DEPARTMENT: Reimbursement	**POLICY DESCRIPTION:** Requirements for Providers/Suppliers to Establish and Maintain the Medicare Enrollment Application (CMS-855)
PAGE: Page 1 of 3	**REPLACES POLICY DATED:** 9/1/09, 5/15/10, 5/1/14, 9/1/17
EFFECTIVE DATE: April 1, 2020	**REFERENCE NUMBER:** RB.016
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All Company-affiliated Facilities including, but not limited to, hospitals, ambulatory surgery centers, home health agencies, physician practices, service centers, outpatient imaging centers, and all Corporate Departments, Groups, Divisions and Markets.

Leadership of the Ambulatory Surgery Division will provide guidance as to how facilities in the Ambulatory Surgery Division are to operationalize the requirements of this policy.

PURPOSE: To receive payment for covered Medicare items or services from either Medicare (in the case of an assigned claim) or a Medicare beneficiary (in the case of an unassigned claim), a provider or supplier must be enrolled in the Medicare program. Once enrolled, the provider or supplier receives billing privileges for an item that was furnished or a service that was rendered and is issued a valid billing number. (See 45 CFR Part 162 for information on the National Provider Identifier and its use as the Medicare billing number.)

The purpose of this policy is to establish protocols for the completion and maintenance of the Medicare Enrollment Application (CMS-855) which is the mechanism used by CMS to gather information on providers and suppliers. It is also used for the purpose of authorizing billing numbers and establishing eligibility to furnish services to Medicare beneficiaries. Compliance is extremely important to avoid the deactivation or revocation of billing privileges.

POLICY: All Company-affiliated facilities that bill or have bills submitted on their behalf for Medicare services must adhere to regulatory guidelines outlined in Subpart P of the Code of Federal Regulation. Such regulations contain the requirements for enrollment, periodic resubmission and certification of enrollment information for revalidation. The CMS-855 is also used for timely reporting of updates and changes to enrollment information. Failure to comply with the regulation can result in deactivation or even revocation of billing privileges. Deactivation is where **billing privileges are stopped**, but can be restored upon the submission of updated information. Revocation is where **billing privileges are terminated.**

Enrollment

All Company-affiliated facilities should have a current completed Medicare Enrollment Application available. If not, and the prior application was filed using CMS' internet-based Provider Enrollment, Chain and Ownership System (PECOS), the most current application can be accessed via https://pecos.cms.hhs.gov. If the prior application was not filed using PECOS, the Fiscal Intermediary/Medicare Administrative Contractor (FI/MAC) – Provider Enrollment division may be contacted for the most recent application.

Timely Reporting of Updates and Changes to Enrollment Information

CMS may deactivate a provider or supplier's Medicare billing privileges if the provider or supplier does not report a change to the information supplied on the enrollment application within 30 calendar days for a change in ownership or control, or 90 calendar days for all other changes (different requirements for IDTFs, physicians, nonphysician practitioners, physician and nonphysician practitioner organizations).

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Common occurrences in hospitals which require reporting are:

- Change in Authorized Official (typically the CEO) - update section 15 within 30 days
- Change in Delegated Official (typically the CFO) – update section 16 within 30 days
- Change in Managing Employees – update section 6 within 90 days; these are typically the CEO & CFO, and therefore should be updated at the same time as sections 15 and 16 (within 30 days)
- Board of Directors change (section 6 – Director/Officer/90 days)
- Opening/Closing of provider-based entities (section 4 – Practice Locations/90 days)

Periodic Resubmission and Certification of Enrollment Information for Revalidation

Each Provider or supplier must resubmit and recertify the accuracy of its enrollment information every 5 years. CMS will contact the provider when it is time to revalidate their enrollment information. The revalidation process could include on-site inspections by CMS. CMS also has the right to perform off cycle revalidations.

CMS may revoke a provider's billing privileges and any other corresponding provider agreement if the provider fails to furnish complete and accurate information. Enrollment applications for resubmission or recertification along with supporting documentation must be filed within 60 calendar days of the provider's notification from CMS. Hospital claims that include a service location address will only be processed by the FI/MAC if the address is an exact match to a practice location reported in Section 4 – Practice Locations.

DEFINITIONS:

Authorized Official is the individual to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statues, regulations, and program instructions of the Medicare program (for example chief executive officer, chief financial officer, general partner, chairman of the Board, or direct owner).

Delegated Official is an individual who is delegated by the Authorized Official the authority to report changes and updates to the enrollment record. The delegated official must be an individual with ownership or control interest in, or be a W-2 managing employee of the provider.

PROCEDURE:

1. A completed copy of the Medicare Enrollment Application will be maintained by the facility's Authorized Official and his/her Delegated Official.

2. On a monthly basis, the facility's Ethics and Compliance Officer with the Authorized Official and/or the Delegated Official will review the Medicare Enrollment Application for any changes, including adverse legal actions and/or convictions, legal names as well as changes to the provider's ownership interest and control information. This step will be documented on the ECO Checklist of

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Responsibilities.

3. The Authorized Official and/or the Delegated Official will be responsible for submitting any changes to the provider's FI/MAC within the appropriate timeframe (30 or 90 calendar days, as noted under Policy). Prior to submission, legal operations counsel must be contacted to verify if changes that involve adverse legal actions/convictions, legal names and changes to the provider's ownership interest and control information have been properly reported. To ensure compliance regarding the service location address, changes to Section 4 – Practice Locations should be sent to the applicable Division Reimbursement Director and the Regs Helpline for approval prior to submission. Changes should be submitted electronically using PECOS.

4. The Authorized Official and/or the Delegated Official will follow up with the FI/MAC to ensure all changes have been received and accepted within 60 days of submission of the changes. Any additional information requested by the FI/MAC will be submitted within the requested time frame.

REFERENCES:

1. 42 CFR 424.80, 500ff, 502, 515, 516, 517, 535(a)(6), 535(a)(7), 540(a), 550(b)
2. 42 CFR 489.18, 42 CFR 505
3. Medicare Program Integrity Manual (CMS Pub 100-08)
4. http://www.cms.hhs.gov/MedicareProviderSupEnroll