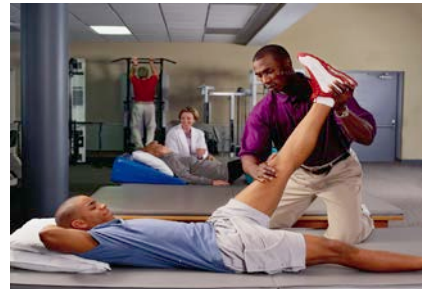

Outpatient Physical Therapy/Speech Pathology (OPT/SP) Provider Change of Ownership (CHOW) Process

What is a Change of Ownership (CHOW)?

A CHOW typically occurs when there is a change in the owning party of the OPT/SP. Changes in the owning party can include individuals, corporations and general partnerships (i.e. a new partnerships agreement would constitute a CHOW). For additional specific information on what ownership changes would constitute a CHOW, please refer to [Chapter 3](#) of the CMS State Operations Manual (SOM), section 3210.1.

How do I complete an OPT/SP CHOW?

In accordance with Chapter 3 of the State Operations Manual (SOM), section 3210, an OPT/SP provider must complete and submit all necessary documents to complete the CHOW process. All CHOW materials are located below or requested through the Bureau of Facility Standards at (208) 334 – 6626, option 4.



What is included in the OPT/SP CHOW packet?

The CHOW packet includes what must be submitted and approved by the Bureau of Facility Standards prior to the CHOW being processed (items #1 - #4) and resource information related to OPT/SPs (items #5 - #7) as follows:

1. Request for Certification - [CMS-1856](#),
2. Health Insurance Benefits Agreement - [CMS-1561](#), (**Two Originals Required**)
3. "Office of Civil Rights Clearance for Medicare Certification" (OCR) packet. This form must be answered and submitted, on line, via <https://ocrportal.hhs.gov/ocr/pgportal/>. You will receive an e-mail from the OCR stating you completed the civil rights submission. The e-mail will contain an OCR number. Submit a copy of this e-mail with your other application materials as indicated below,
4. Fiscal year ending date [form](#),

5. [Appendix E](#), Guidance to Surveyors: Outpatient Physical Therapy or Speech Pathology Services,
6. [Appendix Z](#), Emergency Preparedness (EP),
7. [Appendix Q](#), Core Guidelines For Determining Immediate Jeopardy

How do I complete the CHOW packet?

Please complete the CHOW documents (Items #1- #4) and return them along with a copy of the **signed** Bill of Sale to the Bureau of Facility Standards. Ensure that all questions are answered completely, and that all information is submitted. All hand-printed applications must be clearly printed and easily readable.

Where do I send my completed CHOW materials?



The CHOW materials can be submitted by mail and/or hand delivered.

PLEASE KEEP A COPY FOR YOUR RECORDS

1. If you are mailing the application packet, mail to:

Department of Health and Welfare
Bureau of Facility Standards
P.O. BOX 83720
BOISE, ID 83720-0009

2. If you are hand delivering the application packet, deliver to:

Department of Health and Welfare
Bureau of Facility Standards
3232 Elder Street
Boise ID 83705

What happens after I submit my CHOW materials?

Bureau of Facility Standards staff will review the materials you submitted. If the materials are incomplete or if there are questions, Bureau staff will contact you.

Once the CHOW materials have been approved and the Bureau of Facility Standards receives notification from the Medicare Administrative Contractor (MAC) that the [CMS-855A](#), Medicare Enrollment Application has been approved, the CHOW packet will be

forwarded to the CMS Regional Office X, in Seattle, Washington, for final review and decision-making. **Please see below for additional information related to the CMS-855A.**

How long will the CHOW process take?

The length of the OPT/SP CHOW process varies dependent on multiple factors such as whether the submitted information is complete, whether additional information needs to be submitted, current work load and availability of resources necessary to complete the CHOW review, etc. Therefore, it is not possible for the Bureau of Facility Standards to establish specific timeframes.

How do I get paid for providing services?

The Centers for Medicare/Medicaid Services **require all OPT/SP providers undergoing a CHOW to complete the form CMS-855A, Medicare Enrollment Application**, and forward it to the MAC for approval. The form [CMS-855A](#) can be accessed on the Internet or requested directly from your MAC:

[Medicare Provider Enrollment](#)

Read the instructions on the web site and obtain the form by clicking on the version you will need for your computer.

Noridian Administrative Services
P.O. Box 6726
Fargo, ND 58108-6726
888/608-8816

www.noridianmedicare.com

To become a Medicaid provider, you must complete an enrollment application online to Molina Medicaid Solutions. To submit an Idaho Medicaid provider application, go to <http://www.idmedicaid.com> (Molina Medicaid Solutions Web site). Click on the Provider Enrollment link on the left side of the page. A step-by-step guide is located under the User Guide link on the left side of the screen. We recommend you open this guide in a separate browser window before you begin your application.

To begin your application, open a new browser window at <http://www.idmedicaid.com>, click on the Provider Enrollment link on the left side of the page and then click on the New Provider Enrollment Application link in the center of the page. The new

enrollment online application is simple to navigate, and online help text appears for each field when you hold your cursor over the field. Additional provider enrollment help is available at (866) 686-4272 choose option 0.

This is a completely separate process from applying for Medicare certification.

Additional information

For additional information please access the website and reference information below or contact the Bureau of Facility Standards at (208) 334-6626, option 4 or email questions to fsb@dhw.idaho.gov.

Bureau of Facility Standards Informational Letters

[OPT/SP](#)

Centers for Medicare & Medicaid Services

[Outpatient Rehabilitation Center](#)



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

BUREAU OF FACILITY STANDARDS
DEBRA RANSOM, R.N., R.H.I.T. – Chief
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888

FISCAL YEAR ENDING

FACILITY NAME: _____

FISCAL YEAR END DATE: _____

OWNER/ADMINISTRATOR

DATE