CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 412	**Date: March 30, 2012**
	Change Request 7646

SUBJECT: General Update to Chapter 15 of the Program Integrity Manual (PIM) - Part II

I. SUMMARY OF CHANGES: This change request (CR) is the second in a series of transmittals designed to update chapter 15 of the PIM. The revisions in this CR: (1) are editorial in nature, or (2) incorporate existing policies directly into chapter 15.

EFFECTIVE DATE: April 30, 2012
IMPLEMENTATION DATE: April 30, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/Table of Contents
R	15/15.1.2/Medicare Enrollment Application (Form CMS-855)
D	15/15.7.5.2/Verification of Legalized Status
R	15/15.8.4/Denials
R	15/15.19.1/Application Fees
R	15/15.20.2/Reserved for Future Use
D	15/15.21.9/Compliance Standards for Enrollment of Mail Order Pharmacies and Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Delivered Through Other Than the Supplier's Location or Beneficiary Address
R	15/27.1/CMS or Contractor Issued Deactivations
R	15/27.2/Revocations
R	15/27.2.1/Special Instructions Regarding Revocations of Certified Suppliers and Providers
D	15/15.34.3/Mailing Annual "Supplier Responsibilities" Letter
D	15/15.34.3.1/Mailing Annual Material to Physicians
D	15/15.34.3.2/Mailing Annual Material to Non-physician Sole Practitioners
D	15/15.34.3.3/Mailing Annual Material to Physicians and Non-physician Practitioner Organizations

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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: 412	Date: March 30, 2012	Change Request: 7646

SUBJECT: General Update to Chapter 15 of the Program Integrity Manual (PIM) - Part II

Effective Date: **April 30, 2012**
Implementation Date: April 30, 2012

I. GENERAL INFORMATION

A. Background: This change request (CR) is the second in a series of transmittals designed to update chapter 15 of the PIM. The revisions in this CR: (1) are editorial in nature, or (2) incorporate existing policies directly into chapter 15.

B. Policy: The purpose of this CR is to continue the process of updating chapter 15 of the PIM.

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	
7646.1	**NOTE:** The contractor shall view the reorganization of the denial and revocation reasons in, respectively, sections 15.8.4 and 15.27.2 of chapter 15.	X		X	X	X					National Supplier Clearinghouse (NSC)

III. PROVIDER EDUCATION 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	
	None										

IV. SUPPORTING INFORMATION

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

Use "Should" to denote a recommendation.

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

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

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

Post-Implementation Contact(s):
Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *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.

Medicare Program Integrity Manual
Chapter 15 - Medicare Enrollment

Table of Contents

(Rev.412, Issued: 03-30-12)

15.1.2 – Medicare Enrollment Application (*Form* CMS-855)
15.20.2 – *Reserved for Future Use*
15.27.1 – CMS or Contractor Issued Deactivations
15.27.2 - *Revocations*
15.27.2.1 – *Special Instructions Regarding Revocations of Certified Providers and Certified Suppliers*

15.1.2 – Medicare Enrollment Application (*Form* CMS-855)

(Rev. 412, Issued: 03-30-12, Effective: 04- 30-12, Implementation: 04-30-12)

Providers and suppliers, including physicians, may enroll or update their Medicare enrollment record using the:

- Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- Paper enrollment application process (e.g., *Form* CMS-855I).

The Medicare enrollment applications are issued by CMS and approved by the *Office of Management and Budget.*

*T*he five *enrollment applications* are distinguished as follows:

- CMS-855I - This *application should* be completed by *physicians* and non-physician *practitioners who* render Medicare Part B services *to beneficiaries*. (This includes a physician or practitioner who: (1) is the sole owner of a professional corporation, professional association, or limited liability company, and (2) will bill Medicare through this business entity*.)*

- CMS-855R - An individual who renders Medicare Part B services and seeks to reassign his or her benefits to an eligible entity should complete this form for each entity eligible to receive reassigned benefits. The *individual* must be enrolled in the Medicare program as an individual prior to reassigning his or her benefits.

- CMS-855B - This application should be completed *by s*upplier organization*s* (e.g., ambulance compan*ies*) that will bill Medicare for Part B services furnished to Medicare beneficiaries. It is not used to enroll individuals.

- CMS-855A - This application should be completed by institutional providers (e.g., hospital*s*) that will furnish Medicare Part A services *to b*eneficiaries.

- CMS-855S – This application should be completed *by suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)*. The *National Supplier Clearinghouse (NSC)* is responsible for processing this type of enrollment application.

A separate application must be submitted for each provider/supplier type.

When a prospective provider or supplier contacts the contractor to obtain a paper enrollment *Form* CMS-85*5,* the contractor shall *encourage the provider or supplier to submit the application using Internet-based PECOS. The contractor shall also notify the provider or supplier of:*

- The CMS Web site *at which information on Internet-based PECOS can be found and at which the* paper applications can be accessed (www.cms.hhs.gov/MedicareProviderSupEnroll).

- *A*ny supporting documentation required for the applicant's provider/supplier type.

- *Other required forms, including:*

  - The Electronic Funds Transfer Authorization Agreement (*Form* CMS-588) (Note: The NSC is only required to collect the *Form* CMS-588 with initial enrollment applications.)

  - The Electronic Data *Interchange agreement* (Note: This does not apply to the NSC.)

  - The Medicare Participating Physician or Supplier Agreement (*Form* CMS-460). *The contractor shall explain to the provider or supplier* the purpose of the agreement and how it differs from the actual enrollment process. *(This only applies to suppliers that complete the Forms CMS-855B and CMS-855I.)*

- The contractor's address *so* that the applicant knows where to return the completed application.

- If the applicant is a certified supplier *or certified* provider*, the need to c*ontact the State agency for any *S*tate-specific forms and to begin preparations for a State survey. (This does not apply for those certified entities*, such as federally qualified health centers,* that do not receive a State survey.) The notification can be given in any manner the contractor chooses.

15.8.4 – Denials

(Rev. 412, Issued: 03-30-12, Effective: 04- 30-12, Implementation: 04-30-12)

A. Denial Reasons

Per 42 CFR §424.530(a), *the* contracto*r* must deny an enrollment application if any of the situations described below are present, and must provide appeal rights.

When issuing a 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 *15* as the basis for denial.

If the applicant is a certified provider or certified supplier and one of the denial reasons listed below is implicated, the contractor need not submit a recommendation for denial to the State/*Regional Office (RO)*. The contractor can simply: (1) deny the application, (2) close out the PECOS record, and (3) send a denial letter to the *provider. The*