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## **RE: OUTPATIENT PHYSICAL THERAPY/SPEECH PATHOLOGY**

This letter is in response to your request for information regarding Medicare approval to provide Outpatient Physical Therapy or Speech Therapy services or information regarding a Change of Ownership (CHOW). This Office is responsible for assisting the Centers for Medicare and Medicaid Services (CMS) in performing the certification function for those providers wishing to participate in the Medicare Program.

### **PRE-SURVEY REQUIREMENTS:**

You must download, complete, and return these forms to this office. Please note that TWO signed originals of the HCFA 1561, Health Insurance Benefit (HIB) Agreement are required. Instructions for completing the FIIB are as follows:

- On the first and third line of the HIB form, enter the entrepreneurial name of the facility. If a trade name is used, follow the entrepreneurial name by the d/b/a (trade name). Ordinarily, the entrepreneurial name is the same as the legal name used on all official IRS correspondence concerning payroll withholding taxes, such as the W-3 or 941 forms. For example, Health Services, Inc., owner of Atlanta Physical Therapy Services, would enter on the agreement: "Health Services, Inc. d/b/a Atlanta Physical Therapy Services." A partnership of several persons would complete the agreement to read: "Robert Johnson, Louis Miller, and Paul Allen, ptr. d/b/a Atlanta Physical Therapy Services." A sole proprietorship would complete the agreement to read: "John Smith d/b/a Atlanta Physical Therapy Services."
- It is imperative that the PERSON WHO SIGNS the agreement is AUTHORIZED BY THE LEGAL OWNERS to sign and enter into this provider agreement with CMS. Original signature, title, and date of signature are required following the words "accepted for the provider of services by."

As of November 1, 2001, all HCFA 855 provider enrollment forms will be supplied to you by your Fiscal Intermediary (FI). Please contact your FI for the 855 Forms and for answers to questions related to completion of the forms the CMS web site is [www.cms.gov/medicare/enrolment](http://www.cms.gov/medicare/enrolment). The FI will notify this Office of its recommendation for approval or denial for enrollment or change of ownership (CHOW) within 60 calendar days of receipt of the completed 855 application. Once this Section is notified that the initial Medicare enrollment or CHOW has been approved and all other required forms have been submitted, the Medicare survey process will be initiated or the CHOW will be processed.

**PLEASE NOTE THAT A SURVEY CAN NOT BE CONDUCTED OR A CHOW PROCESSED UNTIL AN APPROVED HCFA 855 FORM IS RECEIVED FROM THE FI.**

### **THE MEDICARE SURVEY PROCESS:**

You must be supplying services, (i.e., have patients) before this Office can survey or recommend certification to CMS; therefore, please indicate on the "Request for Medicare Survey Form", the date you anticipate being fully operational and ready for a Medicare survey. Please indicate the days and hours of operation. If the date you anticipate being fully operational changes, please notify this Office immediately. By CMS policy, all certification surveys must be UNANNOUNCED. The Specialized Health Care Section will conduct the unannounced federal when you are operational, ready for the Medicare survey, all the required HCFA forms are complete, and the FI has approved your provider enrollment (855 form). Our surveyors will inspect your facility, conduct interviews, review documents, and undertake other procedures necessary to evaluate the extent to which your facility meets the Conditions of Participation for OPT/SP.

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If your facility is found to be in full compliance with the Medicare Conditions of Participation, then this Office will recommend to CMS that you facility be certified for participation in the Medicare program effective the date of the survey.

If condition level deficiencies are identified during the course of the survey, this Office will recommend to CMS that your application to participate in the Medicare program be denied. If CMS accepts this recommendation, CMS will send a notice giving the reasons for denial and informing you of your right to appeal.

If deficiencies below the condition level are identified during the course of the survey, you will be given an opportunity to submit an acceptable plan of correction. This Office will recommend to CMS that your OPT/SP be certified effective the date that you submit an acceptable plan of correction.

**LABORATORY SERVICES:**

If you anticipate that your facility will be performing any clinical laboratory testing or specimen collection, you need to contact the Diagnostic Service Unit at (404) 657-5450. This unit will assist you in determining whether there are additional Federal and State laboratory requirements that your facility will have to meet.

**ISSUANCE OF PROVIDER NUMBER:**

After the Health Care Section determines that all requirements for participation in the Medicare program are met, we will notify you via an approval letter. The letter will include your effective date of certification and your OPT/SP identification number. Your selected fiscal intermediary will also be notified of your certification. After the two HCFA 1561 forms (Health Insurance Benefit Agreement) are signed by CMS, one will be placed in your HFRD file and the other signed form forwarded to your facility. Please note that you cannot claim provider reimbursement for services furnished for Medicare patients prior to approval from CMS.

Should you have any questions concerning this information or the completion of enclosed forms (with the exception of the HCFA 855), please do not hesitate to contact us at (404) 657-5411

**Required documents**

- Medicare Rules and Regulations
- Request for Medicare Survey Memo
- HCFA 1856 —Request for Certification
- HCFA 1561 — Health Insurance Benefits Agreement (2) originals