CMS Manual System

Pub. 100-16 Medicare Managed Care

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 82 **Date: APRIL 25, 2007**

SUBJECT: Revision to Chapter 6 – Relationships with Providers

I. SUMMARY OF CHANGES: A reference is being inserted into Chapter 6, §70 – "Institutional Provider and Supplier Certification," to indicate that certain surgical procedures and Positron Emission Tomography (PET) scans must be performed at Medicare-approved facilities. This change is being made to conform to recent updates in Original Medicare requirements contained in national coverage determinations. Specifically, carotid artery stenting, Ventricular Assist Device (VAD) destination therapy, bariatric surgery, certain oncologic PET scans in Medicare-specified studies, and lung volume reduction surgery must be performed at Medicare-certified facilities. In addition, we are also adding links to the CMS Web site lists of approved facilities for organ transplant centers.

NEW/REVISED MATERIAL - EFFECTIVE DATE*/IMPLEMENTATION DATE: Not Applicable. Instruction is revising material that was previously in the manual.

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	6/70/Institutional Provider and Supplier Certification

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 20xx operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

70 - Institutional Provider and Supplier Certification

(Rev.82, Issued: 04-25-07, Effective/Implementation: N/A)

Regardless of the MA organization's usual policies for determining that an institutional provider or supplier is qualified to serve its enrollees, the MA organization must determine that each institutional provider or supplier that has signed a contract or participation agreement with the MA organization has met the following three requirements. Current documentation should be obtained at least every 3 years, and contracts should provide for notice from the provider of any change in its Medicare approval, state licensure, or accreditation status.

1. Medicare Approval

   An MA organization must ensure that Medicare-covered basic benefits are provided only by providers that have signed participation agreements ("provider agreements") with CMS, and by suppliers approved by CMS as meeting conditions for coverage of their services. The following types of providers and suppliers must have met requirements for participation in Medicare (also specified at 42 CFR 498.2):

   - Hospitals (either JCAHO accreditation or Medicare certification). Note that Medicare also certifies organ procurement organizations (OPOs) and that organ transplants must generally be performed in certified organ transplants centers;
   - Home Health Agencies (HHAs);
   - Hospices;
   - Clinical laboratories (a CMS-issued CLIA certificate or a hospital-based exemption from CLIA);
   - Skilled Nursing Facilities (SNFs);
   - Comprehensive Outpatient Rehabilitation Facilities (CORFs);
   - Outpatient Physical Therapy and Speech Pathology Providers;
   - Ambulatory Surgery Centers (ASCs);
   - Providers of end-stage renal disease services;
   - Providers of outpatient diabetes self-management training;

- Portable x-ray Suppliers; and

- Rural Health Clinic (RHCs) and Federally Qualified Health Center (FQHCs).

Inquiries regarding the Medicare participation of specific providers and suppliers can be directed to the regional office plan manager.

In addition, MA plans must also comply with all CMS requirements related to an approved benefit, including the use of approved facilities, as applicable. Note that being certified as a Medicare approved facility is required for performing certain procedures, such as carotid artery stenting, VAD destination therapy, bariatric surgery, certain oncologic PET scans in Medicare-specified studies, and lung volume reduction surgery. For lists of approved facilities for these procedures, please see link: http://www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp#TopOfPage.

For lists of approved organ transplants facilities, please see links: http://www.cms.hhs.gov/ApprovedTransplantCenters/ and http://www.cms.hhs.gov/esrdgeneralinformation/02_data.asp.

2. Is licensed to operate in the state, and is in compliance with any other applicable state or Federal requirements.

3. Is reviewed and approved by an appropriate accrediting body, or meets the standards established by the MA organization itself. Accrediting bodies include the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, the Community Health Accreditation Program (CHAP), and the Continuing Care Accreditation Commission. This standard does not require that an MA organization accept the findings of an accrediting body in determining whether to contract with a provider, or that it reject providers that are not accredited. However, an MA organization that does not rely on independent accreditation must develop its own standards for approval of institutional providers and determine that such providers meet those standards before including them in its network. Primary source verification of accreditation and licensure is not required, unless otherwise provided in the MA organization's Medicare contract. Accordingly, an MA organization may rely on documentation supplied by the institutional provider.

(Source: 42 CFR 422.204(b)(1) and (3) and additional instructions.)