

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash –

Revised products from the Medicare Learning Network® (MLN)

- [“Long Term Care Hospital Prospective Payment System: High Cost Outliers,”](#) Fact Sheet, ICN 006396, Downloadable only.

MLN Matters® Number: MM8155 **Revised**

Related Change Request (CR) #: CR 8155

Related CR Release Date: May 16, 2013

Effective Date: March 18, 2013

Related CR Transmittal #: R462PI

Implementation Date: March 18, 2013

Update to Chapter 15 of the Program Integrity Manual (PIM)

Note: This article was revised on May 20, 2013, to reflect a updated change request (CR). The CR removed changes that were made to Section 15.5.20 of the PIM. The CR release date, transmittal number and link to the transmittal were also changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Carriers, A/B Medicare Administrative Contractors (A/B MACs), Fiscal Intermediaries (FIs), or Medicare Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8155 to alert providers of updates to Chapter 15 of the “Medicare Program Integrity Manual (PIM).” Chapter 15 deals with Medicare provider enrollment and CR8155 highlights the issues below. Make sure your staff is familiar with the Key Points of this MLN Matters® Article.

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Key Points

The following are the provider enrollment issues addressed in CR8155:

1. **Owning and Managing Individuals:** If your Medicare contractor is unsure as to whether the officers and directors/board members of the enrolling provider or supplier's corporate owner/parent also serve as the enrolling provider or supplier's officers and directors/board members, your contractor will contact you for clarification.
2. **If there is a Change in Correspondence or Special Payments Address/Change of Electronic Funds Transfer (EFT) Information:** Your Medicare contractor may confirm the change with the contract person listed.
3. **Rejections:** Your Medicare contractor may reject an application that was signed more than 120 days prior to the date on which the contractor received the application—assuming the provider or supplier failed to furnish a new, appropriately-signed certification statement within 30 days of the contractor's request to do so.
4. **Timeframe:** Absent a CMS instruction or directive to the contrary, your Medicare contractor will send a rejection letter no later than five business days after the contractor concludes that the provider or supplier's application should be rejected.
5. **Be Aware:** If your contractor rejects an application, it will either (1) keep the original application and all supporting documents, or (2) make a copy or scan of the application and documents and return the originals to the provider. If the contractor chooses the former approach and the provider requests a copy of its application, the contractor may fax or mail it to the provider.
6. **Potential Identity Theft or Other Fraudulent Activity:** In conducting the verification activities described in Section 15.7.5 of Chapter 15, if the contractor believes that a case of identity theft or other fraudulent activity likely exists, the contractor will notify its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) at CMS immediately.
7. **Non-Certified Suppliers and Individual Practitioners:** Absent a CMS instruction or directive to the contrary, an approval letter under Section 15.9.1 of Chapter 15 will be sent no later than five business days after the contractor concludes that the provider or supplier meets all Medicare requirements and that his/her/its application can be approved.
8. **Unsolicited Additional Information:** Any new or changed information that a provider submits prior to the date the contractor finishes processing a previously submitted change request is no longer considered to be an update to that change request; rather, it is considered to be and will be processed as a separate change request. The contractor may process both changes simultaneously, but the change that was submitted first will be processed to completion prior to the second one being processed to completion.
9. **Miscellaneous Policies:** In situations where a provider with multiple PTANs is to be deactivated for non-billing, the contractor will only deactivate the non-billing PTAN(s).
10. **Partnerships:** Only partnership interests in the enrolling provider need be disclosed in section 5 of the Form CMS-855. 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

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percent indirect ownership interest in the enrolling provider, this indirect ownership interest would have to be disclosed in section 5.

11. **Processing and Approval of Corrective Action Plans (CAPs):** The contractor shall process a CAP within 60 days of receipt. During this period, the contractor shall not toll the filing requirements associated with a reconsideration request. If the contractor approves a CAP, it shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For new or restored billing privileges – and unless stated otherwise in another CMS directive or instruction - the effective date is based on the date the supplier came into compliance with all Medicare requirements.

Additional Information

You can find the official instruction, CR8155, issued to your carrier, FI, A/B MAC, or RHHI by visiting <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R462PI.pdf> on the CMS website. The entire revised Chapter 15 of the PIM is attached to that CR.

To review other changes to Chapter 15 issued in November of 2012, you may refer to MM8019 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8019.pdf> on the CMS website.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

News Flash - Flu Season Isn't Over – Continue to Recommend Vaccination - While each flu season is different, flu activity typically peaks in February. Yet, even in February, the flu vaccine is still the best defense against the flu. The [CDC](#) recommends yearly flu vaccination for everyone 6 months of age and older; and although anyone can get the flu, adults 65 years and older are at greater risk for serious flu-related complications that can lead to hospitalization and death. Every office visit is an opportunity to check your patients' vaccination status and encourage flu vaccination when appropriate. And getting vaccinated is just as important for health care personnel who can get sick with the flu and spread it to family, colleagues and patients. Be an example by getting your flu vaccine and know that you're helping to reduce the spread of flu in your community. Note: influenza vaccines and their administration fees are covered Part B benefits. Influenza vaccines are NOT Part D-covered drugs. *For More Information:*

- 2012-2013 [Seasonal Influenza Vaccines Pricing](#).
- [MLN Matters® Article MM8047](#), "Influenza Vaccine Payment Allowances - Annual Update for 2012-2013 Season."
- [CMS Medicare Learning Network® 2012-2013 Seasonal Influenza Virus Educational Products and Resources](#) and [CMS Immunizations](#) web pages for information on coverage and billing.
- [HealthMap Vaccine Finder](#) – a free, online service where users can find nearby locations offering flu vaccines as well as other vaccines for adults.
- The [CDC's](#) website offers a variety of provider resources for the 2012-2013 flu season.

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