| CMS Manual System | **Department of Health & Human Services (DHHS)** |
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| Pub 100-08 Medicare Program Integrity | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 416** | **Date: April 13, 2012** |
| | **Change Request 7698** |

**Transmittal 405, dated January 26, 2012, is being rescinded and replaced by Transmittal 416, Date April 13, 2012, to delete section 15.14.11 from "Section II: Changes in the Manual Instructions" of the Transmittal and "the Table of Contents" of the Manual Instructions. All other information remains the same.**

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

**I. SUMMARY OF CHANGES:** The purpose of this change request is to move the remaining sections of Chapter 10 of the Program Integrity Manual (PIM) into Chapter 15 of the PIM.

**EFFECTIVE DATE: February 27, 2012**

**IMPLEMENTATION DATE: February 27, 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 |
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| D | 10/2.2.8/Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) |
| D | 10/3/Pre-Screening and Application Returns |
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**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.*

# Medicare Program Integrity Manual
## Chapter 15 - Medicare Provider/Supplier Enrollment

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## *15.5.16 – Delegated Officials*

***(Rev. 416 , Issued: 04-13-12 , Effective 02-27-12, Implementation: 02-27-12)***

*(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 <u>not</u> 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, chain home office, or management company. One cannot use his/her status as a W-2 managing employee of the provider's parent company, management company, or chain home office as a basis for his or her role as a delegated official of the provider.*

- *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.*

## *15.5.17 – Reserved for Future Use*
***(Rev. 416 , Issued: 04-13-12, Effective 02-27-12, Implementation: 02-27-12)***

## *15.5.18 – Ambulance Attachment*
***(Rev. 416 , Issued: 04-13-12, Effective 02-27-12, Implementation: 02-27-12)***

### *A. Geographic Area*

*The applicant must list the geographic areas in which it provides services. If the supplier indicates that it provides services in more than one contractor's jurisdiction, it must submit a separate CMS-855B to each contractor.*

### *B. Licensure Information*

*With respect to licensure:*

- *The contractor shall ensure that the supplier submits all applicable licenses and certificates.*

- *If the supplier performs services in multiples States within the same contractor jurisdiction, it must submit all necessary licenses and certificates for each State. Separate full CMS-855Bs are not required for each State; however, the contractor shall create separate enrollment records in PECOS for each.*

- *An air ambulance supplier that is enrolling in a State to which it flies in order to pick up patients (that is, a State other than where its base of operations is located) is not required to have a practice location or place of business in that State. So long as the air ambulance supplier meets all other criteria for enrollment in Medicare, the contractor for that State may not deny the supplier's enrollment application solely on the grounds that the supplier does not have a practice location in that State. (This policy only applies to air ambulance suppliers.)*

### *C. Paramedic Intercept Information*

*Paramedic intercept services typically involves an arrangement between a basic life support (BLS) ambulance supplier and an advanced life support (ALS) ambulance supplier, whereby the latter provides the ALS services and the BLS supplier provides the transportation component. (See 42 CFR §410.40 for more information.) If the applicant indicates that it has such an arrangement, it must attach a copy of the agreement/contract.*

### *D. Vehicle Information*

*Air ambulance suppliers must submit the following:*

- *A written statement signed by the president, chief executive officer, or chief operating officer that gives the name and address of the facility where the aircraft is hangared; and*

- *Proof that the air ambulance supplier or its leasing company possesses a valid charter flight license (FAA Part 135 Certificate) for the aircraft being used as an air ambulance. If the air medical transportation company owns the aircraft, the owner's name on the FAA Part 135 certificate must be the same as the supplier's name on the enrollment application. If the air medical transportation company leases the aircraft from another entity, a copy of the lease agreement must accompany the enrollment application. The name of the company leasing the aircraft from that other entity must be the same as the supplier's name on the enrollment application.*

***E. Hospital-Based Ambulances***

*An ambulance service that is owned and operated by a hospital need not complete a CMS-855B if:*

- *The ambulance services will appear on the hospital's cost-report; and*

- *The hospital possesses all licenses required by the State or locality to operate the ambulance service.*

*If the hospital decides to divest itself of the ambulance service, the latter will have to complete a CMS-855B if it wishes to bill Medicare.*

## *15.5.19 – IDTF Attachment*

***(Rev. 416 , Issued: 04-13-12, Effective 02-27-12, Implementation: 02-27-12)***

*Sections 15.5.19 through 15.5.19.7 of this chapter contain provider enrollment instructions regarding entities that must enroll as and bill for the technical component of diagnostic tests as an independent diagnostic testing facility (IDTF).*

## *15.5.19.1 – IDTF Standards*

***(Rev. 416 , Issued: 04-13-12 , Effective 02-27-12, Implementation: 02-27-12)***

***A. IDTF Standards***

*Consistent with 42 CFR §410.33(g), each IDTF must certify on its CMS-855B enrollment application that it meets the following standards and all other requirements:*

1. *Operates its business in compliance with all applicable Federal and State licensure and regulatory requirements for the health and safety of patients.*

    - *The purpose of this standard is to ensure that suppliers are licensed in the business and specialties being provided to Medicare beneficiaries. Licenses are required by State and/or Federal agencies to make certain that guidelines and*

*regulations are being followed to ensure businesses are furnishing quality services to Medicare beneficiaries.*

- *The responsibility for determining what licenses are required to operate a supplier's business is the sole responsibility of the supplier. The contractor is not responsible for notifying any supplier of what licenses are required or that any changes have occurred in the licensure requirements. No exemptions to applicable State licensing requirements are permitted, except when granted by the State.*

- *The contractor shall not grant billing privileges to any business not appropriately licensed as required by the appropriate State or Federal agency. If a supplier is found providing services for which it is not properly licensed, billing privileges may be revoked and appropriate recoupment actions taken.*

*2. Provides complete and accurate information on its enrollment application. Changes in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported to the Medicare fee-for-service contractor on the Medicare enrollment application within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 days.*

***NOTE: This 30-day requirement takes precedence over the certification in section 15 of the CMS-855B whereby the supplier agrees to notify Medicare of any changes to its enrollment data within 90 days of the effective date of the change. By signing the certification statement, the IDTF agrees to abide by all Medicare rules for its supplier type, including the 30-day rule in 42 CFR §410.33(g)(2).***

*3. Maintain a physical facility on an appropriate site. For the purposes of this standard, a post office box, commercial mailbox, hotel, or motel is not considered an appropriate site. The physical facility, including mobile units, must contain space for equipment appropriate to the services designated on the enrollment application, facilities for hand washing, adequate patient privacy accommodations, and the storage of both business records and current medical records within the office setting of the IDTF, or IDTF home office, not within the actual mobile unit.*

- *IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.*

- *The requirements in 42 CFR §410.33(g)(3) take precedence over the guidelines in sections 15.5.4 and 15.5.4.2 of this chapter pertaining to the supplier's practice location requirements.*

- *The physical location must have an address, including the suite identifier, which is recognized by the United States Postal Service (USPS).*

*4. Has all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. The IDTF must—*

*(i) Maintain a catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers at the physical site;*

*(ii) Make portable diagnostic testing equipment available for inspection within 2 business days of a CMS inspection request; and*

*(iii) Maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, and provide this information to the designated fee-for-service contractor upon request, and notify the contractor of any changes in equipment within 90 days.*

*5. Maintain a primary business phone under the name of the designated business. The IDTF must have its--*

*(i) Primary business phone located at the designated site of the business or within the home office of the mobile IDTF units.*

*(ii) Telephone or toll free telephone numbers available in a local directory and through directory assistance.*

*The requirements in 42 CFR §410.33(g)(5) take precedence over the guidelines in sections 15.5.4 and 15.5.4.2 of this chapter pertaining to the supplier's telephone requirements.*

*IDTFs may not use "call forwarding" or an answering service as their primary method of receiving calls from beneficiaries during posted operating hours.*

*6. Have a comprehensive liability insurance policy of at least $300,000 per location that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a nonrelative-owned company. Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing insurance agent and the underwriter. In addition, the IDTF must--*

*(i) Ensure that the insurance policy must remain in force at all times and provide coverage of at least $300,000 per incident; and*

*(ii) Notify the CMS designated contractor in writing of any policy changes or cancellations.*

*7. Agree not to directly solicit patients, which includes - but is not limited to - a prohibition on telephone, computer, or in-person contacts. The IDTF must accept only those patients referred for diagnostic testing by an attending physician, who is furnishing a consultation or treating a beneficiary for a specific medical problem and*