CHANGE REQUEST 1199

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NEW/REVISED MATERIAL-- ***EFFECTIVE DATE: July 1, 2000***
IMPLEMENTATION DATE: July 15, 2000

The purpose of this manual issuance is to clarify HCFA's policy on the issue of whether an air ambulance supplier must have a practice location in a State it flies to in order to receive a billing number in that State.

Section 1030.5, Enrollment Procedures for General Application, this addresses the question of whether an air ambulance supplier must have a practice location in a State it flies to in order to receive a billing number in that State.

HCFA received an inquiry from an air ambulance supplier that flies to various States throughout the nation, picks up patients, and transports them to a facility in the supplier's home State. The supplier had been attempting to enroll with carriers in each of these various States. It did so based on the general principle - outlined in MCM, Part 3, §3102(C)(2) - that the carrier serving the home base of the ambulance company that transports the patient on the first leg of the trip has jurisdiction over all claims arising from the trip. For instance, a hospital patient in State X wants additional care at a facility in State Y. A ground ambulance company based in State X takes the patient to the airport. The air ambulance supplier flies her to an airport in State Y, and then a ground ambulance company in State Y takes her to the State Y facility in question. The carrier serving the State X ground ambulance company thus has jurisdiction over all claims concerning the trip, including the air ambulance supplier's claim. This is because the State X ground ambulance company was responsible for the first leg of the entire trip. In addition, the carrier servicing State X is in the best position to identify the "nearest appropriate facility," as defined by MCM, Part 3, §2120.3(F).

Under the scenario described above, the air ambulance supplier (and the State Y-based ground supplier) may submit claims to the State X carrier (or "first leg" carrier), even though each fully understands that their claims will, in all probability, be denied because the State Y facility was not the nearest appropriate facility. When the claim is denied, the supplier will receive a denial notice from the carrier. After receiving the denial notice, the supplier will submit this notice to the beneficiary, informing him or her that the claim is not payable by Medicare and that the claim should be filed with the beneficiary's supplemental insurer.

Many carriers have denied enrollment applications submitted by air ambulance suppliers because the supplier does not have a practice location in that particular carrier's State. The air ambulance supplier making this inquiry disputes this reasoning on the grounds that: (1) nothing in the Code of Federal Regulations requires an air ambulance supplier to have a practice location in each State it flies to, and (2) such a requirement would unduly burden air ambulance suppliers.

Under this manual issuance, therefore, an air ambulance supplier may enroll in a State to which it flies in order to pick up patients (that is, a State other than where its base of operations is located) regardless of whether it maintains a practice location or place of business in that State.

These instructions should be implemented within your current operating budget.

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allow us to deny an applicant from enrolling in the program.

6. Air Ambulance - Practice Location Exception--An air ambulance supplier may enroll in a State to which it flies in order to pick up patients (that is, a State other than where its base of operations is located), regardless of whether it maintains a practice location or place of business in that State. So long as the air ambulance supplier meets all other criteria for enrollment in the Medicare program, the carrier in that State may not deny the supplier's enrollment application solely on the ground that the supplier does not have a practice location in that State. To require an air ambulance supplier to set up a practice location in each State it flies to would place a substantial and unnecessary burden on the supplier. This policy, however, applies only to air ambulance suppliers. It is inapplicable to all other suppliers and providers. In addition, the carrier may deny an air ambulance supplier's application for a reason other than the lack of a practice location. For example, if the air ambulance supplier's owner was excluded from the Medicare program, the carrier can deny the application irrespective of whether the supplier has a practice location in that State. The carrier is only prohibited from denying an air ambulance supplier's application on the sole basis that the supplier does not have a practice location in that State. The carrier reserves the right to deny an enrollment application for any other reason consistent with Medicare policies and regulations, as outlined in the MCM, Part 4, §1030.

Independent Diagnostic Testing Facilities (IDTF) (Attachment 2).--Attachment 2 must be completed to identify each supervising physician, service, service site, employee and contractor taking tests, and when indicated each physician performing interpretations. When possible, a new IDTF should be visited prior to enrolling the IDTF in the Medicare program.

NOTE: Some businesses may operate mobile units that perform services within your State but have a business office and business phone in another State. These applicants may list an out-of-State business address but must disclose the vehicle registration numbers of any mobile units that operate in your State. This is optional if not a State requirement.

If a supplier has mobile units that provide services in your State, they must be enrolled in the State where services are provided even if their business address is out-of-State. The supplier must be licensed in each State in which they provide services.

1. Identification of Practice Location.--

a. Review information regarding operating mobile units to verify that vehicles are regularly inspected and are properly recertified according to State and local licensure laws. Review copies of each vehicle license or registration. If information is incomplete, continue to process the application. Once you process the application, inform the applicant the reason(s) for returning the application. (See §1030.2.) Evidence of recertification must be submitted to you on an ongoing basis, as required by State and local law.

b. All practice locations must be identified and entered into your provider enrollment system. Mobile Units must furnish the address where the vehicle is stored.

c. The applicant must inform you if this location is used for any other purpose. If yes, annotate your provider enrollment system.

d. All diagnostic tests and/or services performed at a different site than the practice location must be listed. Check that the legal business name is the same name reported to the IRS using Form CP 575 or any other legal IRS document. If the legal business name is different than that reported to the IRS, continue to process the application but return the application for clarification. (See §1030.2) Verify that the addresses are physical addresses. Post office boxes are not acceptable.

2. Identification of Supervising/Directing Physician(s).--Verify the identity of the

supervising physician. If a supervising physician is identified, verify that he/she is enrolled in Medicare. The supervising physician must be enrolled before completing enrollment of the IDTF.

3. Service Performance.--The applicant must list all service codes that they intend to interpret, perform, supervise, or bill. This information should also be submitted for services performed by its contractors.

Identify each physician who will be performing or supervising the interpretations.

For each CPT-4-or HCPCS code listed, any nonphysician personnel used by the IDTF to perform the tests must demonstrate the basic qualifications to perform the tests in question and have training and proficiency as evidenced by licensure or certification by the appropriate State health or education department. In the absence of a State licensing board, the technician must be certified by an appropriate national credentialing body. The IDTF must maintain documentation available for review that these requirements are met. If a technician has adequate education, experience, and or training for test performance, but lacks licensure or certification, the applicant can be enrolled, if the technician is scheduled to take the licensure or certification test. Then the carrier must follow-up to determine that the technican has actually passed the test. If the technician does not obtain the required license or certification within a reasonable period of time, they can no longer perform the medical test(s).

If information is incomplete, continue the application verification process and return the application with a request for corrected/missing information. (See §1030.2.)

4. Referral Records.--Note where the applicant maintains records of the physician's written order and the name of the technician who rendered the service are maintained. If information is incomplete, continue the application verification process and return the application with a request for corrected/missing information. (See §1030.2.)

5. Supervising/Directing Physician Exclusion Information.--Check the supervising/directing physician's name, SSN, and/or Medicare/Medicaid numbers against the OIG list of currently excluded suppliers and the GSA monthly "List of Parties." If the supervising/directing physician is currently excluded from the Medicare program, process the application, but deny the application according to procedures in §1030.3, Denial 1. If the applicant has not indicated a supervising/directing physician, deny the application according to procedures in §1030.3, Denial 5.

If any adverse legal action has been indicated or discovered, have your Fraud and Abuse Units investigate to determine if the adverse legal action would preclude or be reason for denial of enrollment. Contact any other carriers that may have enrolled the applicant to ensure that no future payments are made and the other carriers are aware of the exclusion and to recoup any overpayments.

For any supervising/directing physician who shows outstanding criminal fines or restitution orders, contact the OIG's office and forward your findings.

If there are any pending adverse actions, flag the applicant's record to alert you to keep current the final decision of these pending legal actions. Pending adverse legal actions do not allow us to deny an applicant from enrolling in the program.

Any previously excluded supervising/directing physician, must be verified through the OIG to confirm that they are now eligible for enrollment.

6. Signature of Supervising/Directing Physician(s).--Verify that each supervising/directing physician has signed the application acknowledging their supervision and/or responsibilities for directing tests performed by the IDTF.

If information is incomplete, continue the application verification process and return the application with a request for corrected/missing information. (See §1030.2.)

Home Health Agencies (Attachment 3).--If you receive Attachment 3, return the application to the applicant referring them to the RHHI.

1030.6 HCFA-855R, Individual Reassignment of Benefits.--The form HCFA-855R is to be completed for any individual who will reassign their benefits to an eligible entity. Also, the form must be completed for the following situations:

o An individual practitioner is currently enrolled in Medicare and will reassign benefits to an entity that is currently enrolled.

o An individual that has been reassigning benefits to an entity and is terminating the reassignment.

o An individual reporting a change in the type of income tax withholding or the practice location(s) with which he or she is associated.

o All individual contractors, physicians, and other non-physician practitioners who will be reassigning their Medicare benefits to a new or a prospective new owner due to the occurrence or potential occurrence of a Change of Ownership (CHOW). As defined in 42 CFR §489.18.

If the individual supplier wants to reassign his or her benefits and has not been enrolled, the applicant must complete Form HCFA-855 (see §1030.5) as well as HCFA-855R. The newly enrolling entity who is going to receive benefits must complete Form HCFA-855, see §1030.5, under group. The group members must also complete the HCFA-855R.

Any time a Form HCFA-855R is received that results in the physician exceeding 5 individual reassignments contact the physician to verify that all reassignments are still current and legitimate and to update your provider file and the UPIN.

1. Entity Identification.--The applicant must provide the legal business name to whom Medicare benefits are being reassigned. This is the name the entity uses to report to the IRS.

2. Individual Identification.--Each member who is reassigning or terminating reassignment of his or her benefits to an entity must complete this section. For individuals who receive Form 1099, all services must be provided at the group setting. If any information is missing, return the application with a request for corrected/missing information. (See §1030.2.)

Verify that the entity receiving reassigned benefits and all members who are reassigning benefits are not excluded from the Medicare program by checking the OIG exclusion list and the GSA "List of Parties." If the entity is excluded, process the application, but deny the application according to procedures in §1030.3. If a group member is excluded, inform the entity that it cannot add this member to its organization. Contact any other carriers that may have enrolled the applicant to ensure that no future payments are made and to recoup any overpayments.

The group must disclose for each individual who will bill under the group number the Internal Revenue Service (IRS) withholding method. If a member indicates that he or she receives the IRS Form-1099 at the end of the calendar year, the applicant can reassign his or her benefits to the group if he or she meets the requirements in §3060. If the group does not meet these requirements, deny the application.

3. Practice Location(s).--The locations where the member will furnish services must be specified.

Verify that these address(es) are physical addresses. Post office boxes and drop boxes are not acceptable for these addresses. This address is requested for each location where the applicant renders services to Medicare beneficiaries.

If you cannot verify that the practice location/business exists or that the group is licensed to operate at the practice location/business, continue to process the application. Once you process the application, inform the applicant the reason(s) for denial. (See procedures in §1030.3.)

4. Billing Agency/Management Service Organization Address.--The applicant must complete this section indicating if he/she is using a billing agency. Confirm that the group is associated with the billing agency's name indicated. The group must have previously submitted a copy of the billing agency agreement covering the applicant. The agreement must meet the requirements in Part 3, §3060. (See 1030.5.)

5. Reassignment of Benefits Statement.--Each member must complete this section to reassign his/her benefits. Follow instructions in Part 3, §3060 to ensure that the group is eligible to receive payment. If the group does not provide a copy of the reassignment of benefits statement for each physician, complete processing the application and follow procedures for requesting further information in §1030.4.

6. Contact Person.--This is the individual that you can call if you have any questions regarding the information furnished in the application. If the applicant does not provide a name, contact the individual who signed the application for any questions that need clarification.

7. Attestation Statement.--The applicant must sign the attestation statement. If the attestation statement is not signed, return the application with a request for corrective action. (See §1030.2.) You may not accept a copy or fax. You must file the signature copy with the original. An authorizing representative must be an officer, chief executive officer, or senior or majority partner of the business organization that is applying for or currently has the Medicare billing number.

The completed Form HCFA-855 must be signed, as outlined below, by an individual whose signature binds the supplier to Medicare rules and requirements.

(a) In the case of an individual, the enrolling individual must sign the Form HCFA-855;

(b) In the case of a sole proprietorship or sole mass immunization biller, the enrolling individual must sign the Form HCFA-855;

(c) In the case of a corporation, an organization or a mass immunization biller within a corporation or organization, an authorized representative of the corporation or organization must sign the Form HCFA-855;

(d) In the case of a partnership, a majority or senior partner must sign the Form HCFA-855; and

(e) In the case of a group, an authorized representative of the group must sign the Form HCFA-855.

1030.7 Change Of Information Form.--The following information can be updated using the Change of Information Form HCFA- 855C:

- Name
- Pay To Address
- E-mail Address

- o Potential Termination of Current Ownership
- o Practice Location Address
- o Billing Agency Address
- o Authorized Representative
- o Mailing Address
- o Specialty
- o Deactivation of Medicare Billing Number
- o Surety Bond Change or Renewal Information
- o Telephone Number
- o Fax Number

You may not change the application based on information received over the telephone.

If an organization/group is requesting a name change, a form from the IRS showing the new name must be submitted with the request.

For any change request that is generated from Form HCFA-855C, you must have an original signature from the supplier to confirm the requested change. For groups, only the authorized representative from the group can request the change. The authorized representative must sign the attestation/certification statement. If the group/organization changes the authorized representative, the representative must complete the attestation/certification statement on Form HCFA-855C showing that he/she has the authority to sign for the group. You cannot accept a copy or fax because you need the original signature.

The completed Form HCFA-855 must be signed, as outlined below, by an individual whose signature binds the supplier to Medicare rules and requirements.

(a) In the case of an individual, the enrolling individual must sign the Form HCFA-855;

(b) In the case of a sole proprietorship or sole mass immunization biller, the enrolling individual must sign the Form HCFA-855;

(c) In the case of a corporation, an organization or a mass immunization biller within a corporation or organization, an authorized representative of the corporation or organization must sign the Form HCFA-855;

(d) In the case of a partnership, a majority or senior partner must sign the Form HCFA-855; and

(e) In the case of a group, an authorized representative of the group must sign the Form HCFA-855.

Any change not listed on Form HCFA-855C must be made directly on Form HCFA-855. The applicant is required to complete only the identifying section and the portion changed or updated in that section of Form HCFA-855.

Form HCFA-855C cannot be used to add a new location. The practice location section of HCFA-855C is to be completed by an existing applicant who is relocating his/her office to another

location. Applicants who are adding a new location as opposed to relocating an existing practice location, must complete those data elements on HCFA-855 that are being added. Do not ask the applicant to complete the entire HCFA-855. If a current supplier is completing sections of Form HCFA-855 to open a new location or record some other change, and you notice missing data in your supplier files, you may ask the applicant to complete any section of the application that is missing from your files. But you can only make this request if the supplier has contacted you to report new information and there is missing information in your files.

1030.8 Enrolling Certified Providers/Suppliers Who Enroll With Carriers.--For the following certified providers/suppliers (portable X-ray, End Stage Renal Disease (ESRD), Ambulatory Surgical Center (ASC), Federally Qualified Health Centers (FQHC), Physical Therapist Independent Practice (PTIP), and Occupational Therapist Independent Practice (OTIP)) who are enrolling with the Medicare program, you will receive Form HCFA-855 with all its supporting documentation from the State agency or RO. If you receive an application directly from the applicant, you may begin review of the application. You must immediately forward a copy of the application to the State agency. If you are unsure if the application was sent to you by the applicant or State agency, look for the stamped carrier address on the front. The State agency should be using a stamped addressed label.

NOTE: The State Agency is responsible for providing the applicant a copy of HCFA-855 and should be first to receive the completed application. This will allow the State agency time to prepare for its survey.

After you receive the application from the State agency, you must review the application and recommend approval or denial to the RO, or request additional information from the applicant. If you recommend the application be denied or approved, contact the appropriate RO. For further information concerning how to proceed after processing the application see C, Recommendation, in §1030.8.

After your recommendation on which action to take, you must notify the RO and the appropriate State agency for providers/suppliers subject to an onsite State agency survey. You will be notified by the RO when the final approval documents have been executed. As soon as you have been given access to the Online Survey, Certification and Reporting (OSCAR) system, you may use it to get information in your review of the application.

You will receive an approval letter and/or a tie-in notice after certification. The supplier will also be contacted by the RO/State agency concerning his/her enrollment in the Medicare program. When you receive the approval letter you can issue a Part B supplier number and begin processing claims. Send a copy of the approved application to the State agency.

Rural health clinics must enroll with the intermediary. Most RHCs will have been previously enrolled as a group with the carrier. Verify that those entities who enroll as a RHC submit claims with the appropriate contractor. The RHC can bill a carrier for only services which do not meet the definition of RHC services.

The application and the enrollment procedures are for applicants who are 1)seeking to be a new Medicare approved supplier 2) seeking reenrollment and/or 3) advising you of a change of ownership.