



NATIONAL PROVIDER
ENROLLMENT CONFERENCE

59 Million Patients, 2 Million Providers, ONE Mission

MEDICARE & MEDICAID PROVIDER ENROLLMENT

MARCH 2019

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Session Overview



- Putting Patients First
- How Enrollment Works
- Medicare Policy Updates
- Revalidation
- Medicaid Enrollment
- Our Enrollment Systems
- Protecting the Program
- Enforcement Actions





Putting Patients First



Poll Question 1

By the Numbers



632.9

BILLION

in **Medicare** (expenditures)



552.3

BILLION

in **Medicaid** (expenditures)



2 MILLION
Providers



59 MILLION
Patients



Poll Question 2

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

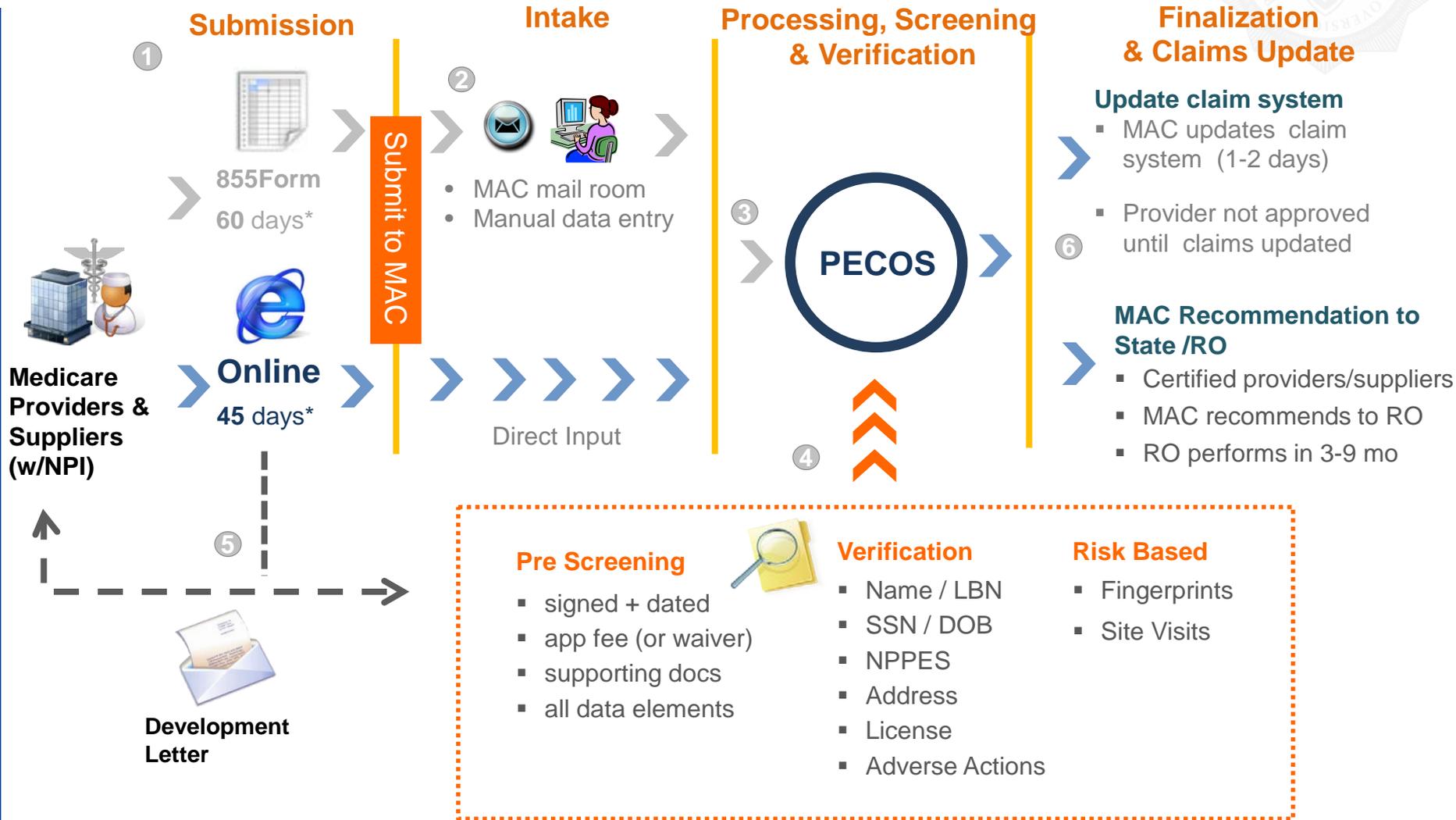


We will keep refining our systems, policies, transparency, and our vision



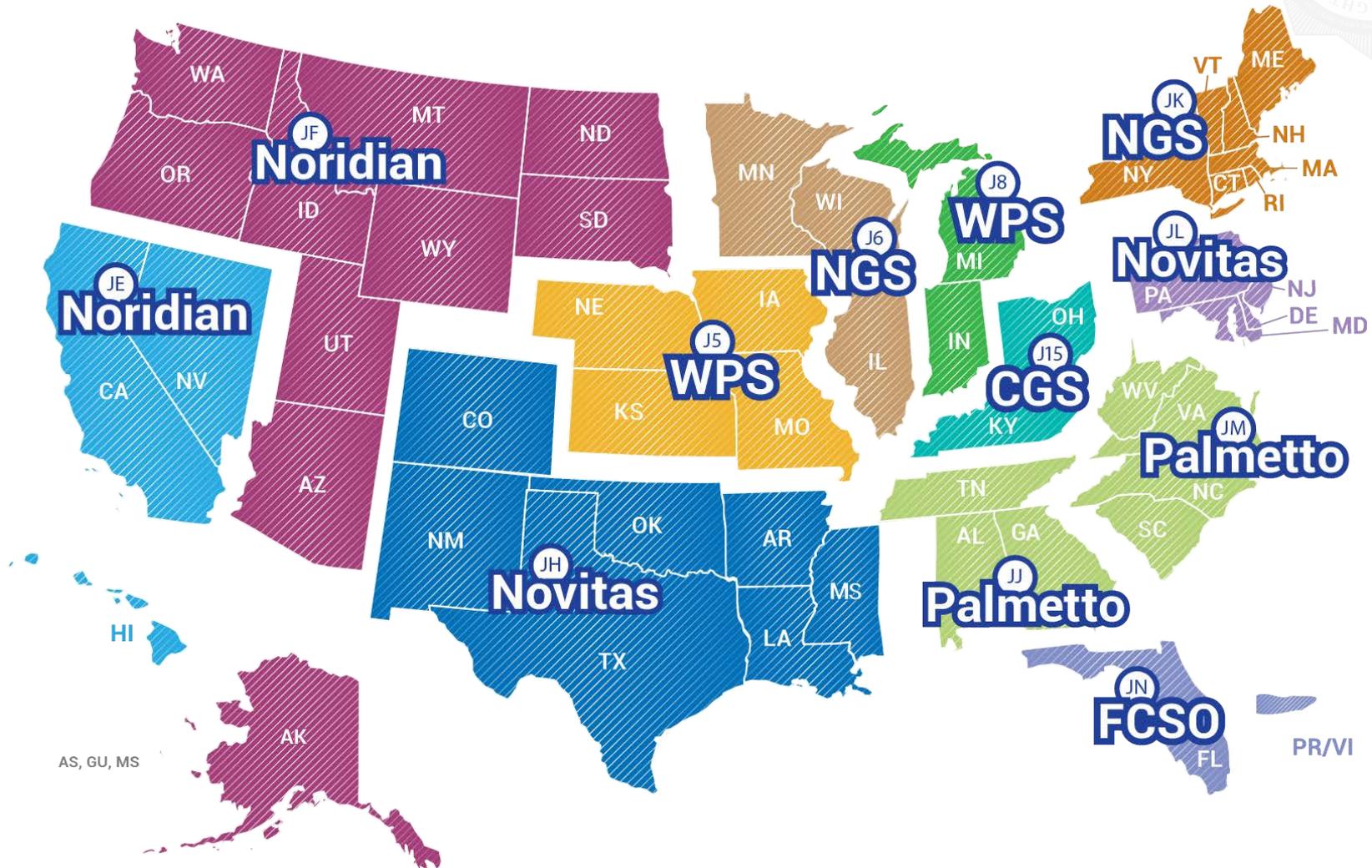
How Enrollment Works

How Enrollment Works



* If the app is complete, and no site visit

MAC Jurisdictions





Policy Updates

Recent Policy Changes



- Online applications must be e-signed or signature uploaded (*October 2018*) ★
 - Difficult for MACs to match paper signature to web submission
 - Includes CMS-588 EFT and CMS-460 PAR Agreements
- No longer accept handwritten CMS-855 paper applications (*late 2019*) ★
 - All paper applications shall be typed using the fillable CMS-855 form option
 - MACs will return application if entire fields or sections are hand-written
 - No appeal rights
 - Could impact your effective date

Recent Policy Changes | April 2019[★]



- IDTFs are not required to report equipment that is being leased for less than 90 days
- Private practices providing IDTF services to ANY outside patients must enroll as an IDTF
- MACs will request a change of information application if they are notified that a Interpreting or Supervising Physician no longer provides services at an IDTF
 - IDTF must remove the Interpreting or Supervising Physician from the IDTF enrollment and/or replace if that was the only physician on file
 - Failure to appropriately update the IDTF enrollment may result in revocation
- The effective date for IDTFs undergoing a CHOW that results in a new enrollment is date the business was transferred to the new owner

Recent Policy Changes



- Providers who are reassigned to a deactivated/revoked organization will have 90 days to submit a new practice location or reassignment before being deactivated
- MACs should not call to speak directly to providers reporting a change in specialty
- MACs should not request a diploma or degree unless education requirements cannot be verified online
 - Mostly impacts non-physician practitioners
- MACs should not request a SSN card or driver's license for identification

Recent Policy Changes



- MACs should not request a phone, utility, power bill or lease to validate LBN or DBA
 - Lease only required to validate exclusive use of facility for PT/OT or ambulance suppliers leasing aircraft
- MACs shall only request the dated signature of at least one authorized/delegated official for applications requiring development
- MACs may accept a CP-575, federal tax department ticket, or any other pre-printed document from the IRS to validate TIN and/or LBN

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 ROs are not consistent
- Changes in enrollment information is often reported to the RO outside of the CMS-855 process

Survey and Certification Transition



Phased Implementation



Phase I (Summer 2019)

All certified provider enrollment applications that do not require a state survey

- Voluntary terminations
- CHOWs
- Address changes
- FQHC (initials and location changes)



Phase II (Late 2019)

All certified provider enrollment applications that do require a state survey

- Initials
- Involuntary terminations
- Relocations



CMS will transfer **some** survey and certification functions for certified providers to the **Center for Program Integrity** and the **MACs**

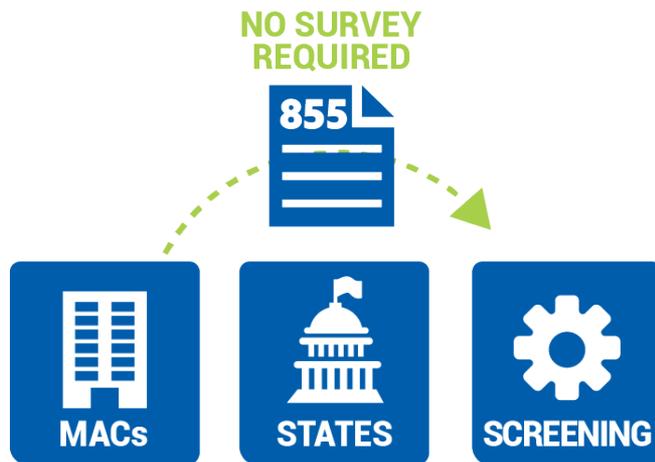
Advantages

Reduce application processing times

- In some cases, MACs are able to process enrollment applications without making a recommendation to the CMS RO/State, if no survey is required.
- Direct coordination between the MACs and States for survey related actions.
- This process **will not** eliminate the need for a survey, if required.

Streamline the application process

- MACs will collect required information with the CMS-855 to avoid additional development requests from the CMS RO/state (OCR attestation, provider agreements, certification forms).



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 DOs for the employer



DO

Delegated Official

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 DO requirements than PECOS
- May add the employer to his profile, manage staff and connections for the employer
- Multiple DOs permitted

Who Can Sign the Enrollment Application?



Initial:

A **AO**
AUTHORIZED OFFICIAL

B

S

Changes & Revals:

AO
AUTHORIZED OFFICIAL

OR

DO
DELEGATED OFFICIAL

All:

I **IP**
INDIVIDUAL PROVIDER

O

Adding:

IP
INDIVIDUAL PROVIDER

+

DO / **AO**
DELEGATED OFFICIAL / AUTHORIZED OFFICIAL

Changing / Terminating:

IP
INDIVIDUAL PROVIDER

OR

DO / **AO**
DELEGATED OFFICIAL / AUTHORIZED OFFICIAL

Release of Enrollment Information



	Individual Provider	AO / DO	Contact Person	Outside Person / Entity
PTANs	X	X	X	
Effective Dates	X	X	X	
Group Affiliations	X	X	X	
Practice Locations	X	X	X	
Revalidation Status Information	X	X	X	X
Approval Letters	X	X	X	

Part C & D Preclusion List



CMS-4182F
starts 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, or
- Could have revoked if enrolled in Medicare; and
- Conduct that led to the revocation is considered detrimental to the Medicare program



50%
of revoked felons continue to prescribe opioids to Medicare beneficiaries

Part C & D Preclusion List



What happens if I'm on the Preclusion List?



You will receive an email and letter from CMS in advance of your inclusion on the Preclusion List



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



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

Part C & D Preclusion List



Beginning APR 2019

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 refer to:

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html>

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



Poll Question 3



Question & Answer Session



Revalidation



Poll Question 4

Revalidation Basics



5-year cycles

3-year for DME suppliers

When is your revalidation due?

go.cms.gov/MedicareRevalidation

- Lists all affected, 6 - 7 months out
- MACs will send notices 2-3 months prior
- Always due on **last day of the month**
- List includes all reassignments

RESPONSE RATE

90%

We e-mail the PECOS contact

- If multiple contacts exist email most recent on file
- No phone calls
- If no email address, we mail to: correspondence and special payment addresses and/or practice location address

Large Group Coordination

- We mail an “FYI” to **large groups** every 6 months, with a spreadsheet of every relevant provider (Name, NPI, and Specialty)
- MACs can now ask one contact to verify multiple practice locations

60
DAYS TO
RESPOND

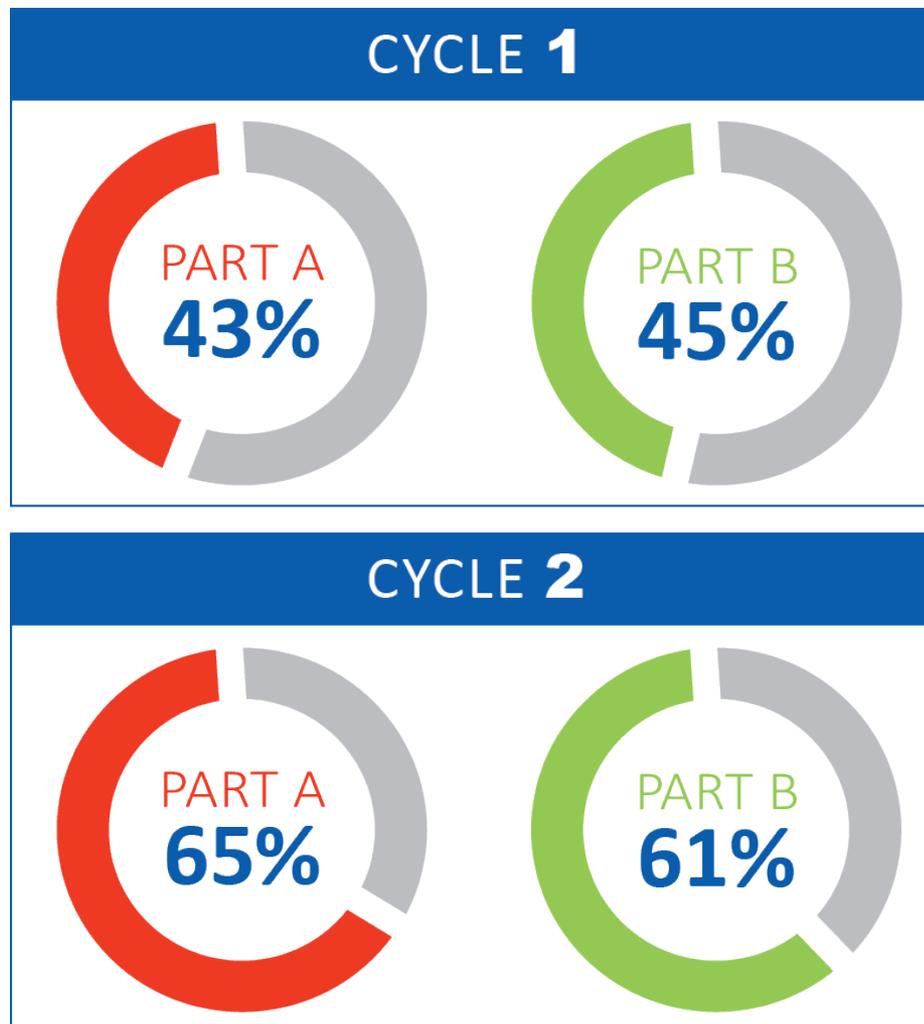
No Response?

- deactivate (not revoke)

Late Revalidation?

- break in billing

Revalidation Web Submissions



Revalidation Details



Unsolicited Revalidations

- If your record's due date is "TBD", do not send an application
- CMS will accept applications submitted within 7 months before due date, any application submitted beyond this timeframe will be returned
- If you want to *update or change* your enrollment record, send the relevant 855 form

Deactivations

- If you don't provide a complete revalidation your Medicare billing privileges will be deactivated
- Respond to all development requests by your MAC within 30 days
- If we deactivate you, you need to resend a complete enrollment application for reactivation
- If CMS reactivates you, you keep your old PTAN, and you are reactivated to the receipt date of the new application + 30 days for retrospective billing
- Approval letters include gap in billing language

Revalidation Details

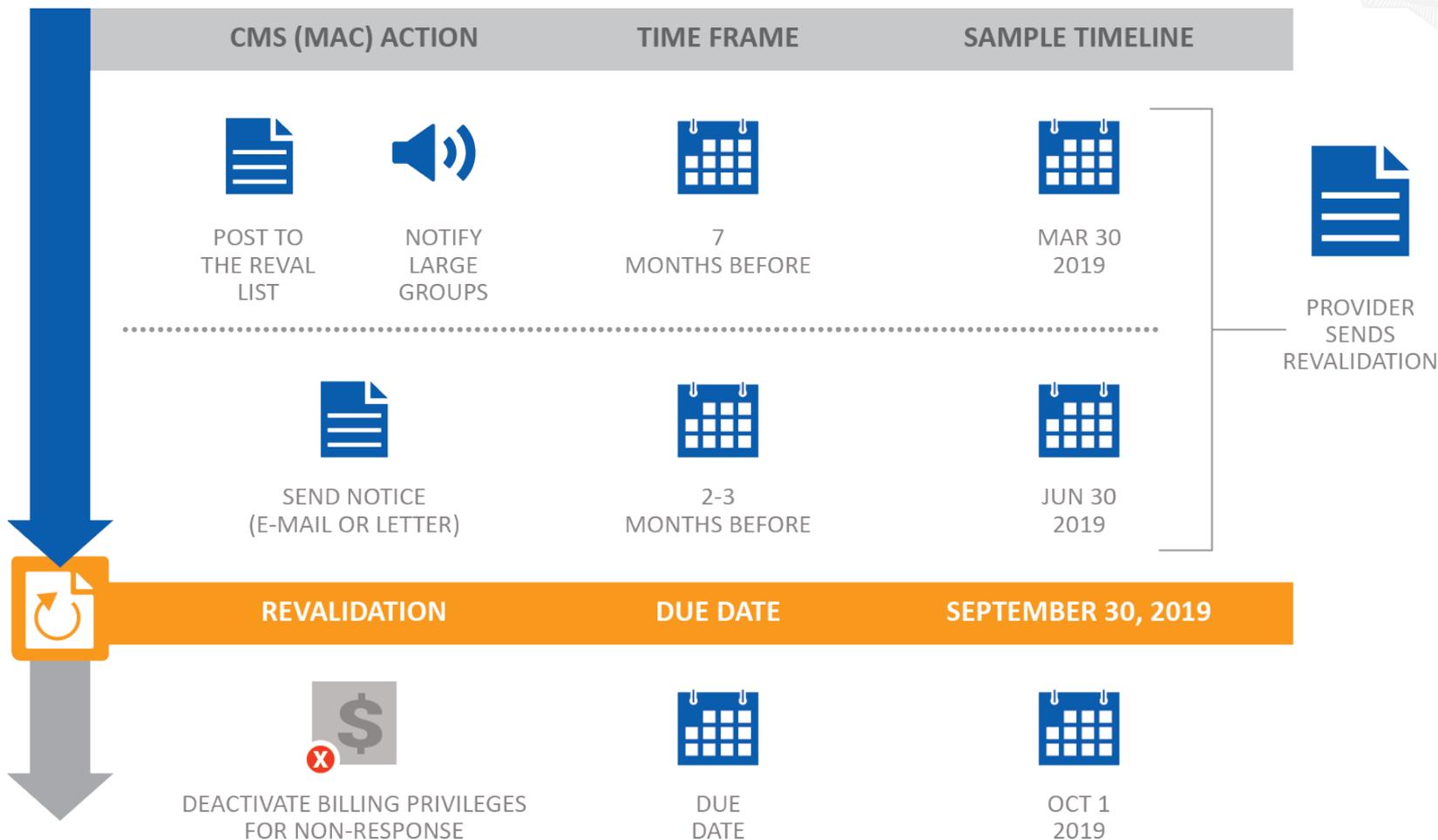


Changes received prior to revalidation

- Changes received within 7 months of revalidation due date may be processed as a revalidation, or

- Provider can choose to continue with the change in lieu of revalidation
 - MAC will process the change and proceed with revalidation process
 - Changes reported within 7 months of revalidation due date are not required to be reported on the revalidation application
 - MAC will not override the previous changes

Revalidation Timeline





Poll Question 5

Missing Reassignments - No Break in Billing



SCENARIO #1

- Revalidation application sent with missing reassignments
- Response received **before** due date

Application Received	09/01/2019
Development Letter Sent	10/15/2019
Development Due	11/15/2019
Development Received	11/10/2019
Revalidation Due	10/31/2019
Revalidation Complete	11/30/2019

- Revalidation notice includes reassignments for Groups A, B & C
- Revalidation application is received but only addresses reassignment for Group A
- MAC develops to Contact Person for missing reassignments for Groups B & C
- Provider responds with information for Groups B & C prior to the revalidation due date or the development due date (Section 1, 2, 4 & 15 of the 855I or a full 855I)
- **No break in billing**

Missing Reassignments - Break in Billing



SCENARIO #2

- Revalidation sent with missing reassignments.
- Response received **after** due date

Application Receipt	10/01/2019
Development Letter Sent	10/15/2019
Development Due	11/15/2019
Revalidation Due	10/31/2019
Reassignment End	11/15/2019
Revalidation Receipt	12/01/2019
Reactivation Effective	12/01/2019

- Revalidation notice includes reassignments for Groups A, B & C
- Revalidation application is received but only addresses reassignment for Group A
- MAC develops for missing reassignments for Groups B & C
- No response received from provider
- Group A's reassignment is revalidated. Groups B & C's reassignments are deactivated effective with the latter of the revalidation due date or the development due date
- Provider submits a reactivation application after the due date (full 855R required)
- Effective date for Groups B & C is based on receipt date of reactivation application
- **Break in billing**



Poll Question 6

Revalidation Look-up Tool



Data.CMS.gov Get Started Developers Q Sign In

MEDICARE REVALIDATION LIST

Medicare providers must revalidate their enrollment record information every three or five years. CMS sets every provider's revalidation due-date at the end of a month, and posts the upcoming six to seven months online. A due date of "TBD" means that CMS has not set the date yet.

Find a Provider

Provider Name or National Provider Identifier (NPI):

Organization Name	First Name	Last Name
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NPI

Location

Any State

All records
 Only records with due dates
 Records with due dates in the specified range

FIND PROVIDER

Access Data

[DOWNLOAD FULL DATASETS \(ZIP\)](#)

[About the tool](#)

- **All Due Dates will not be removed and will continue to be displayed on the website even after a Provider has revalidated successfully.**
- This data was last refreshed on December 22nd, 2017
- Revalidation due dates included on this list range between March 31st, 2016 and July 31st, 2018
- The next data refresh is tentatively scheduled for March 1st, 2018
- Affiliations now include Reassignments as well as PA Employment Relationships
- Data now includes DME Due Dates between November 1st, 2016 and July 31st, 2018
- DME Suppliers are identified on the downloadable file in a new column called "Enrollment Type" and are identified as "1"

Revalidation Look-up Tool



data.cms.gov/revalidation

3 Sets of Data Files

for online filtering and download as Microsoft Excel, comma-delimited text files, xml...

Online tables

Browse, search, and filter the entire list online, then save to a file. (Some advanced features of each spreadsheet are intended for data specialists)

1. Group practice members only

[A-D](#) | [E-L](#) | [M-R](#) | [S-Z](#)

Search list of all group records and their reassigned members.

2. Entire list of providers and suppliers

Search list of all provider and supplier enrollment records.

3. Reassignments and PA Employment relationships

Search list of all reassignments and employment relationships.

For data specialists: Export this table and "join" it with Table 2 to create advanced group queries. Refer to the [data dictionary \(PDF\)](#) for more options.

How to use the online tables:

1. Sort on a column by clicking its grey header
2. Search with the [Find in this Dataset] search bar
3. Filter the data by clicking the blue [Filter] button
4. Download the file by clicking the light blue [Export] button

Revalidation Look-up Tool



Looking for reassigned providers?

Use “Group practice members only”

- Sort, download and save by large groups
- Includes all individuals that reassign to the group
- Shows the individual’s total number of reassignments

Sort and filter by:

- Group Enrollment ID, State, and LBN
- Individual Enrollment ID
- Individual NPI
- Individual State
- Individual First and Last Name
- Individual Specialty Code
- Individual Revalidation Due Date
- Total Reassignments

The screenshot displays the Data CMS.gov interface for the Revalidation Look-up Tool. The table lists provider information with several columns highlighted by callouts:

Group PAC ID	Group Enrollment ID	Group Legal_Business Name	Group Due Date	Individual Enrollment ID	Individual NPI	Individual Due Date	Individual First Name	Individual Last Name
1	1189384203	A & A Audiology, Pc	TBD	100080809000172	1306861356	TBD	Tonia	Fleming
2	11759440585	A & A Chiropractic, Llc	TBD	10000015000132	1134399694	TBD	Sharon	Barnum
3	11531422056	A & A Eye Associates, Pc	06/30/2017	100101222000009	1538154588	09/30/2017	Daniel	Anderson
4	1153442205	A & A Eye Associates, Pc	06/30/2017	100081150000148	1407852296	07/01/2016	Amarca	Temnykh
5	1074425004	A & A Health Systems, Inc.	TBD	100030236000000	1063479723	TBD	Sherya	sent
6	4002802019	A & A Hearing Group, Pa	TBD	100100727000402	1596700995	08/01/2015	Ashley	Anderson
7	4002882819	A & A Hearing Group, Pa	TBD	1000106000084	1818982026	TBD	Amy	Anderson
8	0648317685	A & A Optical Inc	TBD	16000513	1548255226	TBD	Wendy	Anderson
9	0648317685	A & A Optical Inc	TBD	000005	1033002329	11/30/2015	Jessie	Anderson
10	8426342513	A & A Physicians	TBD	100000000000000	100000000000000	07/01/2017	Justin	Anderson
11	8523256590	A & A Vision	TBD	100000000000000	100000000000000	TBD	Kevin	Anderson
12	91222000	A & A Vision	09/30/2017	100000000000000	100000000000000	TBD	Kevin	Anderson
13	520000000000000	A & A Vision	09/30/2017	100000000000000	100000000000000	TBD	Kevin	Anderson
14	520000000000000	A & A Vision	09/30/2017	100000000000000	100000000000000	TBD	Kevin	Anderson
15	520000000000000	A & A Vision	09/30/2017	100000000000000	100000000000000	TBD	Kevin	Anderson
16	520000000000000	A & A Vision	09/30/2017	100000000000000	100000000000000	TBD	Kevin	Anderson
17	520000000000000	A & A Vision	09/30/2017	100000000000000	100000000000000	TBD	Kevin	Anderson
18	520000000000000	A & A Vision	09/30/2017	100000000000000	100000000000000	TBD	Kevin	Anderson
19	520000000000000	A & A Vision	09/30/2017	100000000000000	100000000000000	TBD	Kevin	Anderson
20	520000000000000	A & A Vision	09/30/2017	100000000000000	100000000000000	TBD	Kevin	Anderson
21	520000000000000	A & A Vision	09/30/2017	100000000000000	100000000000000	TBD	Kevin	Anderson
22	520000000000000	A & A Vision	09/30/2017	100000000000000	100000000000000	TBD	Kevin	Anderson
23	520000000000000	A & A Vision	09/30/2017	100000000000000	100000000000000	TBD	Kevin	Anderson
24	520000000000000	A & A Vision	09/30/2017	100000000000000	100000000000000	TBD	Kevin	Anderson
25	520000000000000	A & A Vision	09/30/2017	100000000000000	100000000000000	TBD	Kevin	Anderson
26	520000000000000	A & A Vision	09/30/2017	100000000000000	100000000000000	TBD	Kevin	Anderson

Revalidation Look-up Tool



Find a Provider

INDIVIDUAL SEARCH

Provider Name or National Provider Identifier (NPI):

Organization Name	ARMINE	SMITH
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NPI

Location

Any State

All records
 Only records with due dates
 Records with due dates in the specified range

FIND PROVIDER

Search by: Individual Last Name, First Name or NPI

search results show matching providers and # of reassignments

RECORD RESULTS

[< BACK TO REVALIDATION SEARCH](#)

MATCHING PROVIDERS

WITH FIRST NAME OF "ARMINE", LAST NAME OF "SMITH"

START OVER

Displaying records 1 – 2 of 2.

Armine Smith Due Date: TBD State: DC Total Providers: 2	SPECIALTY Urology NPI: 1871704809
Armine Smith Due Date: 03/31/2017 State: MD Total Providers: 3	SPECIALTY Urology NPI: 1871704809

RECORD

[< BACK TO PROVIDER SEARCH RESULTS](#)

ARMINE SMITH

REVALIDATION DUE DATE:
03/31/2017
LAST UPDATED DATE: JULY 1ST,
2017
STATE: MD

START OVER

Specialty
Urology
NPIs: 1871704809

Organizations this individual belongs to:

Displaying records 1 – 3 of 3.

Johns Hopkins Community Physicians Due Date: TBD State: MD Total Providers: 84	SPECIALTY Clinic/Group Practice NPI: 1770518003
Johns Hopkins Community Physicians Due Date: TBD State: MD Total Providers: 387	SPECIALTY Clinic/Group Practice NPI: 1255355972, 1578593865...
Johns Hopkins University Due Date: TBD State: MD Total Providers: 3110	SPECIALTY Clinic/Group Practice NPI: 1033190442, 1588638978...

Records include details and links to all affiliated records

(e.g. Individual records show details on affiliated organizations or providers, plus a link to the group's record)

Revalidation Look-up Tool



Find a Provider

ORGANIZATION SEARCH

Provider Name or National Provider Identifier (NPI):

Johns Hopkins Community Physician: x First Name Last Name

NPI

Location

Any State

All records
 Only records with due dates
 Records with due dates in the specified range

FIND PROVIDER

RECORD

JOHNS HOPKINS COMMUNITY PHYSICIANS

REVALIDATION DUE DATE: TBD
LAST UPDATED DATE: JULY 1ST, 2017
STATE: MD

START OVER

Individuals in this organization
Displaying records 61 - 70 of 70

Sarita Sharma
Due Date: TBD
State: MD
Total Providers: 1

Armine Smith
Due Date: 03/31/2017
State: MD
Total Providers: 3

Anjali Singh
Due Date: TBD
State: MD
Total Providers: 2

SPECIALTY
Clinic/Group Practice
NPI: 1770518003

SPECIALTY
Urology
NPI: 1871704899

SPECIALTY
Internal Medicine
NPI: 1378728170

Records will include details and links to all affiliated records

(e.g. group records show details on affiliated individuals, plus a link to the individual record)

MATCHING PROVIDERS

WITH ORGANIZATION NAME OF "JOHNS HOPKINS COMMUNITY PHYSICIAN"

RECORD RESULTS

START OVER

Displaying records 1 - 5 of 5.

Johns Hopkins Community Physicians
Due Date: TBD
State: DC
Total Providers: 335

SPECIALTY
Clinic/Group Practice
NPI: 1255359972

Johns Hopkins Community Physicians
Due Date: TBD
State: MD
Total Providers: 387

SPECIALTY
Clinic/Group Practice
NPI: 1255359972

Johns Hopkins Community Physicians
Due Date: TBD
State: MD
Total Providers: 387

SPECIALTY
Clinic/Group Practice
NPI: 1578598868

Search by: Organization Name or NPI

search results show # of reassignments

& physician assistants

Because of Your Feedback



Changes we've made

- Advanced notice of your revalidation due date
- Reassignment information on revalidation notices
- Revalidation look up tool
- Improved letters to include gap in billing language
- Extend revalidation submission to 7 months

How you can help

- Talk to your provider
- Use the revalidation look up tool
- Respond timely
- Set up your access to PECOS now
- Use PECOS to submit your revalidation



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.



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...

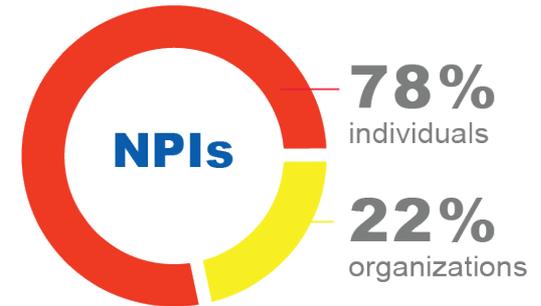
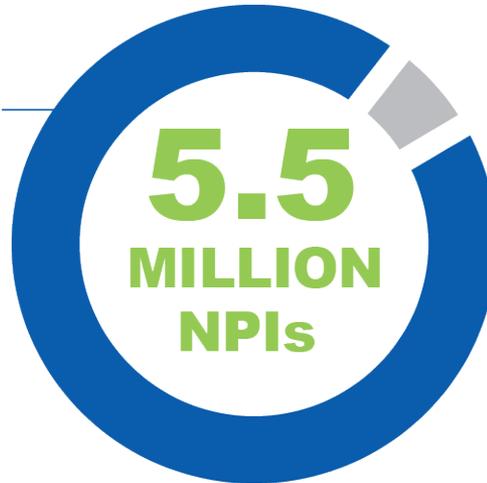
30,000

New NPIs

57,000

Updates

95%
created
online



Challenges

- Low usability / readability
- Targeted to providers, not admins
- Old technology, narrow design
- Strict customer service policies
- All lead to... **outdated records**

Recent Changes...

- New design with easier screens
- Surrogacy (like PECOS)
- More data fields
- Improved customer service

Maintain NPI Records

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

NPPES | Data Related Updates

A screenshot of the NPPES Endpoint registration form. The form is titled "Endpoint" and includes a header with a user profile icon. Below the header, there is a section for "Indicates Required Fields" and a paragraph explaining that endpoints provide a secure way for participants to send health information. A sub-section titled "More information about Endpoints and how to enter them:" contains several input fields: "Endpoint Type", "Endpoint", "Endpoint Description", "Direct Address" (with the value "Sugar.Bear@hotmail.com"), "Endpoint User", and "Endpoint Content Type". Below these fields are two radio buttons for "Is the Endpoint affiliated to another organization?" (Yes/No) and a dropdown menu for "Endpoint Location" with an "Add New Endpoint Location" button. At the bottom, there is a consent checkbox and a paragraph: "By checking this box, I provide consent that the information listed above to be shared publicly for the purpose of exchanging healthcare information electronically and that the information listed is accurate to my best knowledge." Two buttons, "CLEAR" and "SAVE", are located at the bottom right of the form.

- Endpoint (Electronic addresses) Information Collection
- EFI File Upload To Allow Large Files
- Data Dissemination supplemental Files

NPPES | User Privilege Updates



The screenshot shows the "Contact Information" form in the NPPES system. At the top, a progress bar indicates the current step is "CONTACT INFO" (step 5 of 7). The form includes several sections:

- Indicates Required fields:** Two checkboxes: "Contact Person is same as Provider" and "Contact Person is same as myself".
- Personal Information:** Fields for Prefix, First, Middle, Last, and Suffix.
- Credentials:** Fields for "Credential(s) (MD, DO, etc.)" and "Title/Position".
- Telephone Information:** Fields for Telephone Number, Extension, Contact Person Email, and Confirm Contact Person Email.
- Buttons:** "CLEAR" and "SAVE" buttons.

Below the form is a table with a filter icon and a table header:

Primary Contact...	Name	Title/Position	Telephone Number	Email	Actions
	Sam Smith	CEO	443-656-9097	Sam.smith@mercy.org	

- Allow users to add multiple contacts on the contact persons section
- Allow Delegated Officials to deactivate NPIs

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



Poll Question 7

PECOS Today



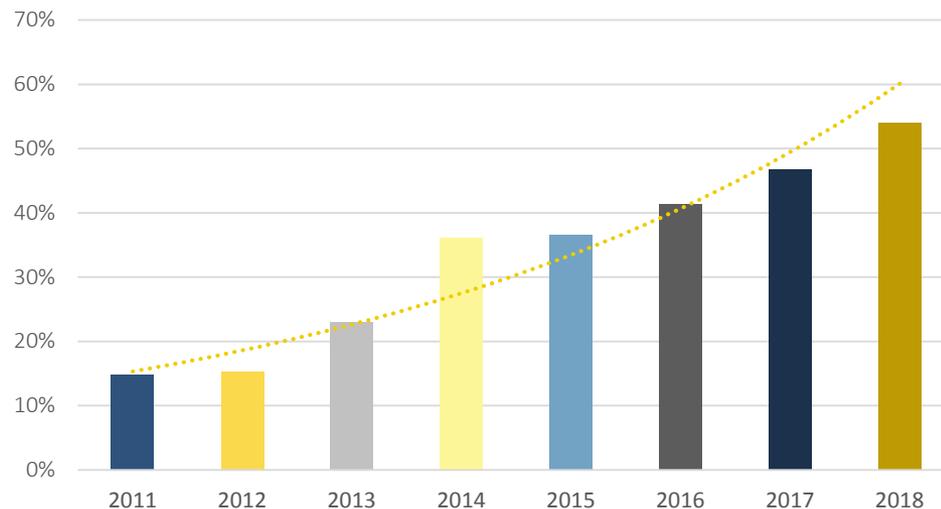
**Over 2.2 Million
Enrollments**

Every month...

17,000 new enrollments

Encouraging Online Applications

% of PECOS Web Applications by Year



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

PECOS | 2018 Enhancements



Upload Signature Documents

Home > My Associates > My Enrollments > Change of Information > Submission Process

Manage Signatures

Name: WILDMAN HEALTH PROVIDERS INC **TIN:** XX-XXXXXXX
Web Tracking ID: T010820180000068

NEW! PECOS now allows users to upload signed documents. Please upload your certification statement(s), authorization statement(s), and CMS-588 forms on this page, or after submission, by navigating to the My Enrollments page and selecting the Manage Signatures option.

Note: Users will no longer be able to mail in signature documents. Please select either Electronic or Upload.

NEW! - Any Authorized or Delegated Officials with an ITIN will not be able to submit electronic signatures. Authorized or Delegated Officials with an ITIN entered on this application **must now upload their signature documents.**

Please select a signature method for each signer:

Name: DANIEL PLAINVIEW [You] SSN: XXX-XX-XXXX * Signature Method for DANIEL PLAINVIEW: <input type="radio"/> E-Sign (Sign Now) <input type="radio"/> Upload	Role: AUTHORIZED OFFICIAL Document: ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT
Name: Newton Signer SSN: XXX-XX-XXXX * Signature Method for Newton Signer: <input type="radio"/> Electronic <input type="radio"/> Upload	Role: AUTHORIZED OFFICIAL Document: AUTHORIZED OFFICIAL CERTIFICATION STATEMENT FOR DMEPOS SUPPLIER

- Upload signature feature is now available and Paper is not an option as a signature method
- Once the user selects Upload, they will be prompted to upload each signature document
- Users can upload a signature document either during the submission process or after submitting the application



Required Signer for Submission of Organization Enrollments

Home > My Associates > My Enrollments > Change of Information > Submission Process

Select Signatories

(*) Red asterisk indicates a required field.

Signatory for Organization Enrollment

The selected Signer will be responsible the Electronic Funds Transfer Agreement and Certification Statement for the Organization Enrollment.

* Authorized Signer

Please select authorized signer
NEW AO
NEW DO
APRIL KEPNER

[NEXT PAGE](#)

[RETURN TO MY ENROLLMENTS](#)

- DOs are listed and available for selection as Authorized Signers

- DOs are included as required signers in Manage Signatures

Home > My Associates > My Enrollments > Change of Information > Submission Process

Manage Signatures

Name: SOLEIL HEALTH CENTER TIN: XX-XXXXXX
Web Tracking ID: T062120180000002

NEW! PECOS now allows users to upload signed documents. Please upload your certification statement(s), authorization statement(s), and CMS-588 forms on this page, or after submission, by navigating to the My Enrollments page and selecting the Manage Signatures option.

Note: Users will no longer be able to mail in signature documents. Please select either Electronic or Upload.

Please select a signature method for each signer:

Name: NEW AO SSN: XXX-XX-XXXX * Signature Method for NEW AO:	Role: AUTHORIZED OFFICIAL Document: AUTHORIZED OFFICIAL CERTIFICATION STATEMENT FOR CLINICS AND GROUP PRACTICES
<input type="radio"/> Electronic <input type="radio"/> Upload	

Name: NEW DO SSN: XXX-XX-XXXX * Signature Method for NEW DO:	Role: DELEGATED OFFICIAL Document: DELEGATED OFFICIAL CERTIFICATION STATEMENT FOR CLINICS AND GROUP PRACTICES
<input type="radio"/> Electronic <input type="radio"/> Upload	

[PREVIOUS PAGE](#) [NEXT PAGE](#)

PECOS | 2018 Enhancements



CMS-588



Electronic Funds Transfer (EFT)
Authorization Agreement PDF
in PECOS PI was updated to
the newer version

Medicare Enrollment
for Providers and Suppliers

Home > My Associates > My Enrollments > Application Questionnaire

View and Print Application

Printing Instructions

Each document listed below may be saved to your computer and/or printed for your personal records by clicking the "View and Print" link next to each document. Only the Certification / Authorization Statement(s) and the required supporting documentation must be printed and mailed to the Medicare contractor. Please do not mail a copy of this application to the Medicare contractor if you are submitting it electronically.

View and Print [PDF]	Authorized Official Certification Statement for Institutional Providers
View and Print	Medicare Supplier Enrollment Application Privacy Act Statement for Institutional Providers
View and Print	Supporting Documentation
View and Print [PDF]	CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement

Note:

- Documents in PDF format require the Adobe Acrobat Reader. If you experience problems with PDF documents, please download the latest version of the Reader.

PREVIOUS PAGE

Recent Enhancements | January 2019



New Physician Specialties

- Added New Physician Specialties: **Medical Genetics and Genomics**

Application Questionnaire

Primary Medicare Services Rendered (*) Red asterisk indicates a required field.

Note: A separate application is required for each primary healthcare service rendered.

* Please select the primary Medicare Services rendered by the applicant.

Part B Physician Specialties

- ENDOCRINOLOGY
- FAMILY PRACTICE
- GASTROENTEROLOGY
- GENERAL PRACTICE
- GENERAL SURGERY
- GERIATRIC MEDICINE
- GERIATRIC PSYCHIATRY
- GYNCOLOGICAL ONCOLOGY
- HAND SURGERY
- HEMATOLOGY
- HEMATOLOGY/ONCOLOGY
- HEMATOPOIETIC CELL TRANSPLANT
- HOSPICE/PALLIATIVE CARE
- HOSPITALIST
- INFECTIOUS DISEASE
- INTERNAL MEDICINE
- INTERVENTIONAL RADIOLOGY
- INTERVENTIONAL PAIN MANAGEMENT
- INTERVENTIONAL RADIOLOGY
- MAXILLOFACIAL SURGERY
- MEDICAL GENETICS AND GENOMICS
- MEDICAL TOXICOLOGY
- NEPHROLOGY
- NEUROLOGY

Practitioner Specialty

Information

- Practitioner Specialty Information was successfully added.

Topic Summary

The practitioner specialty for this enrollment is listed below for your reference. This topic allows you to identify any secondary specialties for the practitioner. (more information about Practitioner Specialty)

Practitioner Specialty Information

Practitioner Specialties

Practitioner Type: Physician

Primary Physician Specialty: MEDICAL ONCOLOGY (EDIT)

Secondary Physician Specialties: MEDICAL GENETICS AND GENOMICS (ADD) (DELETE)

Application Questionnaire

Primary Medicare Services Rendered (*) Red asterisk indicates a required field.

Note: A separate application is required for each primary healthcare service rendered.

* Please select the primary Medicare Services rendered by the applicant.

Part B Physician Specialties

- Select Physician Specialty
- PAIN MANAGEMENT
- PATHOLOGY
- PEDIATRIC MEDICINE
- PERIPHERAL VASCULAR DISEASE
- PHYSICAL MEDICINE AND REHABILITATION
- PLASTIC AND RECONSTRUCTIVE SURGERY
- PODIATRY
- PREVENTATIVE MEDICINE
- PSYCHIATRY
- PULMONARY DISEASE
- RADIATION ONCOLOGY
- RHEUMATOLOGY
- SINGLE OR MULTISPECIALTY CLINIC OR GROUP
- SLEEP MEDICINE
- SPORTS MEDICINE
- SURGICAL ONCOLOGY
- THORACIC SURGERY
- UNDERSEA AND HYPERBARIC MEDICINE
- UNDEFINED PHYSICIAN TYPE (SPECIFY)
- UROLOGY
- VASCULAR SURGERY

Practitioner Specialty

Topic Summary

The practitioner specialty for this enrollment is listed below for your reference. This topic allows you to identify any secondary specialties for the practitioner. (more information about Practitioner Specialty)

Practitioner Specialty Information

Practitioner Specialties

Practitioner Type: Physician

Primary Physician Specialty: UNDERSEA AND HYPERBARIC MEDICINE (EDIT)

Secondary Physician Specialties: (ADD)

- Added New Physician Specialty: **Undersea and Hyperbaric Medicine**



Medicare ID Look Up Tool

Medicare Enrollment
for Providers and Suppliers

R7.32 SYSTEST [CLOUD 7]
Home | Help | Log Out

Home

Welcome Anitha Jonnala

Release Notes

Want to learn what's new in the latest PECOS release? Please review the [Release Notes](#)[PDF].

System Notifications

Note: JavaScript must be enabled in your internet browser for PECOS to work properly. If JavaScript is currently disabled in your browser, refer to the Accessibility section in PECOS Help for instructions on enabling JavaScript.

Details

- Some features of PECOS are not compatible with IE 10 and IE 11 browsers. These issues can be remediated by enabling Compatibility View. For assistance, please contact your internal IT support helpdesk. For more details on this compatibility view settings for IE 10 please go to the following [site](#).
- For more details on this compatibility view settings for IE 11 please go to the following [site](#).

Manage Medicare and Account Information

MY ASSOCIATES

- Enroll in Medicare for the first time
- View and update existing Medicare information
- Continue working on saved applications

ACCOUNT MANAGEMENT

- Update your user account information, request or remove access to organizations
- Manage access to Medicare enrollments

REVALIDATION NOTIFICATION CENTER

Help

- User Account
- Manage Access

Additional Resources

- New! Medicare ID Search Tool**
- Go To Guides
- FAQs
- Glossary
- Who Should I Call? [PDF, 214 KB]
- Application Status Kiosk
- Additional Links

- From the Home Page, access the new Link for the Medicare ID Look Up tool under Additional Resources

CMS **PECOS**

Medicare ID Search Tool

Individual Search | Organization Search

First Name: Last Name: Enrollment State: NPI:

- The User is navigated from the PECOS Welcome Page to a new window where they can use the Medicare ID Search Tool



CMS-855I Revisions

MEDICARE ENROLLMENT APPLICATION
**PHYSICIANS AND
NON-PHYSICIAN PRACTITIONERS**

CMS-855I

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.
SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.
SEE SECTION 12 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION.

- Removed Country and State of birth references for associates and managing employee
- Added Employer Medicare ID to Physician Assistant Employment Arrangement
- Removed Intern and Fellowship data collection in Section 2
- Added electronic record storage field to patient record storage address
- Added new Medical Record Correspondence Address
- Cleaned up supporting documentation list



Use HRSA Data to Prepopulate FQHC Initial Enrollment Applications

Organization Name	EIN NUMB	Site Name	Physical Address
PORT LIONS HEALTH CLINIC	920038225	Akhiok Health Clinic	125 Airport Way, Akhiok, AK 99615
PORT LIONS HEALTH CLINIC	920038225	Mill Bay Clinic	2414 MILL BAY RD, KODIAK, AK 99615-6654
PORT LIONS HEALTH CLINIC	920038225	Karluk Health Clinic	26 Alex Brown Street, Karluk, AK 99608
PORT LIONS HEALTH CLINIC	920038225	Kodiak Area Native Association	3449 REZANOF DR E, KODIAK, AK 99615-6952
PORT LIONS HEALTH CLINIC	920038225	Ouzinkie Health Clinic	3rd and C Street, Ouzinkie, AK 99644
PORT LIONS HEALTH CLINIC	920038225	Larsen Bay Health Clinic	3rd Street, Larsen Bay, AK 99624
PORT LIONS HEALTH CLINIC	920038225	Port Lions Health Clinic	500 Molina, Port Lions, AK 99550
PORT LIONS HEALTH CLINIC	920038225	Old Harbor Health Clinic	500 Molina Drive, Port Lions, AK 99550
PORT LIONS HEALTH CLINIC	920038225	Port Lions Health Clinic	500 Molina Drive, Port Lions, AK 99550

Application Questionnaire

HRSA FQHC Physical Location Address

To begin the FQHC initial enrollment application process, select an available Physical Location address from the list below, or select the New Address option to enroll a location not listed. The addresses below were provided by the Health Resources and Services Administration (HRSA).

An address with a status other than Available is either already enrolled as an FQHC, or an FQHC application has been submitted for it. Please navigate to the My Enrollments page to view the status of the FQHC enrollment or application for this address.

Use a HRSA Physical Location Address

Records per page: 10 Search: []

Selected	Physical Location Address	Status
<input type="radio"/>	125 Airport Way, Akhiok, AK 99615	Available
<input checked="" type="radio"/>	2414 Mill Bay Rd, Kodiak, AK 99615-6654	Available
<input type="radio"/>	26 Alex Brown Street, Karluk, AK 99608	Available
<input type="radio"/>	3449 E Rezanof Dr, Kodiak, AK 99615-6952	Available
<input type="radio"/>	3rd and C Street, Ouzinkie, AK 99644	Approved
<input type="radio"/>	3rd Street, Larsen Bay, AK 99624	Available
<input type="radio"/>	4030 Clinic Drive, Igiugig, AK 99613	Available
<input type="radio"/>	500 Molina, Port Lions, AK 99550	Available
<input type="radio"/>	500 Molina Drive, Port Lions, AK 99550	Available
<input type="radio"/>	805 Frontage Rd, Kenai, AK 99611-9104	Awaiting Processing

Displaying 1 to 10 of 15 entries Previous 1 2 Next

Use a New Physical Location Address

If you are submitting an FQHC initial enrollment application for a physical location address not listed above, please select this option. You will enter the physical location address during the application process.

Use New Physical Location Address

PREVIOUS PAGE NEXT PAGE CANCEL

- ✓ HRSA will provide FQHC data (Physical and Mailing Addresses) to CMS
- ✓ CMS will upload data to PECOS for Selection
- ✓ PECOS will pre-populate initial enrollment applications with selected Physical and Mailing Addresses

Physician Compare



[medicare.gov/physiciancompare](https://www.medicare.gov/physiciancompare)

- Public directory of healthcare providers in Medicare.
- Based mostly on PECOS; updated twice a month

The screenshot displays the Medicare Physician Compare website. On the left is the main navigation area with the Medicare.gov logo and various search options. On the right is a detailed view of search results for "Internal medicine" within 1 mile of Los Angeles, CA. Two physicians are listed: Steven A Miles (0.00 mile) and Farshid Fararooy (0.36 mile). The results include their primary and additional specialties, addresses, and phone numbers. A search filter on the right allows users to modify their results by location and name.

Learn more: Search “physician compare” at [cms.gov](https://www.cms.gov)

Get support: PhysicianCompare@Westat.com

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

National View of Enrollment



National Profile

Displays all information about an individual, provider, or supplier in a centralized location

One Application for Multiple Enrollments

Allows providers operating in multiple states to submit one application



Enrollment Management Tools



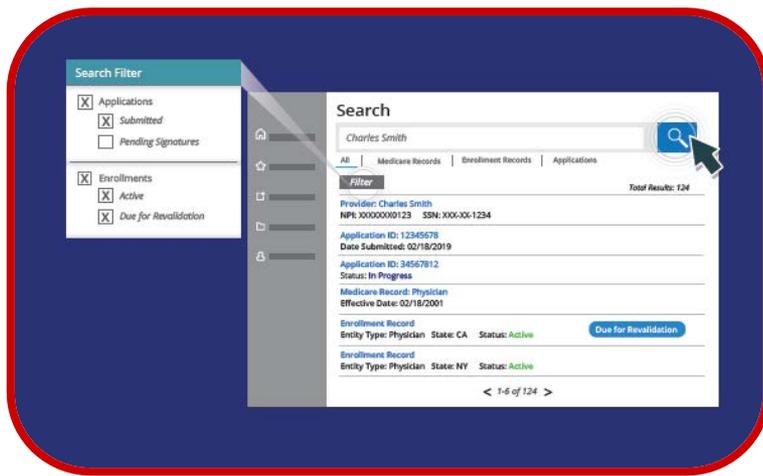
Fast and Flexible Application Submission

Offers flexibility when starting, completing, and submitting an application



Enhanced Search Capability

Enables you to search for information from anywhere within the system and refine results



You May Be Wondering



Q: When will the PECOS 2.0 improvements begin rolling out?

A: We're expecting updates to the PECOS system will be introduced in late 2020.

Q: Will this impact claims submission or payment?

A: No. These improvements will not impact billing or claims information.

Q: Will I need to do anything when these changes begin?

A: No. There is no need for Providers or their support staff to take any action.

Q: Will I still have access to all my providers and their information?

A: Yes, absolutely. The improvements and updates will not impact the data that is already in the system. You will still have access to all of the same providers and application submission functions you do today, including your revalidation information.

You May Be Wondering



Q: What enhancements to PECOS can we expect?

A: Changes will include a new look and feel, new tools for managing provider information and applications, faster processing, submitting fewer duplicate applications, and greater access to information (eg. Approval letters, and requests for information).

Q: Will I or my staff need to undergo training to learn the updates?

A: We will be working with the community via focus groups to insure the changes will be simple easy-to-use processes that should not require extensive re-training. We will also have information available to help answer questions.

Q: Does this mean I can't submit paper applications?

A: We hope to encourage as many users as possible to transition to the online system when they see the simplicity and speed. However, we will continue to allow submission of completed paper applications as we improve the system.



Question & Answer Session

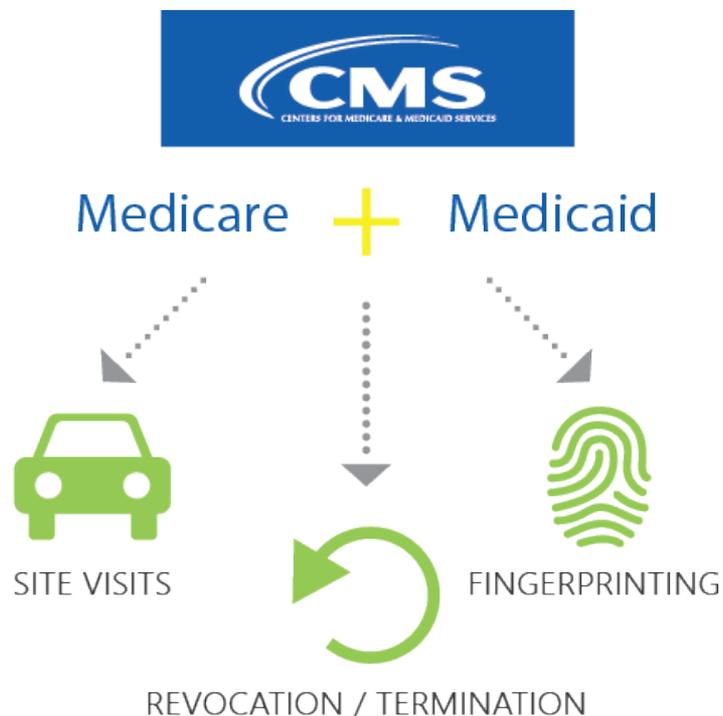


Medicaid Enrollment

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

What CMS Provider Enrollment Can / Can't Do with States



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

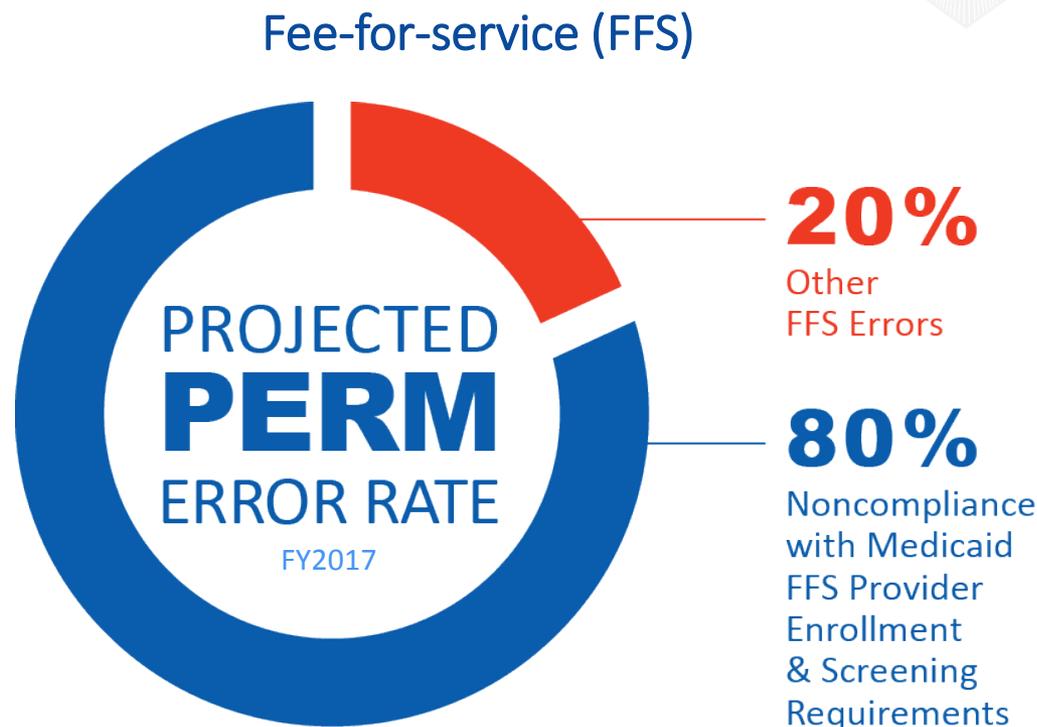


Poll Question 8

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 Updated July 2018

- 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/affordable-care-act/downloads/program-integrity/mpec-7242018.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

Retroactive Dates of Service (Section 1.6B)

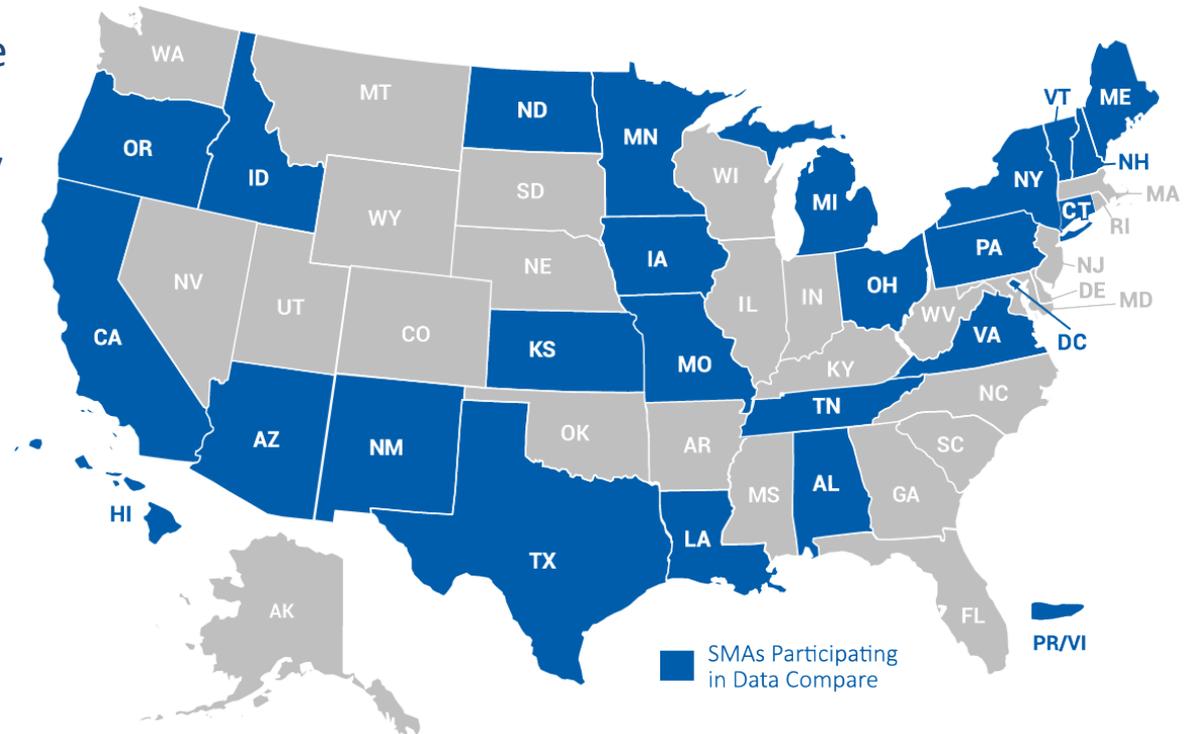
- SMA makes determination to grant a retroactive billing date based on compliance

Data Compare Service

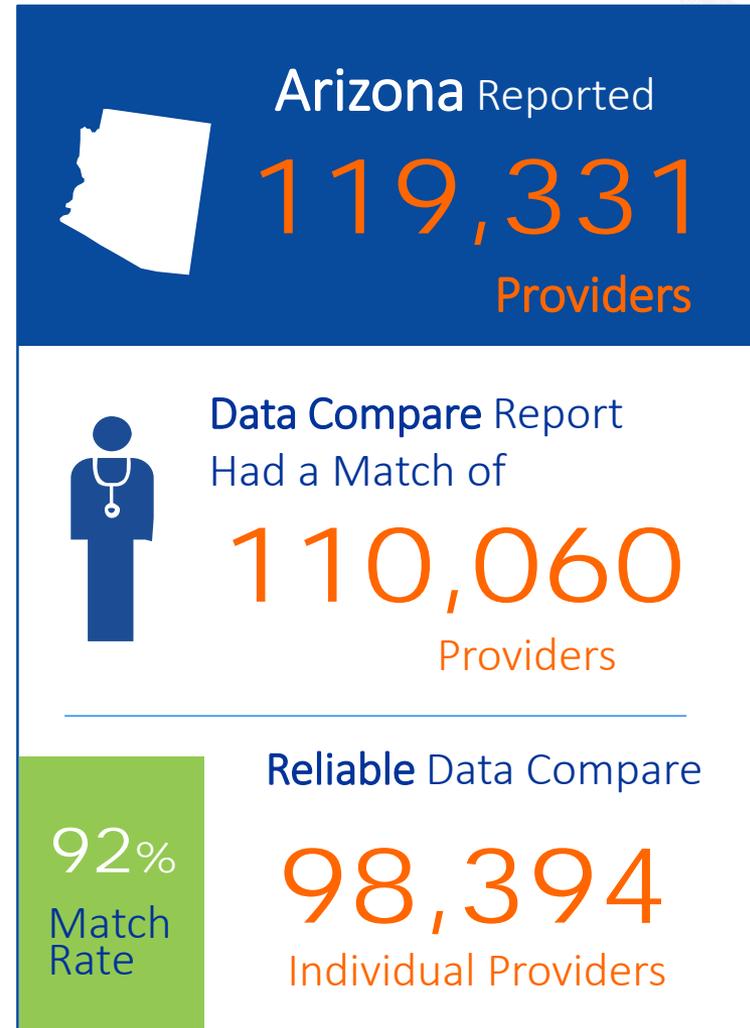
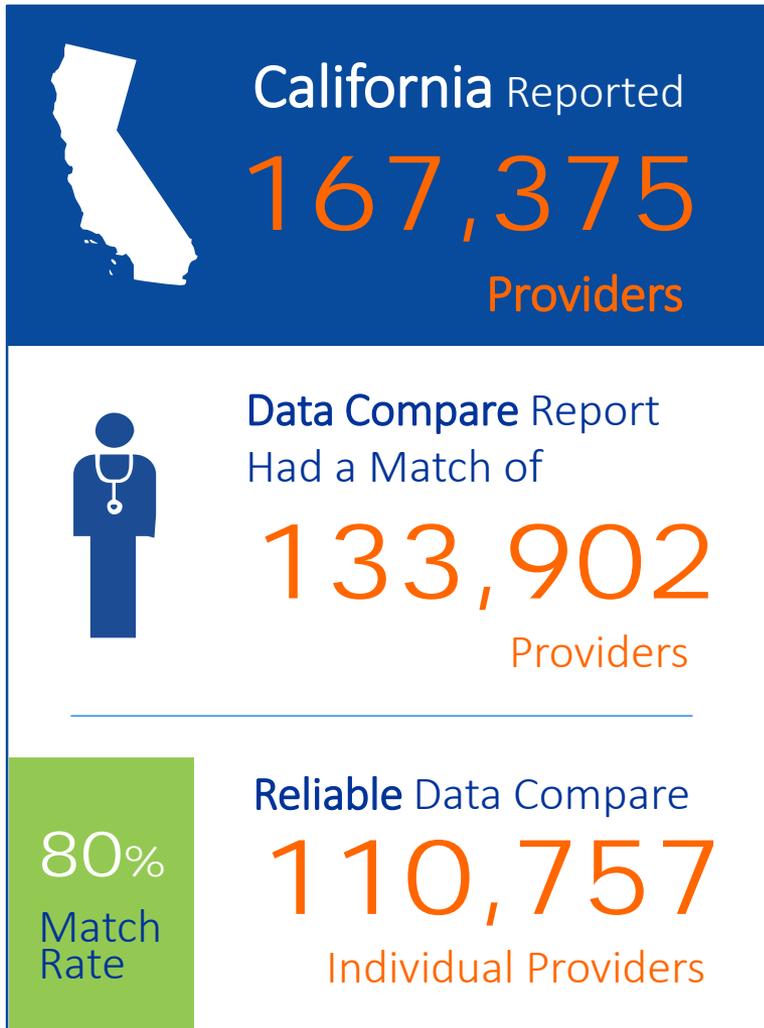


SMA that have participated in Data Compare

- 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



State Best Practices



BEST PRACTICES

Use of CMS Data Compare Service enabled Oregon to leverage Medicare screening and complete revalidation for 90% of their providers.



BEST PRACTICES

Automated checks of the Death Master File built into the online application identify inaccurate data in real time and prevent application submission.



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.

Medicaid Managed Care



CMS-2390

starts JAN 2018



Medicaid Managed Care network providers that furnish, order, refer or prescribe must:

enroll in Medicaid



Reduces Fraud

1. Ensures compliance with enrollment requirements across all programs
2. Ensures services are provided by qualified providers
3. Ensures consistency across CMS programs



Question & Answer Session



Protecting the Program

Stronger Screening



SITE VISIT



Increase Site Visits Authority: 42 CFR 424.517

- For high Medicare reimbursements
- In high risk geographic areas

ADDRESS



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

BILLING



Deactivate for Non-billing

- EXEMPTIONS: order/refer/prescribe; certain specialties e.g., pediatricians, dentists and mass immunizers (roster billers)

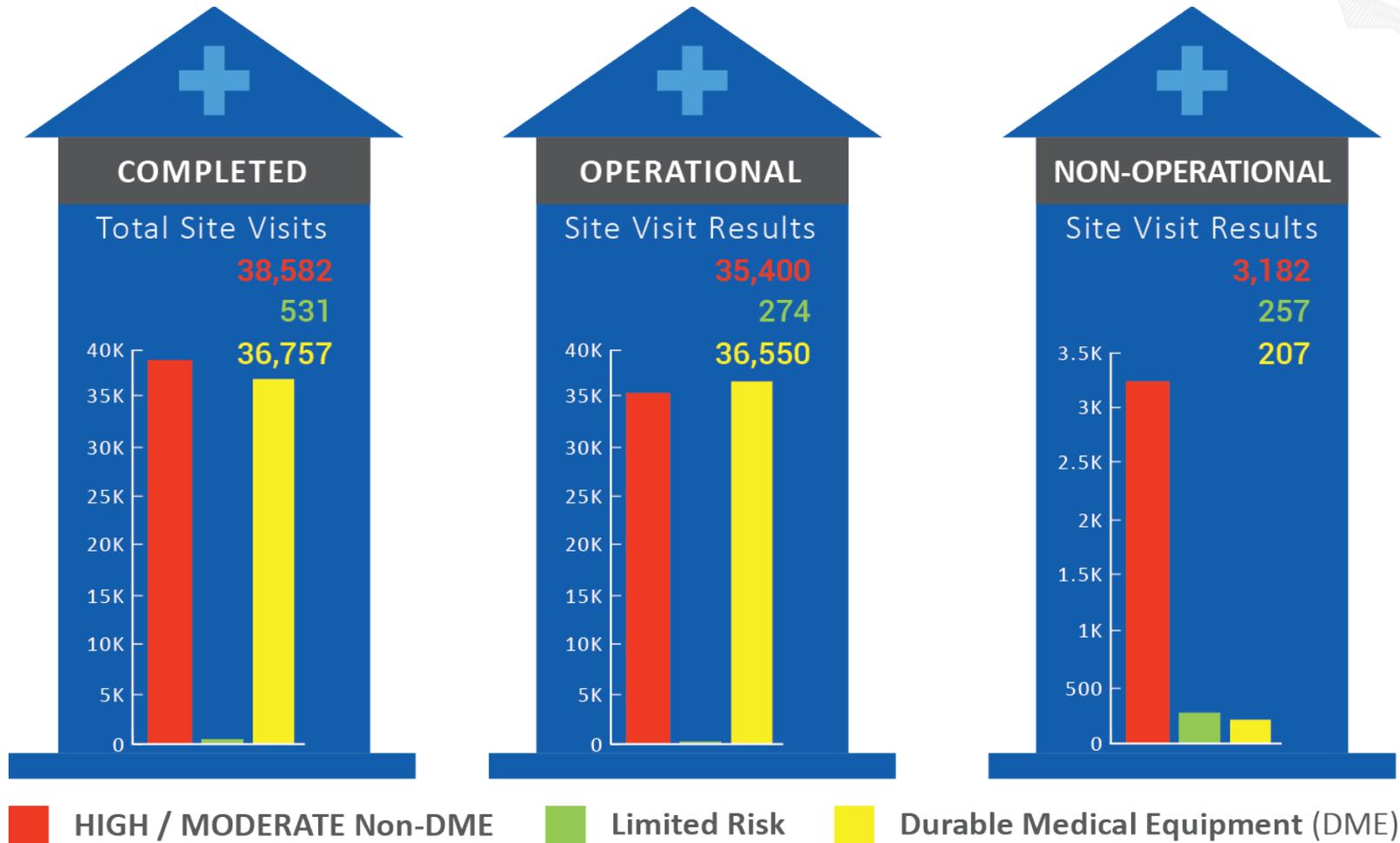
SCREEN



Screen Medicaid-only Providers

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

Site Visit Data



*FY 2018



Poll Question 9

Fingerprinting



[CMSfingerprinting.com](https://www.cms.gov/fingerprints)

Applies to:

- New HHAs
- New DME suppliers
- New MDPP suppliers
- High risk providers/suppliers

Excludes:

- Managing Employees
- Officers
- Directors

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

5%⁽⁺⁾ Ownership/Partners

in a high risk provider/supplier

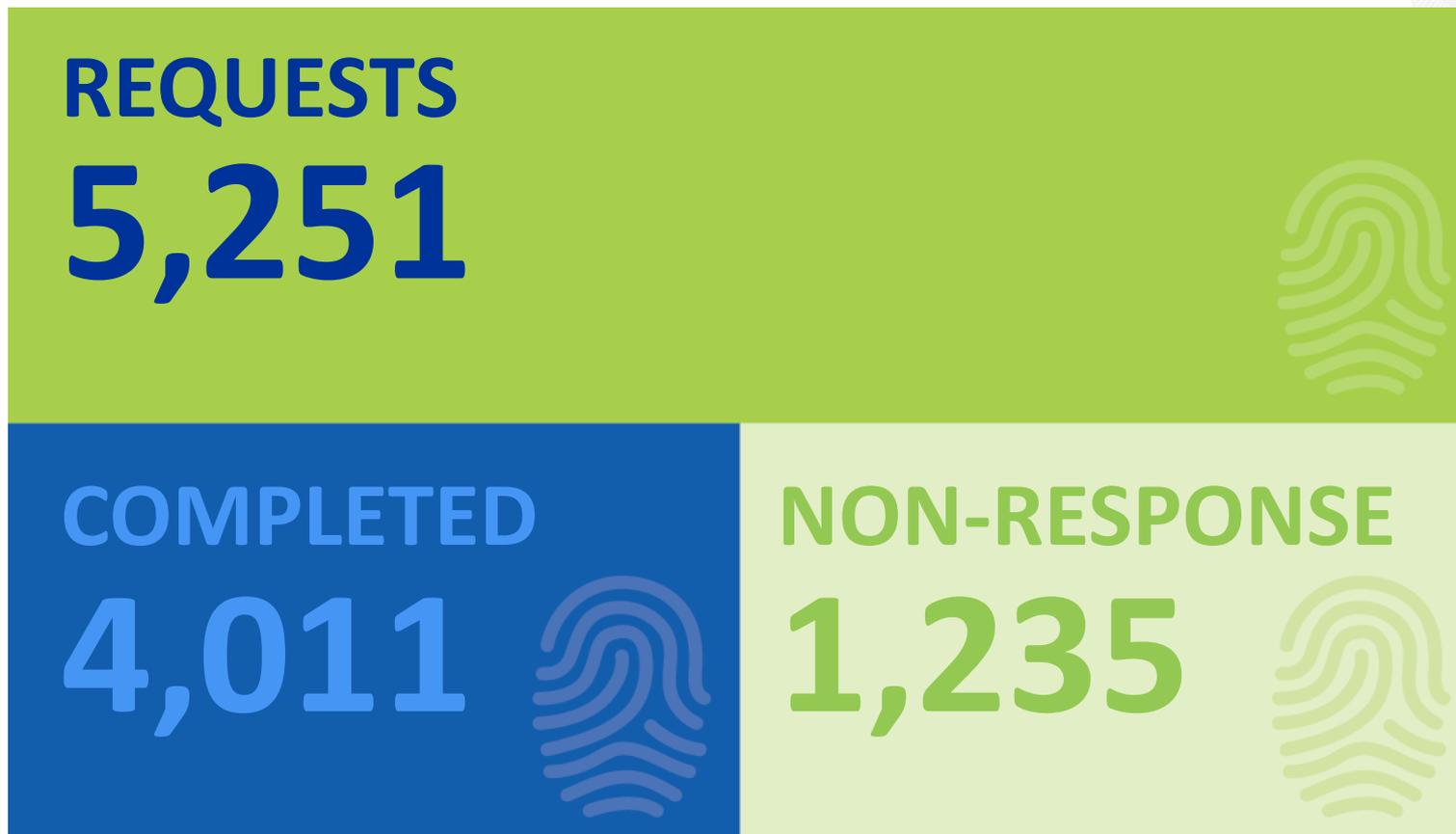
- Letter will be sent giving 30 days to get fingerprinted
- Medicare phased rollout

If the provider/supplier:

- Has a felony conviction
- Refuses fingerprinting

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

Fingerprint Data



*FY 2018

Continuous Monitoring



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



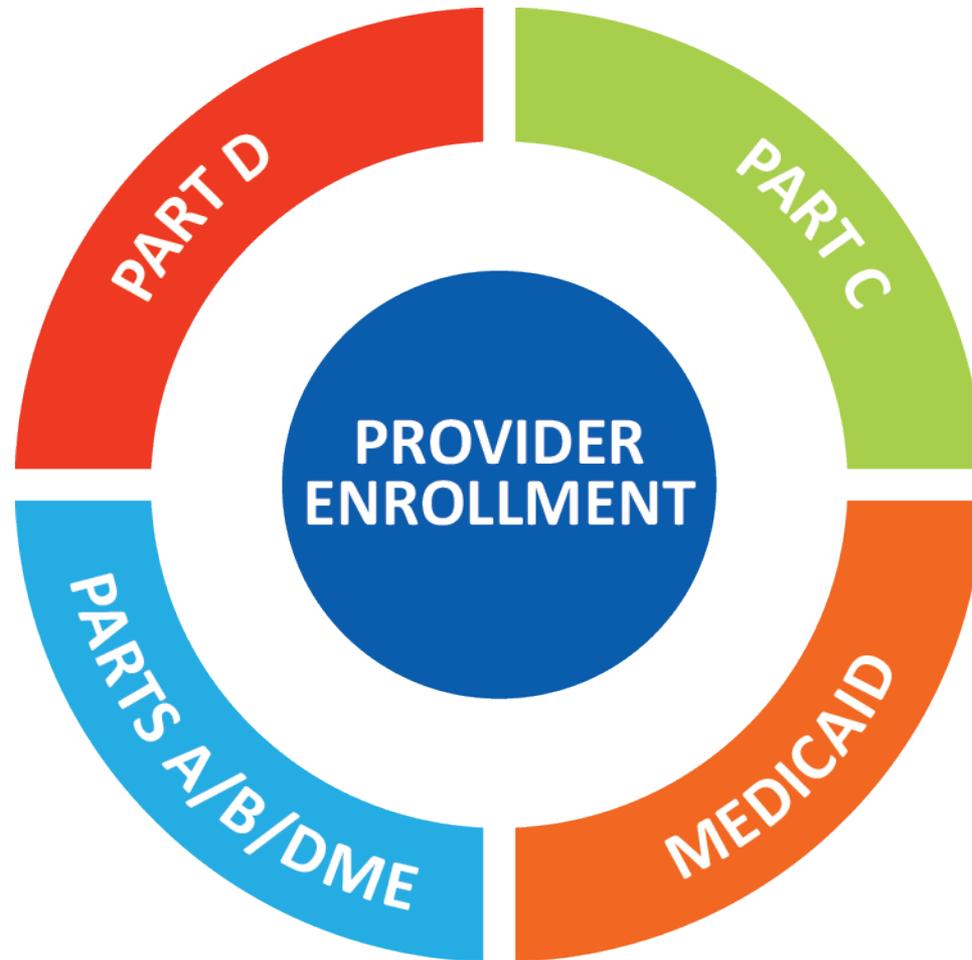
Opt Out File

- Currently opted-out of Medicare
- Updated quarterly

Connections Between All Programs



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





Poll Question 10



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*)
- 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 Medicare payment suspension (current)

X Medicare revocation (**ever**)

Deactivations and Reactivations



CMS can **deactivate** Medicare billing privileges for:

- ✗ Non-billing for 12 months
- ✗ **Failure to respond to revalidation**
- ✗ **Failure to report a change with 90 days (practice location, managing employee)***
- ✗ Failure to report a change in ownership in 30 days

To **reactivate** Medicare billing privileges:

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



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

** Reporting a change of information to the state, Regional Office, or another agency does not meet Medicare's reporting requirements and may lead to deactivation/revocation.*



DEACTIVATIONS

1,092,385

OCT 1, 2011 SEPT 30, 2018



38%

Percent deactivated for failure to respond to revalidation

Reasons to Deny



CMS can **deny** Medicare applications for:

- x **Felony conviction**
- x DEA suspended or revoked
- x Medicare payment suspension (active)
- x Excluded from federal program
- x Insufficient capital (HHA)
- x **False or misleading information**
- x Fee not paid (including if hardship exception denied)
- x **Noncompliance: program requirements**
- x **On-site review, showing noncompliance**
- x Temporary moratorium
- x **\$1,500 overpayment (current)** Unless:
 - approved repayment plan
 - offset or appeal
 - bankruptcy



DENIALS

15,190

OCT 1, 2011 SEPT 30, 2018



Reasons to Revoke



CMS can **revoke** Medicare billing privileges for:

- x Felony conviction
- x DEA suspended or revoked
- x Medicaid billing privileges terminated
- x excluded from federal program
- x pattern or practice of prescribing
- x non-operational (onsite visit)
- x insufficient capital (HHA)
- x Abuse of billing privileges
- x Misuse of billing number
- x **False or misleading information**
- x Fee not paid (including if hardship exception denied)
- x Noncompliance: document requirements
- x **Noncompliance: program requirements**
- x **Failure to report to MAC...**

...in **30 days**: ownership change, practice location change, adverse legal action

...in **90 days**: all other information

- Must report to the MAC
- Notifying a state, Regional Office, or another agency is not enough

1–3 Year
Re-enrollment bar



REVOCATATIONS
51,649

OCT 1, 2011

SEPT 30, 2018

How to Appeal



1 Corrective Action (CAP)

For all denial reasons, but only noncompliance revocation reason

Simply correct the issue:

- Send CAP within 30 days
- MAC/CMS has 60 days to process

2 Reconsideration

- Provider must appeal within 60 days
- MAC/CMS has 90 days to process

Providers can send a Reconsideration and a CAP together, but if we accept the CAP, we void the Reconsideration

3 Administrative Law Judge

4 HHS Departmental Appeals Board

5 Federal District Court

- **If denial/revocation overturned...**
Hearing officer sends letter to provider; directs MAC to reinstate them.
- **If denial/revocation upheld...**
Hearing officer sends letter to provider; provider can accept or appeal further.

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
7,283

Total Medicaid
TERMINATION
SUBMISSIONS

more than
641

Total Medicaid
TERMINATION
SUBMISSIONS
Resulting in
Medicare
REVOCATION

more than
5,482

Total Medicare
REVOCATION
FILE ENTRIES

*FY 2018



Question & Answer Session

Resources



[cms.gov](https://www.cms.gov)

- ordering and referring, DMEPOS accreditation, supplier standards
- MAC contacts: (search for Medicare enrollment contact")

[cms.gov/Revalidation](https://www.cms.gov/Revalidation)

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

[PECOS.cms.hhs.gov](https://www.pecos.cms.hhs.gov)

account creation, videos, providers resources , FAQs

[888-734-6433](tel:888-734-6433)

PECOS Help Desk

ProviderEnrollment@cms.hhs.gov

Provider Enrollment contact

FFSPProviderRelations@cms.hhs.gov

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

[cms.gov/EHRIncentivePrograms](https://www.cms.gov/EHRIncentivePrograms)

Electronic Health Record website

[cms.gov MLN Matters®](https://www.cms.gov/MLN) Articles

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



Thank You

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

Centers for Medicare & Medicaid Services