NATIONAL PROVIDER ENROLLMENT CONFERENCE

59 Million Patients, **2 Million** Providers, **ONE** Mission

Medicare & Medicaid Provider Enrollment

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Overview

Morning Session

- Introduction to Medicare
- Provider Enrollment Overview
- Submission
- Intake

Afternoon Session

- Processing, Screening and Verification
- Finalization and Claims
- Provider Enrollment Policy
- PECOS

Poll Question

Poll Question

Introduction to Medicare

What is Medicare?

Medicare is a federal health insurance program for:

- People 65 and older,
- Certain younger people with disabilities, and
- People of any age with End-Stage Renal Disease

Different parts of Medicare help cover specific services (A, B, C and D)

Medicare Part A (Hospital Insurance)

Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care

- Hospital
- Federally Qualified Health Center
- Community Mental Health Center
- Skilled Nursing Facility
- Home Health Agency

Medicare Part B (Medical Insurance)

Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services

- Physician/Non-Physician Practitioner Services
- Clinic/Group Practices
- Independent Diagnostics Testing Facilities (IDTF)
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers

Medicare Part C (Medicare Advantage Plans)

Part C provides Part A and Part B benefits offered by a private company that contracts with Medicare

- Health Maintenance Organizations
- Preferred Provider Organizations
- Private Fee-for-Service Plans
- Special Needs Plans
- Medicare Medical Savings Account Plans

Medicare Part D (Prescription Drug Coverage)

Part D offers coverage for prescription drugs

- Original Medicare
- Some Medicare Cost Plans
- Some Medicare Private Fee-for-Service Plans
- Medicare Medical Savings Account Plans

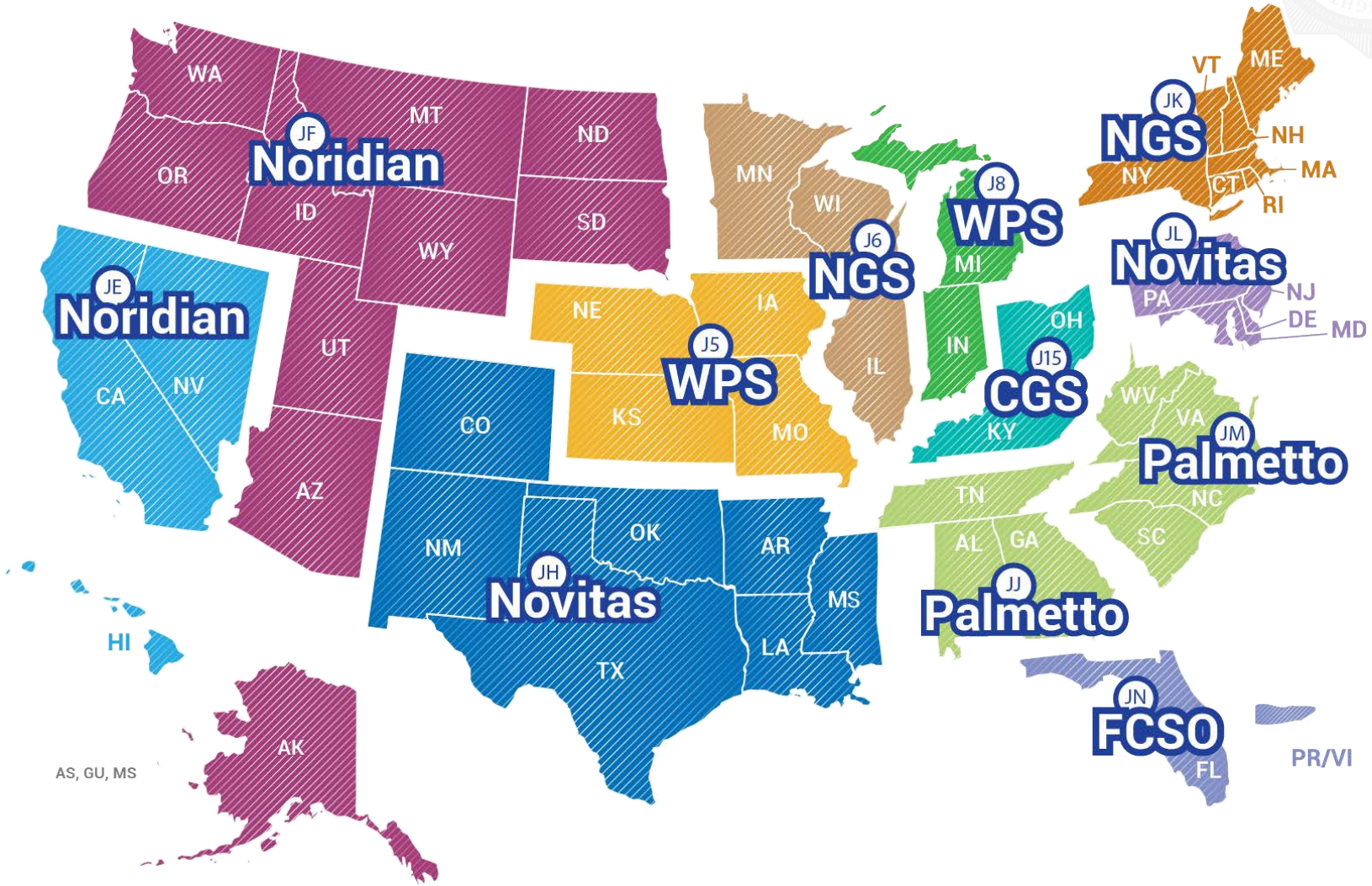
Poll Question

What is a Medicare Administrative Contractor (MAC)?

A private health care insurer that has been awarded a geographic jurisdiction to:

- Enroll providers in the Medicare program
- Process Medicare claims (Part A/B and DME)
- Respond to provider inquiries
- Educate providers about Medicare billing requirements

A / B MACs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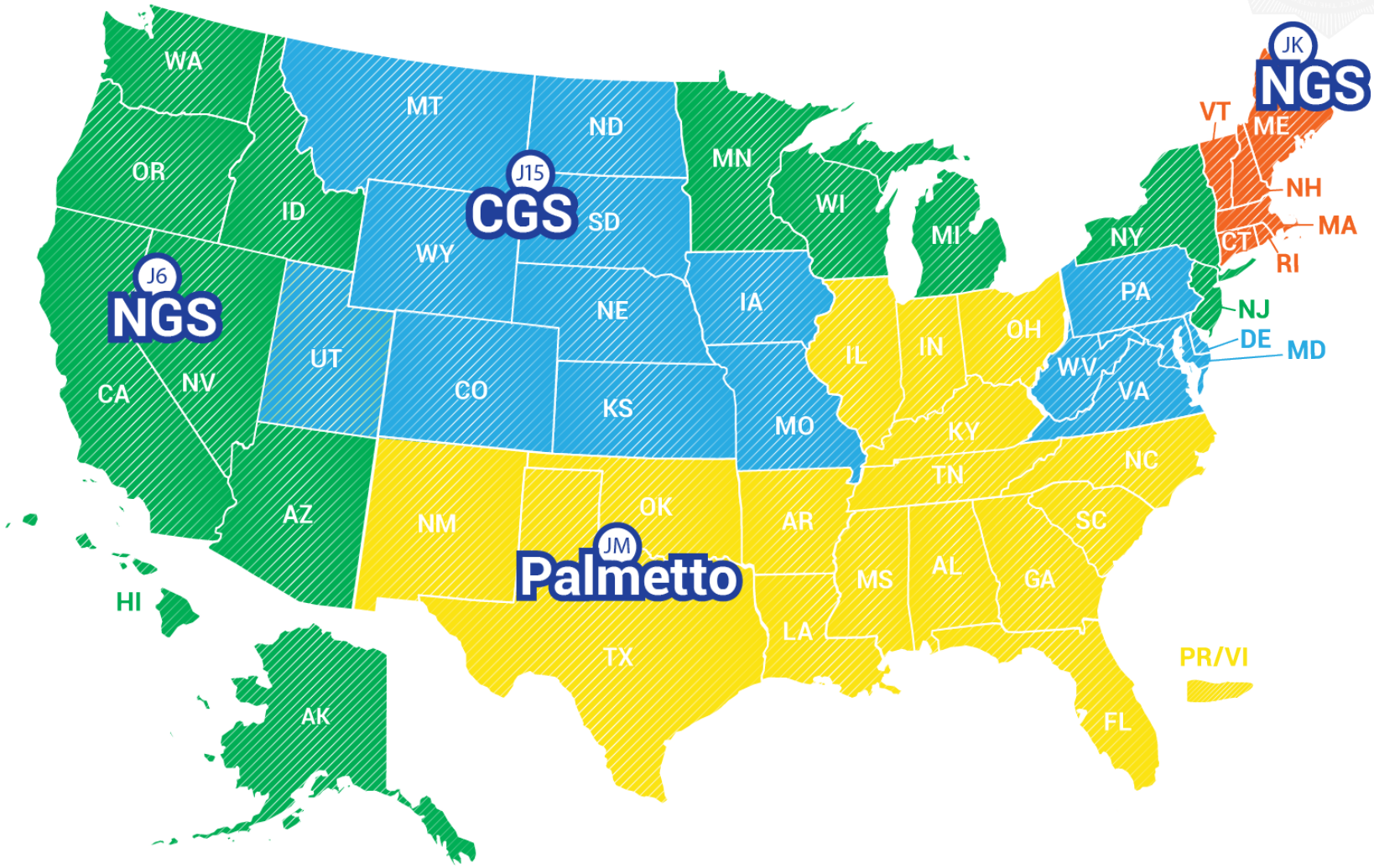
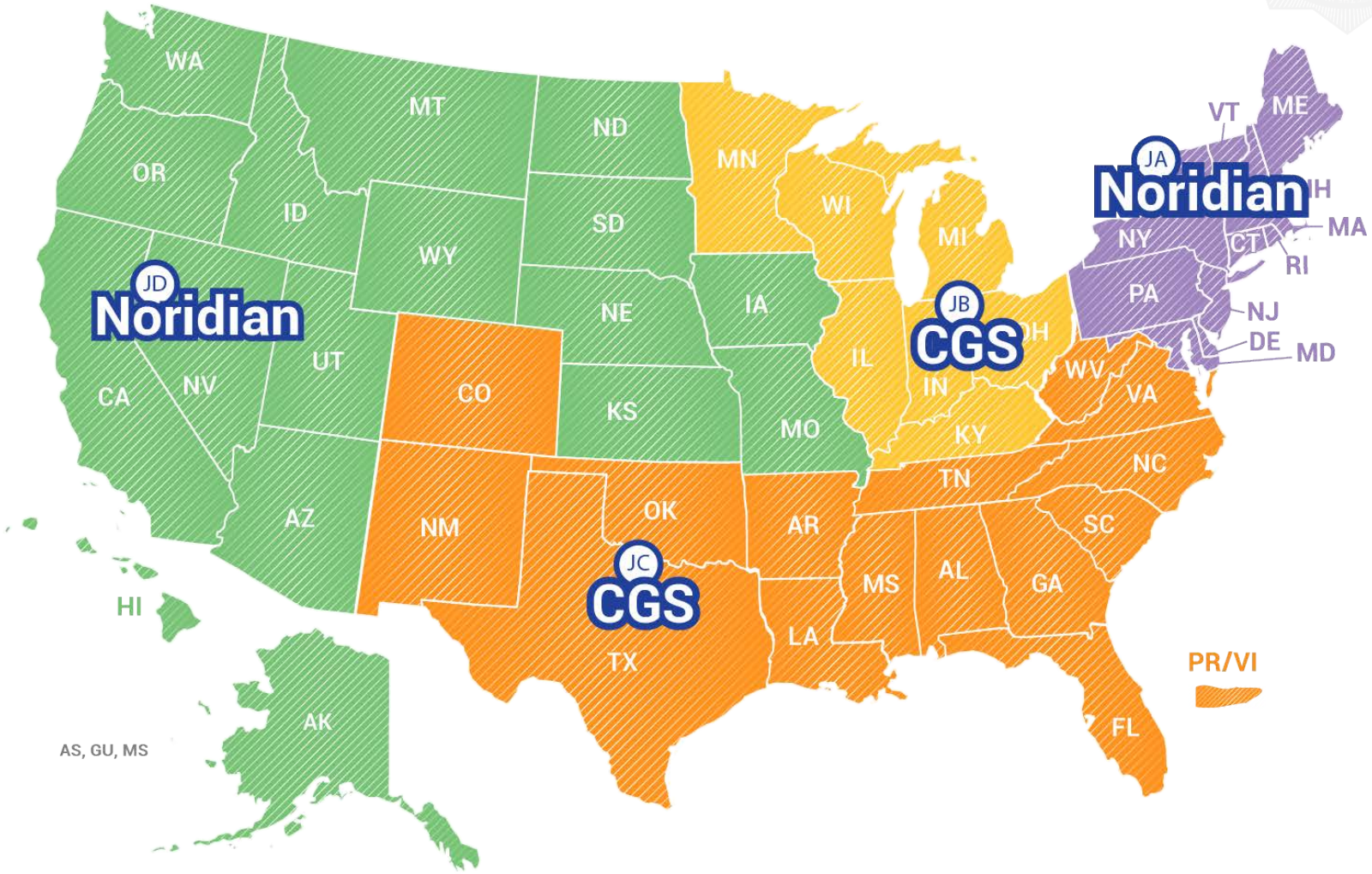
Home Health & Hospice MACs



What is the National Supplier Clearinghouse (NSC)?

- National contractor responsible for enrolling all DME suppliers
- Ensures that DME suppliers meet and maintain all Federal and State requirements to bill the Medicare program
- Claims are processed by 4 DME MACs

DME MACs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Question & Answer Session

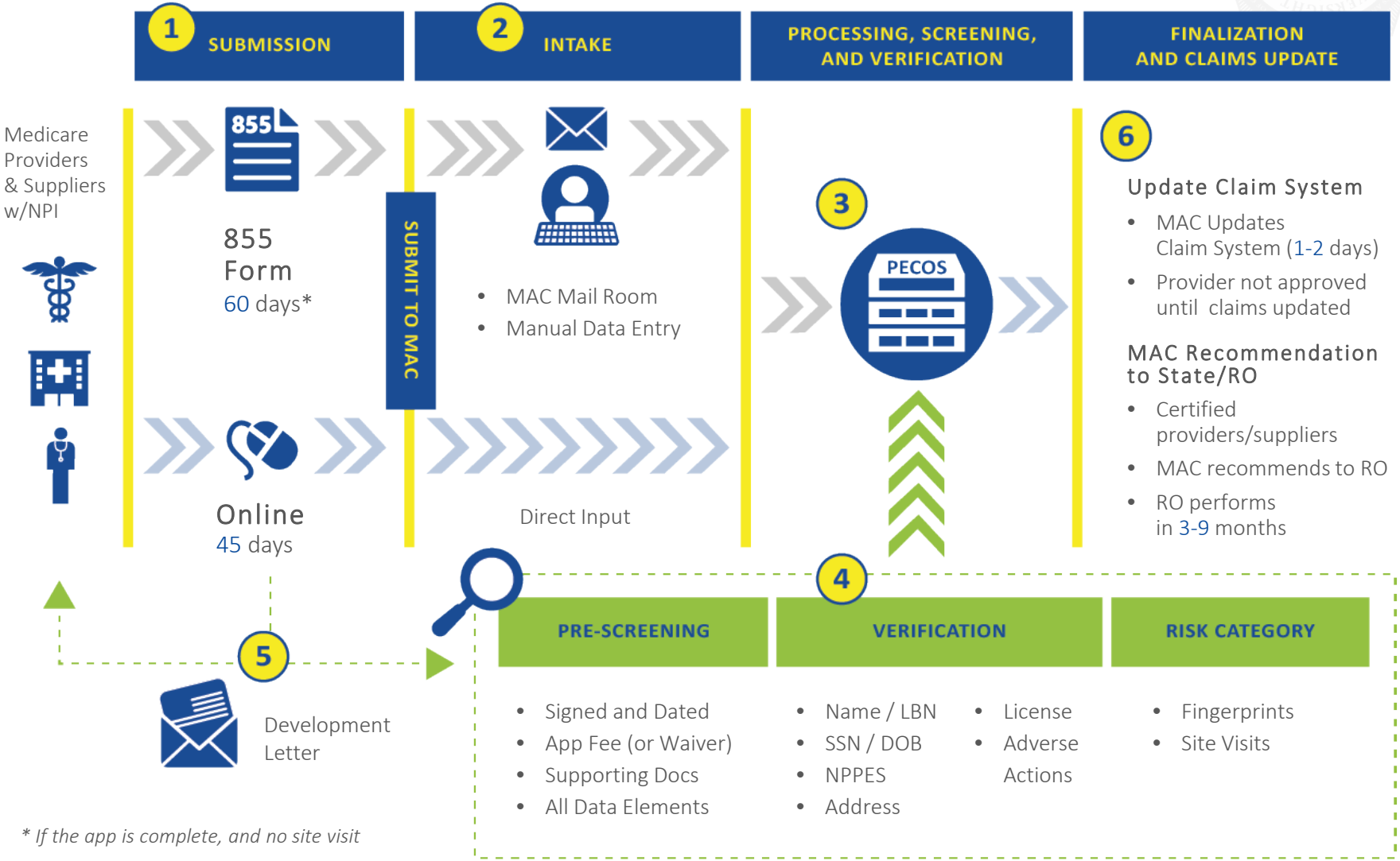
Provider Enrollment Overview

Provider Enrollment Regulations / Statutes

Establishes enrollment requirements, conditions for participation and payments

- The Social Security Act (1861)
- Federal regulations (42 CFR 424)
- Program Integrity Manual 100-08, Chapter 15

How Enrolling Works



** If the app is complete, and no site visit*

Submission

Medicare Providers & Suppliers w/NPI

855
Form
60 days*

Online
45 days

** If the app is complete, and no site visit*

National Provider Identifier

- **Type 1**
  Individual healthcare providers (i.e., physicians, dentists, chiropractors, physical therapists)
- **Type 2**
  Organizational healthcare providers (i.e., hospitals, home health agencies, clinics, labs, group practices, suppliers of durable medical equipment)

Providers must obtain an NPI prior to enrolling in the Medicare Program.

Healthcare providers can apply for NPIs in one of three ways:

- Online via National Plan & Provider Enumeration System (NPPES)
- Paper NPI Application/Update Form (CMS-10114)
- Electronic File Interchange (EFI) whereby an approved EFI Organization can submit the healthcare provider's application on their behalf (i.e., through a bulk enumeration process).

NPPES Registry (for online queries):
https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do

Taxonomy Codes vs. Specialty Types

Taxonomy Codes

- Providers select a taxonomy code when applying for an NPI
- Uniquely identifies providers in order to assign them NPIs, not to ensure that they are credentialed or qualified to render health care
- May or may not be the same category used by Medicare for enrollment purposes

Specialty Types

- Self-designated on the CMS-855 application
- Describes the specific type of medical practice or services provided
- Used by CMS for enrollment and claims processing

Taxonomy / Specialty Crosswalk

- CMS crosswalks the types of providers/suppliers who are eligible to enroll in Medicare with the appropriate taxonomy codes
- Can be accessed at data.cms.gov/Medicare-Enrollment/CROSSWALK-MEDICARE-PROVIDER-SUPPLIER-to-HEALTHCARE/j75i-rw8y
- Updated on a quarterly basis

CMS-855 Enrollment Applications

- **CMS-855A** Institutional Providers (Part A)
- **CMS-855B** Clinics/Group Practices and Certain Other Suppliers *(Part B, non-DME Suppliers)*
- **CMS-855I** Physicians and Non-Physician Practitioners *(Part B, non-DME Individuals)*
- **CMS-855R** Reassignment of Medicare Benefits *(Supplemental to CMS-855I form)*
- **CMS-855S** Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) *(Part B, DME Suppliers)*)
- **CMS-855O** Eligible Ordering, Referring and Prescribing Physicians and Non-Physician Practitioners *(Part B , Part-D and non-DME Individuals)*

Authorized and Delegated Officials

AO Authorized Official

Enroll, make changes and ensure compliance with enrollment requirements

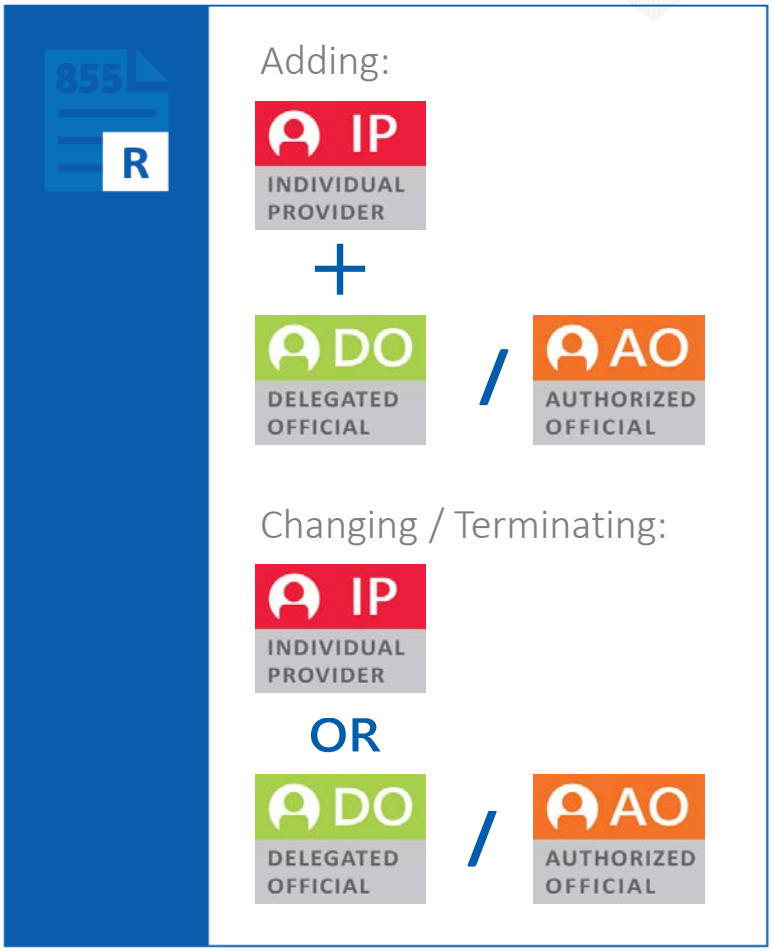
- CEO, CFO, partner, chairman, owner, or equivalent appointed by the org
- May sign all applications *(must sign initial application)*
- Approves DOs

DO Delegated Official

Appointed by the AO with authority to report changes to enrollment information

- Ownership, control, or W-2 managing employee
- Multiple DOs permitted
- May sign changes, updates & revalidations *(cannot sign initial application)*

Who Can Sign the Enrollment Application?



Application Fees

Application fee for 2018 is $569

- 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

Refund Request

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

Poll Question

CMS-588
Electronic Funds Transfer (EFT) Agreement

- All providers must receive Medicare payments via EFT
- Must include a copy of a voided check or bank letter verifying account information
- Providers who reassign all of their benefits to a group are ***not*** required to submit an EFT agreement

CMS-460 Participation Agreement

Participation

- Medicare reimbursement is 5 percent higher than nonparticipating physicians and other suppliers
- Medicare issues payments directly to you because the claims are always assigned

Nonparticipation

- Medicare reimbursement is 5 percent lower than participating physicians and other suppliers
- You cannot charge the beneficiary more than the limiting charge, 115 percent of the Medicare Physician Fee Schedule amount
- You may accept assignment on a case-by-case basis

CMS-855
Submission Reasons

- New Enrollee (Initial)
- Change of Information
- Revalidation
- Reactivation
- Voluntary Withdrawal

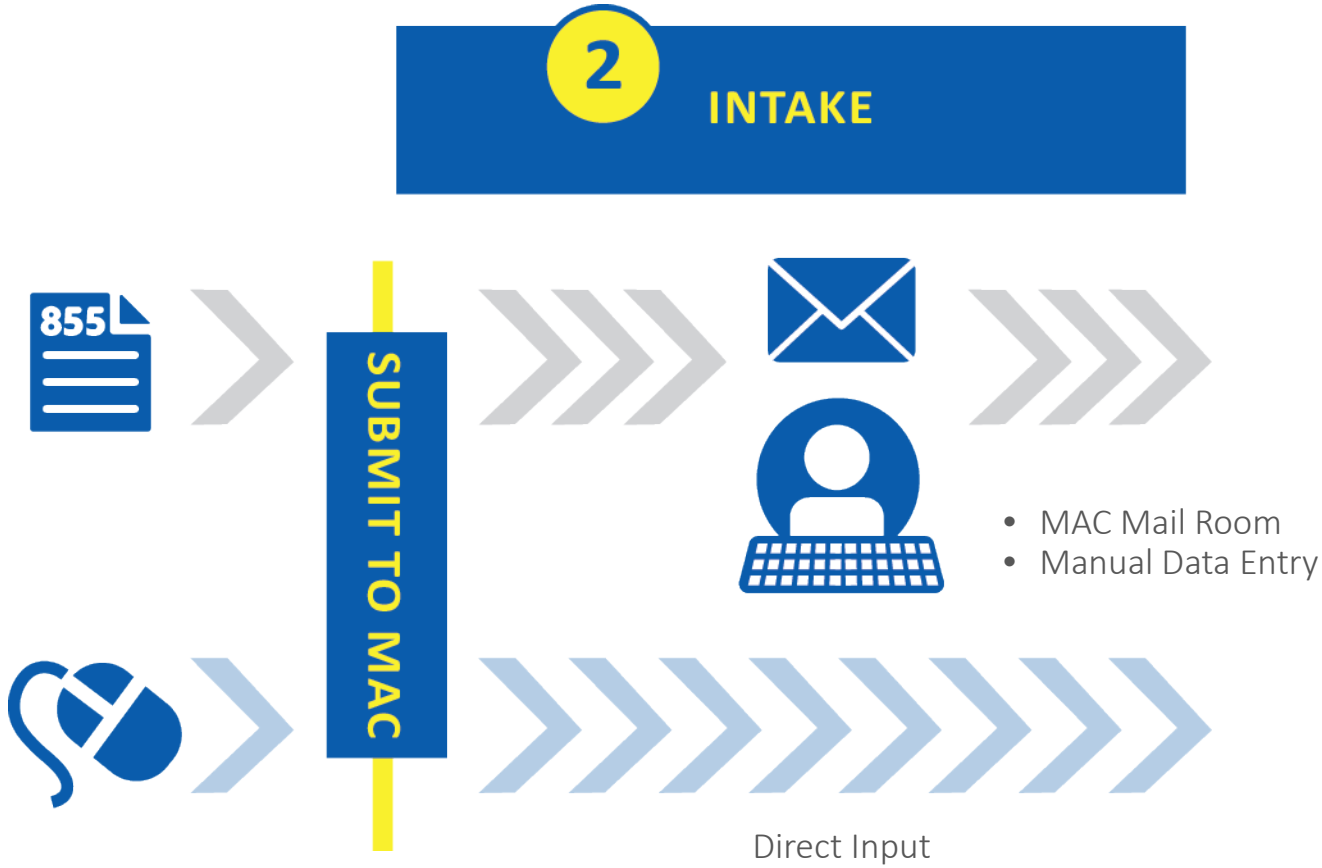
New Enrollee (Initial)

- **Welcome to Medicare!**
- You are submitting an application to initially enroll in the Medicare program or to initially enroll in a new MAC jurisdiction
- Must submit a complete application

Poll Question

Question & Answer Session

Intake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INTAKE
855
SUBMIT TO MAC
• MAC Mail Room
• Manual Data Entry
Direct Input

Receipt Date Determination

Receipt date is important in determining your effective date

Paper Applications

- Based on the date the MAC received the package in the mail

Web Applications

- Electronic Signatures – the date all signatures are completed in PECOS
- Paper Signatures – Based on the date the MAC received the signatures in the mail

Impacts to Receipt Date

Fee Payments

- If received after the application is submitted, the receipt date is the fee paid date

Hardship Waiver Approval

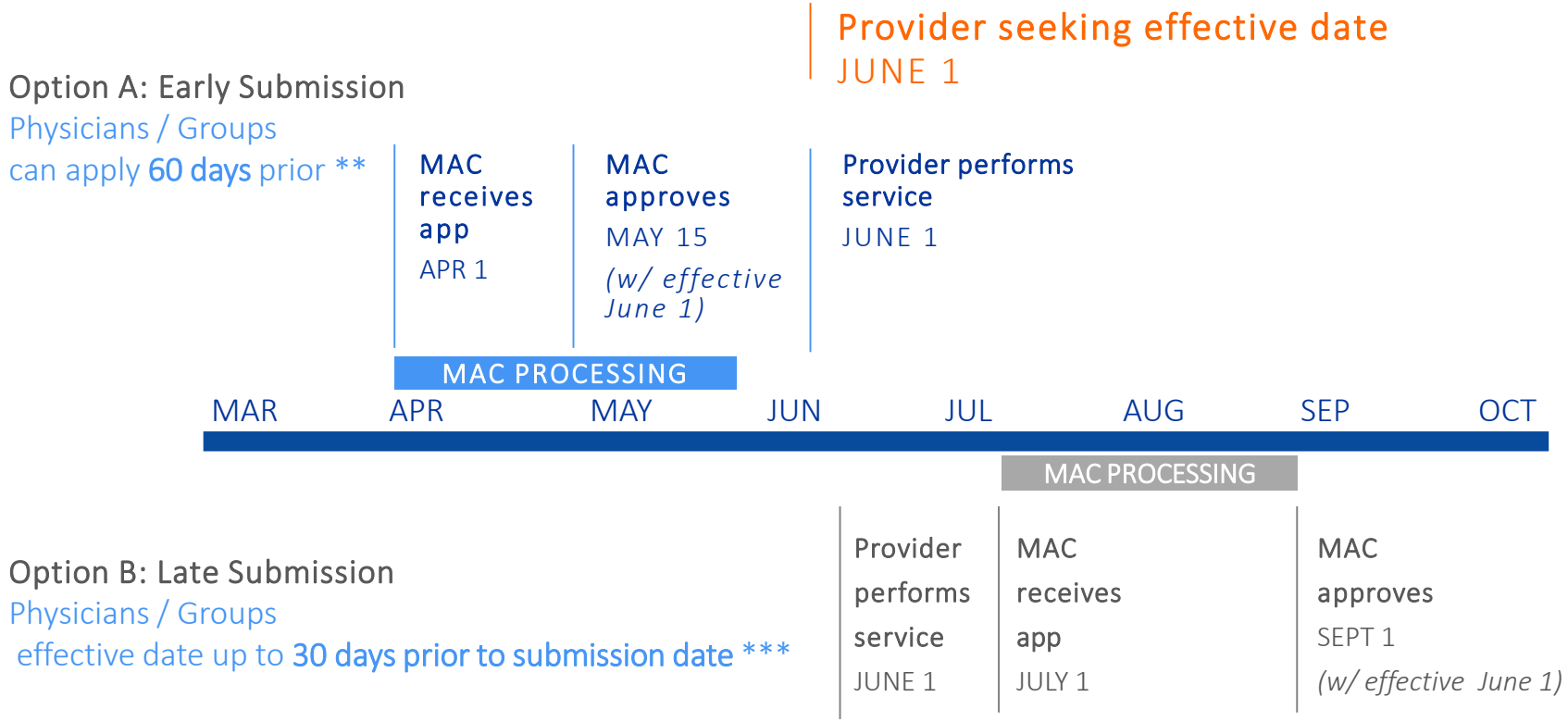
- The date CMS notifies the MAC that the hardship waiver is approved

Poll Question

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)



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

Medicare Effective Dates | Part B

Scenario	Effective Date
▪ Application receipt date of 6/10/18 with app requested date of 7/01/18	▪ 7/01/18 (no retro, based on requested effective date on application)
▪ Application receipt date of 6/10/18 with app requested date of 6/01/18 and all requirements met	▪ 6/01/18 (based on requirements met date)
▪ Application receipt date of 6/10/18 with app requested date of 3/01/18	▪ 5/11/18 (30-day retro)
▪ Application receipt date of 6/10/18 with app requested date of 6/01/18, license effective date 6/28/18	▪ 6/28/18 (based on license effective date)

Effective Dates *(cont.)*

Independent Diagnostic Testing Facility (IDTF)

- The later of: (1) the receipt date of the application or (2) the date all Medicare requirements were met

Ordering and Referring Only Providers (CMS-855O)

- Receipt date of the application

Medicare Effective Dates | Part A

Provider seeking effective date
SEPT 1, 2018

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

MAC receives app
APR 1, 2018

MAC recommends approval to State/RO
JUNE 1, 2018

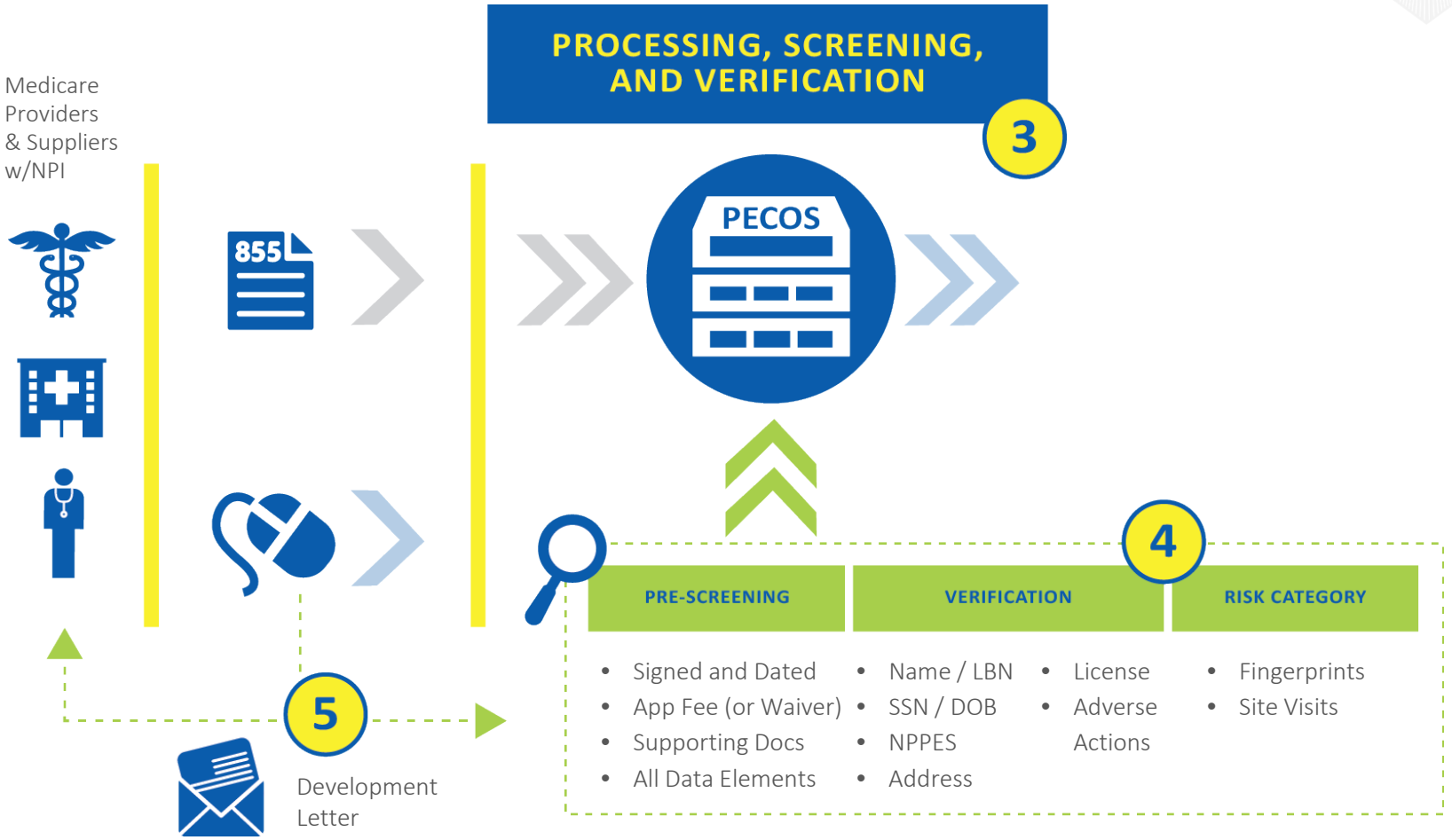
State survey completed
DEC 1, 2018

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

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

Question & Answer Session

Processing, Screening and Verification



What Causes Delays?

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. Authorized or Delegated Official (sec 15/16)

By…

- email
- fax
- phone
- letter

30 days to respond

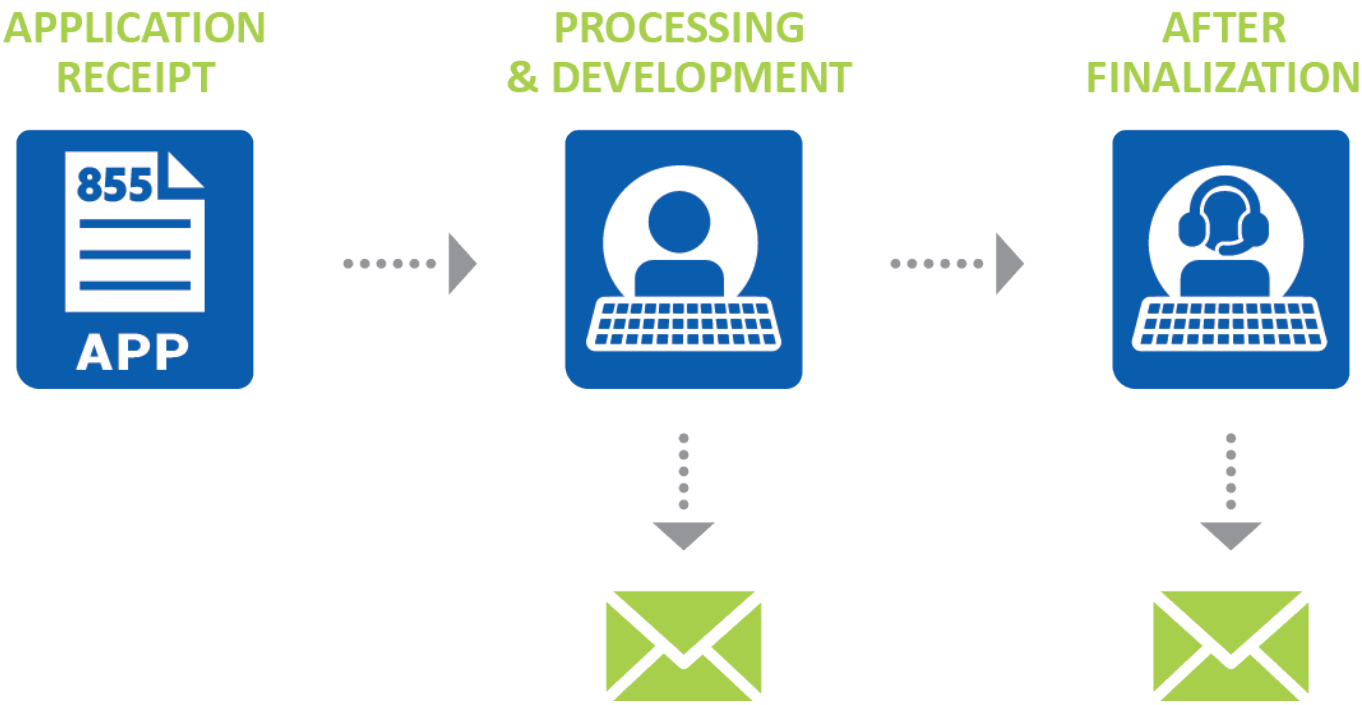
No response?

- delays
- rejections
- later effective date

Poll Question

MAC Notification Letters

Who is listed on MAC notification letters?

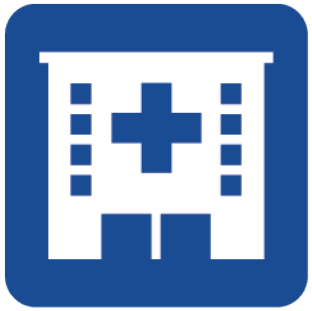


How Addresses are Used

Correspondence

Used to contact the provider directly

- Approval letters
- Revalidation notices
- Revocation letters



Practice Location

Where you render services to beneficiaries

- Revalidation notices
- Site visit

Special Payment

Where all other payment information is sent

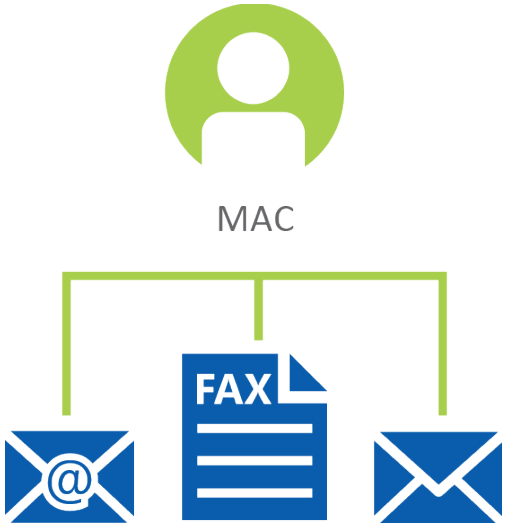
- Revalidation notices
- Remittance notices
- Paper checks

Contact Person

Person to contact regarding your application

- Development requests
- Approval letters

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. Authorized or Delegated Official (sec 15/16)

By…

1. email
2. fax
3. letter

Addition of contact persons must still be reported on appropriate CMS-855

Certification Statement Requirements

PAPER

EXAMPLES OF INVALID CERT:
Copied / Stamped Signatures • Unsigned • Undated • Wrong Person Signed

BEST WAY TO SUBMIT YOUR CERT STATEMENT:

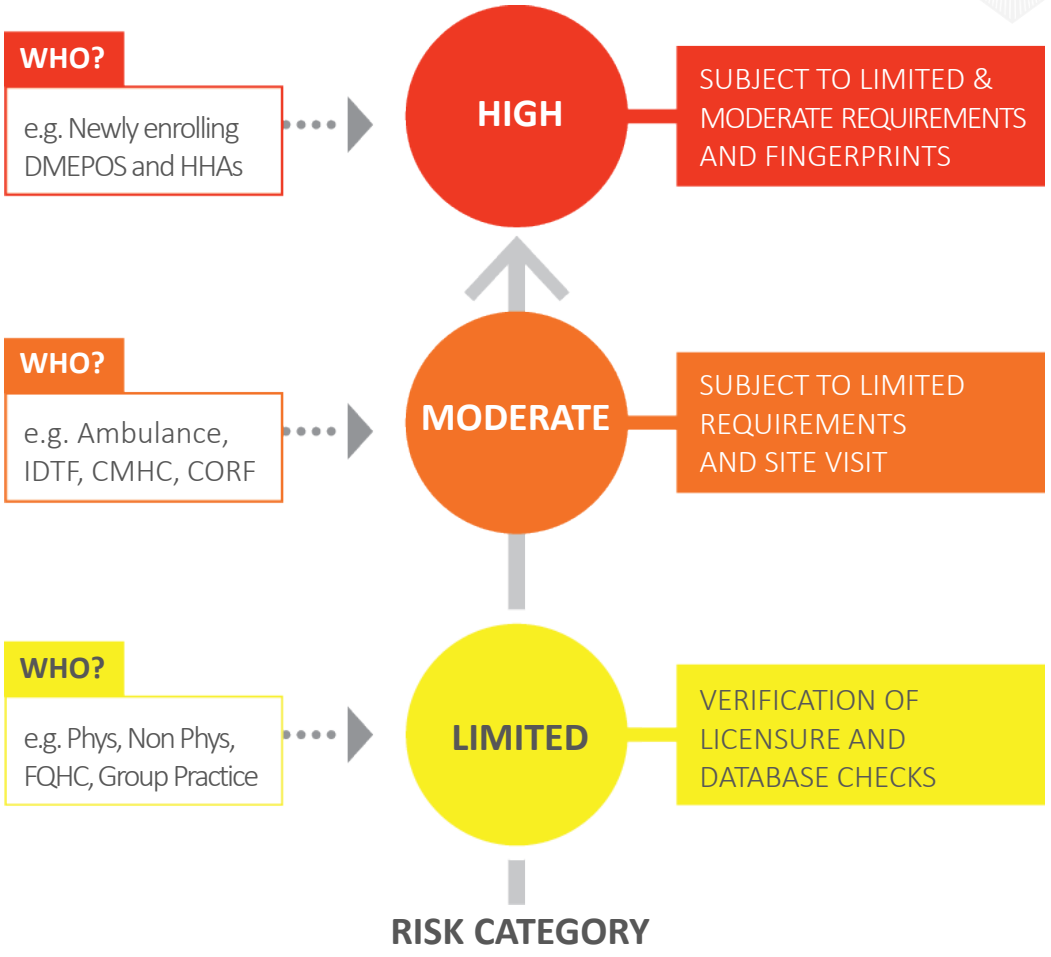
WEB

BEST WAY TO SUBMIT YOUR CERT STATEMENT:

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)

Fingerprinting

CMSfingerprinting.com

Applies to:

- New HHAs
- New DME suppliers
- New MDPP 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

If the provider/supplier:

- Has a felony conviction
- Refuses fingerprinting

Then CMS may deny the application, or revoke their billing privileges

Poll Question

Question & Answer Session

Finalization and Claims

FINALIZATION AND CLAIMS UPDATE

6

Update Claim System

- MAC Updates Claim System (1-2 days)
- Provider not approved until claims updated

MAC Recommendation to State/RO

- Certified providers/suppliers
- MAC recommends to RO
- RO performs in 3-9 months

Approved

- The enrolling provider / supplier has been determined to be eligible under Medicare rules and regulations to be granted Medicare billing privileges
- Provider is not approved until claims system is updated (within 1 – 2 days)
- Approval letter is sent to the contact person. If no contact person is listed the letter is sent to the provider at their correspondence address

Poll Question

What is a PTAN?

- A Medicare-only number issued to providers upon enrollment to Medicare
- Used to authenticate the provider when using the Interactive Voice Response (IVR) phone system, internet portal or on-line application status
- The PTAN's use should generally be limited to the provider’s contact with their MAC
- The NPI must be used to bill the Medicare program

Physician / Non-Physician PTANs

- Individuals are assigned PTANs based on their private practice and group affiliations (i.e. sole proprietor, reassignment of benefits)
- Individuals who reassign their benefits receive a member PTAN for each group PTAN they reassign to
- A sole owner would have a Group PTAN assigned for the business and a member PTAN for themselves

Group / Supplier PTANs

- PTANs are assigned per EIN, per State
- An existing provider would require a new PTAN if:
  - Adding a new location in a different payment locality in the same State
  - Enrolling a different provider type
  - Exception: Hospitals that receive a PTAN per department

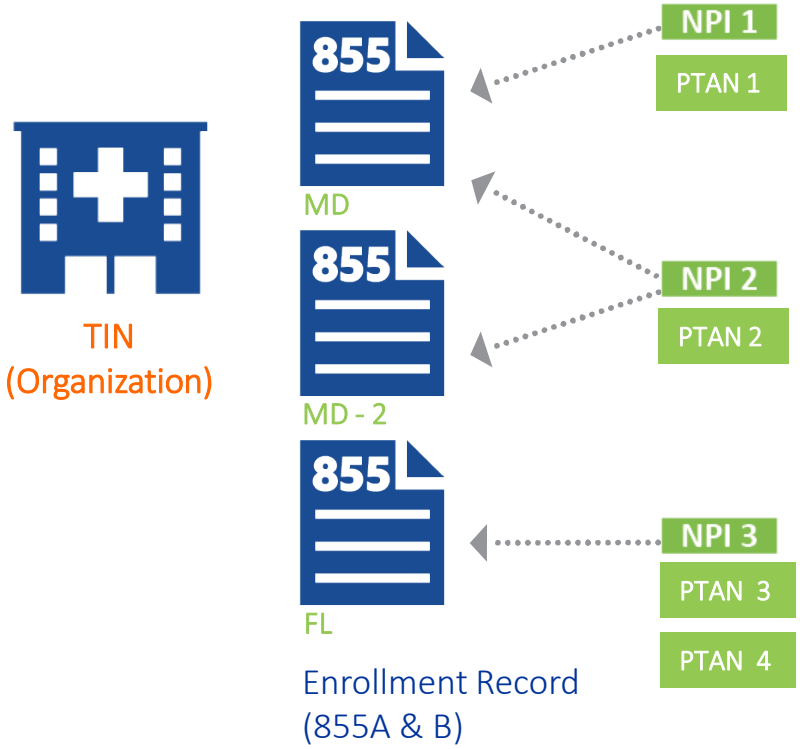
What is a CCN?

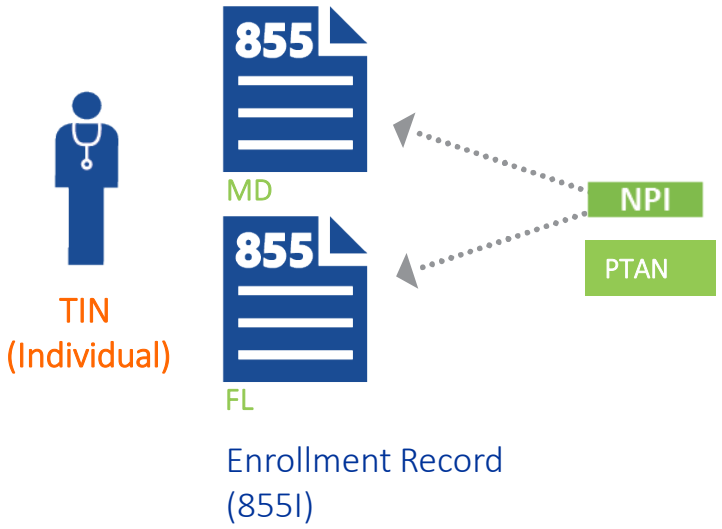
- A CCN is a CMS Certification Number issued to Part A/B certified providers
- Used for verifying Medicare certification, assessment-related activities and communications
- The CMS RO assigns the CCN
  - 6 or 10 digits
  - The first 2 digits identify the state in which the provider is located
  - The last 4 digits identify the type of facility

Poll Question

Understanding the TIN / NPI / PTAN Relationship

TIN to NPI to PTAN – Part A & B (non-DME)

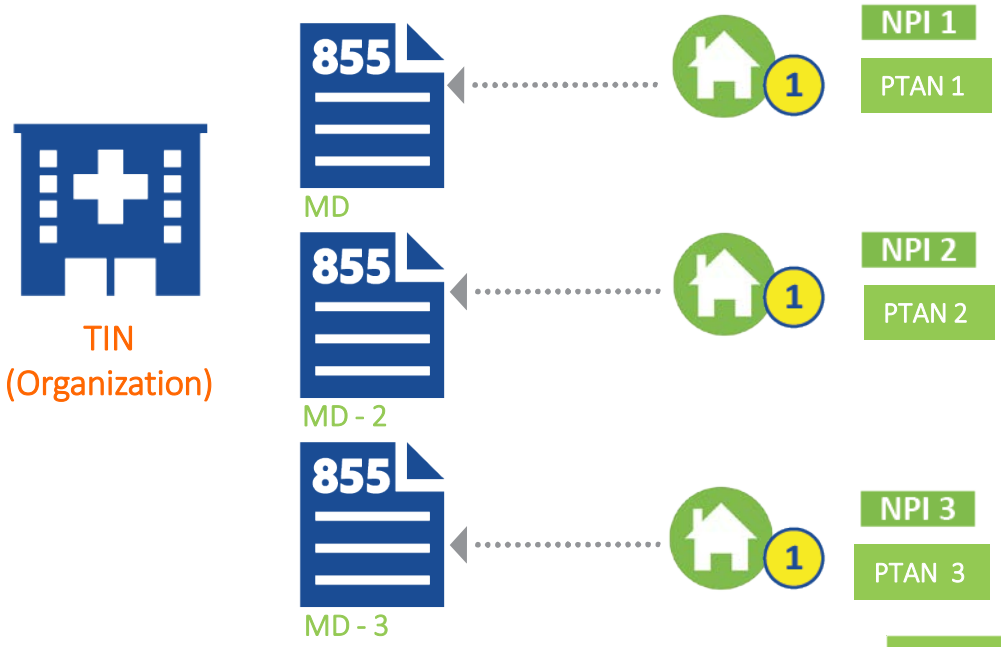




- Organizations can have multiple enrollments per state
- Organizations can have multiple NPIs
- Individuals can only have one NPI

Understanding the TIN / NPI / PTAN Relationship

TIN to NPI to PTAN – Part B (DME)



- Organizations can have multiple enrollments per state
- DME suppliers can only have one location per enrollment
- A separate NPI is required per enrollment

Returns

- Unsolicited revalidation application
- Sent to incorrect contractor
- Submitted more than 60 days prior to the effective date
  - Part A certified providers, Ambulatory Surgical Centers (ASCs) and Portable X-ray Suppliers (PXRS) applications submitted more than 180 days prior to the effective date
- Submitted an application prior to the expiration of a re-enrollment bar
- Submitted an application prior to the expiration of the appeal window for a previously denied application

How to Avoid a Return

- If submitting via paper be sure to send to the correct MAC
- Don’t submit applications more than 60 or 180 days in advance of the effective date
- Don’t submit a revalidation more than 6 months in advance of your revalidation due date
- Don’t submit the application multiple times

Rejections

- Failure to provide complete information within 30 days of the MAC's request
  - Missing information/documentation
  - Unsigned, undated certification statement
  - Old version of the CMS-855 application
  - Incorrect application submitted
  - Failure to submit application fee
  - Failure to submit all required forms (e.g. CMS-855Rs for group enrollments)

How to Avoid Rejections

- Don’t delay in responding to the request for information letter from your MAC
- Contact the MAC if you aren’t sure what you need to do to return accurate corrections

Denied

- The enrolling provider is ineligible to receive Medicare billing privileges
- Denial letter will include appeal rights
- A new enrollment application cannot be submitted until :
  - Appeal rights have lapsed, or
  - Notification received that the determination was upheld

Question & Answer Session

Other Submission Types

Changes of Information

- You are submitting an enrollment application to notify Medicare of a change(s) to your enrollment information

CHANGE OF PRACTICE LOCATION

CHANGE OF CORRESPONDENCE ADDRESS

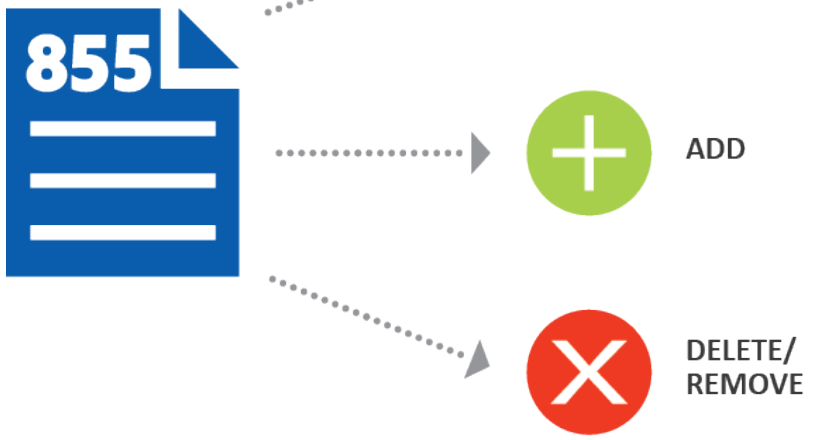
CHANGE OF OWNERSHIP

Changes of Information

- **Within 30 days**
  - Change of ownership or control, including changes in authorized or delegated official(s)
  - Adverse Legal Action (e.g., suspension or revocation of any state or Federal license)
  - Change in practice location (includes any new reassignments)
- **Within 90 days**
  - All other changes to enrollment

Note: *Timeframes may vary by provider type.*
Refer to SE1617 on CMS.gov for more information

When to Select Change / Add / Delete



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

- Add additional enrollment information to existing information *(practice locations)*
- App fee is required

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

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

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

Revalidation

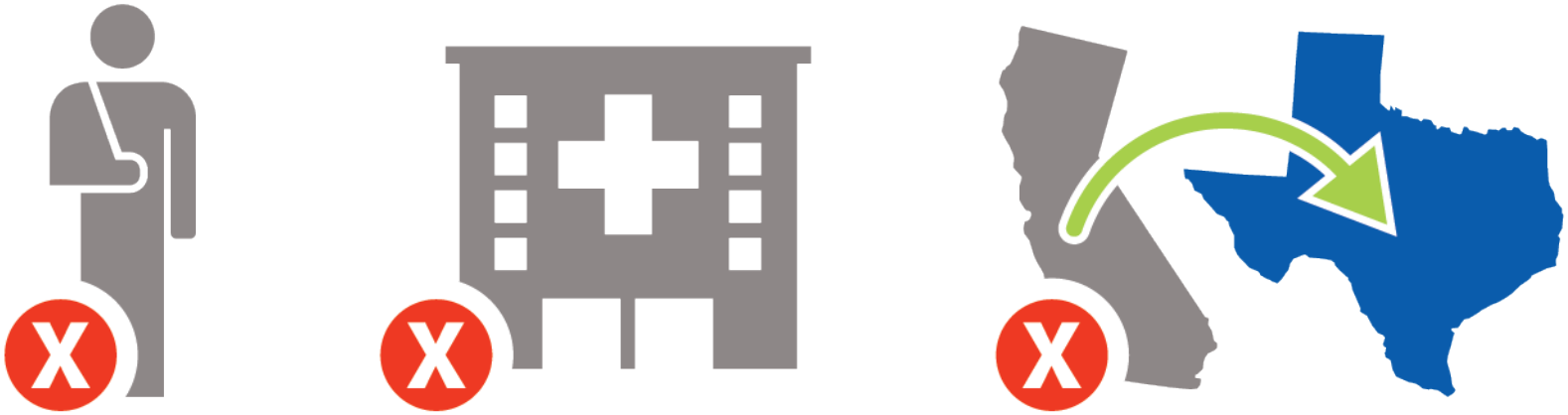
- Verify the accuracy of your enrollment information that exists on file with Medicare
- DME suppliers revalidate every 3 years and all other providers/suppliers every 5 years

Reactivation

- You are returning to Medicare after a deactivation
- Must submit a complete CMS-855 to reactivate
- Effective date is based on the receipt date of the application
- You will be issued a new Provider Transaction Access Number (PTAN)
  - Except for deactivations due to non-response to revalidation

Voluntary Withdrawal

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



Opt-Out of Medicare

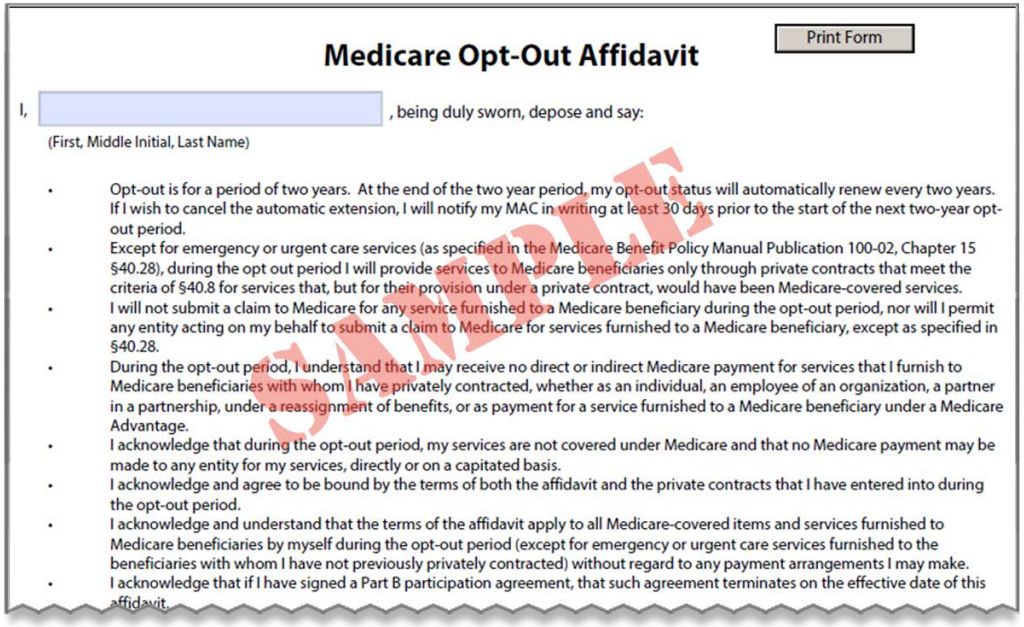
Physicians/practitioners who do not wish to enroll in the Medicare program may "opt-out"

What this means:

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

Filing an Opt-Out Affidavit

- A standard CMS form is not available
- Some MACs have a form available on their website
- Must be filed with all MACs who have jurisdiction over the claims the physician/ practitioner would have otherwise filed with Medicare



Print Form

Medicare Opt-Out Affidavit

I, _____, being duly sworn, depose and say:

(First, Middle Initial, Last Name)

- Opt-out is for a period of two years. At the end of the two year period, my opt-out status will automatically renew every two years. If I wish to cancel the automatic extension, I will notify my MAC in writing at least 30 days prior to the start of the next two-year opt-out period.
- Except for emergency or urgent care services (as specified in the Medicare Benefit Policy Manual Publication 100-02, Chapter 15 §40.28), during the opt out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of §40.8 for services that, but for their provision under a private contract, would have been Medicare-covered services.
- I will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in §40.28.
- During the opt-out period, I understand that I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare Advantage.
- I acknowledge that during the opt-out period, my services are not covered under Medicare and that no Medicare payment may be made to any entity for my services, directly or on a capitated basis.
- I acknowledge and agree to be bound by the terms of both the affidavit and the private contracts that I have entered into during the opt-out period.
- I acknowledge and understand that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by myself during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.
- I acknowledge that if I have signed a Part B participation agreement, that such agreement terminates on the effective date of this affidavit.

SAMPLE

Impacts of Opting-Out

- May not receive direct or indirect Medicare payment for services furnished to Medicare beneficiaries
  - Traditional Medicare fee-for- service
  - Under a Medicare Advantage plan
- Cannot terminate early unless opting out for the first time and within 90 days after the effective date of the opt-out period
  - Locked in for 2 years if you miss the 90 day window
- May order or certify items and services or prescribe Part D drugs for Medicare beneficiaries
  - NPI
  - Date of Birth
  - Social Security Number
  - Confirmation if an Office of Inspector General (OIG) exclusion exists

Provider Enrollment Policy

Poll Question

Physician Assistant

CAN

- Enroll in Medicare for services provided
- Establish an employer relationship using 855I *(section 2E)*
- Terminate an employer relationship using Section 2F of 855I (PA) or Section 2G of 855B (Org)

CANNOT

- Individually enroll and receive direct payment *(Payments made only to PA's employer)*
- Organize/incorporate and bill for services directly
- Reassign benefits

- Employer can be an Individual or Organization
- MAC affiliates PA to employer's TIN and will develop for which employer PTANs to link PA
- Structure PA employer relationships to link to an enrollment vs employer's TIN *(future)*

Physical Therapist

- Required to undergo a site visit unless PT performs services in patient's homes, nursing homes, etc.
- Must maintain space used exclusively for your practice
- Site visit will be performed at the group's location if you reassign all benefits

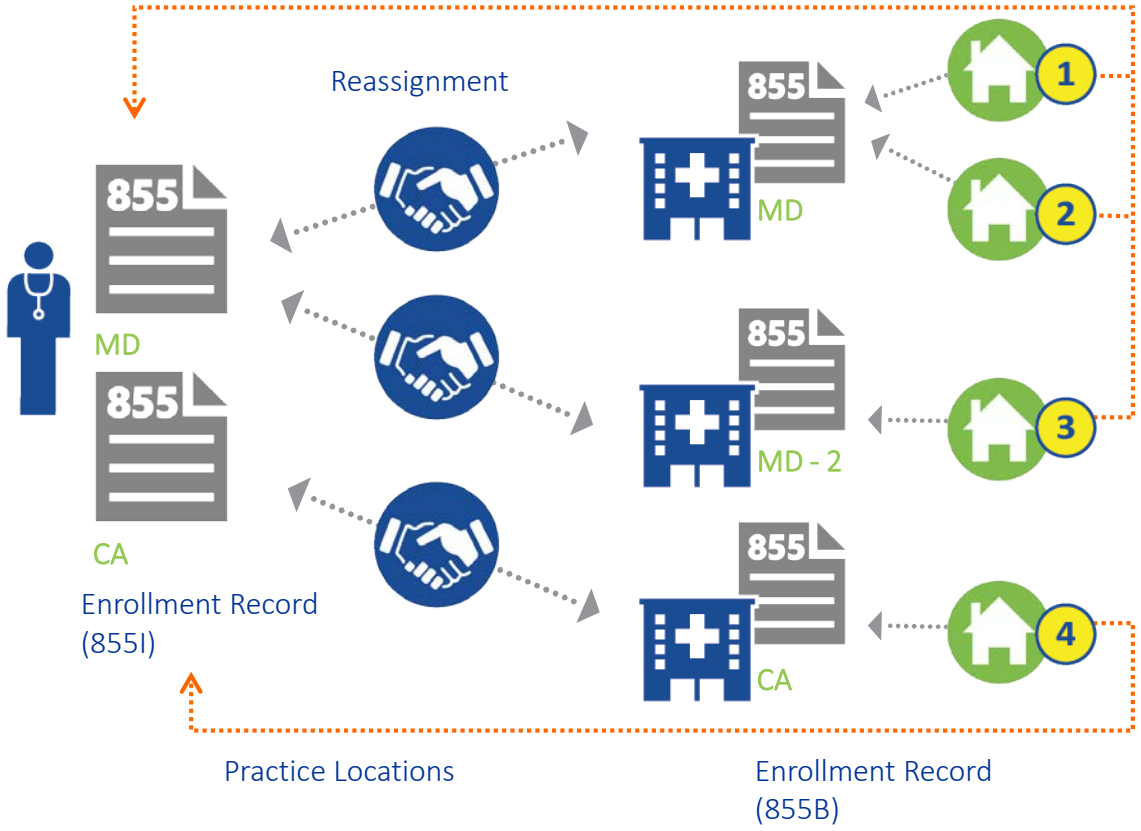
Nurse Practitioner

Enrolling for the first time?

- ✓ Must be certified by a recognized national certifying body
- ✓ Must possess a master's degree in nursing or Doctor of Nursing Practice (DNP) doctoral degree

Reassigning Benefits

Reassignments & Practice Locations



- Individual provider reassigns their right to bill Medicare and receive payments for some or all of their services
- A CMS-855R is required for each organization the provider reassigns benefits
- An Authorized or Delegated Official of the organization must sign the CMS-855R
- Termination of the reassignment can be done by the practitioner or the employer

Knowledge Check

Interns and Residents

- Interns are NOT permitted to enroll in Medicare
- Residents are permitted to enroll in Medicare
  - Must be licensed
  - Complete the CMS-855I or CMS-855O
  - Section 2C of the CMS-855I collects information on your residency program
  - Cannot bill for services provided as part of your residency program

Ordering and Certifying

CMS-6010
since JAN 2014

Anyone who orders or refers services:

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

CMS-855O  **CMS-855I**

- Convert from an ordering and certifying 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

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

Ordering and Certifying

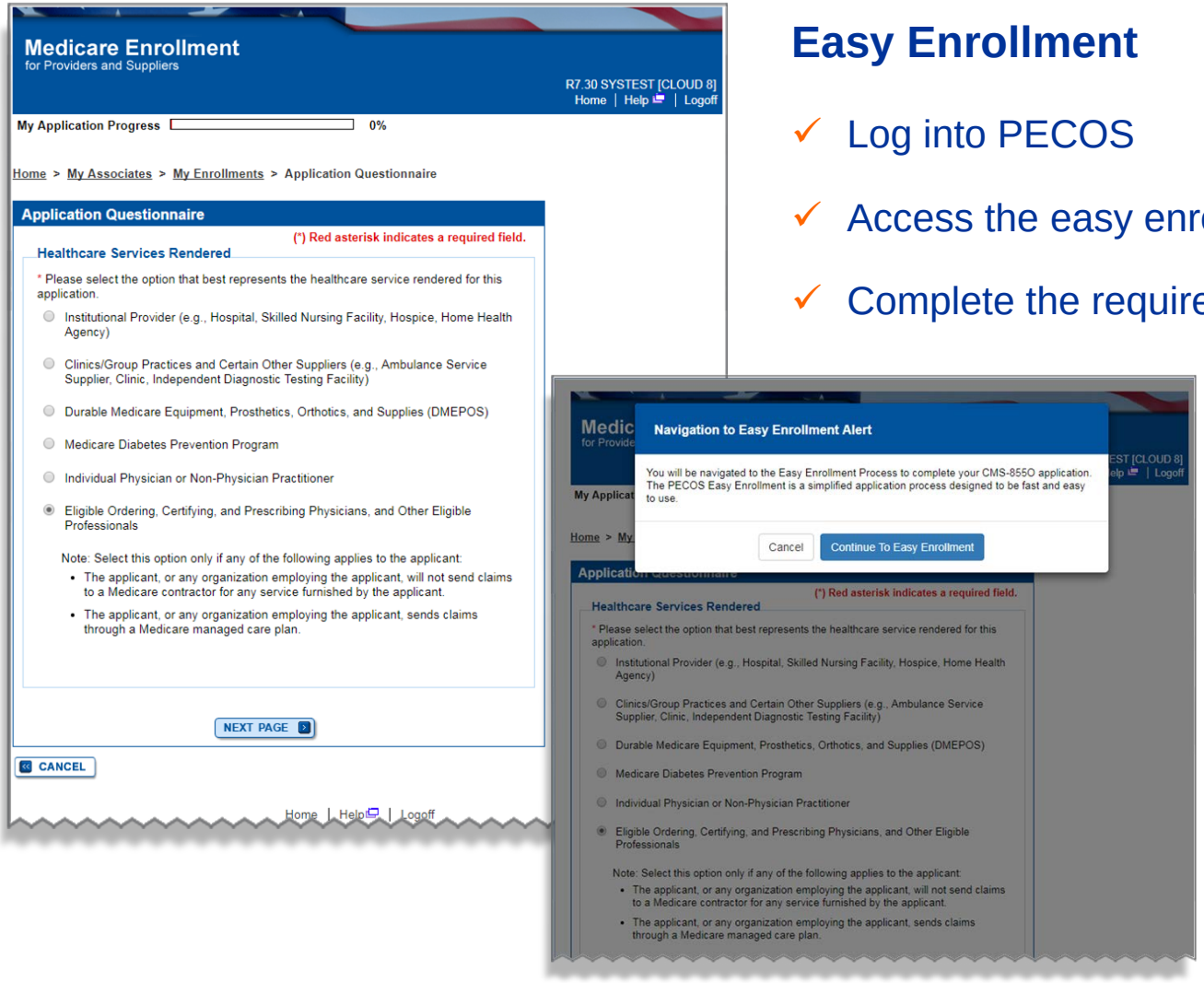
- CMS-855O is a national enrollment

- Providers who relocate to another state are not required to dis-enroll in the current state and re-enroll in the new state

- The MAC that maintains the CMS-855O enrollment in PECOS will process the change of information, even if the provider is relocating to a state outside of their jurisdiction

- The MAC will update the provider's record with any new licenses and/or certifications obtained as a result of the provider's relocation

CMS-855O Easy Enroll | October 2017



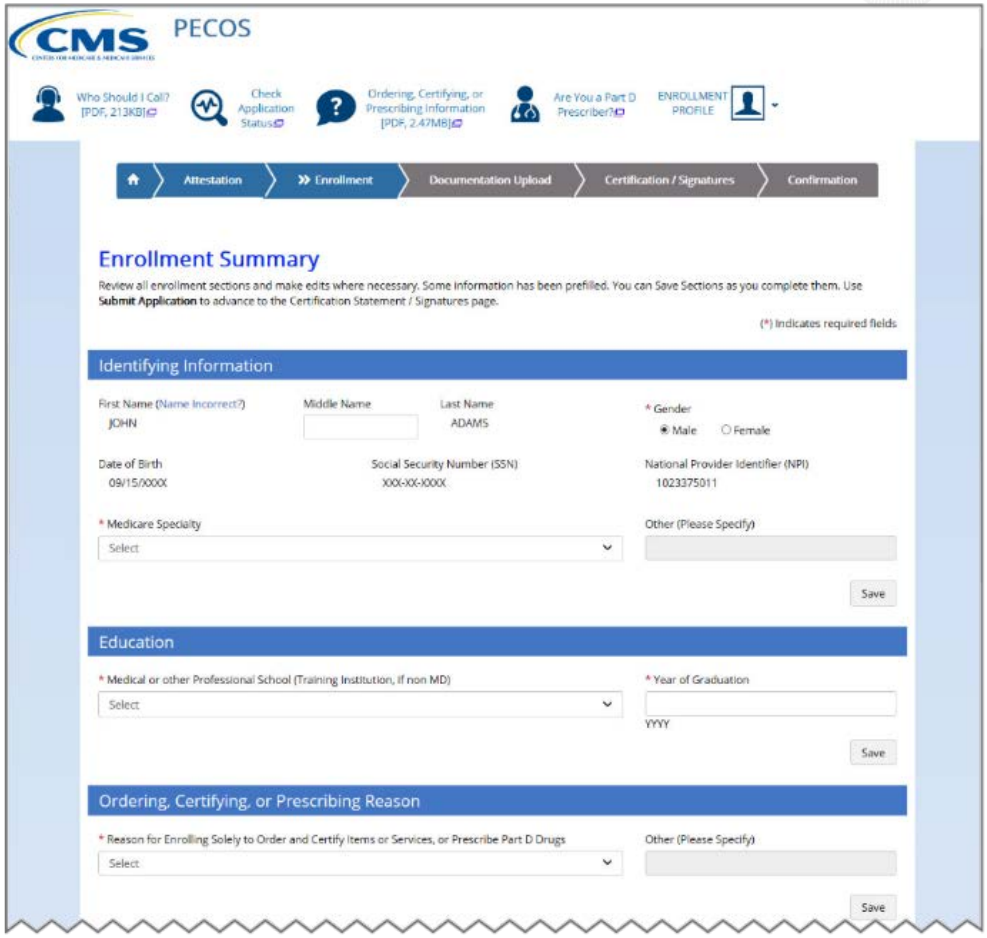
Easy Enrollment

- ✓ Log into PECOS
- ✓ Access the easy enroll interface
- ✓ Complete the required workflow changes

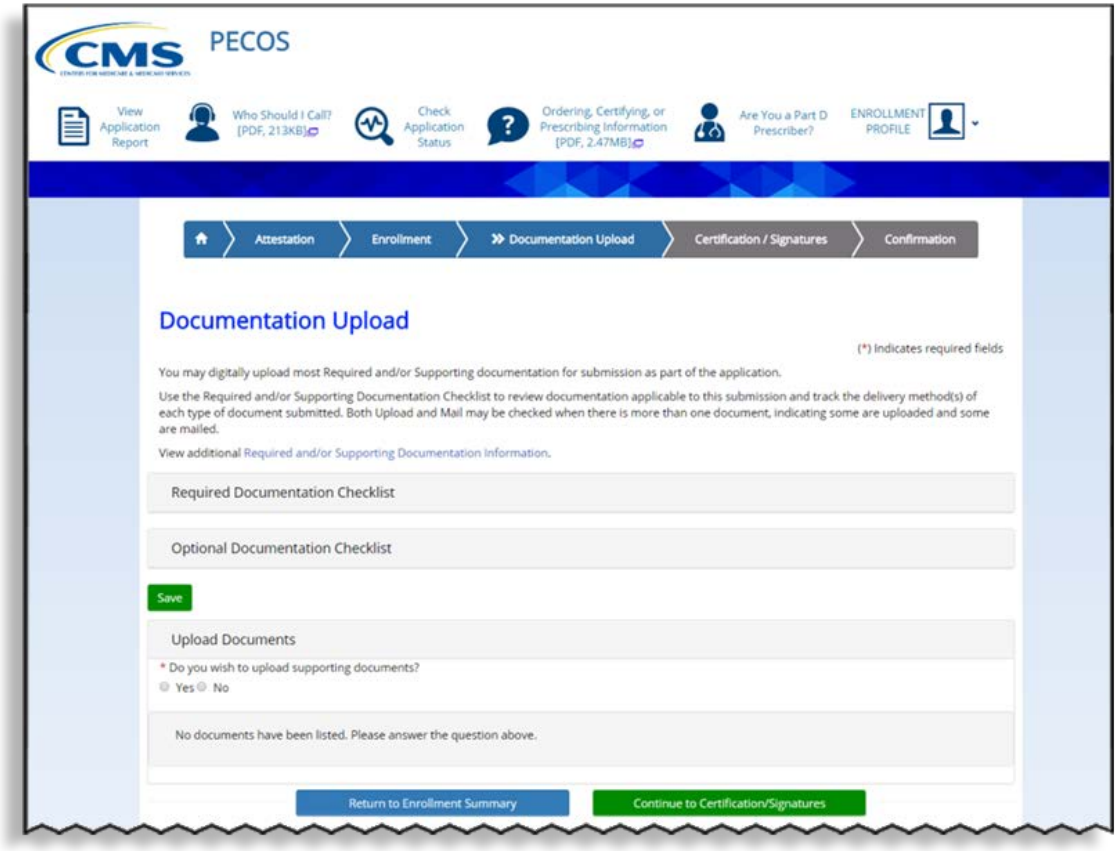
CMS-855O Easy Enroll| October 2017

855O Easy Enrollment - PECOS PI

- ✓ 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.



CMS-855O Easy Enroll | October 2017



Documentation Upload

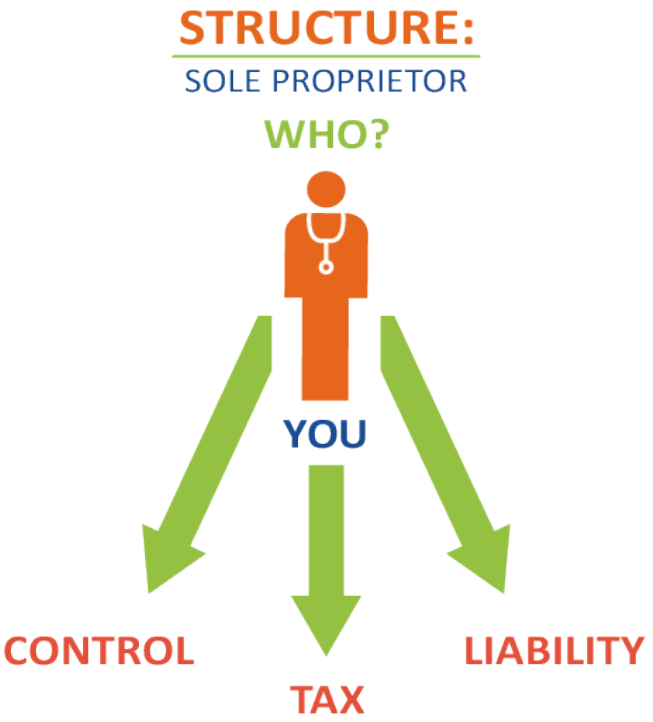
- ✓ Users will be able to upload supporting documentation for their CMS-855O easy enroll application
- ✓ Enter license information to route application to the appropriate contractor

Question & Answer Session

Business Structures and Ownership/Managing Control

Sole Proprietors

- ✓ One person owns the business
- ✓ Unincorporated
- ✓ The individual may bill under their SSN or an EIN
- ✓ If the business has an EIN, it will be under the owner's name and not a business name
- ✓ May have employees



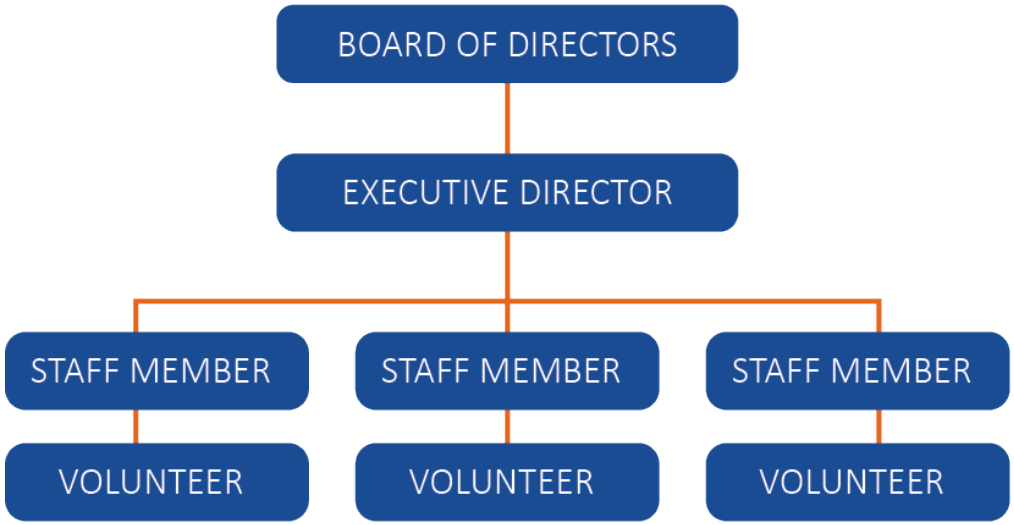
Sole Owner LLC and Corporations

- ✓ A separate and distinct entity from the owner
- ✓ Incorporation documentation submitted to the State
- ✓ EIN will be under the business name
- ✓ Owner is shielded from liability, only the business can be sued and liable for debts

Partnerships

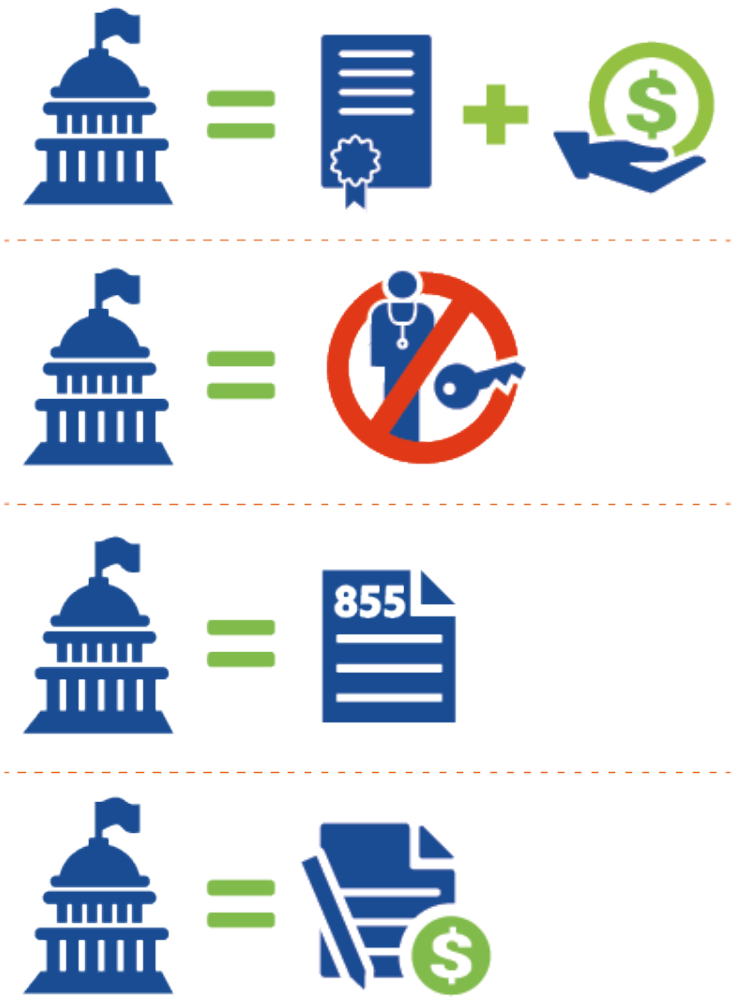
- ✓ An association of two or more individuals or entities
- ✓ Each partner is liable for all debts and pays taxes on any income earned from the business
- ✓ Partnerships have a partnership agreement to outline duties, responsibilities, powers
- ✓ Each partner can manage the day to day operations

Non-profit Organizations



- ✓ Non-Profits are acquired to promote political, social, religious, or charitable goals
- ✓ Obtains a 501(c)(3) certification from IRS or a similar status in the State to become tax exempt
- ✓ Do not have owners
- ✓ Board makes business decisions

Government-Owned Entities (GOEs)



- ✓ Government body (Federal, State, city or county) is legally and financially responsible
- ✓ GOE's do not have owners
- ✓ Must list the government body and managing employees on the enrollment application
- ✓ Documentation required indicating the governing body is responsible for Medicare payments

Direct vs Indirect Ownership

- Any organization or individual that has at least 5% ownership of the assets of the supplier
- Includes partnership interest
- Government entities would only list the county in Section 5 and any employees who run the provider's operations in Section 6.

Example:

The supplier Medical Clinic Inc., is owned by Forest Labs LLC, Dr. John Sparks and Dr. Amelia Crews. The doctors have a partnership. Forest Labs LLC would be reported in Section 5 as a 5% Owner and each doctor would be reported in Section 6 as 5% Owners.

Foreign Ownership

- Any individual or organization submitted in Sections 5/6 of an CMS-855 application must supply a valid TIN:
  - Employer Identification Number (EIN)
  - Social Security Number (SSN)
  - Individual Taxpayer Identification Number (ITIN)

- If an individual or organization is not legally eligible to obtain a TIN or ITIN, documentation must be submitted to provide an explanation

Managing Employees

- Any individual that has operational or managerial control of the day to day business decisions and operations
- May be a W-2 employee or contracted
- Any enrolling supplier must include at least one managing employee
- A managing employee is optional for Individuals enrolling via the CMS-855I

Provider Enrollment Chain and Ownership System (PECOS)

Poll Question

What is PECOS?

The Provider Enrollment, Chain and Ownership System (PECOS) is the system that houses all provider's enrollment and billing information.

PECOS can be used in lieu of the paper CMS-855 enrollment application to:

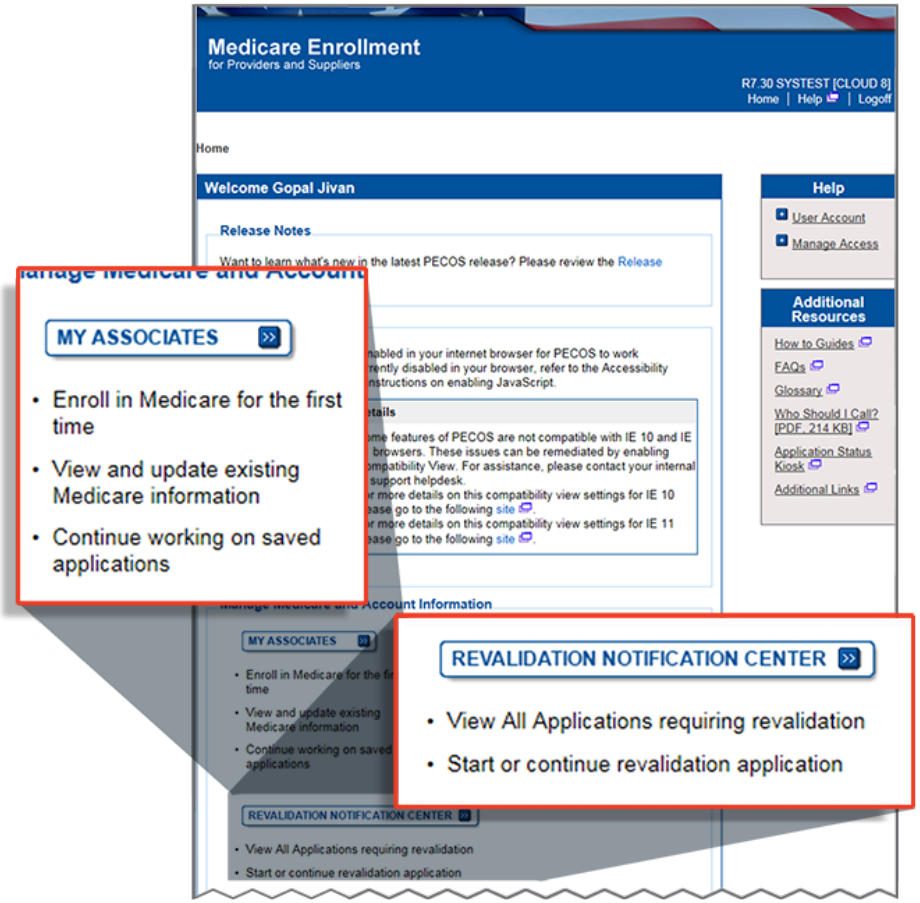
- ✓ Submit an initial Medicare enrollment application
- ✓ Submit changes to existing Medicare enrollment information
- ✓ Revalidate your enrollment information
- ✓ Track the status of an enrollment application
- ✓ Reactivate an existing enrollment record
- ✓ Withdraw from the Medicare Program

Advantages to using PECOS

Using PECOS Is Easy!

- Faster than paper-based enrollment (45 day processing time vs. 60 days for paper)
- Tailored application process means you only supply information relevant to YOUR application
- More control over your enrollment information, including reassignments
- Easy to check and update your information for accuracy
- Less staff time and administrative costs to complete and submit enrollment to Medicare

PECOS Key Features | Home Page



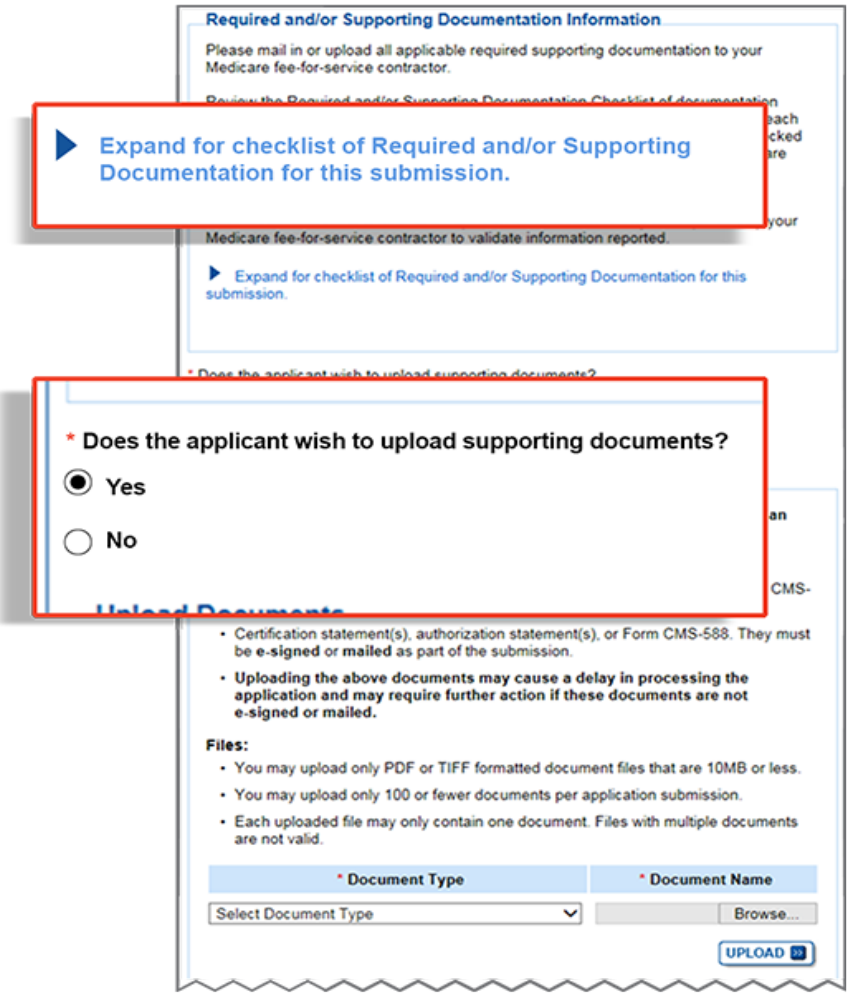
My Associates

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

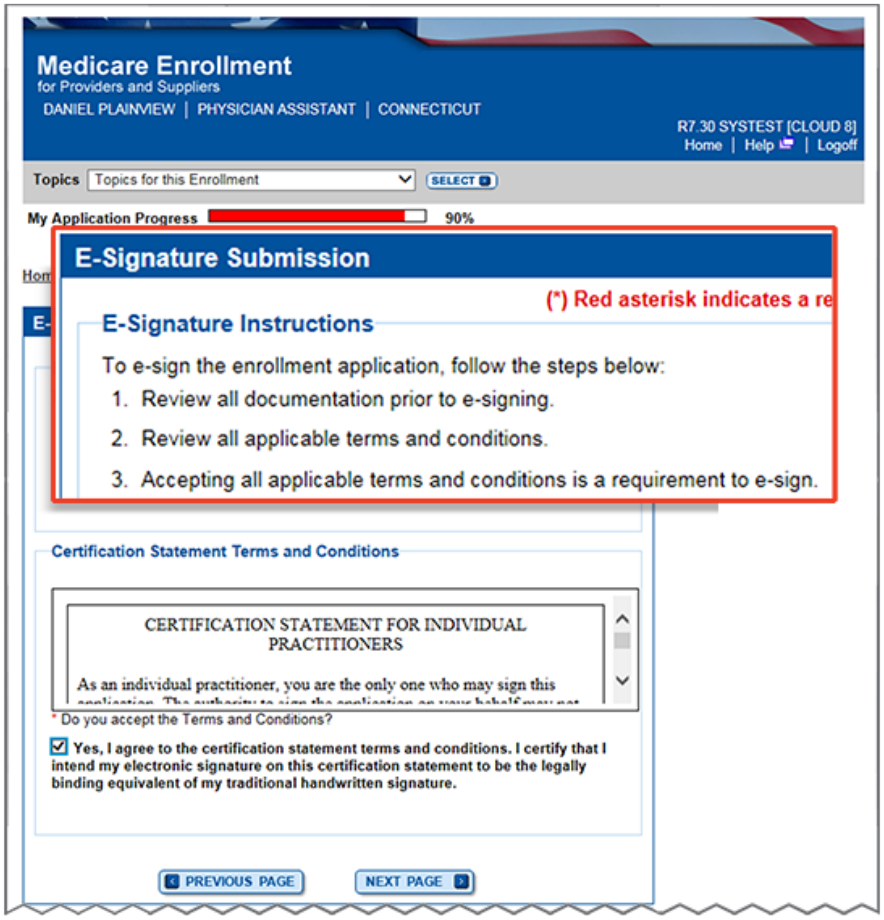
PECOS Key Features | Upload Digital Documents



- ✓ 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

Poll Question

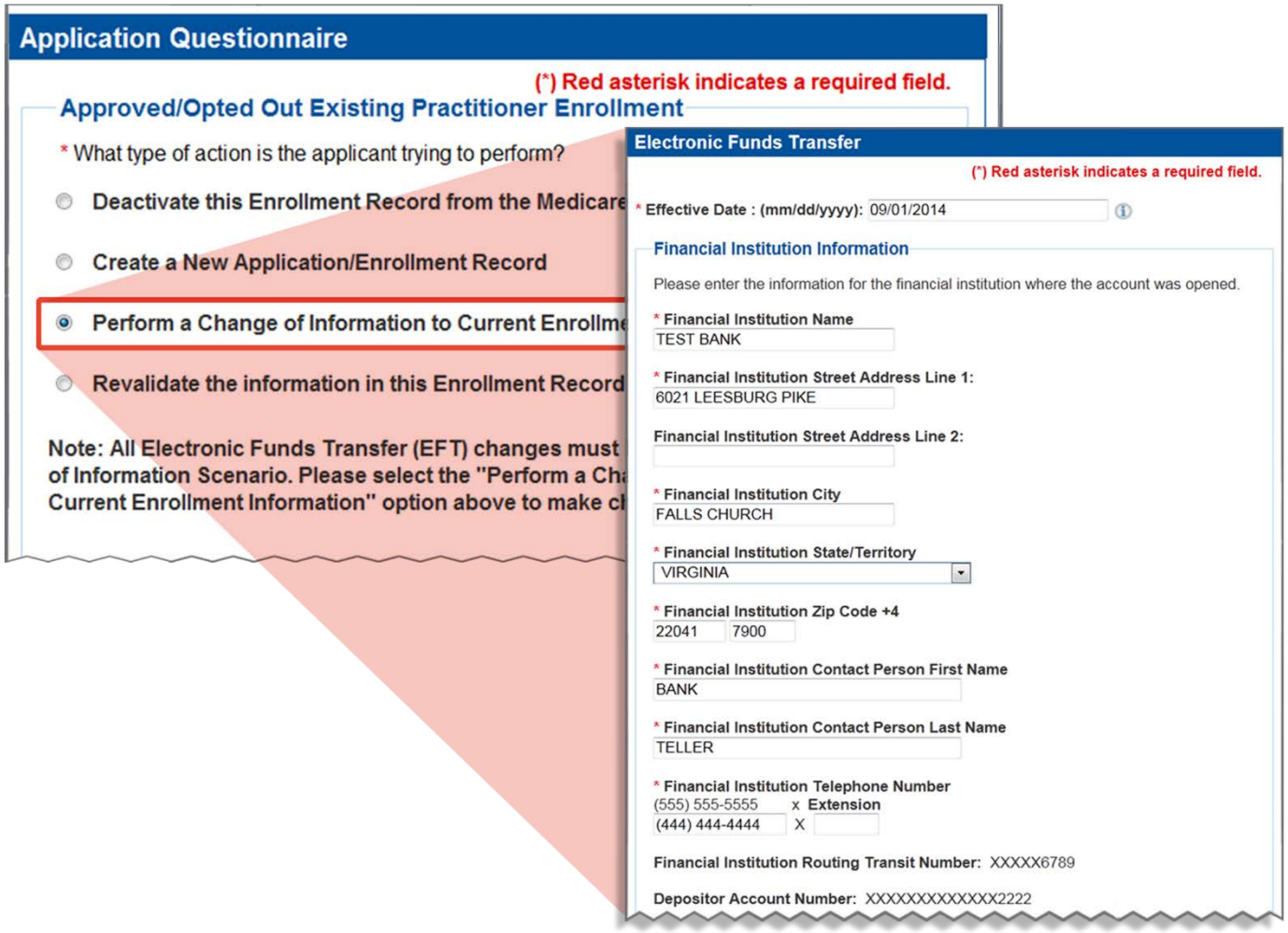
PECOS Key Features | E-Signature



- ✓ Ability to electronically sign any application submission (*including ones that require multiple signatures*)

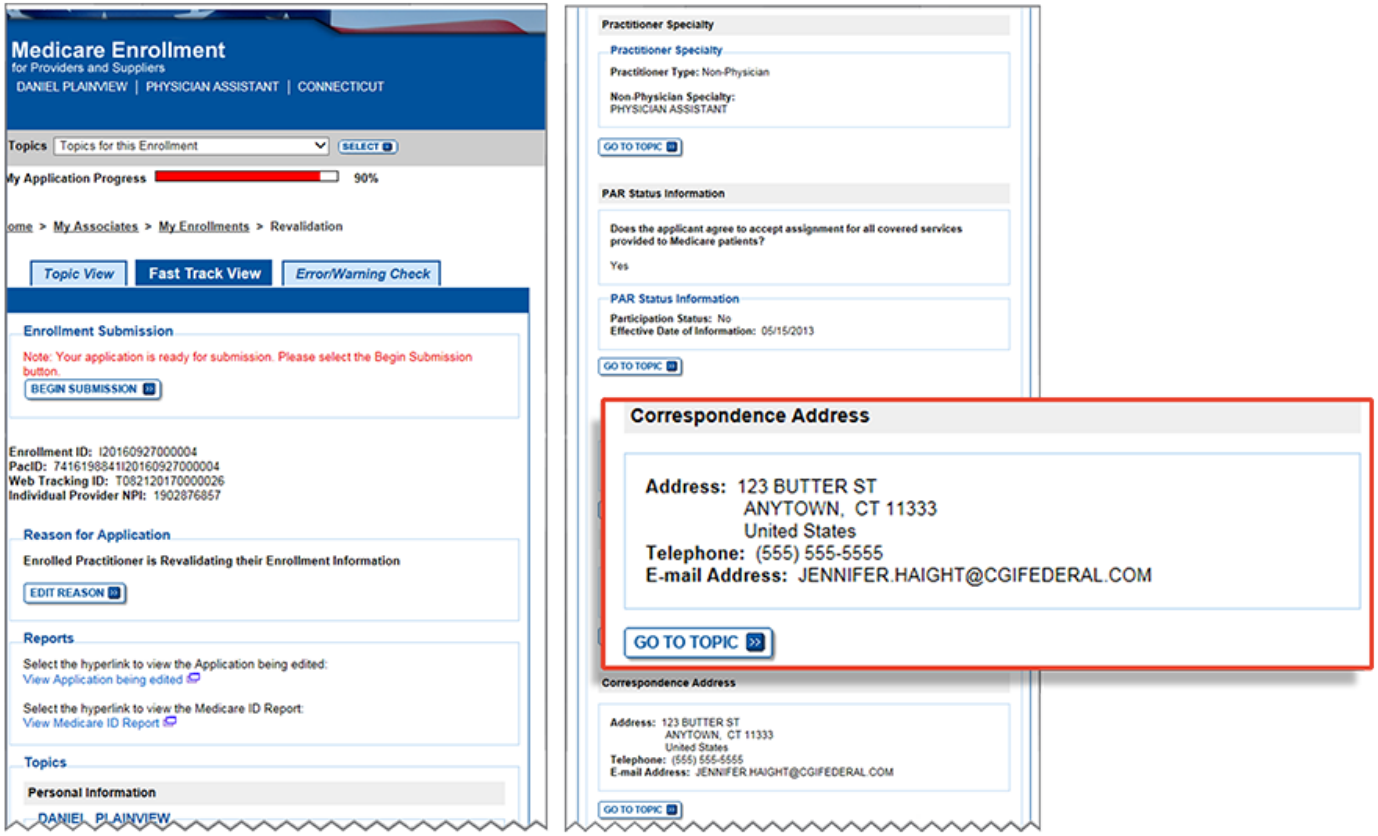
PECOS Key Features | EFT Updates

Ability to submit or update EFT (CMS-588) information

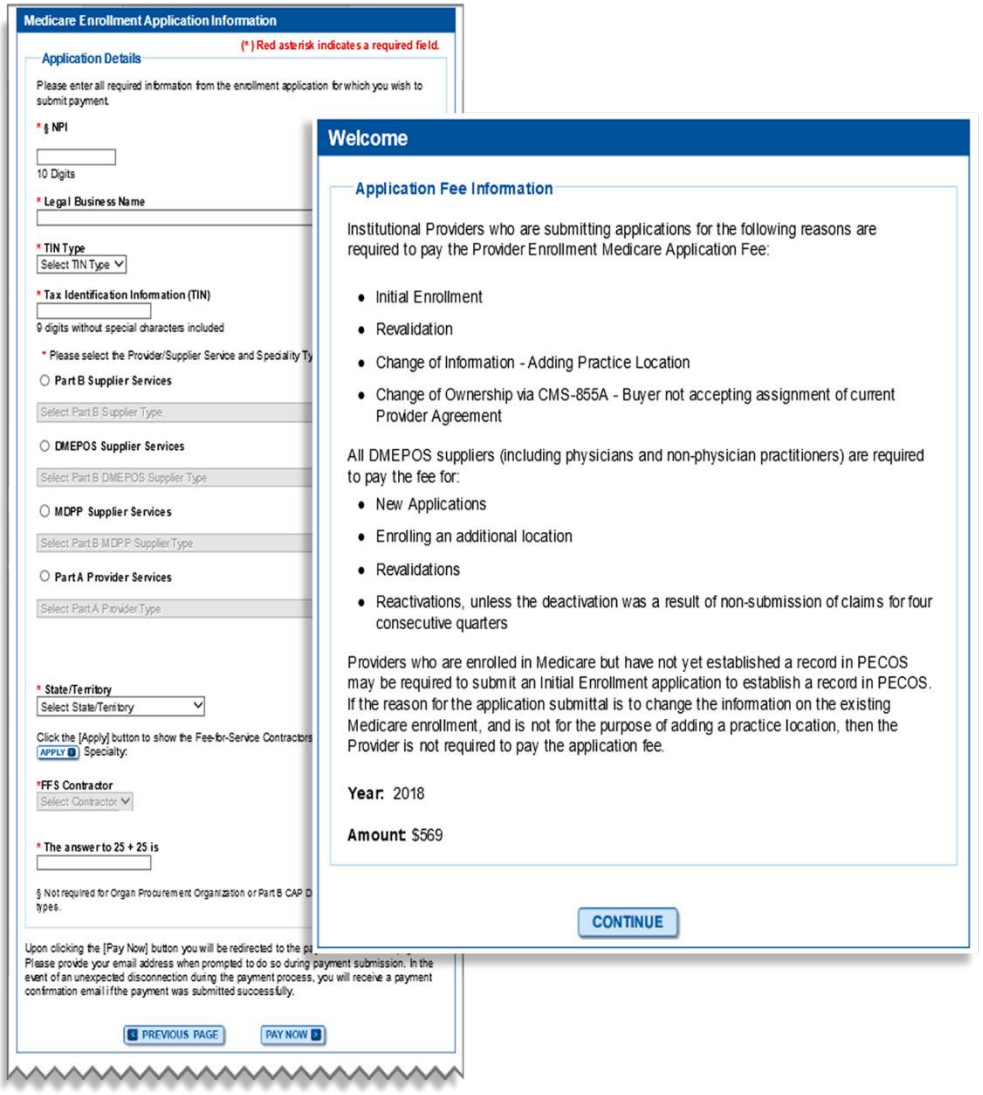


PECOS Key Features | Fast Track View

Fast Track View tab displays comprehensive summary of the provider's enrollment information



PECOS Key Features | Application Fee



- ✓ Ability to securely submit Application Fee payment online

Poll Question

Who Should I Call?

PECOS — LOGIN, FORGOT USERNAME/ PASSWORD, SYSTEM ERROR MESSAGES → EUS (EXTERNAL USER SERVICES)	PECOS — I&A ACCOUNT, SURROGACY, CONNECTIONS → EUS (EXTERNAL USER SERVICES)
APP — COMPLETING A 855 APPLICATION PAPER OR WEB → MAC (MEDICARE ADMINISTRATIVE CONTRACTOR)	APP — COMPLETING A NPI APPLICATION → ENUMERATOR
APP — ENROLLMENT APPLICATION STATUS SUBMISSION REASON, SPECIALTY TYPE → MAC (MEDICARE ADMINISTRATIVE CONTRACTOR)	APP — WHO IS REQUIRED TO OBTAIN AN NPI AND WHAT TYPE OF NPI? → MAC (MEDICARE ADMINISTRATIVE CONTRACTOR)
APP — ENROLLMENT APPLICATION FEE PAYMENT OR REFUND → MAC (MEDICARE ADMINISTRATIVE CONTRACTOR)	APP — REVALIDATION → MAC (MEDICARE ADMINISTRATIVE CONTRACTOR)

Resources

cms.gov

- ordering and referring, DMEPOS accreditation, supplier standards, part D enrollment
- CMS-855 processing guides
- MAC contacts: (search for Medicare enrollment contact")

cms.gov/Revalidation

- search all records online
- view and filter online spreadsheets
- export to Excel, or connect to with API

PECOS.cms.hhs.gov

account creation, videos, providers resources , FAQs

ProviderEnrollment@cms.hhs.gov

Provider Enrollment contact

FFSProviderRelations@cms.hhs.gov

"ListServ" sign-up: Notice of program and policy details, press releases, events, educational material

888-734-6433

PECOS Help Desk (EUS)

cms.gov MLN Matters® Articles

articles on the latest changes to the Medicare Program and enrollment education products

CMS-855 Processing Guides

For Providers | For MACs

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

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."

CMS-855O Processing Guide

For Providers | For MACs

"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."

CMS-855I Processing Guide | Coming Soon

For Providers | For MACs

"On the CMS-855I, the physician must indicate his/her supplier specialties, showing "P" for primary and "S" for secondary. The provider may select only one primary specialty but may select multiple secondary specialties. A physician must meet all Federal and State requirements for the type of specialty(s) checked…."

*"The physician assistant must furnish his/her NPI in section 1 of the application, and must list his/her employers in section 2E. Since PAs cannot reassign their benefits – even though they are reimbursed through their employer – they should **not** complete a CMS-855R….."*

Thank You

April 2018 | This summary material was part of an in-person presentation. It was current at the time we presented it. It does not grant rights or impose obligations. We encourage you to review statutes, regulations, and other directions for details.

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

Centers for Medicare & Medicaid Services