

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11576	Date: August 25, 2022
	Change Request 12868

SUBJECT: Final Round of Transition of Enrollment and Certification Activities for Various Certified Provider and Supplier Types and Transactions

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 10 of CMS Publication (Pub.) 100-08, Program Integrity Manual, with instructions regarding the processing of various certified provider and supplier enrollment transactions.

EFFECTIVE DATE: September 30, 2022

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

IMPLEMENTATION DATE: September 30, 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	10/10.2/10.2.1.3/End-Stage Renal Disease Facilities (ESRDs)
R	10/10.2/10.2.1.7/Hospices
R	10/10.2/10.2.1.8/Hospitals and Hospital Units
R	10/10.6/10.6.1.1/Changes of Ownership (CHOWs) - Transitioned Certified Providers and Suppliers
R	10/10.6/10.6.1.1.3.2/Step 2 – Post-Initial Review Actions and Scenarios
R	10/10.6/10.6.1.2/Changes of Information – Transitioned Certified Providers and Suppliers

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: 11576	Date: August 25, 2022	Change Request: 12868
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SUBJECT: Final Round of Transition of Enrollment and Certification Activities for Various Certified Provider and Supplier Types and Transactions

EFFECTIVE DATE: September 30, 2022

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

IMPLEMENTATION DATE: September 30, 2022

I. GENERAL INFORMATION

A. Background: As stated in previous CMS sub-regulatory guidance, CMS is "transitioning" certain administrative functions involving certified provider/supplier types and enrollment transactions from the CMS Survey & Operations Group (SOG) Locations to the Medicare Administrative Contractors (hereafter "contractors") and CMS' Provider Enrollment & Oversight Group. These transitions have occurred over several rounds. Effective September 30, 2022, the final round of enrollment transactions will transition. These will involve:

- End-stage renal disease (ESRD) facility initial enrollment applications, changes of ownership, and changes of information
- Hospice initial enrollment applications, changes of ownership, and changes of information
- Hospital initial enrollment applications, changes of ownership, and changes of information

This CR will update Chapter 10 of CMS Pub. 100-08 with instructions regarding the processing of these transactions, effective September 30, 2022.

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 MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12868.1	The contractor shall process ESRD facility, hospice, and hospital initial applications in accordance with the instructions in Chapter 10 of Pub. 100-08.	X								
12868.2	The contractor shall process ESRD facility,	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	hospice, and hospital change of ownership applications in accordance with Section 10.6.1.1 in Chapter 10 of Pub. 100-08.									
12868.3	The contractor shall process ESRD facility, hospice, and hospital change of information applications in accordance with Section 10.6.1.2 in Chapter 10 of Pub. 100-08.	X								
12868.4	The contractor shall, as applicable, utilize the model letters in Section 10.7.5.1 in Chapter 10 of Pub.100-08 for ESRD facility, hospice, and hospital enrollment applications.	X								
12868.5	The contractor shall observe that Business Requirements .1 through .4 apply to all applications other than those for which the contractor received a final decision (e.g., CMS-1539, CMS-2007 (tie-in notice)) from the state or SOG Location before October 3, 2022. (That is, they apply to all applications that -- (1) The contractor has not yet received from the	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	provider/supplier or has not yet sent to the state; or (2) Are pending with the state or SOG Location).									
12868.6	The contractor shall observe that - - unless it is directed otherwise -- any information it needs regarding the status of an ESRD facility, hospice, or hospital application it has already forwarded to the state shall be obtained from the state, rather than the SOG Location.	X								
12868.7	The contractor shall abide by the site visit instructions in Section 10.2.1.7 in Chapter 10 of Pub. 100-08.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

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:
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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. 11576; Issued: 08-25-2022)

10.2.1.3 - End-Stage Renal Disease Facilities (ESRDs)

(Rev. 11576; Issued: 08-25-22; Effective: 09-30-22; Implementation: 09-30-22)

(In this section 10.2.1.3, the terms “ESRD” and “ESRD facility” have the same meaning and will be used interchangeably).

A. General Background Information

ESRD facilities are entities that provide renal services and related care for patients with irreversible and permanent kidney failure. As ESRD facilities are technically “suppliers,” they sign a supplier agreement rather than a provider agreement. Even if the ESRD facility is a hospital unit, it signs an agreement that is separate and distinct from the hospital’s agreement. ESRD entities/facilities cannot be mobile.

The provider-based rules for ESRD facilities are outlined in 42 CFR § 413.174 and are slightly different than those in the main provider-based regulation (42 CFR § 413.65). (For instance, § 413.174 uses the term “hospital-based” as opposed to “provider-based.”)

The ESRD Network is a group of organizations under contract with CMS that serve as liaisons between the agency and ESRD providers. The organizations oversee the care that ESRD patients receive, collect data, and furnish technical assistance to ESRD providers and patients.

B. Types of ESRD Facilities

Pub. 100-07, *State Operations Manual*, lists several classifications of ESRD facilities. They are summarized as follows:

1. Hospital-Based ESRD Facility

A hospital-based ESRD facility is a separately certified ESRD facility that (1) is an outpatient department of a hospital and (2) meets the ESRD conditions of coverage at 42 CFR Part 494. A hospital-based ESRD facility is owned and administered by a hospital or critical access hospital and is physically located on the hospital campus. If a hospital operates multiple separately certified hospital-based ESRD facilities, each separate ESRD facility must have its own CCN and be separately enrolled.

A hospital-based ESRD facility is discussed at 42 CFR § 413.174(c) and *must* meet the criteria listed therein (e.g., ESRD facility and hospital have a common governing body and are financially integrated). Hospital-based ESRD facilities are assigned CCNs from the 2300-2499 series.

2. Satellite Renal Dialysis Facility (Hospital-Based)

A satellite renal dialysis facility is a hospital-owned and hospital-administered ESRD facility but is not located on the campus of the hospital. A single hospital may have several satellite renal dialysis facilities. Each satellite facility: (1) is separately certified and surveyed; (2) must independently meet the ESRD conditions of coverage; (3) is assigned its own CCN; and (4) be separately enrolled. Satellite renal dialysis facilities (hospital-based) are assigned CCNs in the 3500-3699 series.

3. Independent Renal Dialysis Facility

An independent renal dialysis facility is any *outpatient* ESRD facility that does not meet the definition of a hospital-based renal dialysis facility or satellite renal dialysis facility as

described in the paragraphs above. An independent renal dialysis facility may be physically located on a hospital campus, but it is not owned and/or administered by the hospital. Independent renal dialysis facilities are assigned CCNs in the 2500-2899 series and are individually enrolled.

4. Special Purpose Renal Dialysis Facility (SPRDF) (§ 494.120)

This type of renal disease facility is temporarily certified to furnish dialysis at special locations on a short-term basis (i.e., up to 8 months in any 12 month period) to a group of dialysis patients who would otherwise be unable to obtain treatment in the geographical area. The SOG Location must clearly specify the limited nature of the SPRDF certification, the time period covered by the certification, and the automatic termination of payment on the last day of the certification period in its notifications. The special locations for SPRDF fall into two categories:

(A) Vacation Camps - Vacation camps serve dialysis patients temporarily residing there. A vacation camp SPRDF would allow campers to receive hemodialysis at the camp site, avoiding interruption of the camping experience. Vacation camps may be approved for the duration of the camp but up to a maximum of 8 months in any 12-month period.

(B) Emergency Circumstance SPRDFs - These locations are set up to provide dialysis services to those ESRD patients who would otherwise be unable to obtain such services in their geographical area as a result of a natural or man-made disaster or a need for a greater capacity to dialyze patients who may have been evacuated from another location. The CMS SOG Location may extend the time period in emergency SPRDF approvals, where necessary, beyond the standard eight-month period based upon the termination of the emergency condition.

SPRDFs are assigned CCNs in the 3700-3799 series when owned and administered by a hospital and in the 2900-2999 series for independent facilities. *Although they are individually enrolled, they cannot convert to a permanent ESRD facility (i.e., to a non-SPRDF). They must instead reapply as a brand new ESRD facility and receive an initial certification survey.*

C. Processing Instructions for ESRD Initial Form CMS-855A Applications

An ESRD facility is separately and individually certified and does not have any branch, multiple, or parent locations. As such, each type of ESRD facility/location must independently and separately enroll as such via the Form CMS-855A; multiple sites cannot be listed on a single application.

Note that the instructions in this section 10.2.1.3(C) apply to all ESRD facility types except for SPRDFs. This ESRD type is not “transitioning” as that term is described in this chapter. *Accordingly, the contractor shall continue to process initial applications from SPRDFs consistent with longstanding instructions rather than those described in this section 10.2.1.3(C) (e.g., receiving the final approval from the SOG location rather than the state; no need to send the application to PEOG after final SOG location approval).*

1. Receipt of Application

Upon receipt of an initial ESRD Form CMS-855A application, the contractor shall undertake the following (in whichever order the contractor prefers unless directed otherwise in this chapter):

(A) Perform all data validations otherwise required per this chapter.

(B) Ensure that the application(s) is complete consistent with the instructions in this section 10.2.1.3 and this chapter.

(C) Ensure that the ESRD facility has submitted all documentation otherwise required per this chapter. For ESRD initial enrollment, this also includes the following:

- Evidence of successful electronic submission of the Form HHS-690 through the Office of Civil Rights (OCR) portal, as applicable. (Evidence should be either written or electronic documentation.) (See <https://www.hhs.gov/sites/default/files/forms/hhs-690.pdf> for more information.)*
- Part I of the Form CMS-3427A (End Stage Renal Disease Application and Survey and Certification Report) (See Pub. 100-07, chapter 2, section 2247B for more information on this form.)*
- A certificate of need (CON) if required by state law (though SPRDFs need not submit a CON)*

(The ESRD must complete and submit Part I of the Form CMS-3427A, though the ESRD need not complete those sections of the form reserved for CMS. For organizational ESRDs, an authorized official (as defined in § 424.502) must sign the form; for sole proprietorships, the sole proprietor must sign. Note that there is no provider agreement for ESRD facilities.)

Notwithstanding the foregoing, if the Form HHS-690, Part I of the Form-CMS-3427A, and/or CON evidence is missing, unsigned, undated, or otherwise incomplete, the contractor need not develop for the form(s) or the information thereon. (Nor need the contractor: (1) research individual state laws to ascertain whether the state requires a CON; or (2) review the data on the CON.) The contractor shall instead notify the state in its recommendation letter which document(s) was/were missing or otherwise incomplete. For all other missing or incomplete required documentation, the contractor shall follow the normal development instructions in this chapter.

2. Conclusion of Initial Contractor Review

(Nothing in this section 10.2.1.3(C) prohibits the contractor from returning or rejecting the ESRD application if otherwise permitted to do so per this chapter. When returning or rejecting the application, the contractor shall follow this chapter's procedures for doing so.)

(A) Approval Recommendation

If, consistent with the instructions in section 10.2.1.3(C) and this chapter, the contractor believes an approval recommendation is warranted, the contractor shall send the recommendation to the state pursuant to existing practice and this chapter's instructions. The contractor need not copy the SOG Location or PEOG on the recommendation. Unless CMS directs otherwise, the contractor shall also send to the provider the notification letter in section 10.7.5.1(E) of this chapter.

The state will: (1) review the recommendation package for completeness; (2) review the contractor's recommendation for approval; (3) perform any state-specific functions; and (4) contact the contractor with any questions. The contractor shall respond to any state inquiry in Item (4) within 5 business days. If the inquiry involves the need for the contractor to obtain additional data, documentation, or clarification from the ESRD, however, the timeframe is 15 business days; if the provider fails to respond to the contractor within this

timeframe, it shall notify the state thereof. The contractor may always contact its PEOG BFL should it need the latter's assistance with a particular state inquiry.

(B) Denial

If the contractor determines that a denial is warranted, it shall follow the denial procedures outlined in this chapter. This includes: (1) using the appropriate denial letter format in section 10.7.5.1 of this chapter; and (2) if required under section 10.6.6 (or another CMS directive) of this chapter, referring the matter to PEOG for review prior to denying the application.

3. Completion of State Review

The state will notify the contractor once it has completed its review. There are two potential outcomes:

(A) Approval Not Recommended

If the state does not recommend approval, it will notify the contractor thereof. (The contractor may accept any notification that is in writing (e-mail is fine).) No later than 5 business days after receiving this notification, the contractor shall commence the actions described in section 10.2.1.3(C)(2)(B) above.

(B) Approval Recommended

If the state recommends approval, it will typically do so via a Form CMS-1539; however, the contractor may accept any documentation from the state signifying that the latter recommends approval. (Note that the contractor will not receive a formal tie-in notice.)

No later than 5 business days after receipt of the recommendation from the state, the contractor shall send an e-mail to MedicareProviderEnrollment@cms.hhs.gov with the following information and documents:

- The Form CMS-855 application (or PECOS Application Data Report) and all application attachments*
- A copy of the Form CMS-1539 from the state or similar documentation received from the AO*
- A copy of the draft approval letter, with the effective date shown on the Form CMS-1539 (or similar documentation) included in the draft letter. (See section 10.7.5.1 for the model approval letter.)*

PEOG will review the documentation. Based on the information received from the contractor, PEOG will also (1) assign an effective date, (2) assign a CCN, and (3) enter the relevant data into the applicable national database, and (4) approve (with possible edits) the approval letter. Within 5 business days of receiving from PEOG the effective date, and CCN the contractor shall: (1) send the approval letter to the ESRD, with a copy to the state and/or AO (as applicable); and (2) switch the PECOS record from "approval recommended" to "approved" consistent with existing instructions.

D. Additional/Changed Stations

If an enrolled ESRD seeks to add/change services or stations (e.g., add ESRD services in SNFs, additional modalities), the ESRD need not submit a Form CMS-855A application to do so, for these services and stations do not constitute practice locations and cannot otherwise be reported on the application. Instead, the ESRD contacts the state or accreditation

organization (AO) to request these changes. The ESRD must complete a Form CMS-3427 and submit it to the state or AO (as applicable). A survey may be performed, and the state will update the applicable national database with any administrative changes.

The state will also send a CMS-1539 or approval letter to the contractor as notification of the additional/change service(s) or station(s). Consistent with longstanding practice, the contractor shall, as applicable, enter any relevant data on the CMS-1539/approval notice into its applicable system(s). (This may typically be needed for billing purposes.) No further action by the contractor is needed.

E. ESRD Location Changes

An ESRD facility that is changing its location must submit either a Form CMS-855A change of information application or an initial enrollment application. The specific transaction type involved (change request or initial) will depend on the particular situation. These situations include the following, and they will generally trigger the termination of the ESRD's existing CCN and the issuance of a new one.

(i) A hospital-based ESRD facility is relocating to an off-campus location in the same state.

In this situation, the ESRD's current CCN will be retired.

If the off-campus location will still function under a common governing body, operate under the hospital's policies and practices, continue to serve the same community, and utilize the same staff at this new location, the new CCN will be that of a renal satellite facility. The application can be processed as a change of information pursuant to the instructions in section 10.6.1.2(A).

If the off-campus location will no longer be operationally, administratively, or financially integrated with the hospital, the new CCN will be that of an independent dialysis facility. The hospital must voluntarily terminate this location from its enrollment, and the site must enroll as a new ESRD facility.

If the contractor has any questions as to whether the relocated location will still be sufficiently integrated with the hospital to permit a change of information application rather than an initial enrollment, the contractor may contact the state for guidance. The processing time clock stops while the contractor awaits the state's guidance.

(ii) An independent ESRD facility is relocating to become a hospital-based facility or a renal satellite facility of a hospital

Since the ESRD facility will be serving a different community under different policies, etc., the facility must terminate its existing enrollment and enroll as a new ESRD facility.

(iii) An independent ESRD facility is relocating to another location and will remain independent

If the ESRD facility will be serving a different community, the facility must terminate its existing enrollment and enroll as a new/initial ESRD facility. If it will serve the same community, the relocation can be processed as a change of information.

(iv) ESRD facility relocating out-of-state

If an ESRD facility of any type (e.g., independent, satellite) is relocating out-of-state --- and notwithstanding any other instruction to the contrary in this chapter ---- it must terminate its existing enrollment and enroll as an initial/new applicant.

F. CHOWs and Changes of Information

For ESRD CHOWs, the contractor shall follow the instructions in section 10.6.1.1 of this chapter. For ESRD changes of information, the contractor shall follow the instructions in section 10.6.1.2 of this chapter.

G. ESRD Survey and Certification

The standard CMS survey and certification form used for ESRDs is the Form CMS-3427. For more information on this form, see Pub. 100-07, chapter 2, section 2247B.

For further information on ESRD facilities, refer to:

- Section § 1881 of the Social Security Act
- 42 CFR Part 405, Subpart U
- Pub. 100-07, chapter 2, section 2270 – 2287B
- Pub. 100-02, chapter 11
- Pub. 100-04, Claims Processing Manual, chapter 8

10.2.1.7 - Hospices

(Rev. 11576; Issued:08-25-22; Effective: 09-30-22; Implementation: 09-30-22)

A. General Background Information

A hospice is a public agency or private organization or subdivision of either of these that is primarily engaged in providing a comprehensive set of services such as the assessment and management of pain. Typically, the need for services is identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.

B. *Processing Instructions for Hospice Initial Form CMS-855A Applications*

1. Receipt of Application

Upon receipt of a hospice initial Form CMS-855A application, the contractor shall undertake the following (in whichever order the contractor prefers unless directed otherwise in this chapter):

(A) Perform all data validations otherwise required per this chapter.

(B) Ensure that the application(s) is complete consistent with the instructions in this chapter.

(C) Ensure that the hospice has submitted all documentation otherwise required per this chapter. For hospice initial enrollment, this also includes the following:

- *Form CMS-1561 (Health Insurance Benefit Agreement, also known as a “provider agreement”)*
- *Evidence of successful electronic submission of the Form HHS-690 through the Office of Civil Rights (OCR) portal, as applicable. (Evidence should be either written or electronic documentation.) (See <https://www.hhs.gov/sites/default/files/forms/hhs-690.pdf> for more information.)*

(An authorized official of the hospice must complete, sign, date, and include the Form CMS-1561, though the hospice need not complete those sections of the form reserved for CMS.)

Notwithstanding the foregoing, if the Form CMS-1561 or the Form HHS-690 evidence is missing, unsigned, undated, or otherwise incomplete, the contractor need not develop for the form(s) or the information thereon; the contractor shall instead notify the state in its recommendation letter which document(s) was/were missing or otherwise incomplete. For all other missing or incomplete required documentation, the contractor shall follow the normal development instructions in this chapter.

2. Conclusion of Initial Contractor Review

(Nothing in this section 10.2.1.7(B) prohibits the contractor from returning or rejecting the hospice application if otherwise permitted to do so per this chapter. When returning or rejecting the application, the contractor shall follow this chapter’s procedures for doing so.)

(A) Approval Recommendation

If, consistent with the instructions in section 10.2.1.7(B)(2) and this chapter, the contractor believes an approval recommendation is warranted, the contractor shall send the recommendation to the state pursuant to existing practice and this chapter’s instructions. The contractor need not copy the SOG Location or PEOG on the recommendation. Unless CMS directs otherwise, the contractor shall also send to the provider the notification letter in section 10.7.5.1(E) of this chapter.

The state will: (1) review the recommendation package for completeness; (2) review the contractor’s recommendation for approval; (3) perform any state-specific functions; and (4) contact the contractor with any questions. The contractor shall respond to any state inquiry in Item (4) within 5 business days. If the inquiry involves the need for the contractor to obtain additional data, documentation, or clarification from the hospice, however, the timeframe is 15 business days; if the provider fails to respond to the contractor within this timeframe, it shall notify the state thereof. The contractor may always contact its PEOG BFL should it need the latter’s assistance with a particular state inquiry.

(B) Denial

If the contractor determines that a denial is warranted, it shall follow the denial procedures outlined in this chapter. This includes: (1) using the appropriate denial letter format in section 10.7.5.1 of this chapter; and (2) if required under section 10.6.6 (or another CMS directive) of this chapter, referring the matter to PEOG for review prior to denying the application.

3. Completion of State Review

The state will notify the contractor once it has completed its review. There are two potential outcomes:

(A) Approval Not Recommended

If the state does not recommend approval, it will notify the contractor thereof. (The contractor may accept any notification that is in writing (e-mail is fine).) The site visit described in subsection (D)(1) below need not be performed. No later than 5 business days after receiving this notification, the contractor shall commence the actions described in section 10.2.1.7(B)(2)(B) above.

(B) Approval Recommended

If the state recommends approval, it will typically do so via a Form CMS-1539; however, the contractor may accept any documentation from the state signifying that the latter recommends approval. (Note that the contractor will not receive a formal tie-in notice.)

No later than 5 business days after receipt of the recommendation from the state, the contractor shall order the site visit described in subsection (D)(1) below.

If the hospice fails the site visit, the contractor shall follow the denial procedures addressed in subsection (B)(2)(B) above. If the hospice passes the site visit, the contractor (within 3 business days of completing its review of the results) shall send an e-mail to MedicareProviderEnrollment@cms.hhs.gov with the following information and documents:

- The Form CMS-855 application (or PECOS Application Data Report) and all application attachments*
- A copy of the Form CMS-1539 from the state or similar documentation received from the accrediting organization*
- A copy of the provider-signed Form CMS-1561*
- A copy of the draft approval letter, with the effective date shown on the Form CMS-1539 (or similar documentation) included in the draft letter. (See section 10.7.5.1 for the model approval letter.)*

PEOG will countersign the provider agreement. Based on the information received from the contractor, PEOG will also (1) assign an effective date, (2) assign a CCN, and (3) enter the relevant data into the applicable national database and (4) approve (with possible edits) the approval letter. Within 5 business days of receiving from PEOG the signed provider agreement, effective date, and CCN, the contractor shall: (1) send the approval letter and a copy of the CMS-countersigned provider agreement to the hospice; (2) send a copy of both the approval letter and the provider agreement to the state and/or accrediting organization (as applicable); and (3) switch the PECOS record from “approval recommended” to “approved” consistent with existing instructions.

C. Multiple Practice Locations

Hospices are not precluded from having multiple practice locations if permitted by the *state*. If the *state* disapproves an additional practice location, the location must seek Medicare approval as a separate hospice with its own enrollment and provider agreement. (See Pub. 100-07, chapter 2, section 2088 for the policies regarding multiple hospice locations.)

If the hospice submits a change of information application to add or relocate a practice location, the contractor shall process the application consistent with section 10.6.1.2(A) of this chapter. The contractor should be aware, however, that the state may not approve the location addition/change

D. Site Visits

1. Initial application - The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not convey Medicare billing privileges to the provider prior to the completion of the NSVC's site visit and the contractor's review of the results.

2. Revalidation – If a hospice submits a revalidation application, the contractor shall order a site visit through PECOS. This is to ensure that the provider is still in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the revalidation application prior to the completion of the NSVC's site visit and the contractor's review of the results.

3. New/changed location - If a hospice is (1) adding a new location or (2) changing the physical location of an existing location, the contractor shall order a site visit of the new/changed location through PECOS new/changed location through PECOS *no later than 5 business days after the contractor receives the approval recommendation from the state but before the contractor sends to PEOG the applicable e-mail described in section 10.6.1.2(A)(3) of this chapter. (See the latter section for more information.)* This is to ensure that the new/changed location is in compliance with CMS's enrollment requirements. The scope of the site visit will be consistent with sections 10.6.20(A) and 10.6.20(B) of this chapter. The NSVC will perform the site visit. The contractor shall not make a final decision regarding the change of information application prior to the completion of the NSVC's site visit and the contractor's review of the results.

E. Additional Information:

For more information on hospices, refer to:

- Sections 1861(u) and 1861(dd) of the Social Security Act
- 42 CFR Part 418
- Pub. 100-07, chapter 2, sections 2080 – 2089
- Pub. 100-04, chapter 11
- Pub. 100-02, chapter 9

10.2.1.8 - Hospitals and Hospital Units

(Rev. 11576; Issued:08-25-22; Effective: 09-30-22; Implementation: 09-30-22)

(This section 10.2.1.8 applies to “standard” hospitals (as the term “hospital” is defined in § 1861(e)(1)), psychiatric hospitals, hospital units, and transplant programs. It does not apply to critical access hospitals, which are a separate provider type and are not “transitioning.”)

A. General Background Information

Hospitals and hospital units are a provider type that enrolls via the Form CMS-855A. An exception to this is when the hospital is requesting enrollment to bill for practitioner services for hospital departments, outpatient departments, outpatient locations, and/or hospital clinics; in this circumstance, a new Form CMS-855B enrollment application is required.

B. *Processing Instructions for Hospital Initial Form CMS-855A Applications*

1. Receipt of Application

Upon receipt of a hospital initial Form CMS-855A application, the contractor shall undertake the following (in whichever order the contractor prefers unless directed otherwise in this chapter):

(A) Perform all data validations otherwise required per this chapter.

(B) Ensure that the application(s) is complete consistent with the instructions in this chapter.

(C) Ensure that the hospital has submitted all documentation otherwise required per this chapter. For hospital initial enrollment, this also includes the following:

- Form CMS-1561 (Health Insurance Benefit Agreement, also known as a “provider agreement”)*
- Evidence of successful electronic submission of the Form HHS-690 through the Office of Civil Rights (OCR) portal, as applicable. (Evidence should be either written or electronic documentation.) (See <https://www.hhs.gov/sites/default/files/forms/hhs-690.pdf> for more information.)*

(An authorized official (as defined in § 424.502) must complete, sign, date, and include the Form CMS-1561, though the hospital need not complete those sections of the form reserved for CMS.)

Notwithstanding the foregoing, if the Form CMS-1561 or the Form HHS-690 evidence is missing, unsigned, undated, or otherwise incomplete, the contractor need not develop for the form(s) or the information thereon; the contractor shall instead notify the state in its recommendation letter which document(s) was/were missing or otherwise incomplete. For all other missing or incomplete required documentation, the contractor shall follow the normal development instructions in this chapter.

2. Conclusion of Initial Contractor Review

(Nothing in this section 10.2.1.8(B) prohibits the contractor from returning or rejecting the hospital application if otherwise permitted to do so per this chapter. When returning or rejecting the application, the contractor shall follow this chapter’s procedures for doing so.)

(A) Approval Recommendation

If, consistent with the instructions in section 10.2.1.8(B)(2) and this chapter, the contractor believes an approval recommendation is warranted, the contractor shall send the recommendation to the state pursuant to existing practice and this chapter’s instructions. The contractor need not copy the SOG Location or PEOG on the recommendation. Unless CMS directs otherwise, the contractor shall also send to the provider the notification letter in section 10.7.5.1(E) of this chapter.

The state will: (1) review the recommendation package for completeness; (2) review the contractor’s recommendation for approval; (3) perform any state-specific functions; and (4) contact the contractor with any questions. The contractor shall respond to any state inquiry in Item (4) within 5 business days. If the inquiry involves the need for the contractor to obtain additional data, documentation, or clarification from the hospital, however, the timeframe is 15 business days; if the provider fails to respond to the contractor within this timeframe, it shall notify the state thereof. The contractor may always contact its PEOG BFL should it need the latter’s assistance with a particular state inquiry.

(B) Denial

If the contractor determines that a denial is warranted, it shall follow the denial procedures outlined in this chapter. This includes: (1) using the appropriate denial letter format in

section 10.7.5.1 of this chapter; and (2) if required under section 10.6.6 (or another CMS directive) of this chapter, referring the matter to PEOG for review prior to denying the application.

3. Completion of State Review

The state will notify the contractor once it has completed its review. There are two potential outcomes:

(A) Approval Not Recommended

If the state does not recommend approval, it will notify the contractor thereof. (The contractor may accept any notification that is in writing (e-mail is fine).) The site visit described in subsection (D)(1) below need not be performed. No later than 5 business days after receiving this notification, the contractor shall commence the actions described in section 10.2.1.8(B)(2)(B) above.

(B) Approval Recommended

If the state recommends approval, it will typically (though not always) do so via a Form CMS-1539; the contractor may accept any documentation from the state signifying that the latter recommends approval. (Note that the contractor will not receive a formal tie-in notice.)

No later than 5 business days after receipt of the recommendation from the state, the contractor shall send an e-mail to MedicareProviderEnrollment@cms.hhs.gov with the following information and documents:

- The Form CMS-855 application (or PECOS Application Data Report) and all application attachments*
- A copy of the Form CMS-1539 from the state or similar documentation received from the accrediting organization*
- A copy of the provider-signed Form CMS-1561*
- A copy of the draft approval letter, with the effective date shown on the Form CMS-1539 (or similar documentation) included in the draft letter. (See section 10.7.5.1 for the model approval letter.)*

PEOG will countersign the provider agreement. Based on the information received from the contractor, PEOG will also (1) assign an effective date, (2) assign a CCN, and (3) enter the applicable data into the applicable national database, and (4) approve (with possible edits) the approval letter. Within 5 business days of receiving from PEOG the signed provider agreement, effective date, and CCN, the contractor shall: (1) send the approval letter and a copy of the CMS-countersigned provider agreement to the hospital; (2) send a copy of both the approval letter and the provider agreement to the state and/or accrediting organization (as applicable); and (3) switch the PECOS record from “approval recommended” to “approved” consistent with existing instructions.

C. Additional Enrollment Information

1. Swing-Bed Designation

A “swing-bed” hospital is one that is approved by CMS to furnish post-hospital skilled nursing facility (SNF) services. That is, hospital (or critical access hospital (CAH)) patients’ beds can “swing” from furnishing hospital services to providing SNF care without the patient necessarily being moved to another part of the building. It receives a separate survey and

certification from that of the hospital. Thus, if swing-bed designation is terminated, the hospital still maintains its certification. In addition, the hospital is given an additional CCN to bill for swing-bed services. (The third digit of the CCN will be the letter U, W, Y or Z.)

In general, and as stated in 42 CFR § 482.58, in order to obtain swing-bed status the hospital must, among other things: (1) have a Medicare provider agreement; (2) be located in a rural area; and (3) have fewer than 100 non-newborn or intensive care beds. Swing-bed hospitals, therefore, are generally small hospitals in rural areas where there may not be enough SNFs, and the hospital is thus used to furnish SNF services.

A separate provider agreement and enrollment for the swing-bed unit is not required. (The hospital's provider agreement incorporates the swing-bed services.) The hospital can add the swing-bed unit as a practice location via the Form CMS-855A.

Additional data on "swing-bed" units can be found in Pub. 100-07, chapter 2, sections 2036 – 2040.

2. Psychiatric and Rehabilitation Units

Though these units receive a state survey, a separate provider agreement and enrollment is not required. (The hospital's provider agreement incorporates these units.) The hospital can add the unit as a practice location to the Form CMS-855A.

3. Multi-Campus Hospitals

A multi-campus hospital (MCH) has two or more hospital campuses operating under one CCN. The MCH would report its various units/campuses as practice locations on the Form CMS-855A. For additional information on multi-campus hospitals, see Pub. 100-07, chapter 2, section 2024.

4. Physician-Owned Hospitals

As defined in 42 CFR § 489.3, a physician-owned hospital (POH) means any participating hospital (as defined in 42 CFR §489.24) in which a physician or an immediate family member of a physician has an ownership or investment interest in the hospital. The ownership or investment interest may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in the hospital. (This definition does not include a hospital with physician ownership or investment interests that satisfy the requirements at 42 CFR § 411.356(a) or (b).)

Section 2(A)(4) of the Form CMS-855A asks the applicant to identify whether it is a physician-owned hospital. If the applicant indicates in Section 2(A)(2) that it is a hospital, it must complete Section 2(A)(4). Applicants that are not hospitals need not complete Section 2(A)(4).

At this time, POHs are not required to submit a completed Form CMS-855POH or a completed Attachment 1 of the Form CMS-855A. As stated in the March 12, 2015 announcement in MLN Connects Provider eNews, CMS has extended the deadline for the POH Initial Annual Ownership/Investment Report due to concerns about the accuracy of the data collected in the report. Future instruction regarding the reporting of POH ownership and investment will be provided on the CMS physician self-referral website.

5. Critical Access Hospitals

Critical access hospitals (CAHs) are not considered to be a hospital sub-type for enrollment purposes. CAHs instead must be enrolled as a separate, distinct provider type. Thus, if an existing hospital wishes to convert to a CAH, it must submit a Form CMS-855A as an initial enrollment.

6. Hospital Addition of Practice Location

In situations where a hospital is adding a practice location, the contractor shall notify the provider in writing that its recommendation for approval does not constitute approval of the facility or group as provider-based under 42 CFR § 413.65.

If the contractor makes a recommendation for approval of the provider's request to add a hospital unit, the contractor shall forward the package to the state agency as described in this chapter.

7. Transplant Programs

A transplant program is a component within a transplant hospital that provides transplantation of a particular type of organ to include: heart, lung, liver, kidney, pancreas, or intestine. All organ transplant programs must be located in a hospital that has a Medicare provider agreement. The transplant program will receive a CCN that is separate and distinct from the hospital.

For purposes of Medicare enrollment, a hospital transplant program is treated similarly to a hospital sub-unit. If the hospital wishes to add a transplant program, it must check the "other" box in Section 2A2 of the Form CMS-855A, write "transplant program" (and the type(s) thereof, such as liver transplant program, kidney transplant program, etc.) on the space provided, and follow the standard instructions for adding a hospital sub-unit. (If multiple types of transplant programs are listed, the contractor shall (a) treat each as a separate sub-unit for enrollment purposes and (b) process the application in the same fashion it would a hospital application that is reporting/adding multiple sub-units.) No separate enrollment in PECOS need be created for the transplant center.

D. Section 4 of the Form CMS-855A

Regarding Section 4 of the Form CMS-855A, the hospital must list all addresses where it - and not a separately enrolled provider or supplier it owns or operates, such as a nursing home - furnishes services. The hospital's primary practice location should be the first location identified in Section 4A and the contractor shall treat it as such - unless there is evidence indicating otherwise. NOTE: Hospital departments located at the same address as the main facility need not be listed as practice locations on the Form CMS-855A.

If an enrolled hospital seeks to add *or delete* a rehabilitation, psychiatric, or swing-bed unit, it should submit a Form CMS-855 change of information request and not, *respectively*, an initial enrollment application *or a voluntary termination application*.

E. Non-Participating Emergency Hospitals, Veterans Administration (VA) Hospitals, and Department of Defense (DOD) Hospitals

Non-participating emergency hospitals, VA hospitals and DOD hospitals no longer need to complete a Form CMS-855A enrollment application in order to bill Medicare.

F. Form CMS-855B Applications Submitted by Hospitals

1. Group Practices

If an entity is enrolling via the Form CMS-855B as a hospital-owned clinic/physician practice, the contractor shall contact the applicant to determine whether the latter will be billing any of the listed locations as provider-based. If the applicant will not be billing as provider-based, the contractor shall process the application normally. If, however, the applicant will bill as provider-based, the contractor shall notify the applicant that the hospital must report any changed practice locations to its contractor via the Form CMS-855A.

If the supplier is enrolling as a hospital department (under the “Clinic/Group Practice” category on the Form CMS-855B) or an existing hospital department is undergoing a change of ownership (CHOW), the contractor shall only issue the necessary billing numbers upon notification that a provider agreement has been issued – or, in the case of a CHOW, the provider agreement has been transferred to the new owner. If, however, the supplier is enrolling as a group practice that is merely owned by a hospital (as opposed to being a hospital department), the contractor need not wait until the provider agreement is issued before conveying billing privileges to the group.

2. Individual Billings

Assume an individual physician works for a hospital and will bill for services as an individual (i.e., not as part of the hospital service/payment). However, he/she wants to reassign these benefits to the hospital. The hospital will need to enroll with the contractor via the Form CMS-855B (e.g., as a hospital department, outpatient location).

10.6.1.1 – Changes of Ownership (CHOWs) – Transitioned Certified Providers and Suppliers

(Rev. 11576; Issued: 08-25-22; Effective: 09-30-22; Implementation: 09-30-22)

(Until further notice from CMS, the instructions in sections 10.6.1.1 through 10.6.1.1.4 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, ASCs, PXRSSs, *hospitals, hospices, and ESRD facilities*. The contractor shall continue to use the existing CHOW instructions--now in section 10.6.22 of this chapter--for all non-transitioned certified provider/supplier types.

When executing the instructions in sections 10.6.1.1 through 10.6.1.1.4, the contractor can disregard directives that obviously do not apply to the provider/supplier type in question (e.g., references to home health agencies do not apply to SNFs).

Except as otherwise noted, the term “CHOW” as used in section 10.6.1.1 et seq. includes CHOWs, acquisitions/mergers, and consolidations. Though the Change of Ownership (CHOW) Information section of the Form CMS-855A separates the applicable transactions into CHOWs, acquisition/mergers, and consolidations for ease of disclosure and reporting, they fall within the general CHOW category under 42 CFR § 489.18 (e.g., an acquisition/merger is a type of CHOW under § 489.18).

Note that the CHOW instructions in 10.6.1.1 through 10.6.1.1.4 apply to HHA CHOWs taking place under 42 CFR § 489.18. For changes in majority ownership under 42 CFR § 424.550(b), see section 10.2.1.6.1 of this chapter.

10.6.1.1.3.2 – Step 2 – Post-Initial Review Actions and Scenarios

(Rev. 11576; Issued: 08-25-22; Effective: 09-30-22; Implementation: 09-30-22)

After the contractor completes the tasks in section 10.6.1.1.3.1, several results are possible. These are discussed below. Should the contractor encounter a scenario not addressed herein, it may contact its PEOG BFL for guidance. As a reminder, nothing in section 10.6.1.1.3.2 prohibits the contractor from returning or rejecting the application if otherwise permitted to do so per this chapter.

A. Scenarios

1. The contractor ascertains that the transaction falls within the scope of § 489.18 and that the new owner has accepted assignment – If there are no apparent grounds for denying the application (e.g., the new owner has a felony conviction, false information was submitted, a newly reported chief executive officer is excluded), the contractor shall make a recommendation for approval to the state consistent with existing practice and via existing means. (This includes sending recommendations via hard copy mail if the state only accepts this method of transmission.) If a denial ground exists, however, the contractor shall refer the matter to its PEOG BFL for guidance before submission to the state, notwithstanding any other instruction in this chapter to the contrary. The contractor should include an explanation of the ground(s) it believes exists for the denial (including the regulatory citation).

(For Form CMS-855B CHOW applications: Note that an approval recommendation can be made (and must be treated as a CHOW) notwithstanding the general rule that a TIN change constitutes an initial enrollment; in other words, the reporting rules regarding CHOWs/assignments in this particular situation take precedence over the “change of TIN” principle.)

2. The contractor ascertains that the transaction falls within the scope of § 489.18 but the new owner has not accepted assignment – The contractor shall:
(a) return the application; and (b) notify the new owner in the return letter that it must submit the following within 30 days from the date of the return letter: (i) an initial Form CMS-855 application to enroll as a new provider; and (ii) a voluntary termination application for the existing provider. If the new owner fails to do so within 30 days of the request, the contractor shall contact its PEOG BFL via e-mail with this information notwithstanding any other instruction to the contrary in this chapter. PEOG will review the matter and respond to the contractor.

3. The contractor ascertains that the transaction does not fall within the scope of § 489.18 (e.g., stock transfer), regardless of whether the new owner accepted assignment - This qualifies as an ownership change under 42 CFR § 424.516 rather than a CHOW under § 489.18. The contractor shall: (a) return the application; and (b) notify the provider in the return letter that it must submit a Form CMS-855 application to report the ownership change within 30 days of the return letter. If the provider fails to do so, the contractor shall contact its PEOG BFL via e-mail with this information notwithstanding any other instruction to the contrary in this chapter.

(The only exception to the policies in the previous paragraph is if (1) the submission is a Form CMS-855B and (2) the § 424.516 ownership change also involves a change of TIN. In this scenario, the contractor shall: (a) return the application; and (b) notify the supplier in the return letter that it must submit the following within 30 days from the date of the return letter: (i) an initial Form CMS-855B application to enroll as a new supplier; and (ii) a voluntary termination application. If the supplier fails to do so, the contractor shall contact its PEOG BFL the contractor shall contact its PEOG BFL via e-mail with this information notwithstanding any other instruction to the contrary in this chapter.

B. Referral to State

If the contractor believes that a recommendation for approval per section 10.6.1.1.3.2(A)(1) is warranted, it shall send a recommendation letter to the state (with a copy to the accreditation organization (AO), if applicable). The letter shall follow the format of existing model CHOW recommendation letters in section 10.7 et seq. of this chapter. (Neither the SOG Location nor PEOG need be copied on the letter.) The CHOW package shall: (1) be sent to the state in a manner consistent with existing and past practice; and (2) contain all the applicable documents described in section 10.6.1.1.3.1(A)(iii) above. (For instance, the package must include, among other things, the CMS-377 for ASC and the CMS-3427 for ESRD facilities.) *For hospital CHOWs, the contractor shall also note in either the recommendation letter or the accompanying e-mail whether the hospital currently has any active sub-units reported in PECOS (e.g., psychiatric unit, transplant program).*

The state will: (1) review the package for completeness; (2) review the contractor's recommendation for approval; (3) perform any state-specific functions; and (4) contact the contractor with any questions. The contractor shall respond to any state inquiry in Item (4) within 5 business days. If the inquiry involves the need for the contractor to obtain additional data, documentation, or clarification from the provider, however, the timeframe is 15 business days; if the provider fails to respond to the contractor within this timeframe, it shall notify the state thereof. The contractor may always contact its PEOG BFL should it need the latter's assistance with a particular state inquiry.

10.6.1.2 – Changes of Information – Transitioned Certified Providers and Suppliers

(Rev. 11576; Issued: 08-25-22; Effective: 09-30-22; Implementation: 09-30-22)

(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, PXRSSs, *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 of hospital physician/practitioner group 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.)
- Excluding hospital physician/practitioner group practice locations, change and/or relocation of a practice location regardless of whether a survey of the new site may be required.

- 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 voluntarily 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
- Except as described in section 10.6.1.2(A), addition of hospital practice location
- 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.