CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 230	Date: DECEMBER 14, 2007
	Change Request 5802

SUBJECT: Update to Chapter 10

I. SUMMARY OF CHANGES: This change request (CR) represents a technical update to certain sections of Publication 100-08, chapter 10. With the exception of those items listed in the business requirements, all changes identified in this CR are merely editorial, grammatical, or structural in nature. No provider enrollment policies in these sections are being altered or revised.

NEW / REVISED MATERIAL
EFFECTIVE DATE: JANUARY 1, 2008
IMPLEMENTATION DATE: JANUARY 7, 2008

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/4.5/Owning and Managing Organizations
R	10/4.5.1/Types of Business Organizations
R	10/4.6/Owning and Managing Individuals
R	10/4.7/Chain Organizations
R	10/4.8/Billing Agencies
R	10/4.12/Special Requirements for Home Health Agencies (HHAs)
R	10/4.15/Certification Statement
R	10/4.16/Delegated Officials
R	10/4.20/Processing CMS-855R Applications
R	10/5.1/General Verification Principles
R	10/5.2/Verification of Data
R	10/5.3/Requesting and Receiving Clarifying Information
R	10/5.4/Special Verification Procedures for CMS-855B, CMS-855I and CMS-855R Applications
R	10/6.2/Denials

R	10/13.2/Contractor Issued Revocations

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 230	Date: December 14, 2007	Change Request: 5802

SUBJECT: Update to Chapter 10

Effective Date: January 1, 2008
Implementation Date: January 7, 2008

I. GENERAL INFORMATION

A. Background: This change request (CR) represents a technical update to certain sections of Publication 100-08, chapter 10. With the exception of the items identified in the business requirements below, all changes identified in this CR are merely editorial, grammatical, or structural in nature, and do not involve the revision or alteration of any existing provider enrollment policies.

B. Policy: The purpose of this CR is to make various editorial and technical changes to certain sections of Publication 100-08, chapter 10.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5802.1	The contractor shall note that if a provider submits a CMS-855 change of information, the contractor may accept the signature of a delegated official of the provider in Section 15 of the CMS-855.	X		X	X	X					
5802.2	The contractor shall ensure that all denial (or recommended denial) letters identify the specific statute(s) and/or regulation(s) in question, as well as a detailed factual explanation for the contractor's decision.	X		X	X	X					
5802.3	The contractor shall ensure that all revocation letters identify the specific statute(s) and/or regulation(s) in question, as well as a detailed factual explanation for the contractor's decision.	X		X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/	DM	FI	CA	RH	Shared-System Maintainers	OTHER

							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	None.

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Frank Whelan, frank.whelan@cms.hhs.gov, (410) 786-1302
Post-Implementation Contact(s): Frank Whelan, frank.whelan@cms.hhs.gov, (410) 786-1302

VI. FUNDING

A. For *Fiscal Intermediaries and Carriers:* No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

B. *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.

4.5 – Owning and Managing Organizations

(Rev. 230; Issued: 12-14-07; Effective: 01-01-08; Implementation: 01-07-08)

(This section only applies to section 5 of the CMS-855A and CMS-855B. It does not apply to the CMS-855I.)

All organizations that have any of the following must be listed in section 5A of the CMS-855:

1. A 5 percent or greater direct or indirect ownership interest in the provider.

The *following illustrates* the difference between direct and indirect ownership:

EXAMPLE: The supplier listed in section 2 of the CMS-855B is an ambulance company that is wholly (100 percent) owned by Company A. *Company* A is considered to be a direct owner of the supplier (the ambulance company), in that it actually owns the assets of the business. Now assume that Company B owns 100 percent of Company A. Company B is considered an indirect owner - but an owner, nevertheless - of the supplier. In other words, a direct owner has an actual ownership interest in the supplier, whereas an indirect owner has an ownership interest in an organization that owns the supplier.

For purposes of enrollment, ownership also includes "financial control." Financial control exists when:

(a) An organization or individual is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the provider or any of the property or assets of the provider, and

(b) The interest is equal to or exceeds 5 percent of the total property and assets of the provider.

2. A partnership interest in the provider, regardless of: (1) the percentage of ownership the partner has, and (2) whether the partnership interest is that of a general partner *or limited* partner (e.g., all limited partners in a limited partnership must be listed in section 5A).

3. Managing control of the provider.

A managing organization is one that exercises operational or managerial control over the provider, or conducts the day-to-day operations of the provider. The organization need not have an ownership interest in the provider in order to qualify as a managing organization. For instance, the *entity* could be a management services organization under contract with the provider to furnish management services for one of the provider's practice locations.

Contractors shall also note the following *with respect to* owning and managing organizations:

- Such organizations generally fall into one of the following categories: (1) corporations (including non-profit corporations); (2) partnerships and limited partnerships; (3) limited liability companies; (4) charitable and religious organizations; (5) governmental/tribal organizations.

- Any entity listed as the applicant in section 2 of the CMS-855 need not be reported in section 5A. The only exception to this involves governmental entities, which must be listed in section 5A even if they are already listed in section 2.

- With respect to governmental organizations, the letter referred to in the CMS-855 form instructions for section 5 must be signed by an appointed or elected official of the governmental entity who has the authority to legally and financially bind the government to the laws, regulations, and program instructions of Medicare. There is no requirement that this government official also be an authorized official, or vice versa.

- Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body should be listed in section 5A of the CMS-855. The applicant should submit a copy of its 501(c)(3) approval notification for non-profit status. If it does not possess such documentation but nevertheless claims it is a non-profit entity, the applicant may submit any other documentation that supports its claim, such as written documentation from the State, etc. This documentation is necessary if the applicant does not list any owners in section 5 or section 6 of the application.

- The contractor shall review all organizations listed in section 5A against Qualifier.net. If an adverse legal action is found, the contractor shall follow the instructions in section 4.3 of this manual.

- Owning/managing organizations need not submit an IRS CP-575 document unless requested by the contractor (e.g., the contractor discovers a potential discrepancy between the organization's legal business name and tax identification number in Qualifier.net.)

4.5.1 - Types of Business Organizations

(Rev. 230; Issued: 12-14-07; Effective: 01-01-08; Implementation: 01-07-08)

This section explains the legalities of various types of business organizations that may enroll, including sole proprietorships. Note that the *provider's organizational structure can* have a *significant* impact on *the type of information it must furnish on the CMS-855.*

Business organizations are generally governed by State law. Thus, State X may have slightly different rules than State Y regarding certain entities. (In fact, X may permit *the creation of certain types of legal entities* that Y does not.) The discussion below *gives only* a broad overview of the *principal types of business entities* and does not take into account different State nuances.

A. Corporations

A corporation is an entity separate and distinct from its owners *(*called stockholders*,* or shareholders). To form a corporation, various documents – such as articles of incorporation – must be filed with the State in which *the business will* incorporate. The key elements of a corporation are:

- Limited Liability – This is the *main* reason why a business chooses to operate as a corporation. Suppose Corporation X has ten stockholders, each owning 10% of the business. X breached a contract it had with Company Y, and now Y wants to sue X's owners. Unfortunately for Y, it can really only sue X itself*;* it cannot go after *X's shareholders. The* corporation's owners are essentially shielded from liability for the actions of the corporation because, as stated above, a corporation is separate and distinct from its owners.

Despite the concept of limited liability, there may be instances where a corporation's owners/stockholders can be held personally liable for the corporation's debts. *This is* known as **"piercing the corporate veil"** (PCV), whereby one tries to get past the brick wall of the corporation in order to collect money from the owners behind that wall. However, PCV is a difficult thing to do and many courts are unwilling to allow it, meaning that plaintiffs can only collect from the corporation itself.

- *"Double"* Taxation – This is the *principal* reason why a *business chooses* not to be a corporation. *"Double"* taxation means that*:* (1) the corporation itself must pay taxes, AND (2) each shareholder must pay taxes on any dividends he/she receives from the business.

- Board of Directors – Most corporations are run by a governing body, *typically* called a Board of Directors.

Two special types of corporations contractors may encounter are:

- **"Professional Corporation"** or "PC." In general, a PC: (1) is organized for the sole purpose of rendering professional services (such as medical or legal), and (2) all stockholders in the PC must be licensed to render such services. Thus, if A, B and C want to form a physician practice (each is a 1/3 stockholder) and only A is a medical professional, the PC probably cannot be formed (depending, of course, on what the applicable State PC statute says). In addition, the title of a PC will usually end in "PC," "PA" (Professional Association) or "Chartered."

- **"Close" Corporation** (or "closely-held" corporation) – This is a type of corporation with a very limited number of stockholders. Unlike a "regular" corporation, the entity's board of directors *generally does not* run the business; rather, the shareholders do. The stock is typically not sold to outsiders.

Although PCs and CCs are considered "corporations" for enrollment purposes, State laws governing these entities are often different from those that govern "regular" corporations *(i.e., States* have separate statutes for "regular" corporations and for PCs/CCs.) In many cases, an entity must specifically elect to be a PC or CC when filing *its* paperwork with the State.

B. Partnerships

A partnership is an association of two or more persons/entities who carry on a business for profit. Each partner in a partnership is an owner. If A and B form the "Y Partnership" and each contributes $50,000 to start up the business, each partner *owns* one-half of Y.

In several *respects*, a partnership is the opposite of a corporation:

- Each partner is liable for all the debts of the partnership. Using the example above, suppose the Y Partnership breached a contract it *had with* Mr. X, who now sues for $10,000. Since each partner is liable for all debts, X can collect the entire $10,000 from A, or from B, or $5,000 from each, etc. This is because, unlike a corporation, a partnership is not really a separate and distinct entity from its partners/owners*; the* partners <u>are</u> the partnership. If Y had been a corporation, the owners (A and B) would *likely have been* be shielded from liability.

- There is no "double taxation" with partnerships. The partnership itself does not pay taxes, although each partner pays taxes on any income *he/she earns* from the business.

- Unlike a corporation, a partnership generally does not file papers with the State upon its creation (i.e., it does not file the equivalent of articles of incorporation). Instead, a partnership has a "partnership agreement," which *amounts to* a contract between the partners outlining duties, responsibilities, powers, etc.

- Each partner has the right to participate in running the business's day-to-day operations, unless the partnership agreement dictates otherwise.

An alternative type of partnership is a limited partnership (as opposed to a "general partnership," described above). While possessing many of the characteristics of a general partnership, there are some key differences. First, a limited partnership (LP) must file formal documents with the State. Second, a LP has two *types* of partners –general and limited. The general partner(s) runs the business, yet is personally responsible for all of the LP's debts. Conversely, the limited partner(s) have limited liability yet cannot participate in the management of the business.

C. Limited Liability Companies (LLC)

A limited liability company (LLC) is a legal entity that is neither a partnership nor a corporation, but has characteristics of both. Its owners have limited liability (just like stockholders in a corporation). In addition, the LLC does not pay Federal taxes (similar to a partnership), although its owners – usually referred to as "members" - must pay taxes on any dividends they reap. An LLC thus contains the best attributes of corporations and partnerships, which is why LLCs are rapidly gaining in popularity.

An LLC should not be confused with a limited liability <u>corporation</u>, which is a type of corporation in some States. A limited liability <u>company</u> is <u>not</u> a corporation or partnership, but a distinct legal entity created and regulated by special State statutes.

Note that certain CMS-855 information is required of different entities. The primary example of this is in section 6 (Managing Individuals). If the provider is a corporation, it must list its officers and directors on the form. Partnerships and LLCs, on the other hand, do not have officers or directors and thus need not list them.

D. Joint Ventures

A joint venture is when two or more persons/entities combine efforts in a business enterprise and agree to share profits and losses. It is very similar to a partnership, and is treated as a partnership for tax purposes. The key difference is that a partnership is an ongoing business, while a joint venture is a temporary, one-time business undertaking. A joint venture, therefore, can be classified as a "temporary partnership."

E. Non-Profit Organizations

The term "non-profit organization" is misleading. It is not an organization that is forbidden to make a profit. Rather, it means that all *of the organization's* profits are put back into the entity to promote its goals, which are usually political, social, religious, or charitable in nature. In other words, the NPO is not organized primarily for profit, but instead to further some other goal. An entity can acquire NPO status by obtaining a 501(c)(3) certification from the IRS (meaning it is tax-exempt) or by acquiring such status from the State it is located in.

NPO status is important for enrollment purposes because NPOs generally do not have owners. Thus, a NPO need not list any owners in sections 5 or 6 of the CMS-855.

F. Sole Proprietorships

A business is a sole proprietorship if it meets *all* of the following criteria:

- It files a Schedule C (1040) with the IRS (this form reports the business's profits/losses)
- One person owns all of the business's assets
- It is not incorporated

A sole proprietorship is not a corporation. Suppose a physician operates his/her business as a home health agency. If he/she incorporates his/her business, the business becomes a corporation (even though the physician is the only stockholder). Thus, the frequently-used term "unincorporated sole proprietorship" is a misnomer, because sole proprietorships by definition are unincorporated. In addition, merely because the sole proprietor hires employees does not mean that the business is no longer a sole proprietorship. Assume W is a sole proprietor and he hires X, Y, and Z as employees. W's business is still a sole proprietorship because he *remains* the 100% owner of the business. *On the other hand, if* W had sold parts of his sole proprietorship to X, Y, and *Z the* business would no longer be a sole proprietorship, as there is now more than one owner.

G. Government-Owned Entities

For purposes of enrollment, a government-owned entity (GOE) exists when a particular government body (e.g., Federal, State, city or county agency) will be legally and financially responsible for Medicare payments received. For example, suppose Smith County operates Hospital X. Medicare overpaid X $100,000 last year. If Smith County is the party responsible for reimbursing Medicare this amount, X is considered a government-owned entity.

Note that:

- GOEs do not have "owners." Thus, section 5 of the CMS 855 need only contain the name of the government body in question. Using our example above, this would be Smith County.

- For section 6 (Managing Individuals), the only people that *must* be listed are "managing employees." This is because GOEs do not *have corporate* officers or directors.

The entity must submit a letter from the government body certifying that the government will be responsible for *any* Medicare payments.

4.6 – Owning and Managing Individuals

(Rev. 230; Issued: 12-14-07; Effective: 01-01-08; Implementation: 01-07-08)

(This section applies to section 6 of the CMS-855A, the CMS-855B, and the CMS-855I.)

All individuals who have any of the following must be listed in section 6A:

1. A 5 percent or greater direct or indirect ownership interest in the provider. (See section 4.5 of this manual for information on the distinction between direct and indirect ownership, as well as the definition of "financial control.")

2. A partnership interest in the provider, regardless of: (1) the percentage of ownership the partner has, *or* (2) whether the partnership interest is that of a general partner or *limited* partner (e.g., all limited partners in a limited partnership must be listed in section 6A).

3. Managing control of the provider. (For purposes of enrollment, such a person is considered to be a "managing employee." A managing employee is any individual, including a general manager, business manager, office manager or administrator, who exercises operational or managerial control over the provider's business, or who conducts the day-to-day operations of the business. A managing employee also includes any individual who is not an actual W-2 employee but who, either under contract or through some other arrangement, manages the day-to-day operations of the business.)

In addition:

- "Officers" and "directors", as those terms are defined on the CMS-855 form instructions for section 6, need only be reported if the applicant is a corporation. (For-profit and non-profit corporations must list all of their officers and directors; if a non-profit corporation has "trustees" instead of officers or directors, these trustees must be listed in section 6 *of the CMS-855.*)

- Government entities need only list their managing employees in section 6 *of the CMS-855,* as they do not have owners, partners, corporate officers, or corporate directors.

- The applicant must list at least one managing employee in section 6 if it is completing the CMS-855A or the CMS-855B. A practitioner completing the CMS-855I need not list a managing employee if he/she does not have one.

- *All* managing employees at any of *the practice* locations listed in section 4C of the CMS-855I must be reported in section 6A. However, individuals who: (1) are employed by hospitals, health care facilities, or other organizations shown in section 4C (e.g., the CEO of a hospital listed in section 4C), or (2) are managing employees of any group/organization to which the practitioner will be reassigning his/her benefits, *need* not be reported.

- The contractor shall review all individuals listed in section 6A *of the CMS-855* against Qualifier.net. If an adverse legal action is found, the contractor shall follow the instructions in section 4.3 of this manual.

- Information on processing section 6B (Adverse Legal Actions) *of the CMS-855 can be found in section 4.3 of this manual.*

- It is not necessary for the contractor to request a copy of the *individual's* W-2 to confirm that he/she is in fact a W-2 employee (as opposed to a contracted employee).

4.7 – Chain Organizations

(Rev. 230; Issued: 12-14-07; Effective: 01-01-08; Implementation: 01-07-08)

(This section only applies to the CMS-855A. It is inapplicable to the CMS-855B and the CMS-855I.)

All providers that are currently part of a chain organization or who are joining a chain organization must complete this section with information about the chain home office. A chain organization exists when multiple providers/suppliers are owned, leased, or through any other devices, controlled by a single business entity. This entity is known as the chain home office.

At the current time, the *contractor* shall not hold up the processing of the provider's application while awaiting the issuance of a chain home office number (i.e., a determination as to whether a set of entities qualifies as a chain organization). Such an issuance/determination is not presently required prior to the *contractor* making its recommendation for approval or denial.

The *contractor* shall ensure that:

- The chain home office is identified in section 5A of the CMS-855A and that adverse legal action data is furnished in section 5B. (*For purposes of provider enrollment, a* chain home office automatically qualifies as an owning/managing organization.) Note than an NPI is typically not required for a chain home office.

- The chain home office administrator is identified in section 6A of the CMS-855A and that adverse legal action data for the administrator is furnished in section 6B. *(For purposes of provider enrollment, a chain home office administrator is automatically deemed to have managing control over the provider.)*

The *contractor* shall review both the chain home office and its administrator against Qualifier.net. If an adverse legal action is found, the contractor shall follow the instructions in section *4.3* of this manual.

For more information on chain organizations, refer to:

- *Pub. 100-04, chapter 1, sections 20.3 through 20.3.6.*
- *42 CFR § 421.404*
- *CMS change request 5720*

4.8 – Billing Agencies

(Rev. 230; Issued: 12-14-07; Effective: 01-01-08; Implementation: 01-07-08)

(This section applies to the CMS-855A, the CMS-855B, and the CMS-855I.)

The provider shall complete this section with information about any and all billing agents that prepare and submit claims on its behalf. As all Medicare payments must be made via EFT, the contractor no longer needs to verify the provider's compliance with the "Payment to Agent" rules in Pub. 100-04, chapter 1, section 30.2. The only exception to this is if the contractor discovers that the "special payments" address in section 4 of the provider's application belongs to the billing agent. In this situation, the contractor may obtain a copy of the billing agreement if it has reason to believe that the arrangement violates the "Payment to Agent" rules.

In all cases, the contractor shall review the billing agency and its *TIN* against Qualifier.net. (If the billing agent is an individual who does not have an EIN, the person's SSN should be reported in the TIN section.)

4.12 – Special Requirements for Home Health Agencies (HHAs)

(Rev. 230; Issued: 12-14-07; Effective: 01-01-08; Implementation: 01-07-08)

(This section only applies to the CMS-855A.)

The *contractor* shall verify that the HHA meets all of the capitalization requirements addressed in 42 CFR § 489.28. The *contractor* may request from the provider any and all documentation deemed necessary to perform this task. Failure to meet the capitalization requirements shall result in a recommendation for denial. *For more information on HHA capitalization, review 42 CFR § 489.28 and section 12.1.6 of this manual.*

If the HHA checks "yes" in section 12B, the contractor shall review the HHA nursing registry and the tax identification number against Qualifier.net. (A nursing registry is akin to a staffing agency, whereby a private company furnishes nursing personnel to hospitals, clinics, and other medical providers.)

4.15 – Certification Statement

(Rev. 230; Issued: 12-14-07; Effective: 01-01-08; Implementation: 01-07-08)

CMS-855I

The individual practitioner is the only person who may sign the CMS-855I. (This applies to initial enrollments, changes of information, reactivations, etc.) This includes solely-owned entities listed in section 4A of the CMS-855I. An individual practitioner may not delegate the authority to sign the CMS-855I on his/her behalf to any other person.

CMS-855A and CMS-855B

For initial enrollment and revalidation, the certification statement must be signed and dated by an authorized official of the *provider*.

The provider can have an unlimited number of authorized officials, so long as each meets the definition of an authorized official. However, each authorized official must be listed in section 6 of the CMS-855.

If an authorized official is listed as a "Contracted Managing Employee" in section 6 of the CMS-855, he/she cannot be an authorized official. The contractor shall notify the provider accordingly. If the person is listed as anything else in section 6 and the contractor has no reason to suspect that the person does not have the authority to sign the application on *the provider's behalf*, no further investigation is required.

Should the contractor have doubts about an authorized official's authority, it shall contact that 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 about the official's *binding authority,* it shall notify the provider that the person cannot be an authorized official. If that person was the only authorized official listed and the provider refuses to list a different authorized official, the contractor shall deny the application.

In addition:

- The signature of an authorized official must be original. Faxed, stamped, or photocopied signatures cannot be accepted.

- If an authorized official is being deleted, the contractor need not obtain: (1) that authorized official's signature, nor (2) documentation verifying that the person no longer is or qualifies as an authorized official.

- A change in authorized officials has no bearing on the authority of existing delegated officials to make changes and/or updates to the provider's status in the Medicare program.

- If the provider is submitting a change of information (e.g., new practice location, change of address, new part-owner) 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 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 encompasses two different actions) *for purpose of enrollment processing and reporting.*

- The effective date in PECOS for section 15 *of the CMS-855* should be the date of signature.

- In order to be an authorized official, the person must have and must submit his/her social security number.

- An authorized official must be an authorized official of the provider, not of an owning organization, parent company, or management company.

4.16 – Delegated Officials

(Rev. 230; Issued: 12-14-07; Effective: 01-01-08; Implementation: 01-07-08)

(This section only applies to the CMS-855A and the CMS-855B.)

A delegated official is an individual who is delegated by an authorized official 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 section 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

- A partner of the provider, if the provider is a partnership

The individual must have been delegated the legal authority by an authorized official listed in section 15 *of the CMS-855* to make changes and/or updates to the provider's status in the Medicare program, and to commit the provider to fully abide by the laws, regulations, and program instructions of Medicare.

The contractor shall note the following about delegated officials:

- A delegated official has no authority to sign an initial enrollment application or a revalidation application. The primary function of a delegated official is to sign off on changes of information. However, the changes and/or updates that may be made by delegated officials include situations where the provider is contacted by the contractor to clarify or obtain information needed to continue processing the provider's initial CMS-855 application.

- 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 Joe Smith is hired as an independent contractor by the provider to run its day-to-day-operations. Under the definition of "managing employee" for section 6 of the CMS-855, Smith would have to be listed. However, 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 CMS-855*.

  The provider is not required to submit a copy of the owning/managing individual's W-2 to verify an employment relationship, unless requested by the contractor.

- All delegated officials must be reported in section 6 of the CMS-855.

- The provider can have as many delegated officials as it wants. Conversely, the provider is not required to have any delegated officials at all. Should no delegated officials be listed, however, the authorized official(s) remains the only individual(s) who can make changes and/or updates to the provider's status in the Medicare program.

- The effective date in PECOS for section 16 *of the CMS-855* should be the date of signature.

- In order to be a delegated official, the person must have and must submit his/her social security number.

- If a delegated official is being deleted, documentation verifying that the person no longer is or qualifies as a delegated official is not required, nor is the signature of the deleted official needed.

- 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 status.

- If the provider is submitting a change of information (e.g., new practice location, change of address, new part-owner) 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 CMS-855 is completed for that person, and (3) an existing authorized official signs off on the addition of the delegated 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 encompasses two different actions) *for purpose of enrollment processing and reporting.*

- The delegated official must be a delegated official of *the provider*, not of an owning organization, parent company, or management company.

- *If the provider submits a CMS-855 change of information, the contractor may accept the signature of a delegated official in Section 15 or 16 of the CMS-855.*

4.20 – Processing CMS-855R Applications

(Rev. 230; Issued: 12-14-07; Effective: 01-01-08; Implementation: 01-07-08)

A CMS-855R application must be completed for any individual who will*: (1) reassign his/her benefits to an eligible entity, or (2) terminate an existing reassignment.*

If the individual who wants to reassign his or her benefits is not enrolled in Medicare, the person must complete a CMS-855I as well as the CMS-855R. (The CMS-855I and CMS-855R can be submitted concurrently.) *Moreover, if the entity to which the person's benefits will be reassigned is not enrolled in Medicare, the organization* must complete a CMS-855B. (See section 5.4 for additional instructions regarding the joint processing of CMS-855Rs, CMS-855Bs, and CMS-855Is.)

Note that benefits are reassigned to a supplier, not to the practice location(s) of *the* supplier. As such, *the carrier* shall not require each practitioner in a group to submit a CMS-855R each time the group adds a practice location.

In addition:

- An individual can receive reassigned benefits. The most common example of this is a physician or practitioner who reassigns his/her benefits to a physician who is either: (1) a sole proprietor, or (2) the sole owner of an entity listed in section 4A of the CMS-855I. Here, the only forms that will be required are the CMS-855R, and *separate* CMS-855Is from the reassignor and the reassignee. (No CMS-855B is implicated.) The reassignee himself/herself must sign section 4B of the CMS-855R, as there is no authorized or delegated official involved.

- The carrier shall follow the instructions in Pub. 100-04, chapter 1, section 30.2 to ensure that *a* group or person is eligible to receive reassigned benefits.

- If the individual is initiating a reassignment, both he/she and the group's authorized or delegated official must sign section 4 *of the CMS-855R*. If either of the two signatures is missing, the carrier may return the application per section 3.2 of this manual.

- If the person (or group) is terminating a reassignment, either party may sign section 4 *of the CMS-855R; obtaining* both signatures *is* not required. If no signatures are present, the carrier may return the application per section 3.2 of this manual.

- A CMS-855R is required to terminate a reassignment. The termination cannot be done via the CMS-855I.

- The authorized or delegated official who signs section 4 *of the CMS-855R* must be someone who is currently on file with the carrier as such. If this is a new enrollment, with a joint submission of the CMS-855B, CMS-855I, and CMS-855R, the person must be listed on the CMS-855B as an authorized or delegated *official.*

- The effective date of a reassignment is the date *on which* the individual began or will begin rendering services with the reassignee.

- The carrier need not verify whether the reassigning individual is a W-2 employee or a 1099 contractor.

- There may be situations where a CMS-855R is submitted and the group practice is already enrolled in Medicare. However, the authorized official is not on file. In this case, the carrier shall return the CMS-855R, with a request that the group submit a CMS-855B change request adding the new authorized official.

- In situations where the supplier is both adding and terminating a reassignment, each transaction must be reported on a separate CMS-855R. The same CMS-855R cannot be used for both transactions.

- In situations where an individual is reassigning benefits to a person/entity, both the reassignor and the reassignee must be enrolled with the same carrier.

5.1 – General Verification Principles

(Rev. 230; Issued: 12-14-07; Effective: 01-01-08; Implementation: 01-07-08)

Unless stated otherwise in this manual, the contractor shall comply with the following principles when processing CMS-855 enrollment applications:

- **Completeness:** The contractor shall ensure that the provider completed all required data elements on the CMS-855 *(*including all effective dates*)* and that all supporting documentation has been furnished. The contractor shall also ensure that the provider completed the application in accordance with the instructions on the CMS-855 form. (Note that the instructions on the CMS-855 shall be read and applied in addition to, and not in lieu of, the instructions in this manual.)

- **Written Data Elements:** *Unless stated* otherwise in this manual *or other CMS directive,* the provider shall complete all required data elements on the CMS-855 via the application itself. The contractor shall not accept any required information captured on the CMS-855 via telephone, letterhead, e-mail, etc., regardless of the relative materiality of the data element in question.

- **Validation:** The contractor shall verify and validate all information furnished by the provider on the CMS-855. (See section 5.2 below for more information.)

- **Photocopying Pages -** The contractor may accept photocopied pages in any CMS-855 application it receives so long as the application contains an original signature. For example, suppose a corporation wants to enroll five medical clinics it owns. The section 5 data on the CMS-855B is exactly the same for all five clinics. The contractor may accept photocopied section 5 pages for these providers. However, original signatures must be furnished in section 15 of each application.

- **White-Out & Highlighting** - The contractor shall not write on, or highlight any part of, the original CMS-855 application or any supplementary pages the applicant submits. Provider usage of white-out is acceptable, although the contractor should contact the applicant to resolve any ambiguities. In addition, the contractor must determine whether the amount of white-out used on a particular application is within reason. For instance, if an entire application page is whited-out, the contractor should request that the page be *resubmitted.*

5.2 – Verification of Data

(Rev. 230; Issued: 12-14-07; Effective: 01-01-08; Implementation: 01-07-08)

The general purpose of the verification process is to determine if any of the data furnished on the CMS-855 conflicts with Qualifier.net, supporting documentation, or any other information. The contractor may begin the verification process at any time, including during the prescreening phase.

A. Concurrent Reviews

If the contractor receives multiple CMS-855s for related entities, it can perform concurrent reviews of similar data. For instance, suppose a chain home office submits initial CMS-855A applications for four of its chain providers. The ownership information (sections 5 and 6) and chain home office data (section 7) is the same for all four providers. The contractor need only verify the ownership and home office data once; it need not do it four times – once for each provider. However, the contractor shall document in each provider's file that a single verification check was made for all four *applications.*

For purposes of this requirement: (1) there must be some sort of organizational, employment, or other business relationship between the entities, and (2) the applications *must* have been submitted simultaneously – or at least within a few weeks of each other. As an illustration, assume that Group Practice A submits an initial CMS-855B on January 1. Group Practice B submits one on October 1. Section 6 indicates that Joe Smith is a co-owner of both practices, though both entities have many other owners that are not similar. In this case, the contractor must verify Mr. Smith's data in both January and October. It cannot use the January verification and apply it to Group B's application because*:* (1) the applications were submitted nine months apart, and (2) there is no evidence that the entities are related. (On the other hand, a CMS-855I, CMS-855B, and CMS-855R enrollment package would probably meet the two criteria above.)

B. Qualifier.net

Unless stated otherwise in this manual or in other CMS directives (e.g., JSMs), the contractor shall verify all data furnished on the CMS-855 using Qualifier.net. Such data includes, but is not limited to:

- Adverse legal history of the provider and all entities and persons listed in sections 5 and 6 of the CMS-*855.*
- For non-certified suppliers (e.g., physician clinics), all practice locations and phone numbers listed in section 4 of the CMS-855.
- Legal business names and employer identification numbers of all entities listed in section 5 of the CMS-855. (Social security numbers and dates of birth are validated by PECOS – and reviewed against Qualifier.net for discrepancies – via the procedures outlined in section 4.2.1 of this manual.)
- Billing agency information (e.g., legal business name) listed in section 8 of the CMS-855.
- HHA staffing agencies (e.g., legal business name) listed in section 12 of the CMS-855A.

If there is a discrepancy between the information furnished by the applicant and the information on Qualifier.net, the contractor shall use alternative means to confirm the data in question. Examples of such other means include, but are not limited to:

- **Phone number of provider's practice location or billing agency -** Call*ing* the number listed on the application directly; check*ing* the Yellow Pages.

- **Provider's practice location -** Check*ing* the Yellow Pages; conduct*ing* a site visit.

- **Provider's "doing business as" name -** Review*ing* the IRS CP-575, articles of incorporation, State Web site, etc.

- **Legal business name or tax identification number of an entity listed in section *5 of* the CMS-855** – Ask*ing* for a copy of the entity's CP-575.

If the discrepancy still cannot be resolved, the contractor shall request clarifying information from the provider to help resolve the unverifiable *data.*

Any information on the CMS-855 that is verified via supporting documentation (e.g., certifications, licenses) need not also be verified through Qualifier.net. For instance, suppose a nurse practitioner furnishes her licensure information in section 2 of the CMS-855I and includes a copy of the license as supporting documentation. The carrier need not verify the licensure data against Qualifier.net, as it has already been verified via the documentation. Other examples of data verifiable via documentation include:

- National Provider Identifier (NPI)

- Organization type listed in section 2 of the CMS-855 (e.g., corporation, limited liability company, non-profit status)

- Legal business name and tax identification number of the provider (e.g., IRS CP-575)

- Education listed in section 2 of the CMS-855I

In short, all information furnished on the CMS-855 must be verified via Qualifier.net, unless it is data: (1) exempted from this requirement in this manual or other CMS directive, or (2) that is verifiable via documentation submitted by the provider.

In *addition:*

- *All* Qualifier.net executive summaries are valid for 120 days.

- *The contractor is* not required to run additional Qualifier.net searches on "AKA" names that appear on Qualifier.net.

- There may be instances where CMS directs contractors to verify certain data via the Medicare Exclusion Database and/or the GSA Excluded Parties List System, rather than through Qualifier.net. If a potential hit is found on the GSA List and the contractor needs

to make a positive identity, it shall contact the agency that took the action for further information; based on this data, the contractor shall determine whether it is the same person. If a positive match still cannot be made, the contractor may approve the application.

- *The contractor is* not required to use the Fraud Investigation Database (FID) when processing incoming enrollment applications, including changes of information. If the contractor chooses to use the FID on a particular provider, owner, etc., and the person/entity appears on the FID, the contractor should continue to process the application. However, it should refer the matter to the PSC for guidance.

- In some instances, a contractor may need to contact another Medicare contractor for information regarding the provider. The latter contractor shall respond to the former contractor's request within three business days absent extenuating *circumstances.*

5.3 – Requesting and Receiving Clarifying Information

(Rev. 230; Issued: 12-14-07; Effective: 01-01-08; Implementation: 01-07-08)

A. Requesting Clarifying Data

After the completion of the 15-day pre-screening phase, if the contractor determines that it needs clarifying information from the provider, the contractor shall send a letter to the provider – preferably via e-mail or fax - that contains, at a minimum, the elements listed below:

1. A list of all data to be clarified;

2. A request that the provider submit the clarifying data within a contractor-specified timeframe (i.e., the contractor can use whatever timeframe it wants, so long as it is within reason);

3. The *name and phone number* of a contact person at the contractor site;

4. The CMS Web site at which the CMS-855 forms can be found. The contractor shall instruct the provider to: *(1)* print out the page(s) containing the data in question; *(2)* enter the data on the blank page; *(3)* sign and date a new, blank certification statement; and *(4)* send it to the contractor. (As an alternative, the contractor can fax the blank page(s) and certification statement to the provider.) The provider need not furnish its initials next to the data element(s) in question.

5. A fax number and mailing address to which the data or documentation can be sent.

(The contractor can forgo items 4 and 5 above if resolution of the issue will not involve changes to the CMS-855.)

If the provider fails to furnish all of the requested clarifications within 60 calendar days after the contractor's request, the contractor shall reject the application. It shall notify the provider via letter or e-mail that the application is being rejected, the reason(s) for the rejection, and how to reapply. The contractor is free to keep the original application on file after *the* rejection. If the provider requests a copy of its application, the contractor may fax it to the provider.

In addition:

- **Only One Request Needed** - The "clarification letter" is the only request for clarification that the contractor must make. Obviously, the contractor should respond to any of the provider's telephone calls, e-mails, etc., resulting from the clarification letter. However, the contractor need not – on its own volition – make an additional request for clarification.

  To the maximum extent possible, the contractor should avoid contacting a provider for clarifying information until it has attempted to verify all *of the* data on the application. This will *obviate the need to contact* the provider each time *the contractor* discovers a discrepancy.

- **Resubmission after Rejection** – If the provider's application is rejected, the provider must complete and submit a new CMS-855 and all supporting documentation.

- **Appeals** – The provider may not appeal a rejection of its enrollment application.

- **Policy Application –** Unless stated otherwise in this manual, the policies enunciated in this section 5.3 apply to all CMS-855 applications identified in sections 2.1 and 2.2 *of this manual* (e.g., changes of information, reassignments).

- **Good-Faith Effort by Provider** – If the provider fails to submit the requested clarification within the aforementioned 60-day timeframe but appears to be making a good-faith effort to do so, the contractor may at its discretion continue processing the application.

- **Incomplete Responses** – The provider must furnish all clarifying data requested by the contractor within the applicable timeframe. Whether the provider indeed furnished all the information is a decision resting solely with the contractor.

  Moreover, if the provider furnishes some, but not all, of the requested data within the 60-day period, the contractor is not required to contact the provider again to request the rest of the information. The contractor has the discretion to wait until the expiration of the 60-day period and then reject the application; however, as stated above, it should take into account any good-faith efforts *of* the provider to furnish the information.

- **Rejections vs. Denials** – *If the* provider failed to fully comply with the contractor's request for additional or clarifying *information, there* are two possible outcomes:

- Rejection of the application under 42 CFR § 424.525(a), due to the provider's failure to furnish clarification within 60 days of the request, or

- Denial of the application if one of the denial reasons in section 6.2 of this manual is implicated.

If the contractor is faced with this situation, it *is free to* contact its DPSE contractor liaison for guidance prior to making its decision to reject or deny.

- **Commencement of Timeframe** – The 60-day clock described above commences when the contractor mails, faxes, or e-mails the letter.

B. Relationship to the Pre-Screening Process

The contractor *may* begin the verification process during the pre-screening phase described in section 3.1 of this manual. If the contractor, in doing so, uncovers data requiring further development (e.g., problems verifying the SSN of a managing employee; Qualifier.net indicates that a person may be using two SSNs), the contractor may include this request for clarifying information within the pre-screening letter. This, in turn, means that the provider must furnish: (1) all data and documentation requested in the pre-screening letter within 60 calendar days of the request, and (2) all clarifications asked for in the contractor's request for clarifying information within 60 calendar days of the request.

EXAMPLE 1: The provider submits a CMS-855B on March 1. The contractor pre-screens the application and finds that all data elements have been completed and all required documentation submitted. Hence, no pre-screening letter is needed. Since several SSN discrepancies were found during the validation process, however, the contractor sent a request for clarifying information to the provider on March 20. In this scenario, the provider must furnish all of the requested data/clarifications by May 19.

EXAMPLE 2: The provider submits a CMS-855B on March 1. The contractor completed its pre-screening of the application on March 7 and found that three relatively minor data elements were missing, thus triggering the need for a pre-screening letter to be sent no later than March 16. The contractor decides to begin the verification process on March 8 and completes validation on March 13, *finding* two SSN discrepancies. The contractor thus sends out a single letter on March 14 addressing both the missing data elements (pre-screening) and the SSN issues (request for clarifying information). In this situation, the provider must furnish both the missing data elements and the requested clarification by May 13.

Now suppose that the contractor had not completed the entire verification process by March 16. In its pre-screening letter, the contractor *identified the missing information and requested clarification of the two SSN discrepancies.* The contractor completed the validation process on April 2; that same day, the contractor sent a request for additional information to the provider regarding two EIN discrepancies. *In this scenario,* the provider must furnish the missing information and SSN clarifications by May 13. Even if it does so, it must still provide the EIN clarifications by June 1 (or 60 days after the April 2 letter was sent). If the provider fails to

comply with the March 14 letter, *the contractor* may reject the application on May 13 without waiting to see if the provider can furnish the requested EIN clarifications.

C. Receiving Clarifying Information

Unless stated otherwise in this manual, any data collected on the CMS-855 for which the contractor requested clarification must be furnished by the provider on the applicable page(s) of the CMS-855. A newly-signed and dated certification statement must also be submitted. Note that this certification statement must be separate and distinct from the previous certification statement; that is, the provider cannot simply add its signature to the existing statement. It must sign a separate one.

The contractor can receive the clarifying information, including the new certification statement, via fax. Upon receipt, the contractor shall verify the new data. (The contractor need not re-verify the existing data on the application.)

D. Unsolicited Submission of Clarifying Information

Any new or changed information submitted by an applicant prior to the date the contractor finishes processing the application is considered to be an update to the original application. (It is immaterial whether the data was requested by the contractor.) The data is not considered to be a separate change of information. For instance, suppose the provider submitted an initial enrollment application to the fiscal intermediary. On the 58th day – one day before the intermediary planned to make its recommendation for approval – the provider on its own volition submitted updates to its section 6 data. The intermediary must process this information prior to making its recommendation, even if it takes *the application* beyond the 60-day limit. The *contractor* cannot make its recommendation as planned on the 59th day and simply process the section 6 data as a change of information after the fact. Of course, if the late-arriving data takes the timeframe over 60 days, the contractor should document the file and explain the special circumstances involved.

E. Site Visits

In addition to the site visits required for all IDTF, DME and CMHC applicants (which have their own site visit instructions), the contractor may conduct site visits: *(1) of* other applicants seeking enrollment in the Medicare program, or *(2)* to verify the status of currently enrolled providers. Such site visits should be unannounced; the contractor representatives shall always conduct themselves in a professional manner, disclosing to the provider appropriate identifying credentials and explaining the purpose of the visit. The contractor shall maintain records of all site visits to support decisions regarding the denial or revocation of a Medicare billing number.

5.4 - Special Verification Procedures for CMS-855B, CMS-855I and CMS-855R Applications

(Rev. 230; Issued: 12-14-07; Effective: 01-01-08; Implementation: 01-07-08)

A. Reassignment Packages

In situations where an entity wants to simultaneously enroll a group practice, the individual practitioners therein, and to reassign benefits accordingly, the *contractor* shall adhere to the instructions contained in the scenarios below. During the pre-screening process, the *contractor* shall examine the incoming forms to see if a reassignment may be involved.

- Only the CMS-855Rs are submitted - If a brand new group with new practitioners is attempting to enroll but submits only the CMS-855Rs for its group members (i.e., neither the initial CMS-855B nor the initial CMS-855Is were submitted), the *contractor* may return the application*s* if the group fails to submit all of the other forms necessary to process the enrollment package within 15 calendar days after receipt of the CMS-855Rs.

- Only the CMS-855B is submitted - If a brand new group wants to enroll but submits only the CMS-855B without attaching the CMS-855Is and CMS-855Rs for its group members (i.e., the CMS-855B arrives alone, without the other forms), the *contractor* may return the application if the group fails to submit all of the other forms necessary to process the enrollment package within 15 calendar days after receipt of the CMS-855B.

- Only the CMS-855I is submitted – *Suppose* an individual: *(1) s*ubmits only the CMS-855I without attaching the CMS-855B and CMS-855R (i.e., the CMS-855I arrives alone, without the other forms), and *(2) i*ndicates on the CMS-855I that he/she will be reassigning all of his/her benefits to the group practice. *In this scenario, the contractor may return the application if the applicant fails to submit all of the other forms necessary to process the enrollment package within 15 calendar days after receipt of the CMS-855I.*

In *each* of the aforementioned situations, the *contractor* can also return all other forms that were submitted as part of the incomplete enrollment package. For instance, suppose an individual reassigning all of his/her benefits to a group submits his/her CMS-855I on Day 1. The CMS-855B is submitted on Day 15, but no CMS-855R arrives. The *contractor* can return both the CMS-855B and the CMS-855I. (Note also that the 15-day clock *described above* begins when the *contractor* first received part of the reassignment package; in our example above, the clock *started* when the *contractor* received the CMS-855I.)

When applications are returned as described in this section 5.4, the *contractor* shall follow the provisions of section 3.2 of this manual in terms of notification to the provider, no creation of an L & T record in PECOS, etc. The *timeliness clocks for these applications only begin* when and if the entire enrollment package is submitted within the initial 15-day period.

In situations where an individual will be reassigning part (but not all) of his/her benefits to a group, the *contractor* shall not return the *CMS-855I application* if the CMS-855R and the CMS-

855B do not arrive. Rather, the *contractor* shall begin processing the individual's CMS-855I with respect to the practice location for the individual's practice.

B. Other Items

The contractor shall note the following:

- If an individual is joining a group that was enrolled prior to the CMS-855B (i.e., the group never completed a CMS-855), the *contractor shall* obtain a CMS-855B from the group. During this timeframe, the *contractor* shall not withhold any payment from the group. Once the group's application is received, the *contractor* shall add the new reassignment; if the CMS-855R was not submitted, the *contractor* shall secure it from the supplier.

- If a supplier is changing its tax identification number, *the transaction shall be treated as a* brand new enrollment as opposed to a change of information. Consequently, the supplier must complete a full CMS-855 application and a new enrollment record must be created in PECOS. (This does not apply to ASCs and portable x-ray suppliers. These entities can submit a TIN change as a change of information unless a CHOW is involved. If the latter is the case, the instructions in subsection (C) of section 5.6 of this manual *should* be followed.)

- If the supplier is adding or changing a practice location and the new location is in another State within the contractor's jurisdiction, the *contractor* shall ensure that the supplier furnishes all applicable licenses, certifications, etc., for that State. A complete CMS-855 application for the new State is not required, though the *contractor* shall create a new enrollment record in PECOS for the new State.

- All members of a group practice must be entered into PECOS.

6.2 – Denials

(Rev. 230; Issued: 12-14-07; Effective: 01-01-08; Implementation: 01-07-08)

A. Denial Reasons

Per 42 CFR § 424.530(a), carriers must deny, and intermediaries must recommend a denial of, an enrollment application if any of the situations described below are present. (Carriers should only recommend denial in the case of ASCs and portable x-ray suppliers.) The carrier/RO must provide appeal rights.

When issuing a denial or recommendation for denial, the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR § 424.530(a)(1)) into its determination letter. The contractor shall not use provisions from this chapter 10 as the basis for denial or recommendation thereof.

Denial Reason 1 (42 CFR § 424.530(a)(1))

The provider or supplier is determined not to be in compliance with the *Medicare* enrollment requirements described in this section or *on* the enrollment application applicable *to* its provider or supplier type, and has not submitted a plan of corrective action as outlined in part 488 of this chapter.

Denial Reason 2 (42 CFR § 424.530(a)(2))

The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier who is required to be reported on the CMS-855 is—

- Excluded from Medicare, Medicaid, or any other Federal health care program, as defined in 42 CFR §1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Social Security Act, or

- Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with section 2455 of the Federal Acquisition Streamlining Act.

Denial Reason 3 (42 CFR § 424.53*0*(a)(3))

The provider, supplier, or any owner of the provider or supplier was, within the 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include--

- Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

- Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

- Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

- Any felonies *outlined in section 1128* of the Social Security Act.

Denial Reason 4 (42 CFR § 424.530(a)(4))

The provider or supplier *submitted* false or misleading information on the enrollment application to *gain* enrollment in the Medicare program. (The contractor shall contact its DPSE contractor liaison prior to issuing or recommending denial of an application on this ground.)

Denial Reason 5 (42 CFR § 424.530(a)(5))

The CMS determines, upon onsite review or other reliable evidence, that the provider or supplier is not operational to furnish Medicare covered items or services, or does not meet Medicare enrollment requirements to furnish Medicare covered items or services. This includes, *but is not limited to,* the following situations:

- The applicant does not have a license(s) or is not authorized by the Federal/State/local government to perform the services for which it intends to render. *(In its denial letter, the contractor shall cite the appropriate statute and/or regulations containing the licensure/certification/authorization requirements for that provider or supplier type. For a listing of said statutes and regulations, refer to section 12 et seq. of this manual. Note that the contractor must identify in the denial letter the exact provision within said statute/regulation that the provider/supplier has failed to comply with.)*

- The applicant does not have a physical business address or mobile unit where services can be rendered and/or does not have a place where patient records are stored to determine the amounts due such provider or other person (as set forth in §1833(e) of the Social Security Act.)

- The applicant does not meet CMS regulatory requirements for the specialty. (In *its* denial letter, the contractor shall *cite the appropriate statutory and/or regulatory citations containing the licensure/certification/authorization requirements for that provider or supplier type. For a listing of said statutes and regulations, refer to section 12 et seq. of this manual. Note that the contractor must identify in the denial letter the exact provision within said statute/regulation that the provider/supplier is not in compliance with.)*

- The applicant does not qualify as a provider of services or a supplier of medical and health services. An entity seeking Medicare payment must be able to receive reassigned benefits

from physicians in accordance with the Medicare reassignment *provisions* in §1842(b)(6) of the Act (42 U.S.C. 1395u(b)).

***NOTE:** This denial provision should be used in cases where the applicant is not recognized by any Federal statute as a Medicare provider or supplier (e.g., marriage counselors))*

- The applicant does not provide a valid SSN/EIN for the applicant, owner, partner, managing organization/employee, officer, *director, medical director*, and/or delegated or authorized official.

- A home health agency (HHA) does not meet the capitalization requirements *outlined* in 42 CFR § 489.28.

B. Denial Letters

When a decision to deny is made, the carrier shall send a letter to the supplier identifying the reason(s) for denial and furnishing appeal rights. The letter shall follow the format of that shown in section 14 of this manual.

If a recommendation to deny is made (for certified suppliers and providers), the contractor shall send a letter of recommendation for denial to the applicable State agency, with a copy going to the RO's survey and certification unit. The letter shall contain the same data elements listed in section 6.1.2 of this manual; the contractor shall also follow the same procedures for furnishing notification to the State, the RO, and the provider identified in section 6.1.2 above.

*As previously indicated, i*t is imperative that all denial (or recommendation for denial) letters contain sufficient factual and background information so that the reader understands exactly why the denial occurred. It is not enough to simply list one of the denial reasons. *All applicable statutes and regulations, as well as a detailed factual rationale for the contractor's decision, must be identified in the letter.* For instance, if an application is denied based on falsification, the carrier must identify in its letter the falsified information, how and why the carrier determined it was false, *the regulation in question,* etc. If there were multiple reasons for denial, the letter shall state as such *and shall furnish all of the aforementioned statutes, regulations, facts, etc. applicable to each reason. For more detailed information on the appropriate composition of denial letters, see section 19 of this manual.*

C. Post-Denial Submission of Enrollment Application

A provider or supplier that is denied enrollment in the Medicare program cannot submit a new enrollment application until the following has occurred:

- If the denial was not appealed, the provider or supplier may reapply after its appeal rights have lapsed.

- If the denial was appealed, the provider or supplier may reapply after it received notification that the determination was upheld.

D. 30-Day Effective Date of Denial

A denial is effective 30 calendar days after the contractor sends its denial notice to the provider.

As stated in 42 CFR § 424.530(c), if the denial was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare services, the denial may be reversed if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the denial notification. The contractor, however:

- Need not solicit or ask for such proof in its denial letter. It is up to the provider to furnish this data on its own volition.

- Has the ultimate discretion to determine whether sufficient "proof" exists.

See section 19 of this manual for information on Corrective Active Plans (CAP).

13.2 – Contractor Issued Revocations

(Rev. 230; Issued: 12-14-07; Effective: 01-01-08; Implementation: 01-07-08)

A. Revocation Reasons

The contractor may issue a revocation (or recommend a revocation) using revocation reasons 1 through 10 below without prior approval from CMS. Section 13.3 lists an additional revocation reason that requires DPSE review and approval.

When issuing a revocation, the contractor shall insert the appropriate regulatory basis (e.g., 42 CFR § 424.535(a)(1)) into its determination letter. The contractor shall not use provisions from this chapter 10 as the basis for revocation.

Revocations based on non-compliance:

Revocation 1 (42 CFR § 424.535(a)(1))

The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section or in the *enrollment application applicable to* its provider or supplier type, and has not submitted a plan of corrective action *as outlined in 42 CFR Part 488.*

Noncompliance includes, but is not limited to the provider or supplier no longer having a physical business address or mobile unit where services can be rendered and/or does not have a place where patient records are stored to determine the amounts due such provider or other person and/or the provider or supplier no longer meets or maintains general enrollment *requirements.*

Revocation 2

The provider or supplier has lost its license(s) or is not authorized by the Federal/state/local government to perform the services for which it intends to render. *(In its revocation letter, the contractor shall cite the appropriate statutory and/or regulatory citations containing the licensure/certification/authorization requirements for that provider or supplier type. For a listing of said statutes and regulations, refer to section 12 et seq. of this manual. Note that the contractor must identify in the revocation letter the exact provision within said statute/regulation that the provider/supplier has failed to comply with.)*

Revocation 3

The provider or supplier no longer meets CMS regulatory requirements for the specialty for which it has been enrolled. *(In its revocation letter, the contractor shall cite the appropriate statutory and/or regulatory citations containing the licensure/certification/authorization requirements for that provider or supplier type. For a listing of said statutes and regulations, refer to section 12 et seq. of this manual. Note that the contractor must identify in the revocation letter the exact provision within said statute/regulation that the provider/supplier is not in compliance with.)*

Revocation 4 (42 CFR § 424.535(a)(1))

The provider or supplier (upon discovery) does not have a valid SSN/employer identification number for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or delegated or authorized official.

Revocations based on provider or supplier conduct:

Revocation 5 *(42 CFR § 424.535(a)(2))*

The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is:

(i) Excluded from the Medicare, Medicaid, and any other Federal health care program, as defined in § 1001.2 of this chapter, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.

(ii) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with the FASA implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 C.F.R. part 76.

If an excluded party is found, notify DPSE immediately. DPSE will notify the Government Task Leader (GTL) for the appropriate PSC. The GTL will, in turn, contact the Office of Inspector General's office with the findings for further investigation.

Revocations based on felony:

Revocation 6 *(42 CFR § 424.535(a)(2))*

The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries to continue enrollment.

(i) Offenses include—

(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(C) Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

(D) Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.

(ii) Revocations based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.

Revocations based on false or misleading information:

Revocation 7 *(42 CFR § 424.535(a)(4))*

The provider or supplier certified as ‘‘true’’ misleading or false information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current law and regulations.)

If it is discovered that the provider or supplier deliberately falsified, misrepresented, or omitted information contained in the application or deliberately altered text on the application form, issue a revocation or recommendation for revocation.

Revocations based on misuse of billing number:

Revocation 8 *(42 CFR § 424.535(a)(7))*

The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers who enter into a valid reassignment of benefits as specified in § 424.80 or a change of ownership as outlined in § 489.18 of this chapter.

Additional revocation reasons:

Revocation 9 *(42 CFR § 424.535(a)(5))*

CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of, or to provide Medicare covered items or services for, Medicare patients. Upon on-site review, CMS determines that—

(i) A Medicare Part A provider is no longer operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.

(ii) A Medicare Part B supplier is no longer operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations.

Revocation 10 *(42 CFR § 424.535(a)(6))*

The provider or supplier fails to furnish complete and accurate information and all supporting documentation within 60 calendar days of the provider or supplier's notification from CMS to submit an enrollment application and supporting documentation.

B. Revocation Letters

As previously indicated, it is imperative that all revocation letters contain sufficient factual and background information so that the reader understands exactly why the revocation occurred. It is not enough to simply list one of the revocation reasons. All applicable statutes and regulations, as well as a detailed factual rationale for the contractor's decision, must be identified in the letter. For instance, if a *provider is revoked based on the submission of false information*, the carrier must identify in its letter the falsified information, how and why the carrier determined it was false, *the regulation in question,* etc. If there were multiple reasons for *revocation*, the letter shall state as such *and shall furnish all of the aforementioned statutes, regulations, facts, etc. applicable to each reason. For more detailed information on the appropriate composition of revocation letters, see section 19 of this manual.*

When a provider or supplier number is revoked, the contractor must maintain documentation as required by section 10 of this manual. In addition, when a provider's or supplier's billing privileges are revoked, the provider agreement in effect at the time of revocation is also terminated.

Prior to issuing a revocation for a Part A provider or a certified Part B supplier, the contractor shall notify DPSE and the applicable regional office's survey and certification unit.

C. Effective Date of Revocations

Revocations issued by a contractor other than the National Supplier Clearinghouse (NSC) become effective within 30 days of the initial revocation notification.

As stated in 42 CFR § 424.535(d), if the revocation was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare services, the revocation may be reversed if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days of the revocation notification. The contractor, however:

- *Need not solicit or ask for such proof in its recommendation letter. It is up to the provider to furnish this data on its own volition.*

- *Has the ultimate discretion to determine whether sufficient "proof" exists.*