Medicare & Medicaid
Provider Enrollment

Presented by
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Provider Enrollment & Oversight Group
Center for Medicare & Medicaid Services

Charles Schalm, Deputy Director
Provider Enrollment & Oversight Group
Center for Medicare & Medicaid Services
Session Overview

- How Enrollment Works
- Medicare Policy Updates
- Medicaid Enrollment
- Revalidation
- Our Enrollment Systems
- Protecting the Program
- Enforcement Actions
First thoughts

1. Listening to you
   We hear you, and we’ve learned a lot from you.

2. Finding a balance
   We believe enrollment should be easy for most providers, and hard for bad actors.

3. Always improving
   We will keep refining our systems, policies, transparency, and our vision.
How enrollment works
How enrollment works

1. **Submission**
   - 855Form 60 days*
   - Online 45 days*
   - Medicare Providers & Suppliers (w/NPI)

2. **Intake**
   - Direct Input
   - MAC mail room
   - Manual data entry

3. **Processing, Screening & Verification**
   - PECOS
   - Pre Screening
     - signed + dated
     - app fee (or waiver)
     - supporting docs
     - all data elements
   - Verification
     - Name / LBN
     - SSN / DOB
     - NPPES
     - Address
     - License
     - Adverse Actions

4. **Finalization & 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 mo

* If the app is complete, and no site visit
What causes delays?

30-35% delayed

need at least 1 round of corrections

- missing documents
  IRS documents, CMS 588 EFT, voided check, bank letter, education documentation, par agreement, cert term page, org charts
- missing fields missing signature/date
- wrong signature (paper)
- incorrect information
- missing application fee

How the MAC develops for missing information

<table>
<thead>
<tr>
<th>Contacts the...</th>
<th>By...</th>
<th>No response?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Contact person (sec 13)</td>
<td>email, fax, phone, letter</td>
<td>delays</td>
</tr>
<tr>
<td>2. Individual provider (sec 2)</td>
<td></td>
<td>rejections</td>
</tr>
<tr>
<td>3. Auth or Del Official (sec 15/16)</td>
<td></td>
<td>later effective date</td>
</tr>
</tbody>
</table>

30 days to respond
MAC Notification Letters

Who is listed on MAC notification letters?

APPLICATION RECEIPT

PROCESSING & DEVELOPMENT

AFTER FINALIZATION

MAC analyst is the point of contact listed on the letter

MAC call center is the point of contact listed on the letter
Medicare effective dates | Part B

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)

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

<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>MAC receives app</td>
<td>MAC approves</td>
<td>Provider performs service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APR 1</td>
<td>MAY 15 (w/ effective June 1)</td>
<td>JUNE 1</td>
<td></td>
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</tbody>
</table>

**Provider seeking effective date**
JUNE 1

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

<table>
<thead>
<tr>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
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<td>JUNE 1</td>
<td></td>
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</tr>
</tbody>
</table>

**MAC PROCESSING**

**Must be in compliance at requested effective date (operational, licensed)**
Medicare effective dates | Part A

Effective date is based on:
- Completion of survey
- Regional Office determines all requirements are met

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

<table>
<thead>
<tr>
<th>Hospitals / HHAs / SNFs</th>
<th>can apply up to <strong>180 days</strong> prior **</th>
</tr>
</thead>
</table>

**Provider seeking effective date**

**OCT 1 2016**

<table>
<thead>
<tr>
<th>MAC receives app</th>
<th>MAC recommends approval to RO</th>
<th>RO approves, w/ effective Oct 1 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARCH ’16</td>
<td>JULY 1 ’16</td>
<td>OCT 1 2016</td>
</tr>
</tbody>
</table>

**PROCESSING**

<table>
<thead>
<tr>
<th>MAR ’16</th>
<th>JUN’16</th>
<th>OCT ’16</th>
<th>JAN ’17</th>
<th>MAR ’17</th>
<th>JUN ’17</th>
</tr>
</thead>
<tbody>
<tr>
<td>RO PROCESSING</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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**CENTERS FOR MEDICARE & MEDICAID SERVICES**
Enrollment Arrangements (Telehealth)

**MM8545 | Inter-jurisdictional**

- **Dr. Smith**
  - 123 Main St. Maryland (855I)
- **Jones Medical Group**
  - 123 Main St. Maryland (855B)
- **Novitas (MAC)**
- **First Coast (MAC)**
  - 456 Elm St. Florida (855B)

**Telework**
Application Fees

- supports provider enrollment and screening activities
- required for institutional providers when initially enrolling, revalidating or adding a practice location
  Home Health Agencies, DME supplier, Hospital, IDTF
- application fee varies from year-to-year
- must be paid electronically via PECOS
  credit or debit card (no checks permitted)
- MACs will develop for missing application fees and reject the application if not submitted within 30 days

A refund may be issued if...
1. A hardship exception request is approved
2. The application was rejected prior to the MAC’s initiation of the screening process
3. The application denied due to temporary moratorium
4. Fee not required for the transaction in question or not part of an application submission

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

Pay the application fee at https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do

Refund request

application fee for 2017 is $560
### Authorized and Delegated Officials – CMS 855 & I&A

<table>
<thead>
<tr>
<th><strong>AO</strong> Authorized Official</th>
<th><strong>DO</strong> Delegated Official</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enroll, make changes and ensure compliance with enrollment requirements</td>
<td>Appointed by the AO with authority to report changes to enrollment information</td>
</tr>
<tr>
<td>- CEO, CFO, partner, chairman, owner, or equivalent appointed by the org</td>
<td>- Ownership, control, or W-2 managing employee</td>
</tr>
<tr>
<td>- May sign all applications <em>(must sign initial application)</em></td>
<td>- Multiple DOs permitted</td>
</tr>
<tr>
<td>- Approves DOs</td>
<td>- May sign changes, updates &amp; revalidations <em>(cannot sign initial application)</em></td>
</tr>
</tbody>
</table>

### Assign surrogacy and controls access to PECOS and NPPES records

- Less restrictive AO requirements than 855
- Automatically approved if listed as AO on 855; if not, CP575 must be provided to approve access
- Manage staff and connections for the employer
- Approve DOs for the employer

### Authority to assign surrogacy and controls access to PECOS and NPPES records

- Delegated by the AO of org provider or 3rd party org
- May add the employer to his profile, manage staff and connections for the employer
- Multiple DOs permitted
Who can sign the enrollment application?

- **Initial:**
  - Authorized Official (AO)
  - OR
  - Delegated Official (DO)

- **Changes & Revals:**
  - Authorized Official (AO)

- **All:**
  - Individual Provider (IP)

- **Adding:**
  - Individual Provider (IP)
  - Delegated Official (DO)
  - Authorized Official (AO)

- **Changing/Terminating:**
  - Individual Provider (IP)
  - Delegated Official (DO)
  - Authorized Official (AO)
Certification statement requirements

**PAPER**
- **CERT**: INVALID CERT → MAC DEVELOPS
- **CERT**: MISSING CERT → MAC DEVELOPS

**WEB**
- **PECOS**: INVALID CERT → MAC DEVELOPS
- **PECOS**: MISSING CERT → MAC DEVELOPS
  - **EXCEPTIONS OF INVALID CERT**: Copied / Stamped Signatures • Unsigned • Undated • Wrong Person Signed
  - **BEST WAY TO SUBMIT YOUR CERT STATEMENT**: SEND WITH CMS 855
    - OR
    - IF YOU MUST, MAC WILL ACCEPT: FAX, E-MAIL, (IF SIG ON FILE) OR MAIL, BUT WILL LEAD TO DELAYS

**BEST WAY TO SUBMIT YOUR CERT STATEMENT:**
- **PECOS**: E-SIGN
  - OR
  - IF YOU MUST, MAC WILL ACCEPT: FAX, E-MAIL, (IF SIG ON FILE) OR MAIL, BUT WILL LEAD TO DELAYS
  - *Be sure to include web tracking ID if using paper cert statement*
Contact Person

- any contact listed on an enrollment record may request a copy of approval and revalidation letters
- MAC will send by...
  - email
  - fax
  - mail

(excludes certification letters or Tie In notices issued by Regional Office)

How to end date a contact person?

Requests may be submitted by...

1. Current Contact person (sec 13)
2. Individual provider (sec 2)
3. Auth or Del Official (sec 15/16)

By...

- email
- fax
- letter

Addition of contact persons must still be reported on appropriate CMS-855
When to Select Change/Add/Delete

Applicable CMS-855 sections (change/add/delete options)

1. Location information (855A/855B/855I/855S)
2. Ownership/Managing Control (855A/855B/855I/855S)
3. Billing Agency (855A/855B/855I/855S)
4. AO/DO (855A/855B/855S)
5. Attachments 1&2 (855B)

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
Ordering and Certifying

Anyone who orders or refers services:

CMS-6010
since Jan 2014

enroll in Medicare
or opt-out through an affidavit

State-licensed residents may enroll to order or refer using the CMS-855O, and may be listed on claims.

Claims for covered items and services from un-licensed interns and residents may still specify the name and NPI of the teaching physician.

Reduces fraud

Claims affected:
See article SE1305 for all edits

- Clinical laboratories: ordered tests
- Imaging centers: ordered images
- DMEPOS: ordered equipment, supplies
- Home Health Agencies
Ordering and Certifying

Converting CMS-855O to CMS-855I enrollment via PECOS

Conversion Steps:

- Follow current process for creating a new application
- PECOS displays existing approved enrollment and uses it to pre-populate the new application
- Provider must confirm the withdrawal of the existing 855O enrollment

- Convert from an ordering and referring only provider to a billing provider and vice versa
- No break in billing
- The effective date of the withdrawn 855O is one day prior to the effective date of the 855I
Updates to Program Integrity Manual

- MACs should not call to speak directly to providers reporting a change in specialty

- MACs should not request a diploma or degree unless education requirements cannot be verified online

- MACs should not request a SSN card or driver’s license for identification.

- MACs should not request a phone, utility, power bill or lease to validate LBN or DBA
  - Lease only required to validate exclusive use of facility for PT/OT or ambulance suppliers leasing aircraft

- For applications that require development, MACs shall only request the dated signature of at least one authorized/delegated officials

- Approval letters will list all changed/updated information for change of information submissions.
Updates to Program Integrity Manual

- **CMS-855R processing guide**
  - addendum to PIM chapter 15 on CMS.gov
  - used by MACs and providers
  - includes application completion and processing instructions

- **CMS-855O processing guide (Coming Soon)**
  - addendum to PIM chapter 15 on CMS.gov
  - used by MACs and providers
  - includes application completion and processing instructions
CMS-855R Processing Guide
For Providers | For MACs
“Verification must occur of licenses and or certifications. The only licenses that must be submitted with the application are those required by Medicare or the state to function as the supplier type in question. Licenses and permits that are not of a medical nature are not required,
...
If the MAC is aware that a particular state does not require license/certification and the “Not Applicable” boxes are not checked in Section 2C, no further development is needed.”

“Communications regarding the processing of the CMS-855R shall be sent to the contact person listed. If multiple contact persons are listed, the MAC shall contact the first contact person listed on the application. If they are not available, the MAC shall contact the other person(s) listed, unless the individual practitioner indicates otherwise via any means.”
"A physician/eligible professional need not submit a copy of his/her degree unless specifically requested to do so by the MAC. To the maximum extent possible, the MAC shall use means other than the physician’s submission of documentation—such as a State or school Web site—to validate the person’s educational status."

"If the physician/eligible professional is submitting an initial enrollment application a PTAN need not be listed, as one has not been assigned; the physician/eligible professional can enter the word “pending” in this field or leave the field blank.

If the 855O enrollment is being terminated, the PTAN should be listed... The MAC may use the shared systems, PECOS, or its provider files as a resource for determining the PTAN before developing for this information."
Program Integrity Manual Revamp

For Providers | For MACs

- more user friendly
- new structure driven by application and provider type
- remove outdated and inaccurate information
- consolidate sections identifying similar processes
- add new and clarify existing policy

Target Completion: Early 2018
“If the revalidation application is received but requires development (i.e., missing information such as application fee, hardship request, PTANs, documentation, signature), the contractor shall notify the provider or supplier via mail, phone, fax or email....

The contractor shall not require further development for missing documentation if the information already exist on file with the contractor (i.e., diploma....)”
Provider Enrollment Moratoria

**Initial implementation**
July 2013
- HHA and HHA sub-units (Miami, Chicago)
- Ambulance and ambulance suppliers (Houston)

**Expanded and extended**
Jan 2014
- HHA and HHA sub-units (Miami, Ft. Lauderdale, Detroit, Dallas, Chicago)
- Ambulance and ambulance suppliers (Houston, Philadelphia, surrounding New Jersey)

**Lifted**
Jul 2016
- Emergency ambulance services

**Extended**
Jan and July 2017
- State wide
- HHA and HHA sub-units (Florida, Illinois, Michigan, Texas)

**Expanded and extended**
Jul 2016
- State wide
- HHA and HHA sub-units (Florida, Illinois, Michigan, Texas)
- Non-emergency ambulances and ambulance suppliers (New Jersey, Pennsylvania, Texas)

For more information refer to the Federal Register notice at https://www.federalregister.gov
Medicaid Enrollment
Medicaid Provider Enrollment

CMS Center for Program Integrity manages Medicare and Medicaid enrollment.

Advantages

Less burden for states and providers
In some cases, states can screen Medicaid providers using our Medicare enrollment data (site visits, revalidation, application fees, fingerprinting).

More consistency among states
Clearer sub-regulatory guidance
Each state has a CMS point-of-contact

Medicaid Provider Enrollment Compendium (MPEC)
Similar to the Medicare Program Integrity Manual
Medicaid Provider Enrollment Compendium

**MPEC**  Updated Jun 2017

- for State Medicaid Agencies (SMA) and providers
- guidance on federal Medicaid enrollment standards (42 CFR 455 Subparts B, E)
- states may be stricter than Federal regs

**sample guidance**

**Revalidation** (Section 1.5.2, 1.5.3)
- required every 5 years (includes ordering and referring physicians)
- discretion to require revalidation on a more frequent basis
- conduct full screening appropriate to provider’s risk level
- may rely on Medicare or another state’s screening

**Approval letters** (Section 1.7)
- SMAs should not request MAC “welcome letter” as a condition of provider enrollment

**Ownership Discrepancies** (Section 1.5.3)
- SMAs recommended to report ownership discrepancies for dually enrolled providers

**Retroactive Dates of Service** (Section 1.6B)
- SMA makes determination to grant a retroactive billing date based on compliance
Relying on Medicare Screening

- SMA determines to what extent it may reduce its own screening through reliance on Medicare’s screening activities
- States MAY rely upon Medicare screening, however are not required to
- For SMAs to rely on Medicare's screening:
  - must have occurred in the last 5 years
  - must be the same provider in Medicare
  - must be an “approved” Medicare provider

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Comparison</th>
<th>Risk Category</th>
<th>SMA Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Risk Category</td>
<td>=</td>
<td>Medicare Risk Category</td>
<td>None</td>
</tr>
<tr>
<td>Medicaid Risk Category</td>
<td>&gt;</td>
<td>Medicare Risk Category</td>
<td>Gap Screening</td>
</tr>
<tr>
<td>Medicaid Risk Category</td>
<td>&lt;</td>
<td>Medicare Risk Category</td>
<td>None</td>
</tr>
</tbody>
</table>

*Exception for DME and HHA risk levels*
<table>
<thead>
<tr>
<th>Provider Information</th>
<th>Medicare Risk Category</th>
<th>Risk Level: Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Richard McRoberts</td>
<td>Correspondence Address: 123 East Way, Springfield</td>
<td>Doing Business As Name:</td>
</tr>
<tr>
<td>Date of Birth: 11/03/1957</td>
<td>Address Line 2: Suite #200</td>
<td>TIN: XXX-XX-3109 (SSN)</td>
</tr>
<tr>
<td>NPI: 1023054806</td>
<td>State: MA</td>
<td>IRS Information: LLC</td>
</tr>
<tr>
<td>NPI Verified in NPPES? YES</td>
<td>Point of Contact: Dave Wilson</td>
<td></td>
</tr>
<tr>
<td>Medicare Risk Category:</td>
<td>Reassigning Practitioner: Mary Williams</td>
<td></td>
</tr>
<tr>
<td>Reassigning Practitioner NPI: 1037463526</td>
<td>Reassigning End Date: 01/15/2017</td>
<td></td>
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<tr>
<td>Reassigning End Date: 01/15/2017</td>
<td>Reassigning Effective Date: 04/13/2015</td>
<td></td>
</tr>
<tr>
<td>Receiving Reassignments From:</td>
<td>Change of Ownership Information</td>
<td></td>
</tr>
<tr>
<td>Type: Merger/Acquisition</td>
<td>Effective Date: 05/30/2013</td>
<td></td>
</tr>
<tr>
<td>Provider Agreement Accepted?: Yes</td>
<td>Buyer/Seller Entity Name: AMS, Inc.</td>
<td></td>
</tr>
<tr>
<td>Buyer/Seller Entity TIN: XXX-XX-4637</td>
<td>Buyer/Seller NPI: 1023964536</td>
<td></td>
</tr>
</tbody>
</table>

**CMS**

**Centers for Medicare & Medicaid Services**
### Medicare Provider Info:

**Current Status Information**
- **Current Status:** Approved
- **First Approved On:** 04/30/2003
- **Status Effective Date:** 04/30/2003

#### Enrollment Timeline (Based on Medicare ID)

<table>
<thead>
<tr>
<th>Status</th>
<th>Active</th>
<th>Inactive</th>
<th>Active</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status Reason</td>
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<td></td>
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<tr>
<td>Status Reason</td>
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<td></td>
</tr>
</tbody>
</table>

### Practice Location Info:

**Location Name:** Smith Medical, Inc.

- **Address:** 87465 West Avenue
- **City:** Worcester
- **State:** MA
- **ZIP:** 37485

- **Address:** Room 965
- **Address:** Room 965
- **Address:** Room 965

- **Site Visit Date:** 02/15/2016
- **Site Visit Result:** PASS

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CMS
Centers for Medicare & Medicaid Services
Disclosure Info:

- Name: John Smith
- Role Effective Date: 03/15/2015
- Date of Birth: 04/01/1977
- SSN (Last 4): 3000-XX-3297
- FCBC Order Date: 04/10/2015
- FCBC Result: PASS
- Sanction Code:
- Sanction Effective Date:
- Sanction End Date:
- APS Profile Link:
- Screening Order Date: 05/16/2016
- Screening Result: PASS

- Name: John Smith
- Role Effective Date: 03/15/2015
- Date of Birth: 04/01/1977
- SSN (Last 4): 3000-XX-3297
- FCBC Order Date: 04/10/2015
- FCBC Result: PASS
- Sanction Code:
- Sanction Effective Date:
- Sanction End Date:
- APS Profile Link:
- Screening Order Date: 05/16/2016
- Screening Result: PASS

- Managing Entity:
- Name: John Smith
- Role Effective Date: 03/15/2015
- Date of Birth: 04/01/1977
- SSN (Last 4): 3000-XX-3297
- FCBC Order Date: 04/10/2015
- FCBC Result: PASS
- Sanction Code:
- Sanction Effective Date:
- Sanction End Date:
- APS Profile Link:
- Screening Order Date: 05/16/2016
- Screening Result: PASS
Screening History:

MEDICARE SCREENING HISTORY (RICHARD MCROBERTS)

Provider Screening Information
Date Ordered: 04/12/2016

Revalidation Information
Revalidation Due Date: 09/20/2017
Revalidation Completed Date: 10/16/2017
Revalidation Status: COMPLETED

SSA Death Master File Information
Date Reported on Death Master File: 09/20/2017
Date of Death: 10/16/2017
Revalidation Status: COMPLETED

OIG LEIE Medicare Exclusionary Database (MED) Information
Date Reported on MED File: 09/20/2017
MED Sanction: [Blank]
Date Reported on Waiver File: [Blank]
Waiver End Date: [Blank]
Data Compare Service

SMAs that have participated in Data Compare

- Process that SMAs may leverage to rely upon Medicare screening data to comply with ACA requirements
  
  CMS works with SMAs to identify dually enrolled providers who have already been screened in Medicare to assist them in completing their revalidation and screening requirements
CMS State Visits

State Visits are a way to:

- Build a relationship
- Ask and answer questions related to federal enrollment requirements
- Review MPEC guidance
- Discuss challenges and barriers
- Brainstorm opportunities to tackle challenges and barriers
- Find ways CMS can better support the SMA, help reduce burden, and provide guidance
- 100% voluntary
CMS and State Assessment Contractor conduct assessments of the SMA’s progress with screening and enrollment requirements.

- Visits are 100% voluntary.
- Work with the SMAs to identify best practices and opportunities for improvement.
- Identify ways CMS can better support the SMAs, help reduce burden, and provide guidance.
# State Best Practices

<table>
<thead>
<tr>
<th>State</th>
<th>Best Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR</td>
<td>Use of CMS Data Compare Service enabled Oregon to leverage Medicare screening and complete revalidation for 90% of their providers.</td>
</tr>
<tr>
<td>CT</td>
<td>Automated checks of the Death Master File built into the online application identify inaccurate data in real time and prevent application submission.</td>
</tr>
<tr>
<td>IN</td>
<td>Indiana is able to process enrollments within 15 days or less.</td>
</tr>
<tr>
<td>WI</td>
<td>Wisconsin established a 24 hour auto-enrollment process.</td>
</tr>
<tr>
<td>VA</td>
<td>Virginia established a 100% online enrollment process.</td>
</tr>
<tr>
<td>AL</td>
<td>Alabama compares ownership data against Medicare data in PECOS to identify potentially outdated or fraudulent data and returns the application if there are mismatches.</td>
</tr>
</tbody>
</table>
Medicaid Managed Care

CMS-2390
starts JUL 2018

Medicaid Managed Care network providers that furnish, order, refer or prescribe must:

- enroll in Medicaid

Reduces fraud
1. Ensures compliance with enrollment requirements across all programs
2. Ensures services are provided by qualified providers
3. Ensures consistency across CMS programs
Revalidation
Revalidation Basics

5-year cycles
3-year for DME suppliers

When is your revalidation due?
go.cms.gov/MedicareRevalidation

- Lists all affected, 6 months out
- MACs will send notices 2-3 months prior
- Always due on last day of the month
- List includes all reassignments

We email the contact person for development
- If multiple contacts exist email most recent on file
- No phone calls
- If no email address, we mail to: correspondence and special payment addresses and/or practice location address

Large Group Coordination
- We mail an “FYI” to large groups every 6 months, with a spreadsheet of every relevant provider (name, NPI, and specialty)
- MACs can now ask one contact to verify multiple practice locations

Response Rate

79%

60 days to respond

No response?
- deactivate (not revoke)

Late revalidation?
- break in billing
- new effective date
Revalidation Details

Unsolicited revalidations

- if your enrollment’s due date is “TBD”, do not send an application
- CMS will accept applications submitted within 6 months before due date, any application submitted beyond this timeframe will be returned
- if you want to update or change your enrollment record, send the relevant 855 form

Deactivations

- if you don’t provide a complete revalidation your Medicare billing privileges will be deactivated
- respond to all development requests by your MAC within 30 days
- if we deactivate you, you need to resend a complete enrollment application for reactivation
- if CMS reactivates you, you keep your old PTAN, and you are reactivated to the receipt date of the new application
Revalidation Details

Changes received prior to revalidation

- change of information applications received prior to the revalidation notice being mailed are processed as normal
- MAC will still mail revalidation notice
- changes reported within 6 months of revalidation due date are not required to be reported on the revalidation application
  - MAC will process the change and proceed with processing the revalidation
  - MAC will not override the previous changes
Revalidation timeline

<table>
<thead>
<tr>
<th>CMS (MAC) ACTION</th>
<th>TIMEFRAME</th>
<th>SAMPLE TIMELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>POST TO THE REVAL LIST</td>
<td>6 MONTHS BEFORE</td>
<td>MAR 30 2017</td>
</tr>
<tr>
<td>NOTIFY LARGE GROUPS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEND NOTICE (E-MAIL OR LETTER)</td>
<td>2-3 MONTHS BEFORE</td>
<td>JUN 30 2017</td>
</tr>
<tr>
<td>REVALIDATION</td>
<td>DUE DATE</td>
<td>SEPTEMBER 30, 2017</td>
</tr>
<tr>
<td>DEACTIVATE BILLING PRIVILEGES FOR NON-RESPONSE</td>
<td>DUE DATE</td>
<td>SEPT 30 2017</td>
</tr>
</tbody>
</table>
## Missing reassignments – no break in billing

### Scenario #1
- Revalidation application sent with missing reassignments.
- Response received **before** due date

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/01/2017</td>
<td>Application Received</td>
</tr>
<tr>
<td>10/15/2017</td>
<td>Development Letter Sent</td>
</tr>
<tr>
<td>11/15/2017</td>
<td>Development Due</td>
</tr>
<tr>
<td>11/10/2017</td>
<td>Development Received</td>
</tr>
<tr>
<td>10/31/2017</td>
<td>Revalidation Due</td>
</tr>
<tr>
<td>11/30/2017</td>
<td>Revalidation Complete</td>
</tr>
</tbody>
</table>

- Revalidation notice includes reassignments for Groups A, B & C
- Revalidation application is received but only addresses reassignment for Group A.
- MAC develops to Contact Person for missing reassignments for Groups B & C
- Provider responds with information for Groups B & C prior to the revalidation due date or the development due date (Section 1, 2, 4 & 15 of the 855I or a full 855I)

**No break in billing**
**Scenario #2**

- Revalidation sent with missing reassignments.
- Response received **after** due date

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Receipt</td>
<td>10/01/2017</td>
</tr>
<tr>
<td>Development Letter Sent</td>
<td>10/15/2017</td>
</tr>
<tr>
<td>Development Due</td>
<td>11/15/2017</td>
</tr>
<tr>
<td>Revalidation Due</td>
<td><strong>10/31/2017</strong></td>
</tr>
<tr>
<td>Reassignment End</td>
<td>11/15/2017</td>
</tr>
<tr>
<td>Reactivation Receipt</td>
<td>12/01/2017</td>
</tr>
<tr>
<td>Reactivation Effective</td>
<td>12/01/2017</td>
</tr>
</tbody>
</table>

- Revalidation notice includes reassignments for Groups A, B & C
- Revalidation application is received but only addresses reassignment for Group A
- MAC develops for missing reassignments for Groups B & C
- No response received from provider
- Group A’s reassignment is revalidated. Groups B & C’s reassignments are deactivated effective with the latter of the revalidation due date or the development due date
- Provider submits a reactivation application after the due date (full 855R required)
- Effective date for Groups B & C is based on receipt date of reactivation application
- **Break in billing**
Revalidation lookup tool

Medicare providers must revalidate their enrollment record information every three or five years. CMS sets every provider’s revalidation due-date at the end of a month, and posts the upcoming six months online. A due date of “TBD” means that CMS has not set the date yet.

CMS offers several ways for you to view and group the revalidation dates of every provider:
- This data was last refreshed on July 1st, 2017
- Revalidation due dates included on this list range between March 31st, 2016 and January 31st, 2015
- The next data refresh is tentatively scheduled for September 1st, 2017
- Affiliations now include Reassignments as well as PA Employment Relationships
- Data now includes DME Due Dates between November 1st, 2016 and January 31st, 2017
- DME Suppliers are identified on the downloadable file in a new column called “Enrollment Type” and are identified as “1”
Revalidation lookup tool

data.cms.gov/revalidation

3 sets of data files
for online filtering and download
as Microsoft Excel, comma-delimited text files, xml...

<table>
<thead>
<tr>
<th>Online tables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Browse, search, and filter the entire list online, then save to a file. (Some advanced features of each spreadsheet are intended for data specialists)</td>
</tr>
</tbody>
</table>

1. **Group practice members only**
   - A-D | E-L | M-R | S-Z
   - Search list of all group records and their reassigned members.

2. **Entire list of providers and suppliers**
   - Search list of all provider and supplier enrollment records.

3. **Reassignments and PA Employment relationships**
   - Search list of all reassignments and employment relationships.

   **For data specialists:** Export this table and “join” it with Table 2 to create advanced group queries. Refer to the data dictionary (PDF) for more options.

**How to use the online tables:**

1. Sort on a column by clicking its grey header
2. Search with the [Find in this Dataset] search bar
3. Filter the data by clicking the blue [Filter] button
4. Download the file by clicking the light blue [Export] button
Revalidation lookup tool

Looking for reassigned providers?

Use “Group practice members only”

- sort, download and save by large groups
- includes all individuals that reassign to the group
- shows the individual’s total number of reassignments

Sort and filter by:
- Group Enrollment ID, State, and LBN
- Individual Enrollment ID
- Individual NPI
- Individual State
- Individual First and Last Name
- Individual Specialty Code
- Individual Revalidation Due Date
- Total Reassignments
Revalidation lookup tool

Find a Provider

Provider Name or National Provider Identifier (NPI):

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>ARMINE</th>
<th>SMITH</th>
</tr>
</thead>
</table>

NPI

Location

Any State

- All records
- Only records with due dates
- Records with due dates in the specified range

FIND PROVIDER

INDIVIDUAL SEARCH

Search by: Individual Last Name, First Name or NPI
search results show matching providers and # of reassignments

MATCHING PROVIDERS
WITH FIRST NAME OF “ARMINE”, LAST NAME OF “SMITH”

Displaying records 1 – 2 of 2.

Armine Smith
Due Date: TBD
State: DC
Total Providers: 2

Armine Smith
Due Date: 03/31/2017
State: MD
Total Providers: 3

RECORD RESULTS

ARMINE SMITH
REVALIDATION DUE DATE: 03/31/2017
LAST UPDATED DATE: JULY 1ST, 2017
STATE: MD

SPECIALTY
Urology
NPI: 1671794030

START OVER

Organizations this individual belongs to:
Displaying records 1 – 3 of 3.

Johns Hopkins Community Physicians
Due Date: TBD
State: MD
Total Providers: 367

Johns Hopkins Community Physicians
Due Date: TBD
State: MD
Total Providers: 367

Johns Hopkins University
Due Date: TBD
State: MD
Total Providers: 3110

RECORD

Records include details and links to all affiliated records
(e.g. Individual records show details on affiliated organizations or providers, plus a link to the group’s record)
Revalidation lookup tool

Search by: Organization Name or NPI
search results show # of reassignments & physician assistants

Records will include details and links to all affiliated records
(e.g. group records show details on affiliated individuals, plus a link to the individual record)
Revalidation

• Changes we’ve made:
  - Advanced notice of your revalidation due date
  - Search and download all reassignments
  - Reassignment information on revalidation notices

• How you can help:
  - Talk to your provider
  - Use the revalidation look up tool
  - Respond timely
  - Set up your access to PECOS now
  - Use PECOS to submit your revalidation
Our Enrollment Systems
NPPES (NPI) today

Every month...
- 23,000 new NPIs
- 68,000 updates

94% created online
- 76% individuals
- 24% organizations

5 MILLION NPIs

Challenges
- low usability / readability
- targeted to providers, not admins
- old technology, narrow design
- strict customer service policies
- all lead to... outdated records

In May 2017...
- new design with easier screens
- surrogacy (like PECOS)
- more data fields
- improved customer service
NPPES Redesign

YouTube video introducing the new NPPES:
https://youtu.be/BOJCAj1P2u8

“Getting Ready for the new NPPES” FAQ:
https://nppes.cms.hhs.gov/NPPES/powerpoint/GettingReadyForTheNewNPPES.pptx

- Single Sign on for both Type 1 & 2 users
- Modernized & Easy to use - Streamlined data entry
- Context sensitive Help and Smart Filters
- Print or download a PDF version of the NPI application upon submission
NPPES Redesign | Main Page

- Ability for surrogates to work on behalf of providers to create/update NPI records
- One User ID and Password to access NPI records
- Ability to request initial NPI notification to be sent to the contact person on file
NPPES Redesign | Address Page

- Multiple Practice Locations
- Address Standardization
- Partial Application Save
Streamlined taxonomy entry

Ability to easily change primary taxonomy

Links to taxonomy definition websites
NPPES | Future Enhancements

- Ability to submit pending applications after an address error is resolved
- Ability to update primary practice location address
- Ability to process EFI CSV files containing group taxonomies
- Medicare “Other Identifiers” removed from NPPES and NPI Registry
What is PECOS?

The Provider Enrollment Chain and Ownership System (PECOS) is a national database of Medicare provider and supplier enrollment information. PECOS is used to collect and maintain the data submitted on CMS 855 enrollment form.

PECOS Provider Interface (PECOS PI) - [https://pecos.cms.hhs.gov](https://pecos.cms.hhs.gov) can be used to:

- Submit an initial Medicare enrollment application
- View or submit changes to your existing Medicare enrollment information
- Submit a Change of Ownership (CHOW) of the Medicare-enrolled provider
- Add or change reassignment of benefits
- Reactivate an existing enrollment record
- Withdraw from the Medicare Program
PECOS Today

Over 2 million enrollments

Encouraging Online Applications

% of PECOS Web Applications by Year

- Completely paperless process
- Faster than paper-based enrollment
- Tailored application process
- Easy to check and update your information for accuracy

Every month...

18,000 new enrollments
PECOS Key Features | Home Page

**My Associates**
Ability to search and filter applications by Name, Provider Type, TIN, NPI etc. to view/update Medicare information or to enroll in Medicare

**Revalidation Notification Center**
Ability to start a revalidation, view notifications, or view in progress revalidations
PECOS Key Features | Upload Digital Documents

- Ability to upload electronic versions of supporting documents during completion of an enrollment application
- View a dynamic “required documents list” based on enrollment application type
PECOS Key Features | E-Signature

- Ability to electronically sign any application submission (including ones that require multiple signatures)
PECOS Key Features | EFT Updates

Ability to submit or update EFT (CMS-588) information
PECOS Key Features | Fast Track View

Fast Track View tab displays comprehensive summary of the provider’s enrollment information
PECOS Key Features | Application Fee Payment

- Ability to securely submit Application Fee payment online

**Application Fee Payment Information**

Institutional Providers who are submitting applications for the following reasons are required to pay the Provider Enrollment Medicare Application Fee:

- Initial Enrollment
- Revalidation
- Change of Information - Adding Practice Location
- Change of Ownership via CMS-855A - Buyer Provider Agreement

All DMEPOS suppliers (including physicians and required to pay the fee for:

- New Applications
- Enrolling an additional location
- Revalidations
- Reactivations, unless the deactivation was a four consecutive quarters

Providers who are enrolled in Medicare but have PECOS may be required to submit an Initial Entry in PECOS. If the reason for the application is a change in Medicare enrollment and is not for the year, then the provider is not required to pay the application fee.

**Year: 2017**

**Amount $560**

* Would you like to pay the application fee now?

- [ ] Yes
- [ ] No
- [ ] I have already submitted payment for this application

Click the Refresh button to view the latest Payment Information.
Users will be able to see the Medicare Application Fee payment amount on the PECOS Payment Confirmation Page after a successful payment.
PECOS Upcoming Changes | Jan 2018

- **Supporting Documents List**
  Removal of SSN and Driver License information from supporting documents list

- **IDTF Fee Payment Requirement Update**
  IDTF Facilities adding a new Base of Operations will no longer require a Fee Payment

- **Returned for Corrections**
  Returned for Corrections applications will be added to the Application Warnings Section on the My Associates Page
Physician Compare

medicare.gov/physiciancompare

- Public directory of healthcare providers in Medicare.
- Based mostly on PECOS; updated twice a month

Learn more: Search “physician compare” at cms.gov

Get support: PhysicianCompare@Westat.com
### Who Should I Call?

<table>
<thead>
<tr>
<th>Issue</th>
<th>Contact</th>
<th>Issue</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Login, forgot username/password, system error messages</td>
<td>PECOS EUS External User Services</td>
<td>I&amp;A account, surrogacy, connections</td>
<td>PECOS EUS External User Services</td>
</tr>
<tr>
<td>Completing a 855 Application paper or web</td>
<td>APP MAC Medicare Administrative Contractor</td>
<td>Completing a NPI Application</td>
<td>APP npi Enumerator</td>
</tr>
<tr>
<td>Enrollment application status submission reason, specialty type</td>
<td>APP MAC Medicare Administrative Contractor SMA State Medicaid Agency</td>
<td>Who is required to obtain an NPI and what type of NPI?</td>
<td>APP MAC Medicare Administrative Contractor SMA State Medicaid Agency</td>
</tr>
<tr>
<td>Enrollment application fee payment or refund</td>
<td>APP MAC Medicare Administrative Contractor SMA State Medicaid Agency</td>
<td>Revalidation</td>
<td>APP MAC Medicare Administrative Contractor SMA State Medicaid Agency</td>
</tr>
</tbody>
</table>
What is Easy Enrollment?

- Simplified, easy to use application, designed to enable users to submit an 855O enrollment in a fraction of the time
- Mobile accessibility and easy authentication

Data.CMS.Gov


PECOS PIN Request Page

- Search and Click ‘Enroll Me Now’

- Enter Email Address and request Secure PIN
Easy Enroll

**Easy Enrollment Log-In**

- Enter Valid SSN and DOB for the Prescriber
- Successfully pass SSA and NPPES validation
- Enter system issued secure PIN for the email address
- Successfully complete Robot Prevention Check question
Easy Enroll

**Adverse Legal Action Attestation**

- Only prescribers who do not have any Adverse Legal Actions to report may complete an Easy Enrollment.
- Those prescribers who do have Adverse Legal Actions are encouraged to use Internet based PECOS to submit an electronic 855O application.
Easy Enroll

Enrollment Summary

✓ Pre-filled single page design

✓ Improved usability experience limits clicks and allows users to submit an application in fraction of the time it takes currently

✓ Enter license information to route application to the appropriate contractor
Easy Enroll

E-Signature Page

- Provider can E-Sign directly on the application
- Surrogate users can submit an E-Signature Request by entering the email address of the appropriate Provider
Easy Enroll

Submission Confirmation Page

- Provides tracking information on the submitted application
- Provides access to the Medicare Enrollment Report and the Application Status Kiosk to check the status of your submitted application
- Provides information on the Contractor who will process the application
Providers and suppliers that access the 855O form in PECOS will be navigated to the Enrollment Summary of the Easy Enrollment.

Here, all required information will be available on one page for ease of navigation and processing, streamlining the existing 855O form.
PECOS Redesign

PECOS 2.0 is a **ground up redesign** of the current PECOS system that controls enrollment for all Medicare Providers and Suppliers.

- Platform for Enrollment
- Streamlined Interface
- Modern APIs and Automation
- Increase agency and industry interoperability.

Support increased **alignment between Medicare and Medicaid**, and enhanced Part C and D oversight.

Support agency program integrity objectives through **standardized processes**, and allowing greater ability leverage enrollment data and verification controls.

Change workflow for users from complex non-intuitive process to simplified compartmentalized functions.

Extensive **API hub** allowing other systems to read, create and **update records systematically** in PECOS.

Target: 2018-19  |  Currently in Procurement
Protecting the Program
Screening Levels

Screening level may be elevated to “high” if:

- Excluded from Medicare/other Federal Health Care program
- Terminated from Medicaid
- Applied for Medicare within 6 months after temporary moratorium
- Within the last 10 years, you had:
  - Medicare payment suspension
  - Medicare billing privileges revoked
  - Final adverse action(s)
Site Visits – National Site Visit Contractor (NSVC)

- all enrollment site visits conducted by the NSVC (except Durable Medical Equipment (DME) suppliers)
- required for moderate/high risk providers – initial enrollment, revalidation, adding a new location
- CMS has the authority to perform site visits on all providers
- verifies practice location information to determine compliance with enrollment requirements
- separate from state site visits for certified providers

What to expect during a site visit?

1. An external or internal review, by an inspector, with limited disruption to your business
2. Photographs of the business
3. Inspector will possess a photo ID and a letter of authorization issued and signed by CMS
   - To verify that an inspector is credentialed to perform a site visit contact MSM Security Service, at 1-855-220-1071.

Refer to SE1520 on CMS.gov for more information
Site Visits – National Supplier Clearinghouse (NSC)

- all DME supplier enrollment site visits conducted by the NSC
- required for initial enrollments and revalidation
- verifies compliance with supplier standards:
  - hours of operation
  - licenses/certifications
  - patient records
  - proof of business records (rental agreements,)
  - inventory

What to expect during a site visit?

1. An internal review by an inspector
2. Photographs of the business
3. Staff interviews

Inspector will possess:
- photo identification
- letter stating reason for the visit signed by the NSC manager
- site visit acknowledgment form (signed by the supplier attesting the visit was completed)
Stronger screening

Increase site visits
- for high Medicare reimbursements
- in high risk geographic areas

Find vacant or invalid addresses
- better automatic address verification in PECOS
- includes US Postal Service feature that confirms the address is real (UPS store, mailboxes, unlikely to deliver mail)
- may trigger a site visit

Deactivate for non-billing
- EXEMPTIONS: order/refer/prescribe; certain specialties e.g., pediatricians, dentists and mass immunizers (roster billers)

Authority: 42 CFR 424.517
Fingerprinting

CMSfingerprinting.com

Applies to:
- new HHAs
- new DME suppliers
- high risk providers /suppliers

Excludes:
- Managing Employees
- Officers
- Directors

If the initial fingerprints are unreadable a 2nd set of fingerprints will be requested

5%\(^{(+)}\) ownership/partners in a high risk provider/supplier

- Letter will be sent giving 30 days to get fingerprinted
- Medicare phased rollout
- SMAs may rely on Medicare’s fingerprint results
- SMAs may request fingerprints in advance of Medicare to comply with July 2018 deadline

If the provider/supplier:
- has a felony conviction
- refuses fingerprinting

then CMS or SMA may deny the application, or revoke/terminate their billing privileges
Continuous monitoring

licensure + vitals

exclusions + sanctions

adverse actions

practice locations

License via Automated screening
SSA Death Master File
NPI and LBN Integrated via NPPES

OIG and GSA websites Integrated in PECOS Monthly checks

Criminal alerts via Automated screening

Ad hoc site visits
Data sharing

Public data files from PECOS

- **Public Provider Enrollment File**
  - currently approved individuals and orgs
  - reassignments
  - practice location data (limited)
  - primary and secondary specialty
  - updated quarterly

- **Revalidation File**
  - currently approved, and due for revalidation
  - individuals and orgs
  - revalidation due date
  - reassignments
  - updated every 60 days

- **Ordering Referring File**
  - currently approved individuals
  - valid opt-out
  - eligible to order/refer
  - updated twice a week

Public data files from PECOS:
- all files contain Names and NPIs
- available at data.cms.gov
Connections between all programs

Failure to maintain accurate enrollment data could impact your participation in other Medicare & Medicaid programs.
Enforcement Actions
Adverse legal actions

Required during:
- initial enrollment
- revalidation (*even if previously reported*)
- within 30 days of the action

Applies to......
- ind providers
- inds and orgs in section 5/6 (owners, managing employees, AO/DO)

Failure to report...
- deny application or revoke billing privileges
  - possible revocation back to the date of the action (*felony, sanction, exclusion*)

- felony conviction in last 10 years
  - crimes against persons
  - financial crimes
- misdemeanor conviction
  - patient abuse or neglect
  - theft, fraud, embezzlement
- sanction or exclusion (*ever*)
- license revocation or suspension (*ever*)
- accreditation revocation or suspension (*ever*)
- Medicare payment suspension (current)
- Medicare revocation (*ever*)
Deactivations and Reactivations

CMS can deactivate Medicare billing privileges for:

- non-billing for 12 months
- failure to respond to revalidation
- failure to report a change with 90 days (practice location, managing employee)*
- failure to report a change in ownership in 30 days

To reactivate Medicare billing privileges:

- must submit a complete CMS-855 application
- effective date based on receipt date of the reactivation application
- does not require a new state survey for certified providers (exception for HHAs)

* Reporting a change of information to the state, Regional Office, or another agency does not meet Medicare’s reporting requirements and may lead to deactivation/revocation.

Billing privileges were paused, but can be restored upon the submission of a new enrollment application or updated information.
DEACTIVATIONS

755,876

OCT 1, 2011

SEPT 30, 2016

302,350

44%

Percent of total that were deactivated for failure to respond to revalidation
**Reasons to deny**

**CMS can deny** Medicare applications for:

- **felony conviction**
- DEA suspended or revoked
- Medicare payment suspension (active)
- excluded from federal program
- insufficient capital (HHA)
- false or misleading information
- fee not paid (including if hardship exception denied)
- noncompliance: program requirements
- on-site review, showing noncompliance
- temporary moratorium
- $1,500 overpayment (current)  

**Unless:**
- approved repayment plan
- offset or appeal
- bankruptcy

A/B JAN 2016 | DME APR 2016
DENIALS
9,092

TOP 3 REASONS FOR DENIAL

- Temporary Moratorium: 12%
- Non-Operational: 21%
- Non-Compliance: Provider/Supplier Type Requirements not met: 41%

OCT 1, 2011

SEPT 30, 2016
Reasons to revoke

CMS can revoke Medicare billing privileges for:

- felony conviction
- DEA suspended or revoked
- Medicaid billing privileges terminated
- excluded from federal program
- pattern or practice of prescribing
- non-operational (onsite visit)
- insufficient capital (HHA)
- abuse of billing privileges
- misuse of billing number
- false or misleading information
- fee not paid (including if hardship exception denied)
- noncompliance: document requirements
- noncompliance: program requirements
- failure to report to MAC...

1–3 year
Re-enrollment bar

...in 30 days: ownership change, practice location change, adverse legal action

...in 90 days: all other information

- Must report to the MAC.
- Notifying a state, Regional Office, or another agency is not enough.
REVOCATIONS

47,254

OCT 1, 2011

SEPT 30, 2016

33,698

71%

Percent of total that were for (a)(1) non-compliance
How to appeal

1 Corrective Action (CAP)
For all denial reasons, but only noncompliance revocation reason
Simply correct the issue:
- send CAP within 30 days
- MAC/CMS has 60 days to process

2 Reconsideration
- Provider must appeal within 60 days
- MAC/CMS has 90 days to process
Providers can send a Reconsideration and a CAP together, but if we accept the CAP, we void the Reconsideration.

3 Administrative Law Judge

4 HHS Departmental Appeals Board

5 Federal District Court

- If denial/revocation overturned...
  Hearing officer sends letter to provider; directs MAC to reinstate them.

- If denial/revocation upheld...
  Hearing officer sends letter to provider; provider can accept or appeal further.
Medicaid Terminations

- If Medicare revokes “for-cause” then the states **must** terminate a provider from their program
- If one state terminates “for-cause” then all states **must** terminate a provider from their program
- If terminated from any state “for-cause”, CMS has the **discretion** to revoke from Medicare

**Scenario #1**
- A provider is terminated for cause from California Medicaid
- The provider wants to enroll in Oregon Medicaid

- Provider cannot enroll in Oregon’s Medicaid program because he is prohibited from enrolling in another state’s Medicaid program while actively terminated in California.

**Scenario #2**
- A provider is revoked for cause from Medicare
- The provider would like to enroll in New Mexico Medicaid

- When a provider is revoked for cause from Medicare in any jurisdiction, the provider is unable to enroll in any state Medicaid program. Provider would not be permitted to enroll in New Mexico’s Medicaid program.

**Scenario #3**
- A provider is terminated for cause from Arizona Medicaid
- The provider is also enrolled in Texas

- When a provider is terminated for-cause from a state Medicaid program, ALL other State Medicaid programs MUST also terminate the provider. Here Texas must terminate this provider. If the provider is also enrolled in Medicare, CMS has the discretion to revoke.
Medicaid Terminations

more than 5,000 Total Medicaid TERMINATION SUBMISSIONS

more than 600 Total Medicaid TERMINATION SUBMISSIONS Resulting in Medicare REVOCATION

more than 3,000 Total Medicare REVOCATION FILE ENTRIES
Resources

cms.gov
- ordering and referring, DMEPOS accreditation, supplier standards, part D enrollment
- 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

888-734-6433
PECOS Help Desk

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
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If you need more accessibility options for the material, contact 
providerenrollment@cms.hhs.gov

Centers for Medicare & Medicaid Services