NATIONAL PROVIDER ENROLLMENT CONFERENCE

57 Million Patients, 2 Million Providers, ONE Mission

Avoiding Processing Delays

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Objectives

Attendees will be able to…

- Identify the leading causes of processing delays and how to avoid them
- Identify the consequences associated with processing delays
- Differentiate between PECOS Web and paper-based applications
- Identify the appropriate Medicare Administrative Contractor (MAC)
- Formulate your enrollment scenario and determine what application(s) is right for you

Session Overview

1. Processing Delays
2. Development Requests
3. How to Avoid Processing Delays
4. Submitting Your Application to the Correct Contractor
5. PECOS Web Versus Paper Applications
6. Understanding Your Enrollment Scenario
7. Common Development Reasons
8. Assessment for Understanding

Processing Delays

Processing delays are any stoppage in the processing of an application due to errors submitted by the applicant

- 30 – 35% of applications result in delays
- Incomplete applications are typically delayed 30-45 days
- Development Requests exceed 50% for paper apps and are approximately 25% for Web apps

Causes of Delays:

- Missing Documents
  - IRS Documents
  - CMS 588 EFT Form
  - Voided Check
  - Bank Letter
  - Education Documentation
  - CMS 460 PAR Agreement
- Missing Fields
- Missing Signatures
- Wrong Signatures (paper)
- Incorrect Information
- Missing Application Fee
- Submission to the wrong contractor
- Failure to respond to development
- Submitting the wrong application

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Submitting Application for a Change of Information When Actually Revalidating

SECTION 1: BASIC INFORMATION ***(Continued)***

A. Check one box and complete the required sections

☐ Your organization has **Consolidated** with another organization You are the: ☐ Former organization ☐ New organization	Medicare Identification Number of the Seller/Former Owner *(if issued)*: NPI: Tax Identification Number:	**Former Organizations: 1A, 2H, 13,** and either **15** or **16** **New Organization: Complete all** sections except **2F** and **2G**
☐ You are **changing** your Medicare information	Medicare Identification Number *(if issued)*: NPI:	**Go to Section 1B**
☐ You are **revalidating** your Medicare enrollment	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections except 2F, 2G, and 2H**

Checking "Other" as the Type of Provider When Initially Enrolling

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

A. Type of Provider

The provider must meet all Federal and State requirements for the type of provider checked. Check only one provider type. If the provider functions as two or more provider types, a separate enrollment application (CMS-855A) must be submitted for each type.

1. Type of Provider (other than Hospitals— See 2A2). Check only one:

- ☐ Community Mental Health Center
- ☐ Comprehensive Outpatient Rehabilitation Facility
- ☐ Critical Access Hospital
- ☐ End-Stage Renal Disease Facility
- ☐ Federally Qualified Health Center
- ☐ Histocompatibility Laboratory
- ☐ Home Health Agency
- ☐ Home Health Agency (Sub-unit)
- ☐ Hospice
- ☐ Indian Health Services Facility
- ☐ Organ Procurement Organization
- ☐ Outpatient Physical Therapy/Occupational Therapy/ Speech Pathology Services
- ☐ Religious Non-Medical Health Care Institution
- ☐ Rural Health Clinic
- ☐ Skilled Nursing Facility
- ☐ Other (Specify):_____

You may only select one provider type

If you need to check more than one, you must submit a separate enrollment

Not Completing Adverse Legal History in Sections 3

SECTION 3: FINAL ADVERSE ACTIONS/CONVICTIONS *(Continued)*

FINAL ADVERSE LEGAL HISTORY

1. Has your organization, under any current or former name or business identity, ever had a final adverse action listed on page 16 of this application imposed against it?

   ☐ YES–Continue Below ☐ NO–Skip to Section 4

2. If yes, report each final adverse action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

If you select yes, you must report each final adverse legal action

If you fail to accurately disclose, it's considered the same as not disclosing at all

All applicable final ALAs must be reported, regardless of whether records were expunged or any appeals are pending

Must be reported regardless of whether the ALA occurred in a state different from that in which you are seeking enrollment

Consequences of Delays - Development

MAC Determines Missing Information

- Required Data/Documentation is Missing, and/or
- Clarification is Needed, and/or
- The Certification Statement is Invalid

MAC Develops for Missing Information

- MAC contacts the Contact Person, Individual Provider, or Authorized/Delegated Official
- MAC sends development request via letter, fax, or email
- Provider/suppliers have 30 days to respond completely and accurately to developments

Failure to Respond to Development

- MAC rejects the application if the 30-day period has elapsed
- Up to MAC discretion to make a second request for development

How to Avoid Processing Delays

- Know Your Resources
- Submit Your Application to the Correct MAC
- Understand Your Application Scenario
- Use PECOS Web Rather than Paper Applications
- Be Aware of Common Application Errors

Know Your Resources

- Contact your MAC for guidance
- Your MACs have tutorials, webinars, articles, etc. to educate you on how to properly submit applications.
- MLN Articles
- Read the introductions to each section on the applicable CMS 855 you are completing for instructions

Practice Location Information

SECTION 4: PRACTICE LOCATION INFORMATION

INSTRUCTIONS

- Report all practice locations within the jurisdiction of the Medicare fee-for-service contractor to which you will submit this application.
- If the provider is adding a practice location in the same State and the location requires a separate provider agreement, a separate, complete CMS-855A must be submitted for that location. The location is considered a separate provider for purposes of enrollment, and is not considered a practice location of the main provider. If a provider agreement is not required, the location can be added as a practice location.
- If the provider is adding a practice location in another State and the location requires a separate provider agreement, a separate, complete CMS-855A must be submitted for that location. (This often happens when a home health agency wants to perform services in an adjacent State.)
- If the provider is adding a practice location within another fee-for-service contractor's jurisdiction and the provider is not already enrolled with that fee-for-service contractor, the provider must submit a full, complete CMS-855A to that fee-for-service contractor—regardless of whether a separate provider agreement is required. It cannot add the location as a mere practice location.
- Provide the specific street address as recorded by the United States Postal Service. Do not furnish a P.O. Box.

IMPORTANT: The provider should list its primary practice location first in Section 4A. The "primary practice location" must be associated with the NPI that the provider intends to use to bill for Medicare services.

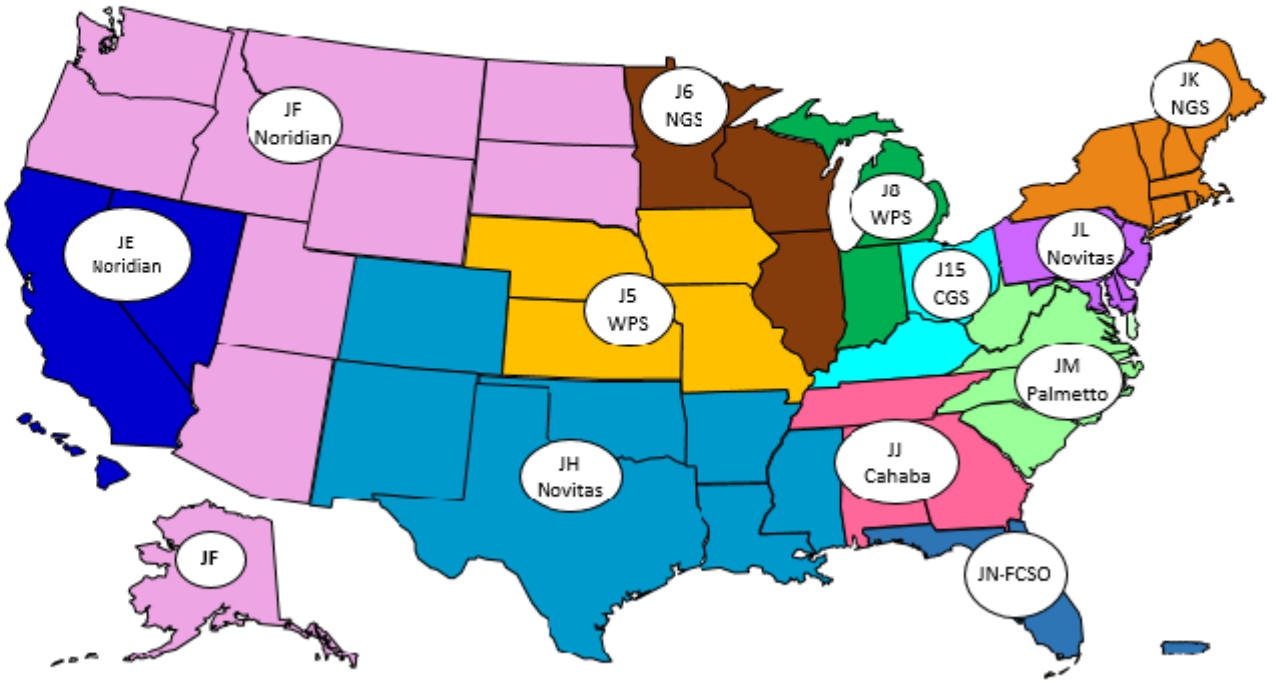
If you have any questions as to whether the practice location requires a separate State survey or provider agreement, contact your fee-for-service contractor.

Community Mental Health Centers (CMHCs) must report all alternative sites where core services are provided (proposed alternative sites for initial enrollment and actual alternative sites for those CMHCs already participating in Medicare). In accordance with provisions of the Public Health Service Act, a CMHC is required to provide mental health services principally to individuals who reside in a defined geographic area (service area). Therefore, CMHCs must service a distinct and definable community. Those CMHCs operating or proposing to operate outside of this specific community must have a separate provider agreement/number, submit a separate enrollment application, and individually meet the requirements to participate. CMS will determine if the alternative site is permissible or whether the site must have a separate agreement/number. CMS will consider the actual demonstrated transportation pattern of CMHC clients within the community to ensure that all core services and partial hospitalization services are available from each location within the community. A CMHC patient must be able to access and receive services he/she needs at the parent CMHC site or the alternative site within the distinct and definable community served by the parent.

Submitting Your Application to the Correct Medicare Administrative Contractor

The Medicare contractor that services your State or practice location is responsible for processing your enrollment application. To avoid having your application returned, be sure to submit to the correct contractor.

A/B Jurisdiction Map
as of December 2015



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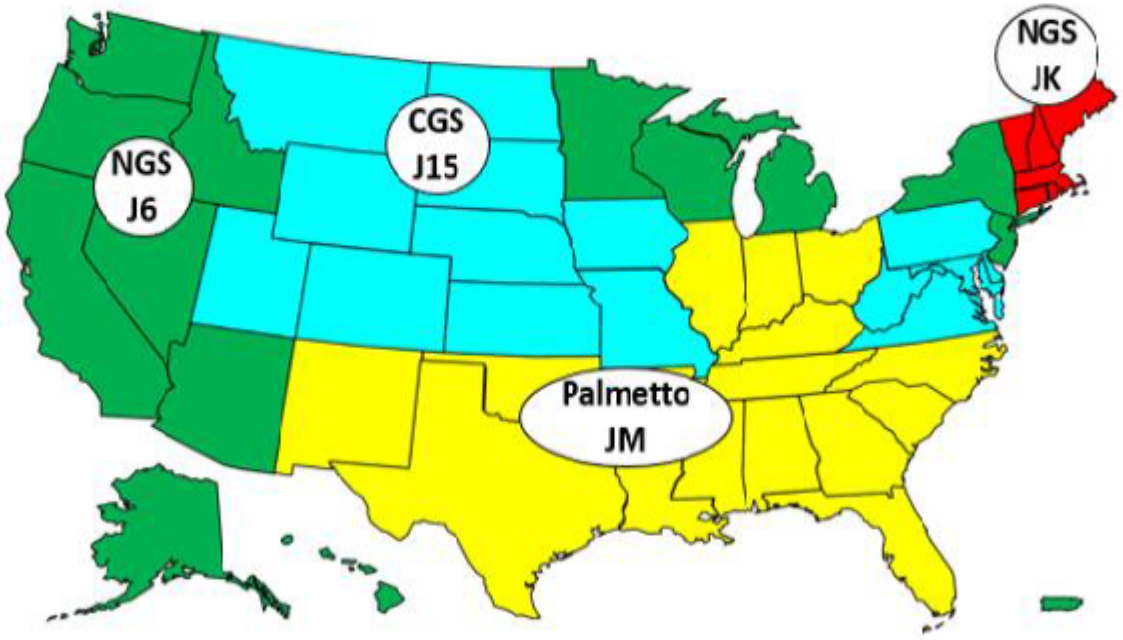
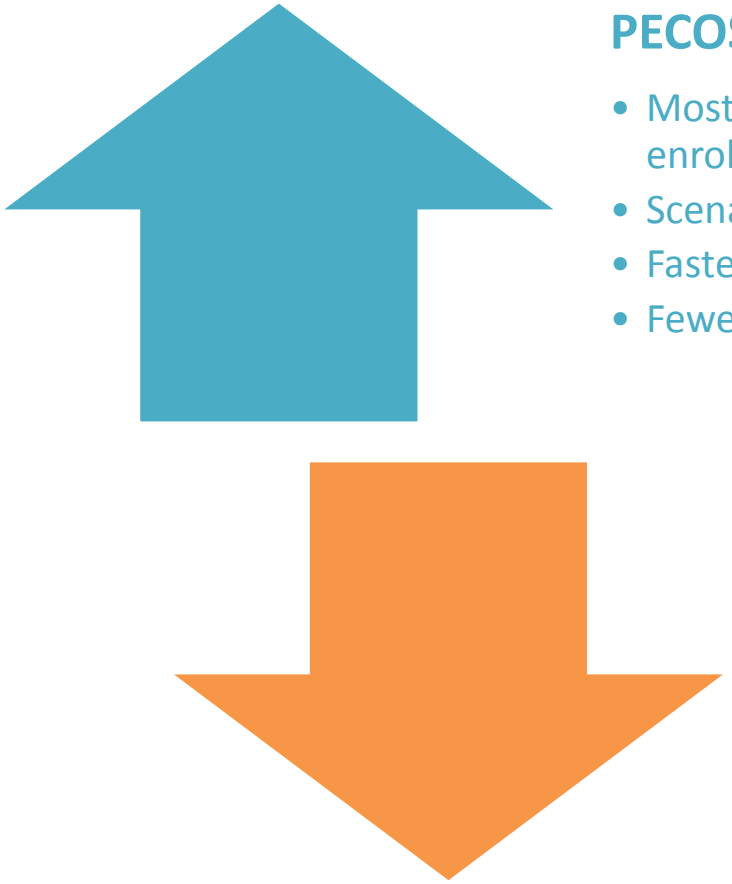
Home Health & Hospice MAC Areas
as of December 2015



PECOS Web Versus Paper



PECOS Web

- Most efficient and effective way to submit enrollment applications
- Scenario driven application
- Faster processing times
- Fewer development requests

For more information on how to submit your enrollment online, attend tomorrow's Session II presentation with Carl Schell from 9:00-10:15

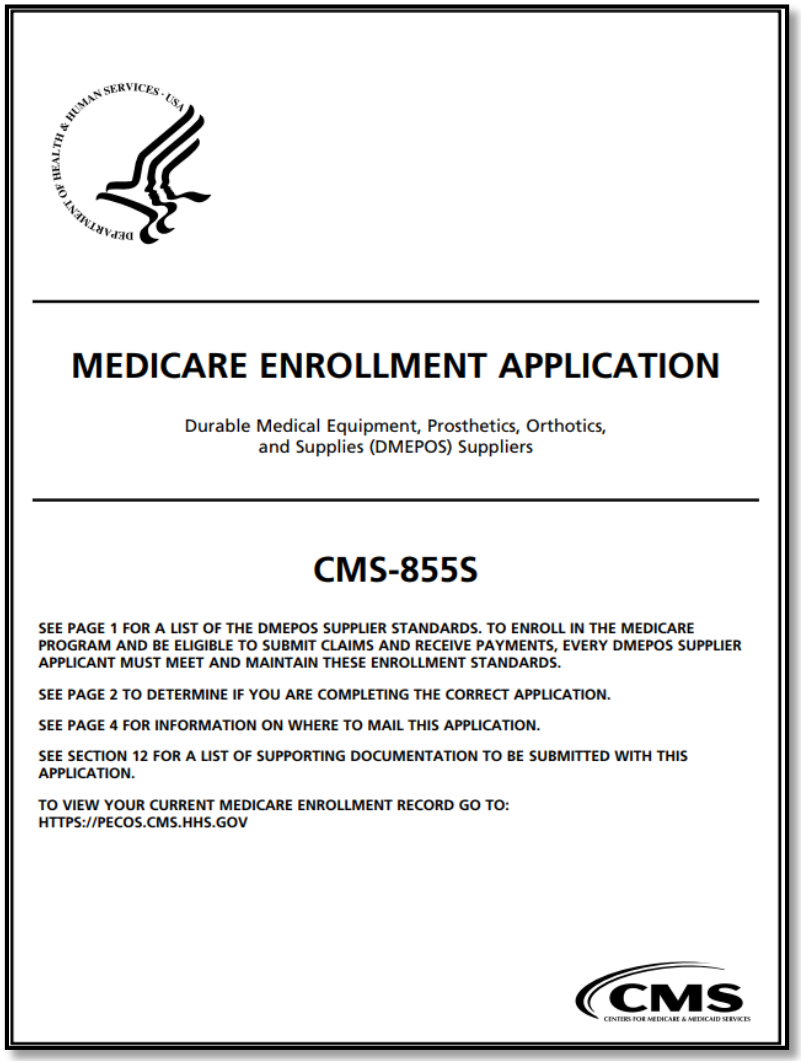
PAPER Application

- Archaic method of submission
- Allows for more opportunity for human error
- Takes longer to process
- Relies on snail mail for submission

Understand your enrollment Scenario

- Are you a new organization, a newly graduated physician, or enrolling with a different scenario?
  - The answer to this type of question drives the application(s) and supporting documentation you will need to enroll
  - Your enrollment scenario may necessitate the need for submission of other applications (i.e., CMS 855I(s), CMS 855R(s))
  - Understand the difference between a sole proprietor and a sole ownership
  - Physician Assistants will always perform their enrollment actions on the CMS 855I

CMS 855 S



MEDICARE ENROLLMENT APPLICATION

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

CMS-855S

SEE PAGE 1 FOR A LIST OF THE DMEPOS SUPPLIER STANDARDS. TO ENROLL IN THE MEDICARE PROGRAM AND BE ELIGIBLE TO SUBMIT CLAIMS AND RECEIVE PAYMENTS, EVERY DMEPOS SUPPLIER APPLICANT MUST MEET AND MAINTAIN THESE ENROLLMENT STANDARDS.

SEE PAGE 2 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 4 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE SECTION 12 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION.

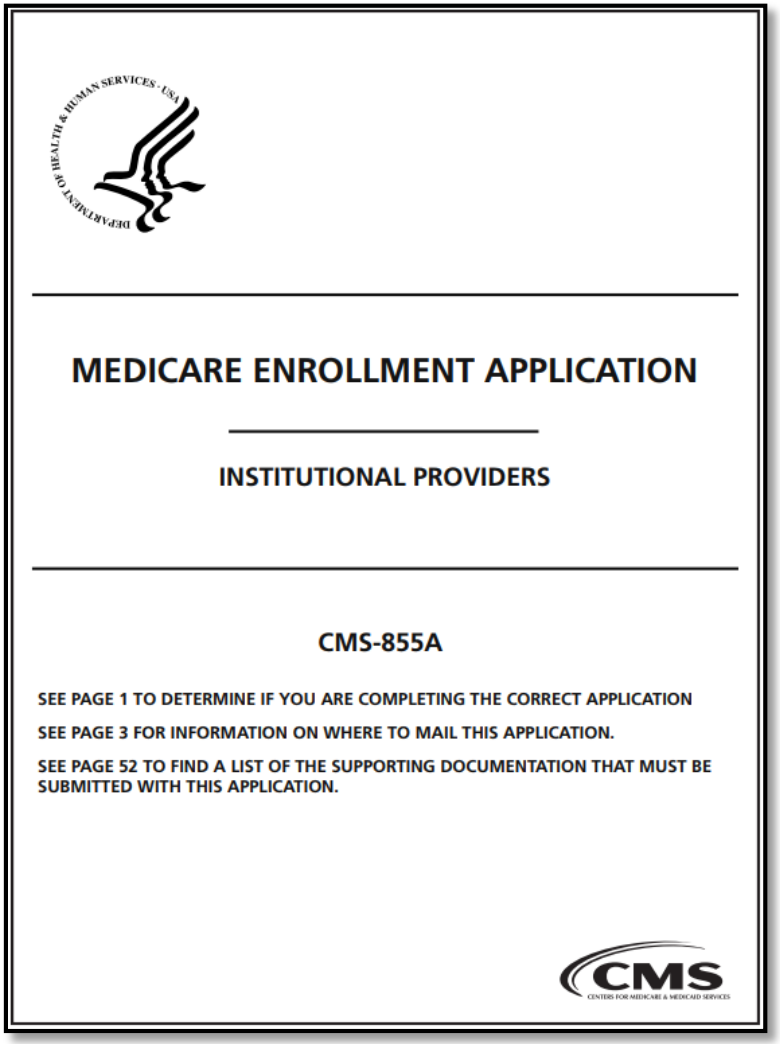
TO VIEW YOUR CURRENT MEDICARE ENROLLMENT RECORD GO TO: HTTPS://PECOS.CMS.HHS.GOV

- **Used to enroll, revalidate or facilitate changes of:**
  - Durable Medicare Equipment, Prosthetics, Orthotics and Suppliers (DMEPOS) Suppliers
- **Most Common Development Reasons:**
  - Submission of an outdated version or unsigned/undated application (CMS 855S was last updated in 5/16)
  - Inconsistency in use of the LBN and/or EIN throughout the application and supporting documentation (i.e., EFT, voided check, NPPES)
  - Failure to pay Application Fee

CMS 855S

- For more information on the 855S, please attend day 2, session I led by Michael Cimmino and Michael Holoman
- For questions about completing the 855S, please visit the NSC MAC's website for enrollment assistance
  - https://www.palmettogba.com/nsc

CMS 855A



MEDICARE ENROLLMENT APPLICATION

INSTITUTIONAL PROVIDERS

CMS-855A

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION

SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 52 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

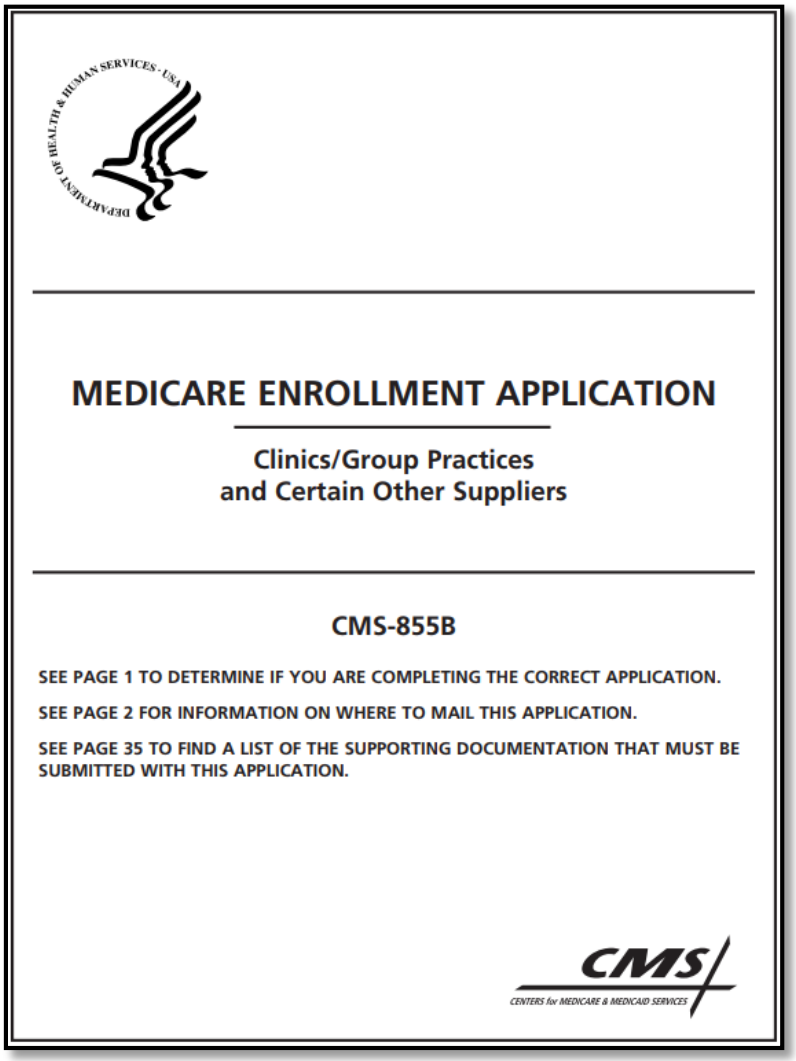
- **This application is used to enroll, revalidate or facilitate changes of**:
  - Institutional providers (i.e., Hospitals, Outpatient Physical Therapy, Rural Health Clinics, Skilled Nursing Facilities) that plan to bill Medicare for Part A medical services
- **Most Common Development Reasons:**
  - Submission of an outdated version or unsigned/undated application (CMS 855A was last updated in 7/11)
  - Incomplete or inaccurate sections – specifically sections three, four and six
  - Application is signed by someone who does not qualify as an authorized/delegated official or has not been previously added as an authorized/delegated official
  - Organizational diagram identifying organization ownership/control
  - Bill of sale for change of ownerships
  - HRSA Notice of Grant Award

CMS 855A

- Please review the presentation outline by *Joe Schultz & Diane Gordon* **-** 855A Enrollment & Policy Overview

- Please visit the your MAC's website for enrollment assistance
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf

CMS 855B



MEDICARE ENROLLMENT APPLICATION

Clinics/Group Practices
and Certain Other Suppliers

CMS-855B

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 35 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

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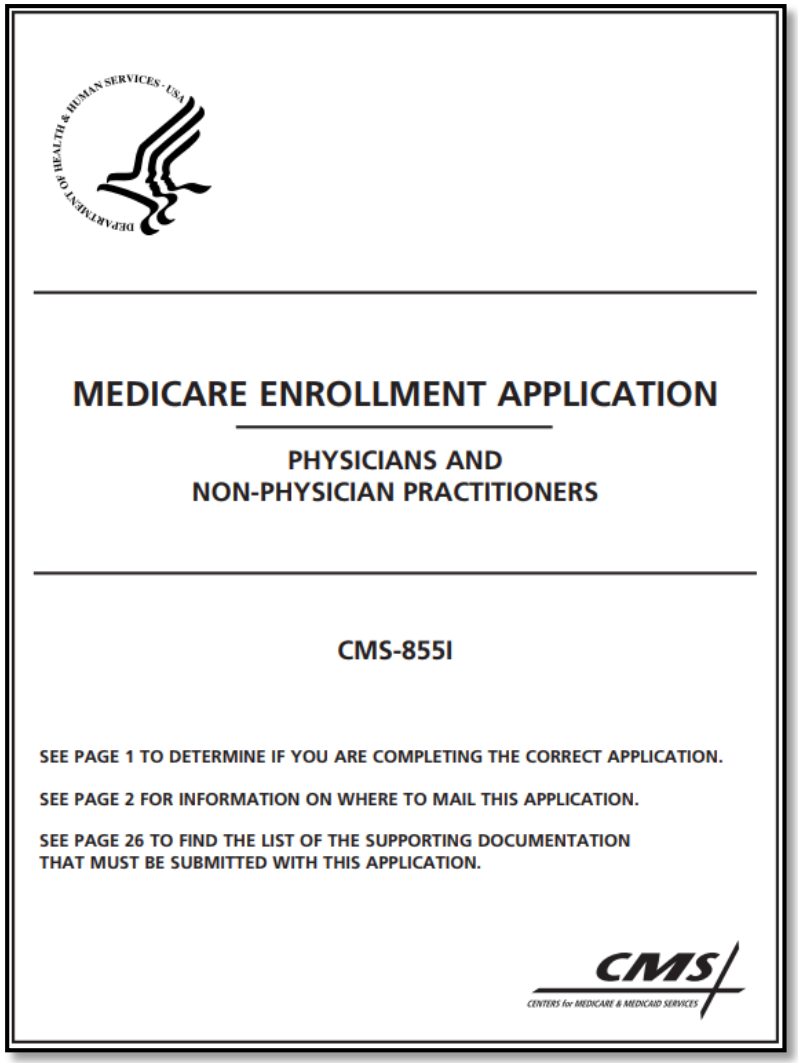
- **This application is used to enroll, revalidate or facilitate changes of:**
  - Clinics/Group Practices and Certain Other Suppliers (i.e., Clinical Laboratories, Ambulatory Surgical centers, Independent Diagnostic Testing Facilities, Mammography Centers) that plan to bill Medicare for Part B medical services that wish to reassign benefits to your practice
- **Most Common Development Reasons:**
  - Submission of an outdated version or unsigned/undated application (CMS 855B was last updated in 7/11)
  - Final Adverse Action documents are not included or do not support requirements
  - Attachment 1 for Ambulance Service Suppliers
  - Attachment 2 for Independent Diagnostic Testing Facilities

CMS 855B

- Please review the presentation outline by Joanne Lucas and Andrea King - 855B Enrollment and Policy Overview
- Please visit the your MAC's website for enrollment assistance
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf

CMS 855I



MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND
NON-PHYSICIAN PRACTITIONERS

CMS-855I

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 26 TO FIND THE LIST OF THE SUPPORTING DOCUMENTATION
THAT MUST BE SUBMITTED WITH THIS APPLICATION.

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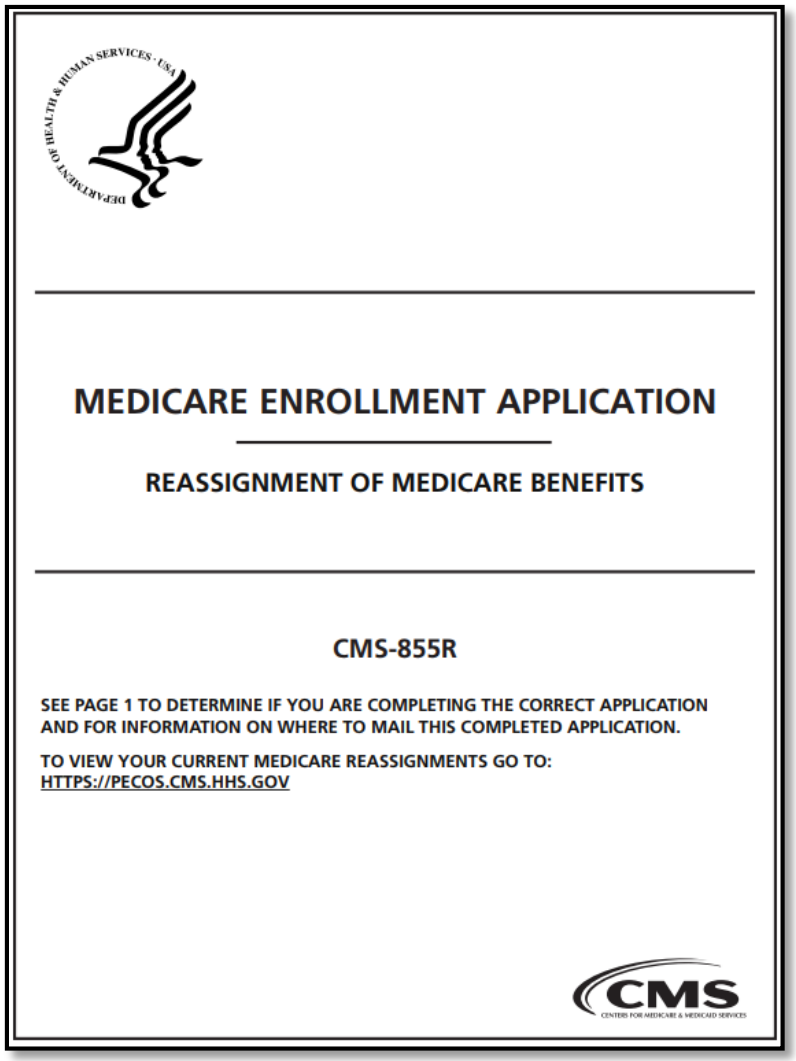
- **This application is used to enroll, revalidate or facilitate changes of:**
  - Physicians and Non-Physician Practitioners that plan to bill Medicare for Part B medical services
- **Most Common Development Reasons:**
  - Submission of an outdated version or unsigned/undated application (CMS 855I was last updated in 7/11)
  - CMS 855R is needed but not submitted
  - Final Adverse Action documents are not included or do not support requirements

CMS 855I

- For more information on the 855I, please attend or review the Day 2, Session I presentation led by Belinda Gravel and William Price
- Please visit the your MAC's website for enrollment assistance
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf

CMS 855R



MEDICARE ENROLLMENT APPLICATION

REASSIGNMENT OF MEDICARE BENEFITS

CMS-855R

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION AND FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

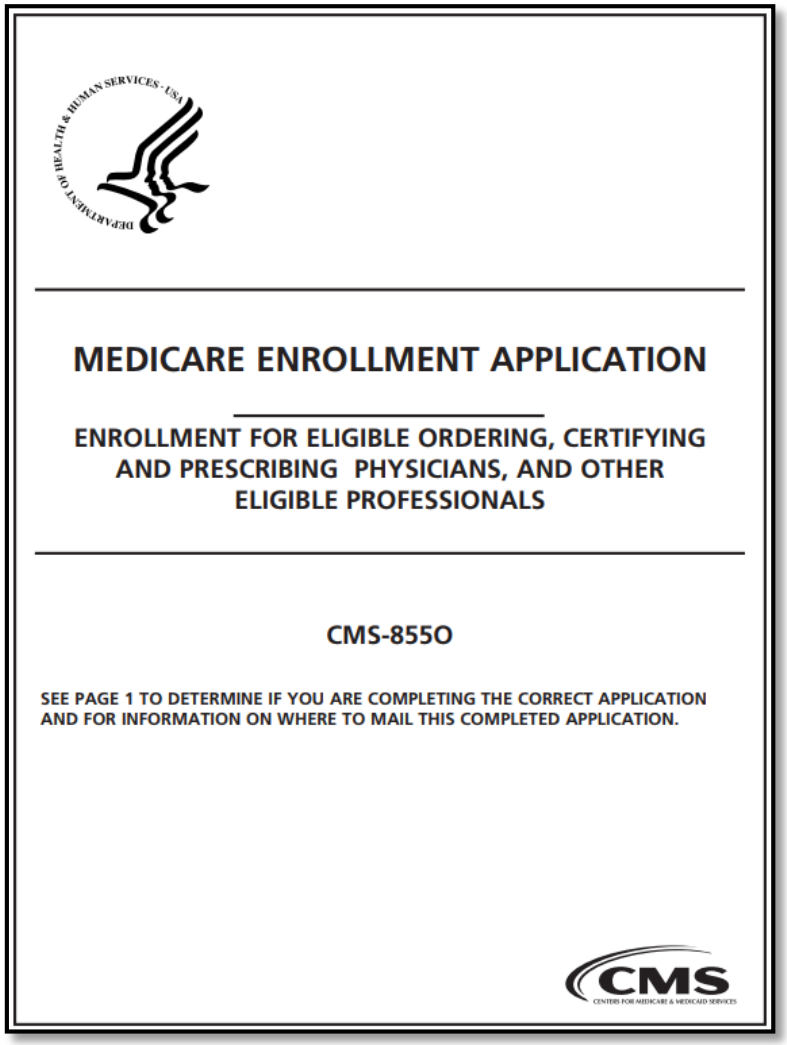
TO VIEW YOUR CURRENT MEDICARE REASSIGNMENTS GO TO:
HTTPS://PECOS.CMS.HHS.GOV

- **This application is used to reassign benefits and facilitate changes of:**
  - Reassigned benefits for Physicians and Non-Physician Practitioners
- **Most Common Development Reasons:**
  - Submission of an outdated version or unsigned/undated application (CMS 855R was last updated in 4/16)
  - Not submitting the CMS 855I simultaneously

CMS 855R

- For more information on the 855R, please attend or review the Day 2, Session I presentation led by Belinda Gravel and William Price
- Please visit the your MAC's website for enrollment assistance
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf

CMS 855O



MEDICARE ENROLLMENT APPLICATION

ENROLLMENT FOR ELIGIBLE ORDERING, CERTIFYING AND PRESCRIBING PHYSICIANS, AND OTHER ELIGIBLE PROFESSIONALS

CMS-855O

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION AND FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

- **This application is used to enroll:**
  - Eligible ordering, certifying, and prescribing physicians and other eligible professionals
- **Most Common Development Reasons:**
  - Submission of an outdated version or unsigned/undated application (CMS 855O was last updated in 1/17)

CMS 855 O

- For more information on the 855O, please attend or review the Day 2, Session II presentation led by Alisha Sanders and Sandy Boyer
- Please visit the your MAC's website for enrollment assistance
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf

Common Development Reasons – Legal Business Name

Common Development Reasons – CMS 588 EFT

CMS requires all providers and suppliers enrolling in the Medicare program or updating their enrollment data to receive payments via electronic funds transfer.

CMS 588

The CMS-588 must be signed by the enrolling individual or the authorized/delegated official who signed the Medicare enrollment application (CMS 855)

Please include a voided check or bank letter that confirms the legal business name, account number and routing number

Prior to submission, verify the bank account is in good standing and ready to receive financial transactions

Check for Supporting Documentation Requirements

- Section 17 of the CMS 855(A/B/S/I) applications contains a list of supporting documentation needs for your enrollment scenario. The most needed documents are:
  - CMS-460 – Participation Agreement
  - CMS-588 - Electronic Funds Transfer Authorization Agreement with bank confirmation (i.e., voided check, bank letter)
  - IRS document confirming the Tax Identification Number
  - Bill of sale or purchase agreement if a change has occurred
  - Licensure/Diploma/Certification documents are only needed if contractors are unable to confirm online

Designate a Reliable Contact Person

- Ensure your contact person is reliable, accessible, and knowledgeable
  - Make sure to include a fax number and email for letters to be sent to avoid delays in getting it sent via regular mail
  - Respond to requests for additional information promptly and accurately

Did You Sign Your Application?

- Applications must be signed and dated by the appropriate individuals
- Signatures must be original and in ink (we prefer blue)
- Copied or stamped signatures are not acceptable

Summary

Avoid processing delays by…

- Submitting the correct application in a complete and accurate manner
- Using PECOS Web to submit
- Submitting to the correct MAC
- Responding quickly and accurately to any development requests
- Using resources offered by the MACs to answer any application questions
- Understanding your enrollment scenario and determining what application(s) and documents are right for you

Questions?

- Quiz Time

Resources

- Information relative to Internet-based PECOS can be located at: www.cms.gov/MedicareProviderSupEnroll by clicking on the Internet-based PECOS link on the menu
- Copies of all Medicare enrollment applications can be found at: http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp
- Locate the list of Medicare fee-for-service contractors by State at https://www.cms.gov.Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf
- If you do not have an NPI or need to request changes, you can contact the NPI Enumerator at: https://nppes.cms.hhs.gov CMS 855 or call the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326