Provider Enrollment Focus for 2013

Improve the way providers view and interact with CMS while maintaining the integrity and security of provider information.

Core Areas:

• Customer Service
• Online Enrollment (PECOS)
• Data Accuracy & Integrity (Revalidation)
• Strengthen Fraud Prevention
CUSTOMER SERVICE

Take a proactive role in helping Providers get answer to questions and work more efficiently
What Providers Were Saying

“...oh yea, we all call any MAC at least 3 times if we have a question. Then take the average answer... and you need to make sure you change up the time of day you call to make sure you get a new shift.” *(Lack of consistent information to the provider community when they contact a MAC does not create a feeling of confidence or trust.)*

“We have $1M in billing at stake related to a single provider we have been working to enroll for months.” *(Providers lose millions of dollars a year due to processing delays.)*

**Avg. Processing Time**

<table>
<thead>
<tr>
<th>Processing Time (Days)</th>
<th>Paper Applications</th>
<th>Web Applications</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td></td>
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</tr>
<tr>
<td>40</td>
<td></td>
<td></td>
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<tr>
<td>20</td>
<td></td>
<td></td>
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<tr>
<td>0</td>
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</tr>
</tbody>
</table>

“Processing provider enrollment applications is second only in complexity to auditing Medicare Hospital Cost Reports”...

-- Senior Executive, Medicare Administrative Contractor (MAC)
Our Change in Culture

We heard you!

Provider & Medicare Contractor Focus Groups

New features and changes are based on listening to providers and Medicare contractors and crafting solutions around the needs instead of implementing features or policies that simply meet regulation.

Culture of Customer Service

Changing the attitude of Provider Enrollment at CMS and MACs to one of collaboration and support. Working with the Provider to understand what they have a question about, and providing the correct answer or getting them to the right person, with the first call.

🌟 = Changes directly from groups like this in the last 12 months.
Proactive Education & Outreach

- **List Serv** - Notification of program and policy details, updates and announcements, press releases, event reminders, educational material announcements, and other news and information for Medicare Fee For Service (FFS) providers. To join send an email to FFSProviderRelations@cms.hhs.gov

- **CMS.gov** – Questions about enrollment criteria and links to hot topics like Revalidation, Ordering and Referring, and DMEPOS Accreditation and Supplier Standards.

- **PECOS Homepage** – [https://pecos.cms.hhs.gov/](https://pecos.cms.hhs.gov/) - Redesigned to have quick links to account creation, video tutorials, providers resources, and FAQs.

- **MedLearn (MLN)** - MedLearn (MLN) – Articles designed to inform Medicare FFS providers about the latest changes to the Medicare Program. To sign up for MLN Matters notifications go to CMS.gov and search: MedLearn.

- **National Provider Calls** - educational conference calls conducted for the Medicare FFS provider community that educate and inform participants about new policies and/or changes to the Medicare program.
Recent Processing Improvements
(to support providers)

• Submit enrollment applications and updates 60 days in advance instead of 30 days.

• Ability to fax certain information to the MACs.

• Require MACs to develop for missing information rather than return the application due to being incomplete.
Recent Processing Improvements
(to speed up processing)

• Frequent workgroup calls with all MACs to ensure any policy or direction is communicated consistently and discussed as needed.

• E-Signature & Digital Documents
(These applications have 30% less development, and 25% faster processing time.)
PECOS ENHANCEMENTS

Increase the use of systems and reduce processing time by improving the tools and information available to Providers by enhancing PECOS.
“The changes you are making [to PECOS] are really great, but if I still need to send in a paper at the end of the process why should I go online rather than submit paper.” *(30% of applications require some form of additional development for missing information.)*

“I like PECOS, but if it takes me 15 minutes to find the record I am looking for to even begin to make a change it is faster for me to just use paper.” *(Only 15% of providers are using Internet based PECOS to enroll or submit changes to their Medicare enrollment.)*

“...the problem is that Providers are not the ones who update and manage their records, it is their office manager or the credentialing staff at the group they work for that does all the real work.” *(Program, processes, and system complexity makes it longer to do anything, and most programs or systems do not account for the reality of how the industry functions.)*
Our Solution: Provider Driven Changes

**Increase Usability:**
Evaluate the user experience from start to finish, simplify online registration processes, reduce data entry time, and provide tools for large groups and organizations.

**All Digital Process:**
Remove paper from the enrollment process, leverage new and existing best practice technology, and allow increased connectivity for large providers.

**Transparency:**
Increased access to information and communication about the status of enrollments.
Updated PECOS Homepage

- Improved homepage layout with quicker access to what providers need most.

  ✔ Access to account information.

  ✔ Video walkthroughs of how to enroll or update your information using PECOS.

  ✔ Direct links to resources such as revalidation mailing and ordering & referring lists.
Filter, Search, and Reformat

- Allow large groups or chains to quickly find particular enrollments.

  - Search & Filter (Enrollment Type, NPI, Enrollment Status, Medicare ID, State, and Specialty)
  - Increased information about each enrollment up front.
  - Ability to see the status of changes that have been submitted.
  - Ability to see if a request for revalidation has been sent by the MAC.
View All Current Enrollment Information on a Single Screen & Quickly Update

- The ability to switch between a Topic View (walkthrough driven mode), and Fast Track View (advanced data entry mode).

[Image of enrollment information screen]

- Vehicle Information
  - You have indicated that the applicant does not have any information for this topic.
  - **GO TO TOPIC**

- Geographic Location
  - This topic is not applicable for this enrollment application.
  - **GO TO TOPIC**

- Rendering Healthcare Services at a Patient’s Home
  - You have indicated that the applicant does not have any information for this topic.
  - **GO TO TOPIC**
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.

  ✓ Reduce paper.

  ✓ Reduce application processing time.
Providers are now able to enter and store multiple contact persons in the Contact Person Information section.
E-Signature

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

- Reduces paper.

- Reduces application processing time.
Printable HTML Record of the information currently on record with CMS (and any pending submissions)

<table>
<thead>
<tr>
<th>Type of Update</th>
<th>Status</th>
<th>Tracking ID</th>
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</thead>
<tbody>
<tr>
<td>Change of Information</td>
<td>EDIT</td>
<td>T091720120000</td>
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**CURRENT MEDICARE ENROLLMENT RECORD**

This is your current Medicare Enrollment in PECOS. This is not a Medicare Application, please do not upload this record to your electronic submission or mail this record to your Fee For Service Contractor.

Report Date: 09/17/2012

PERSONAL INFORMATION: Anna Jones

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>SSN</th>
<th>Gender</th>
<th>IRS Proprietary/Non-Profit Status</th>
<th>Accepting New Patients?</th>
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<tr>
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<table>
<thead>
<tr>
<th>Type of Other Name</th>
<th>Other Name</th>
<th>Medicare ID</th>
<th>Medicare ID Type</th>
<th>Medicare ID Effective Date</th>
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<tbody>
<tr>
<td>Former or Maiden Name</td>
<td>A.J.</td>
<td>XXXXXXXX</td>
<td>PIN</td>
<td>04/22/2012</td>
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<table>
<thead>
<tr>
<th>Country of Birth</th>
<th>State of Birth</th>
<th>Medicare School or Other Professional School</th>
<th>Year of Graduation</th>
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<tbody>
<tr>
<td>United States</td>
<td>Wyoming</td>
<td>Virginia Commonwealth University</td>
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</table>

PHYSICIAN SPECIALTY

- **Physician Type**: Internal Medicine
- **Primary Physician Specialty**: Internal Medicine
- **Secondary Physician Specialty**: Internal Medicine

**PHYSICAL LOCATION and "SPECIAL PAYMENTS" Information**

<table>
<thead>
<tr>
<th>Physical Location Name</th>
<th>Effective Date</th>
<th>Location Type</th>
<th>Physical Address</th>
<th>Medicare ID</th>
<th>NPI</th>
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<tr>
<td>Jones Medical</td>
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<table>
<thead>
<tr>
<th>Payments Address</th>
<th>CLIA/FDA Certification Number(s)</th>
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<tr>
<td>222 Avenue Rd</td>
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<tr>
<td>Clarks XXXXXXXX</td>
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</table>
In an effort to provide more information readily & increase transparency, we have a Reassignment Report available for groups. The report allows for groups to see the status of all providers that have reassigned benefits, and download a report if needed.
Simplified Access for Individual Providers, Organizations & Support Staff

- Reset forgotten passwords and usernames online, without calling CMS.
- Streamlined process for Organizations to register an Authorized Official.
- Ability for Organizations and Providers to quickly approve Staff or others to work on their behalf.
Additional Changes

- Ability to select previously used address information when completing an application.

- Ability to quickly update and resubmit any application returned for corrections.

- Reducing the number of screens and steps for frequent changes and Revalidation.

- Ability to electronically submit EFT updates via PECOS as part of any application submission.
DATA ACCURACY & INTEGRITY (REVALIDATION)
Revalidation: What is it?

What is the Revalidation Project ... and how will it affect me?

- The revalidation project is an effort by CMS, mandated by Section 6401(a) of the Affordable Care Act, to verify all information on file for existing Medicare Providers, and to ensure they meet all standards associated with the new screening criteria.

- Approximately 1.5 Million Providers & Suppliers must be revalidated by March 25, 2015.

- Sometime in the next 24 months you will receive a request to revalidate the information on your Medicare enrollment(s).
Revalidation: Overview

- All providers/suppliers enrolled with Medicare prior to March 25, 2011 must revalidate their enrollment information.
- Providers/suppliers must submit the revalidation application only after being asked by their MAC to do so.
- All providers/suppliers must be revalidated every 5 years.
  - DMEPOS Suppliers must be revalidated every 3 years
The MAC will conduct multiple outreach attempts before administrative action is taken.

The MAC will deactivate instead of revoke if you don’t respond.

The MAC will accept Fax/Email submission of supporting documents.

Documents already on file do not need to be resubmitted.

Extensions may be granted by the MAC.
Revalidation: via Internet Based PECOS

Internet-Based PECOS – The quickest way to revalidate. (https://pecos.cms.hhs.gov)

- Revalidation Dates
- Accessing Sample Revalidation Letters
- Status of your Revalidation Application
- Fast Track View
Revalidation: Phase 3

- July 2013 through March 2015
- Start the revalidation process for all remaining providers/suppliers required by ACA prior to March 25, 2015
- Continued customer oriented focus
  - Phone call notification for no-response
  - Deactivation rather than revocation
  - On-line submission – PECOS Revalidation Fast Track
Revalidation: Outreach

- Post revalidation mailing list monthly on CMS.gov
- Reference tools (FAQs, MLN articles) available online for providers and MACs
- Continue quarterly focus groups with providers/suppliers
- Continue to address provider associations through MAC Sponsored Outreach Events, AMA Workgroups, Open Door Forums, etc.
Revalidation:
Top 10 Questions from Providers

1. If I have different Enrollments in different states, will I receive all the requests at the same time? – No, each MAC is responsible for sending their own mailings.

2. How will I know when to expect my letter? – You will receive a letter in a yellow envelope, it will be posted on CMS.gov, and it will be listed on your enrollment in PECOS.

3. What do I need to do to receive an extension, and what reasons are approved? – Call your MAC. There are a wide number of reasons and CMS has instructed them to accept all reasonable requests.

4. Does the Application Fee apply to me? – If you are a provider or supplier that meets the requirement listed in CMS 6028, then yes. (see PECOS Homepage for a simple list)

5. What happens if I don’t reply to a request to Revalidate? – You have 60 days to respond, after which time you will be deactivated.
6. What if I have multiple Medicare IDs, will I get letter for each one? – If you received a notice during Phase I you may have received a letter for each Medicare ID; however, from Phase II forward you will receive a letter for each enrollment.

7. What if I receive a notice for a Medicare ID I don’t recognize? – Complete your revalidation based on information you know to be correct, and alert your MAC to deactivate any numbers that are no longer valid, or you do not recognize.

8. Will all of the Members in my group get the letter at the same time? – No. Groups and Individuals that reassign benefits will be sent separate independent notices. Regardless of a providers reassignment status, they are responsible for revalidating their own record.

9. What address will my Revalidation Notice be sent to? Your revalidation notice will be sent to your Correspondence Address on record and Physical Location.

10. Where can I go for more information about Revalidation? You can visit the PECOS homepage, or CMS.gov for the list of notices sent, sample revalidation letter, FAQs, and other helpful tips.
Revalidation Resources

- Sample A/B Revalidation Letter

- SE1126: Further Details on the Revalidation of Provider Enrollment Information SE1126

- MM7350: Implementation of Provider Enrollment Provisions in CMS-6028-FC MM7350

- SE1130: Implementation of Pay.gov Application Fee Collection Process through PECOS SE1130
NATIONAL FRAUD PREVENTION PROGRAM

New Programs, updated regulation, and increased awareness to the community to help prevent, detect, and take immediate action against fraud, waste, and abuse.
National Fraud Prevention Program: New Programs and Initiatives

Automated Provider Screening

Uses thousands of independent databases to validate information, in an effort to improve and standardize the enrollment data verification by MACs.

Fingerprinting and Background Checks

Adding requirements for fingerprinting and background checks for High Risk Providers and their owners.

Increased Identify Verification (Identity Proofing)

Add Identity Proofing processes to ensure the person who is logging into an enrollment system is who they say they are.

CPI Command Center

Cross agency health care investigation teams taking immediate action on Medicare and Medicaid fraud
Updated Regulation: Ordering & Referring

**Ordering & Referring:** CMS-6010 requires all Providers who Order or Refer services for certain procedures, services, or medical equipment, to be enrolled in an approved or opt out status with Medicare, or claims will be denied.

- CMS is closely monitoring the number of providers not yet enrolled or registered with Medicare, and the number of informational messages.

- Part B, DME & HHA Providers are being contacted when there have been Organizational NPIs (Type II NPIs) on the claim.
Updates on Ordering and Referring Edits

Continued education and outreach:

- The physician or non-physician practitioner who has elected to order and refer must be enrolled in Medicare in an approved or opt-out status.

- The ordering/referring National Provider Identifier (NPI) must be for an individual physician or non-physician practitioner (not an organizational NPI).

- The physician or non-physician practitioner must be of a specialty that is eligible to order and refer.

- CMS-855O is the Medicare enrollment form to register to solely order and refer.
Updates on Ordering and Referring Edits

Interns and Residents:

- The final rule states that State-licensed residents may enroll to order or refer 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.

- If States provide provisional licenses or otherwise permit residents to practice or order and refer services, interns and residents are allowed to enroll to order and refer consistent with State law.
1. **How should the ordering or referring provider’s name be listed on the claim?** – The ordering/referring provider’s full legal name should be included on the claim. The edits will compare the first letter of the first name and the first four letters of the last name. NPPES, PECOS and the name used on the claim form should all match. Middle names (initials) and suffixes should not be listed in the ordering/referring fields.

2. **Will claims be denied for providers who appear on the Pending Contractor Review report on CMS.gov when the edits are turned on?** – Yes, CMS will deny claims for ordering/referring providers that appear on the list in a pending status as of May 1st.

3. **Does the ordering/referring requirement apply to referrals to physician specialists?** - No
4. **How will technical vs. professional components of imaging services be affected by the edits?** – The edits will impact the technical component of imaging services furnished by IDTFs, mammography centers, portable X-ray facilities, and radiation therapy centers that are enrolled in Medicare via the CMS–855B. The professional component will not be impacted.

5. **Are claims submitted for Part B drugs excluded from the denial edits?** – Yes

6. **What is the appropriate action to take if the ordering and referring provider is listed on the ordering and referring file on CMS.gov but the billing provider is still receiving informational messages?** – Ensure the name of the ordering and referring provider used on the claim matches the name on the ordering and referring file found on CMS.gov. Contact your local Medicare Administrative Contractor (MAC).
7. If the ordering or referring provider enrolls in Medicare after a service has been provided, will the claim be paid after the enrollment is complete? – The edits are based on the date of service (DOS). The ordering/referring provider is required to be enrolled in Medicare prior to the DOS, otherwise, the claim will be denied.

8. Do the ordering/referring edits apply to Hospitalist who are licensed physicians employed by a hospital? - Doctors of medicine or osteopathy, and doctors of podiatric medicine are the only Medicare-enrolled individual physicians who may order/refer for Part A when a plan of treatment is needed and submitted from an HHA for beneficiary services. If the hospitalist is either of those specialties then they may order/refer.

9. Are hospital-based physician services excluded from the denial edits? – Yes

10. What action can I take if my claim is denied by the edits? - Providers can file an appeal or work through their local Medicare Administrative Contractor (MAC).
Ordering and Referring Educational Material

Available on CMS.gov regarding provider enrollment and ordering and referring.

- **MM6417** – Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)

- **MM6421** – Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers’ Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)

- **MM6129** – Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services

- **MM6856** - Expansion of the Current Scope of Editing for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) claims processed by Medicare Regional Home Health Intermediaries (RHHIs)

- **SE1305** - Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)
Wrap Up!

✓ We hear you, and are improving customer service and processing guidance to help.

✓ PECOS has more information about your records on file, has improved with your input, and is now a fully electronic process – ensuring your application will be processed faster than submitting paper.

✓ Revalidation is here, you will receive a notice when it applies to you, and there will be multiple ways to check if a notice was sent to you.

✓ We are taking immediate and collaborative action to investigate and stop fraud, waste, and abuse.
Questions and Discussion

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&
Mark Majestic
Deputy Director, Provider Enrollment Operations Group

Center for Program Integrity
Centers for Medicare & Medicaid Services
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