Health Care Regulation and Quality Improvement
800 NE Oregon Street, Suite 305
Portland, Oregon 97232
971-673-0540
971-673-0556 (Fax)

This letter is in response to your expression of interest in becoming a provider of ambulatory surgical services under the Medicare program. Your facility must be licensed before applying for Medicare certification.

The Oregon Health Authority, Health Care Regulation and Quality Improvement section (HCRQI), has an agreement with the U.S. Department of Health and Human Services, Certification for Medicare and Medicaid Services (CMS), formerly Health Care Financing Administration (HCFA), to assist in determining whether health care facilities meet, and continue to meet, required conditions of participation for the Medicare program.

If you desire to participate in Medicare, and if you believe your facility substantially meets the required conditions, please complete and return to this office the following forms:

(1) CMS 370 - Health Insurance Benefit Agreement (2-signed originals required), found online at:
http://www.cms.hhs.gov/cmsforms/downloads/CMS370.pdf

(2) CMS 377 - Request to Establish Eligibility, found online at:
http://www.cms.hhs.gov/cmsforms/downloads/CMS377.pdf

In addition to the necessary forms and accompanying instructions, regulations may be found online at:

(1) Part 416, Federal Medicare Regulations for Ambulatory Surgical Centers & Federal Interpretive Guidelines for Part 416, can be found online at:
http://www.cms.hhs.gov/manuals/downloads/som107ap_l_ambulatory.pdf

The Medicare regulations include the standards, which must be met in regard to the care of patients and the principles of reimbursement for provider costs. To qualify for Medicare payments, your facility must be in compliance with the Medicare Conditions of Participation and the requirements for reimbursement,

including financial solvency.

The person signing the Health Insurance Benefit Agreement must have the authorization of the facility's owners to enter into this agreement.

Medicare regulations do not permit CMS to enter into a provider agreement with an institution or organization which is bankrupt or insolvent or with respect to a court preceding in bankruptcy or solvency is pending. In order to indicate that your facility meets the solvency requirements, please complete the enclosed Statement of Financial Solvency. Note that this form requires you to inform the CMS regional office if court proceedings in bankruptcy or solvency are instituted prior to acceptance of your provider agreement.

Please note that the initial licensing survey must be completed prior to your start of operation, since you may not operate an ambulatory surgical facility without a State license. The Medicare certification survey, however, cannot be conducted until after you have provided care for patients; the patients do not need to be Medicare beneficiaries. This means that the surveys will take place on separate days.

Also, a Medicare certification survey cannot be conducted until we have received approval of your enrollment application (CMS 855B) from the insurance carrier.

Please contact Noridian Government Services Government Programs Division, if you have any questions relative to its completion. You will need to access the CMS website located at www.cms.hhs.gov/medicare/enrollment which contains a list of FIs and carriers by State and specialty, along with the telephone number. The CMS 855B form is available on the above website or you may obtain a copy of the CMS 855B form from Noridian Government Services Government Programs Division of North Dakota, 4305 13th Avenue, South Fargo, N.D. 58103-3373 or by calling 1-877-908-8431 Option 2" to become a new provider. Effective 10/1/2001 the state Agency (SA) will not be involved in the mailing and/or processing of the 855B forms, other than receiving a copy of the submitted 855B form that your facility submits to Noridian Government Services Government Programs Division of North Dakota for approval.

In addition, if your facility performs laboratory tests for the purpose of diagnosis and treatment or assessment of individuals' health, you must have and display a current Oregon license to do so. For information, call Department of Human Services Center for Public Health Laboratories, Laboratory Licensing Section, at (503) 229-5853.

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. The CMS-855 must have been approved, all of the required documentation must have been submitted, and the provider fully operational in order for a survey to be conducted.

At the present time the onsite certification survey will need to be conducted by a CMS-approved accreditation organization (AO), and such accreditation is "deemed" to be equivalent to a recommendation by the SA for CMS certification. To schedule the initial accreditation survey, contact The Joint Commission (630-792-5800), Accreditation Association for Ambulatory Health Care (847-853-6060), American Association for Accreditation of Ambulatory Surgery Facilities (1-888-545-5222), or American Osteopathic Association Healthcare Facilities Accreditation Program (312-202-8258).

CMS instructs States to place a higher priority on recertification of existing providers, on similar work for existing providers, and on complaint investigations than for initial surveys of new providers/suppliers seeking Medicare participation.

However, providers may apply by letter to CMS for 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. There is no special form utilized 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. Send this letter and the accompanying documentation to this office (SA). The SA will review the documentation for completeness and may choose to make a recommendation before forwarding the request to CMS.

Also, a representative of the State Fire Marshal's Office will survey your facility to evaluate the extent to which your facility meets the Life Safety Code Requirements. Following these two surveys, we will recommend to CMS whether your facility should participate.

When it is determined that all requirements of Medicare are met, the Health

Insurance Benefit Agreement will be countersigned, and a copy will be returned to you with the notification that your facility has been approved.

Your Medicare insurance carrier will not reimburse you for services provided to Medicare beneficiaries prior to your official date of certification, which can be no earlier than the date of the onsite certification survey, if your facility is found to be in complete compliance, or the date of an acceptable plan of correction, if deficiencies are cited; this also includes verifying compliance or lack of compliance with the requirements of the Life Safety Code.

You are required to notify this office if in the future you plan to transfer ownership to another owner, ownership group, or to a leasee. Please be advised that the courts have upheld CMS's right to hold new owners responsible for the overpayment of the old owners based on regulations at 42 CFR 489.18. CMS has the rights to recover from the buyer even when a sales agreement specifically states that the buyer will not accept liability of the seller. The enclosed chart has been prepared to outline the effect of a new owner's acceptance or refusal of assignment of an existing Medicare provider agreement.

Those facilities, which are denied certification in the program, will be notified and given the reasons for the denial and information about their rights to appeal the decision. Please do not hesitate to call us at 971-673-0540 with any questions you may have.

Sincerely,

Client Care Surveyor
CMS Representative
Oregon Health Authority
Public Health Division
Health Care Regulation and Quality Improvement

If you need this information in an alternate format, please call our office at (971) 673-0540 or TTY (971) 673-0372.

MEDICARE PROVIDER AGREEMENTS AND CHANGES OF OWNERSHIP

NEW OWNER ACCEPTS ASSIGNMENT OF PREVIOUS OWNER'S PROVIDER AGREEMENT

Consequences: New owner is given previous owner's provider number and agreement. There is no break in coverage, but new owner becomes liable for all penalties, sanctions, and liabilities imposed on or incurred by previous owner. If, after accepting the assignment, the new owner subsequently elects to terminate its provider agreement, it must (under the provisions of section 1866(b)(1) of the Act) file a written notice of its intention, and follow the procedures for voluntary termination.

- The regulations specify that when there is a change of ownership, the existing Medicare agreement is automatically assigned to the new owner (42 CFR 489.18(c)). New owners are not required to accept assignment of the agreement but they must state their refusal in writing.

NEW OWNER REFUSES ASSIGNMENT OF PREVIOUS OWNER'S PROVIDER AGREEMENT

Consequences: The previous owner's provider agreement terminates on the date the previous owner ceased doing business.

- NEW OWNER DOESN'T WANT TO PARTICIPATE IN PROGRAM
  Consequences: New owner has, in effect, purchased only capital assets. The business ceased being a Medicare provider on the last day of business of the previous owner.
- NEW OWNER WANTS TO PARTICIPATE IN PROGRAM
  Consequences: New owner will have to request to participate in the program, undergo an initial survey, meet the participation requirements, and be certified. There will be no Medicare coverage or payments until the provider is certified, and no retroactive payments for the period between the termination of the previous owner's provider agreement and the commencement of the new owner's provider agreement. However, the new owner is free of any penalties, sanctions, or liabilities imposed on or incurred by the previous owner.