Overview

- How Application Submission Works
- Part B Initial enrollment
- Establishing a Reassignment
- Part B Adding or Changing a Practice locations
- Part B Changing Owners and Managing Control
- Voluntary Withdrawal
- Deactivation/Reactivation
- Part A Initial Enrollment and Changing Practice Locations
- Part A CHOW
- DMEPOS
- Opt-Out
- Ordering and Certifying
- Medicare Participation
How Application Submission Works

1. **SUBMISSION**
   - 855 Form
     - Online 45 days
     - 855 Form 60 days*
   - Development Letter

2. **INTAKE**
   - Direct Input
   - MAC Mail Room
   - Manual Data Entry

3. **PROCESSING, SCREENING, AND VERIFICATION**
   - PECOS
     - Pre-screening
       - Signed and Dated
       - App Fee (or Waiver)
       - Supporting Docs
       - All Data Elements
     - Verification
       - Name / LBN
       - SSN / DOB
       - NPPES
       - Address
     - Risk Category
       - License
       - Adverse Actions

4. **FINALIZATION AND CLAIMS UPDATE**
   - Update Claim System
     - MAC Updates Claim System (1-2 days)
     - Provider not approved until claims updated
   - MAC Recommendation to State/RO
     - Certified providers/suppliers
     - MAC recommends to RO
     - RO performs in 3-9 months

*If the app is complete, and no site visit*
Part B Initial Enrollment

Effective date is the later of:
- Application Receipt Date
- Date of first services at a new location (up to 30 days prior to application receipt)

** Must be in compliance at requested effective date (operational, licensed)

<table>
<thead>
<tr>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
<th>AUG</th>
<th>SEP</th>
<th>OCT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MAC PROCESSING</strong></td>
<td><strong>MAC receives app APR 1</strong></td>
<td><strong>MAC approves MAY 15 (w/ effective June 1)</strong></td>
<td><strong>Provider seeks effective date JUNE 1</strong></td>
<td><strong>Provider performs service JUNE 1</strong></td>
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</tbody>
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**Option A: Early Submission**
Physicians / Groups can apply **60 days prior**

| Provider performs service JUNE 1 |
| MAC approves SEPT 1 (w/ effective June 1) |

**Option B: Late Submission**
Physicians / Groups effective date up to **30 days prior to submission date**

| MAC approves SEPT 1 (w/ effective June 1) |

**Must be in compliance at requested effective date (operational, licensed)**
# Medicare Effective Dates | Part B

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Application receipt date of 6/10/18 with app requested date of 7/01/18</td>
<td>▪ 7/01/18 (no retro, based on requested effective date on application)</td>
</tr>
<tr>
<td>▪ Application receipt date of 6/10/18 with app requested date of 6/01/18 and all requirements met</td>
<td>▪ 6/01/18 (based on requirements met date)</td>
</tr>
<tr>
<td>▪ Application receipt date of 6/10/18 with app requested date of 3/01/18</td>
<td>▪ 5/11/18 (30-day retro)</td>
</tr>
<tr>
<td>▪ Application receipt date of 6/10/18 with app requested date of 6/01/18, license effective date 6/28/18</td>
<td>▪ 6/28/18 (based on license effective date)</td>
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Receipt Date Determination

Receipt date is important in determining your effective date of Medicare billing privileges.

**Paper Applications**
- Based on the date the MAC received the package in the mail
- MAC will develop for missing signatures

**Web Applications**
- Date the application is submitted
- Must still e-sign or upload
- MAC will develop for missing signatures
Part B Establishing a Reassignment

- CMS applies the Medicare billing effective date rules to the establishment of reassignments

- The effective date of a reassignment shall be the later of the date of filing or the date the reassignor first began furnishing services at the new location

- Retrospective billing date may be applied
### Part B Establishing a Reassignment

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Effective Date</th>
</tr>
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</table>
| Applicant is enrolled as a sole proprietor and will now also reassign his benefits | Based on date of receipt of application  
Retrospective billing date may be applied. |
| Applicant reassigns to group A and will now reassigns to group B         | Based on date of receipt of application  
Retrospective billing date may be applied. |
| Applicant reassigns to group A and will not be issued a new PTAN with group A | Based on date of receipt of application  
Retrospective billing date may be applied. |
Knowledge Check
Part B Adding or Changing a New Practice Location

Option A: Add location 60 days prior

Option B: Submit after the effective date but within 30 day reporting requirement.

Option C: Submit after the effective date, NOT within 30 day reporting requirement, however, you are now in compliance.

- In accordance with 42 C.F.R. § 424.516(d)
  - 30 day reporting requirement
- Non-compliance may result in administrative action
- PECOS will display the effective date listed on the application (not before the enrollment effective date).
When to Select Change / Add / Delete

- **CHANGE**
  - Replace existing information with new information (e.g., practice location, ownership)
  - Update existing information (e.g., change in suite #, telephone #)
  - App fee is **not** required

- **ADD**
  - Add additional enrollment information to existing information (practice locations)
  - App fee may be required

- **DELETE/REMOVE**
  - Remove existing enrollment information
  - App fee is **not** required
  - Deleting a practice location in PECOS removes the special payment address and requires re-entry

For information on which actions trigger the application fee requirement by provider/supplier type refer to the Application Fee Matrix on CMS.gov.

Refer to SE1617 for reporting requirements

1. Applicable CMS-855 sections (change/add/delete options)
2. Location information (855A/855B/855I/855S)
3. Ownership/Managing Control (855A/855B/855I/855S)
4. Billing Agency (855A/855B/855I/855S)
5. AO/DO (855A/855B/855S)
6. Attachments 1&2 (855B)
Part B Changing Owners and Managing Control

- Accuracy of Ownership and Managing Control is vital to maintain compliance and avoiding administrative action

**Option A: Early Submission**
Physicians / Groups can submit **60 days** prior

**Effective Date of Change – June 1***

**Option B: Compliance**
Physicians / Groups **must report within 30 days of change**

**Option C: Post Compliance**
Physicians / Groups **must report within 30 days of change not submitted** within 30 day reporting requirement, however, **you are now in compliance**

*The effective date you see in PECOS will reflect the accurate information that you report on the application*
Part B Voluntary Withdrawal

- You will no longer be rendering services to Medicare patients
- You are planning to cease (or have ceased) operations
- You are relocating to another state and no longer intend to practice in the current state
Part B Voluntary Withdrawal

- The date you see in PECOS will be the day AFTER the voluntary termination date you put on the application.

- One party (individual or organization) cannot voluntarily enroll on behalf of the other.

- If the organization terminates an individual on active PTAN, the individual has 90 days to report update information prior to deactivation.
Part B Terminating a Reassignment

- One of the two parties (individual or organization) must report the voluntary termination of Medicare billing privileges within 90 days of the change of information.

- The date you see in PECOS will be the day AFTER the voluntary termination date you put on the application.
Knowledge Check
Deactivation Effective Dates

- Deactivation of enrollment will only happen in accordance with one of the following regulatory deactivation authorities
- It will not happen without prior notice.

424.540 Deactivation of Medicare billing privileges
(1) Non billing
(2) Provider or Supplier does not report a change of information
(3) Provider or Supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application.
424.540 Deactivation of Medicare billing privileges

(1) Non Billing

- At a minimum the provider must not bill or order and refer for 12 full months.

- The MAC will send a letter at a minimum of 5 days in advance.

- The deactivation effective date is prospective and will be listed on the letter.
424.540 Deactivation of Medicare billing privileges

(2) Provider or Supplier does not report a change of information

- If the provider is found to be in non-compliance with reporting requirements.

- The MAC will send a letter at a minimum of 5 days in advance.

- The deactivation effective date is prospective and will be listed on the letter.
424.540 Deactivation of Medicare billing privileges

(3) Provider or Supplier Fails to Respond to a Request from CMS

- Revalidation authority
- DOES apply to off-cycle revalidation
- Does NOT happen without prior notice
- Provider given a minimum of 7 months notification
Part B Reactivating an Enrollment

- Reactivation is essentially the **SAME** as initial enrollment

- Effective date is limited to the date of receipt of the application
  - Retrospective billing date **DOES** apply

- The ONLY situation that you keep you PTAN, is reactivation from non-response to revalidation
Part B Reactivating a Reassignment

- Effective date is limited to the date of receipt of the application
- Retrospective billing date DOES apply
Question & Answer Session
Hospitals / HHAs / SNFs can apply up to **180 days prior**

<table>
<thead>
<tr>
<th><strong>Provider seeking effective date</strong></th>
<th><strong>SEPT 1, 2018</strong></th>
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**MAC receives app**
APR 1, 2018

**MAC recommends approval to State/RO**
JUNE 1, 2018

**State survey completed**
DEC 1, 2018

**RO approves, w/ effective date DEC 1, 2018 when RO determined all requirements were met**

**PROCESSING**
APR ’18
JUN’18
SEPT ’18
DEC ’18
JAN ’19
APR ’19

**STATE/RO PROCESSING**

**Must be in compliance at requested effective date (operational, licensed)**
Part A Practice Location Changes

Option A:  
Add location 60 days prior

Option B:  
Submit after the effective date but **within 90 day reporting requirement.**

Option C:  
Submit after the effective date, **NOT within 90 day reporting requirement,** however, you are now in compliance.

- In accordance with 42 C.F.R. § 424.516(e)
- 90 day reporting requirement
- Non-compliance may result in administrative action
- No survey required in most case
- The CCN/PTAN effective date will remain the original date
- PECOS will reflect what is reported on the application
Part A Changes of Ownership

- No survey required

- CHOW effective date must match the bill of sale

- The CCN/PTAN effective date will remain the original date
DMPOS Initial Enrollment and Additional Practice Locations

- Compliance is KEY

- Medicare billing effective date = date the NSC has verified the supplier’s compliance with all standards and regulations and completed the overall enrollment process.
DMPOS TIN Changes

**Total ownership change –**

- New PTAN issued
- The effective date of the new Medicare ID may be retroactive to the date of the bill of sale
  - The previous Medicare ID will be deactivated the date of the bill of sale regardless of the effective date of the new Medicare ID.

**Same Owners different TIN –**

- The NSC will work with the supplier to establish the effective date of the new Medicare ID and will deactivate the previous ID with the same date
- New PTAN issued
DMPOS Reactivations

- Reactivation effective date = Date of deactivation,
  - Except for suppliers that were deactivated for non-billing or that voluntarily terminated enrollment
  - Must be in compliance with all standards and regulations at that date.

- Not in compliance on deactivation date, then the reactivation date = date confirmed to be in compliance.
  - Retroactive date will not exceed 12 months prior to the deactivation date due to the claims filing deadline requirement.

- For suppliers that were deactivated for non-billing or that voluntarily terminated, = date the reactivation application was received
Physicians/practitioners who do not wish to enroll in the Medicare program may “opt-out”

What this means:

- The physician/practitioner nor the beneficiary submits a bill and is reimbursed by Medicare for services rendered (beneficiary pays out-of-pocket)
- A private contract is signed between the physician/practitioner and the beneficiary
- The physician/practitioner submits an affidavit to Medicare to opt-out of the program
Opt-Out

- **Participating physicians and Non-Physician Practitioners**
  - Opt Out Affidavit is received **at least 30 days prior** to the first day of the next calendar quarter (1/1, 4/1, 7/1 or 10/1)
    - Opt Out effective date will be the first of the next quarter
  - Affidavit submitted **within** 30 days prior to the next calendar quarter (example 9/18 receipt date), the *following* calendar quarter, 1/1 would apply

- **Non-Participating Physicians and NPPs**
  - Opt Out Effective date is the date the physician/NPP signs the affidavit that meets the requirements
Impacts of Opting-Out

- May not receive direct or indirect Medicare payment for services furnished to Medicare beneficiaries
  - Traditional Medicare fee-for-service
  - Under a Medicare Advantage plan

- Cannot terminate early unless opting out for the first time and within 90 days after the effective date of the opt-out period
  - Locked in for 2 years if you miss the 90 day window

- May order or certify items and services or prescribe Part D drugs for Medicare beneficiaries
  - NPI
  - Date of Birth
  - Social Security Number
  - Confirmation if an Office of Inspector General (OIG) exclusion exists
Ordering and Certifying

- Effective date is the date of receipt
- CMS-855O is a national enrollment
- Providers who relocate to another state are not required to dis-enroll in the current state and re-enroll in the new state
- The MAC that maintains the CMS-855O enrollment in PECOS will process the change of information, even if the provider is relocating to a state outside of their jurisdiction
- The MAC will update the provider’s record with any new licenses and/or certifications obtained as a result of the provider’s relocation
Participation vs Non-Participation

- A physician, practitioner or supplier can submit a CMS-460 form upon
  - **Initial Enrollment**
    - Participation effective date = Effective date of the enrollment

  OR

  - **Open Enrollment** (usually mid-November to December 31)
    - Participation effective date = Date indicated on the form
Question & Answer Session
Resources

**cms.gov**
- ordering and referring, DMEPOS accreditation, supplier standards
- MAC contacts: (search for Medicare enrollment contact”)

**cms.gov/Revalidation**
- search all records online
- view and filter online spreadsheets
- export to Excel, or connect to with API

**PECOS.cms.hhs.gov**
account creation, videos, providers resources, FAQs

**ProviderEnrollment@cms.hhs.gov**
Provider Enrollment contact

**FFSProviderRelations@cms.hhs.gov**
“ListServ” sign-up: Notice of program and policy details, press releases, events, educational material

**cms.gov/EHRIncentivePrograms**
Electronic Health Record website

**cms.gov MLN Matters® Articles**
articles on the latest changes to the Medicare Program and enrollment education products
Thank You

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Centers for Medicare & Medicaid Services