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 enrolling works
How enrolling works

1. **Submission**
   - Medicare Providers & Suppliers (w/NPI)
   - 855Form
   - 60 days*
   - Online
   - 45 days*
   - Direct Input
   - MAC mail room
   - Manual data entry

2. **Intake**
   - Submit to MAC

3. **Processing, Screening & Verification**
   - PECOS

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

5. **Development Letter**

6. **Pre Screening**
   - signed + dated
   - app fee (or waiver)
   - supporting docs
   - all data elements

7. **Verification**
   - Name / LBN
   - SSN / DOB
   - NPPES
   - Address
   - License
   - Adverse Actions

8. **Risk Based**
   - Fingerprints
   - Site Visits

* If the app is complete, and no site visit

CMS | Decision Health | April 2017
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

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

By...
- email
- fax
- phone
- letter

30 days to respond

No response?
- delays
- rejections
- later effective date
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>MAC receives app</th>
<th>MAC approves MAY 15 (w/ effective June 1)</th>
<th>Provider performs service JUNE 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>APR 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Provider seeking effective date JUNE 1**

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

<table>
<thead>
<tr>
<th>MAC receives app</th>
<th>MAC approves SEPT 1 (w/ effective June 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>JULY 1</td>
<td></td>
</tr>
</tbody>
</table>

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

**Hospitals / HHAs / SNFs**
can apply up to **180 days** prior **

<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 '16</td>
</tr>
</tbody>
</table>

**Provider seeking effective date**

OCT 1 2016

**PROCESSING**

MAR '16 JUN'16 OCT '16 JAN '17 MAR '17 JUN '17
Enrollment Arrangements (Telehealth)

MM8545 | Inter-jurisdictional

Dr. Smith

123 Main St. Maryland (855I)

Reassignment

Jones Medical Group

123 Main St. Maryland (855B)

Novitas (MAC)

First Coast (MAC)

456 Elm St. Florida (855B)

Jones Medical Group

CMS | Decision Health | April 2017
Policy Updates
Authorized and Delegated Officials – PECOS & I&A

**Authorized Official**
- Enroll, make changes and ensure compliance with enrollment requirements
- Appointed by the AO with authority to report changes to enrollment information
- CEO, CFO, partner, chairman, owner, or equivalent appointed by the org
- may sign all applications *(must sign initial application)*
- approves DOs

**Delegated Official**
- Assigned surrogacy and controls access to PECOS and NPPES records
- ownership, control, or W-2 managing employee
- multiple DOs permitted
- may sign changes, updates and revalidations *(cannot sign initial application)*

**Authorized Official**
- Authority to assign surrogacy and controls access to PECOS and NPPES records
- less restrictive AO requirements than PECOS
- automatically approved if listed as AO in PECOS
- if not, CP575 must be provided to approve access
- manage staff and connections for the employer
- approve DOs for the employer

**Delegated Official**
- Appointed 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:** Only the organization’s Authorized Official (AO)

**Changes and revals:** Either the AO or Delegated official (DO)

**All app types:** Only the individual provider

**Adding:** Both the individual provider and the org’s AO/DO.

**Changing/terminating:** Individual provider or the org’s AO/DO.
# Certification statement requirements

## Certification Statements:

<table>
<thead>
<tr>
<th>Certification Statements:</th>
<th>Paper</th>
<th>Web</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAC develops for invalid cert statement with other missing items</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>MAC develops for missing cert statement with other missing items (if web signature is missing, MAC will not proceed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAC processing won’t start until signed cert statement is received (within 20 days of submission, otherwise rejected)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>paper signatures accepted through email, fax, (if original on file) or mail</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>paper cert statements downloaded from cms.gov must include the web tracking ID</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

---

**Invalid signatures...**

1. Unsigned
2. Undated
3. Copied/stamped signatures
4. Wrong person signed

**No response?**

- rejections
- delays
- later effective date
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
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
Updates to Program Integrity Manual

- **Reassignment effective dates**
  - based on later of the date of filing or the date the reassignor first began furnishing services at the new location
  - consistent with initial applications
  - applies to CMS-855R accompanied by an initial CMS-855I and stand-alone CMS-855R

- **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
"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.”
Updates to CMS-855 Enrollment Applications

- **CMS-855O**
  - must use revised version beginning Jan 2018
  - title changed for use by prescribers
  - added Interventional Cardiology and 5 other specialties; Oral Surgeons (Dentist Only) split into Oral Surgeon and Dentist
  - providers are able to add an additional contact person (optional)

- **CMS-855S**
  - must use revised version beginning Jan 2017
  - split “external infusion pumps and/or supplies” and “insulin infusion pumps and/or supplies” into two separate products
  - deleted “Hemodialysis Equipment and/or Supplies” and “Home Dialysis Equipment and/or Supplies”
  - replaced “Invasive Mechanical Ventilation Devises” with “Ventilators: All Types – Not CPAP or RAD”
Updates to CMS-855 Enrollment Applications

- **CMS-588 (EFT)**
  - must use revised version beginning Jan 2018
  - indicate if EFT is for an ind or org (Reason for Submission/Account Holder Information)
  - financial institution’s contact person (optional)
  - additional digits added to account number to make consistent with industry standard

- **CMS-855 POH**
  - POHs are not required to submit a completed CMS-855POH or Attachment 1 (CMS-855A) as of Mar 2015
When to Select Change/Add/Delete

**CHANGE**
- replace existing information with new information (ex. practice location, ownership)
- update existing information (ex. change in suite #, telephone #)
- app fee is not required

**ADD**
- add additional enrollment information to existing information (practice locations)
- app fee is 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

**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
## Provider Enrollment Moratoria

<table>
<thead>
<tr>
<th>Year</th>
<th>Implementation</th>
<th>Description</th>
</tr>
</thead>
</table>
| 2013 | Initial implementation | July 2013
  - HHA and HHA sub-units *(Miami, Chicago)*
  - Ambulance and ambulance suppliers *(Houston)*

| 2014 | 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)*

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

| 2017 | Extended | Jan 2017
  - 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 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**

- 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
Medicare/Medicaid Managed Care

**CMS-2390**

starts JUL 2018

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

enroll in Medicaid

**CMS-1654**

starts JAN 2019

Providers in a Medicare Advantage organization network must:

enroll in Medicare

**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 PECOS contact 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

No response?
- deactivate (not revoke)

Late revalidation?
- break in billing
- new effective date

Response Rate
79%
60 days to respond
Revalidation details

**Unsolicited revalidations**
- if your record’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 Revalidation 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</td>
<td>2-3 months before</td>
<td>JUN 30, 2017</td>
</tr>
<tr>
<td>(email or letter)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Revalidation**
  - due date
  - deactivate billing privileges for non-response
  - due date
  - SEP 30, 2017

Provider sends revalidation
Missing reassignments – no break in billing

Scenario #1

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

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Received</td>
<td>04/01/2017</td>
</tr>
<tr>
<td>Development Letter Sent</td>
<td>05/15/2017</td>
</tr>
<tr>
<td>Development Due</td>
<td>06/15/2017</td>
</tr>
<tr>
<td>Development Received</td>
<td>06/10/2017</td>
</tr>
<tr>
<td>Revalidation Due</td>
<td>05/31/2017</td>
</tr>
<tr>
<td>Revalidation Complete</td>
<td>06/30/2017</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 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**
Missing reassignments – 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>05/01/2017</td>
</tr>
<tr>
<td>Development Letter Sent</td>
<td>05/15/2017</td>
</tr>
<tr>
<td>Development Due</td>
<td>06/15/2017</td>
</tr>
<tr>
<td>Revalidation Due</td>
<td>05/31/2017</td>
</tr>
<tr>
<td>Reassignment End</td>
<td>06/15/2017</td>
</tr>
<tr>
<td>Reactivation Receipt</td>
<td>07/01/2017</td>
</tr>
<tr>
<td>Reactivation Effective</td>
<td>07/01/2017</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
Medicare Revalidation List

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 March 1st, 2017
- Revalidation due dates included on this list range between March 31, 2016 and September 30th, 2017
- The next data refresh is tentatively scheduled for May 1st, 2017
- Affiliations now include Reassignments as well as PA Employment Relationships
- Data now includes DME Due Dates between November 1st 2016 and September 30, 2017
- DME Suppliers are identified on the downloadable file in a new column called “Enrollment Type” and are identified as “1”

Search all records

Quickly view specific providers or suppliers online.

Individual Last Name OR Organization Name

Individual First Name

NPI State

○ all records
○ only records with due dates
○ records due within a date range

Search

Online tables

Browse, search, and filter the entire list online, then save to a file. (Some advanced features of each spreadsheet are intended for data specialists)

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

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:

- Sort on a column by clicking its grey header
- Search with the [Find in this Dataset] search bar
- Filter the data by clicking the blue [Filter] button
- Download the file by clicking the light blue [Export] button
3 sets of data files
for online filtering and download
as Microsoft Excel, comma-delimited text files, xml...

1. **Group practice members only** (recommended)
   For finding reassignments to your group
   All group records and their reassigned members
   Split into four files, alphabetically

2. **Entire list of providers and suppliers**
   A search list of all enrollment records, used for finding any provider/supplier.

3. **Reassignments and PA Employment relationships**
   Technical staff can “join” this with data file #2 to create advanced group queries
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
Recent enhancements

- results displayed alphabetically and by Due Date by organization name / last name, then by nearest due date (with TBD last)

- 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 connections in I&A now
  – Use PECOS to submit your revalidation
Our systems
NPPES (NPI) today

5 million NPIs

94% created online

76% individuals

24% organizations

Every month...

23,000 new NPIs
68,000 updates

Challenges

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

In Summer 2017...

- new design with easier screens
- surrogacy (like PECOS)
- more data fields
- improved customer service
NPPES Redesign | coming very soon

- 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

Login Page

Registered Users Sign In
Log in to view, update your National Provider Identifier (NPI) record.
User ID
Password

SIGN IN
FORGOTTEN USER ID or PASSWORD

Create a New Account
You need an Identity & Access Management System (I&AM) User ID and Password to create and manage NPI.

ANNOUNCEMENTS

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
Ability for surrogates to work on behalf of providers to create/update NPI records

One Userid 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
PECOS Today

2 million enrollments

45% created online

Encouraging Online Applications
- My associates Page
- Better navigation
- Part D Easy Enrollment

Communication + Efficiency
- review and update NPI records during PECOS updates
- include additional information on emails (NPI/Medicare ID)
- enhancements to Supporting Docs
- sort data in alphabetical order

Every month...
18,000 new enrollments
Removal of EIN Effective Date

The EIN Effective Date field has been removed from the Organization Information topic for all submission types (initial enrollment, change of information, revalidation, and reactivation).
My Associates Page

Ability to filter on the following elements:

- Enrollment, Provider Type
- Associate Legal Business Name
- Associate Last Name, First Name
- TIN, NPI (Exact match)
- State/Territory
PECOS Changes | recent updates

Reassignment Enhancements:
- Change/Terminate a Reassignment - Only the AO or Individual needs to sign

PI Unlock Application Feature:
PI users will have the ability to unlock applications that have been submitted if the following conditions are met:
- All Signatures have not been received by the MAC
- All Signature options are E-Signatures
What is Easy Enrollment?
Simplified, easy to use application, designed to enable users to submit an 855O enrollment in fraction of the time

Mobile accessibility and easy authentication

Data.CMS.Gov
https://data.cms.gov/855OEasyEnroll

Search and Click ‘Enroll Me Now’

PECOS PIN Request Page
Enter Email Address and request Secure PIN
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 | Now available

Adverse Legal Action Attestation

Warning: Only authorized and eligible users should submit enrollments to Medicare & Medicaid.

If you have any adverse legal actions to report you cannot use the Easy Enrollment process and must enroll using Internet-based PECOS.

For help using PECOS, the How-to Guide is here to help or visit our How-to Enroll page to learn more.

View the Final Adverse Legal Actions (PDF, 182KB) document for more information.

Attestation:

- I attest that I have no adverse legal actions to report.

CONTINUE

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 | Now available

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 | Now available

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
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

### Submission Confirmation Details and Tracking

<table>
<thead>
<tr>
<th>Confirmation Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong> JOHN SMITH</td>
</tr>
<tr>
<td><strong>NPI:</strong> 1223334444</td>
</tr>
<tr>
<td><strong>Web Tracking ID:</strong> T110120160000000</td>
</tr>
<tr>
<td><strong>Submission Date:</strong> Wed Nov 01 12:27:32 EDT 2016</td>
</tr>
<tr>
<td><strong>Submission ID:</strong> <a href="mailto:john.smith@example.com">john.smith@example.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enrollment Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Email Address of E-Signatory:</strong> <a href="mailto:john.smith@example.com">john.smith@example.com</a></td>
</tr>
<tr>
<td><strong>Role:</strong> ORDERING, CERTIFYING, OR PRESCRIBING PHYSICIAN OR OTHER ELIGIBLE PROFESSIONAL</td>
</tr>
<tr>
<td><strong>Signature Status:</strong> E-SIGNATURE COMPLETED</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Administrative Contractor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare Contractor:</strong> Lone Star Health, LLC.</td>
</tr>
</tbody>
</table>
| LONE STAR HEALTH, LLC.  
LONE START PART D PROVIDER ENROLLMENT  
P.O. BOX 1234  
AUSTIN, TX, 78752-1212 |

### Supporting Documentation and Additional Information

Please mail in all applicable required supporting documentation as requested by your Medicare service contractor.

You have 15 days after the submission date of your enrollment submission to comply with sending all documentation. Any errors may cause a delay in processing the application and may require further action if these documents are not mailed.

Please note the Easy Enrollment can no longer be used to create additional enrollments for the listed individual. If the application is returned for corrections or you wish to submit a change of Information, you may do so by accessing Internet-based PECOS. Our How-to Guide is here to assist.
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
Protecting the program
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
- 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

5% (+) ownership/partners in a high risk provider/supplier

- Phased rollout
- MACs will send a letter
- 30 days to get fingerprinted

If the provider/supplier:
- has a criminal record
- refuses fingerprinting

then CMS could deny the application, or revoke their billing privileges
Continuous monitoring

- **licensure + vitals**
  - License via Automated screening
  - SSA Death Master File
  - NPI and LBN Integrated via NPPES

- **exclusions + sanctions**
  - OIG and GSA websites Integrated in PECOS Monthly checks

- **adverse actions**
  - Criminal alerts via Automated screening

- **practice locations**
  - Ad hoc site visits
Data sharing

Across CMS programs

- HITECH
- Accountable Care Orgs
- DME Competitive Bids
- States

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

Part D Prescriber File
- all Individuals
- eff. periods for prescribing
- opt-out
- updated weekly

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

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

**Adverse Event**

*Provider’s* medical license was suspended by the State licensing authority and the provider failed to report this adverse action to CMS within the required timeframe.

(Reporting Periods by Regulation citation: 42 CFR §424.516)

**CMS Action**

CMS Subsequently **revoked** this providers Medicare billing privileges for:

**Noncompliance**

as the provider did not hold a valid medical license

*(CAP and Reconsideration Appeal Rights Apply)*

**Failure to Report**

as the provider did not report the medical license suspension to the MAC

*(Reconsideration Appeal Rights Apply)*
Adverse Event

**Provider** submitted an 855 application, listing John Doe as its managing employee and reported no prior adverse actions.

**John Doe** was convicted of a healthcare fraud felony offense eight years prior to the submission of the application.

**CMS** detects the felony conviction after the enrollment was approved through ongoing provider screening.

CMS Action

CMS Subsequently **revoked** this provider's Medicare billing privileges for:

**False or Misleading Information** as the provider omitted the managing employee’s felony conviction on its revalidation application. *(Reconsideration Appeal Rights Apply)*

**Felony Conviction** as the managing employee has a felony conviction within the last 10 years *(Reconsideration Appeal Rights Apply)*

**CMS** notifies the **State Medicaid Agencies (SMA)** to terminate the provider after the Medicare appeal is complete.
Non-Operational (Onsite Visit)

Adverse Event

Provider initially enrolled with 123 Healthcare Lane, Anytown, DC 98765 reported as their practice location.

Provider relocated their practice location to 456 New Site Drive, Anytown, DC 98765.

Provider failed to report their change of practice location within the required timeframe.

(Reporting Periods by Regulation citation: 42 CFR §424.516)

CMS Action

CMS Subsequently revoked this providers Medicare billing privileges for:

Non-Operational
as the provider was no longer operational at the address listed on its 855 application (Reconsideration Appeal Rights Apply)

Failure to Report
as the provider did not report the change in practice location to the MAC (Reconsideration Appeal Rights Apply)

CMS notifies the State Medicaid Agencies (SMA) to terminate the provider after the Medicare appeal is complete.
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.
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

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

Centers for Medicare & Medicaid Services