Medicare Provider Enrollment Compliance Conference

April 25-28, 2023

Presented by

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Centers for Medicare & Medicaid Services

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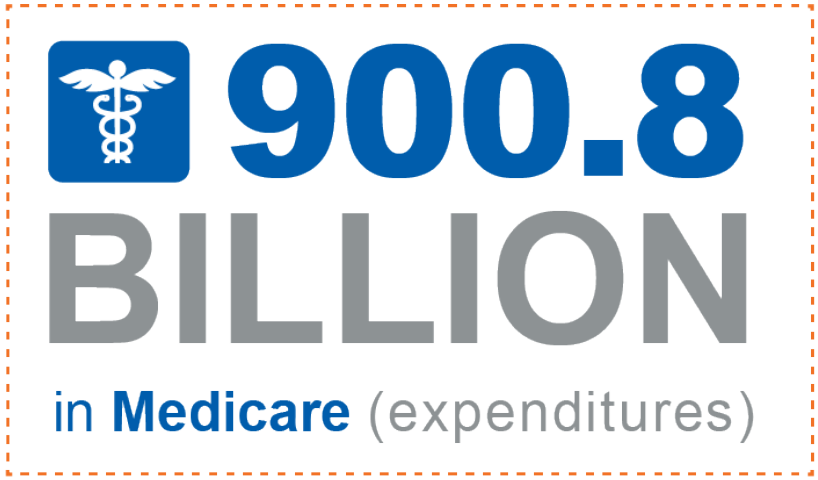
Deputy Director
Provider Enrollment & Oversight Group
Centers for Medicare & Medicaid Services

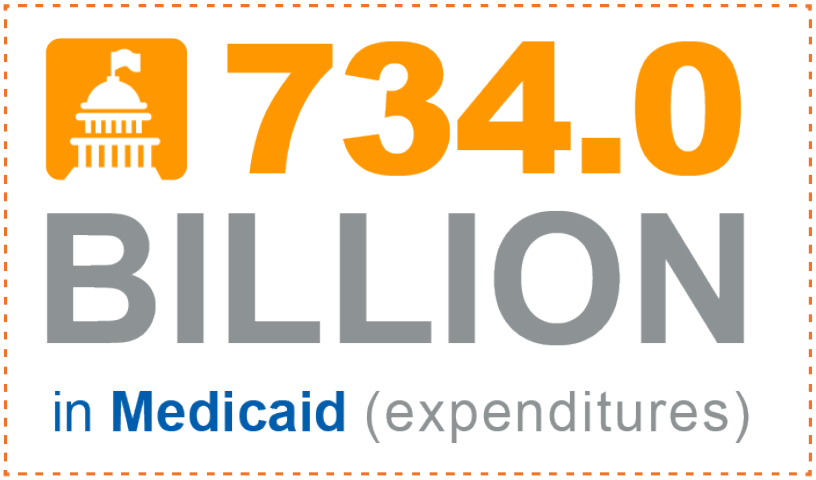
Session Overview

- Putting Patients First
- How Enrollment Works
- PHE Waivers and Flexibilities
- Medicare Policy Updates
- Survey and Certification Transition
- Revalidation
- Our Enrollment Systems
- Medicaid Enrollment
- Protecting the Program
- Enforcement Actions

Putting Patients First

By the Numbers





Why We're Here

LISTENING TO YOU

We hear you, and we've learned a lot from you

FINDING A BALANCE

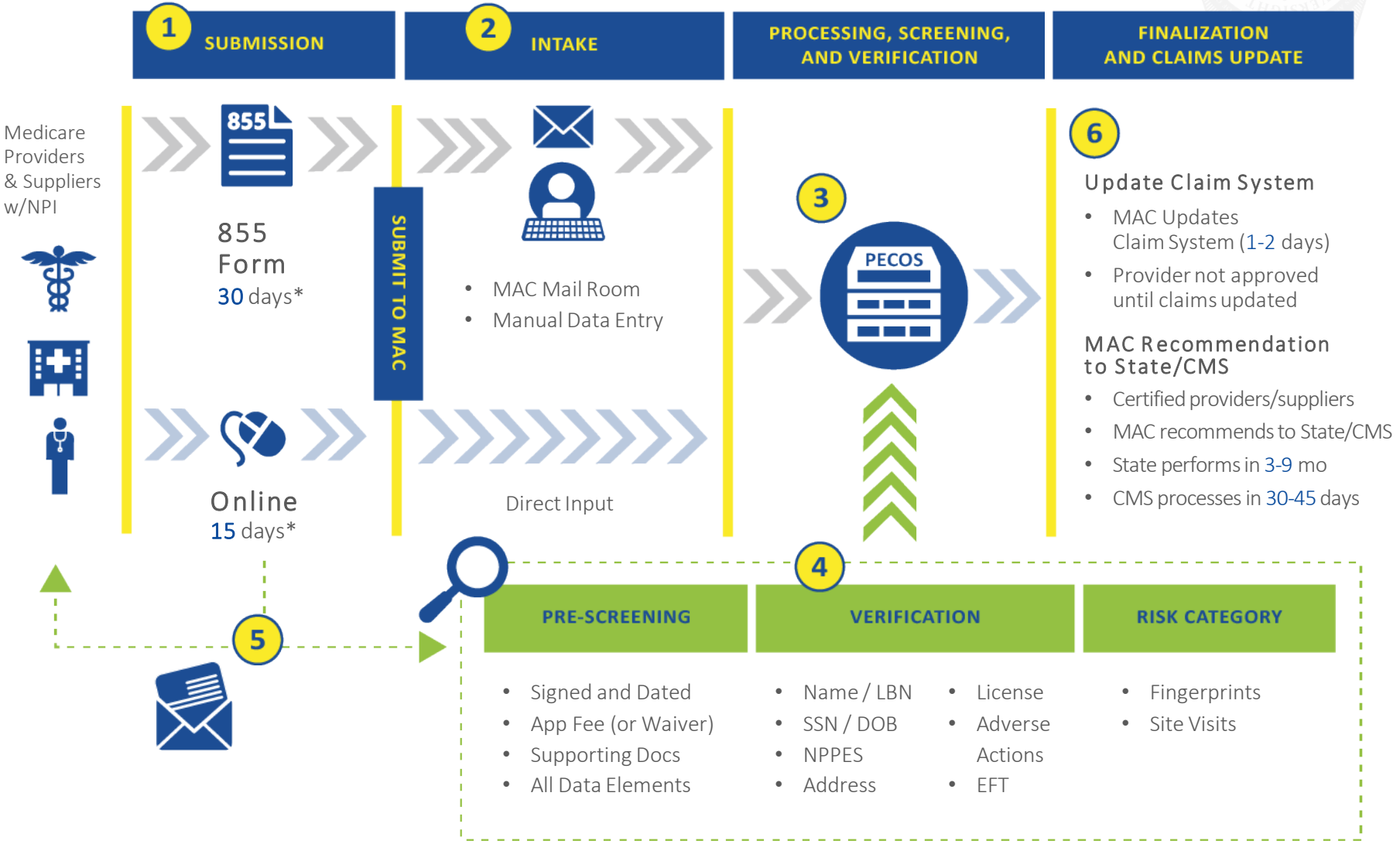
We believe enrollment should be **easy** for most providers, and **hard** for bad actors

ALWAYS IMPROVING

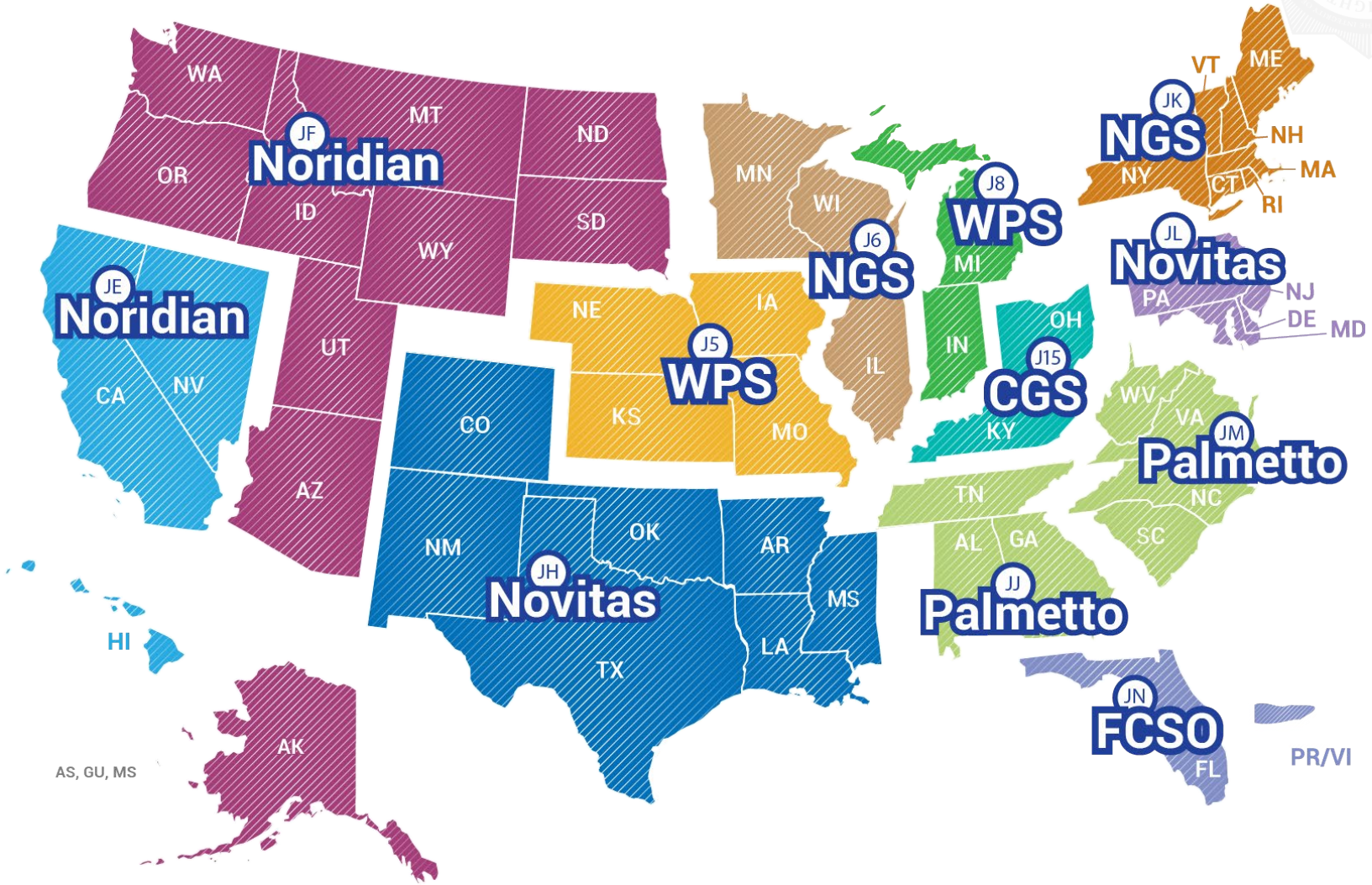
We will keep refining our systems, policies, transparency, and our vision

How Enrollment Works

How Enrolling Works

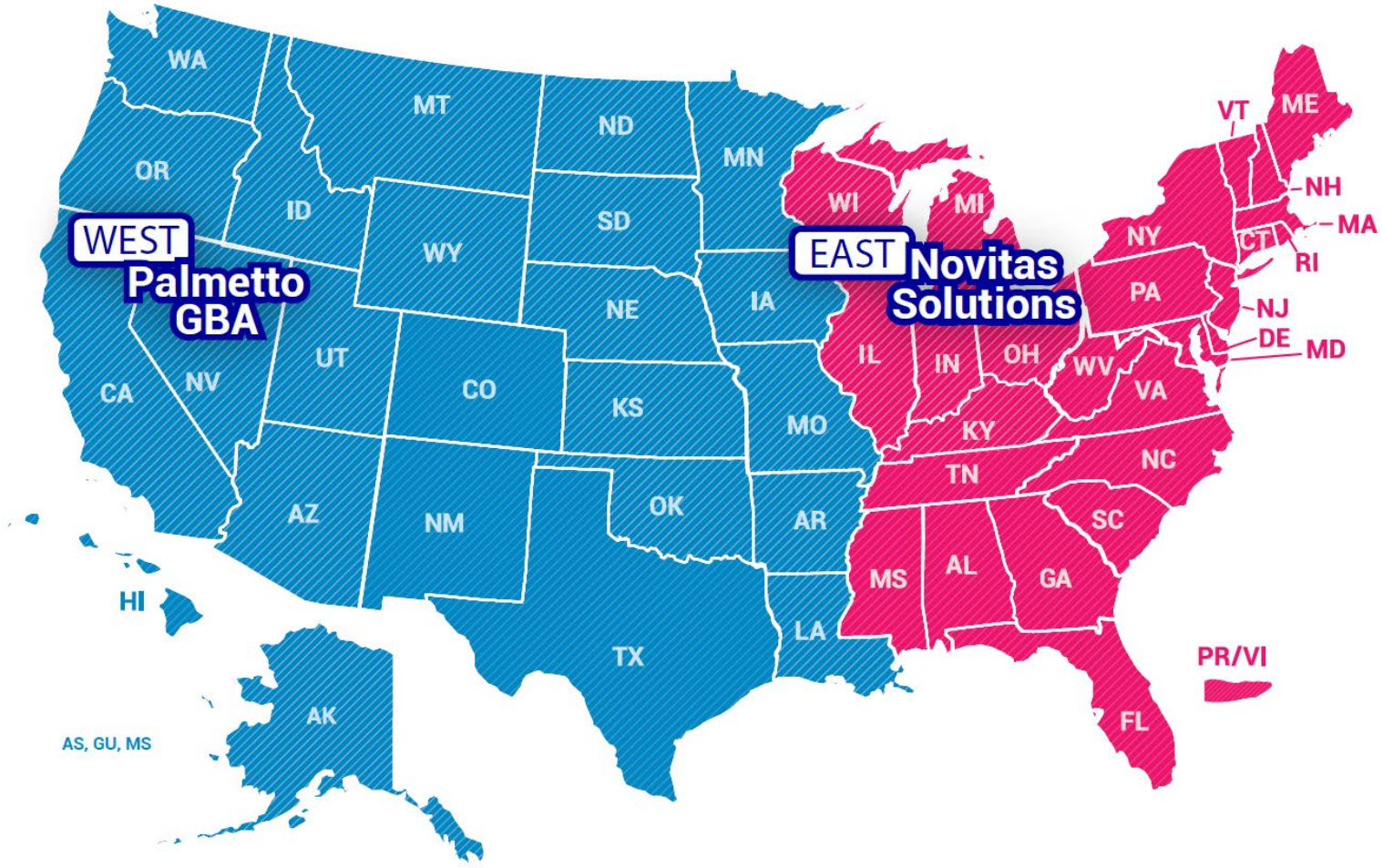


MAC Jurisdictions



National Provider Enrollment (NPE) East/West

National Provider Enrollment Contractor for DMEPOS suppliers in Medicare



Map As of November 2022

PHE Waivers and Flexibilities

PHE Waivers and Flexibilities

- Established toll-free MAC hotlines for certain Part A and B providers to enroll and receive temporary Medicare billing privileges
- Expedited application processing (clean web applications in 7 days and clean paper applications in 14 days)
- Granted retrospective billing up to 90 days
- Allowed practitioners to cancel their opt-out status early to enroll
- Waived requirement to report home address to furnish telehealth services

Waivers and Flexibilities Extended Beyond the PHE

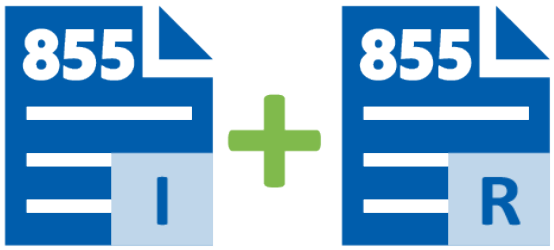
- Report home address to furnish telehealth services **(extended through December 2023)**
- Pharmacies enrolled as an Independent Clinical Lab with a valid CLIA certification can continue to provide diagnostic laboratory services (COVID testing) at the level identified under its CLIA certification
- Pharmacies can continue to administer and bill under Part B for COVID-19 vaccine administration directly without enrolling as mass immunizers

Temporary Billing Privileges through the Hotlines

- Providers granted temporary billing privileges during the PHE will need to submit a complete CMS-855 to establish full Medicare billing privileges
- MACs will issue letters in June 2023
- Providers will have 90 days to respond
- Site visit and fingerprints, if applicable
- Temporary billing privileges deactivated for non response

Medicare Policy Updates

CMS-855I/855R Consolidation



- Practitioners and groups can establish, terminate or change reassignments using only the 855I
- 855R data elements moved to the 855I
  - Reassignment connections
  - Primary/secondary practice location
  - Signatures
- Tentative release for public use in Summer 2023

- 855R discontinued when the revised 855I is implemented
- Tentative discontinue in Summer 2023

CMS-855A Revisions

- Defines and collects additional types of organizational ownership and/or managing control
  - Private equity company
  - Real estate investment trusts
- Adds new Rural Emergency Hospital (REH) provider type
- Expands location types to include provider-based locations
- Captures ITINs for owners/managing employees
- Adds section for Opioid Treatment Program Personnel
- Tentative release for public use in Summer 2023

Rural Emergency Hospitals (REH)

- New Medicare provider type established January 1, 2023
- Addresses the growing concerns over closures of rural hospitals
- Must be a Medicare enrolled Critical Access Hospital (CAH) or rural hospital with no more than 50 beds as of December 27, 2020 to convert to an REH
- Submit a change of information via PECOS or a paper CMS-855A to convert to an REH, rather than an initial application
- See cms.gov/medicare/provider-enrollment-and-certification and https://www.cms.gov/files/document/mln2259384-rural-emergency-hospitals.pdf

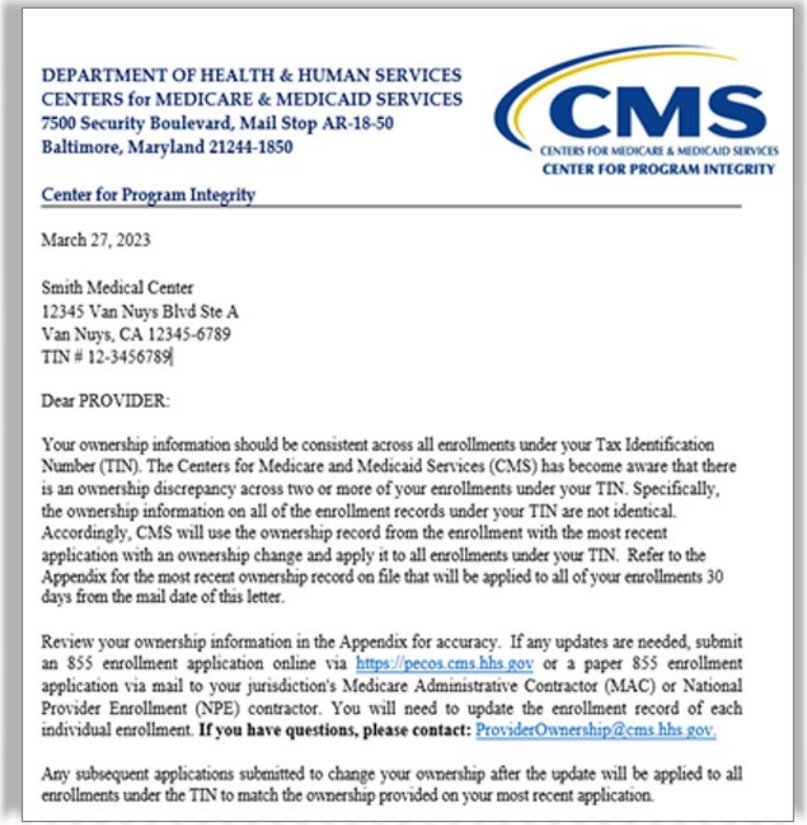
Reporting Changes of Information

- **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

Ownership Discrepancies Across Enrollments

- Ownership information must be consistent across all enrollments under your TIN
- CMS will systematically update all your enrollments with your most current ownership record in PECOS
- Advanced notice issued to providers in March 2023
- The notice included an Appendix with your current ownership on file and the enrollments to be updated



DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS for MEDICARE & MEDICAID SERVICES
7500 Security Boulevard, Mail Stop AR-18-50
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR PROGRAM INTEGRITY

Center for Program Integrity

March 27, 2023

Smith Medical Center
12345 Van Nuys Blvd Ste A
Van Nuys, CA 12345-6789
TIN # 12-3456789

Dear PROVIDER:

Your ownership information should be consistent across all enrollments under your Tax Identification Number (TIN). The Centers for Medicare and Medicaid Services (CMS) has become aware that there is an ownership discrepancy across two or more of your enrollments under your TIN. Specifically, the ownership information on all of the enrollment records under your TIN are not identical. Accordingly, CMS will use the ownership record from the enrollment with the most recent application with an ownership change and apply it to all enrollments under your TIN. Refer to the Appendix for the most recent ownership record on file that will be applied to all of your enrollments 30 days from the mail date of this letter.

Review your ownership information in the Appendix for accuracy. If any updates are needed, submit an 855 enrollment application online via https://pecos.cms.hhs.gov or a paper 855 enrollment application via mail to your jurisdiction's Medicare Administrative Contractor (MAC) or National Provider Enrollment (NPE) contractor. You will need to update the enrollment record of each individual enrollment. **If you have questions, please contact:** ProviderOwnership@cms.hhs.gov.

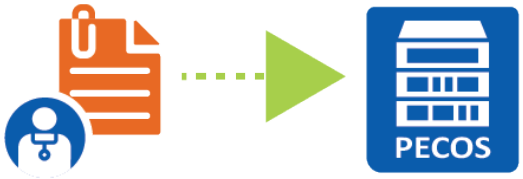
Any subsequent applications submitted to change your ownership after the update will be applied to all enrollments under the TIN to match the ownership provided on your most recent application.

Ownership Discrepancies Across Enrollments

If the ownership information is correct, no further action needed

Ownership information will be applied to all enrollments under your TIN, 30 days from the mail date of the letter

If the information is incorrect submit a change through PECOS or a paper CMS-855 for each enrollment



OR

- Send questions to providerownership@cms.hhs.gov

Authorized and Delegated Officials - PECOS & I&A

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)*

AO Authorized Official

Assign surrogacy and controls access to PECOS and NPPES records

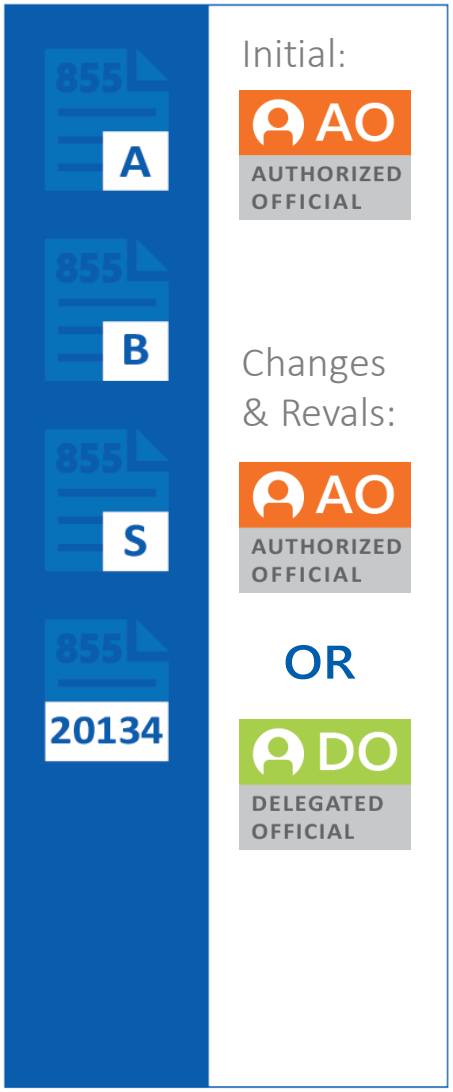
- CEO, CFO, partner, chairman, owner, or equivalent appointed by the org. AO requirements are same as PECOS
- Automatically approved if listed as AO in PECOS; if not, CP575 must be provided to approve access
- Manage staff and connections for the employer
- Approve Access Managers(AM) for the employer

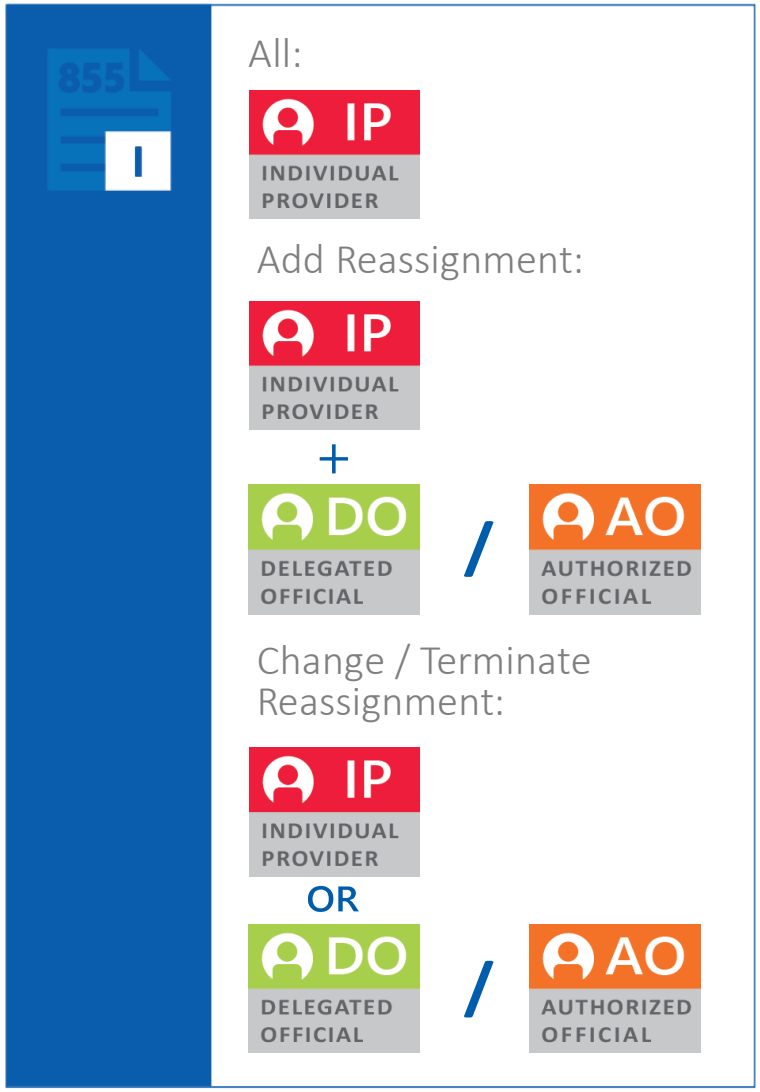
AM Access Manager

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

- Delegated by the AO of org provider or 3rd party org
- Less restrictive than DO requirements for PECOS
- May add the employer to his profile, manage staff and connections for the employer
- Multiple AMs permitted

Who Can Sign the Enrollment Application?





Survey and Certification Transition

Survey and Certification Transition

What we've heard…

- The survey and certification process can take several months without any provider transparency
- Providers are unsure who to contact to request a status of their enrollment application
- Processes amongst the CMS Locations are not consistent
- Changes in enrollment information is often reported to the CMS Location outside of the CMS-855 process
- States are delayed in receiving MAC recommendation packages

Survey and Certification Transition

CMS transferred **95%** of survey and certification functions for certified providers to the **Provider Enrollment & Oversight Group** and the **MACs**

Advantages

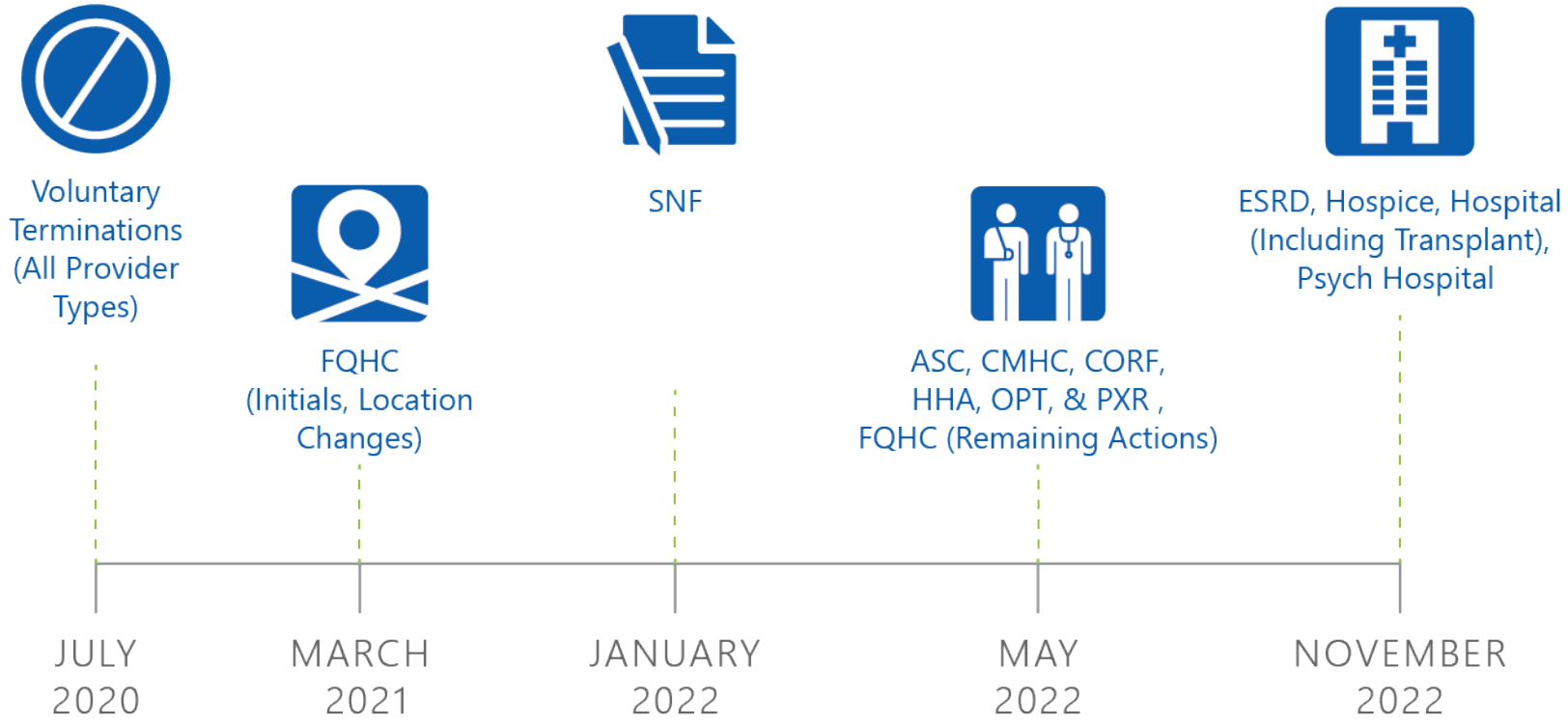
Reduces application processing times

- In some cases, application processing times have been reduced by **almost 25%**
- MACs coordinate directly with the State and AOs for their required actions (e.g. survey)
- This process **does not** eliminate the need for a survey, if required

Streamlines the application process

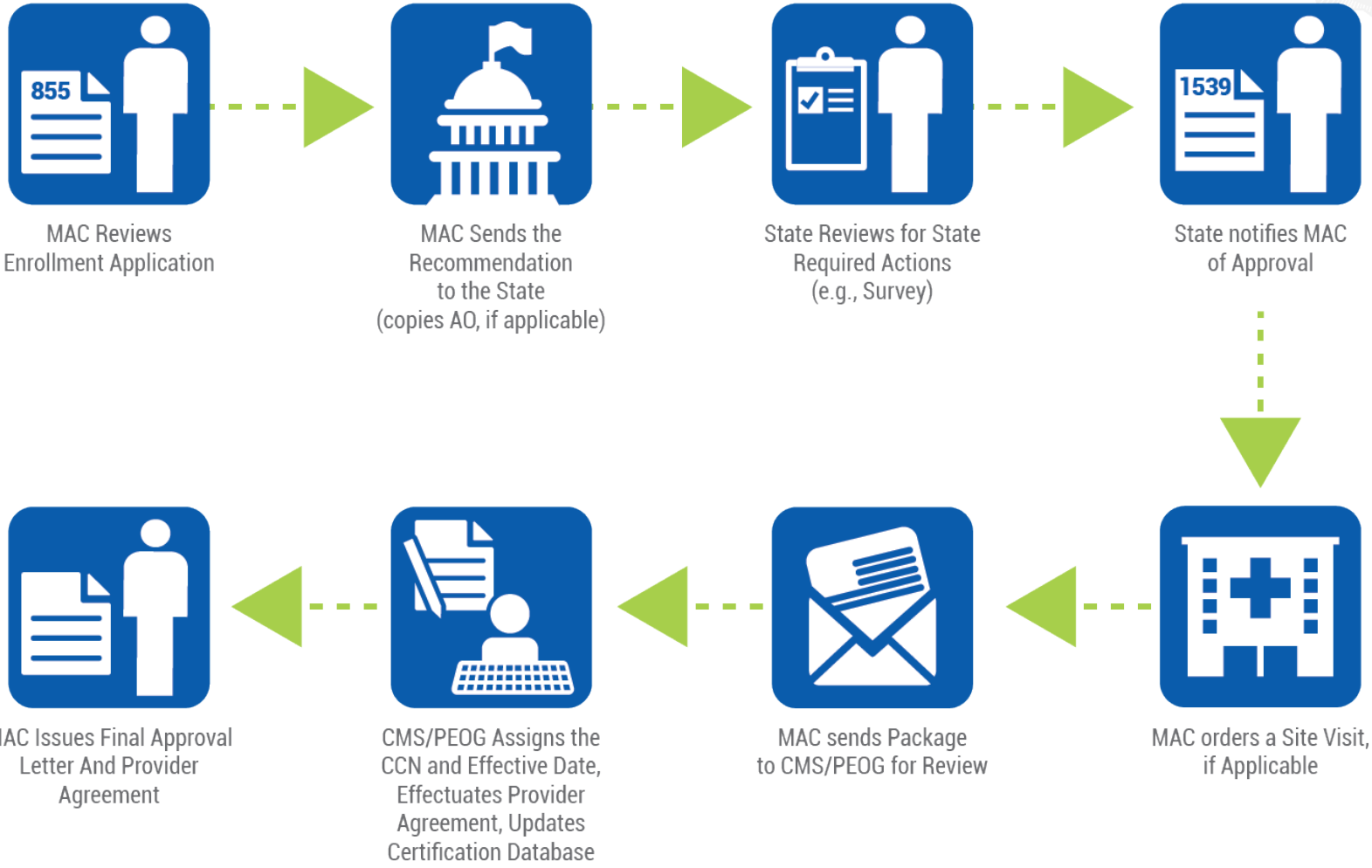
- Secure platform for sending MAC recommendation packages electronically to states to avoid lost packages
- MACs collect required documents supporting the CMS-855 enrollment (provider agreement, OCR attestation, notice of grant award)
- States continue to collect related survey documentation for compliance with the provider agreements
- Establishes POCs for application statuses

Survey and Certification Transition



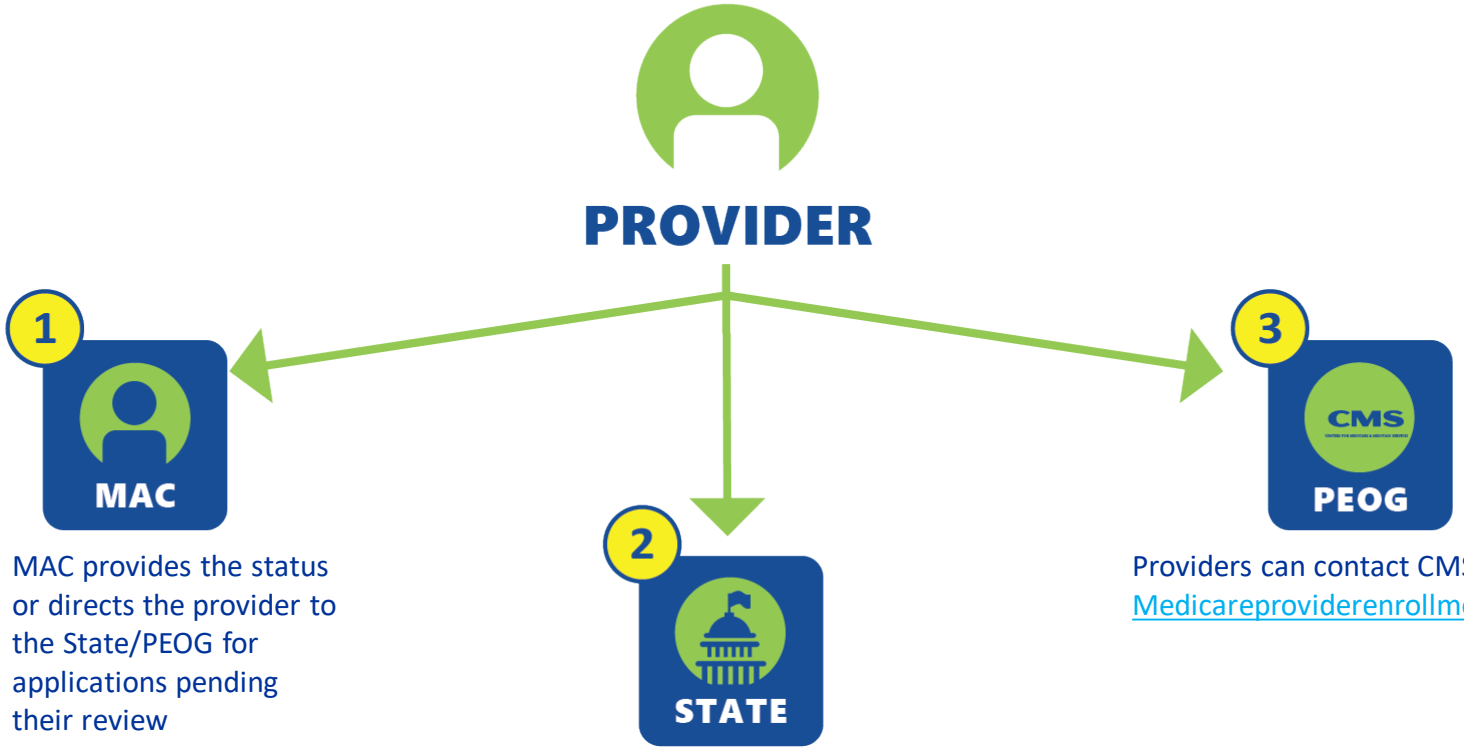
Note: State survey timeframes are not impacted by the transition.

Survey and Certification Transition



Who Should I Call?

First Point of Contact is Always your MAC



MAC provides the status or directs the provider to the State/PEOG for applications pending their review

Providers can contact the State using contact information in Approval Recommended Letter

Providers can contact CMS/PEOG at Medicareproviderenrollment@cms.hhs.gov

Question & Answer Session

Revalidation

Revalidation - Impacts of the PHE

Revalidation activities waived from March 2020 – October 2021

- No letters sent for new due dates
- No payment holds
- No deactivations for non-response or failure to respond to development requests

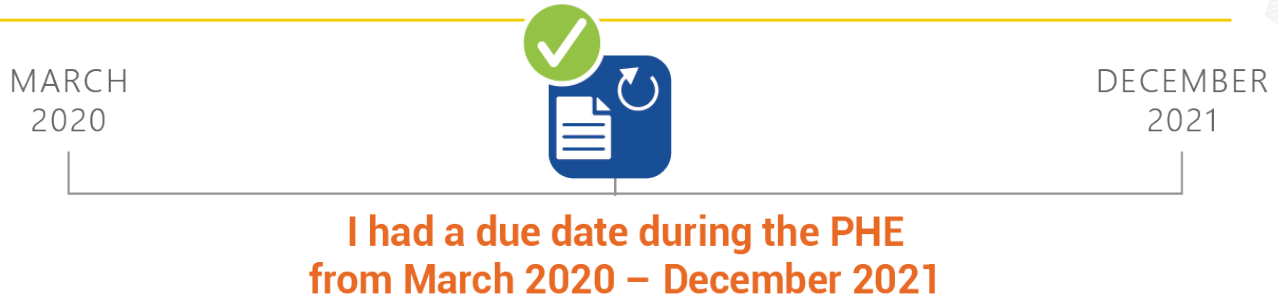
Revalidations resumed in November 2021 for January 2022 due dates

- Targeted some providers and suppliers that missed their revalidation due date during the PHE but not all
  - Volumes were lower (25% of pre PHE volumes)
- Adjusted Due Dates on Revalidation Look-Up Tool
- No payment holds or deactivations for non response

Revalidation – Impacts of the PHE

- No deactivations for failure to respond to revalidation
- If you submitted and received approval, no further action needed
- If you did not respond, you will receive an additional chance to comply before deactivation (includes non response to revalidation development)
  - Follow up letters will be sent late summer/early fall

Revalidation – Impacts of the PHE

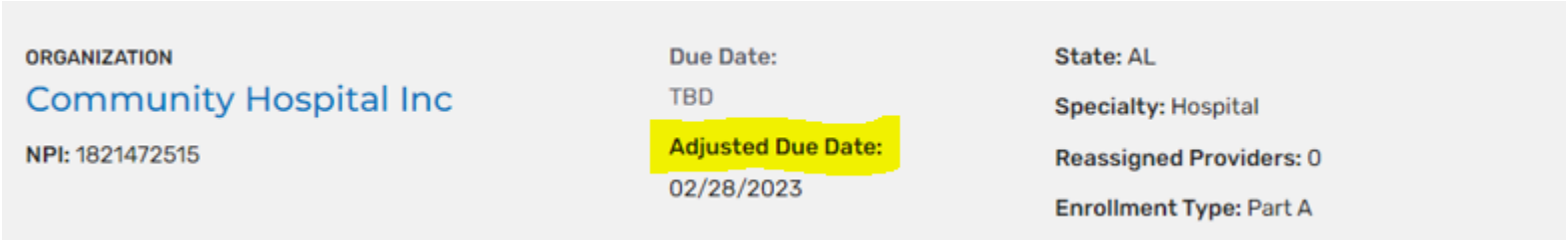


- If you submitted and received approval, no further action needed
- Providers and suppliers are **NOT** accountable for the due dates during this time period

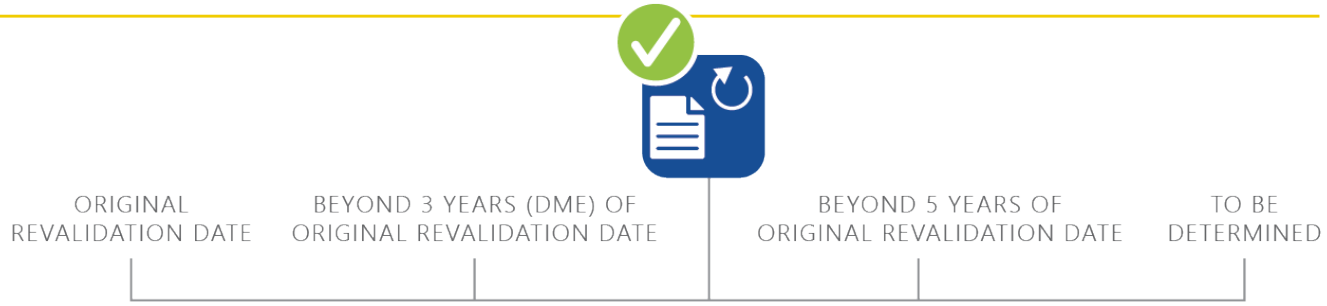
Revalidation - Current Status

My adjusted due date is between January 2022 - May 2023

- Posted as 'Adjusted Due Dates' on the Revalidation Look-Up Tool
  - Adjusted due dates are due dates CMS established during the PHE
- Submit your revalidation as requested based on Adjusted Due Date on the revalidation look up tool and a letter from your MAC
- If you did not respond, you will receive an additional chance to comply before deactivation (includes non response to revalidation development)
  - Letters will be sent late summer/early fall

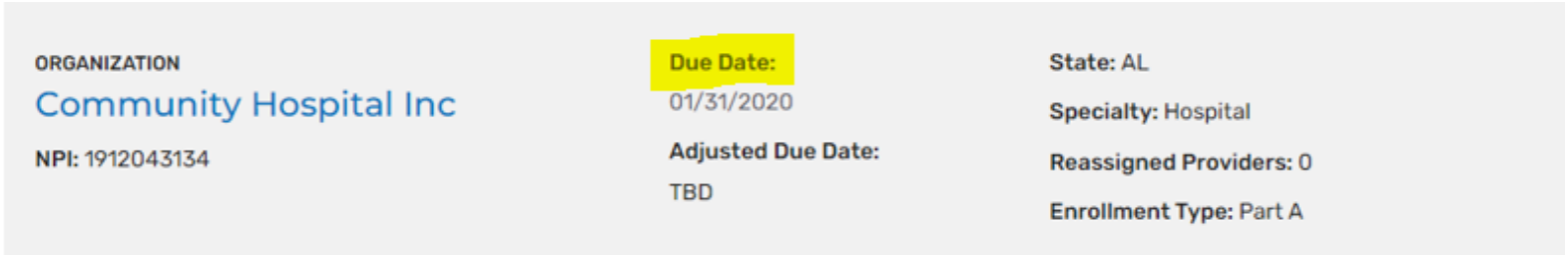


Revalidation – Post PHE



My due date is TBD and/or I am beyond 3 (DME) or 5 years of original revalidation due date?

- No action needed until you see a revalidation due date on the revalidation look up tool and/or receive a letter from your MAC
- Revalidation due dates on or after July 2023, will show under 'Due Dates' and not 'Adjusted Due date'
- Our goal is to post online notification of due dates six to seven (6-7) months in advance. Letters will always be sent out at least 90 days in advance



Revalidation - Post PHE

- Resume payment holds and deactivations for non-response
- Increase the volume of revalidation due dates beginning Fall 2023
  - Evenly disperse revalidation due dates consistent with pre PHE volumes
- Providers may be asked to revalidate off-cycle (in advance of or beyond their 3 or 5 year due date)
  - Off-cycle revalidation notifications may not happen 6 months in advance but at least 90 days given
- Communicate changes to the revalidation process through MLN newsletters, Open Door Forums, and provider enrollment website

Question & Answer Session

Provider Enrollment Systems

Provider Enrollment Systems

Provider Enrollment is the gateway to the Medicare Program. NPPES and PECOS serve as the systems of record for NPI and Provider Enrollment Information.

Provider Enrollment also supports claims payment, fraud prevention programs, and law enforcement through the sharing of data.

What is NPPES?

The National Plan and Provider Enumeration System electronically enumerates and assigns National Provider Identifier numbers for all providers nationwide.

NPPES
National Plan & Provider Enumeration System

The NPI number is a 10 digit unique identifier that is assigned to Healthcare Providers and Organizations across the United States.

NPPES Provider Interface - https://nppes.cms.hhs.gov/ can be used to:

- ✓ Submit initial NPI application
- ✓ View or submit changes to your existing NPI record
- ✓ Deactivate your NPI record

NPPES NPI Registry - https://npiregistry.cms.hhs.gov/ can be used to:

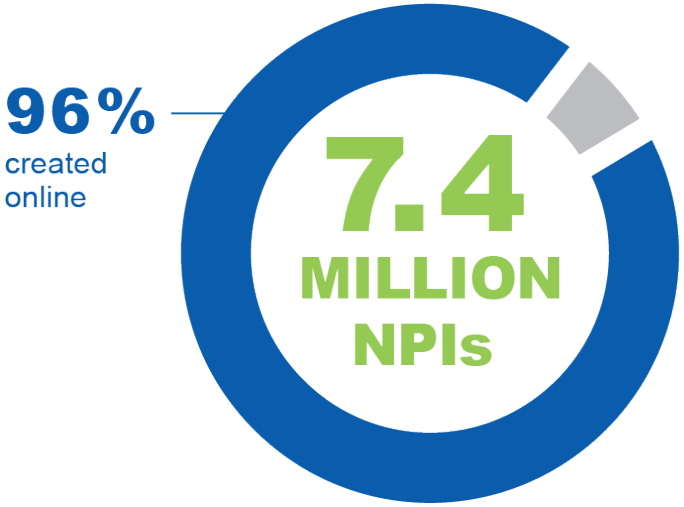
- ✓ Search for NPI records of Health Care providers in the NPPES system

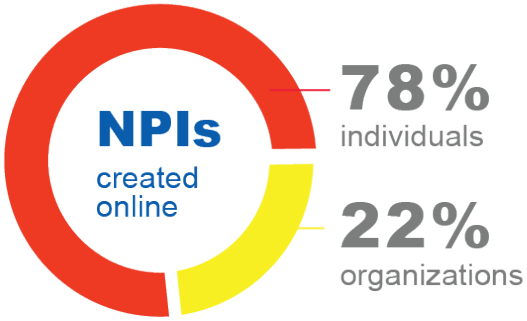
NPPES (NPI) Today

Every Month…

39,000
New NPIs

57,000
Updates



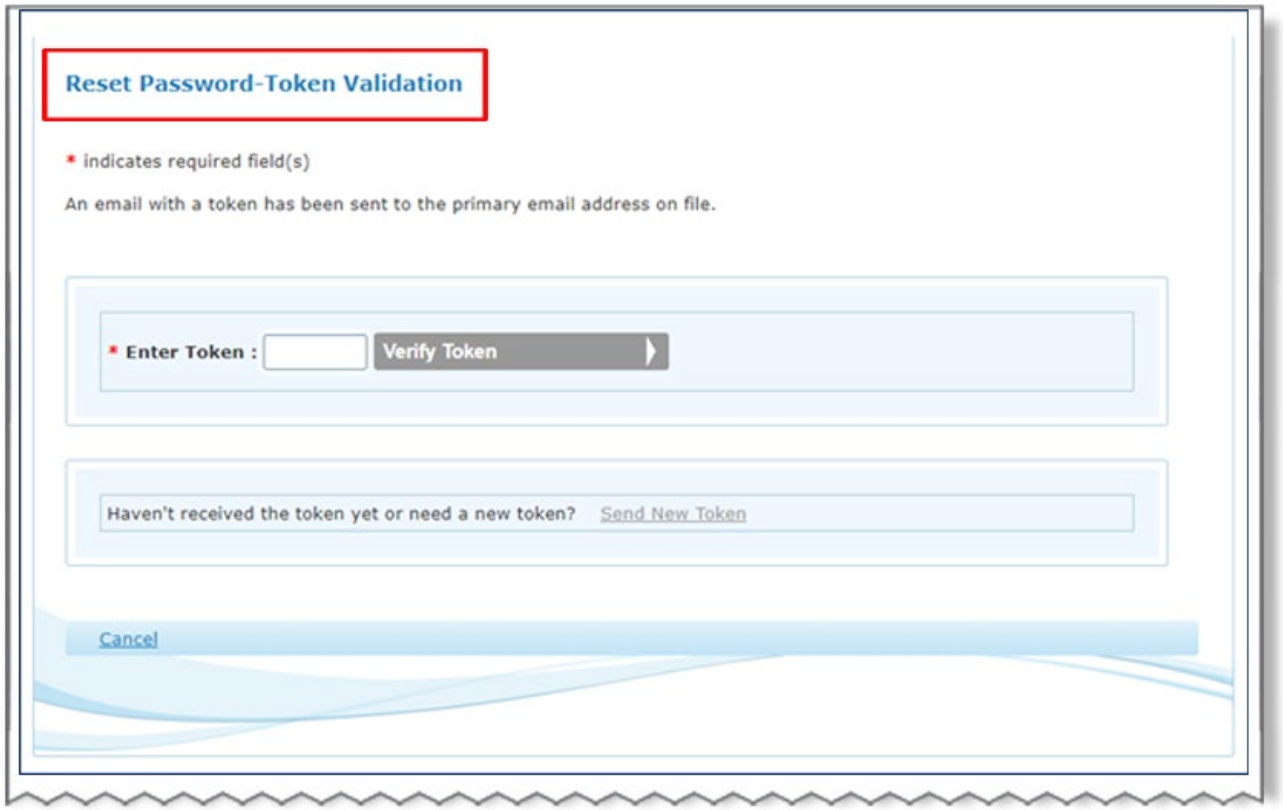


Maintain NPI Records

- National reach
- Used by Federal/State government and private plans to validate information

NPPES | Updates

Forgot User ID or Password



- Email Token Functionality
- Forgot User ID or Password

NPPES | Updates

Interoperability and Patient Access Final Rule (CMS-9115-F)

- Requirement to have digital contact information in NPPES applies to individual providers and clinicians

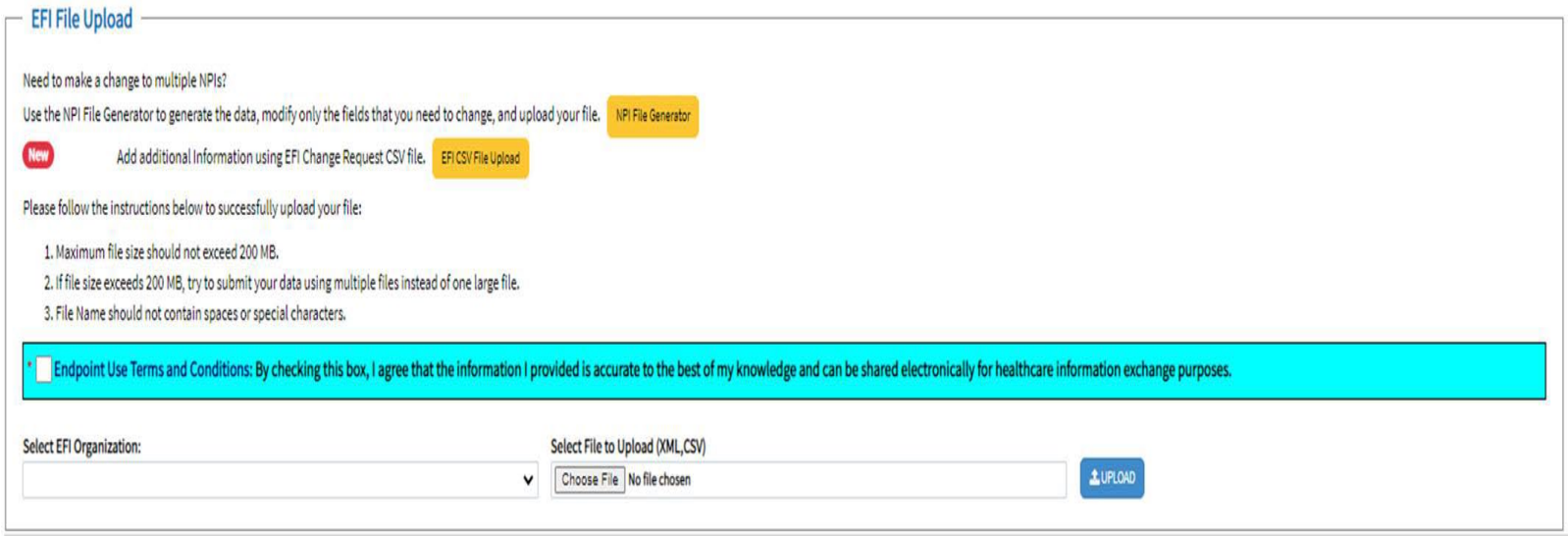
- CMS publicly reports the names and NPIs of those providers who do not have digital contact information included in the NPPES system

- Large organizations with many providers who wish to conduct a bulk upload or update of provider digital contact information will be able to do so through the Electronic File Interchange (EFI) process.

NPPES | Updates

NPPES Electronic File Interchange(EFI) enhancements for Bulk Updates

- ✓ Enables provider organizations to add additional information to existing NPIs
- ✓ Use to add endpoint, taxonomy, practice location, contact information, and other identifier information to NPIs.
- ✓ Available in XML and csv formats



What is PECOS?

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

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

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

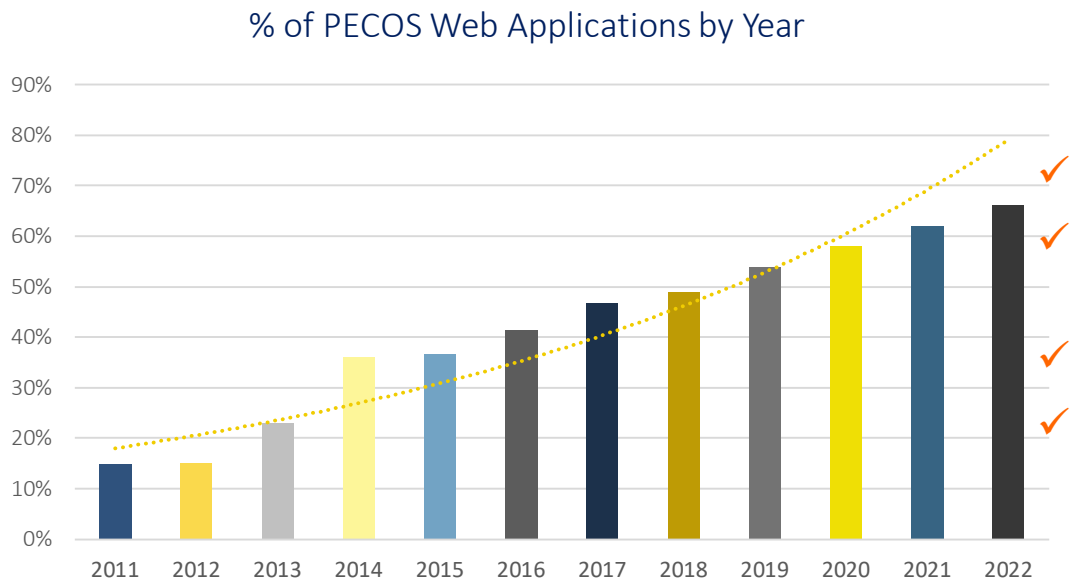
PECOS Today

Over 2.7 Million Enrollments

Every month…

19,000 new enrollments

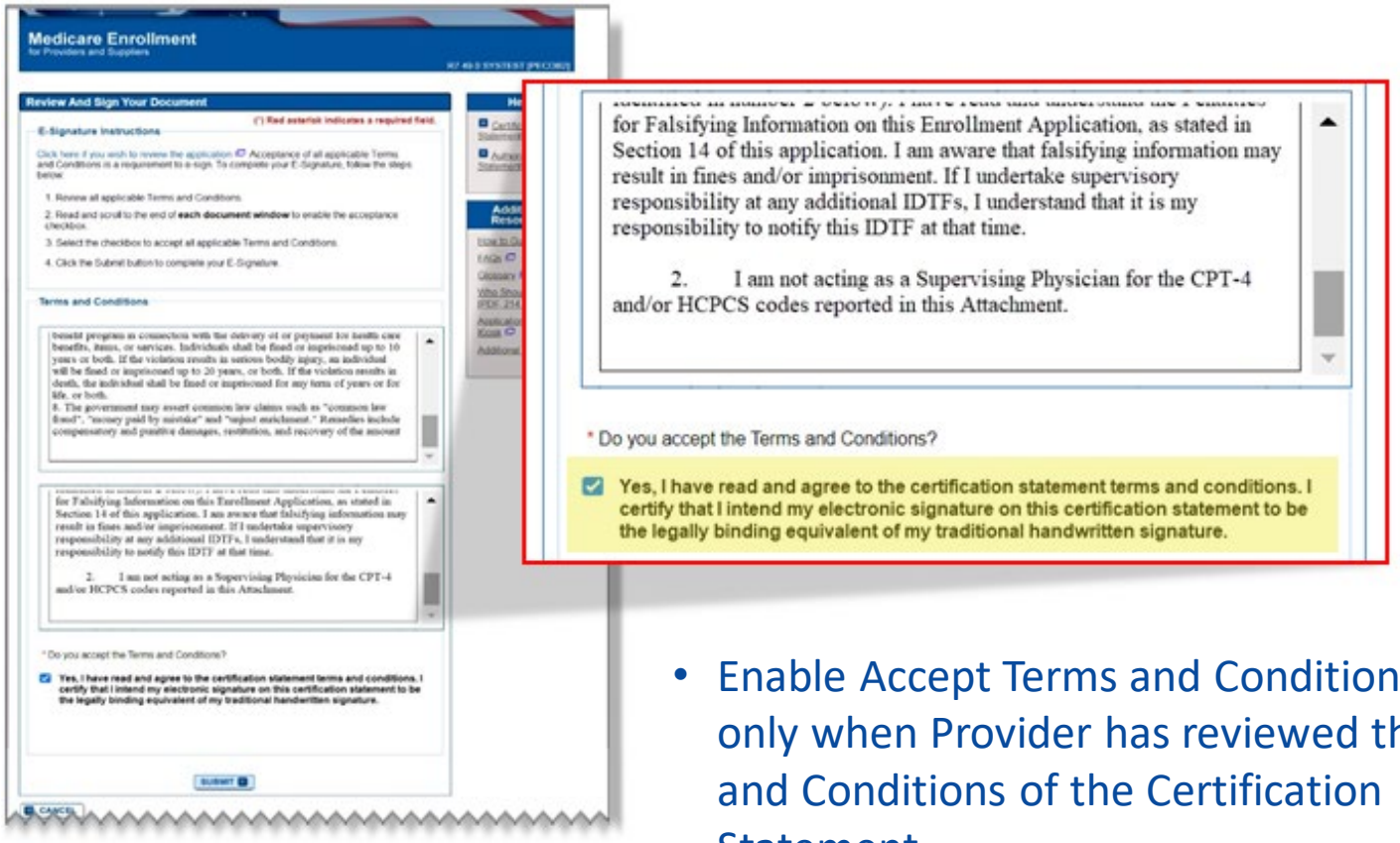
Encouraging Online Applications



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

July 2022 PECOS Enhancements

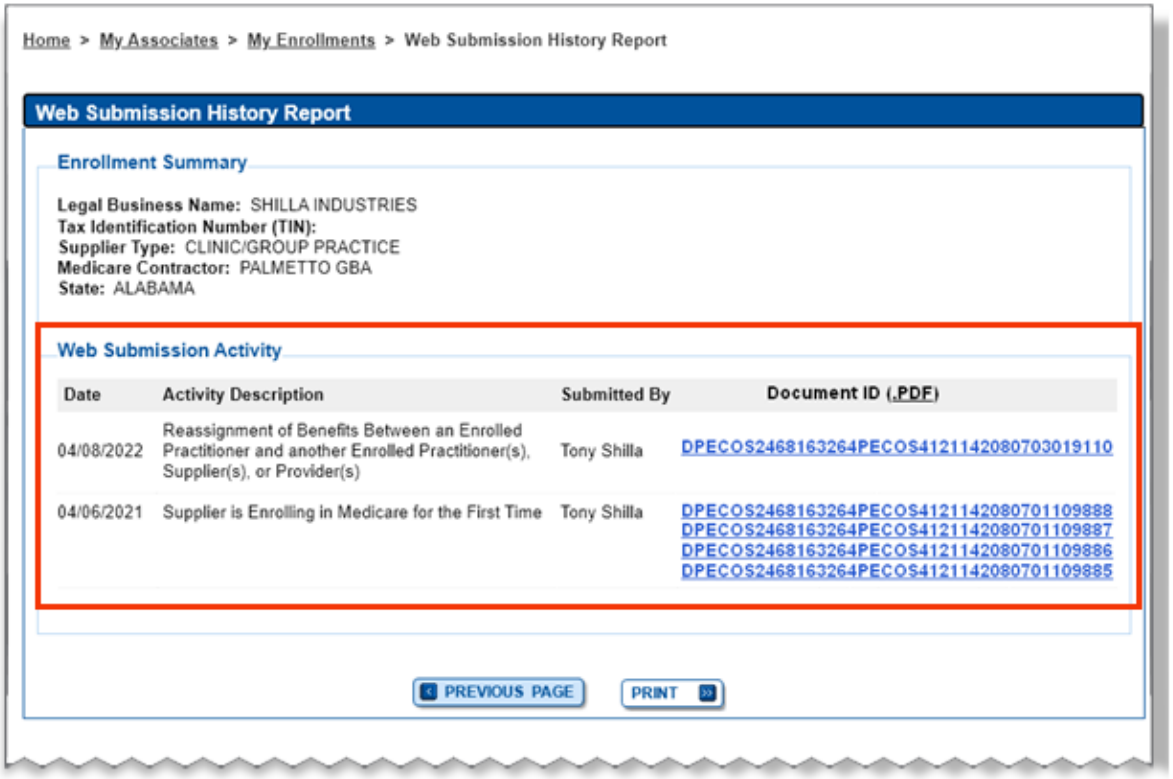
Scroll to accept Terms and Conditions



- Enable Accept Terms and Conditions button only when Provider has reviewed the Terms and Conditions of the Certification Statement

October 2022 PECOS Enhancements

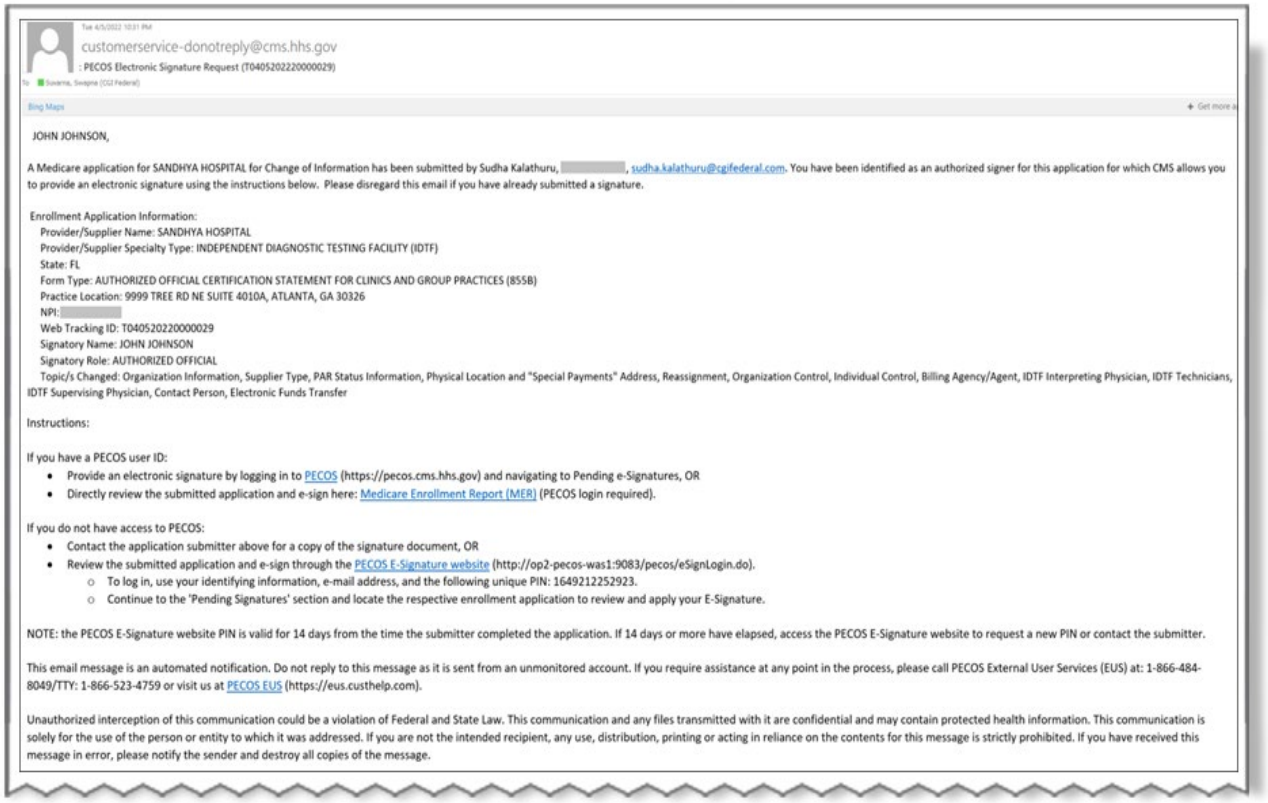
Medicare Enrollment Report with Signatures



- Submitted applications processed by MACs will have the application and applicable uploaded or e-signed documents saved as a pdf file.
- The user will be able to view, print, or download the file by selecting the links provided.

October 2022 PECOS Enhancements

Medicare Enrollment Report (MER) (PECOS login required).



customerservice-donotreply@cms.hhs.gov
: PECOS Electronic Signature Request (T0405202220000029)

JOHN JOHNSON,

A Medicare application for SANDHYA HOSPITAL for Change of Information has been submitted by Sudha Kalathuru, [redacted], sudha.kalathuru@cgifederal.com. You have been identified as an authorized signer for this application for which CMS allows you to provide an electronic signature using the instructions below. Please disregard this email if you have already submitted a signature.

Enrollment Application Information:
Provider/Supplier Name: SANDHYA HOSPITAL
Provider/Supplier Specialty Type: INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF)
State: FL
Form Type: AUTHORIZED OFFICIAL CERTIFICATION STATEMENT FOR CLINICS AND GROUP PRACTICES (855B)
Practice Location: 9999 TREE RD NE SUITE 4010A, ATLANTA, GA 30326
NPI: [redacted]
Web Tracking ID: T040520220000029
Signatory Name: JOHN JOHNSON
Signatory Role: AUTHORIZED OFFICIAL
Topic/s Changed: Organization Information, Supplier Type, PAR Status Information, Physical Location and "Special Payments" Address, Reassignment, Organization Control, Individual Control, Billing Agency/Agent, IDTF Interpreting Physician, IDTF Technicians, IDTF Supervising Physician, Contact Person, Electronic Funds Transfer

Instructions:

If you have a PECOS user ID:
- Provide an electronic signature by logging in to PECOS (https://pecos.cms.hhs.gov) and navigating to Pending e-Signatures, OR
- Directly review the submitted application and e-sign here: Medicare Enrollment Report (MER) (PECOS login required).

If you do not have access to PECOS:
- Contact the application submitter above for a copy of the signature document, OR
- Review the submitted application and e-sign through the PECOS E-Signature website (http://op2-pecos-was1:9083/pecos/eSignLogin.do).
  - To log in, use your identifying information, e-mail address, and the following unique PIN: 1649212252923.
  - Continue to the 'Pending Signatures' section and locate the respective enrollment application to review and apply your E-Signature.

NOTE: the PECOS E-Signature website PIN is valid for 14 days from the time the submitter completed the application. If 14 days or more have elapsed, access the PECOS E-Signature website to request a new PIN or contact the submitter.

This email message is an automated notification. Do not reply to this message as it is sent from an unmonitored account. If you require assistance at any point in the process, please call PECOS External User Services (EUS) at: 1-866-484-8049/TTY: 1-866-523-4759 or visit us at PECOS EUS (https://eus.custhelp.com).

Unauthorized interception of this communication could be a violation of Federal and State Law. This communication and any files transmitted with it are confidential and may contain protected health information. This communication is solely for the use of the person or entity to which it was addressed. If you are not the intended recipient, any use, distribution, printing or acting in reliance on the contents for this message is strictly prohibited. If you have received this message in error, please notify the sender and destroy all copies of the message.

- MER report link in the 'PECOS Electronic Signature Request' emails
- Signatories can select the link to view or print the submitted enrollment application.

PECOS Redesign

PECOS 2.0

- ✓ Simplified interface focused on automated functions
- ✓ Increase speed of application processing
- ✓ Track the status of an application from submission through approval
- ✓ Support increased alignment between Medicare and Medicaid
- ✓ Reduce redundant data collection
- ✓ Policy resources and help tutorials

PECOS 2.0 First Look Video

PECOS Redesign FAQ

Q: When will I be able to start using the newly designed PECOS?

A: PECOS will be available for you by the end of 2023. For more updates on when PECOS will be available, visit CMS.gov.

Q: Will PECOS be unavailable for a period of time?

A: PECOS will not be unavailable for an extended period of time.

Q: Will records in the current PECOS transfer to the newly designed PECOS?

A: Yes, data in the current PECOS will transfer to the newly designed PECOS. Applications currently in progress can be continued in the newly designed PECOS from where you left off. Applications that were previously closed will be available but will include limited information. All records transferred from the current PECOS to the newly designed PECOS will be noted as such to make them easily identifiable.

You May Be Wondering

Q: Will "my connections" change?

A: No. As a provider or supplier, you will have access to the connections you have been approved for in I&A.

Q: How will I learn how to use PECOS?

A: A robust Knowledge Base will be available to all users. The Knowledge Base will include materials to teach you how to use PECOS, answer any questions you may have, and much more.

Q: Will paper applications still be an acceptable form of submission?

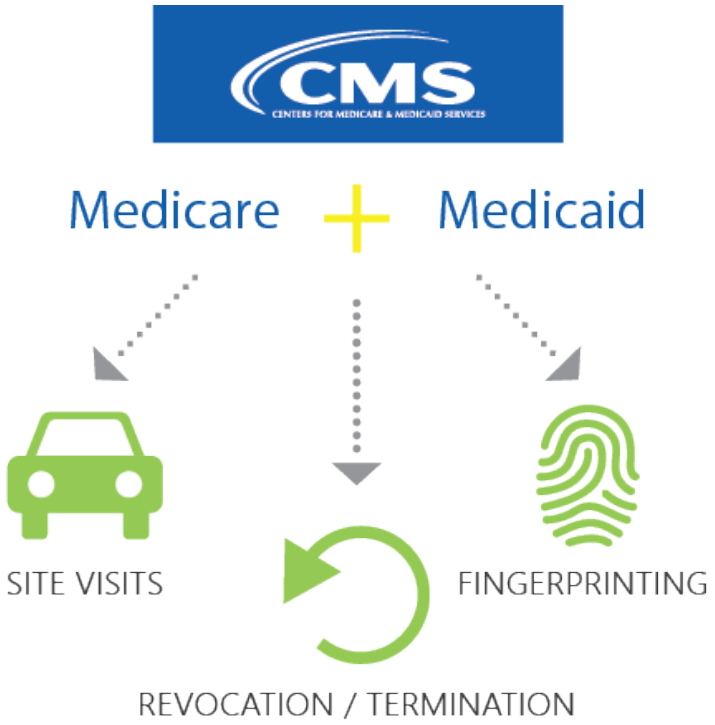
A: Paper applications are currently still being accepted for Medicare Enrollment. It is highly encouraged to complete applications through PECOS. Applications submitted through PECOS generally require less time for processing, making you eligible to bill Medicare faster. For more information on the acceptance of paper applications, visit CMS.gov.

Question & Answer Session

Medicaid Enrollment

Medicaid Provider Enrollment

CMS **Center for Program Integrity** manages **Medicare** and **Medicaid** enrollment.



Advantages

Less burden for states and providers

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

More consistency among states

Clearer sub-regulatory guidance

Each state has a CMS point-of-contact

Medicaid Provider Enrollment Compendium (MPEC)

Similar to the Medicare Program Integrity Manual

How Can CMS Help?

Can

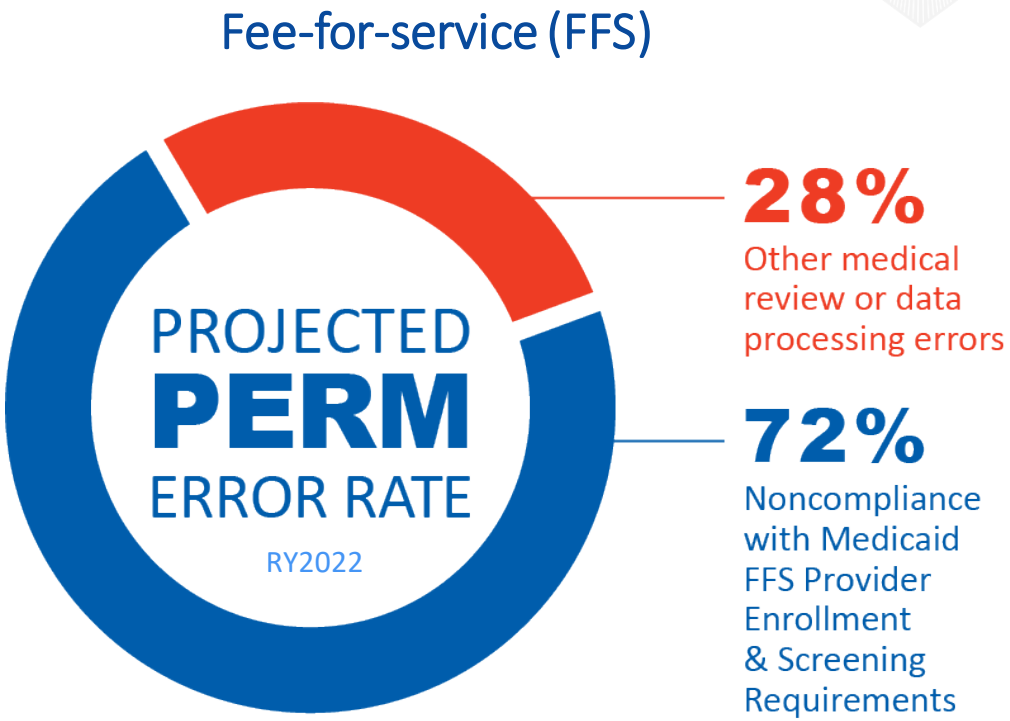
- Provide sub-regulatory guidance
- Support states in their statutory compliance efforts
- Provide Medicare data and screening activities to leverage for Medicaid enrollment
- Share best practices and make recommendations

Can't

- Require states alter their enrollment process
- Align the enrollment process across all states
- Require timeframes for processing applications
- Define the manner by which the states implement Federal regulations

Improper Error Rates

- Measures improper payments in Medicaid and CHIP and produces error rates for each program
- Error rates are based on reviews of:
  - FFS,
  - Managed care, and
  - Eligibility



Medicaid Provider Enrollment Compendium

MPEC

- 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 regulations
- Find at https://www.medicaid.gov/sites/default/files/2021-05/mpec-3222021.pdf

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

Out of State Providers (Section 1.5.1C)

- SMAs may pay claims for out-of-state providers who are unenrolled in certain circumstances

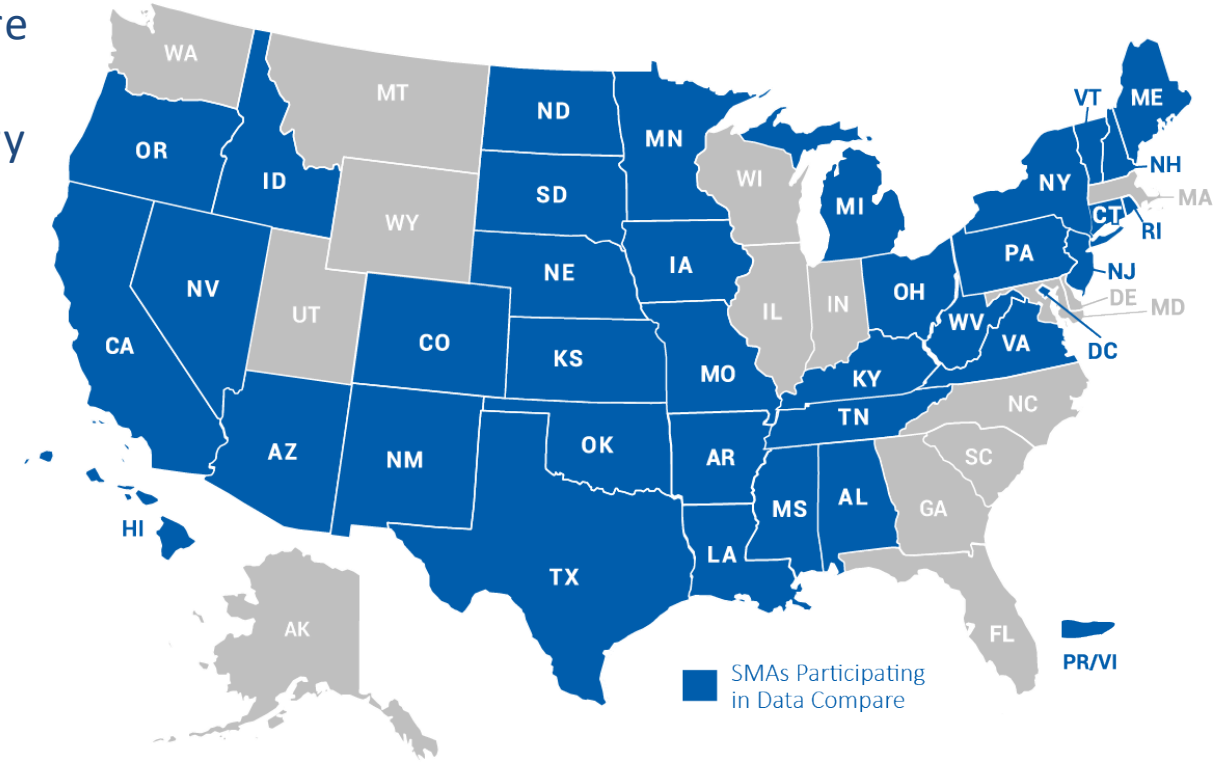
Retroactive Dates of Service (Section 1.6B)

- SMA makes determination to grant a retroactive billing date based on compliance

Data Compare Service

SMAs that have participated in Data Compare

- Ability for SMAs to rely upon Medicare screening data to comply with statutory requirements
- Identifies dually enrolled providers who have already been screened in Medicare



Data Compare Results

California Reported

117,497

Providers

Data Compare

Report Had a Match of

112,201

Providers

95.5% Match Rate

Reliable Data Compare

115,780

Individual Providers

Oklahoma Reported

65,282

Providers

Data Compare

Report Had a Match of

43,508

Providers

66.6% Match Rate

Reliable Data Compare

34,769

Individual Providers

Nevada Reported

40,348

Providers

Data Compare

Report Had a Match of

31,312

Providers

77.6% Match Rate

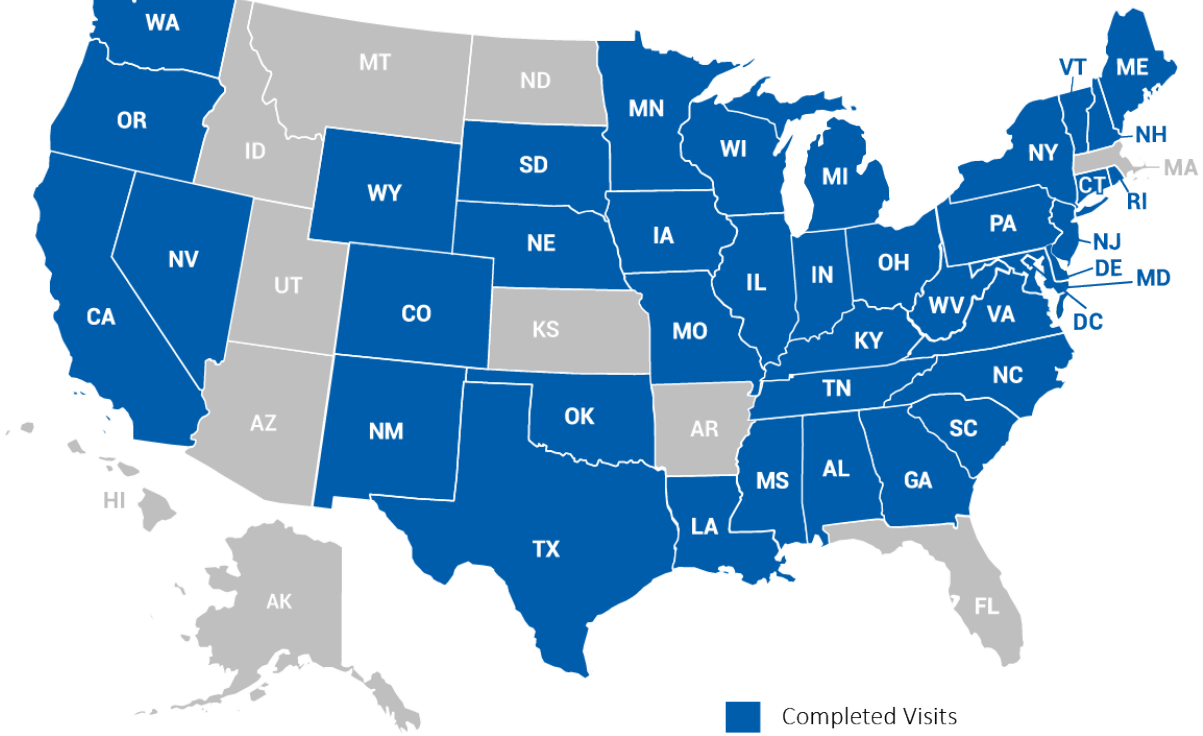
Reliable Data Compare

21,899

Individual Providers

CMS State Assessment Visits

- CMS conducts assessments of the SMA's progress with screening and enrollment requirements
- Visits are 100% voluntary
- Work with the SMAs to identify best practices and opportunities for improvement
- Identify ways CMS can better support the SMAs, help reduce burden, and provide guidance



State Best Practices

BEST PRACTICES

Montana created an abbreviated enrollment application for Referring, Ordering, Prescribing and Attending providers by removing sections that don't apply, to reduce provider burden and expedite the enrollment process.

BEST PRACTICES

California performs automated searches of the Death Master File and generates alerts on deceased providers, which allows billing numbers to be deactivated in a timely manner and prevents potential identity theft.

BEST PRACTICES

Virginia established a 100% online enrollment process.

BEST PRACTICES

Ohio has worked closely with its Program Integrity Unit and Ohio's Medicaid Fraud Control Unit to develop robust site visit protocols, which are provider type specific.

PHE Unwinding

- Enrollment and screening of temporarily enrolled providers
  - 6 months to complete enrollment and any screening waived under the PHE
  - SMAs should notify impacted providers immediately upon lifting of the PHE
  - Screening waived under the PHE may include fingerprinting, site visits, and payment of the application fee
- Revalidation of providers paused under the PHE
  - The timeline for completing revalidations that were paused under the PHE is the length of the PHE plus 6 months
  - SMAs have 6 months to notify providers of the requirement to revalidate and the remaining time to complete revalidation

Question & Answer Session

Protecting the Program

Stronger Screening

Increase Site Visits **Authority:** 42 CFR 424.517

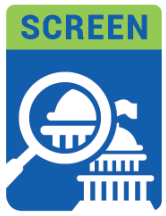
- For high Medicare reimbursements
- In high risk geographic areas

Find Vacant or Invalid Addresses

- Better automatic address verification in PECOS
- Includes US Postal Service feature that confirms the address is real (UPS store, mailboxes, unlikely to deliver mail)
- May trigger a site visit

Deactivations

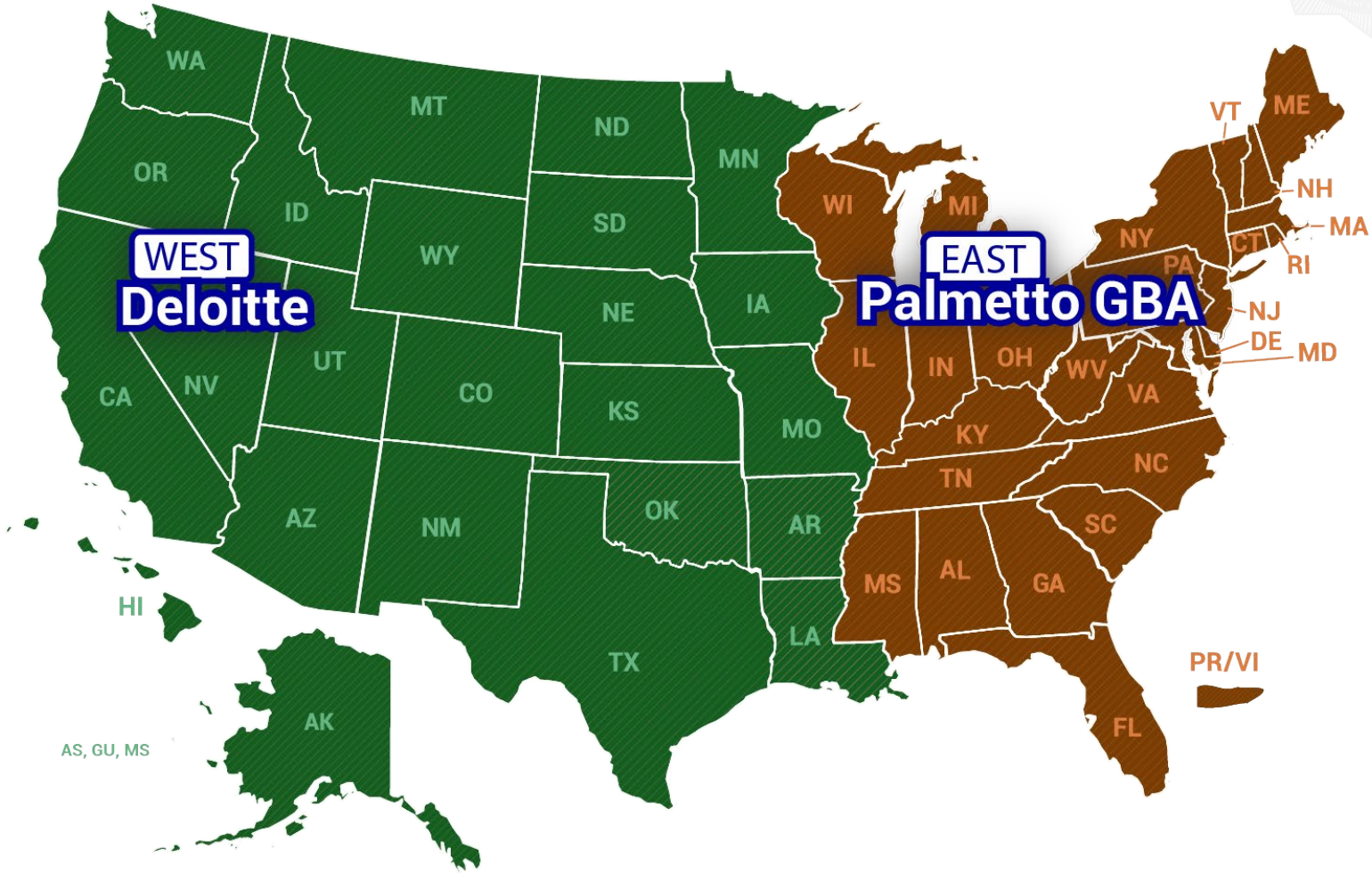
- Non-billing. EXEMPTIONS: order/refer/prescribe; certain specialties e.g., pediatricians, dentists and mass immunizers (roster billers)
- Inactive NPIs
- Deceased associates
- No active practice locations or reassignments for more than 90 days



Screen Medicaid-only Providers

- Improves efficiency and coordination across Medicare and Medicaid programs
- Reduces state and provider burden

National Site Visit Contractor (NSVC)



Site Visits | National Site Visit Contractors (NSVCs)

- All enrollment site visits conducted by the NSVC
- 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/AO surveys for certified providers

What to expect during a site visit?

1. Unannounced site visit conducted during normal business hours 9am – 5pm
2. An external or internal review, by an inspector, with limited disruption to your business
3. Photographs of the business
4. Inspector will possess a photo ID and a letter of authorization issued and signed by CMS
   - To verify an inspector is associated with a CMS ordered site visit contact your MAC

Fingerprinting

CMSfingerprinting.com

Applies to:

- New HHA, DME, MDPP, OTP, SNF
- Existing HHA, DME, MDPP, OTP, SNF reporting a change of ownership or new owner
- High risk providers/suppliers

Excludes:

- Managing Employees
- Officers
- Directors

5%(+) Ownership/Partners

in a high risk provider/supplier

- Letter will be sent giving 30 days to get fingerprinted
- Medicare phased rollout

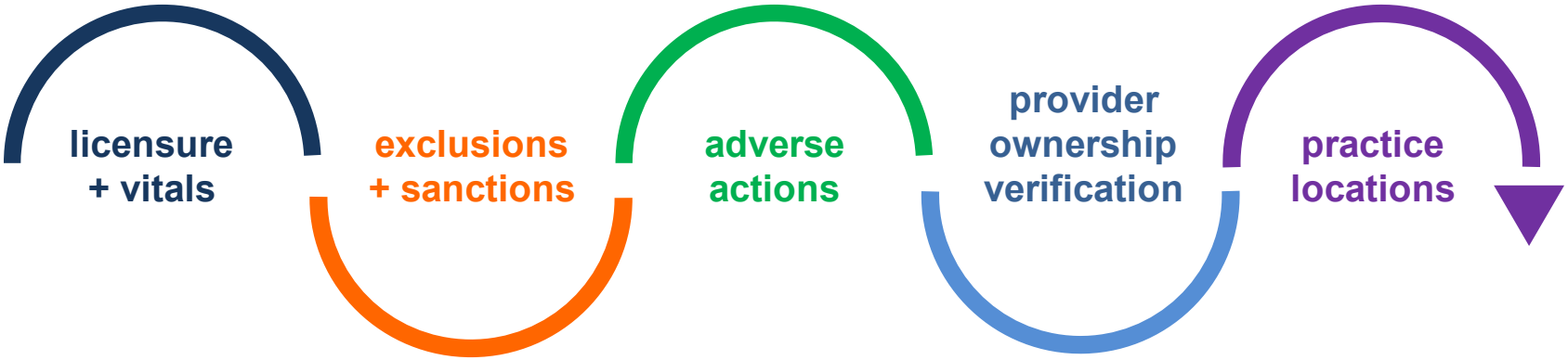
If the provider/supplier:

- Has a felony conviction
- Refuses fingerprinting

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

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

Continuous Monitoring



License via Automated screening

SSA Death Master File

NPI and LBN Integrated via NPPES

OIG and GSA websites Integrated in PECOS Monthly checks

Criminal alerts via Automated screening

Ownership reported to PECOS verified against state sources, i.e., Secretary of State data

Ad hoc site visits

Data Sharing

Public data files from PECOS

- All files contain Names and NPIs
- Available at data.cms.gov

Public Provider Enrollment File

- Currently approved individuals and orgs
- Reassignments
- Practice location data (limited)
- Primary and secondary specialty
- Updated quarterly

Revalidation File

- Currently approved, and due for revalidation
- Individuals and orgs
- Revalidation due date
- Reassignments
- Updated every 60 days

Ordering Referring File

- Currently approved individuals
- Valid opt-out
- Eligible to order/refer
- Updated twice a week

Data Sharing

Public data files from PECOS

- All files contain Names and NPIs
- Available at data.cms.gov

Opt Out File

- Currently opted-out of Medicare
- Updated quarterly

Hospital , SNF, HHA & Hospice All Ownership File Change of Ownership File

- All ownership for currently enrolled Hospitals and SNFs – updated monthly
- All ownership for currently enrolled HHA and Hospices – updated quarterly
- CHOW transactions since 2016 for currently enrolled Hospitals ,SNFs , HHAs and Hospice– updated quarterly

Mass immunizers List

- Currently enrolled Mass Immunizers/Centralized flu billers
- Updated weekly

Question & Answer Session

Enforcement Actions

Adverse Legal Actions

Required during:

- Initial enrollment
- Revalidation *(even if previously reported)*
- Within 30 days of the action

Applies to……

- Individual providers
- Individuals and organizations 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 or loss of licensure)*
- No longer required to report **Medicare Payment Suspensions** or **CMS-Imposed Medicare Revocations** *(April 2018)*

x **Felony conviction in last 10 years**
  - Crimes against persons
  - Financial crimes

x Misdemeanor conviction
  - Patient abuse or neglect
  - Theft, fraud, embezzlement

x **Sanction or exclusion** (ever)

x **License revocation or suspension** (ever)

x Accreditation revocation or suspension (ever)

x Medicaid exclusion, revocation or terminations (ever)

Deactivations

CMS can deactivate Medicare billing privileges for:

Deactivations & Reactivations

Most Common Deactivation Reasons:

- x No claims submitted
- x Voluntary withdrawals

Newest Deactivation Reasons:

Effective January 1, 2022

- x Not compliant with enrollment requirements
- x Practice location is non-operational
- x Provider or supplier is deceased
- x Provider or supplier has voluntarily withdrawn from Medicare
- x The provider is the seller in an HHA change of ownership under § 424.550(b)(1)

Billing privileges were paused, but can be restored upon the submission of a new enrollment application with updated information*

To reactivate Medicare billing privileges:

- ✓ **Must submit a complete CMS-855 application**
- ✓ **Effective date based on receipt date of the reactivation application**
- ✓ May submit a rebuttal to overturn deactivation
- ✓ Does not require a new state survey for certified providers (exception for HHAs)

Deactivations

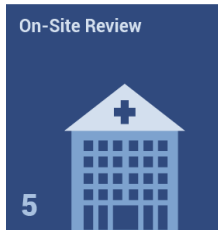
Reasons to Deny

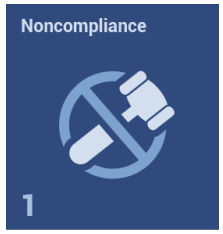
CMS can deny Medicare enrollment for:

Reasons to Deny

Most Common Reasons:

- Felony conviction within last ten years
- On-site review, showing noncompliance
- Noncompliance: program requirements





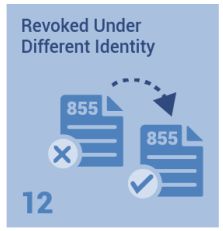
Newest Denial Reasons:

Effective January 1, 2020

- Patient Harm

Effective March 17, 2020

- Affiliations that pose an undue risk
- Revoked under different name, numerical identifier or business identity
- Other Program Terminations
  - *the provider or supplier is currently terminated or suspended (or otherwise barred) from participation in a state Medicaid program or any other federal health care program; or the license is currently revoked or suspended in a state other than that in which the provider or supplier is enrolling.*



Denials

Reasons to Revoke

CMS can revoke Medicare billing privileges for:

Reasons to Revoke

Most Common Reasons

- 424.535(A)(9) Failure To Report
- 424.535(A)(1) Noncompliance *(DME Standards Not Met)*
- 424.535(A)(1) Noncompliance *(Not Professionally Licensed)*

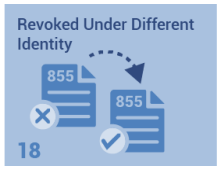
Newest Revocation Reasons

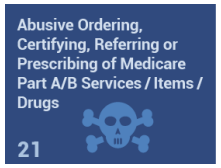
Effective January 1, 2020

- Patient Harm

Effective March 17, 2020

- Affiliations that pose an undue risk
- Revoked under different name, numerical identifier or business identity.
- Debt that has been referred to Treasury
- Billing from non-compliant location
- Abusive ordering, certifying, referring, or prescribing of Part A or B services, items or drugs.





Re-enrollment Bar

Revoked providers or suppliers are barred from participating in the Medicare program from the date of the revocation until the end of the re-enrollment bar.

Re-enrollment bar lasts 1 – 10 years*

- *However,* CMS may add up to 3 more years to the provider or supplier's reenrollment bar if the provider or supplier is attempting to circumvent its existing reenrollment bar by enrolling in Medicare under a different name, numerical identifier or business identity.

Re-enrollment bar

1–10 Years*

**CMS may impose a reenrollment bar of up to 20 years if the provider or supplier is being revoked from Medicare for the second time.*

Revocations

Protecting Medicare Part C & D

CMS-4182F

started JAN 2019

Replaces the Medicare Advantage (MA) and Prescriber enrollment requirements and creates a Preclusion list

Preclusion List

- Applies to individuals/entities
- Currently revoked and under an active re-enrollment bar,
- Could have revoked if enrolled in Medicare; or
- Convicted of a felony within last ten years under federal/state law; and
- Conduct that led to the revocation or felony is considered detrimental to the Medicare program

Part C & D Preclusion List

What happens if I'm on the Preclusion List?

You will receive a letter from CMS in advance of your inclusion on the Preclusion List

The letter will be sent to your PECOS (enrolled) or NPPES (unenrolled) mailing address

The letter will include the effective date of your preclusion and your applicable appeal rights

Part C & D Preclusion List

Medicare Advantage (Part C)

- MA plans will deny payment for a health care item or service if the individual/entity is on the Preclusion List

Prescriber (Part D)

- Pharmacy will deny prescriptions at point of sale if the provider is on the Preclusion List

Part C & D Preclusion List

For more information on the Preclusion List see: https://www.cms.gov/medicare/provider-enrollment-and-certification/preclusion-list

- Frequently Asked Questions (FAQs)
- Preclusion List Reference Guide
- Guidance to the Healthcare Plans
- Contact providerenrollment@cms.hhs.gov for questions

CMS Preclusion list

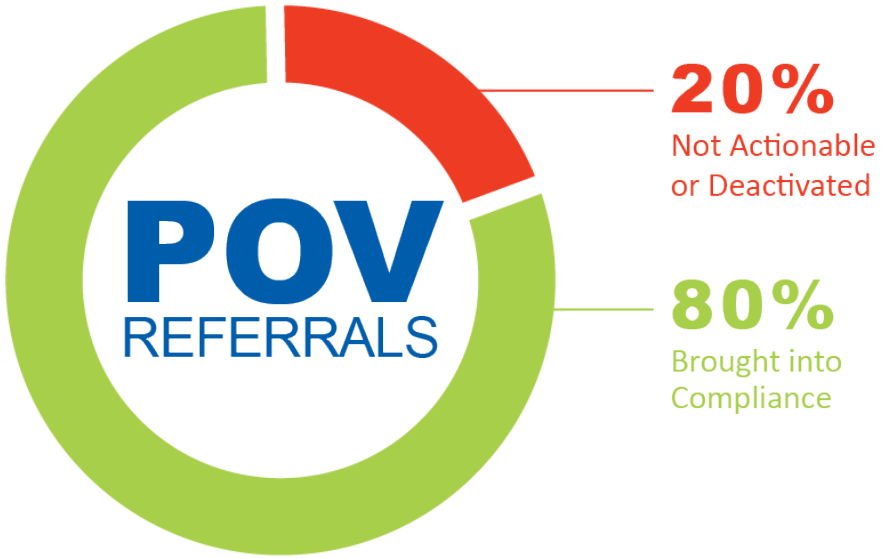
PRECLUDED ENTITIES

4,826

JAN 1, 2019 — SEPT 30, 2022

Provider Ownership Verification (POV)

- POV verifies the accuracy of provider/supplier reported ownership data against the Secretary of State and other available sources and refers discrepancies to CMS
- Total POV Referrals reviewed: 146



Medicaid Terminations

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

SCENARIO #1

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

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

SCENARIO #2

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

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

SCENARIO #3

- A provider is terminated for cause from Arizona Medicaid
- The provider is also enrolled in Texas

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

Medicaid Terminations

more than

191

Total Medicaid **TERMINATION** SUBMISSIONS Resulting in Medicare **REVOCATION**

more than

2,797

Total Medicaid **TERMINATION** SUBMISSIONS

more than

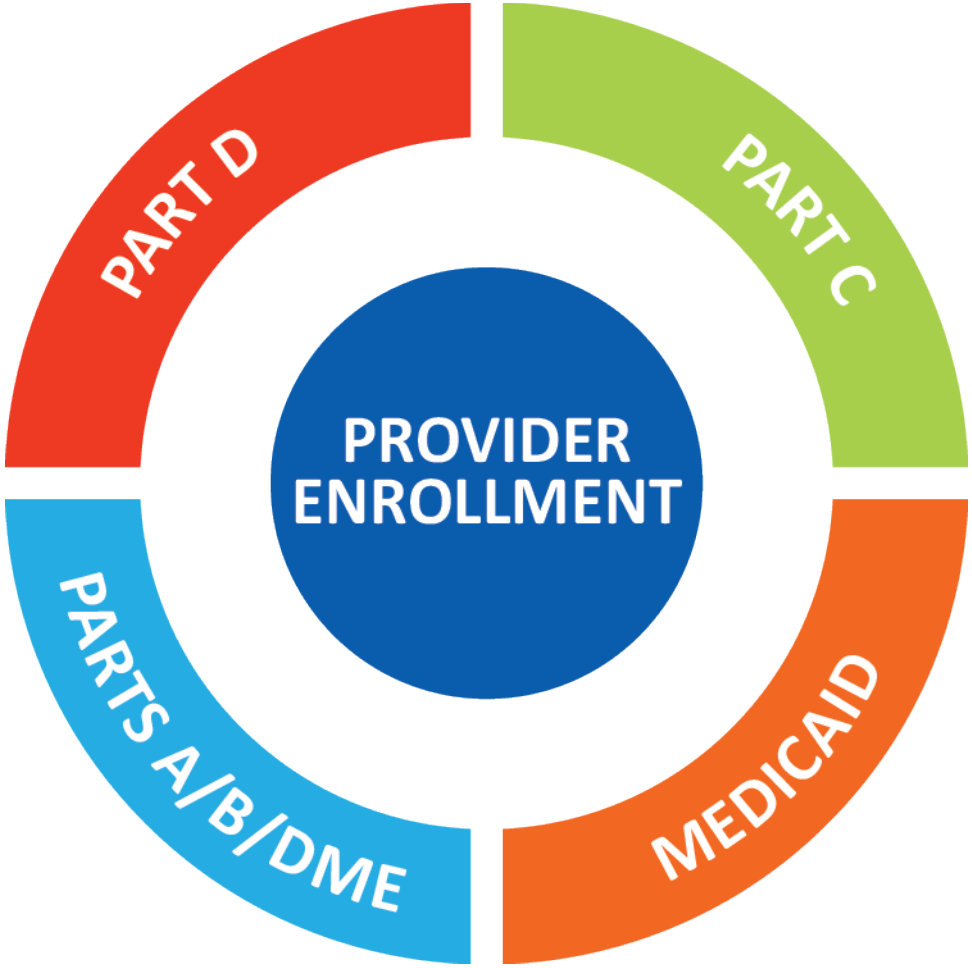
1,354

Total Medicare **REVOCATION** FILE ENTRIES

*FY 2022

Connections Between All Programs

Failure to maintain accurate enrollment data could impact your participation in other Medicare & Medicaid programs



Question & Answer Session

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 and enrollment education products

Thank You

April 2023 | 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