

National Provider Enrollment Conference

Nashville, TN (March 12 – 13, 2019)

Frequently Asked Questions (FAQs)



National Provider Identifier (NPI)

1. When are subpart NPIs recommended?

CMS encourages all providers to obtain subpart NPIs in a manner similar to how they receive CMS Certification Numbers (CCNs) (i.e., a “one-to-one relationship”). For instance, suppose a home health agency is enrolling in Medicare. It has a branch as a practice location. The main provider and the branch will typically receive separate CCNs. It would be advisable for the provider to obtain an NPI for the main provider and another one for the branch – that is, one NPI for each CCN. For more information on subparts refer to section 15.3D of the Program Integrity Manual (PIM) at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf>.

2. In the National Plan and Provider Enumeration System (NPPES) do I select a general taxonomy code for my Physician Assistants (PAs) and Nurse Practitioners (NPs) or select the specialty that they are practicing?

Providers shall select the taxonomy that closely describes the health care provider’s type, classification or specialization.

Application Fee

3. Is there a cap on the application fee amount?

No. Per Section 6401(a) of the Affordable Care Act (ACA) that established the application fee requirements, the fee will vary from year-to-year based on adjustments made pursuant to the Consumer Price Index for Urban Areas (CPI-U).

Policy

4. Where can I find the Program Integrity Manual (PIM), chapter 15?

The PIM, chapter 15 can be found at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf>. It contains the resources and procedures the Medicare Administrative Contractors (MACs) and the National Supplier Clearinghouse (NSC) use to establish and maintain provider and supplier enrollment in the Medicare program. The PIM is updated on a periodic basis.

5. Are Licensed Clinical Social Workers (LCSWs) required to enroll to bill Medicare?

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Yes. LCSWs should complete the CMS-855I application and the CMS-855R if they wish to reassign benefits.

6. Can a biller be added as a contact person on a provider's CMS-855 application?

Yes. A CMS-855 application would need to be submitted to add the contact to the provider's enrollment.

7. Do I need to add each of our group practice locations to the individual provider's enrollment if they reassign benefits to our group?

Providers that reassign benefits to your group inherit all of your group's practice locations and are able to render services at any of these locations as long as they are associated with all of your group's PTANs. You do not need to separately report these practice locations on the individual provider's enrollment record. However, as part of the CMS-855R, you may designate a primary and secondary practice location of the group where you render healthcare services most of the time.

NOTE: If your group has multiple PTANs, you will need to associate the individual provider to some or all of the PTANs on the individual providers CMS 855I form.

8. Which CMS-855 application is used to enroll Locum Tenens?

Generally, locum tenens (substitute physician or physical therapist) need not enroll via the CMS 855 enrollment form because they will not be providing the services to Medicare patients over a continuous period of longer than 60 days. If the substitute physician or physical therapist will be providing services beyond 60 days, they would need to enroll using the appropriate CMS-855 application.

9. What are the timeframes for processing CMS-855 applications?

The average processing times are 45 calendar days for web applications and 60 calendar days for paper applications. However, some of the MACs are able to process applications in advance of these timeframes.

10. What is the standard development timeframe? Some MACs only allow for 7 days to respond to development.

Providers are given 30 days to respond to the MAC's request for additional information. The MAC may make a second request for the outstanding information if not initially received. The MAC may establish its own deadline for the provider's submission of the remaining information, though it must be at least 7 business days from the date of the second request.

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11. When was the new CMS-855I form issued?

The 12/18 version of the CMS-855I application was issued in January 2019 and is available at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855i.pdf>.

12. Some MACs are currently developing for sections of the new version of the CMS-855I form (specifically the Medical Record Correspondence Address, section 2E) and others are not. Am I required to complete this section?

MACs have been instructed that if the CMS-855I application is submitted and the Medical Record Correspondence Address information is completed by the provider, to update PECOS accordingly. MACs will only develop if the information is partially completed to obtain the full information.

If the Medical Record Correspondence Address information is not completed by the provider, MACs will select that the medical record correspondence address is the same as the Correspondence address. MACs are not required to develop for this information if this section is not completed. This applies to all submission types (e.g. initials, changes of information, etc.).

13. Is a new CMS-855 enrollment application required for a Tax Identification Number (TIN) change under Part B?

Yes. This transaction is treated as a brand new enrollment as opposed to a change of information. The provider must complete a full CMS-855 or CMS-20134 application and a new enrollment record is created in PECOS.

This does not apply to ambulatory surgical centers and portable x-ray suppliers. These entities can submit a TIN change as a change of information unless a change of ownership is involved.

14. What application should a physician who is a sole proprietor complete who wishes to bill under their Social Security Number (SSN)?

Sole proprietors should complete the CMS-855I application.

15. What application do I submit if I am a retiring physician leaving a group?

A CMS-855I should be submitted selecting the option "You are voluntarily terminating your Medicare enrollment".

16. If a provider leaves our group practice, who is responsible for submitting the change of information application to deactivate him from our group practice?

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It is ultimately the individual provider's responsibility to notify Medicare of any changes in their practice locations or reassignments. However, these applications are often submitted by the group which is also acceptable. For more information on Medicare's reporting requirements refer to <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1617.pdf>.

17. We are continuously closing and opening offices how soon should we notify Medicare?

Providers/suppliers are generally required to report changes in practice locations within 30 days. For more information on Medicare's reporting requirements refer to <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1617.pdf>.

18. Do we need to submit W-2 forms along with the CMS-855 application?

No. The MAC is not required to request a copy of an individual's W-2 to confirm that he/she is a W-2 employee (as opposed to a contracted employee), although it reserves the right to do so if additional clarification is needed to correctly process the enrollment application.

19. When would a CMS-855B be submitted by a hospital?

A hospital or individual hospital department may submit a CMS-855B to enroll and bill for Part B services (e.g. clinic services).

20. What type of provider would fill out the CMS-20134 application?

The CMS-20134 form is for suppliers who wish to furnish Medicare Diabetes Prevention Program (MDPP) services.

21. If the physician sees patients at multiple locations, should they be listed on the CMS-855?

Providers must disclose on the CMS-855 all practice locations where services are rendered to Medicare beneficiaries.

22. Some of our physicians have private practices. Do we need to list their private practice locations as a practice location on our enrollment?

No. The physician would list their private practice locations on their CMS-855I application in section 4B. These locations should not be reported on the group's enrollment application.

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23. The MAC is delayed in processing my original CMS-855 application to report multiple practice locations. I now have an additional location to add. Am I required to wait until my original application is processed to report the new location?

No. You may submit an application while another application is in process to fulfill your obligation to report the changed information. If you are unable to submit an application online because of PECOS limitations, you may submit via paper.

24. Can a global update to all my enrollment records be done on one CMS-855 application?

Currently global updates cannot be completed on one application, however, CMS is considering this as a future enhancement to PECOS.

25. My organization's partners and board of directors change every 6 months. What is CMS' expectation for reporting these changes?

It is required that providers/suppliers report all changes in ownership to their MAC. Failure to comply with the requirements to report changes in your Medicare enrollment information could result in the revocation of your Medicare billing privileges. Refer to <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1617.pdf> for the timeframes for reporting changes to your enrollment information.

26. The NSC maintains a list of licenses required per site. Is there anything similar to this on clinical side?

There is not currently a similar document on the clinical side.

Revalidation

27. I have not received a revalidation letter from my MAC, however, I am listed on the revalidation look up tool with a due date. Can I submit my revalidation application?

Yes. Providers/suppliers can submit their revalidation up to 7 months in advance of their listed due dates on <http://go.cms.gov/MedicareRevalidation>.

28. Can I submit a change of information application if it's before my revalidation due date?

Yes. Providers should still submit changes of information if they are not yet due to revalidate. MACs will process the change of information submission and proceed with the revalidation process as normal.

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29. How are the 3 and 5 year revalidation due dates determined?

Due dates are established based on your last successful revalidation or initial enrollment (approximately 3 years for DME suppliers and 5 years for all other providers/suppliers). Generally, this due date will remain with you throughout subsequent revalidation cycles.

30. I am attempting to complete a revalidation for a provider who is reassigning benefits to multiple groups, however, in PECOS only one group can revalidate at a time. How can I revalidate the reassignment for my group?

If you are an individual who reassigns benefits to more than one group or entity, you must include all organizations to which you reassign your benefits on one revalidation application. If you have someone else completing your revalidation application for you, we encourage coordination with all entities to which you reassign benefits to ensure your reassignments remain intact.

31. Why are air ambulance suppliers required to submit a written statement of the airport from where the aircraft is hangered with the name and address of the facility if a site visit is performed validating this information?

MACs have been instructed not to request this written statement from air ambulance suppliers. The CMS-855B will be updated to remove this requirement in the future.

Participation Agreement (CMS-460)

32. How can I find out if we are a participating provider (i.e., completed the CMS-460)?

You can review your PAR status by logging into PECOS at <https://pecos.cms.hhs.gov/pecos/login.do>. You can also contact your Medicare Administrative Contractor (MAC) to see if a CMS-460 has been submitted for you. MAC contact information can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf.

33. Do individual providers linked to a group have to elect their own participation status?

Individual physicians and non-physician practitioners who reassign all benefits to a clinic/group practice inherit the Par status elected by the clinic/group practice. However, if the individual physician or non-physician practitioner maintains a private practice, separate from the reassignment of benefits agreement, he/she may designate their own Par status for his/her private practice.

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34. Can I complete the CMS-460 via PECOS or does it need to be done via paper?

The CMS-460 must be completed via paper, however, you can upload the form in PECOS and submit along with your electronic application.

Electronic Funds Transfer (EFT) (CMS-588)

35. Is a CMS-588 required for a physician who reassigns all of their benefits to a group?

No. The physician is not receiving payment directly. The group is being paid for the services provided by the physician. Therefore, the group would submit the CMS-588.

36. Should the organization's Legal Business Name (LBN) or Doing Business as (DBA) name be listed on the bank letter?

All Medicare payments must be made to the provider under their LBN. Therefore, the bank letter should contain the provider's LBN.

37. Are EFT agreements required to be renewed periodically?

No. Providers are only required to submit a new EFT agreement if there are changes in their account information or if CMS revises the form to collect new data elements.

38. What is the time frame in which the EFT letter needs to be dated?

There is not currently an established timeframe.

39. Is the CMS-588 Electronic Funds Transfer (EFT) application required with revalidation?

If the MAC has the most recent EFT form on file (i.e., either the 05/10, 09/13, or 01/17 version), a new EFT is not required during revalidation.

40. MACs have been requiring duplicate CMS-588's if a provider has more than one PTAN. Is this necessary?

No. MACs are able to accept a single CMS-588 for multiple PTANs.

Medicare Billing Numbers

41. What is a CCN?

A CMS Certification Number (CCN) is assigned to Part A facilities for billing and administrative purposes and identifies them in Medicare claims and other transactions (including cost reports

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for those providers that are required to file Medicare cost reports). The CCN is equivalent to a Provider Transaction Access Number (PTAN).

42. I am an Ambulatory Surgical Center (ASC) and have a Provider Transaction Access Number (PTAN) and CCN. Why?

All certified providers and suppliers are issued a CMS Certification Number (CCN) by the CMS Regional Office when they have confirmed that all survey and certification requirements are met. However, Medicare Administrative Contractors (MACs) will issue a PTAN to a newly certified ASC that may/may not be different than the CCN. ASCs shall use the MAC issued PTAN for billing the Medicare program.

43. I have a PTAN assigned for my California enrollment and will be opening a new location in Texas. Will a new PTAN be assigned?

Yes. A new enrollment would need to be established in Texas and a new PTAN assigned.

Medicare Effective Dates

44. How far in advance can I submit a change in practice location?

Providers can submit their applications up to 60 days (Part B) or 180 days (Part A) in advance of their effective date.

45. What is a retrospective billing date?

Consistent with 42 CFR §424.521(a), certain individuals and organizations may retrospectively bill for services when:

- The supplier has met all program requirements, including state licensure requirements, and
- The services were provided at the enrolled practice location for up to—
 - 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or
 - 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

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46. Is retrospective billing permitted for a reactivation?

Yes. MACs may grant retrospective billing privileges for providers and suppliers who are reactivating.

Interns, Residents and Fellows

47. Can fellows enroll to bill Medicare?

No. Fellows are not eligible to enroll in Medicare.

48. Do I need to submit a new CMS-855 if the provider is no longer a resident and will be joining my group?

A CMS-855 is not required to inform Medicare that the provider is no longer a resident, however a CMS-855 is required if the resident will be practicing at a new location.

Certified Providers/Suppliers

49. What is the difference between a certified provider and non-certified provider?

A certified provider or supplier is an institutional health care provider or supplier who renders Part A or B services (e.g., home health agency, hospital, nursing home, dialysis facility, or ambulatory surgical center) and is required to pass an inspection conducted by a state government agency and/or review by the CMS Regional Office before being approved by Medicare.

A non-certified provider is a health care provider who renders Part B services (e.g. physician/non-physician practitioner, clinic/group practice, IDTF, or ambulance suppliers) that is not required to undergo the certification process conducted by a state government agency before being approved by Medicare.

50. What is the difference between relocation and an address change?

A relocation occurs when a certified provider moves their practice location to a new geographic location that serves a different community or population. A relocation usually requires a new survey and certification by the CMS Regional Office prior to approval.

An address change occurs when an existing organization moves its Medicare approved primary site, a rehabilitation agency moves any of its approved extension locations to a new practice location or a rehabilitation agency adds a new practice location. However, the facility is servicing the same patients, in the same service area, and is maintaining the same staff.

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51. Can Phase 1 of the survey and certification transition include providers undergoing a change of ownership (CHOW) that results in a change in MACs (e.g. going from hospital based to freestanding)?

The CHOW process is included in phase 1 of the survey and certification transition.

Federally Qualified Health Center (FQHC)

52. Can a section of my public hospital be considered an FQHC?

Perhaps. Three types of entities are eligible to become an FQHC: Health Center Program grantees, Health Center Program Look-Alikes and tribal entities. However, in order to qualify as a health center, the organization must separate from that of the hospital and the health center must have patient majority board. For more information please see <https://bphc.hrsa.gov/programrequirements/index.html>.

53. Can multiple FQHC sites share an NPI?

Yes, however, it is not recommended.

54. Is a separate application needed for a new FQHC site?

Yes. Each location must be separately enrolled and will receive its own CMS Certification Number.

55. Can an FQHC be a DME supplier?

If an FQHC provides DME items and services and meets all the DME supplier standards found at 42 C.F.R. 424.57(c), they could enroll as a DME supplier.

56. Are FQHC's required to pay the fee?

Yes. An application fee is required to be submitted by an FQHC when initially enrolling, revalidating or adding a practice location.

57. What is the Medicare enrollment process for an FQHC look alike wishing to become an FQHC?

A Look-Alike Health Center must apply for and receive a Health Center Program Federal Award in order to become an FQHC.

58. Do FQHCs have to revalidate as a facility as well as revalidate their individual providers?

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FQHCs must revalidate their facility enrollment every 5 years. Individual providers are enrolled with Medicare Part B, via the CMS-855I form, and are revalidated separately from the FQHC.

59. Does the Health Resources and Services Administration (HRSA) publish a list of approved FQHC facilities?

Yes. You can search for approved Health Centers on the HRSA webpage:

<https://bphc.hrsa.gov/uds/datacenter.aspx?q=d>.

Authorized Officials (AOs) and Delegated Officials (DOs)

60. Who can be an AO and is it possible to have several AO's?

An AO is an appointed official (e.g., chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

Multiple AOs are permitted.

61. MACs are requiring that the AO be at the provider level and not at the chain home office. However, we do not have an AO eligible individual at the provider level. How can we resolve this issue?

This scenario will be handled on a case-by-case basis. Providers should contact CMS at providerenrollment@cms.hhs.gov or their MAC for further instructions.

62. Can CMS expand the scope of who can be a DO? Large organizations find it difficult to have someone at the "top" sign off on the CMS-855 applications?

A delegated official (DO) is an individual who is delegated by the "Authorized Official" the authority to report changes and updates to the provider/supplier's enrollment record. The delegated official must be an individual with an ownership or control interest in (as that term is defined in section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of, the provider/supplier.

The DO does not have to be at the "top". They can be a W-2 managing employee of the provider/supplier.

63. How do you update the AO if they are no longer with the company?

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If the AO is no longer with the company, a new AO must be added using the appropriate CMS 855 enrollment form. A signature from the departed AO is not required.

Provider Enrollment Chain and Ownership System (PECOS)

64. What is the difference between the Provider Enrollment Chain and Ownership System (PECOS) and the Identity and Access (I&A) Management System?

PECOS is a system that supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely submit, and manage their Medicare enrollment information. I&A is the system that allows new and existing providers to create and maintain a user profile for the sole purpose of gaining access into PECOS or NPPES.

65. How long can a PECOS application sit in the system without being submitted?

A web application can remain untouched in an open status for 120 days. A web application can remain untouched in a rejected status for 60 days.

66. How do you change a Legal Business Name (LBN) in PECOS?

While in an application, navigate to the Organization Information topic then select the Edit button. The next page displays an Edit LBN button, which will allow the provider to type over the LBN. Upon submission of the application and processing/approval by the MAC, the LBN will be updated.

Note that the LBN on the My Enrollments page may still reflect the previous LBN because it comes from I&A so the provider will also need to update the LBN in I&A. In addition, the user must ensure the LBN matches the CP-575 information in NPPES.

67. Where can you see that a change of ownership (CHOW) has occurred in the system?

The approved enrollment in PECOS does not show the CHOW information.

68. What is the difference between the change of information and revalidation options in PECOS?

Submitting a change of information means that you are replacing existing enrollment information with new information (e.g. billing agency, managing employee) or updating existing information (e.g. change in suite #, telephone #).

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Submitting a revalidation means that you are recertifying that the information that Medicare has on file is accurate and up-to-date. Any outdated information should be updated and submitted to your MAC.

69. How do you terminate a physician's reassignment in PECOS?

While in PECOS, the provider should navigate to the topic containing the terminated employee and select the Delete button. The user will then be prompted to enter a termination date. In this example, if the terminated employee is in the Individual Control topic, the user will select the Delete button for this individual.

70. Is it possible to streamline a process between PECOS and the state's Medicaid system so that after you receive approval from Medicare the information about enrollment can be sent to Medicaid directly?

CMS will take this into consideration in future.

71. Can home health agencies complete an initial enrollment application in PECOS?

Yes.

72. Can CMS generate an e-mail to remind the AO or DO to sign the CMS-855 after it is submitted?

This change is scheduled to be implemented in October 2019.

73. How do you remove a rejected application in PECOS?

Providers are not able to remove a rejected application in PECOS.

74. Can CMS turn on the contact person e-mail capability, PECOS has this functionality?

This change is scheduled to be implemented in October 2019.

75. Are we considering a system similar to PECOS for all Medicaid systems?

CMS is planning towards a consolidated option for the Medicaid State Agencies. More information will be shared with the provider community when it becomes available.

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Opt-Out

76. Provider opted out in Texas but has since moved to Maine. Is the provider eligible to enroll in Maine?

No. Opt-out status is national. As required by the Medicare statute and regulations, Medicare will not cover any services provided by a physician or practitioner who chooses to opt-out of Medicare, and no Medicare payment can be made to that physician or practitioner directly, except in an emergency or urgent care situation. The physician or practitioner cannot choose to opt-out of Medicare for some Medicare beneficiaries but not others; or for some services but not others.

The physician or practitioner will need to wait the full 2 years before he is eligible to enroll.

77. Why would a provider choose to opt out?

This is a personal business decision made by the provider. Generally some providers don't wish to partner with Medicare or are not in agreement with Medicare's payment amounts.

78. Where can I find a list of providers who have opt out?

For a list of practitioners who have opted out of Medicare go to <https://data.cms.gov/Medicare-Enrollment/Opt-Out-Affidavits/7yuw-754z>.

79. How are opt out effective dates determined?

The initial 2-year opt-out period for a non-participating or non-enrolled physician or non-physician practitioner (NPP) that is eligible to opt-out begins the date the affidavit is signed, provided the affidavit meets the requirements and is filed within 10 days after the physician or practitioner signs his or her first private contract with a Medicare beneficiary. A physician or NPP that is eligible to opt-out that is enrolled and is a participating Medicare provider will receive the first of the next calendar quarter as the opt-out effective date, if the opt-out affidavit is received 30 days or more prior to the next calendar quarter. If received less than 30 days from the next calendar quarter, the physician or NPP will receive the first of the next calendar quarter as their opt-out effective date.

Maintaining Compliance with Enrollment Requirements

80. Would a denial of a medical license need to be reported?

If there was underlying conduct that fits one of the types of adverse actions that is listed on the application, then yes. If the denial was based on an administrative reason that falls outside of the adverse legal actions on the applications, then no.

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81. Would a juvenile felony conviction need to be reported?

If the conviction is determined to be a felony conviction under 42 C.F.R. § 1001.2, then yes. The age of the individual doesn't determine whether the conviction needs to be reported. In all likelihood it would need to be reported, as even an expungement—where the information about a case is removed from court and law enforcement records—needs to be reported.

82. Does a compliance officer need to report adverse issues regarding nurses that work at a hospital or group such as record maintenance sanctions, improper billing, etc.?

This is determined on a case by case basis depending on the situation. If the nurse is in a managing role and needs to be reported in section 6 (or other applicable section that pertains to managing employees), then any adverse actions that are listed on the application would need to be included under his or her entry on the application.

83. Do the adverse actions of a supervising physician need to be reported?

Review the particular application that is being submitted and determine every field where the supervising physician needs to be reported. Then look at the questions for each role. If the field for one of his roles includes the question, “does this person have any adverse actions that appear in section XYZ?” then the adverse actions need to be reported.

84. If a provider is revoked, how do we see the re-enrollment bar?

The re-enrollment bar will be reflected in the revocation letter.

85. Does CMS have the ability to expedite how quickly the Administrative Law Judge (ALJ) implements a decision?

No.

86. Can I continue to submit claims after I have been deactivated?

Providers may continue to submit claims for dates of service (DOS) prior to their deactivation date for up to 1 year. For more information on the time limits for filing Medicare claims refer to <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7270.pdf>.

Preclusion List

87. What criteria is used to add providers to the preclusion list?

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The Preclusion List is comprised of any individual or entity that meets the following criteria:

- Is currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program, or
- Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare Program.

For more information on the preclusion list, refer to <https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProviderSupEnroll/PreclusionList.html>

88. When were the preclusion list requirements effective?

The preclusion list requirements were implemented on January 1, 2019. Effective April 1, 2019, Medicare Advantage (MA) plans began denying payment for health care items or services furnished by an individual or entity on CMS's Preclusion List. Similarly, Part D plans began rejecting or denying pharmacy claims for Part D drugs prescribed by individuals on the Preclusion List.

89. Can CMS provide a list of precluded NPIs so organizations can ensure they are not employing precluded providers?

Currently, only approved CMS healthcare plans, with a valid Health Plan ID, can gain access to the Preclusion List.

Medicaid Provider Enrollment

90. Do State Medicaid Agency's (SMA's) have access to PECOS?

Yes. SMAs are able to review a provider's enrollment status in Medicare.

91. Is failure to submit fingerprints a cause for termination?

Yes, per 42 CFR 455.416(e), if a provider, or any person with a 5 percent or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Medicaid agency within 30 days of a CMS or a State Medicaid agency request, the state Medicaid agency must terminate or deny enrollment.

92. Is there still a Medicaid moratoria on RHC enrollment in Tennessee?

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Yes, a six month extension was approved effective April 25, 2019.

93. Several states have informed providers they will not rely on fingerprinting conducted by Medicare and will require providers to undergo a Fingerprint based criminal background check a second time to enroll with Medicaid. Is this allowable?

Yes, states have the option but are not required to rely on screening performed by Medicare.

General Information

94. Will the conference be held in Nashville every year or will the venue change?

The venue will change. The dates and location of the next conference have not yet been determined. CMS will make conference information available on <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Provider-Enrollment-Events.html>.

95. Will slides from all presentations be made available?

The PowerPoint slides for each session can be found at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Provider-Enrollment-Events.html>.