CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11682	**Date: November 4, 2022**
	Change Request 12880

SUBJECT: Seventh General Update to Provider Enrollment Instructions in Chapter 10 of CMS Publication (Pub.) 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 10 of Pub. 100-08 with provider enrollment instructions regarding ownership disclosures, electronic funds transfers (EFTs), special payment addresses, and other topics.

EFFECTIVE DATE: December 5, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 5, 2022

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	10/10.2/10.2.1.6.2/HHA Capitalization
R	10/10.2/10.2.5/Suppliers That Enroll Via the Form CMS-855S
N	10/10.2/10.2.5.1/DMEPOS Supplier Accreditation
N	10/10.2/10.2.5.2/Fraud Level Indicators for DMEPOS Suppliers - Development and Use
N	10/10.2/10.2.5.3/Surety Bonds
N	10/10.2/10.2.5.3.1/Basics of the Surety Bond Requirement
N	10/10.2/10.2.5.3.2/Claims against Surety Bonds
N	10/10.2/10.2.5.4/Indian Health Services (IHS) Facilities' Enrollment as DMEPOS Suppliers
N	10/10.2/10.2.5.5/Pharmacy Enrollment as a DMEPOS Supplier - Accreditation
R	10/10.2/10.2.7/Opioid Treatment Programs
R	10/10.6/10.6.1.2/Changes of Information – Transitioned Certified Providers and Suppliers
R	10/10.6/10.6.2/Establishing Effective Dates
R	10/10.6/10.6.7.1/Organizational Owning and Managing Information
R	10/10.6/10.6.7.2/Individual Owning and Managing Information
N	10/10.6/10.6.21.1/Additional Miscellaneous Enrollment Topics
N	10/10.6/10.6.23/Special Instructions for Electronic Funds Transfer (EFT) Accounts and Special Payment Addresses

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not 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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 11682	Date: November 4, 2022	Change Request: 12880

SUBJECT: Seventh General Update to Provider Enrollment Instructions in Chapter 10 of CMS Publication (Pub.) 100-08

EFFECTIVE DATE: December 5, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 5, 2022

I. GENERAL INFORMATION

A. Background: Chapter 10 of CMS Pub. 100-08 outlines policies related to Medicare provider enrollment and instructs contractors on the processing of Form CMS-855 provider enrollment applications. This CR clarifies several provider enrollment topics, including ownership disclosures, Electronic Funds Transfer (EFT) accounts, special payment addresses, and other topics.

B. Policy: This CR does not involve any legislative or regulatory policies.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12880.1	The contractor shall adhere to the ownership instructions in Sections 10.6.7.1(C) and (D)(6) and 10.6.7.2(B)(6) in Chapter 10 of Pub. 100-08.	X	X	X						NSC
12880.2	The contractor shall adhere to the EFT and special payment address instructions in Section 10.6.23 in Chapter 10 of Pub. 100-08.	X	X	X						
12880.2.1	The contractor shall apply the instructions identified in Business	X	X	X						

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Requirement 12880.2 to all applications that the contractor has not yet received or are still in process as of the implementation date of this CR.									
12880.3	The contractor shall adhere to the home health agency capitalization instructions in Section 10.2.1.6.2 in Chapter 10 of Pub. 100-08.	X		X						
12880.4	The contractor shall adhere to the reassignment effective date instructions in Section 10.6.2 in Chapter 10 of Pub. 100-08.		X							
12880.5	The contractor shall adhere to the processing timeframes for surety bond cancellations described in Section 10.2.5.3.1(F) in Chapter 10 of Pub. 100-08.									NSC
12880.6	The contractor shall observe and adhere to the clarifications in Section 10.2.7(B)(9) in Chapter 10 of Pub. 100-08 regarding opioid treatment	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	programs.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12880.7	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X	X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Program Integrity Manual
Chapter 10 – Medicare Enrollment
Table of Contents
(Rev. 11682; Issued: 11-04-2022)

Transmittals for Chapter 10

10.2.1.6.2 – HHA Capitalization

(Rev. 11682; Issued: 11-04-2022; Effective: 12-05-2022; Implementation: 12-05-2022)

A. Background

Effective January 1, 2011, and pursuant to 42 CFR §§ 489.28(a) and 424.510(d)(9), an HHA entering the Medicare program - including a new HHA resulting from a change of ownership if the change of ownership results in a new provider number being issued - must have available sufficient funds (known as initial reserve operating funds) at (1) the time of application submission and (2) all times during the enrollment process, to operate the HHA for the three-month period after the Medicare contractor conveys billing privileges (exclusive of actual or projected accounts receivable from Medicare). This means that the HHA must also have available sufficient initial reserve operating funds during the 3-month period following the conveyance of Medicare billing privileges.

B. Points of Review

At a minimum, the contractor shall verify that the HHA meets the required amount of capitalization *at the following times:*

- 1st Review - Prior to making its recommendation for approval to the state
- 2nd Review – *Between 30 and 35 calendar days after making its recommendation to the state. (Only the request for proof of capitalization need be initiated between 30 and 35 calendar days. The verification need not be completed within or by this timeframe.)*
- 3rd Review - After the contractor receives the state recommendation but before it sends to PEOG the e-mail described in section 10.2.1.6(B)(3)(B)
- 4th Review - During the 3-month period after the contractor conveys Medicare billing privileges to the HHA

For initial applications, the contractor shall verify that the HHA meets all of the capitalization requirements addressed in 42 CFR §489.28. (Note that capitalization need not be reviewed for revalidation, reactivation applications, and changes of ownership that do not require a new/initial enrollment under §424.550(b).) The contractor may request from the HHA any and all documentation deemed necessary to perform this task.

The HHA must submit proof of capitalization within 30 calendar days of the contractor's request to do so. Should the HHA fail to furnish said proof and billing privileges have not yet been conveyed, the contractor shall deny the HHA's application pursuant to §424.530(a)(8)(i) or (ii), as applicable. If billing privileges have been conveyed, the contractor shall revoke the HHA's billing privileges per §424.535(a)(11).

Should the contractor deem it necessary to verify the HHA's level of capitalization more than once within a given period (e.g., more than once between the time a recommendation is made and the completion of the state review process), the contractor shall seek approval from its PEOG BFL.

C. Determining Initial Reserve Operating Funds

Initial reserve operating funds are sufficient to meet the requirement of 42 CFR §489.28(a) if the total amount of such funds is equal to or greater than the product of the actual average cost per visit of three or more similarly situated HHAs in their first year of operation (selected by CMS for comparative purposes) multiplied by the number of visits projected by

the HHA for its first 3 months of operation--or 22.5 percent (one fourth of 90 percent) of the average number of visits reported by the comparison HHAs--whichever is greater.

The contractor shall determine the amount of the initial reserve operating funds by using reported cost and visit data from submitted cost reports for the first full year of operation from at least three HHAs that the contractor serves that are comparable to the HHA seeking to enter the Medicare program. Factors to be used in making this determination shall include:

- Geographic location and urban/rural status;
- Number of visits;
- Provider-based versus free-standing status; and
- Proprietary versus non-proprietary status.

The adequacy of the required initial reserve operating funds is based on the average cost per visit of the comparable HHAs, by dividing the sum of total reported costs of the HHAs in their first year of operation by the sum of the HHAs' total reported visits. The resulting average cost per visit is then multiplied by the projected visits for the first 3 months of operation of the HHA seeking to enter the program, but not less than 90 percent of average visits for a 3-month period for the HHAs used in determining the average cost per visit.

D. Proof of Operating Funds

As described further in section 10.2.1.6.2(E) and (G) below, the HHA must provide CMS with adequate proof of the availability of initial reserve operating funds. In some cases, an HHA may have all or part of the initial reserve operating funds in cash equivalents. For purposes of the capitalization requirement, cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and that present insignificant risk of changes in value. A cash equivalent that is not readily convertible to a known amount of cash as needed during the initial 3-month period for which the initial reserve operating funds are required does not qualify as meeting the initial reserve operating funds requirement. Examples of cash equivalents for purposes of the capitalization requirement are Treasury bills, commercial paper, and money market funds.

As with funds in a checking, savings, or other account, the HHA also must be able to document the availability of any cash equivalents. CMS may later require the HHA to furnish: (1) another attestation from the financial institution that the funds remain available; and/or (2) documentation from the HHA that any cash equivalents remain available until a date when the HHA will have been surveyed by the state agency or by an approved accrediting organization. The officer of the HHA who will be certifying the accuracy of the information on the HHA's cost report must certify what portion of the required initial reserve operating funds constitutes non-borrowed funds, including funds invested in the business by the owner. That amount must be at least 50 percent of the required initial reserve operating funds. The remainder of the reserve operating funds may be secured through borrowing or line of credit from an unrelated lender.

E. Borrowed Funds

1. General Information

If borrowed funds are not in the same account(s) as the HHA's own non-borrowed funds, the HHA also must provide proof that the borrowed funds are available for use in operating the HHA. As part of this, and except as stated in section 10.2.1.6.2(E)(2) and (H) below, the HHA must (at a minimum) furnish: (1) a copy of the statement(s) of the HHA's savings, checking, or other account(s) containing the borrowed funds; and (2) an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and are

immediately available to the HHA. As with the HHA's own (that is, non-borrowed) funds, CMS later may require the HHA to establish the current availability of such borrowed funds; this could include furnishing an attestation from a financial institution or other source (as may be appropriate) to establish that such funds will remain available until a date when the HHA will have been surveyed by the state agency or by an approved accrediting organization.

2. Inability to Obtain Attestation Statements

Several national bank chains are no longer providing the attestation statements referenced in 42 CFR § 489.28(d) and § 489.28(e) (e.g., to verify the existence of capitalization funds for HHAs). Accordingly, the contractor may accept a current bank statement unaccompanied by an attestation from an officer of the bank or other financial institution if the HHA cannot secure the attestation. (See the phrase "(if the financial institution offers such attestations)" in revised § 489.28(d) and (e).) All efforts must be exhausted, however, to obtain the attestation of funds statement before the contractor can forgo this requirement. In no circumstances shall the contractor instruct the HHA to obtain a different bank that will provide an attestation statement. All other documents listed in section 10.2.1.6(G) must be obtained if required.

F. Line of Credit

If the HHA chooses to support the availability of a portion of the initial reserve operating funds with a line of credit, it must provide CMS with a letter of credit from the lender. CMS later may require the HHA to furnish an attestation from the lender that the HHA, upon its certification into the Medicare program, continues to be approved to borrow the amount specified in the letter of credit.

G. Documents

As part of ensuring the prospective HHA's compliance with the capitalization requirements, the contractor shall obtain the following from the HHA:

- A document outlining the HHA's projected budget – preferably, a full year's budget broken out by month
- A document outlining the number of anticipated visits - preferably a full year broken out by month
- An attestation statement from an officer of the HHA defining the source of funds
- Copies of bank statements, certificates of deposits, etc., supporting that cash is available (must be current)
- Except as stated in section 10.2.1.6.2(E)(2) above, a letter from an officer of the bank attesting that funds are available
- If available, audited financial statements

The contractor shall also ensure that the capitalization information in Section 12 of the Form CMS-855A is provided.

10.2.5 – Suppliers That Enroll Via the Form CMS-855S

(Rev. 11682; Issued: 11-04-2022; Effective: 12-05-2022; Implementation: 12-05-2022)

Section 10.2.5*, et al. instructs the contractor* on the appropriate handling of certain situations involving DMEPOS suppliers.

10.2.5.1 – DMEPOS Supplier Accreditation

(Rev. 11682; Issued: 11-04-2022; Effective: 12-05-2022; Implementation: 12-05-2022)

A. General Requirement

DMEPOS suppliers must be accredited prior to submitting an application to the contractor. The contractor shall deny any DMEPOS supplier's enrollment application if the enrollment package does not contain an approved accreditation upon receipt.

The contractor shall revoke an enrolled DMEPOS supplier's billing privileges if the supplier fails to: (1) obtain and submit supporting documentation that it has been accredited; or (2) maintain its required accreditation.

In the future, Medicare will deny claims for DMEPOS suppliers that fail to maintain accreditation information on file with the contractor.

B. Exemptions

Individual medical practitioners, inclusive of group practices of same, do not require accreditation as a condition of enrollment. The practitioner types are those specifically stated in Sections 1848(K)(3)(B) and 1842(b)(18)(C) of the Social Security Act. In addition, the practitioner categories of physicians, orthotists, prosthetists, optometrists, opticians, audiologists, occupational therapists, physical therapists, and suppliers who provide drugs and pharmaceuticals (only) do not require accreditation as a condition of enrollment.

Although suppliers that provide only drugs and pharmaceuticals are exempt from the accreditation requirement, suppliers that provide equipment to administer drugs or pharmaceuticals must be accredited.

C. Changes of Ownership

A change of ownership application for an existing supplier location submitted by a new owner company with a new tax identification number (TIN) shall be denied (consistent with 42 CFR § 424.57) if the new owner does not have an accreditation that covers all of its locations. If the old owner has such an accreditation, the new owner can be enrolled as of the date of sale if the accreditor determines that the accreditation should remain in effect as of the date of sale. (This, however, is only applicable when the new owner also meets all other enrollment criteria found at 42 CFR § 424.57).

Some ownership changes do not result in a complete change of ownership, since the business entity remains the same with no change in TIN. However, in cases where more than 5 percent of the ownership has changed, the following principles apply:

(i) If the change in ownership has not been reported to the contractor within the required 30-day period, the contractor shall proceed with revocation action.

(ii) If the change has been received within the required 30-day period and the supplier has been accredited, the contractor shall immediately notify the accreditor of the ownership change and request that the latter advise the contractor if the accreditation should still remain in effect.

D. Accreditation and Deactivation/Revocation

A non-exempt DMEPOS supplier requesting reactivation after a deactivation (regardless of the deactivation reason) is required to be accredited.

A revoked DMEPOS supplier that has submitted an acceptable corrective action plan can be reinstated without accreditation unless the accreditation was already required prior to revocation.

10.2.5.2 – Fraud Level Indicators for DMEPOS Suppliers - Development and Use

(Rev. 11682; Issued: 11-04-2022; Effective: 12-05-2022; Implementation: 12-05-2022)

A. General Information

The contractor shall perform a fraud potential analysis of all DMEPOS applicants and current DMEPOS suppliers. The fraud level indicator shall represent the potential for fraud and/or abuse. The contractor shall use four fraud level indicator codes as follows:

- *Low Risk (e.g., national drug store chains)*
- *Limited Risk (e.g., prosthetist in a low fraud area)*
- *Medium Risk (e.g., midsize general medical supplier in a high fraud area)*
- *High Risk (e.g., very small space diabetic supplier with low inventory in a high fraud area whose owner has previously had a chapter 7 bankruptcy). High fraud areas shall be determined by contractor analysis with concurrence of the contractor project officer.*

*(**NOTE:** These risk categories are in addition to, and not in lieu of, those specified in 42 CFR § 424.518.)*

In assessing a fraud level indicator, the contractor shall consider such factors as:

- *Experience as a DMEPOS supplier with other payers*
- *Prior Medicare experience*
- *The geographic area*
- *Fraud potential of products and services listed*
- *Site visit results*
- *Inventory observed and contracted*
- *Accreditation of the supplier*

After a fraud level indicator is assigned and the DMEPOS supplier is enrolled, the contractor shall establish a DMEPOS Review Plan based on the fraud level assessment. The DMEPOS Review Plan shall contain information regarding:

- *Frequency of unscheduled site visits*
- *Maximum billing amounts before recommendation for prepay medical review*
- *Maximum billing spike amounts before recommendation for payment suspensions/prepay medical review, etc.*

The fraud level indicator shall be updated based upon information obtained through the Medicare enrollment process, such as reported changes of information.

Information obtained by the Office of Inspector General (OIG), CMS (including CMS satellite office), and/or a Unified Program Integrity Contractor (UPIC) shall be reported to

the contractor project officer. The contractor shall update the fraud level indicator based on information obtained by the OIG, CMS (including CMS satellite office), and/or a UPIC only after the review and concurrence of the contractor project officer.

In addition, the contractor shall monitor and assess geographic trends that indicate or demonstrate that one geographic area has a higher potential for having fraudulent suppliers.

B. When a DMEPOS Fraud Level Indicator Differs from Risk Screening Category under 42 CFR § 424.518

The fraud level indicator described in this subsection is unrelated to the risk screening categories required under 42 CFR § 424.518. Under § 424.518(c)(1)(ii), for example, newly enrolling DMEPOS suppliers are assigned to the "high" risk screening category. Such DMEPOS suppliers are therefore subject to screening activities that correspond to the "high" risk screening category, including an on-site visit and a fingerprint-based criminal background check for all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the supplier. (See § 424.518(c)(2).) The on-site visits that the contractor conducts are responsive to the requirement at § 424.518(c)(2)(i) for a site visit and include gathering information concerning fraud level indicator assignment as required in this subsection. A DMEPOS supplier therefore has both a risk-based screening category assignment pursuant to requirements under § 424.518, and a separate fraud level indicator based upon the guidance in this subsection.

C. Fraud Level Indicator Standards

The contractor shall have documented evidence that it has, at a minimum, met the following requirements:

- *Assigned an appropriate fraud level indicator for at least 95 percent of all DMEPOS suppliers upon initial enrollment or revalidation. The fraud level indicator shall accurately reflect the risk the supplier poses to the Medicare program based on pre-defined criteria above.*

- *Updated the DMEPOS fraud level indicator for each enrolled DMEPOS supplier on an annual basis.*

D. Alert Codes for DMEPOS Suppliers

The contractor shall receive and maintain the following "alert indicators" from the DME MACs and UPICs:

<u>Alert Code and Definition</u>

A - Possible fraudulent or abusive claims identified
B - Overpayments
D - Violations of disclosure of ownership requirements
E - Violations of participation agreements
L - Suspended by contractor outside alert code process
M - Supplier is going through claims appeal process

The contractor shall append the supplier file and transfer to the DME-MACs and/or UPICs the following alert codes in the following circumstances:

<u>Alert Code and Definition</u>

C - Violations of supplier standards
F - Excluded by the OIG or debarred per the System for Award Management
H - Meets supplier standards; however, the contractor recommends increased scrutiny by the contractor (initiated by the contractor only)
N - Supplier being investigated under the "Do Not Forward" initiative (initiated by contractor only)
Q - Low Risk Fraud Level Indicator

R - Limited Risk Fraud Level Indicator
S - Medium Risk Fraud Level Indicator
T - High Risk Fraud Level Indicator

The contractor shall append an Alert Code "H" for any supplier that meets present supplier standards but appears suspect in one of the areas that are verified by the contractor. This alert code notifies the contractors that a supplier may be inclined to submit a high percentage of questionable claims.

The contractor shall share the above information with the DME MACs and/or UPICs by sending alerts within 7 calendar days after identification of a supplier having common ownership or business ties with a sanctioned or suspect supplier for their research and/or action. The contractor also shall forward alert codes submitted by the contractors with the other contractors within 7 calendar days after receipt.

10.2.5.3 – Surety Bonds
(Rev. 11682; Issued: 11-04-2022; Effective: 12-05-2022; Implementation: 12-05-2022)

10.2.5.3.1 – Basics of the Surety Bond Requirement
(Rev. 11682; Issued: 11-04-2022; Effective: 12-05-2022; Implementation: 12-05-2022)

A. Parties Subject and Not Subject to Surety Bond Requirement

All DMEPOS suppliers are subject to the surety bond requirement except:

(1) Government-operated DMEPOS suppliers are exempted if the supplier has provided CMS with a comparable surety bond under state law.

(2) State-licensed orthotic and prosthetic personnel (which, for purposes of the surety bond requirement, does not include pedorthists) in private practice making custom- made orthotics and prosthetics are exempted if—

- *The business is solely-owned and operated by the orthotic and prosthetic personnel, and*

- *The business is only billing for orthotic, prosthetics, and supplies.*

(3) Physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act, are exempted if the items are furnished only to the physician or non-physician practitioner's own patients as part of his or her physician service. The non-physicians covered under this exception are: physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.

(4) Physical and occupational therapists in private practice are exempted if—

- *The business is solely-owned and operated by the physical or occupational therapist;*

- *The items are furnished only to the physical or occupational therapist's own patients as part of his or her professional service; and*

- *The business is only billing for orthotics, prosthetics, and supplies.*

If a previously-exempted supplier no longer qualifies for an exception, it must submit a surety bond to the contractor - in accordance with the requirements in 42 CFR § 424.57 - within 60 days after it knows or has reason to know that it no longer meets the criteria for an exception.

B. Bond Submission

*Effective May 4, 2009, DMEPOS suppliers submitting: (1) an initial enrollment application to enroll in the Medicare program for the first time, (2) an initial application to establish a new practice location, or (3) an enrollment application to change the ownership of an existing supplier, are required to obtain and submit a copy of its required surety bond to the contractor with their Form CMS-855S enrollment application. (**NOTE:** Ownership changes that do not involve a change in the status of the legal entity as evidenced by no change in the tax identification number (or changes that result in the same ownership at the level of individuals (corporate reorganizations and individuals incorporating)) are not considered to be "changes of ownership" for purposes of the May 4, 2009, effective date – meaning that such suppliers are considered "existing" suppliers).*

For any Form CMS-855S application submitted on or after May 4, 2009 by a non-exempt supplier described in this subsection (B), the contractor shall reject the application if the supplier does not furnish a valid surety bond at the time it submits its application. The rejection shall be done in accordance with existing procedures (e.g., reject application after 30 days).

C. Amount and Basis

The surety bond must be in an amount of not less than $50,000 and is predicated on the NPI, not the tax identification number. Thus, if a supplier has two separately-enrolled DMEPOS locations, each with its own NPI, a $50,000 bond must be obtained for each site.

A supplier may obtain a single bond that encompasses multiple NPIs/locations. For instance, if a supplier has 10 separately-enrolled DMEPOS locations, it may obtain a $500,000 bond that covers all 10 locations.

As stated in 42 CFR § 424.57(d)(3), a supplier will be required to maintain an elevated surety bond amount of $50,000 for each final adverse action imposed against it within the 10 years preceding enrollment or reenrollment. This amount is in addition to, and not in lieu of, the base $50,000 amount that must be maintained. Thus, if a supplier has had two adverse actions imposed against it, the bond amount will be $150,000.

A final adverse action is one of the following:

- *A Medicare-imposed revocation of Medicare billing privileges;*
- *Suspension or revocation of a license to provide health care by any State licensing authority;*
- *Revocation or suspension by an accreditation organization;*
- *A conviction of a federal or state felony offense (as defined in § 424.535(a)(3)(i)) within the last 10 years preceding enrollment or re-enrollment; or*
- *An exclusion or debarment from participation in a federal or state health care program.*

D. Bond Terms

The supplier is required to submit a copy of the bond that - on its face - reflects the requirements of 42 CFR §424.57(d). Specific terms that the bond must contain include:

1. *A guarantee that the surety will - within 30 days of receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond of unpaid claims, civil money penalties (CMPs), or assessments - pay CMS a total of up to the full penal amount of the bond in the following amounts:*

a. *The amount of any unpaid claim, plus accrued interest, for which the DMEPOS supplier is responsible, and*

b. *The amount of any unpaid claims, CMPs, or assessments imposed by CMS or the OIG on the DMEPOS supplier, plus accrued interest.*

2. *A statement that the surety is liable for unpaid claims, CMPs, or assessments that occur during the term of the bond.*

3. *A statement that actions under the bond may be brought by CMS or by CMS contractors.*

4. *The surety's name, street address or post office box number, city, state, and zip code.*

5. *Identification of the DMEPOS supplier as the Principal, CMS as the Obligee, and the surety (and its heirs, executors, administrators, successors and assignees, jointly and severally) as the surety.*

The term of the initial surety bond must be effective on the date that the application is submitted to the contractor. Moreover, the bond must be continuous.

E. List of Sureties

The list of sureties from which a bond can be secured is found at Department of the Treasury's "Listing of Certified (Surety Bond) Companies;" the Web site is https://www.fiscal.treasury.gov/fsreports/ref/suretyBnd/c570_a-z.htm. For purposes of the surety bond requirement, these sureties are considered "authorized" sureties, and are therefore the only sureties from which the supplier may obtain a bond.

F. Bond Cancellations and Gaps in Coverage

A DMEPOS supplier may cancel its surety bond, but it must provide written notice of such to the contractor and the surety at least 30 days before the effective date of the cancellation. Cancellation of a surety bond is grounds for revocation of the supplier's Medicare billing privileges unless the supplier provides a new bond before the effective date of the cancellation. The liability of the surety continues through the termination effective date.

The contractor shall:

- *Process post-dated surety bond cancellations within 45 calendar days from the date the contractor received the cancellation.*
- *Process future-dated surety bond cancellations within 45 calendar days from the effective date of cancellation.*

(The contractor may apply a clock stoppage if a surety bond gap is involved and the case must be sent to PEOG for review. The clock stoppage remains in effect until the contractor receives PEOG's final determination.)

If a supplier changes its surety during the term of the bond, the new surety is responsible for any overpayments, CMPs, or assessments incurred by the DMEPOS supplier beginning with the effective date of the new surety bond. The previous surety is responsible for any overpayments, CMPs, or assessments that occurred up to the date of the change of surety.

Pursuant to 42 CFR § 424.57(d)(6)(iv), the surety must notify the contractor if there is a lapse in the surety's coverage of the DMEPOS supplier. This can be done via letter, fax, or e-mail to the contractor.

G. Reenrollment and Reactivation

The supplier must furnish the paperwork described above with any Form CMS-855S reenrollment or reactivation application it submits to the contractor unless it already has the information on file with the contractor. For example, if a supplier has submitted a continuous surety bond to the contractor prior to submission of its reenrollment application, a new copy of surety bond is not be required unless the contractor specifically requests it.

H. Surety Bond Changes

A DMEPOS supplier must submit an addendum to the existing bond (or, if the supplier prefers, a new bond) to the contractor in the following instances: (1) change in bond terms; (2) change in bond amount; or (3) a location on a bond covering multiple non-chain locations is being added or deleted.

10.2.5.3.2 – Claims against Surety Bonds

(Rev. 11682; Issued: 11-04-2022; Effective: 12-05-2022; Implementation: 12-05-2022)

(For purposes of this section, the term "contractor" means the enrollment contractor, unless otherwise indicated. Durable Medical Equipment Medicare Administrative Contractors will be referenced as "DME MACs.")

Pursuant to 42 CFR § 424.57(d)(5)(i), the surety must pay CMS - within 30 days of receiving written notice to do so - the following amounts up to the full penal sum of the bond:

1. The amount of any unpaid claim, plus accrued interest, for which the DMEPOS supplier is responsible.

2.. The amount of any unpaid claim, CMP, or assessment imposed by CMS or the OIG on the DMEPOS supplier, plus accrued interest.

This section 10.2.5.3.2 describes the procedures involved in making a claim against a surety bond.

A. Background

For purposes of the surety bond requirement, 42 CFR § 424.57(a) defines an "unpaid claim" as an overpayment (including accrued interest, as applicable) made by the Medicare program to the DMEPOS supplier for which the supplier is responsible.

The policies in this section 10.2.5.3.2 only apply to overpayment determinations relating to demands first made on or after March 3, 2009. A surety is liable for any overpayments based on dates of service occurring during the term of the surety bond. (For purposes of determining surety liability, the date of the initial demand letter was sent to the provider is the date on which the service was performed/furnished.) Even if the overpayment determination is made after the expiration of the surety bond, the surety remains liable if the date of service was within the surety bond coverage period. In short, the date of service – rather than the date of the overpayment determination or the date the overpayment demand letter was sent to the supplier---is the principal factor in ascertaining surety liability.

As an illustration, assume that a supplier has a surety bond with Company X on August 1, 2015. It performs a service on October 1, 2015. The supplier ends its coverage with Company X effective January 1, 2016 and obtains a new surety bond with Company Y effective that same date. On February 1, 2016, CMS determines that the October 1, 2015 service resulted in an overpayment; on March 2, 2016, CMS sends an overpayment demand letter to the supplier. While the overpayment determination and the sending of the demand letter occurred during Company Y's coverage period, the date of service was within the Company X coverage period. Thus, liability (and responsibility for payment) rests with Company X, even though the supplier no longer has a surety bond with X.

B. Collections – Unpaid Claims

1. Delinquency Period

If the DME MAC determines – in accordance with CMS's existing procedures for making overpayment determinations - that (1) the DMEPOS supplier has an unpaid claim for which it is liable, and (2) no waiver of recovery under the provisions of section 1870 of the Social Security Act is warranted, the DME MAC shall attempt to recover the overpayment in accordance with the instructions in CMS Pub. 100-06, chapter 4.

If 80 days have passed since the initial demand letter was sent to the DMEPOS supplier and full payment has not been received, the DME MAC shall attempt to recover the overpayment. The DME MAC shall review the "List of Bonded Suppliers" the last week of each month to determine which suppliers that have exceeded this 80-day period have a surety bond. Said list:

- *Will be electronically sent to the DME MACs by CMS' Provider Enrollment & Oversight Group on a monthly basis.*
- *Will be in the form of an Excel spreadsheet.*
- *Will contain the supplier's legal business name, tax identification number, NPI, surety bond amount, and other pertinent information.*

If the supplier does not have a surety bond (i.e., is exempt from the surety bond requirement), the DME MAC shall continue to follow the instructions in Pub. 100-06, chapter 4 regarding collection of the overpayment.

2. Request for Payment from Surety – General Requirements

If, however, the supplier has a surety bond (and subject to situations (a) through (f) below), the DME MAC shall send an "Intent to Refer" (ITR) letter to the supplier and a copy thereof to the supplier's surety. The letter ITR and copy shall be sent to the supplier on day 66 after the initial demand letter was sent, and the surety notification shall be sent within 5 days. (The copy to the surety can be sent via mail, e-mail, or fax.)

(NOTE: Under federal law, a delinquent debt must be referred to the Department of Treasury within 120 days. (Per the chart below, this represents Day 150 of the entire collection cycle.) To ensure that the DME MAC meets this 120-day limit but has sufficient time to prepare the surety letter as described in the following paragraph, it is recommended that the DME MAC send the ITR letter several days prior to the 90-day limit referenced in the previous paragraph. This will give the DME MAC a few additional days beyond the 30-day deadline referenced in the next paragraph to send the surety letter.)

If the DME MAC does not receive full payment from the supplier within 30 days of sending the ITR letter (and subject to situations (a) through (f) below), the contractor shall notify the surety via letter that, in accordance with 42 CFR § 424.57(d)(5)(i)(A), the surety must make payment of the claim to CMS within 30 days from the date of the surety letter. (The DME MAC shall send a copy of the surety letter to the supplier on the same date.) The DME MAC shall send the surety letter no later than 30 days after sending the ITR letter (subject to the previous paragraph), depending on the facts of the case. Consider the following situations:

a. If a DMEPOS supplier has withdrawn from Medicare or has had its enrollment deactivated or revoked, the contractor shall send the ITR and the surety letter on the earliest possible day.

b. If the supplier has an extended repayment schedule (ERS) and is currently making payments, the DME MAC shall not send an ITR letter or a surety letter. If the DME MAC is currently reviewing an ERS application from the supplier, the contractor shall delay sending the ITR letter and the surety letter until after the ERS review is complete.

c. If the aggregated principal balance of the debt is less than $25, the DME MAC shall not send an ITR letter or a surety letter. It shall instead follow the instructions in CMS Pub. 100-06, chapter 4 regarding collection of the overpayment.

d. If the DME MAC believes the debt will be collected through recoupment, it shall not send an ITR letter or a surety letter. It shall instead follow the instructions in Pub. 100-06, chapter 4 regarding collection of the overpayment.

e. If the supplier has had a recent offset, the DME MAC may wait to see if future offsets will close the debt, without sending the surety a letter. If the debt is still not paid in full or an ERS has not been established, the DME MAC shall send the surety letter no later than the 115th day after the initial demand letter was sent.

f. A payment demand letter shall not be sent to the surety if the DME MAC is certain that the $50,000 surety bond amount in question has been completely exhausted.

(NOTE: The DME MAC may choose to aggregate debts from the same supplier into one surety letter, provided they are at least 30 days delinquent.)

3. Contents of Surety Letter

The surety letter shall:

a. Follow the format of the applicable model letter found in section 10.7.16 of this chapter.

b. Identify the specific amount to be paid and be accompanied by "sufficient evidence" of the unpaid claim. "Sufficient evidence" is defined in 42 CFR §424.57(a) as documents that CMS may supply to the DMEPOS supplier's surety to establish that the supplier had received Medicare funds in excess of the amount due and payable under the statute and regulations.

c. Be accompanied by the following documents, which constitute "sufficient evidence" for purposes of §424.57(a):

(i) Overpayment Services Report - A computer-generated "Overpayment Services Report" containing the following information:

- *Date of service (i.e., the date the service was furnished/performed, not the date of the overpayment determination or the date of the overpayment or demand letter)*
- *Date on which supplier was paid*
- *Paid Amount*
- *Overpayment Amount*

(NOTE: The report shall not include HICN or any information otherwise protected under the Privacy Act.)

(ii) A copy of the overpayment determination letter that was sent to the supplier

(iii) A statement that payment shall be made via check or money order and that the Payee shall be the DME MAC

(iv) Identification of the address to which payment shall be sent

The DME MAC shall only seek repayment up to the full penal sum amount of the surety bond. Thus, if the supplier has a $60,000 unpaid claim and the amount of the supplier's bond coverage is $50,000, the DME MAC shall only seek the $50,000 amount. The remaining $10,000 will have to be obtained from the supplier via the existing overpayment collection process.

4. Follow-Up Contact

Between 8 and 12 calendar days after sending the surety letter, the DME MAC shall contact the surety by telephone or e-mail to determine whether the surety received the letter and, if it did, whether and when payment will be forthcoming.

If the surety indicates that it did not receive the letter, the DME MAC shall immediately fax or e-mail a copy of the letter to the surety. The surety will have 30 days from the original date of the letter – not 30 days from the date the letter was resent to the surety – to submit payment. To illustrate, suppose the DME MAC on April 1 sends the surety letter, which is also dated April 1. It places the follow-up call to the surety on April 11. The surety states that it never received the letter, so the contractor e-mails a copy of it to the surety that same day. Payment must be received by May 1, or 30 days from the original date of the letter.

If the surety cannot be reached (including situations where a voicemail message must be left) or if the surety indicates that it did receive the letter and that payment is forthcoming, no further action by the contractor is required. If the surety indicates that payment is not forthcoming, the contractor shall (1) attempt to ascertain the reason, and (2) follow the steps outlined below after the 30-day period expires.

The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.

5. Verification of Payment

a. Full Payment of the Claim is Made

If full payment (including interest, as applicable) is made within the aforementioned 30-day period, the DME MAC shall, no later than 10 calendar days after payment was made:

(i) Update all applicable records to reflect that payment was made. (Payment from the surety shall be treated as payment from the supplier for purposes of said record updates.)

(ii) Send a mailed, faxed, or (preferably) e-mailed letter to the supplier (on which the contractor shall be copied):

- *Stating that payment has been made, the date the payment was received, and the amount of the payment*

- *Containing the following quoted verbiage:*

  "You must, within 30 calendar days of the date of this letter, obtain and submit to the contractor additional surety bond coverage in the amount of (insert the amount that the surety paid) so as to ensure that your total coverage equals or exceeds the required $50,000 amount" (or higher if an elevated bond amount is involved due to a final adverse action). ***Failure to timely do so will result in the revocation of your Medicare enrollment****.*

  "Additional surety bond coverage may be obtained by (1) adding to the amount of your existing surety bond so as to equal or exceed $50,000, or (2) cancelling your current surety bond and securing a new $50,000 surety bond. (Obtaining a separate (insert the amount the surety paid) surety bond is impermissible.) In either case, the effective date of the additional coverage must be on or before the date that you submit the additional coverage to the contractor."

If the contractor does not receive the additional bond coverage within this 30-day period, it shall revoke the DMEPOS supplier's Medicare enrollment under § 424.535(a)(1) in accordance with existing procedures. (The effective date of revocation shall be the date on which the DME MAC received payment from the surety.) It is important that the contractor: (1) monitor the supplier's surety bond status upon receiving a copy of the DME MAC's letter to the supplier; and (2) take prompt action against the supplier (consistent with existing procedures) if the supplier does not secure and timely submit the required additional coverage.

b. No Payment of the Claim Made

If the surety fails to make any payment within 30 calendar days of the date of the letter to the surety, the DME MAC shall:

(i) Refer the debt to the Department of Treasury (by HIGLAS on the 120-day deadline) immediately upon the expiration of said 30-day timeframe (i.e., preferably on the same day or the day after, but in all cases no later than the 120-day deadline for sending delinquent debts to the Department of Treasury) and as outlined in Pub. 100-06, chapter 4;

(ii) No later than 14 days after the 30-day period expires, contact the surety via e-mail or telephone to ascertain the reason for non-payment. Only one contact is necessary. A voice mail message may be left. The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.

(iii) No later than 14 days after Step 2 has been completed – and if full payment still has not been received -- send the letter found in section 10.7.16 of this chapter.

(iv) Include information relating to the surety's non-payment in the report identified in section 10.2.5.3.2(D).

c. Partial Payment of the Claim is Made

If the surety pays part of the claim within the 30-day period and a balance is still due and owing, the DME MAC shall do the following:

(i) Refer the unpaid debt to the Department of Treasury (by HIGLAS on the 12-day deadline) immediately upon the expiration of said 30-day timeframe (i.e., preferably on the same day or the day after, but in all cases no later than the 120-day deadline for sending delinquent debts to the Department of Treasury) and as outlined in Pub. 100-06, chapter 4.

(ii) No later than 14 days after the 30-day period expires, contact the surety via e-mail or telephone to ascertain the reason for the partial non-payment. Only one contact is necessary. A voice mail message may be left. The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.

(iii) No later than 14 days after Step (ii) has been completed – and if full payment still has not been received -- send the letter found in Section 10.7.16 of this chapter.

(iv) Include information relating to the surety's partial non-payment in the report identified in section 10.2.5.3.2(D).

(v) No later than 10 calendar days after the partial payment was made:

- *Update all applicable records to reflect that partial payment was made. (Payment from the surety shall be treated as payment from the supplier for purposes of said record updates.)*

- *Send a mailed, faxed, or (preferably) e-mailed letter to the supplier (on which the contractor shall be copied):*

    - *Stating that partial payment was made, the date the payment was received, and the amount of said payment*

    - *Containing the following quoted verbiage:*

      "You must, within 30 calendar days of the date of this letter, obtain and submit to the contractor additional surety bond coverage in the amount of (insert the amount that the surety paid) so as to ensure that your total coverage equals or exceeds the required $50,000 amount" (or higher if an elevated bond amount is involved due to a final adverse action). ***Failure to timely do so will result in the revocation of your Medicare enrollment****.*

      Additional surety bond coverage may be obtained by (1) adding to the amount of your existing surety bond so as to equal or exceed $50,000, or (2) cancelling your current surety bond and securing a new $50,000 surety bond. (Obtaining a separate (insert the amount the surety paid) surety bond is impermissible.) In either case, the effective date of the additional coverage must be on or before the date that you submit the additional coverage to the contractor."

If the contractor does not receive the additional bond coverage within this 30-day period, it shall revoke the DMEPOS supplier's Medicare enrollment under § 424.535(a)(1) in

accordance with existing procedures. (The effective date of revocation shall be the date on which the DME MAC received payment from the surety.) It is important that the contractor (1) monitor the supplier's surety bond status upon receiving a copy of the DME MAC's letter to the supplier and (2) take prompt action against the supplier (consistent with existing procedures) if the supplier does not secure and timely submit the required additional coverage.

6. Successful Appeal

If the supplier successfully appeals the overpayment and the surety has already made payment to the DME MAC on the overpayment, the DME MAC shall – within 30 calendar days of receiving notice of the successful appeal - notify the surety via letter of the successful appeal and repay the surety via check or money order.

7. Summary

The following chart outlines the timeframes involved in the surety bond collection process for overpayments:

Day 1	*Initial Demand Letter Sent*
Day 31	*Debt is Delinquent/Interest Starts*
Day 41	*Recoupment Starts*
Day 66	*Intent to Refer Letter Sent*
Day 115	*Surety Bond Letter Sent*
Day 150	*Referral to Treasury*

C. Claims Pertaining to Assessments and CMPs

1. Request for Payment from Surety

Per 42 CFR § 424.57(a), an assessment is defined as a "sum certain that CMS or the OIG may assess against a DMEPOS supplier under Titles XI, XVIII, or XXI of the Social Security Act." Under 42 CFR § 424.57(a), a CMP is defined as a sum that CMS has the authority, as implemented by 42 CFR § 402.1(c) (or the OIG has the authority, under section 1128A of the Act or 42 CFR Part 1003) to impose on a supplier as a penalty.

The CMS will notify the DME MAC of the need for the latter to collect payment from the surety on an assessment or CMP imposed against a particular bonded DMEPOS supplier. Upon receipt of this notification, the DME MAC shall – regardless of the amount of the assessment or CMP - notify the surety via letter that, in accordance with 42 CFR § 424.57(d)(5)(i)(B), payment of the assessment or CMP must be made within 30 calendar days from the date of the letter. The letter (on which the contractor and the supplier/debtor shall be copied) shall:

- *Follow the format of the applicable model letter found in Section 10.7.16 of this chapter.*
- *Identify the specific amount to be paid and be accompanied by "sufficient evidence." This includes all documentation that CMS (in its notification to the DME MAC as described above) requests the DME MAC to include with the letter (e.g., OIG letter).*
- *State that payment shall be made via check or money order and that the Payee shall be CMS.*
- *Identify the address to which payment shall be sent.*

2. Follow-Up Contact

Between 8 and 12 calendar days after sending the surety letter, the DME MAC shall contact the surety by telephone or e-mail to determine whether the surety received the letter and, if it did, whether and when payment is forthcoming;

If the surety indicates that it did not receive the letter, the DME MAC shall immediately fax or e-mail a copy of the letter to the surety. The surety will have 30 days from the original date of the letter – not 30 days from the date the letter was resent to the surety – to submit payment. To illustrate, suppose the DME MAC on April 1 sends the surety letter, which is also dated April 1. It places the follow-up call to the surety on April 11. The surety states that it never received the letter, so the contractor e-mails a copy of it to the surety that same day. Payment must be received by May 1, or 30 days from the original date of the letter.

If the surety cannot be reached (including situations where a voicemail message must be left) or if the surety indicates that it received the letter and that payment is forthcoming, no further action by the contractor is required. If the surety indicates that payment is not forthcoming, the contractor shall (1) attempt to ascertain the reason and (2) follow the steps outlined below after the 30-day period expires.

The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.

3. Verification of Payment

a. Full Payment of the Claim is Made

If full payment (including interest, as applicable) is made within 30 calendar days of the date of the letter to the surety, the DME MAC shall, no later than 10 calendar days after payment was made:

(i) Update all applicable records to reflect that payment was made. (Payment from the surety shall be treated as payment from the supplier for purposes of said record updates.)

(ii) Notify the applicable CMS Location (formerly CMS Regional Office) via letter or e-mail that payment was made.

(iii) If the OIG imposed the CMP or assessment, notify the OIG via letter that payment was made.

(iv) Send a mailed, faxed, or (preferably) e-mailed letter to the supplier (on which the enrollment contractor shall be copied):

- *Stating that payment has been made, the date the payment was received, and the amount of said payment*

- *Containing the following quoted verbiage:*

  "You must, within 30 calendar days of the date of this letter, obtain and submit to the contractor additional surety bond coverage in the amount of (insert the amount that the surety paid) so as to ensure that your total coverage equals or exceeds the required $50,000 amount" (or higher if an elevated bond amount is involved due to a final adverse action). ***Failure to timely do so will result in the revocation of your Medicare enrollment****.*

"Additional surety bond coverage may be obtained by (1) adding to the amount of your existing surety bond so as to equal or exceed $50,000, or (2) cancelling your current surety bond and securing a new $50,000 surety bond. (Obtaining a separate (insert the amount the surety paid) surety bond is impermissible.) In either case, the effective date of the additional coverage must be on or before the date that you submit the additional coverage to the contractor."

If the contractor does not receive the additional bond coverage within this 30-day period, it shall revoke the DMEPOS supplier's Medicare enrollment under § 424.535(a)(1) enrollment in accordance with existing procedures. (The effective date of revocation shall be the date on which the DME MAC received payment from the surety.) It is important that the contractor (1) monitor the supplier's surety bond status upon receiving a copy of the DME MAC's letter to the supplier and (2) take prompt action against the supplier (consistent with existing procedures) if the supplier does not secure and timely submit the required additional coverage.

b. No Payment of the Claim is Made

If the surety fails to make any payment within the aforementioned 30-day timeframe, the DME MAC shall:

(i) Continue collection efforts as outlined in Pub. 100-06, chapter 4;

(ii) No later than 14 days after the 30-day period expires, contact the surety via e-mail or telephone to ascertain the reason for non-payment. Only one contact is necessary. A voice mail message may be left. The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.

(iii) No later than 14 days after Step 2 has been completed – and if full payment still has not been received -- send the letter found in Section 10.7.16 of this chapter.

(iv) Include information relating to the surety's non-payment in the report outlined in section 10.2.5.3.2(D).

c. Partial Payment of the Claim is Made

If the surety pays part of the claim within the 30-day period and a balance is still due and owing, the DME MAC shall do the following:

(i) Continue collection efforts as outlined in Pub. 100-06, chapter 4;

(ii) No later than 14 days after the 30-day period expires, contact the surety via e-mail or telephone to ascertain the reason for the partial non-payment. Only one contact is necessary. A voice mail message may be left. The contractor shall document any attempts to contact the surety by telephone and the content of any resultant conversations with the surety.

(iii) No later than 14 days after Step (ii) has been completed – and if full payment still has not been received -- send the letter found in Section 10.7.16 of this chapter.

(iv) Include information relating to the surety's partial non-payment in the report identified in section 10.2.5.3.2(D).

(v) No later than 10 calendar days after the partial payment was made:

- *Update all applicable records to reflect that partial payment was made. (Payment from the surety shall be treated as payment from the supplier for purposes of said record updates.)*

- *Send a mailed, faxed, or (preferably) e-mailed letter to the supplier (on which the contractor shall be copied):*

    - *Stating that partial payment was made, the date the payment was received, and the amount of said payment*

    - *Containing the following quoted verbiage:*

    "You must, within 30 calendar days of the date of this letter, obtain and submit to the contractor additional surety bond coverage in the amount of (insert the amount that the surety paid) so as to ensure that your total coverage equals or exceeds the required $50,000 amount" (or higher if an elevated bond amount is involved due to a final adverse action). ***Failure to timely do so will result in the revocation of your Medicare enrollment****.*

    "Additional surety bond coverage may be obtained by (1) adding to the amount of your existing surety bond so as to equal or exceed $50,000, or (2) cancelling your current surety bond and securing a new $50,000 surety bond. (Obtaining a separate (insert the amount the surety paid) surety bond is impermissible.) In either case, the effective date of the additional coverage must be on or before the date that you submit the additional coverage to the contractor."

If the contractor does not receive the additional bond coverage within this 30-day period, it shall revoke the DMEPOS supplier's Medicare enrollment under § 424.535(a)(1) in accordance with existing procedures. (The effective date of revocation shall be the date on which the DME MAC received payment from the surety.) It is important that the contractor (1) monitor the supplier's surety bond status upon receiving a copy of the DME MAC's letter to the supplier and (2) take prompt action against the supplier (consistent with existing procedures) if the supplier does not secure and timely submit the required additional coverage.

4. Successful Appeal

If the DMEPOS supplier successfully appeals the CMP or assessment and the surety has already made payment, CMS will – within 30 days of receiving notice of the successful appeal - notify the surety via letter of the successful appeal and repay the surety.

D. Reporting Requirements

1. Contents

DME MACs shall compile a report on a quarterly basis in the format prescribed in existing CMS directives. The report will capture the following elements:

a. Number of account receivables (debts) reviewed for possible surety bond letter development

b. Number of debts sent to the surety for recovery

c. Amounts recovered directly from sureties (1) during the quarter in question, and (2) since March 3, 2009 (that is, the total/cumulative amount collected since the beginning of the surety bond collection process)

d. Amounts paid by suppliers after the debt was referred to the surety for collection. The report shall include the (1) amount for the quarter in question and (2) total/cumulative amount since March 3, 2009.

e. Names of suppliers and billing numbers for which letters were sent to the surety and/or surety bond recoveries were received

f. Names of suppliers on whose surety bond(s) the surety made payment in the last quarter and to whom the DME MAC consequently sent notice to the supplier that it must obtain additional surety bond coverage to reach the $50,000 threshold.

g. Names and addresses of sureties that have failed to make payment within the quarterly period. For each instance of non-payment, the report shall identify (a) the amount that was requested, (b) the amount that was paid (if any), (3) the name and tax identification number of the supplier in question, and (4) the reason the surety did not pay (to the extent this can be determined).

2. Timing

The quarterly reports shall encompass the following time periods: January through March, April through June, July through August, and September through December. Reports shall be submitted to PEOG (with a copy to the DME MAC COR) --- via the following e-mail address: XXXXXXXX@cms.hhs.gov --- by the 10th day of the month following the end of the reporting quarter. Information on surety collections shall be reported once for each demand letter. That action shall be reported only when the collection process has been fully completed for that specific identified overpayment, which may be comprised of multiple claims. For example, suppose the surety was sent a letter in December but its payment was not received until January. That action would be documented in the report encompassing the months of January, February, and March.

10.2.5.4 – Indian Health Services (IHS) Facilities' Enrollment as DMEPOS Suppliers

(Rev. 11682; Issued: 11-04-2022; Effective:1 2-05-2022; Implementation:12-05-2022)

A. Background

The contractor shall enroll IHS facilities as DMEPOS suppliers in accordance with: (a) the general enrollment procedures cited in chapter 10; (b) the statement of work contained in the contractor's contract with Medicare; and (c) the special procedures cited in this section.

For enrollment purposes, Medicare recognizes two types of IHS facilities: (1) facilities wholly owned and operated by the HIS; and (2) facilities owned by the IHS but tribally operated or totally owned and operated by a tribe. CMS will provide the contractor with a list of IHS facilities that distinguishes between these two types.

On the list, the contractor shall use the column entitled, "FAC OPERATED BY", for this purpose.

B. Enrollment

The supplier shall complete the Form CMS-855S in accordance with the instructions shown therein.

Facilities that are:

- *Totally owned and operated by the IHS are considered governmental organizations. An Area Director of the IHS must sign Section 15 of the Form CMS–855S, be listed in Section 9 of the form, and sign the letter required under Section 8 of the form that attests that the IHS will be legally and financially responsible in the event there is any outstanding debt owed to CMS.*

- *Tribally operated are considered tribal organizations. Section 15 of the Form CMS–855S must be signed by a tribal official who meets the definition of an "authorized official" under 42 CFR § 424.502. The individual must also be listed in Section 9 of the form and must sign the letter required under Section 8 of the form that attests that the tribe will be legally and financially responsible in the event there is any outstanding debt owed to CMS.*

C. Supplier Standards, Exceptions, and Site Visits

All IHS facilities, whether operated by the IHS or a tribe:

1. *Shall meet all required standards, with the exception of the comprehensive liability insurance requirements under 42 CFR § 424.57(c)(10).*

2. *Need not meet the requirement to provide state licenses for their facility/business. For example, if the DMEPOS supplier indicates on its application that it will be providing hospital beds and is located in a state that requires a bedding license, such licensure is not required. However, if it provides a DMEPOS item that requires a licensed professional in order to properly provide the item, it shall provide a copy of the professional license. The licensed professional can be licensed in any state or have a federal license (e.g., a pharmacy does not need a pharmacy license but shall have a licensed pharmacist).*

3. *Shall, like all other DMEPOS suppliers, undergo site visits in accordance with section 10.6.20(A) and 10.6.20(B) of this chapter. (This includes all hospitals and pharmacies enrolling as DMEPOS suppliers.)*

D. Provider Education for IHS Facilities

The contractor shall ensure that its web site includes the information contained in this section 10.2.5.4) that is specific to enrollment of IHS facilities (whether operated by the IHS or a tribe).

E. Specialty Codes

The contractor shall apply the specialty code A9 (IHS) to all IHS enrollments (whether operated by the IHS or a tribe). However, the specialty code A9/A0 shall be applied to facilities that are IHS/tribal hospitals.

Other specialty codes should be applied as applicable (e.g., pharmacies).

10.2.5.5 – Pharmacy Enrollment as a DMEPOS Supplier - Accreditation

(Rev. 11682; Issued: 11-04-2022; Effective: 12-05-2022; Implementation: 12-05-2022)

(Refer to section 10.2.2.7 of this chapter for a discussion of pharmacy enrollment via the Form CMS-855B (i.e., pharmacy not enrolling as a DMEPOS supplier).)

The contractor shall not require that a pharmacy be accredited as a condition of enrollment before January 1, 2011.

The contractor shall determine which enrolled suppliers are pharmacies that are not accredited and who will be enrolled for 5 calendar years prior to January 1 of the next calendar year. The contractor shall then send a notice of revocation by January 10, 2011, to all enrolled pharmacies that are not accredited and who will not be enrolled for 5 calendar years as of January 1, 2011.

The contractor shall prepare a letter which enables all individually enrolled practice locations of pharmacies who have been enrolled for 5 calendar years prior to January 1, 2011, to attest that they are exempt from the requirement to be accredited because their total durable medical equipment, prosthetics orthotics and supplies (DMEPOS) billings subject to accreditation are less than 5 percent of their total pharmacy sales, as determined based upon the total pharmacy sales of the pharmacy for the previous 3 calendar or fiscal years. The letter shall cite that the attestation requires the signature of the authorized or delegated official of the entity. The authorized and delegated officials are defined in Section 15, of the Medicare Enrollment Application (Form CMS-855S), and as described in the internet enrollment application version of PECOS. Before mailing the letters, contractor shall obtain the contractor project officer's approval of the letter. The mailing shall be in the form of an endorsement letter with an enclosed stamped self-addressed envelope. The mailing should be performed between October 1, 2010 and October 31, 2010. For pharmacies with more than one practice location, the letters shall cite the need for each individually enrolled practice location to attest that they are exempt from the accreditation requirements. New locations of enrolled chain pharmacies shall not be considered to have been enrolled for 5 calendar years. Pharmacies that have had a change of ownership in the prior 5 years which resulted in a change in their legal business entity, including a change in their tax identification number (TIN), shall not qualify for an attestation accreditation exemption and therefore shall not be sent the attestation letter.

The contractor shall review the attestations received from pharmacies. Pharmacies that properly signed the attestation letter shall be given an accreditation status of exempt. The contractor shall make attempts to assist and follow-up with pharmacy suppliers that have not submitted or properly completed their attestations. The contractor shall send a notice of revocation by January 10, 2011, to all enrolled pharmacies who were sent an attestation letter and have not properly completed it as of the date of the notice of revocation. The notice of revocation shall cite that the revocation is for a lack of required accreditation.

Between April 1, 2011 and April 30, 2011, the contractor shall compile a sample listing of at least 10 percent of the pharmacies that have submitted a contractor-accepted attestation exempting them from accreditation. The contractor shall develop a letter to be sent to pharmacies that will be audited to determine if their accreditation exemption attestations are correct. The letter shall request submission of evidence substantiating that the validity of the pharmacy supplier's attestation. At a minimum, requested materials for this evidence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods. The contractor shall obtain contractor project officer approval of the letter. Within 45 days after project officer approval of the letter, the contractor shall mail a copy of the letter to the random sample of pharmacies that claimed exemption through an attestation. The contractor shall determine the acceptability of the replies received in response to the audit verification random sample mailing. The contractor shall use DMEPOS billing data for only products and services requiring accreditation to assist in the determination. The contractor shall make attempts to

assist and follow-up with pharmacy suppliers that have not submitted or properly completed their audit verifications. The contractor shall consult with the contractor project officer in cases where it is uncertain as to the acceptability of the supplier's response to the audit request. By June 30, 2011, the contractor shall send a notice of revocation to all enrolled pharmacies that were sent an audit verification letter who did not submit satisfactory evidence that they were compliant with the requirements to obtain an accreditation exemption. The notice of revocation shall cite that the revocation is for a lack of required accreditation.

The contractor shall follow the procedures shown above concerning issuance of attestation letters and audit survey letters for all succeeding years after they have been performed for the first time.

10.2.7 - Opioid Treatment Programs

(Rev. 11682; Issued: 11-04-2022; Effective: 12-05-2022; Implementation: 12-05-2022)

A. Legislative and Regulatory Background

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (hereafter referenced as the "SUPPORT Act") was designed to alleviate the nationwide opioid crisis by: (1) reducing the abuse and supply of opioids; (2) helping individuals recover from opioid addiction and supporting the families of these persons; and (3) establishing innovative and long-term solutions to the crisis. Section 2005 of the SUPPORT Act attempted to fulfill these objectives, in part, by establishing a new Medicare benefit category for opioid treatment programs (OTPs).

An OTP is currently defined in 42 CFR § 8.2 as a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication registered under 21 U.S.C. § 823(g)(1). There are three overarching (but not exclusive) requirements that an OTP must meet in order to bill for OTP services:

1. Accreditation

The OTP must have a current, valid accreditation by an accrediting body or other entity approved by the Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency that oversees OTPs. The accreditation process includes, but is not limited to, an accreditation survey, which involves an onsite review and evaluation of the OTP to determine compliance with applicable federal standards. There are currently six SAMHSA-approved accreditation bodies.

2. Certification

The OTP must have a current, full, valid certification by SAMHSA for such a program. The prerequisites for certification (as well as the certification process itself) are addressed in 42 CFR §8.11 and include, but are not restricted to, the following:

- Current and valid accreditation (described in subsection (A)(1) above)
- Adherence to the federal opioid treatment standards described in 42 CFR § 8.12
- Compliance with all pertinent state laws and regulations, as stated in § 8.11(f)(1)

Under 42 CFR §8.11(a)(3), certification is generally for a maximum 3-year period, though this may be extended by 1 year if an application for accreditation is pending. SAMHSA may revoke or suspend an OTP's certification if any of the applicable grounds identified in 42 CFR § 8.14(a) or (b), respectively, exist.

3. Enrollment

The SUPPORT Act also required that an OTP be enrolled in the Medicare program under section 1866(j) of the Act in order to bill and receive payment from Medicare for opioid use disorder treatment services.

In the Calendar Year (CY) 2020 Physician Fee Schedule final rule (published in the **Federal Register** on November 15, 2019 (84 FR 62567)), CMS established a new 42 CFR § 424.67 containing requirements that OTPs must meet and continually adhere to in order to enroll (and remain enrolled) in Medicare effective January 1, 2020. Since this latter date, OTPs have enrolled in Medicare consistent with 42 CFR § 424.67 and the general provider enrollment requirements of 42 CFR Part 424, subpart P (42 CFR § 424.500-570). This section 10.2.7 outlines the specific enrollment policies associated with OTP enrollment.

B. OTP Enrollment Process

The instructions in this section 10.2.7(B) are in addition to, and not in lieu of, those in CMS Pub. 100-08, Program Integrity Manual (PIM), chapter 10. To the extent there are conflicting instructions, the policies in this section 10.2.7 shall take precedence.

1. Applicable Form CMS-855

a. General Requirements

As of November 16, 2020, OTPs may enroll (and remain enrolled) via the Form CMS-855B or the Form CMS-855A, but not both. Some OTPs currently enrolled via the Form CMS-855B may accordingly seek to change their enrollment to a Form CMS-855A. To ensure that the OTP is at no time enrolled under both Form CMS-855 application types, the contractor shall do the following:

- Upon receipt of an initial Form CMS-855A or Form CMS 855B from an OTP, the contractor shall confirm that the OTP is not currently enrolled as such via another Form CMS-855 application type. (For example, if the contractor receives an initial Form CMS-855A from an OTP, the contractor shall verify that the OTP is not already enrolled via the Form CMS-855B.)

- If the contractor determines that the OTP is not already enrolled as such, the contractor shall process the application normally.

- If, however, the contractor determines that the OTP is already enrolled as such via a different Form CMS-855 application type, the contractor shall verify with an authorized or delegated official of the OTP (by telephone or e-mail) that the OTP is changing its enrollment from a Form CMS-855B to a Form CMS-855A (or vice versa). The OTP in this situation is not required to submit a Form CMS-855 application to voluntarily terminate its prior enrollment.

The Form CMS-855B has been updated to add "Opioid Treatment Program" as a listed provider type. (For the Form CMS-855A (at least until that form is updated), the OTP shall check the "Other" box in Section 2 and state "Opioid Treatment Program.")

An entity that is enrolling or is already enrolled in Medicare as another provider or supplier type may also seek enrollment as an OTP. It must, however, submit a separate Form CMS-855 application to do so; it cannot enroll or be enrolled as an OTP and another provider/supplier type via the same enrollment.

Note that the policies in this section 10.2.7 regarding an OTP's transition from a Form CMS-855B enrollment to a Form CMS-855A enrollment (or vice versa) only apply if the OTP is doing so in the same state in which it is currently enrolled as an OTP. If an OTP is enrolling under a different Form CMS-855 in a state different from that in which it is currently enrolled (e.g., a Form CMS-855B enrolled OTP in State X is enrolling via the Form CMS-855A in State Y), it is considered a brand new enrollment (and not merely a "switch" in OTP enrollment type); this would thus require, for instance, moderate or high-level screening as opposed to limited screening (as discussed further in section 10.2.7(B)(3) below).

2. Applicable Fee

An OTP is an "institutional provider" under 42 CFR § 424.502 and thus is required to pay an application fee pursuant to 42 CFR § 424.514. The contractor shall follow the application fee procedures outlined in chapter 10 of the PIM. A fee is required even when the OTP is changing its enrollment from a Form CMS-855B to a Form CMS-855A, or vice versa.

3. Categorical Screening

Consistent with 42 CFR § 424.518, the contractor shall categorically screen OTP applications as follows:

a. Newly enrolling OTPs that **are not** changing their enrollment from a Form CMS-855B to a Form CMS-855A, or vice versa -

- If the OTP has not been fully and continuously certified by SAMHSA since October 24, 2018, the contractor shall conduct high-risk level categorical screening.

- If the OTP has been fully and continuously certified by SAMHSA since October 24, 2018, the contractor shall conduct moderate-risk level categorical screening.

b. Newly enrolling OTPs that **are** changing their enrollment from a Form CMS-855B to a Form CMS-855A, or vice versa - The contractor shall conduct limited-risk level categorical screening if the OTP had previously completed, as applicable, the moderate or high-risk level screening as part of its initial enrollment. Otherwise, moderate or high-risk level screening (as applicable under § 424.518) shall be conducted.

c. Revalidating OTPs – The contractor shall conduct moderate-risk level categorical screening.

d. Practice Location Addition – The contractor shall conduct moderate-risk level categorical screening (i.e., site visit of the new location consistent with the procedures outlined in this chapter 10).

4. Confirmation of Certification

When processing OTP initial applications (including those involving a change in Form CMS-855 application type) and revalidation applications, the contractor shall confirm and record in PECOS the OTP's SAMHSA certification status as follows:

a. Review the OTP directory at https://dpt2.samhsa.gov/treatment/directory.aspx. The OTP's certification must be full, current, and valid. ("Provisional" certification status is not acceptable.) The OTPs SAMHSA certificate (and the OTP's identification in the SAMHSA directory) need not be have the exact same legal business name as that on the

OTP's IRS document, though the contractor shall develop for clarification if it has questions as to whether the OTP on the application and in the directory are truly the same.

b. Verify that each location listed on the Form CMS-855 is separately and uniquely certified.

c. Enter into PECOS the OTP's relevant certification data obtained from the aforementioned OTP directory. This includes: (1) the OTP number; and (2) the certification effective date (which can be obtained from the OTP's renewal letter). The certification effective date is the date on which SAMHSA acknowledged notification from the accrediting organization and can be verified by reviewing the OTP's renewal letter information in the database. (The contractor need not obtain a copy of the letter from the OTP.)

The expiration date must be obtained via the SAMHSA operating certificate for the location in question; the OTP should submit said certificate with its application.

Irrespective of whether the OTP reported the data described in (4)(c) on the Form CMS-855, the contractor shall use the information in the OTP directory for purposes of data entry.

5. OTP Managing Employees

As with all enrolling providers and suppliers, the OTP must disclose all of its managing employees in Section 6 of the Form CMS-855. Such managing employees must include the OTP's medical director and program sponsor, which the OTP must have pursuant to 42 CFR §§ 8.12(b) and §§ 424.67(b)(5). The contractor shall verify that the medical director is a validly licensed physician or psychiatrist; he/she must be licensed by the state in which the OTP's primary practice location is situated. The contractor may develop with the OTP for any information it needs (and via any manner it chooses) to verify the person's licensure. If the contractor determines that the individual is not appropriately licensed, it shall contact its PEOG BFL for guidance.

The OTP must submit a copy of the organizational diagram required under Section 5 of the Form CMS-855 even if it merely changing its enrollment type from a Form CMS-855B to a Form CMS-855A (or vice versa).

6. OTP Personnel

i. Regulatory Background

Section 424.67 contains several important provisions concerning OTP personnel. These include:

- Completion of Attachment/Supplement (§ 424.67(b)(1)(i)) - Requires the OTP to maintain and submit to CMS (via the applicable Form CMS-855 supplement or attachment) a list of all physicians, other eligible professionals, and pharmacists (regardless of whether the individual is a W-2 employee of the OTP) who are legally authorized to prescribe, order, or dispense controlled substances on the OTP's behalf. The list must include the individual's (1) first and last name and middle initial, (2) social security number, (3) NPI, and (4) license number (if applicable).

- Felony Convictions (§ 424.67(b)(6)(i)(A)) - The OTP must not employ or contract with a prescribing or ordering physician or eligible professional or with any individual legally authorized to dispense narcotics who, within the preceding 10 years, has been convicted of a federal or state felony that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries. The applicable felonies are based on

the same categories of detrimental felonies (as well as case-by-case detrimental determinations) found at § 424.535(a)(3). (It is immaterial whether the individual is (1) currently dispensing narcotics at or on behalf of the OTP or (2) a W-2 employee of the OTP.)

- Revoked/Preclusion List (§ 424.67(b)(6)(ii)) - The OTP must not employ or contract with any personnel (regardless of whether the individual is a W-2 employee of the OTP) who is (1) revoked from Medicare under § 424.535 or any other applicable section in Title 42 or (2) on the preclusion list.

- State Board Action (§ 424.67(b)(6)(iii)) - The OTP must not employ or contract with any personnel (W-2 or otherwise) who has a prior adverse action by a state oversight board (including, but not limited to, a reprimand, fine, or restriction) for a case involving patient harm that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries.

ii. Attachment and Verification

Attachment 3 of the Form CMS-855B collects information on the individuals described in § 424.67(b)(1)(i) above. (The Form CMS-855A will eventually be updated to include a similar attachment, after which OTPs completing that form will have to submit the attachment.) OTPs submitting the Form CMS-855B (either the current/revised/new 07/20 version or the prior 07/11 version) must complete this attachment as described in (and subject to) (ii)(A) below and, once enrolled, report any changes to the information thereon (e.g., new or deleted prescribers) consistent with 42 CFR § 424.516(e).

Irrespective of the type of transaction involved (e.g., initial, revalidation, change of information), the contractor shall accept from the OTP:

- The revised version of the Form CMS-855B (which includes the aforementioned OTP attachment) beginning January 4, 2021.

- The prior (07/11) version of the Form CMS-855B through March 31, 2021. (Any such application received by the contractor after March 31, 2021 shall be returned to the OTP consistent with the instructions in this chapter and other applicable CMS guidance.)

Pursuant to the foregoing, the contractor shall adhere to the following policies and instructions in this section (6)(ii).

(A) When to Submit Attachment

(1) General Principles

The OTP need only submit the attachment for the first time as part of (i) an initial Form CMS-855B enrollment, (ii) a Form CMS-855B revalidation (periodic or off-cycle), or (iii) a change from a Form CMS-855A enrollment to a Form CMS-855B enrollment. (For purposes of this requirement, the term "Form CMS-855B" includes the 07/20 version and the 07/11 version (the latter only through March 31, 2021, however).) The OTP is not required to complete it for the first time as part of a change of information request. Consider the following examples:

Example 1 - Smith OTP enrolled in Medicare via the Form CMS-855B in June 2020, prior to the Form CMS-855B being revised to include the attachment. Smith submits a change request in June 2021 to add a new billing agency. Smith need not complete the attachment at

this time because Smith's application does not fall within any of the three categories in (A)(i) through (iii) above.

Example 2 - Using Example 1, suppose Smith submitted a Form CMS-855B revalidation application (rather than a change of information) in June 2021. Smith would have to complete the attachment at that time.

Example 3 - Again using Example 1, suppose Smith submitted a Form CMS-855A in March 2021 to change its enrollment from a Form CMS-855B. No attachment need be completed because the Form CMS-855A lacks an attachment and because no category in (A)(i) through (iii) above applies.

Example 4 - Again using Example 1, assume Smith in August 2020 hired two pharmacists to dispense controlled substances on its behalf. Smith would neither have to report these persons on the attachment nor complete the attachment in full, for no category in (A)(i) through (iii) above applies.

Example 5 – Suppose Jones OTP submits an initial enrollment application on March 1, 2021 using the 07/11 version of the Form CMS-855B. The contractor may accept the application, but the latter must include the information on the attachment. (If a paper application is used, the OTP must take the attachment from the 07/20 version, complete it, and submit it with its 07/11 application.) If the OTP in this scenario fails to include the attachment, the contractor shall develop for it using the instructions in this chapter.

Example 6 – Using Example 5, suppose Jones enrolled as an OTP in September 2020. It submits a change of information using the 07/11 version of the Form CMS-855B on February 15, 2021. Jones need not submit the OTP attachment with its change request because no category in (A)(i) through (iii) above applies.

Example 7 – Using Example 6, assume Jones submitted its change request on April 15, 2021 rather than February 15. The contractor shall return the application because the 07/11 version is no longer in use; however, Jones need not submit the OTP attachment at that time because no category in (A)(i) through (iii) above applies.

(2) Submission When Not Required

Instances could occur where the OTP submits the Form CMS-855B attachment for the first time when it was not required to do so (i.e., no category in (6)(A)(i) through (iii) applies). The two most likely scenarios would involve: (a) a Form CMS-855A OTP application submission (e.g., initial, change request); or (b) a Form CMS-855B-enrolled OTP submitting a change request.

In the case of (a), the contractor shall not process the attachment and may either keep it in the provider file or return it to the OTP via the general procedures in this chapter for returning applications. Regardless of which of the latter two approaches the contractor takes, the contractor shall: (i) notify the OTP that the attachment was not processed; (ii) explain why; and (iii) state that the attachment will need to be submitted at a later time as determined by CMS. If the contractor elects to retain the attachment, the notification in (i)/(ii)/(iii) above may be given in any matter the contractor chooses.

For (b), the contractor shall process the attachment consistent with the instructions in this section (6)(ii).

(B) Owning/Managing Individuals - Notwithstanding (6)(ii)(A) above, any person otherwise required to be reported on the attachment must also be disclosed in Section 6 of the Form

CMS-855B if he or she qualifies as a 5 percent or greater owner, managing employee, partner, etc. To illustrate, assume Dr. Jones prescribes controlled substances on the OTP's behalf. He is also a managing employee of the OTP. The OTP is initially enrolling in Medicare via the Form CMS-855B. Jones would have to be listed in Section 6 and on the attachment. If Jones left the OTP altogether, the OTP would have to report this in both Section 6 and the attachment; if Jones no longer prescribes drugs for the OTP but remains a managing employee, this would have to be reported via the attachment but not in Section 6.

(C) Timeframe for Changes - Additions/deletions/changes to the information in the attachment must be reported within 90 days of the change per 42 CFR § 424.516(e)(2).

(D) Missing Data - In general, the contractor shall develop (using the procedures outlined in this chapter) for any data that is missing or unverifiable on the attachment. (This includes individuals who the contractor learns (via any means) should be listed on the attachment but were not.) However, and with the exception of names and social security numbers, the contractor may forgo such development if the missing/unverifiable information can be located and validated via other means. This could include, for example: (i) the NPI of the individual (who is also a managing employee) is listed in Section 6 of the Form CMS-855B; or (ii) the person's license number can be obtained through PECOS.

Note that the specific processing exception addressed in (D) applies only to OTPs. Other processing exceptions applicable to other provider and supplier types (as well as to OTPs) can be found elsewhere in this chapter.

(E) Validation of Individuals on Attachment - The contractor shall review all individuals listed on the attachment against the MED and the SAM. (The contractor may combine this step with its check of the same individual if the latter is also listed in Section 6 of the form; it need not perform two separate reviews.) The contractor shall contact its PEOG BFL for further guidance if the contractor determines or learns during its screening that the individual:

- Is OIG excluded;
- Is debarred (per the SAM);
- Is on the preclusion list;
- Has one of the actions described in §§ 424.67(b)(6)(i)(A), 424.67(b)(6)(ii); or §§ 424.67(b)(6)(iii) above; or
- Does not meet applicable requirements to prescribe, order, or dispense controlled substances on the OTP's behalf.

In reviewing all individuals listed on the attachment (and absent a CMS directive to the contrary), the contractor is not required to perform any validation activities beyond those which it would ordinarily perform for persons listed in Section 6. (For example, the contractor need not research each person to determine (i) whether he/she is licensed, (2) what his/her license number is, or (3) whether he/she has ever had a fine imposed against him/her related to patient harm.)

(F) Multiple Locations and Off-Site – All persons who meet the requirements of § 424.67(b)(1)(i) must be listed on the OTP's attachment regardless of where the individual is located (e.g., the primary practice location, one of the OTP's multiple locations, his/her home, etc.) The central issue is whether the individual is authorized to act on the OTP's behalf, not his/her location.

(G) Appropriate Attachment Sections

As there is no section on the Form CMS-855B attachment specific to prescribers, such persons should be listed in the "Ordering Personnel Identification" section rather than the

"Dispensing Personnel Information" section. However, if the contractor determines that the prescriber was inadvertently listed in the "Dispensing" section, it need not require the OTP to move him/her to the "Ordering" section. In addition:

- If the person qualifies as both an ordering and dispensing individual but is only listed in one of the two sections of the attachment, the contractor need not require the OTP to list him/her in both.
- If the person qualifies as either an ordering or dispensing individual but is listed in the incorrect section (e.g., a dispenser is listed in the ordering section), the contractor need not require the OTP to move him/her to the other section.

iii. Person With Adverse Action But Need Not Be Listed on Attachment or in Section 6

There may be instances where the contractor learns (via any means) that an individual described in §§ 424.67(b)(6)(i)(A), 424.67(b)(6)(ii), or §§ 424.67(b)(6)(iii) has one of the actions described within those regulatory sections but was not required to be listed on the OTP's application (either on the attachment or elsewhere on the application). Examples could include the following:

- A W-2 nurse has restrictions on her license due to a patient harm case
- A non-prescribing/non-ordering physician under contract is currently on the preclusion list
- A physician assistant employee is currently revoked from Medicare.

These individuals may not have met the criteria under § 424.67(b)(1)(i) to be reported on the attachment or the OTP may not have yet been required to submit the attachment (e.g., the OTP is enrolled via the Form CMS-855A.) Regardless, if the contractor becomes aware of such an individual, it shall contact its PEOG BFL for guidance.

7. Provider Agreement

i. Basic Requirement

To enroll (and remain enrolled) in Medicare as an OTP, the OTP *(including provider-based OTPs, as discussed in subsection (B)(9) below)* must sign and adhere to the terms of the Form CMS-1561 Provider Agreement. (This is the same agreement signed by certified providers such as hospitals, hospices, and home health agencies. See 42 CFR Part 489, Subparts A through E (as well as CMS Pub. 100-07, State Operational Manual) for general information on provider agreements.) Given this, the contractor shall verify that the OTP submitted a signed and dated Form CMS-1561 with its initial enrollment package. The provider agreement must be signed by an authorized or delegated official (as those terms are defined in § 424.502) of the OTP; the signature can be handwritten or digital. This form may be accepted via mail, fax, email, or document upload. The legal business name on the Form CMS-1561 must match that on the Form CMS-855.

If the OTP failed to submit the Form CMS-1561 as described in the previous paragraph, the contractor shall develop for the document (or any missing or inconsistent data thereon) consistent with the procedures outlined in chapter 10 of the PIM.

ii. Criteria for Inapplicability

The requirement to submit, sign, and date a new Form CMS-1561 does not apply if the OTP meets all of the following requirements: (1) the OTP is already enrolled as such in Medicare; (2) the OTP already has a valid Form CMS-1561 agreement in effect; and (3) the OTP is

newly enrolling solely to change its existing Form CMS-855B enrollment to a Form CMS-855A, or vice versa.

8. Locations

An OTP may have multiple practice locations under a single enrollment so long as they all have the same legal business name and employer identification number. However, it may not split its locations between a Form CMS-855A enrollment and a Form CMS-855B enrollment. All locations must be under one enrollment. To illustrate, suppose an OTP is currently enrolled via the Form CMS-855B. It has four locations - W, X, Y, and Z. The OTP cannot keep W and X under its Form CMS-855B enrollment and switch Y and Z to a Form CMS-855A enrollment. It must retain all locations under the Form CMS-855B enrollment or move them all to a Form CMS-855A enrollment.

Instances might arise where an OTP lists multiple locations on its enrollment application, and one or more locations do not meet full status while one or more do. (For purposes of this situation, "full status" means that the location is separately and uniquely certified. See sections 10.2.7(a)(2) and (B)(4)(b) for more information.) Here, the contractor, in lieu of denying the entire application, may develop with the OTP to either: (1) update the location's status (if full status for it has since been obtained); or (2) remove the location from the enrollment application. Any such development---while encouraged, is not required---shall be performed consistent with the procedures and timeframes outlined in this chapter. The OTP's failure to fully and timely comply with the development request shall result in application's rejection. If the OTP does comply, the contractor can proceed as normal.

9. Provider-Based

As indicated in section 10.3.1.1.13(F)(1) of this chapter, an unenrolled OTP that wishes to become provider-based to a hospital cannot do so via the hospital's submission of a change of information application that adds the OTP as a practice location. The OTP must first enroll as an OTP via an initial enrollment, sign a provider agreement, undergo screening, etc. Once the OTP is enrolled, the hospital may add the OTP as a practice location on its enrollment. The situation is akin to that described in section 10.3.1.1.3(F)(1) regarding provider-based HHAs; section 10.3.1.1.3(F)(1) emphasizes that the HHA must separately enroll as such.

If a hospital submits an application to add--

(i) An unenrolled OTP as a practice location, the contractor shall return the change request on the basis of § 424.526(a)(7); the OTP must submit an initial enrollment application.

(ii) An enrolled OTP as a practice location, the contractor shall process the application consistent with the instructions in this chapter. A separate PECOS record for the OTP site (in its capacity as a hospital practice location) need not be created. Moreover:

- *The enrolled OTP need not sign a new/additional provider agreement*
- *The hospital need not complete the attachment regarding ordering, prescribing, and dispensing personnel, for the attachment is only completed by OTPs. However, if the OTP's addition as a provider-based location results in a change to any of the individually enrolled OTP's existing attachment information (e.g., new prescribers), the OTP must submit a change of information consistent with 42 CFR § 424.516(e)(2). Likewise, any other change to the OTP's individual enrollment stemming from its provider-based status (e.g., new ownership, change in managing employees) must be reported consistent with this chapter's instructions as well as 42 CFR Part 424, subpart P, § 424.67, and any other applicable regulations.*

- *The contractor need not confirm that the OTP location is still SAMHSA-certified*
- *The hospital must pay an application fee since it is adding a new location*
- *The application shall be screened at the limited screening level per 42 CFR § 424.518*
- *Notwithstanding any other instruction to the contrary in this chapter, the contractor shall follow the basic process in subsection (C)(2)(a) below with respect to referring the practice location addition to PEOG so that a CCN can be assigned to the OTP practice location (e.g., include in the e-mail the hospital's and OTP's respective names, the hospital's CCN and NPI, and the individually enrolled OTP's CCN and NPI)*

C. Approval

1. No State Agency or CMS Survey & Operations Group (SOG) Location Involvement

Unlike with many entities that complete the Form CMS-855A, there is no state agency or SOG Location involvement with OTP Form CMS-855A enrollments. Accordingly, no recommendations for approval or other type of referral need be made to the state or SOG Location nor will the SOG Location send any tie-in notice to the contractor. Except as otherwise stated in this section 10.2.7, the application will be reviewed and handled entirely at the contractor level

2. Process of Approval

If the contractor determines that the OTP's application should be approved, it shall undertake the following:

a. For Form CMS-855A applications only, request via PEMACReports@cms.hhs.gov that CMS assign a Form CMS-855A CCN to the enrollment. (This task is required even if the OTP is merely changing its existing enrollment from a Form CMS-855B to a Form CMS-855A.)

b. As applicable (and except as stated in section (B)(7)(ii) above), send the Form CMS-1561 to PEMACReports@cms.hhs.gov for CMS to execute the signature on behalf of the Secretary. CMS will return the executed provider agreement within 3 business days. (The tasks in 2(a) and 2(b) can be completed via the same e-mail.)

c. As applicable, send a copy of the executed provider agreement to the OTP along with the enrollment approval letter. (The contractor shall retain the original provider agreement.)

3. Effective Date of Billing

For newly enrolling OTPs that are not changing their enrollment from a Form CMS-855B to a Form CMS-855A (or vice versa), the contractor shall apply the effective date policies outlined in 42 CFR §§ 424.520(d) and 424.521(a) and explained in chapter 10 of the PIM.

For newly enrolling OTPs that are changing their enrollment from a Form CMS-855B to a Form CMS-855A (or vice versa), the contractor shall apply to the new/changed enrollment the same effective date of billing that was applied to the OTP's initial/former enrollment. (See 42 CFR § 424.67(c)(2).) To illustrate, suppose an OTP initially enrolled via the Form CMS-855B in 2020. The effective date of billing was April 1, 2020. Wishing to submit an 837I claim form for the services it has provided since April 1, 2020 the OTP elects to end its Form CMS-855B enrollment and enroll via the Form CMS-855A pursuant. It successfully does the latter in March 2021. Under § 424.67(c)(2), the billing effective date of the Form CMS-855A enrollment would be retroactive to April 1, 2020 (though the time limits for filing claims found in § 424.44 would continue to apply).

4. In cases where the OTP is changing its Form CMS-855 enrollment type, the contractor shall do the following:

a. End-date/deactivate the prior enrollment effective: (1) the date following that on which the OTP submitted its last claim under its prior enrollment; or (2) the prior enrollment's effective date of billing if no claims were submitted under the prior enrollment. The PECOS L & T basis shall be "Voluntary Termination." The deactivation reason shall be "Voluntary withdrawal: Applicant voluntarily withdrew from Medicare program.

b. Notify the OTP in the approval letter that the OTP's prior enrollment has been end-dated/deactivated and specify said end-date.

10.6.1.2 – Changes of Information – Transitioned Certified Providers and Suppliers

(Rev. 11682; Issued: 11-04-2022; Effective: 12-05-2022; Implementation: 12-05-2022)

(Until further notice from CMS, the instructions in this section 10.6.1.2 apply only to certified provider and certified supplier types that have officially "transitioned" as part of the transition of various certification activities from the SOG Location to the states, the contractors, and PEOG. These provider/supplier types include SNFs, HHAs, CMHCs, CORFs, FQHCs, Part A OPT/OSP providers, ASCs, PXRSs, hospitals, hospices, and ESRD facilities. The contractor shall continue to use the existing change of information instructions--now in section 10.6.22.1 of this chapter--for all non-transitioned certified provider/supplier types.

When executing the instructions in this section 10.6.1.2, the contractor can disregard directives that obviously do not apply to the transitioned provider/supplier type in question (e.g., references to hospitals).

All references to the SOG Location (formerly the "RO") in this section 10.6.1.2 refer to the applicable CMS Regional Office's Survey & Operations Group (SOG) Location. Also, and except as otherwise indicated, all references to "provider" include certified suppliers (e.g., ambulatory surgical centers, portable x-ray suppliers).

The instructions in this section 10.6.1.2 address the handling of changes of information involving certified providers and certified suppliers. With the transition of certain functions from the SOG Locations to the contractors and the Provider Enrollment & Oversight Group (PEOG), the processing instructions for these changes of information are slightly different from previous guidance. In particular: (1) the SOG Locations will be much less involved in the process; (2) tie-in and tie-out notices will no longer be issued; (3) the contractor will be responsible for finalizing changes previously requiring SOG Location approval; and (4) recommendations of approval will be made to (and reviewed by) the state agency (hereafter occasionally referenced simply as "state") only and not the SOG Location.

Except as stated otherwise:

(1) Any provider-specific instructions in section 10.2.1 et seq. of this chapter pertaining to changes of information (e.g., relocation of a federally qualified health clinic site) take precedence over those in this section 10.6.1.2.

(2) Any instructions pertaining to ownership changes in section 10.6.1.1 et seq. of this chapter take precedence over those in this section 10.6.1.2.

(3) Any instructions pertaining to voluntary terminations of entire enrollments and/or provider agreements in section 10.6.1.3 of this chapter take precedence over those in this section 10.6.1.2.

(4) Any instructions in this section 10.6.1.2 concerning the voluntary termination of a branch, sub-unit, or other practice location that does not involve the termination of the entire enrollment and/or provider agreement take precedence over those in section 10.6.1.3. For instance, suppose a certified provider's Form CMS-855A enrollment has three practice locations and/or sub-units. The provider is voluntarily terminating one of them. Here, the contractor shall use the instructions in section 10.6.1.2 when processing this transaction. Now assume that a provider is of a type that must individually and separately enroll each location. The provider has three separately enrolled locations with three separate provider agreements. The provider seeks to terminate one of these locations. Since this will involve the termination of an individual/entire enrollment and corresponding provider agreement, the instructions in section 10.6.1.3 apply.

A. Changes of Information Requiring Recommendation to the State

1. Types

The following Form CMS-855 transactions require an approval recommendation to (and review by) the state prior to approval:

- Addition of outpatient physical therapy/outpatient speech pathology extension site
- Addition of HHA branch
- Addition or deletion of a prospective payment system (PPS)-excluded psychiatric unit, rehabilitation unit, or transplant program
- Addition or deletion of swing-bed approval (see Section 2A2 of the Form CMS-855A)
- Conversion of a hospital from one type to another (e.g., acute care to psychiatric)
- Addition, deletion, or relocation of a hospice practice location
- *Addition, change, and/or relocation of a hospital practice location when a survey of the new site may be required. (If the contractor is uncertain as to whether the state will perform a survey, it may (1) contact the state for guidance or (2) make the referral based on the contractor's experience with these types of changes and with the practices of the state in question. Note that a survey often may be required if the location is shifting outside of the existing geographic area.)*
- Addition of PXRS practice location

2. Initial Contractor Review and Recommendation

The contractor shall process the change request consistent with the instructions in this chapter (e.g., verification of data, developing for missing or conflicting data). If the contractor determines that the change/addition should be approved, it shall send the appropriate recommendation letter (see section 10.7 et seq.) to the state with all applicable documentation that the contractor currently sends in such situations. The SOG Location need not be copied on the letter.

Nothing in this section 10.6.1.2(A)(2):

- Prohibits the contractor from returning or rejecting the application if grounds for doing so exist.
- Supersedes any applicable requirement for performing a site visit (including the timing of such visits).

3. State Review and Contractor Receipt of Recommendation

The state will review the recommendation of approval, the application, and any other pertinent information. If the state decides to perform a survey, it will do so and notify the contractor thereof.

a. State Recommends Approval

If the state concludes that the change/addition should be approved, it will make a recommendation to this effect to the contractor, typically via a Form CMS-1539 and/or similar confirming documentation. No later than 5 business days after receipt of the recommendation, the contractor shall send an e-mail to MedicareProviderEnrollment@cms.hhs.gov containing general identifying data about the provider (including LBN, NPI, CCN, specialty, facility name and address), a copy of the Form CMS-1539 (or other similar documentation evidencing the state's approval recommendation, if available), the draft provider approval letter, and a description of the change to be made. If, to the contractor's knowledge, a new CCN is required, the name and address of the new entity requiring the CCN should be furnished along with the effective date. If a termination is involved (e.g., HHA branch), the contractor shall include the old CCN and the termination date in the e-mail.

Once PEOG responds to the contractor, the latter may finalize its processing of the application (e.g., sending copies of the provider notification of approval to the state and, if applicable, accrediting organization; switching the PECOS record from "approval recommended" to "approved").

b. State Does Not Recommend Approval

If the state does not recommend approval, the contractor shall refer the matter to MedicareProviderEnrollment@cms.hhs.gov for guidance. The e-mail to him/her shall contain (1) the identifying data described in (3)(a) above; (2) a copy of the notification from the state declining to recommend approval; and (3) any other information the contractor deems pertinent. PEOG will review the matter and furnish the contractor additional instructions, which the contractor shall follow.

4. Additional Policies

a. Post-Recommendation Inquiries - Once the contractor has made its recommendation for approval to the state, any inquiry the contractor receives from the provider regarding the status of its change request shall be referred to the state.

b. Pending State Recommendation - So as not to keep the PECOS record in "approval recommended" status interminably, if the contractor does not receive the state's recommendation after 120 days, it may contact the state to see if its recommendation is forthcoming. The contractor may contact the state every 30 days thereafter to ascertain the recommendation's status.

c. State Practice - The PECOS record should not be switched to "Approved" until the contractor receives the state's approval recommendation. However, if the contractor knows that the state in question generally does not review this type of transaction, the contractor

need not send the transaction to the state and shall instead follow the instructions in section 10.6.1.2(B) below.

B. Post-Approval State Notification Required

Form CMS-855 changes that do not mandate a recommendation to the state but do require post-approval correspondence with PEOG and the state (and, if applicable, the accrediting organization) include:

- Except as described in section 10.6.1.2(A), deletions/voluntary terminations of practice locations or hospital subunits. (Note that this scenario is different from cases where the provider is voluntary terminating its enrollment as a whole (per section 10.6.1.3 of this chapter) rather than simply terminating a single location or subunit within its enrollment.)

- LBN, TIN, or "doing business as name" changes that do not involve a CHOW

- Except as described in section 10.6.1.2(A), address changes that generally do not require a survey of the new location

- *A*ddition, *change, and/or relocation of a hospital practice location (including physician/practitioner group practice locations) for which a survey is not required.*

- Ownership changes that involve neither a 42 CFR § 489.18 CHOW nor a § 424.550(b) exempt or non-exempt change in HHA majority ownership (e.g., a 15 percent owner of a hospice sells her ownership stake).

The contractor shall:

(1) Inform PEOG, the state, and the AO (if appropriate) of the changed information (via any mechanism it chooses, including copying PEOG/state/AO on the notification letter or e-mail to the provider) no later than 10 calendar days after it has completed processing the transaction. Such notice to the PEOG/state/AO shall specify the type of information that is changing. (Prior PEOG approval of the change is not required, though PEOG will update applicable national database as needed.)

(2) Switch the PECOS record to "Approved."

C. All Other Changes of Information

1. General Principle

For all Form CMS-855 change requests not identified in section 10.6.1.2(A)(1) and (B) above (and except as stated in subsection (C)(2) below), the contractor shall: (1) notify the provider via letter, fax, e-mail, or telephone that the change has been made; and (2) switch the PECOS record to "Approved." The contractor need not notify the state, SOG Location, or PEOG of the change.

2. FQHCs

If an FQHC is adding, deleting, or changing a Section 13 contact person , the contractor shall send an approval letter via e-mail and copy the MedicareProviderEnrollment@cms.hhs.gov mailbox (with "FQHC COI" in the subject line) thereon. (Aside from this exception, all other instructions in subsection (C)(1) apply to this scenario.) See section 10.2.1.4(D) of this chapter for more information on FQHC changes of information.

D. Revalidations, Reactivations, and Complete Form CMS-855 Applications

1. When Referral Required - In situations where the provider submits a (1) Form CMS-855 reactivation, (2) Form CMS-855 revalidation, or (3) full Form CMS-855 as part of a change of information (i.e., the provider has no enrollment record in PECOS), the contractor shall make a recommendation to the state and switch the PECOS record to "approval recommended" only if the application contains new/changed data falling within one of the categories in section 10.6.1.2(A)(1). For instance, if a revalidation application reveals a new hospital psychiatric unit that was never reported to CMS via the Form CMS-855, the contractor shall make a recommendation to the state and await the state's approval recommendation before switching the record to "Approved." In this situation, the contractor should forward the application to the state with a note explaining that the only matter the state needs to consider is the new hospital unit.

2. No Referral Required - If the application contains new/changed data falling within one of the categories in section 10.6.1.2(B), the contractor can switch the PECOS record to "Approved." It shall also inform the state of the changed information (via any mechanism it chooses, including copying the state on the notification letter or e-mail to the provider) no later than 10 calendar days after it has completed processing the transaction.

E. Unsolicited Notifications from State

If the contractor receives notice of a provider's change of information from the state but the provider never submitted the required Form CMS-855 change request to the contractor, the contractor shall: (1) alert the state of the situation; and (2) contact the provider and have it complete and submit the change request. However, if the data in question is not collected on the Form CMS-855, the contractor need not make this request.

F. Special ESRD Instructions

Notwithstanding any other contrary instruction in this chapter, if an ESRD change of information application results in the issuance of a new or additional CCN, the contractor shall copy the ESRD Network on the approval letter it sends to the provider. The contact information for the ESRD Network can be found at https://esrdnetworks.org/membership/esrd-networks-contact-information/.

G. Clock Stoppages and Processing Alternatives - While awaiting PEOG's reply on any matter in this section 10.6.1.2 in which the contractor is required to refer a matter to PEOG - and beginning on the date following the sending of the e-mail referenced therein - the application processing time clock is stopped. It resumes on the date on which the contractor receives PEOG's final response. Communication between the contractor and PEOG during this "waiting period" (e.g., PEOG request for additional information from the contractor) does not restart the clock.

In addition, nothing in this section 10.6.1.2 negates other permissible clock stoppages and processing alternatives outlined in this chapter that can apply to the applications addressed in this section 10.6.1.2.

10.6.2 – Establishing Effective Dates

(Rev. 11682; Issued: 11-04-2022; Effective: 12-05-2022; Implementation: 12-05-2022)

In reviewing this section 10.6.2, it is important that the contractor keep in mind the distinctions between: (1) the date of enrollment/approval; (2) the effective date of billing privileges under 42 CFR § 424.520(d); and (3) the date from which the supplier may retrospectively bill for services under § 424.521(a).

A. Date of Enrollment/Approval

For suppliers other than ambulatory surgical centers and portable x-ray suppliers, the date of enrollment is the date the contractor approved the application. The enrollment date cannot be made retroactive. To illustrate, suppose a practitioner met all the requirements needed to enroll in Medicare (other than the submission of a Form CMS-855I) on January 1. He submits his Form CMS-855I to the contractor on May 1, and the contractor approves the application on June 1. The date of enrollment is June 1, not January 1.

B. Establishing Effective Dates of Billing Privileges for Certain Suppliers Under 42 CFR § 424.520(d)

1. Applicability

This section 10.6.2(B) applies to the following individuals and organizations:

a. Physicians; physician assistants; nurse practitioners; audiologists; clinical nurse specialists; certified registered nurse anesthetists; anesthesiology assistants; certified nurse- midwives; clinical social workers; clinical psychologists; independently billing psychologists, registered dietitians or nutrition professionals; physical therapists; occupational therapists; speech-language pathologists; and physician and non-physician practitioner organizations (e.g., group practices) consisting of any of the categories of individuals identified above.

b. Ambulance suppliers

c. Part B hospital departments

d. CLIA labs

e. Opioid treatment programs.

f. Mammography centers

g. Mass immunizers/pharmacies

h. Radiation therapy centers

i. Home infusion therapy suppliers

(See 42 CFR §§ 424.520(d)(2) and 424.521(a)(2) for the regulatory listing of these providers/suppliers.)

2. Background

In accordance with 42 CFR § 424.520(d)(1), the effective date of billing privileges for the individuals and organizations identified in § 424.520(d)(2) (and section 10.6.2(B)(1) above) is the later of:

(i) The date the supplier filed an enrollment application that was subsequently approved, or

(ii) The date the supplier first began furnishing services at a new practice location.

NOTE: The date of filing for Form CMS-855 applications is the date on which the contractor received the application, regardless of whether the application was submitted via paper or Internet-based PECOS.

3. Retrospective Billing Under 42 CFR § 424.521(a)

Consistent with 42 CFR § 424.521(a)(1), the individuals and organizations identified in § 424.521(a)(2) (and section 10.6.2(B)(1) above) may retrospectively bill for services when:

(i) The supplier has met all program requirements, including state licensure requirements, and

(ii) The services were provided at the enrolled practice location for up to—

(A) 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or

(B) 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

The contractor shall interpret the aforementioned phase "circumstances precluded enrollment" to mean that the supplier meets all program requirements (including state licensure) during the 30-day period before an application was submitted and no final adverse action (as that term is defined in § 424.502) precluded enrollment. If a final adverse action precluded enrollment during this 30-day period, the contractor shall only establish an effective billing date the day after the date that the final adverse action was resolved--so long as it is not more than 30 days prior to the date on which the application was submitted.

If the contractor believes that the aforementioned Presidentially-declared disaster exception may apply in a particular case, it shall contact its CMS Provider Enrollment & Oversight Group Business Function Lead for a determination on this issue.

4. Summarizing the Distinction Between Effective Date of Billing Privileges and Retrospective Billing Date

As already discussed, the effective date of billing privileges is "the later of the date of filing or the date (the supplier) first began furnishing services at a new practice location." The retrospective billing date, however, is "up to…30 days prior to (the supplier's) effective date (of enrollment)." To illustrate, suppose that a non-Medicare enrolled physician begins furnishing services at an office on March 1. She submits a Form CMS-855I initial enrollment application on May 1. The application is approved on June 1 (which, as discussed in section 10.6.2(A) above, is the date of enrollment). The physician's effective date of billing privileges is May 1, which is the later of: (1) the date of filing, and (2) the date she began furnishing services. The retrospective billing date is April 1 (or 30 days prior to the effective date of billing privileges), assuming that the requirements of 42 CFR § 424.521(a) are met. The effective date entered into PECOS and the Multi-Carrier System will be April 1; claims submitted for services provided before April 1 will not be paid.

C. Effective Date of Reassignment

Per 42 CFR § 424.522(a), the effective date of the reassignment is 30 days before the Form CMS-855R is submitted if all applicable requirements during that period were otherwise met. The contractor shall apply this policy in the following manner:

1. Form CMS-855R submitted as "stand-alone" without Form CMS-855I – The effective date in § 424.522(a) applies to the reassignment unless the effective date that the supplier listed on the Form CMS-855R is later than what the § 424.522(a) date is, in which case the Form CMS-855R-listed effective date controls.

2. Form CMS-855R submitted with Form CMS-855I either simultaneously or as part of development (e.g., physician only submits Form CMS-855I and contractor develops for Form CMS-855R) – The contractor shall apply the Form CMS-855I effective date (per 42 CFR §§ 424.520(d) and 424.521(a)) to the Form CMS-855R. When one or both of these forms requires the contractor to develop for information – and for purposes of establishing the §§ 424.520(d)/424.521(d) effective date -- the contractor may apply the receipt date of the first application that is submitted as complete (i.e. no further development is necessary).

3. Form CMS-855R submitted with Form CMS-855B either simultaneously or as part of development – The contractor shall apply the Form CMS-855B effective date (per 42 CFR §§ 424.520(d) and 424.521(a)) to the Form CMS-855R. When one or both of these forms requires the contractor to develop for information – and for purposes of establishing the §§ 424.520(d)/424.521(d) effective date -- the contractor may apply the receipt date of the first application that is submitted as complete (i.e. no further development is necessary).

Notwithstanding the foregoing, the contractor shall apply the 90-day retroactive billing period referenced in subsection 10.6.2(B)(3)(ii)(B) above to the Form CMS-855R submissions described in this subsection (C) in the event of a Presidentially-declared disaster under the Stafford Act).

D. Effective Date for Certified Providers and Certified Suppliers

Note that 42 CFR § 489.13 governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. Section 489.13 has been revised to state that: (1) the date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met; and (2) such requirements include the contractor's review and verification of an application to enroll in Medicare.

E. Effective Date for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Per § 424.57(b), DMEPOS suppliers must meet, among other requirements, the following conditions in order to be eligible to receive payment for a Medicare-covered item:

(1) The supplier has submitted a completed application to CMS to furnish Medicare-covered items including required enrollment forms. (The supplier must enroll separate physical locations it uses to furnish Medicare-covered DMEPOS, with the exception of locations that it uses solely as warehouses or repair facilities.)

(2) The item was furnished on or after the date CMS issued to the supplier a DMEPOS supplier number conveying billing privileges. (CMS issues only one supplier number for each location.) This requirement does not apply to items furnished incident to a physician's service.

The contractor shall indicate the supplier's status as approved in PECOS upon the contractor making the determination the supplier meets all of the supplier standards found at § 424.57(c). The date the supplier was approved in PECOS shall be the supplier's effective date.

F. Form CMS-855O Effective Dates

Notwithstanding any other instruction in the chapter to the contrary, the effective date of a Form CMS-855O enrollment per 42 CFR § 424.522 is the date on which the Medicare contractor received the Form CMS-855O application if all other requirements are met --- meaning the Form CMS-855O was processed to approval.

G. Effective Date for Medicare Diabetes Prevention Program (MDPP) Suppliers

In accordance with 42 CFR § 424.205(f), the effective date of billing privileges for MDPP suppliers is the later of:

- The date the supplier filed an enrollment application that was subsequently approved,
- The date the supplier filed a corrective action plan that was subsequently approved by a Medicare contractor, or
- The date the supplier first began furnishing services at a new administrative location that resulted in a new enrollment record or Provider Transaction Access Number.

Under no circumstances should an effective date for billing privileges be prior to April 1, 2018. For any Form CMS-20134 submitted prior to April 1, 2018 and subsequently approved, the contractor shall note April 1, 2018 as the MDPP supplier's effective date, even if this date is in the future.

NOTE: The date of filing for paper Form CMS-20134 applications is the date on which the contractor received the application. For Internet-based PECOS applications, the date of filing is the date that the contractor received an electronic version of the enrollment application and a signed certification statement submitted via paper or electronically.

H. Future Effective Dates

If the contractor cannot enter an effective date into PECOS because the provider/supplier, its practice location, etc., is not yet established, the contractor may use the authorized official's date of signature as the temporary effective date. Once the provider/supplier and the effective date are established (e.g., the tie-in notice is received), the contractor shall change the effective date in PECOS.

10.6.7.1 – Organizational Owning and Managing Information

(Rev. 11682; Issued: 11-04-2022; Effective: 12-05-2022; Implementation: 12-05-2022)

Except as stated otherwise, this section 10.6.7.1 only applies to the Organizational Ownership and/or Managing Control Section of the Forms CMS-855A, CMS-855B, CMS-855S and CMS-20134; it is inapplicable to the Form CMS-855I.

A. Ownership Information Required in Forms CMS-855A, CMS-855B, CMS-855S and CMS-20134

All organizations that have any of the following (referenced in (A)(1) through (A)(4) must be listed in the Organizational Ownership and/or Managing Control section of the Form CMS-855 and CMS-20134.

1. <u>5 percent or greater direct or indirect ownership interest in the provider</u>

(i) Direct Ownership

Examples of direct ownership are as follows:

- The provider is a skilled nursing facility that is wholly (100%) owned by Company A.
- A hospice wants to enroll in Medicare. Company X owns 50% of the hospice.

In the first example, Company A is considered a direct owner of the skilled nursing facility, in that it actually owns the assets of the business. Likewise, Company X is a direct owner of the hospice mentioned in the second example. It has 50% actual ownership of the hospice.

(ii) Indirect Ownership

Many organizations that directly own a provider are themselves wholly or partly owned by other organizations (or even individuals). This often results from the use of holding companies and parent/subsidiary relationships. Such organizations and individuals are considered "indirect" owners of the provider. *The term "indirect ownership interest" generally means* any ownership interest in an entity that has an ownership in the ownership interest in an entity that has an ownership interest in the provider or supplier; this also includes an ownership interest in any entity that has an indirect ownership interest in the provider or supplier. Using the first example in the "Direct Ownership" subsection above, if Company B owned 100% of Company A, Company B is considered indirect owner of the provider; in sum, a direct owner has an actual ownership interest in the provider (e.g., owns stock in the business, etc.), whereas an indirect owner has an ownership interest in an organization that owns the provider.

(iii) Examples of Direct vs. Indirect Ownership

The following scenario further illustrates the difference between direct and indirect ownership:

> **EXAMPLE 1:** The supplier listed in the Identifying Information of the Form 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 terms of the calculation and reporting of indirect ownership interests, consider this example from the Form CMS-855A (though note that individuals would need to be reported in the Individual Ownership and/or Managing Control section of the Form CMS-855A and Form CMS-20134, discussed further below):

EXAMPLE 2

LEVEL 3	**Individual X**	**Individual Y**
	5%	30%
LEVEL 2	**Company C**	**Company B**
	60%	40%
LEVEL 1	**Company A**	
	100%	

- Company A owns 100% of the Enrolling Provider
- Company B owns 40% of Company A

- Company C owns 60% of Company A
- Individual X owns 5% of Company C
- Individual Y owns 30% of Company B

In Example 2, Company A (Level 1) is the direct owner of the provider identified in Section 2 of the application. Companies B and C, as well as Individuals X and Y, are indirect owners of the provider. The calculation of ownership shares would be as follows:

LEVEL 1

Company A owns 100% of the Enrolling Provider. Company A must be reported.

LEVEL 2

To calculate the percentage of ownership held by Company C of the Enrolling Provider, multiply the percentage of ownership the LEVEL 1 owner has in the Enrolling Provider by the percentage of ownership the LEVEL 2 owner has in that LEVEL 1 owner.

- Company A, the LEVEL 1 (or direct) owner, owns 100% of the provider. Company C, a LEVEL 2 owner, owns 60% of Company A. Accordingly, multiply 100% (or 1.0) by 60% (.60). The result is .60. Company C indirectly owns 60% of the Enrolling Provider and must be reported.
- Repeat the same procedure for Company B, the other LEVEL 2 owner. Since Company B owns 40% of Company A, multiply this figure by 100% (again, the ownership stake Company A has in the Enrolling Provider). Company B thus owns 40% of the Enrolling Provider and must be reported.

This process is continued until all LEVEL 2 owners have been accounted for.

LEVEL 3

To calculate the percentage of ownership that Individual X has in the Enrolling Provider, multiply the percentage of ownership the LEVEL 2 owner has in the Enrolling Provider by the percentage of ownership the LEVEL 3 owner has in that LEVEL 2 owner Per Example 2:

- Company C owns 60% of the provider, and Individual X (Level 3) owns 5% of Company C. Multiplying 60% (.60) by 5% (.05) results in .03. This means that Individual X owns 3% of the provider and need not be reported as an owner.
- Repeat this process for Company B, which owns 40% of the provider. Individual Y (Level 3) owns 30% of Company B. Multiplying 40% (.40) by 30% (.30) results in .12, or 12%. Since Individual Y owns 12% of the provider, Individual Y must be reported (in Section 6: Individuals).

This process is continued until all owners in LEVEL 3 have been accounted for. This process must be repeated for Levels 4 and beyond.

2. 5 percent or greater mortgage or security interest

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.

All entities with at least a 5 percent mortgage, deed of trust, or other security interest in the provider must be reported in the Organizational Ownership and/or Managing Control section. This frequently will include banks, other financial institutions, and investment firms. To calculate whether this interest meets the 5% threshold, divide the dollar amount of the mortgage/deed of trust/other obligation secured by the provider or any of the property or assets of the provider by the dollar amount of the total property and assets of the provider.

EXAMPLE: Two years ago, a provider obtained a $20 million loan from Entity X to add a third floor to its facility. Various assets of the provider secure the mortgage. The total value of the provider's property and assets is $100 million.

Using the above formula, divide $20 million (the dollar amount of the secured mortgage) by $100 million (the total property and assets of the Enrolling Provider). This results in .20, or 20%. Because Entity X's interest represents at least 5% of the total property and assets of the Enrolling Provider, Entity X must be reported in this section.

3. Partnerships

(a) Any general partnership interest in the provider, regardless of the percentage. This includes: (1) all interests in a non-limited partnership; and (2) all general partnership interests in a limited partnership.

(b) For limited partnerships:

- **Form CMS-855A: Any limited partnership interest that is 10 percent or greater.**

- **Form CMS-855B and Form CMS-20134: Any limited partnership interest, regardless of the percentage.**

Only partnership interests in the enrolling provider need be disclosed in the Organizational Ownership and/or Managing Control section. Partnership interests in the provider's indirect owners need not be reported. However, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be disclosed in this section.

See section 10.6.4(C) of this chapter for more information on the differences between general and limited partnerships.

4. 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 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.

The organizations referred to above generally fall into one or more of the following categories:

- Corporations
- Partnerships and limited partnerships

- Limited liability companies
- Charitable and religious organizations
- Governmental/tribal organizations
- Banks and financial institutions
- Investment firms
- Holding companies
- Trusts and trustees
- Medical providers/suppliers
- Consulting firms
- Management services companies
- Medical staffing companies
- Non-profit entities

In the Organizational Ownership and/or Managing Control section of the Form CMS-855 and CMS-20134, the provider must indicate the type(s) of organizational categories the reported entity falls into.

B. Special Requirements for Governmental and Tribal Entities

If a federal, state, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. The provider must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization attesting that the government or tribal organization will be legally and financially responsible for any outstanding debt owed to CMS. This letter must be signed by an appointed or elected official of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of the Medicare program. This governmental or tribal official, however, need not be an authorized or delegated official, or vice versa; that is, the person need not be one of the provider's authorized or delegated officials listed in the Certification Statement Section of the Form CMS-855 or Form CMS-20134. The only requirement is that the individual have the binding authority described above, and the contractor shall assume such authority exists unless there is evidence to indicate otherwise.

In addition, governmental and tribal entities:

- Must be identified in the Organizational Ownership and/or Managing Control section even if they are already listed in the Identifying Information section.

- Governmental and tribal entities need not submit a copy of an IRS 501(c)(3) form if it is otherwise obvious to the contractor that the entity is a governmental or tribal entity. The contractor can assume that the governmental or tribal entity is non-profit. (See section 10.6.7(D)(3) below and section 10.6.4(G) of this chapter for more information on non-profit entities.)

C. Submission of Diagram

In addition to completing the Organizational Ownership and/or Managing Control section, the provider must submit an organizational structure diagram/flowchart identifying (1) all of the entities listed in this section; and (2) the relationships they have with the provider and each other. (This applies to the Form CMS-855A, CMS-855B, CMS-855S and CMS-20134.) If the provider is a skilled nursing facility or opioid treatment program, it must also include in the diagram/flowchart all entities and individuals that have less than a 5 percent direct or

indirect ownership interest (and were thus not required to otherwise be listed in the Organizational or Individual Ownership and/or Managing Control sections).

The aforementioned diagram/flowchart must be submitted for Form CMS-855 and CMS-20134: (1) initial enrollments; (2) revalidations; (3) reactivations; (4) certified provider and certified supplier changes of ownership based on the principles of 42 § CFR 489.18; and (5) upon any contractor request. *Upon receiving the chart, the contractor shall review the data thereon to ensure it matches what the provider/supplier is reporting on the Form CMS-855/20134. If the data is inconsistent, the contractor shall develop for revised Form CMS-855/20134 data and/or a revised chart, as applicable. If the data remains inconsistent after development, the contractor may reject the application.*

D. Supporting Data/Contractor Request and Additional Information

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

2. **Proof of Owning/Managing Control and Percentages -** Proof of ownership interest, partnership interest, managerial control, security interest, percentage of ownership or control, etc., need not be submitted unless the contractor requests it. This also means that articles of incorporation, partnership agreements, etc., need not be submitted absent a contractor's request.

   In addition, the percentage of managing control need not be reported.

3. **Non-Profit, Charitable and Religious Organizations –** As mentioned in section 10.6.4(G) of this chapter, many non-profit organizations are charitable or religious in nature and are generally typically 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 must be reported in the Organizational Ownership and/or Managing Control. (Individual board members should be listed in the Individual Ownership and/or Managing Control section.)

   Non-profit organizations typically do not have owners, and thus the latter would not need to be listed as such on the application. To confirm its non-profit status, the provider must submit an IRS 501(c)(3) document. If the non-profit entity does have owners, however, they would need to be disclosed in the Ownership and/or Managing Control section consistent with the instructions in section 10.6.7 et seq.

4. **Duplicate Listing -** Any entity listed as the provider in the Identifying Information section of the Form CMS-855A, CMS-855B and CMS-20134 need not be reported in the Organizational Ownership and/or Managing Control section. The only exception involves governmental entities, which must be identified in the Organizational Ownership and/or Managing Control section even if they are already listed in the Identifying Information section.

5. **Disregarded Entities -** In general, a "disregarded entity" is a term the IRS uses for an LLC that – for federal tax purposes only – is effectively indistinguishable from its single owner/member. The LLC's income and expenses are shown on the owner's personal tax return. The LLC itself does not pay taxes.

   If an enrolling provider claims that it is a disregarded entity, the contractor need not obtain written confirmation of this from the provider notwithstanding the instruction in the Supporting Documents section of the Form CMS-855 or CMS-20134 that such

confirmation is required. As a disregarded entity does not receive a CP-575 form from the IRS confirming its legal business name (LBN) and tax identification number (TIN), the contractor may accept from the enrolling provider any government form (such as a W-9) that lists its LBN and TIN. The disregarded entity's LBN and TIN shall be listed in the Identifying Information/Business Information section of the Form CMS-855.

6. Ownership Disclosures

Consistent with the foregoing policies in this section 10.6.7.1, CMS re-emphasizes the following:

(i) The provider/supplier must disclose ALL persons and entities that meet the definition of "owner" in section 10.1.1 of this chapter
(ii) The applicable ownership percentage must be disclosed for each owner listed
(iii) There cannot be indirect owners without direct owners (i.e., the provider/supplier cannot list only indirect owners and no direct owners)
(iv) The combined disclosed ownership percentages for the provider/supplier's organizational and individual direct owners cannot be greater than 100 percent

(Requirements (ii) and (iv) are inapplicable to applications that do not capture percentages of ownership.)

If the provider/supplier's ownership data does not meet the aforementioned requirements, the contractor shall develop for the correct/complete data (e.g., the direct ownership total is greater than 100 percent) consistent with the instructions in this chapter.

10.6.7.2 – Individual Owning and Managing Information

(Rev. 11682; Issued: 11-04-2022; Effective: 12-05-2022; Implementation: 12-05-2022)

A. Owning and Managing Individuals Who Must Be Listed in this Section

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

(i) Ownership - A 5 percent or greater direct or indirect ownership interest in the provider.

(ii) Mortgage/Security Interest - A 5 percent or greater mortgage or security interest in the provider.

(iii) Partnership Interests

- Any general partnership interest in the provider, regardless of the percentage. This includes (1) all interests in a non-limited partnership and (2) all general partnership interests in a limited partnership.

- Limited partnerships - For the CMS-855A, any limited partnership interest that is 10 percent or greater. For the Form CMS-855B, CMS-855S and CMS-20134, any limited partnership interest, regardless of the percentage.

(iv) 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.

(v) Corporate Officers and Directors/Board Members

Officers and directors/board members must be listed in the Individual Ownership and/or Managing Control section if – and only 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 this section of the Form CMS-855A, CMS-855B, CMS-855S and CMS-20134.)

Only the enrolling provider's officers and directors must be reported. Board members of the provider's indirect owners need not be disclosed to the extent they are not otherwise required to be reported (e.g., as an owner or managing employee) in this section. However, there may be situations where the officers and directors/board members of the enrolling provider's corporate owner/parent also serve as the enrolling provider's officers and directors/board members. In such cases – and again assuming that the provider is a corporation – the indirect owner's officers and directors/board members would have to be disclosed as the provider's officers and directors/board members in this section.

With respect to corporations, the term "director" refers to members of the board of directors. If a corporation has, for instance, a Director of Finance who nonetheless is not a member of the board of directors, he/she would not need to be listed as a director/board member in this section. However, he/she may need to be listed as a managing employee in this section.

(See sections 10.6.7.1(A) of this chapter for more information on direct and indirect ownership, mortgage and security interests, and partnerships.)

B. Specific Reporting Policies

1. Proof of Owning/Managing Control and Percentages –- Proof of ownership interest, partnership interest, managerial control (including W-2s and other proof of employment), security interest, percentage of ownership or control, etc., need not be submitted unless the contractor requests it. This also means that articles of incorporation, partnership agreements, etc., need not be submitted absent a contractor's request.

2. Government Entities – Government entities need only report their managing employees, for they do not have owners, partners, corporate officers, or corporate directors.

3. Minimum Number of Managing Employees - The provider must report all managing employees but must have at least one if it is completing the Form CMS-855A, CMS-855B, CMS-855S, or CMS-20134. An individual completing the Form CMS-855I need not list a managing employee if he/she does not have one.

4. Practice Locations on the Form CMS-855I - All managing employees at all practice locations listed in the Business Information/Practice Location Information section of the Form CMS-855I must be reported in the Managing Employee Information section. The only exceptions to this are individuals who are (a) employed by hospitals, health care facilities, or other organizations shown in the Business Information/Practice Location Information section (e.g., the chief executive officer of a hospital listed in this section) or (ii) managing employees of any group/organization to which the practitioner will be reassigning his/her benefits; these persons need not be reported.

5. Partnership Interests Involving Indirect Owners - Only partnership interests in the enrolling provider need be disclosed. Partnership interests in the provider's indirect owners need not be reported. However, if the partnership interest in the indirect owner

results in a greater than 5 percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be reported.

6. *Ownership Disclosures – Concerning ownership disclosures, the contractor shall adhere to the instructions in section 10.6.7.1(D)(6).*

10.6.21.1 – Additional Miscellaneous Enrollment Topics

(Rev. 11682; Issued: 11-04-2022; Effective: 12-05-2022; Implementation:12-05-2022)

(The instructions in this section 10.6.21.1 take precedence over all other contrary instructions in this chapter, including, but not limited to, the existing guidance in sections 10.3.1 et al. The policies in this section will eventually be incorporated into the sections of this chapter that are applicable to the subject matter.)

Type of Practice Location

For Form CMS-855A, CMS-855B, and CMS-855I applications, the contractor may collect the practice location type in Section 4 of the application via telephone or---if the practice location type is otherwise apparent---may forgo development altogether.

10.6.23 – Special Instructions for Electronic Funds Transfer (EFT) Accounts and Special Payment Addresses

(Rev. 11682; Issued: 11-04-2022; Effective: 12-05-2022; Implementation:12-05-2022)

(The instructions in this section 10.6.23 take precedence over all other contrary instructions in this chapter, including, but not limited to, the existing guidance in sections 10.3.1.1.4, 10.3.1.2.4, and 10.3.1.3.4. The policies in this section will eventually be incorporated into the sections of this chapter that are applicable to the subject matter.)

A. Enrolled Providers/Suppliers

1. General Policy

A provider/supplier may only have one EFT account and one special payment address (SPA) per enrollment. As a general rule, multiple EFT accounts or SPAs within an existing enrollment will remain in effect only until the provider/supplier submits any update to its EFT information or SPA data, respectively, for any of these accounts or addresses. At that time, the EFT account or SPA for which the provider/supplier submitted the update will become the lone EFT account or SPA (as applicable) for that enrollment.

For purposes of this requirement:

(i) The term "enrollment" means a single enrollment in a single state involving a single provider/supplier type. The particular PTAN arrangement under the enrollment (e.g., a group practice has three practice locations under its Form CMS-855B enrollment, each with a separate PTAN) is irrelevant for purposes of this requirement; again, the requirement is based on the enrollment, not the PTAN.

(ii) Any submitted change to any of the provider/supplier's EFT or SPA data for any EFT account or SPA within an enrollment --- even a change that the provider/supplier did not cause (e.g., a government-generated zip code change) and even if it is for only one of the enrollment's EFT accounts or SPAs --- triggers the aforementioned requirement. The materiality of the change does not matter. However, the changed data must have actually been submitted via the appropriate CMS form to invoke the requirement; using the example

in the previous sentence, this zip code change would not trigger the requirement unless and until the provider/supplier reports it via a CMS form.

(iii) If the provider/supplier reports the changed EFT or SPA data as part of a revalidation, reactivation, or other enrollment transaction other than a change of information (COI), the requirement is invoked to the same extent as with a COI.

(iv) The requirement applies only to the precise enrollment (e.g., "Enrollment A") for which the change was submitted. It is inapplicable to the provider/supplier's other enrollments ("Enrollments B and C"), even if B and C have:

- *Multiple EFT accounts or SPAs that match those for which the provider/supplier reported a change to its "Enrollment A" EFT or SPA data; and/or*
- *The same LBN or TIN as "Enrollment A."*

(v) A change in EFT data does not invoke the need to "consolidate" the provider/supplier's SPAs if the provider/supplier has multiple SPAs; likewise, a change in SPA data does not require the "consolidation" of the provider/supplier's multiple EFT accounts. (For purposes of this section 10.6.23, the term "consolidate" simply means reducing the provider/supplier's multiple EFT accounts or SPAs to one.)

(vi) Even if the multiple EFT accounts are with the same banking institution, the aforementioned "consolidation" requirement applies.

(vii) Any EFT and/or SPA consolidation under this section 10.6.23 applies to all PTANs under the single enrollment.

(viii) The consolidation requirement applies irrespective of whether the EFT or SPA change that the provider/supplier submitted is approved, denied, rejected, or returned.

(ix) The term "multiple" EFT accounts or SPAs only applies to active EFT accounts/SPAs.

(x) Except as otherwise noted, any consolidation described in this section 10.6.23 becomes effective on the date of the applicable approval, denial, rejection, or return letter (see subsection (A)(2)(i) below).

Consider the following:

> *EXAMPLE – Provider X is enrolled as a group practice and a HIT supplier (i.e., two separate enrollments) in State Y. Currently:*
>
> - *The group practice enrollment has two EFT accounts (one with Smith Bank and one with Jones Bank) and two SPAs (1 James Street and 200 Johnson Street)*
> - *The HIT supplier enrollment has the same two EFT accounts and SPAs as the group practice*
>
> *Provider X submits a change to its Smith Bank account information for the group practice enrollment. In this scenario: (1) the Smith Bank account becomes the lone EFT account for the group practice; (2) the group practice's Jones Bank account becomes inactive in PECOS effective on the date of the notice to the provider/supplier that the originally submitted EFT or SPA change was approved, denied, etc. (see subsection (A)(2)(i) below); (3) the Smith Bank and Jones Bank accounts for the HIT supplier enrollment are unaffected; and (4) the SPAs for Provider X's two enrollments are unaffected.*

2. Operational Procedures

If the contractor receives an EFT or SPA change and determines that the provider/supplier has multiple EFT accounts or SPAs (as applicable and consistent with the guidelines described in subsection (A) above) for that enrollment, the contractor shall follow the procedures described below. (The example in subsection (A) will be used as a format.)

Step 1 – The contractor shall process the EFT data change for the group practice's Smith Bank account as normal.

Step 2 – Upon final completion of its processing of the change, the contractor shall:

i. Send the appropriate approval, denial, etc., letter to the provider/supplier consistent with the instructions in this chapter. The contractor shall, however, add the following language to the letter:

"Under CMS policy, a Medicare provider or supplier may only have one ["EFT account" or "special payment address", as applicable] per enrollment. Consistent therewith, [Contractor name] has designated the ["EFT account" or "special payment address", as applicable] for which you reported changed ["EFT" or "special payment address"] information as the sole ["EFT account" or "special payment address"] for this enrollment. This designation is effective as of the date of this letter. All payments previously sent to your other ["EFT account(s)" or "special payment address(es)"] under this enrollment will now be made to the sole designated ["EFT account" or "special payment address"] described above. If you wish to change this sole designated ["EFT account or "special payment address"], you must submit the applicable [Form CMS-588, Form CMS-855, or Form CMS-20134, as applicable] to do so.

Note that the sole designation described above applies only to the enrollment for which you submitted the requested change to your ["EFT" or "special payment address'] data. It is inapplicable to any other enrollments you have."

The contractor may: (1) notwithstanding any other instruction to the contrary in section 10.7 et seq. of this chapter, alter the forgoing language to conform to the provider/supplier's particular factual situation (prior CMS approval is unnecessary); and (2) insert said language in any part of the letter it chooses.

ii. End-date the "other" EFT account(s) or SPA(s) (as applicable) effective the date of the letter described in subsection (A)(2)(i) above. The contractor shall make all payments under the enrollment to the sole account/SPA beginning the day after the date of the letter.

iii. Apply the PTAN(s) associated with the deleted EFT account/SPA to the sole EFT account/SPA.

iv. Complete all other normal steps required under this chapter for finalizing the transaction in question.

B. Providers/Suppliers Initially Enrolling or Undergoing a CHOW Consistent with Principles of 42 CFR § 489.18

The aforementioned policy that a provider/supplier may only have one EFT account and one SPA per enrollment also applies to: (1) providers/suppliers submitting an initial enrollment application; and (2) new owners in a certified provider/supplier CHOW (i.e., a CHOW consistent with the principles of § 489.18). The contractor shall apply this policy to such applications. If, therefore, the provider/supplier/new owner submits the application with more than one EFT account or SPA, the contractor shall develop for a single EFT account or

SPA (as applicable) consistent with the instructions in this chapter. If the provider/supplier/new owner fails to comply within 30 days, the contractor shall reject the application pursuant to 42 CFR § 424.525(a)(1).