

CMS LETTER

Dear Applicant:

We appreciate your request to be certified for participation in the Medicare program. Due to very substantial federal resource limitations, we must currently adhere to a careful priority schedule as we respond to requests from providers that newly seek to participate in Medicare. We hope this letter is helpful to you in understanding your options in this difficult situation. Two independent and important steps in becoming a Medicare provider are:

Form CMS-855: Form CMS-855 contains background, contact, service, and provider or supplier information that is essential to the approval process. The applications are reviewed and recommended for approval or denial by the Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (MACs) under contract with the Centers for Medicare & Medicaid Services (CMS).

Certification: Most types of providers, and some suppliers, are required to demonstrate that they are in full compliance with Medicare quality and safety requirements. This demonstration is accomplished during an onsite survey conducted by trained and qualified surveyors from the State survey agency (SA) pursuant to an agreement with CMS. There is no charge to the provider or supplier for initial CMS surveys or any later CMS recertification survey. The CMS-855 must have been approved and the provider fully operational in order for a survey to be conducted.

Some provider/supplier types have the additional option to be accredited by a CMS-approved accreditation organization (AO), and such accreditation is “deemed” to be equivalent to a recommendation by the SA for CMS certification. The attached list provides contact information on each such AO, as well as information regarding the types of providers/suppliers for which deeming applies. Note that deeming does not apply to some provider types, such as nursing homes and dialysis facilities.

CMS instructs States to place a higher priority on recertification of existing providers, on complaint investigations, and on similar work for existing providers than for initial surveys of providers or suppliers newly seeking Medicare participation. **Due to severe resource limits for Medicare survey & certification functions, in most States few providers that have an AO option will be surveyed by CMS or the State.**

Short-term acute care hospitals, rehabilitation hospitals, critical access hospitals (but not their distinct part psychiatric and rehabilitation units), home health agencies, hospices, and ambulatory surgical centers all have the option of deemed accreditation. Applicants have the option of applying to one of the CMS-approved AOs. The attachment to this letter conveys the requisite contact information.

Providers may apply by letter to the SA for CMS consideration to grant an exception to the priority assignment of the initial survey if lack of Medicare certification would cause significant access-to-care problems for Medicare beneficiaries served by the provider or supplier. The SA may choose whether to make a recommendation to CMS before forwarding the request to CMS.

There is no special form required to make a priority exception request. However, the burden is on the applicant to provide data and other evidence that effectively establishes the probability of adverse beneficiary health care access consequences if the provider is not enrolled to participate in Medicare. CMS will not endorse any request that fails to provide such evidence and fails to establish the special circumstances surrounding the provider's or supplier's request. CMS recognizes that special circumstances apply to certain types of providers or suppliers, and has made special priority allowances for them. Both dialysis facilities and transplant centers, for example, are afforded a higher priority compared to certain other providers/suppliers because there is no AO option available, end-stage renal disease patients and transplant patients have a unique reliance on Medicare for their care, and access is often an issue.

Hospitals that are applying for rehabilitation hospital status or for an IPPS-excluded unit(s) for rehabilitation and/or psychiatric services **and that have (or will have) attained AO accreditation from a CMS-approved AO for their general hospital operations** will be allowed to submit an attestation of compliance with Medicare requirements by their PPS-excluded unit(s). In addition, they will be required to complete a Form-437, Form-437A, or Form-437B, as applicable, in addition to the attestation. This will avoid the need for both an AO accreditation survey and an on-site PPS-verification survey by an SA, since there is no AO option for verification of such IPPS-excluded units. If you are in this situation, please communicate with the SA as early in the process as possible.

We regret that the resource limitations under which we operate may complicate the process of enrolling in Medicare as a certified provider or supplier.