

## Overview

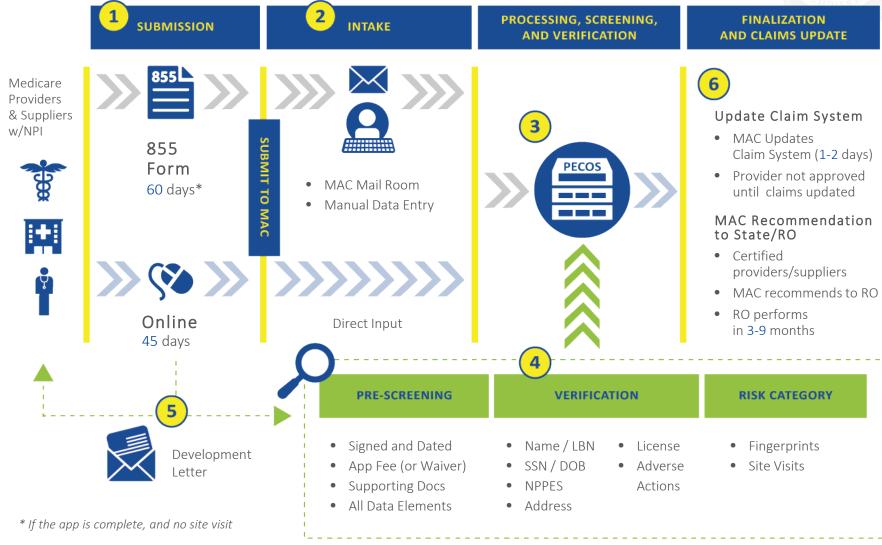
Haishan

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- DMEPOS
- Opt-Out
- Ordering and Certifying
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# How Application Submission Works





## Part B Initial Enrollment



#### Effective date is the later of:

- Application Receipt Date
- Date of first services at a new location (up to 30 days prior to application receipt)

#### Provider seeking effective date Option A: Early Submission Physicians / Groups MAC MAC **Provider performs** can apply 60 days prior \*\* receives approves service app **MAY 15** JUNF 1 APR 1 (w/ effective June 1) **MAC PROCESSING** MAR **APR** MAY JUN JUL **AUG** SEP **OCT MAC PROCESSING** Provider MAC MAC Option B: Late Submission performs receives approves Physicians / Groups service SFPT 1 app effective date up to 30 days prior to submission date \*\*\* (w/effective June 1) JUNF 1 JUIY 1

<sup>\*\*</sup> Must be in compliance at requested effective date (operational, licensed)

# Medicare Effective Dates | Part B



Scenario	Effective Date
<ul> <li>Application receipt date of 6/10/18 with app requested date of 7/01/18</li> </ul>	<ul> <li>7/01/18 (no retro, based on requested effective date on application)</li> </ul>
<ul> <li>Application receipt date of 6/10/18     with app requested date of 6/01/18     and all requirements met</li> </ul>	• 6/01/18 (based on requirements met date)
<ul> <li>Application receipt date of 6/10/18</li> <li>with app requested date of 3/01/18</li> </ul>	• 5/11/18 (30-day retro)
<ul> <li>Application receipt date of 6/10/18         with app requested date of 6/01/18,         license effective date 6/28/18</li> </ul>	• 6/28/18 (based on license effective date)

## Receipt Date Determination



# Receipt date is important in determining your effective date of Medicare billing privileges.

### **Paper Applications**

- Based on the date the MAC received the package in the mail
- MAC will develop for missing signatures

### **Web Applications**

- Date the application is submitted
- Must still e-sign or upload
- MAC will develop for missing signatures

# Part B Establishing a Reassignment



- CMS applies the Medicare billing effective date rules to the establishment of reassignments
- The effective date of a reassignment shall be the later of the date of filing or the date the reassignor first began furnishing services at the new location
- Retrospective billing date may be applied

# Part B Establishing a Reassignment



Scenario	Effective Date
<ul> <li>Applicant is enrolled as a sole proprietor and will now also reassign his benefits</li> </ul>	<ul> <li>Based on date of receipt of application</li> <li>Retrospective billing date may be applied.</li> </ul>
<ul> <li>Applicant reassigns to group A and will now reassigns to group B</li> </ul>	<ul> <li>Based on date of receipt of application</li> <li>Retrospective billing date may be applied.</li> </ul>
<ul> <li>Applicant reassigns to group A and will not be issued a new PTAN with group A</li> </ul>	<ul> <li>Based on date of receipt of application</li> <li>Retrospective billing date may be applied.</li> </ul>

# Knowledge Check



# Part B Adding or Changing a New Practice Location

### Option A:

Add location 60 days prior

#### Option B:

Submit after the effective date but within 30 day reporting requirement.

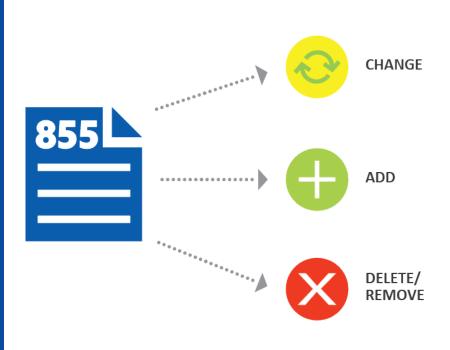
#### Option C:

Submit after the effective date, NOT within 30 day reporting requirement, however, you are now in compliance.

- In accordance with 42 C.F.R. § 424.516(d)
  - 30 day reporting requirement
- Non-compliance may result in administrative action
- PECOS will display the effective date listed on the application (not before the enrollment effective date).

# When to Select Change / Add / Delete





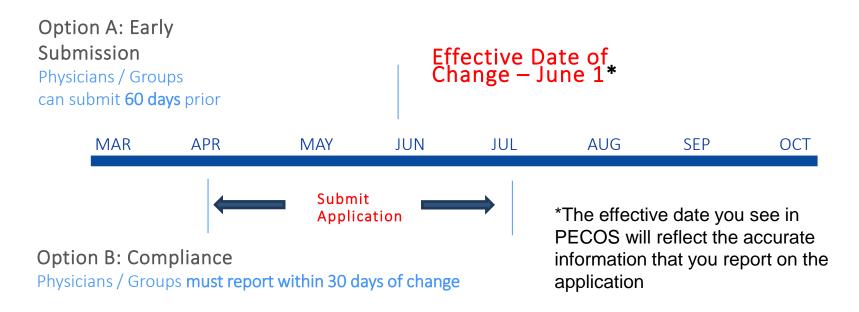
- Replace existing information with new information (ex. practice location, ownership)
- Update existing information (ex. change in suite #, telephone #)
- App fee is <u>not</u> required
- Add additional enrollment information to existing information (practice locations)
- App fee may be required
- Remove existing enrollment information
- App fee is <u>not</u> required
- Deleting a practice location in PECOS removes the special payment address and requires re-entry
- 1. Applicable CMS-855 sections (change/add/delete options)
- 2. Location information (855A/855B/855I/855S)
- 3. Ownership/Managing Control (855A/855B/855I/855S)
- 4. Billing Agency (855A/855B/855I/855S)
- 5. AO/DO (855A/855B/855S)
- 6. Attachments 1&2 (855B)

For information on which actions trigger the application fee requirement by provider/supplier type refer to the Application Fee Matrix on CMS.gov.

Refer to SE1617 for reporting requirements

# Part B Changing Owners and Managing Control

 Accuracy of Ownership and Managing Control is vital to maintain compliance and avoiding administrative action



#### **Option C: Post Compliance**

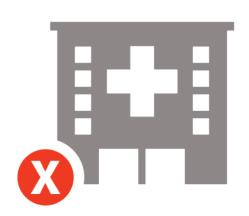
Physicians / Groups must report within 30 days of change not submitted within 30 day reporting requirement, however, you are now in compliance

# Part B Voluntary Withdrawal

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- You will no longer be rendering services to Medicare patients
- You are planning to cease (or have ceased) operations
- You are relocating to another state and no longer intend to practice in the current state







# Part B Voluntary Withdrawal



- The date you see in PECOS will be the day AFTER the voluntary termination date you put on the application.
- One party (individual or organization) cannot voluntary an enrollment on behalf of the other
- If the organization terminates an individuals on active PTAN, the individual has 90 days to report update information prior to deactivation

# Part B Terminating a Reassignment



- One of the two parties (individual or organization)
  must report the voluntary termination of Medicare
  billing privileges within 90 days of the change of
  information.
- The date you see in PECOS will be the day AFTER the voluntary termination date you put on the application.

# Knowledge Check



## **Deactivation Effective Dates**



- Deactivation of enrollment will only happen in accordance with one of the following regulatory deactivation authorities
- It will not happen without prior notice.

#### 424.540 Deactivation of Medicare billing privileges

- (1) Non billing
- (2) Provider or Supplier does not report a change of information
- (3) Provider or Supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application.

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### 424.540 Deactivation of Medicare billing privileges

## (1) Non Billing



- At a minimum the provider must not bill or order and refer for 12 full months.
- The MAC will send a letter at a minimum of 5 days in advance.
- The <u>deactivation effective date</u> is prospective and will be listed on the letter.

## 424.540 Deactivation of Medicare billing privileges

(2) Provider or Supplier does not report a change of information

- If the provider is found to be in non-compliance with reporting requirements.
- The MAC will send a letter at a minimum of 5 days in advance.
- The <u>deactivation effective date</u> is prospective and will be listed on the letter.

### 424.540 Deactivation of Medicare billing privileges

(3) Provider or Supplier Fails to Respond to a Request from CMS

- Revalidation authority
- DOES apply to off-cycle revalidation
- Does <u>NOT</u> happen without prior notice
- Provider given a minimum of 7 months notification

# Part B Reactivating an Enrollment



- Reactivation is essentially the <u>SAME</u> as initial enrollment
- Effective date is limited to the date of receipt of the application
  - Retrospective billing date <u>DOES</u> apply
- The ONLY situation that you keep you PTAN, is reactivation from non-response to revalidation

## Part B Reactivating a Reassignment



- Effective date is limited to the date of receipt of the application
- Retrospective billing date DOES apply



# Question & Answer Session

## Part A Initial Enrollment



Provider seeking effective date SEPT 1, 2018

Hospitals / HHAs / SNFs can apply up to 180 days prior \*\*

MAC receives app
APR 1, 2018

MAC recommends approval to State/RO JUNE 1, 2018 State survey completed DEC 1, 2018

RO approves, w/ effective date DEC 1, 2018 when RO determined all requirements were met

**PROCESSING** 

STATE/RO PROCESSING

APR '18

JUN'18

SEPT'18

DEC '18

JAN '19

APR '19

<sup>\*\*</sup> Must be in compliance at requested effective date (operational, licensed)

# Part A Practice Location Changes



#### Option A:

Add location 60 days prior

#### Option B:

Submit after the effective date but within 90 day reporting requirement.

- In accordance with 42 C.F.R. § 424.516(e)
- 90 day reporting requirement
- Non-compliance may result in administrative action
- No survey required in most case
- The CCN/PTAN effective date will remain the original date
- PECOS will reflect what is reported on the application

#### Option C:

Submit after the effective date, NOT within 90 day reporting requirement, however, you are now in compliance.

# Part A Changes of Ownership



- No survey required
- CHOW effective date must match the bill of sale
- The CCN/PTAN effective date will remain the original date

# DMPOS Initial Enrollment and Additional Practice Locations



- Compliance is KEY
- Medicare billing effective date = date the NSC has verified the supplier's compliance with all standards and regulations and completed the overall enrollment process.

# **DMPOS TIN Changes**



#### Total ownership change –

- New PTAN issued
- The effective date of the new Medicare ID may be retroactive to the date of the bill of sale
  - The previous Medicare ID will be deactivated the date of the bill of sale regardless of the effective date of the new Medicare ID.

#### Same Owners different TIN –

- The NSC will work with the supplier to establish the effective date of the new Medicare ID and will deactivate the previous ID with the same date
- New PTAN issued

### **DMPOS** Reactivations



- Reactivation effective date = Date of deactivation,
  - <u>Except</u> for suppliers that were deactivated for non-billing or that voluntarily terminated enrollment
  - Must be in compliance with all standards and regulations at that date.
- Not in compliance on deactivation date, then the reactivation date = date confirmed to be in compliance.
  - Retroactive date will not exceed 12 months prior to the deactivation date due to the claims filing deadline requirement.
- For suppliers that <u>were</u> deactivated for non-billing or that voluntarily terminated, = date the reactivation application was received

## Opt-Out



# Physicians/practitioners who do not wish to enroll in the Medicare program may "opt-out"

#### What this means:

- The physician/practitioner nor the beneficiary submits a bill and is reimbursed by Medicare for services rendered (beneficiary pays out-of-pocket)
- A private contract is signed between the physician/practitioner and the beneficiary
- The physician/practitioner submits an affidavit to Medicare to opt-out of the program

## Opt-Out



- Participating physicians and Non-Physician Practitioners
  - Opt Out Affidavit is received <u>at least 30 days prior</u> to the first day of the next calendar quarter (1/1, 4/1, 7/1 or 10/1)
    - Opt Out effective date will be the first of the next quarter
  - Affidavit submitted <u>within</u> 30 days prior to the next calendar quarter (example 9/18 receipt date), the *following* calendar quarter, 1/1 would apply
- Non-Participating Physicians and NPPs
  - Opt Out Effective date is the date the physician/NPP signs the affidavit that meets the requirements

# Impacts of Opting-Out

- THOIS WALLS
- May not receive direct or indirect Medicare payment for services furnished to Medicare beneficiaries
  - Traditional Medicare fee-for- service
  - Under a Medicare Advantage plan
- Cannot terminate early unless opting out for the first time and within 90 days after the effective date of the opt-out period
  - Locked in for 2 years if you miss the 90 day window
- May order or certify items and services or prescribe
   Part D drugs for Medicare beneficiaries
  - NPI
  - Date of Birth
  - Social Security Number
  - Confirmation if an Office of Inspector General (OIG) exclusion exists

# Ordering and Certifying





Effective date is the date of receipt



CMS-8550 is a national enrollment



Providers who relocate to another state are not required to dis-enroll in the current state and re-enroll in the new state



The MAC that maintains the CMS-8550 enrollment in PECOS will process the change of information, even if the provider is relocating to a state outside of their jurisdiction



The MAC will update the provider's record with any new licenses and/or certifications obtained as a result of the provider's relocation

## Participation vs Non-Participation



- A physician, practitioner or supplier can submit a CMS-460 form upon
  - Initial Enrollment
    - Participation effective date = Effective date of the enrollment

OR

- Open Enrollment (usually mid-November to December 31)
  - Participation effective date = Date indicated on the form



# Question & Answer Session

## Resources



#### cms.gov

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

#### cms.gov/Revalidation

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

#### PECOS.cms.hhs.gov

account creation, videos, providers resources, FAQs

#### ProviderEnrollment@cms.hhs.gov

Provider Enrollment contact

#### FFSProviderRelations@cms.hhs.gov

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

#### cms.gov/EHRIncentivePrograms

Electronic Health Record website

#### cms.gov MLN Matters® Articles

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



## Thank You

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Centers for Medicare & Medicaid Services