Section 1011 Provider Enrollment

Ask-the-Contractor Teleconference

Novitas Solutions, Inc.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Section 1011 Background

- On December 8, 2003, the president signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173) (MMA), which included Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens.

- The Act requires the Secretary of Health and Human Services to directly pay eligible hospitals, physicians, and ambulance providers (including the Indian Health Service and Indian tribal organizations) for their otherwise unreimbursed costs of providing emergency medical services to undocumented aliens.

Section 1011 and EMTALA

- Emergency care for undocumented aliens is required by Section 1867 (the Emergency Medical Treatment and Labor Act, or EMTALA) of the Social Security Act.

- EMTALA services include related hospital inpatient, outpatient, and ambulance services furnished to undocumented aliens, aliens paroled into the United States at a United States port of entry for the purpose of receiving such services, and Mexican citizens permitted temporary entry to the United States with a laser visa.

Section 1011 Funding

- Section 1011 provided $250 million a year for fiscal years 2005-2008 for payments to eligible providers.
- Two-thirds of the funds were apportioned to the 50 states and the District of Columbia based on their relative percentages of undocumented aliens.
- One-third was apportioned to the six states with the largest number of undocumented-alien apprehensions.
- Payments are made from states' allotments directly to hospitals, certain physicians, and ambulance providers. A Medicare Critical Access Hospital (CAH) is also considered a hospital under the statutory definition.

Section 1011 Funding Still Available

- While 25 states have exhausted their funding allocations as of February 23, 2012, others have considerable funds still available. **$74,370,783** remains to be paid out.

- These states have exhausted their Section 1011 funds: Arkansas, Alabama, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Kansas, Louisiana, Mississippi, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Utah, Virginia and Washington.

Eligible Provider Types

- Hospitals
- Physicians
- Ambulance Companies
- Indian Health System facilities

Provider Eligibility Guidelines

- Hospitals and Indian Health Service Facilities must be enrolled in Medicare
- Physicians must either be enrolled in Medicare or include a CMS 855I enrollment form with their application
- Ambulance Companies must either be enrolled in Medicare or include a CMS 855B enrollment form with their application

Enrollment Options for Hospitals

- Hospital with Roster bills for both hospital and physician services
- Hospital without Roster bills for hospital services and payment to “on call” physicians

Spent Down States

- A state in ‘spent-down’ status has exhausted all available Section 1011 funds.
- This occurs when the estimated reimbursement amount available for each payment request in that state is less than one dollar ($1.00).
- Providers in spent down states should not submit new Section 1011 enrollment applications as no additional funding is available.
- Enrollment forms to update existing information on the provider file will be accepted and processed.

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Complete Enrollment Package

Complete Enrollment Package Requirements

- The following forms MUST be received together:
  - Section 1011 Provider Enrollment Application (form CMS 10115)
  - Electronic Data Interchange Agreement
  - Electronic Funds Transfer Authorization Agreement (form CMS 588) with:
    - Voided Check with matching account and routing numbers

      OR

    - Bank letter (on bank letterhead) verifying account and routing (ACH) numbers

Signature Requirements

- All authorized official signatures must be original signatures (no copies) and show a title deeming fiduciary responsibility within the applying organization

- The following are examples of acceptable authorized official titles:
  - Provider's general partner
  - President
  - Vice President
  - CEO
  - CFO
  - Owner
  - Physician (for Physician Applications ONLY)
  - Fire Chief (for Ambulance Companies)

Hospital with Roster

- Payment for hospital and physician services
  - Hospitals electing to receive payment for both hospital and physician services **MUST complete Attachment 1**
    - Physician signatures are not required on Attachment 1 for Hospital with Roster applicants
    - Physician NPI and SSN are required
- Hospitals may not submit payment requests for certain physicians while allowing others to bill separately

Hospital without Roster

Payment for hospital and a portion of on-call payments made by the hospital for physician services

- If a hospital elects this option, physicians will separately bill for Section 1011 services
- Billing for “On Call” payments requires the use of form CMS 10130B

Physician Applications

- If filing independently, application should contain:
  - Legal Business Name (physician's name)
  - Doing Business As (DBA) – if applicable
  - Physician's original signature
- If Physicians NOT enrolled in Medicare:
  - Must submit a CMS 855I enrollment application along with the Section 1011 enrollment package

Physician Group Applications

Should submit application with the following:

- Legal Business Name (Group's name used for tax purposes)
- Doing Business As (DBA) – if applicable
- Authorized Representative's signature - must be a title with fiduciary responsibility
- Roster of participating physicians (Attachment 1) - must contain original physician's signatures
- Section 1011 Provider Number is not assigned to the Group

Ambulance Provider Applications

- Must submit a separate application for each state the ambulance company serves
  - A unique Section 1011 PIN will be issued for each state
  - For bordering states, the billing state will be the location of patient pickup

- If NOT enrolled in Medicare, must submit a CMS 855B enrollment application along with the Section 1011 enrollment package

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Application Processing

Verification Process at Novitas

- Novitas begins the application verification process when a completed, original application package with all associated documents is received.
- Enrollment Specialists verify the provider's enrollment in Medicare, the NPI, Tax ID, physical address, banking information, state licensure, and perform checks for Fraud, Abuse, Sanctions and/or Debarment.
- The verification process and enrollment takes approximately two weeks to complete.

Provider Notification

- Novitas will send a written notice of the Section 1011 Provider Identification Number (PIN) and program effective date, along with instructions on how to enroll for Direct Data Entry (DDE), when the program enrollment process is complete.

- The EDI department will send the notification of your submitter and/or receiver ID for Electronic Remittance Advice (ERA) and password in a separate mailing after your enrollment is complete.

Direct Data Entry (DDE)

- Direct Data Entry (DDE) enrollment is done via the online form on the Novitas website.
- Allow up to five (5) business days for your DDE Enrollment to be completed.
- The RACF ID and Password for DDE is sent via email from the Security Team.
- Log in within 30 day to activate the DDE account and then use it within 60 days or the password will expire. Each unique user must apply for a logon.
- If a DDE account is inactive 90 days, it is deleted.

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Change Request Forms

Change Requests

- Providers already enrolled in Section 1011 who want to revise an approved enrollment application, (e.g., add/delete physicians on a roster, update the contact-person information, etc.), are required to submit a Section 1011 Provider Enrollment Application with the “Change Request” box on the top of the form checked.
- The original signature of the physician or an authorized official or representative of the provider is required on any revised application.

Additional Change Request Forms

- Before a request for change is processed, Section 1011 examines the provider payment account to verify that both an EFT and EDI forms are on file.
- If not, the EFT or EDI forms must be submitted.
- Banking information submitted on the application will be verified against the provider's existing payment account to ensure the most current information is on file.

Revisions of Provider Information

- When requesting a revision to the Legal Business Name (LBN), Doing Business As (DBA), physical address, contact person information, authorized official or representative, check the “Change Request” box in the upper left-hand corner of the application and make the necessary changes in the affected sections.
- An original signature from the authorized official or representative is required on any revised application.

Additions to Rosters

- When requesting an addition to a hospital, physician, or group roster, check the “Change Request” box in the upper left-hand corner of the application.
- As applicable, include one or both of the following attachments:
  - Section 1011 Attachment 1: Use this form to list the physicians to be added to the hospital roster or group roster. An original signature of the physician is required on Attachment 1.
  - Section 1011 Attachment 2: Use this form to list the hospitals to be added to the group member roster.

Deletion from a Roster

- When requesting a **deletion** of a physician from a hospital or group roster, check the Change Request box in the upper left-hand corner and complete relevant sections of the application.

- As applicable, include one of the following attachments:
  - Section 1011 Attachment 1: Use this form to list the physicians to be deleted from the hospital or group roster.
  - Section 1011 Attachment 2: Use this form to list the hospitals to be deleted from the roster.

Hospital Payment Election Change

- Hospitals may change payment elections only once annually
- If changed before July 1st, the effective date will be October 1st of the same year
- If changed after July 1st, the effective date will be October 1st of the following year
- Hospitals with a Roster must notify all providers of the change in status
- Consider the impact on payment request submissions when changing payment elections.

Voluntary Termination

- When requesting to **withdraw** from the Section 1011 program, check the “Voluntary Termination” box in the upper left-hand corner and complete relevant sections of the application.
- An original signature from the provider, an authorized official or authorized representative is required on any voluntary termination application.
- Be sure all eligible payment requests have been submitted before requesting to withdraw from the Section 1011 Program.

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Common Errors and Omissions

Section 1011 Provider Enrollment Application (CMS-10115) Errors:

- Section 1: If Box 9 is checked *physician*, the physician's name must be entered in Section 1 and listed as Not Applicable (NA) in Section 2.
- Section 1: If Section 9 is checked *Physician Group,* the group name must be entered in Section 1 and the group DBA or NA in Section 2. (Individual applications for each physician within a group are no longer required and should not be submitted.)

Common Errors (continued)

- Section 3: The physical address must include the number, street, city, state and zip code.
- Section 4: Include the contact person's complete address, not just the number and street.
- Section 8: Current Medicare fiscal intermediary or carrier.
- Section 9: Physician Group requires Attachment 1 (physician roster) and Attachment 2 (hospital roster). Individual physician applications are not required for group applications.

Common Errors (continued)

- Section 10: Multiple Medicare provider numbers or no Medicare provider number.
- Section 12: Physician privileges: multiple hospital or no physician privileges. If physicians have privileges at multiple hospitals, they must complete the Section 1011 Hospital Listing (Attachment 2) of the provider-enrollment application.
- Section 12: Physician Group Privileges: Attachment 1 and Attachment 2 are required.

Common Errors (continued)

- Section 14: Applicant's routing-transit number, deposit-account number; specify checking or savings account.
- Section 15: The typed name and title of the authorized official.
- Section 17: Original, authorized official's signature.
- Section 18: Date of the authorized official's signature.
- Attachment 1: Each physician on a physician group roster must provide an original signature.

Common Errors on EFT Form

- Failure to sign the EFT form (originals only!)
- Unauthorized signature on form (only the provider or the Authorized Official can sign)
- Failure to date the form
- Forgetting to include either a voided check or bank letter with confirmation of account information and bank routing number on bank letterhead

Section 1011 Provider Enrollment Website Information

- You will find all necessary forms on the Novitas Section 1011 website at the following address:

  https://www.novitas-solutions.com/section1011

- To download a CMS-855 application, use this link:

  http://www.cms.gov/CMSForms/CMSForms/list.asp?filtertype=dual&datefiltertype=&datefilterinterval=&filtertype=keyword&keyword=855&intNumPerPage=10&cmdFilterList=Show+Items

Section 1011 Enrollment Assistance

- All applications for Medicare enrolled providers will be processed within 15 days of receipt
- Customer Service Specialists are available to help you with enrollment or any question related to the Section 1011 Program.
- Contact our Section 1011 Customer Service Center at **1-866-860-1011** on Monday through Friday from 8:00am to 4:30pm ET.