, or (2) relocate to a new State entirely, the contractor that received the application shall review State licensing board information for the “prior” State to determine:

1. Whether the practitioner had his or her medical license revoked, suspended, or inactivated (due to retirement, death, or voluntary surrender of license), or otherwise lost his or her license, and
2. If the practitioner has indeed lost his or her medical license, whether he or she reported this information to Medicare via the CMS-855I within the timeframe specified in 42 CFR 424.520.

If the practitioner is currently enrolled and did not report the adverse action to Medicare in a timely manner, the contractor shall revoke the practitioner’s Medicare billing privileges and establish a 1-year enrollment bar. If the practitioner is submitting an initial enrollment application (e.g., is moving to a new State and contractor jurisdiction) and did not report the adverse action in section 3 of the CMS-855I, the contractor shall deny the enrollment application and establish a 3-year enrollment bar.

2. Voluntary Withdrawal Reminder

When a practitioner submits a CMS-855I application to either: (1) add a practice location in a new State, or (2) relocate to a new State entirely, the contractor that received the application shall determine whether the practitioner still has an active PECOS enrollment record in the “other” State(s). If PECOS indeed indicates that the individual has an active practice location in the other State(s), the contractor shall remind the practitioner that if he/she no longer intends to practice in that State, he/she must submit a CMS-855I voluntary termination application to the contractor for that jurisdiction. The reminder should be given in the approval letter that the receiving contractor sends to the practitioner or, if more appropriate, in an e-mail or other form of written correspondence.

C. Break in Medical Practice

If the contractor receives a CMS-855I from a practitioner who was once enrolled in Medicare but who has not been enrolled with any Medicare contractor for the previous 2 years, the contractor shall verify with the State where the practitioner last worked whether the practitioner was convicted of a felony or had his or her license suspended or revoked. If such an adverse action was imposed, the contractor shall take action in accordance with the instructions in this chapter.

D. State Relationships

To the maximum extent possible, and to help ensure that it becomes aware of recent felony convictions of practitioners and owners of health care organizations, the contractor shall establish relationships with appropriate State government entities – such as, but not limited to, Medicaid fraud units, State licensing boards, and criminal divisions – designed to facilitate the flow of felony information from the State to the contractor. For instance, the contractor can request that the State inform it of any new felony convictions of health care practitioners.

15.23.2 – Release of Information

(Rev.521, Issued: 06-13-14, Effective: 07-15-14, Implementation: 07-15-14)

On October 13, 2006, CMS published System of Records Notice for the Provider Enrollment, Chain and Ownership System (PECOS) in the Federal Register. Consistent with this notice, once the provider has submitted an enrollment application (as well as after it has been enrolled), the contractor shall not release –

either orally or in writing - provider-specific data to any other person or entity. This includes, but is not limited to, national or State medical associations or societies, clearinghouses, billing agents, provider associations, or any person within the provider's organization other than the provider's authorized official(s) (section 15 of the CMS-855), delegated official(s), (section 16), contact persons (section 13), *or authorized surrogate users*. The only exceptions to this policy are:

- A routine use found in the aforementioned System of Records applies.
- The provider (or, in the case of an organizational provider, an authorized or delegated official): (1) furnishes a signed written letter on the provider's letterhead stating that the release of the provider data is authorized, and (2) the contractor has no reason to question the authenticity of the person's signature.
- The release of the data is specifically authorized in some other CMS instruction or directive.

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

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

In addition:

- When sending e-mails, the contractor shall not transmit sensitive data, such as social security numbers or employer identification numbers.
- The contractor may not send PECOS screen printouts to the provider.
- The contractor shall not send an individual's provider transaction access numbers (PTAN) to a group or organization (including the group's authorized or delegated official). If a group/organization needs to know an individual provider's PTAN, it must contact the provider directly for this information or have the individual provider request this information in writing from the contractor. If the individual provider requests his/her PTAN number, the contractor can mail it to the provider's practice location. The contractor should never give this information over the phone.