



NATIONAL PROVIDER  
ENROLLMENT CONFERENCE

59 Million Patients, 2 Million Providers, ONE Mission

# PROVIDER ENROLLMENT 101

## MARCH 2019

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# Overview



## Morning Session

- Introduction to Medicare
- Provider Enrollment Overview
- Submission
- Intake
- Processing, Screening and Verification
- Finalization and Claims

## Afternoon Session

- Provider Enrollment Policy





# Poll Question 1

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# Poll Question 2

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# Introduction to Medicare

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# What is Medicare?

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## **Medicare is a federal health insurance program for:**

- People 65 and older,
- Certain younger people with disabilities, and
- People of any age with End-Stage Renal Disease

## **Different parts of Medicare help cover specific services (A, B, C and D)**

# Medicare Part A (Hospital Insurance)

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**Part A** covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care

- Hospital
- Federally Qualified Health Center
- Community Mental Health Center
- Skilled Nursing Facility
- Home Health Agency

# Medicare Part B (Medical Insurance)

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**Part B** covers certain doctors' services, outpatient care, medical supplies, and preventive services

- Physician/Non-Physician Practitioner Services
- Clinic/Group Practices
- Independent Diagnostics Testing Facilities (IDTF)
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers
- Medicare Diabetes Prevention Program (MDPP) suppliers

# Medicare Part C (Medicare Advantage Plans)

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**Part C** provides Part A and Part B benefits offered by a private company that contracts with Medicare

- Health Maintenance Organizations
- Preferred Provider Organizations
- Private Fee-for-Service Plans
- Special Needs Plans
- Medicare Medical Savings Account Plans

# Medicare Part D (Prescription Drug Coverage)

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**Part D** offers coverage for prescription drugs

- Original Medicare
- Some Medicare Cost Plans
- Some Medicare Private Fee-for-Service Plans
- Medicare Medical Savings Account Plans



# Poll Question 3

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# What is a Medicare Administrative Contractor (MAC)?

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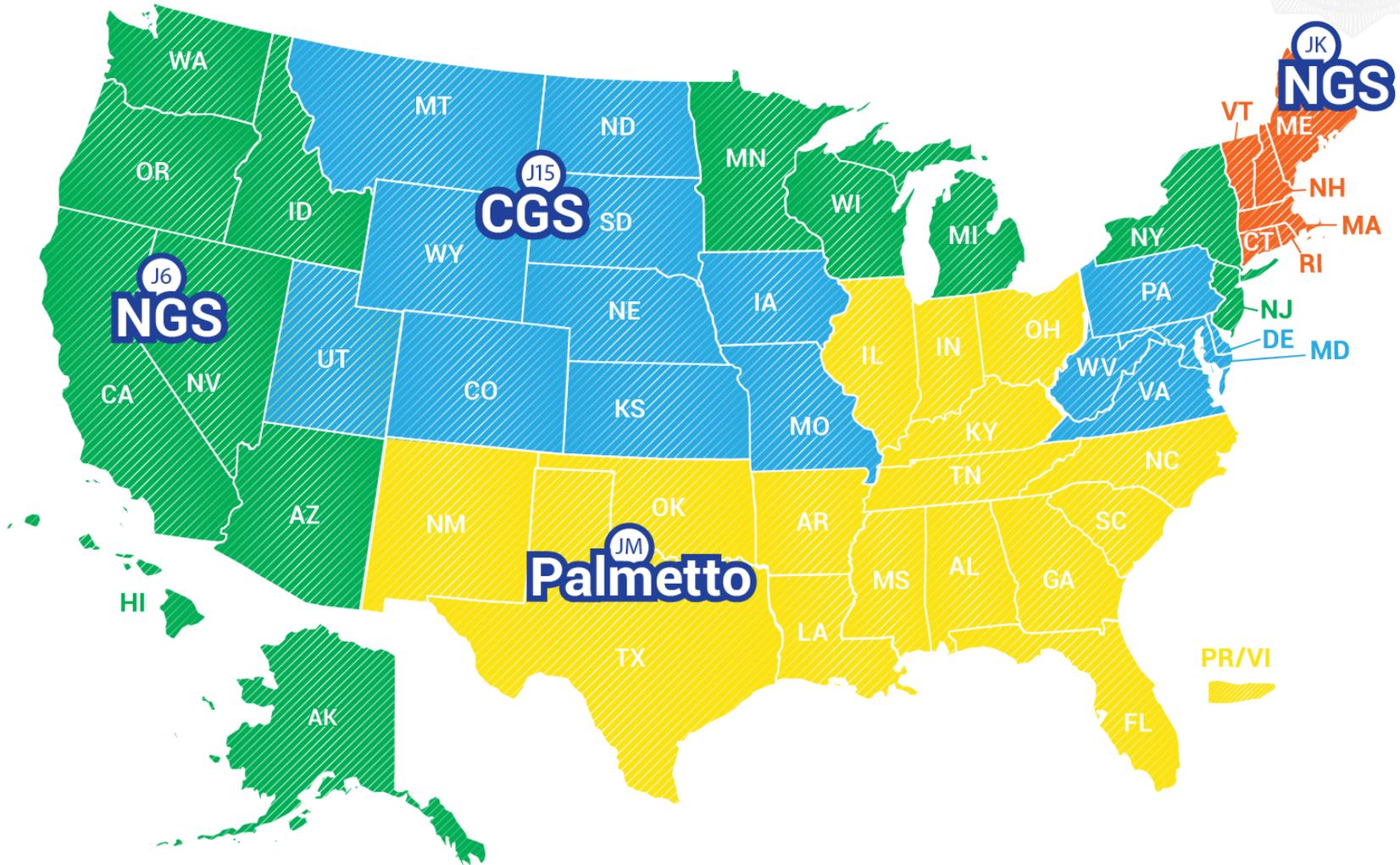


A private health care insurer that has been awarded a geographic jurisdiction to:

- Enroll providers in the Medicare program
- Process Medicare claims (Part A/B and DME)
- Respond to provider inquiries
- Educate providers about Medicare billing requirements



# Home Health & Hospice MACs



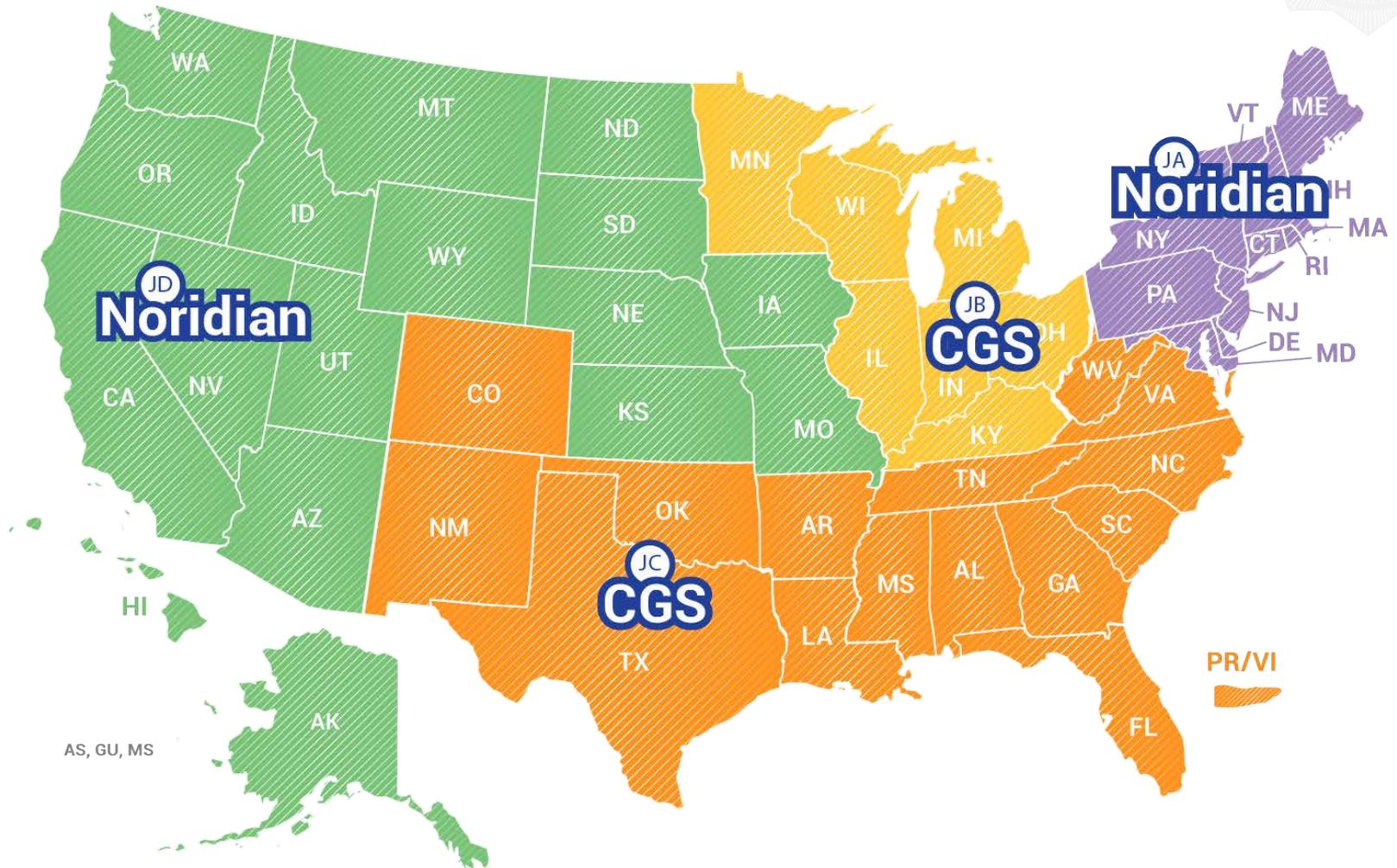
# What is the National Supplier Clearinghouse (NSC)?

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- National contractor responsible for enrolling all DME suppliers
- Ensures that DME suppliers meet and maintain all Federal and State requirements to bill the Medicare program
- Claims are processed by 4 DME MACs

# DME MACs





# Question & Answer Session

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# Provider Enrollment Overview

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# Provider Enrollment Regulations / Statutes

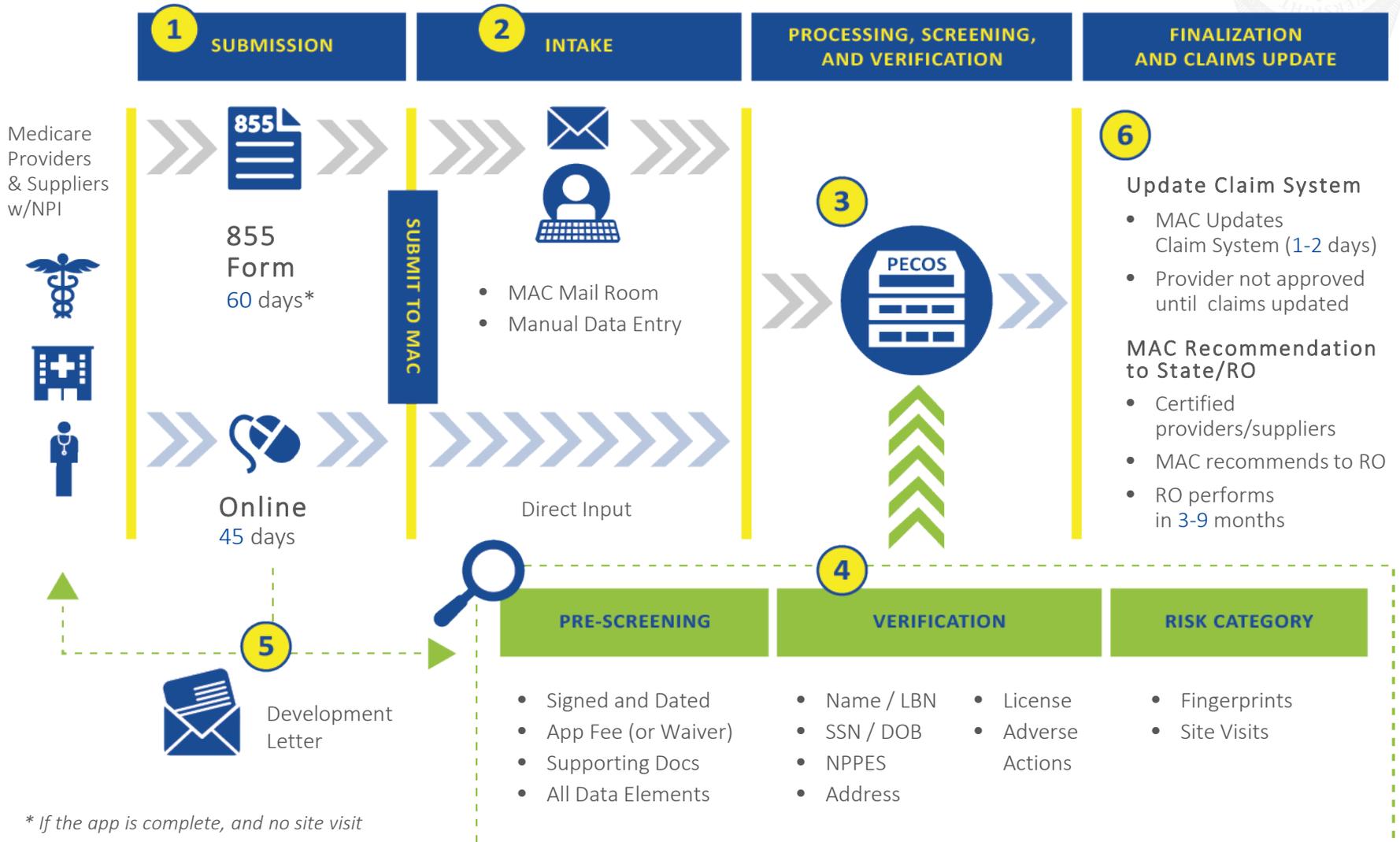
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## **Establishes enrollment requirements, conditions for participation and payments**

- The Social Security Act (1861)
- Federal regulations (42 CFR 424)
- Program Integrity Manual 100-08, Chapter 15

# How Enrolling Works

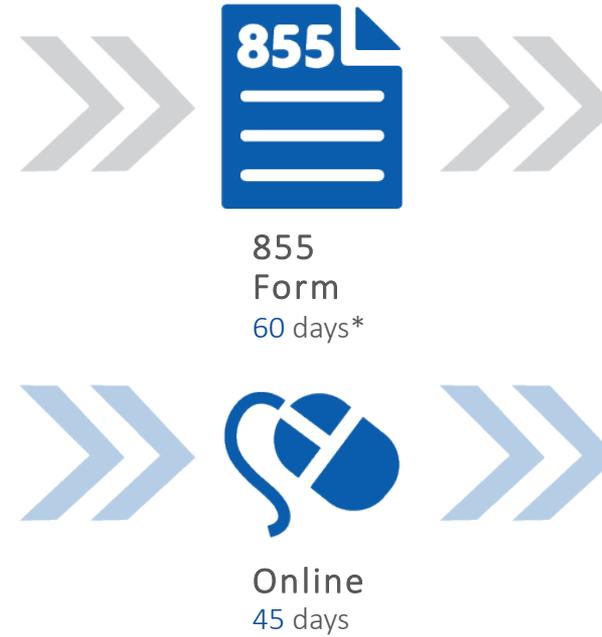
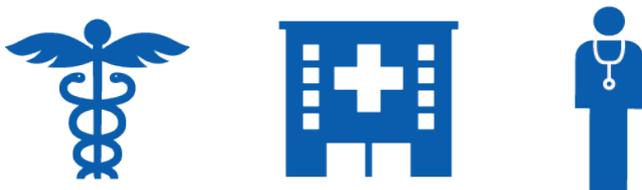


# Submission



## 1 SUBMISSION

Medicare Providers & Suppliers w/NPI



*\* If the app is complete, and no site visit*

# National Provider Identifier



- **Type 1**

Individual healthcare providers (i.e., physicians, dentists, chiropractors, physical therapists)

- **Type 2**

Organizational healthcare providers (i.e., hospitals, home health agencies, clinics, labs, group practices, suppliers of durable medical equipment)

**Providers must obtain an NPI prior to enrolling in the Medicare Program.**

**Healthcare providers can apply for NPIs in one of three ways:**

- Online via National Plan & Provider Enumeration System (NPPES)
- Paper NPI Application/Update Form (CMS-10114)
- Electronic File Interchange (EFI) whereby an approved EFI Organization can submit the healthcare provider's application on their behalf (i.e., through a bulk enumeration process).

NPPES Registry (for online queries):

<https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do>

# Taxonomy Codes vs. Specialty Types



## Taxonomy Codes

- Providers select a taxonomy code when applying for an NPI
- Uniquely identifies providers in order to assign them NPIs, not to ensure that they are credentialed or qualified to render health care
- May or may not be the same category used by Medicare for enrollment purposes

## Specialty Types

- Self-designated on the CMS-855 application
- Describes the specific type of medical practice or services provided
- Used by CMS for enrollment and claims processing

# Taxonomy / Specialty Crosswalk

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- CMS crosswalks the types of providers/suppliers who are eligible to enroll in Medicare with the appropriate taxonomy codes
- Can be accessed at [data.cms.gov/Medicare-Enrollment/CROSSWALK-MEDICARE-PROVIDER-SUPPLIER-to-HEALTHCARE/j75i-rw8y](https://data.cms.gov/Medicare-Enrollment/CROSSWALK-MEDICARE-PROVIDER-SUPPLIER-to-HEALTHCARE/j75i-rw8y)
- Updated on a quarterly basis

# CMS-855 Enrollment Applications



- **CMS-855A** Institutional Providers (Part A)
- **CMS-855B** Clinics/Group Practices and Certain Other Suppliers  
*(Part B, non-DME Suppliers)*
- **CMS-855I** Physicians and Non-Physician Practitioners  
*(Part B, non-DME Individuals)*
- **CMS-855R** Reassignment of Medicare Benefits  
*(Supplemental to CMS-855I form)*
- **CMS-855S** Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) *(Part B, DME Suppliers)*
- **CMS-855O** Eligible Ordering, Referring and Prescribing Physicians and Non-Physician Practitioners  
*(Part B, Part-D and non-DME Individuals)*
- **CMS-20134** Medicare Diabetes Prevention Program (MDPP) Suppliers  
*(Part B, non-DME Suppliers)*

# Authorized and Delegated Officials



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



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)*

# Who Can Sign the Enrollment Application?



**Initial:**

**A**  **AUTHORIZED OFFICIAL**

**B**

**S**

**Changes & Revals:**

**AO**  **AUTHORIZED OFFICIAL**

**OR**

**DO**  **DELEGATED OFFICIAL**

**All:**

**I**  **INDIVIDUAL PROVIDER**

**O**

**Adding:**

**IP**  **INDIVIDUAL PROVIDER**

**+**

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

**Changing / Terminating:**

**IP**  **INDIVIDUAL PROVIDER**

**OR**

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

# Application Fees



Application fee for 2019 is \$586

- Supports provider enrollment and screening activities
- Required for institutional providers when initially enrolling, revalidating or adding a practice location Home Health Agencies, DME supplier, Hospital, IDTF
- Application fee varies from year-to-year
- Must be paid electronically via PECOS
- Credit or debit card (no checks permitted)
- MACs will develop for missing application fees and reject the application if not submitted within 30 days

## Refund Request

### A refund may be issued if...

1. A hardship exception request is approved
2. The application was rejected prior to the MAC's initiation of the screening process
3. The application denied due to temporary moratorium
4. Fee not required for the transaction in question or not part of an application submission

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

*Pay the application fee at <https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do>*



# Poll Question 4

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- All providers must receive Medicare payments via EFT
- Must include a copy of a voided check or bank letter verifying account information
- Providers who reassign all of their benefits to a group are *not* required to submit an EFT agreement



### Participation

- Medicare reimbursement is 5 percent higher than nonparticipating physicians and other suppliers
- Medicare issues payments directly to you because the claims are always assigned

### Nonparticipation

- Medicare reimbursement is 5 percent lower than participating physicians and other suppliers
- You cannot charge the beneficiary more than the limiting charge, 115 percent of the Medicare Physician Fee Schedule amount
- You may accept assignment on a case-by-case basis



- New Enrollee (Initial)
- Change of Information
- Revalidation
- Reactivation
- Voluntary Withdrawal

# New Enrollee (Initial)

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- **Welcome to Medicare!**
- You are submitting an application to initially enroll in the Medicare program or to initially enroll in a new MAC jurisdiction
- Must submit a complete application



# Poll Question 5

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# Question & Answer Session

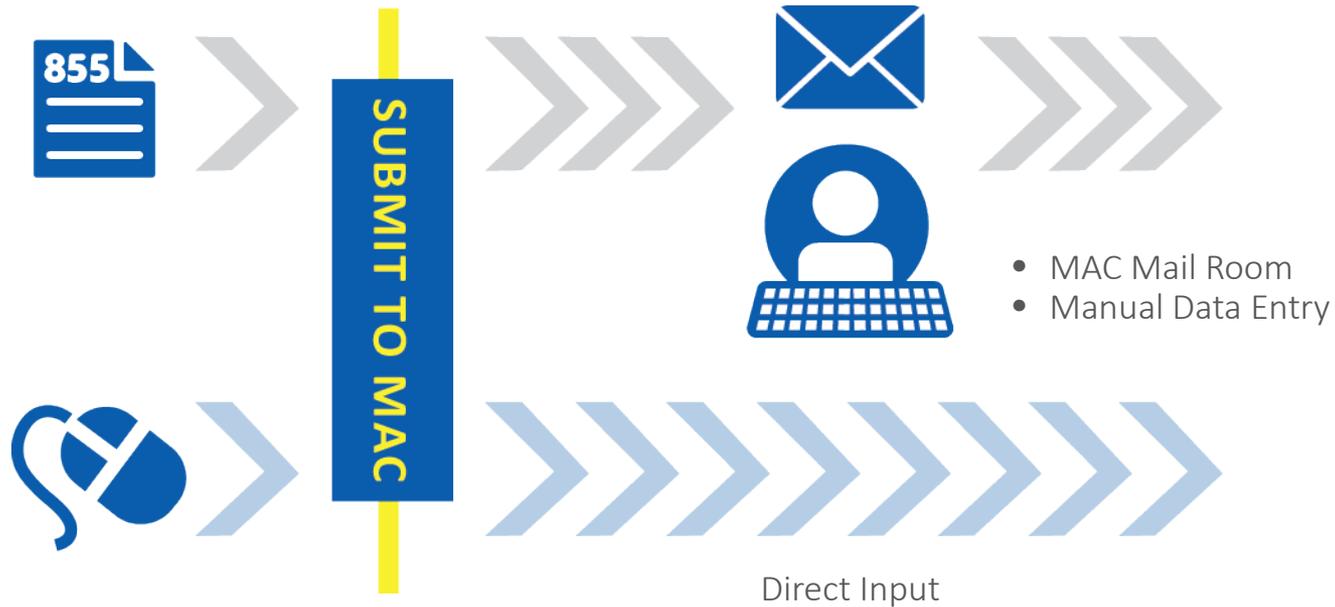
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# Intake



2

## INTAKE



# Receipt Date Determination



**Receipt date is important in determining your effective date**

## **Paper Applications**

- Based on the date the MAC received the package in the mail
- MACs will no longer accept handwritten applications *(late 2019)* ★

## **Web Applications** *(October 2018)* ★

- Based on the date the MAC received the web submission in PECOS
- Must be e-signed or signature uploaded

# Impacts to Receipt Date

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## **Fingerprints**

- The date fingerprint results are received

## **Hardship Waiver Approval**

- The date CMS notifies the MAC that the hardship waiver is approved



# Poll Question 6

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# Medicare Effective Dates | Part B



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  
JUNE 1**

## Option A: Early Submission

Physicians / Groups

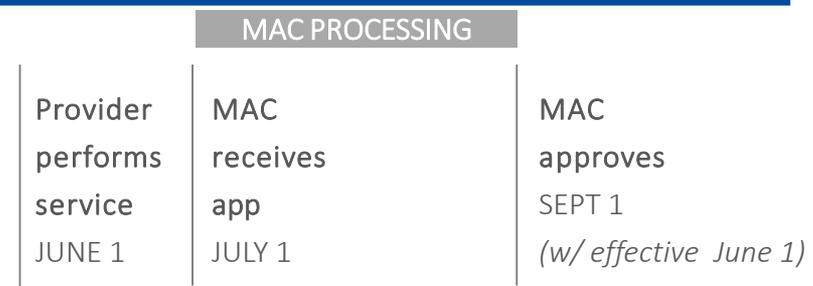
can apply **60 days prior** \*\*



## Option B: Late Submission

Physicians / Groups

effective date up to **30 days prior to submission date** \*\*\*



\*\* Must be in compliance at requested effective date (operational, licensed)

# Medicare Effective Dates | Part B



Scenario	Effective Date
<ul style="list-style-type: none"><li>Application receipt date of 6/10/19 with app requested date of 7/01/19</li></ul>	<ul style="list-style-type: none"><li>7/01/19 (no retro, based on requested effective date on application)</li></ul>
<ul style="list-style-type: none"><li>Application receipt date of 6/10/19 with app requested date of 6/01/19 and all requirements met</li></ul>	<ul style="list-style-type: none"><li>6/01/19 (based on requirements met date)</li></ul>
<ul style="list-style-type: none"><li>Application receipt date of 6/10/19 with app requested date of 3/01/19</li></ul>	<ul style="list-style-type: none"><li>5/11/19 (30-day retro)</li></ul>
<ul style="list-style-type: none"><li>Application receipt date of 6/10/19 with app requested date of 6/01/19, license effective date 6/28/19</li></ul>	<ul style="list-style-type: none"><li>6/28/19 (based on license effective date)</li></ul>



## **Independent Diagnostic Testing Facility (IDTF)**

- The later of: (1) the receipt date of the application or (2) the date all Medicare requirements were met

## **Ordering and Referring Only Providers (CMS-8550)**

- Receipt date of the application

# Medicare Effective Dates | Part A



Provider seeking effective date  
SEPT 1

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



\*\* Must be in compliance at requested effective date (operational, licensed)



# Question & Answer Session

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# Processing, Screening and Verification



Medicare  
Providers  
& Suppliers  
w/NPI



5

Development  
Letter

## PROCESSING, SCREENING, AND VERIFICATION

3



4

### PRE-SCREENING

- Signed and Dated
- App Fee (or Waiver)
- Supporting Docs
- All Data Elements

### VERIFICATION

- Name / LBN
- SSN / DOB
- NPPES
- Address
- License
- Adverse Actions

### RISK CATEGORY

- Fingerprints
- Site Visits

# What Causes Delays?



need at least  
1 round of corrections

## ■ Missing Documents

IRS documents, CMS 588 EFT, voided check, bank letter, education documentation, par agreement, cert term page, org charts

## ■ Missing Fields (missing signature/date)

## ■ Wrong Signature (paper)

## ■ Incorrect Information

## ■ Missing Application Fee

## How the MAC develops for missing information

### Contacts the...

1. Contact person (sec 13)
2. Individual provider (sec 2)
3. Authorized or Delegated Official (sec 15/16)

### By...

- email
- fax
- phone
- letter

# 30

days to  
respond

### No response?

- delays
- rejections
- later effective date



# Poll Question 7

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# MAC Notification Letters



## Who is listed on MAC notification letters?

### APPLICATION RECEIPT



### PROCESSING & DEVELOPMENT



### AFTER FINALIZATION



MAC analyst is the point of contact listed on the letter



MAC call center is the point of contact listed on the letter

# How Addresses are Used



## Correspondence

Used to contact the provider directly

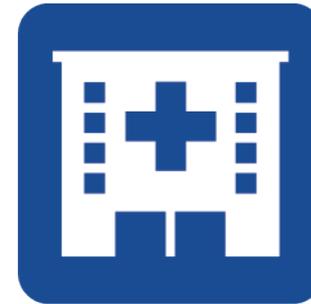
- Approval letters
- Revalidation notices
- Revocation letters



## Medical Record Correspondence

Used to request documentation

- Medical records

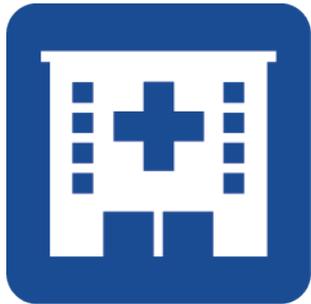


## Practice Location

Where you render services to beneficiaries

- Revalidation notices
- Site visit

# How Addresses are Used



## Primary Practice Location (855R)

Where you render services most of the time

- Physician Compare



## Special Payment

Where all other payment information is sent

- Revalidation notices
- Remittance notices
- Paper checks



## Contact Person

Person to contact regarding your application

- Development requests
- Approval letters

# Contact Person



MAC



- Any contact listed on an enrollment record may request a copy of approval and revalidation letters
- MAC will send by...
  - email
  - fax
  - mail
- (excludes certification letters or Tie In notices issued by Regional Office)

## How to end date a contact person?

### Requests may be submitted by...

1. Current Contact person (sec 13)
2. Individual provider (sec 2)
3. Authorized or Delegated Official (sec 15/16)

### By...

1. email
2. fax
3. letter

*Addition of contact persons must still be reported on appropriate CMS-855*

# Certification Statement Requirements



## PAPER



## WEB



**EXAMPLES OF INVALID CERT:**  
 Stamped Signatures • Unsigned • Undated • Wrong Person Signed



### BEST WAY TO SUBMIT YOUR CERT STATEMENT:



### BEST WAY TO SUBMIT YOUR CERT STATEMENT:

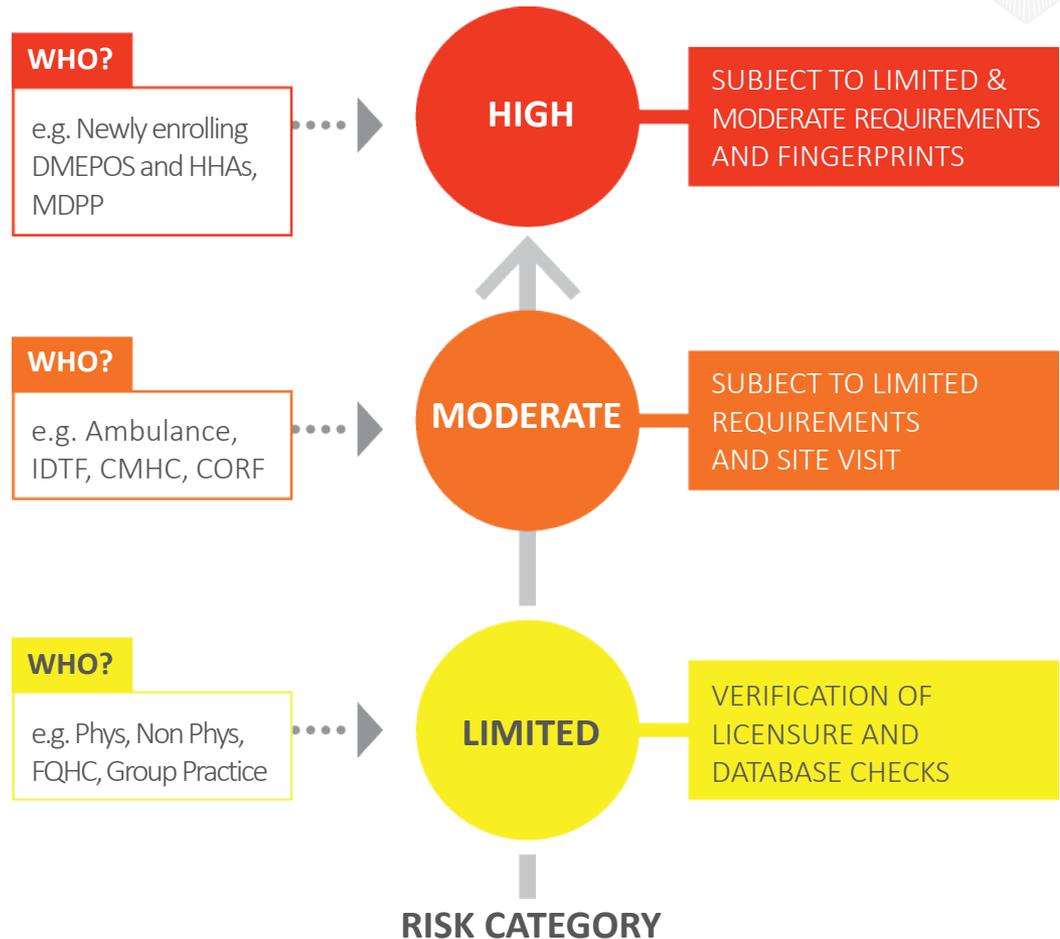


# Screening Levels



## Screening level may be elevated to “high” if:

- Excluded from Medicare/other Federal Health Care program
- Terminated from Medicaid
- Applied for Medicare within 6 months after temporary moratorium
- Within the last 10 years, you had:
  - Medicare payment suspension
  - Medicare billing privileges revoked
  - Final adverse action(s)



# Site Visits | National Site Visit Contractor (NSVC)



- All enrollment site visits conducted by the NSVC (except Durable Medical Equipment (DME) suppliers)
- Required for moderate/high risk providers
  - initial enrollment, revalidation, adding a new location
- CMS has the authority to perform site visits on all providers
- Verifies practice location information to determine compliance with enrollment requirements
- Separate from state site visits for certified providers

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## What to expect during a site visit?

1. An external or internal review, by an inspector, with limited disruption to your business
2. Photographs of the business
3. Inspector will possess a photo ID and a letter of authorization issued and signed by CMS
  - To verify that an inspector is credentialed to perform a site visit contact MSM Security Service, at 1-855-220-1071.

*Refer to SE1520 on CMS.gov for more information*

# Site Visits | National Supplier Clearinghouse (NSC)



- All DME supplier enrollment site visits conducted by the NSC
- Required for initial enrollments and revalidation
- Verifies compliance with supplier standards:
  - Hours of operation
  - Licenses/certifications
  - Patient records
  - Proof of business records (rental agreements)
  - Inventory

## What to expect during a site visit?

1. An internal review by an inspector
2. Photographs of the business
3. Staff interviews

### Inspector will possess:

- Photo identification
- Letter stating reason for the visit signed by the NSC manager
- Site visit acknowledgment form (signed by the supplier attesting the visit was completed)

# Fingerprinting



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

## 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 2<sup>nd</sup> set of fingerprints will be requested*

## 5%<sup>(+)</sup> 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



# Poll Question 8

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# Question & Answer Session

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59 Million Patients, 2 Million Providers, ONE Mission

# PROVIDER ENROLLMENT 101

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Joseph Schultz, CMS  
Team Lead, Division of Enrollment Operations

William Price, National Government Services  
Provider Enrollment Process Expert





## FINALIZATION AND CLAIMS UPDATE

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### Update Claim System

- MAC Updates Claim System (1-2 days)
- Provider not approved until claims updated

### MAC Recommendation to State/RO

- Certified providers/suppliers
- MAC recommends to RO
- RO performs in 3-9 months

# Approved

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- The enrolling provider / supplier has been determined to be eligible under Medicare rules and regulations to be granted Medicare billing privileges
- Provider is not approved until claims system is updated (within 1 – 2 days)
- Approval letter is sent to the contact person. If no contact person is listed the letter is sent to the provider at their correspondence address



# Poll Question 9

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# What is a PTAN?

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- A Medicare-only number issued to providers upon enrollment to Medicare
- Used to authenticate the provider when using the Interactive Voice Response (IVR) phone system, internet portal or on-line application status
- The PTAN's use should generally be limited to the provider's contact with their MAC
- The NPI must be used to bill the Medicare program

# Physician / Non-Physician PTANs

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- Individuals are assigned PTANs based on their private practice and group affiliations (i.e. sole proprietor, reassignment of benefits)
- Individuals who reassign their benefits receive a member PTAN for each group PTAN they reassign to
- A sole owner would have a Group PTAN assigned for the business and a member PTAN for themselves

# Group / Supplier PTANs

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- PTANs are assigned per EIN, per State
- An existing provider would require a new PTAN if:
  - Adding a new location in a different payment locality in the same State
  - Enrolling a different provider type
  - Exception: Hospitals that receive a PTAN per department

# What is a CCN?

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- A CCN is a CMS Certification Number issued to Part A/B certified providers
- Used for verifying Medicare certification, assessment-related activities and communications
- The CMS RO assigns the CCN
  - 6 or 10 digits
  - The first 2 digits identify the state in which the provider is located
  - The last 4 digits identify the type of facility



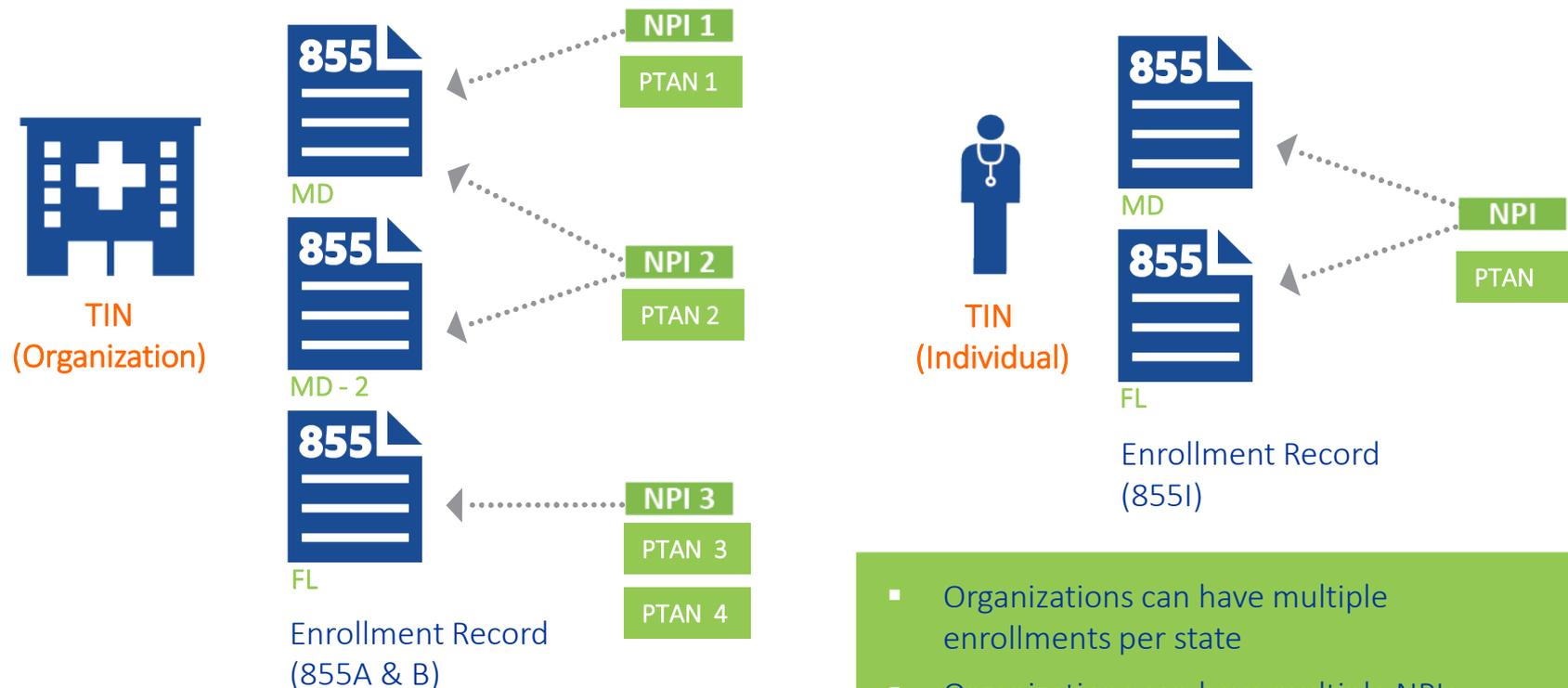
# Poll Question 10

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# Understanding the TIN / NPI / PTAN Relationship



## TIN to NPI to PTAN – Part A & B (non-DME)

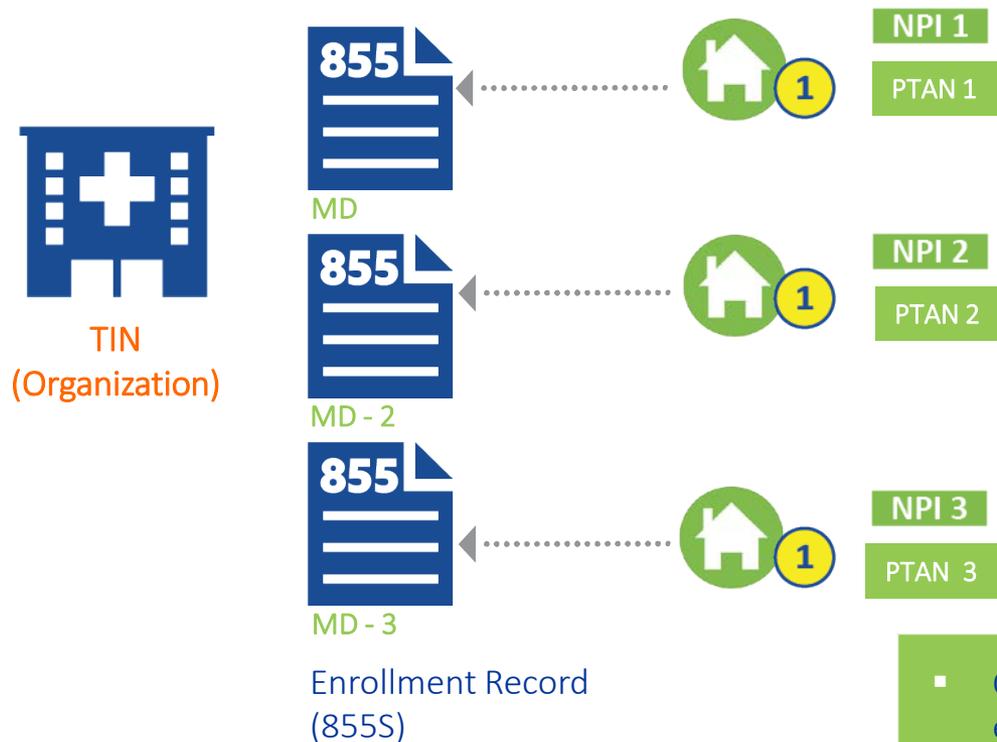


- Organizations can have multiple enrollments per state
- Organizations can have multiple NPIs
- Individuals can only have one NPI

# Understanding the TIN / NPI / PTAN Relationship



## TIN to NPI to PTAN – Part B (DME)



- Organizations can have multiple enrollments per state
- DME suppliers can only have one location per enrollment
- A separate NPI is required per enrollment

# Returns



- Unsolicited revalidation application
- Sent to incorrect contractor
- Submitted more than 60 days prior to the effective date
  - Part A certified providers, Ambulatory Surgical Centers (ASCs) and Portable X-ray Suppliers (PXRS) applications submitted more than 180 days prior to the effective date
- Submitted an application prior to the expiration of a re-enrollment bar
- Submitted an application prior to the expiration of the appeal window for a previously denied application
- Entire fields or sections hand-written on the application (*late 2019*)★

# How to Avoid a Return

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- If submitting via paper be sure to send to the correct MAC
- Don't submit applications more than 60 or 180 days in advance of the effective date
- Don't submit a revalidation more than 7 months in advance of your revalidation due date
- Don't submit the application multiple times
- Use the fillable CMS-855 form option

# Rejections



- Failure to provide complete information within 30 days of the MAC's request
  - Missing information/documentation
  - Unsigned, undated certification statement
  - Old version of the CMS-855 application
  - Incorrect application submitted
  - Failure to submit application fee
  - Failure to submit all required forms (e.g. CMS-855Rs for group enrollments)

# How to Avoid Rejections

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- Don't delay in responding to the request for information from your MAC
- Contact your MAC if you aren't sure what you need to do to return accurate corrections

# Denied

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- The enrolling provider is ineligible to receive Medicare billing privileges
- Denial letter will include appeal rights
- A new enrollment application cannot be submitted until:
  - Appeal rights have lapsed, or
  - Notification received that the determination was upheld



# Question & Answer Session

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# Other Submission Types

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# Changes of Information



- You are submitting an enrollment application to notify Medicare of a change(s) to your enrollment information



CHANGE OF  
PRACTICE LOCATION



CHANGE OF  
CORRESPONDENCE  
ADDRESS



CHANGE OF  
OWNERSHIP

# Changes of Information



## ■ Within 30 days

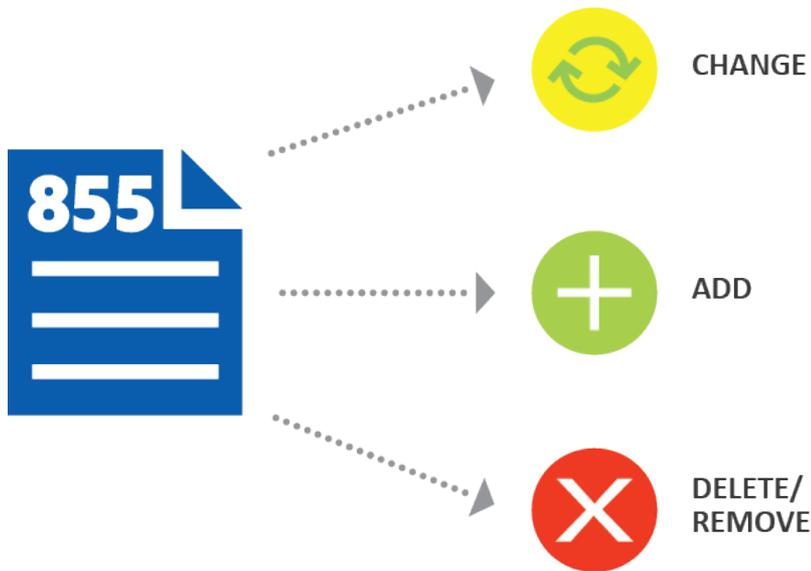
- Change of ownership or control, including changes in authorized or delegated official(s)
- Adverse Legal Action (e.g., suspension or revocation of any state or Federal license)
- Change in practice location (includes any new reassignments)

## ■ Within 90 days

- All other changes to enrollment

**Note:** Timeframes may vary by provider type.  
Refer to SE1617 on CMS.gov for more information

# 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 not required

- Add additional enrollment information to existing information (practice locations)
- App fee is required

- Remove existing enrollment information
- App fee is not 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

# Revalidation



- Verify the accuracy of your enrollment information that exists on file with Medicare
- DME suppliers revalidate every 3 years and all other providers/suppliers every 5 years



# Reactivation



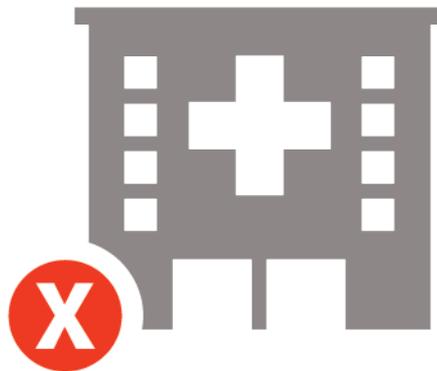
- You are returning to Medicare after a deactivation
- Must submit a complete CMS-855 to reactivate
- Effective date is based on the receipt date of the application
- 30 day retrospective billing permitted
- You will be issued a new Provider Transaction Access Number (PTAN)
  - Except for deactivations due to non-response to revalidation



# Voluntary Withdrawal



- 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



# Opt-Out of Medicare



## 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

# Filing an Opt-Out Affidavit



- A standard CMS form is not available
- Some MACs have a form available on their website
- Must be filed with all MACs who have jurisdiction over the claims the physician/practitioner would have otherwise filed with Medicare

**Print Form**

### Medicare Opt-Out Affidavit

I, , being duly sworn, depose and say:  
(First, Middle Initial, Last Name)

- Opt-out is for a period of two years. At the end of the two year period, my opt-out status will automatically renew every two years. If I wish to cancel the automatic extension, I will notify my MAC in writing at least 30 days prior to the start of the next two-year opt-out period.
- Except for emergency or urgent care services (as specified in the Medicare Benefit Policy Manual Publication 100-02, Chapter 15 §40.28), during the opt out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of §40.8 for services that, but for their provision under a private contract, would have been Medicare-covered services.
- I will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in §40.28.
- During the opt-out period, I understand that I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare Advantage.
- I acknowledge that during the opt-out period, my services are not covered under Medicare and that no Medicare payment may be made to any entity for my services, directly or on a capitated basis.
- I acknowledge and agree to be bound by the terms of both the affidavit and the private contracts that I have entered into during the opt-out period.
- I acknowledge and understand that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by myself during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.
- I acknowledge that if I have signed a Part B participation agreement, that such agreement terminates on the effective date of this affidavit.

# Impacts of Opting-Out



- 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



# Provider Enrollment Policy

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# Poll Question 11

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# Physician Assistant



## CAN

- Enroll in Medicare for services provided
- Establish an employer relationship using 855I (*section 2E*)
- Terminate an employer relationship using Section 2F of 855I (PA) or Section 2G of 855B (Org)



## CANNOT

- Individually enroll and receive direct payment (*Payments made only to PA's employer*)
- Organize/incorporate and bill for services directly
- Reassign benefits

- Employer can be an Individual or Organization
- MAC affiliates PA to employer's TIN and will develop for which employer PTANs to link PA
- Structure PA employer relationships to link to an enrollment vs employer's TIN (*future*)

# Physical Therapist

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- Required to undergo a site visit unless PT performs services in patient's homes, nursing homes, etc.
- Must maintain space used exclusively for your practice
- Site visit will be performed at the group's location if you reassign all benefits

# Nurse Practitioner

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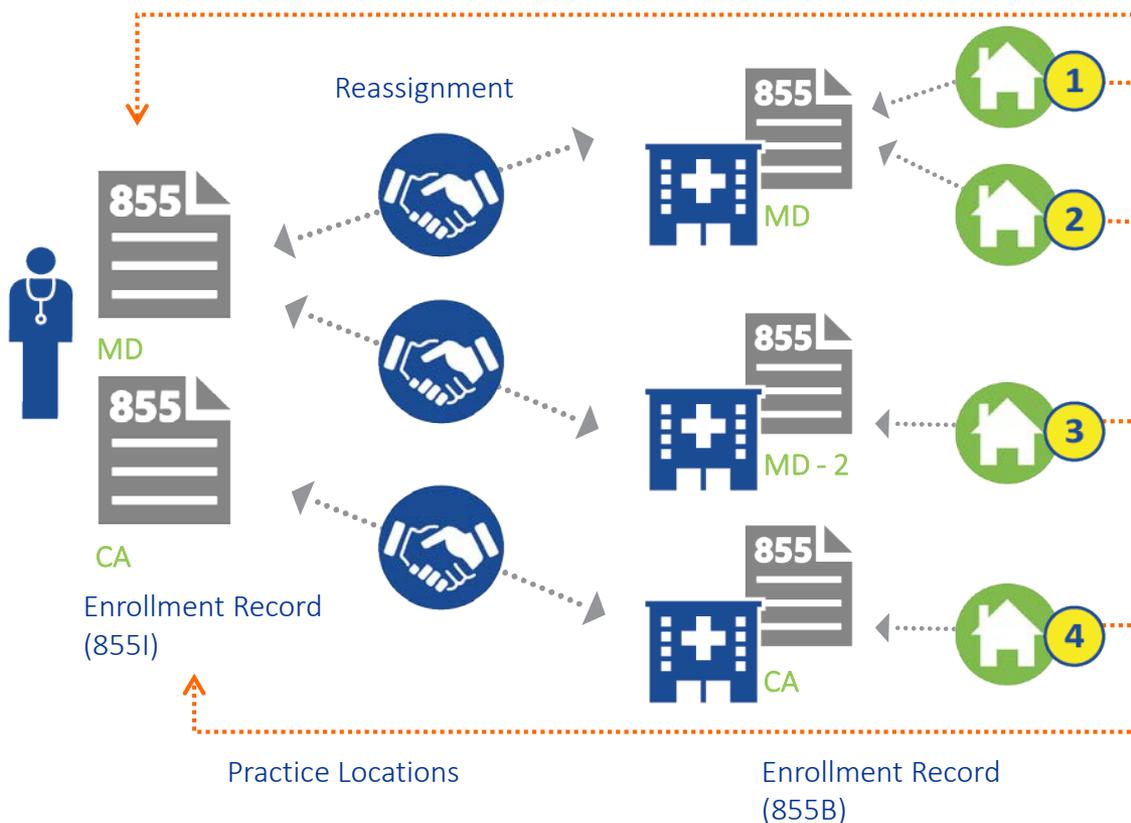
## Enrolling for the first time?

- ✓ Must be certified by a recognized national certifying body
- ✓ Must possess a master's degree in nursing or Doctor of Nursing Practice (DNP) doctoral degree

# Reassigning Benefits



## Reassignments & Practice Locations



- Individual provider reassigns their right to bill Medicare and receive payments for some or all of their services
- A CMS-855R is required for each organization the provider reassigns benefits
- An Authorized or Delegated Official of the organization must sign the CMS-855R
- Termination of the reassignment can be done by the practitioner or the employer



# Poll Question 12

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# Interns and Residents



- Interns are NOT permitted to enroll in Medicare
- Residents are permitted to enroll in Medicare
  - Complete the CMS-855I or CMS-855O
  - Section 2C of the CMS-855I collects information on your residency program
  - Cannot bill for services provided as part of your residency program
  - Must be licensed, if applicable
  - Unlicensed residents enrolling via the CMS-855O must provide: (1) signed contract or (2) letter on institution letterhead

# Ordering and Certifying



**CMS-6010**  
since JAN 2014



Anyone who orders or refers services:

**enroll in Medicare**

or opt-out through an affidavit

State-licensed residents may enroll to order or refer using the CMS-855O, and may be listed on claims.

Claims for covered items and services from un-licensed interns and residents may still specify the name and NPI of the teaching physician.

## Reduces Fraud

Claims affected:

See article [SE1305](#) for all edits

- Clinical laboratories: ordered tests
- Imaging centers: ordered images
- DMEPOS: ordered equipment, supplies
- Home Health Agencies

# Ordering and Certifying



## Converting CMS-8550 to CMS-855I enrollment via PECOS

**CMS-8550**



**CMS-855I**

- Convert from an ordering and certifying only provider to a billing provider and vice versa
- No break in billing
- The effective date of the withdrawn 8550 is one day prior to the effective date of the 855I

### Conversion Steps:

- Follow current process for creating a new application
- PECOS displays existing approved enrollment and uses it to pre-populate the new application
- Provider must confirm the withdrawal of the existing 8550 enrollment

# Ordering and Certifying



- CMS-855O 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-855O 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

# CMS-8550 Easy Enroll | October 2017



**Medicare Enrollment**  
for Providers and Suppliers

R7:30 SYSTEST [CLOUD 8]  
Home | Help | Logoff

My Application Progress  0%

Home > My Associates > My Enrollments > Application Questionnaire

**Application Questionnaire**

**Healthcare Services Rendered** (\*) Red asterisk indicates a required field.

\* Please select the option that best represents the healthcare service rendered for this application.

- Institutional Provider (e.g., Hospital, Skilled Nursing Facility, Hospice, Home Health Agency)
- Clinics/Group Practices and Certain Other Suppliers (e.g., Ambulance Service Supplier, Clinic, Independent Diagnostic Testing Facility)
- Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- Medicare Diabetes Prevention Program
- Individual Physician or Non-Physician Practitioner
- Eligible Ordering, Certifying, and Prescribing Physicians, and Other Eligible Professionals

Note: Select this option only if any of the following applies to the applicant:

- The applicant, or any organization employing the applicant, will not send claims to a Medicare contractor for any service furnished by the applicant.
- The applicant, or any organization employing the applicant, sends claims through a Medicare managed care plan.

[NEXT PAGE](#)

[CANCEL](#)

Home | Help | Logoff

## Easy Enrollment

- ✓ Log into PECOS
- ✓ Access the easy enroll interface
- ✓ Complete the required workflow changes

**Medicare Enrollment**  
for Providers and Suppliers

R7:30 SYSTEST [CLOUD 8]  
Home | Help | Logoff

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- The applicant, or any organization employing the applicant, sends claims through a Medicare managed care plan.

[NEXT PAGE](#)

[CANCEL](#)

Home | Help | Logoff

**Navigation to Easy Enrollment Alert**

You will be navigated to the Easy Enrollment Process to complete your CMS-8550 application. The PECOS Easy Enrollment is a simplified application process designed to be fast and easy to use.

[Cancel](#) [Continue To Easy Enrollment](#)

# CMS-855O Easy Enroll | October 2017



## 855O Easy Enrollment - PECOS PI

- ✓ Providers and suppliers that access the 855O form in PECOS will be navigated to the Enrollment Summary of the Easy Enrollment.
- ✓ Here, all required information will be available on one page for ease of navigation and processing, streamlining the existing 855O form.

**CMS PECOS**

Who Should I Call? [PDF, 213KB] | Check Application Status | Ordering, Certifying, or Prescribing Information [PDF, 2.47MB] | Are You a Part D Prescriber? | ENROLLMENT PROFILE

Attestation → Enrollment → Documentation Upload → Certification / Signatures → Confirmation

### Enrollment Summary

Review all enrollment sections and make edits where necessary. Some information has been pre-filled. You can Save Sections as you complete them. Use **Submit Application** to advance to the Certification Statement / Signatures page.

(\*) Indicates required fields

#### Identifying Information

First Name (Name Incorrect?) Middle Name Last Name \* Gender  
JOHN [ ] ADAMS  Male  Female

Date of Birth Social Security Number (SSN) National Provider Identifier (NPI)  
09/15/XXXX XXX-XX-XXXX 1023375011

\* Medicare Specialty Other (Please Specify)  
[ Select ] [ ]

Save

#### Education

\* Medical or other Professional School (Training Institution, if non MD) \* Year of Graduation  
[ Select ] [ ]  
YYYY

Save

#### Ordering, Certifying, or Prescribing Reason

\* Reason for Enrolling Solely to Order and Certify Items or Services, or Prescribe Part D Drugs Other (Please Specify)  
[ Select ] [ ]

Save



**CMS** PECOS  
Center for Medicare and Medicaid Innovation and Oversight

View Application Report | Who Should I Call? [PDF, 213KB] | Check Application Status | Ordering, Certifying, or Prescribing Information [PDF, 2.47MB] | Are You a Part D Prescriber? | ENROLLMENT PROFILE

Attestation > Enrollment > Documentation Upload > Certification / Signatures > Confirmation

### Documentation Upload

(\*) Indicates required fields

You may digitally upload most Required and/or Supporting documentation for submission as part of the application. Use the Required and/or Supporting Documentation Checklist to review documentation applicable to this submission and track the delivery method(s) of each type of document submitted. Both Upload and Mail may be checked when there is more than one document, indicating some are uploaded and some are mailed.

View additional Required and/or Supporting Documentation Information.

Required Documentation Checklist

Optional Documentation Checklist

**Save**

Upload Documents

\* Do you wish to upload supporting documents?  
 Yes  No

No documents have been listed. Please answer the question above.

[Return to Enrollment Summary](#) [Continue to Certification/Signatures](#)

## Documentation Upload

- ✓ Users will be able to upload supporting documentation for their CMS-855O easy enroll application
- ✓ Enter license information to route application to the appropriate contractor

# 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



# Question & Answer Session

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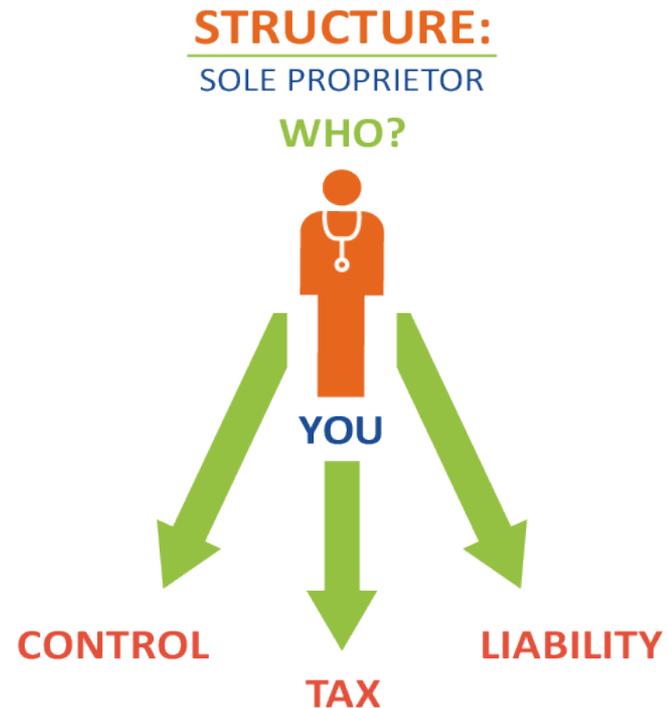
# Business Structures and Ownership/Managing Control

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# Sole Proprietors



- ✓ One person owns the business
- ✓ Unincorporated
- ✓ The individual may bill under their SSN or an EIN
- ✓ If the business has an EIN, it will be under the owner's name and not a business name
- ✓ May have employees



# Sole Owner LLC and Corporations

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- ✓ A separate and distinct entity from the owner
- ✓ Incorporation documentation submitted to the State
- ✓ EIN will be under the business name
- ✓ Owner is shielded from liability, only the business can be sued and liable for debts

# Direct vs Indirect Ownership



- Any organization or individual that has at least 5% ownership of the assets of the supplier
- Includes partnership interest
- Government entities would only list the county in Section 5 and any employees who run the provider's operations in Section 6.

## *Example:*

The supplier Medical Clinic Inc., is owned by Forest Labs LLC, Dr. John Sparks and Dr. Amelia Crews. The doctors have a partnership. Forest Labs LLC would be reported in Section 5 as a 5% Owner and each doctor would be reported in Section 6 as 5% Owners.

# Foreign Ownership

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- Any individual or organization submitted in Sections 5/6 of an CMS-855 application must supply a valid TIN:
  - Employer Identification Number (EIN)
  - Social Security Number (SSN)
  - Individual Taxpayer Identification Number (ITIN)
  
- If an individual or organization is not legally eligible to obtain a TIN or ITIN, documentation must be submitted to provide an explanation

# Managing Employees

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- Any individual that has operational or managerial control of the day to day business decisions and operations
- May be a W-2 employee or contracted
- Any enrolling supplier must include at least one managing employee
- A managing employee is optional for Individuals enrolling via the CMS-855I

# Resources



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

- ordering and referring, DMEPOS accreditation, supplier standards, part D enrollment
- CMS-855 processing guides
- 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

## [ProviderEnrollment@cms.hhs.gov](mailto:ProviderEnrollment@cms.hhs.gov)

Provider Enrollment contact

## [FFSPProviderRelations@cms.hhs.gov](mailto:FFSPProviderRelations@cms.hhs.gov)

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

## [888-734-6433](https://www.pecos.cms.hhs.gov/helpdesk)

PECOS Help Desk (EUS)

## [cms.gov MLN Matters® Articles](https://www.cms.gov/mln-matters)

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

# CMS-855 Processing Guides



## For Providers | For MACs

**Downloads**

- [Chapter 1 - Overview of Medical Review \(MR\) and Benefit Integrity \(BI\) Programs \[PDF, 113KB\]](#)
- [Chapter 2 - Data Analysis \[PDF, 75KB\]](#)
- [Chapter 3 - Verifying Potential Errors and Taking Corrective Actions \[PDF, 607KB\]](#)
- [Chapter 4 - Program Integrity \[PDF, 613KB\]](#)
- [Chapter 5 - Items and Services Having Special DME Review Considerations \[PDF, 195KB\]](#)
- [Chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services \[PDF, 200KB\]](#)
- [Chapter 7 - MR Reports \[PDF, 309KB\]](#)
- [Chapter 8 - Administrative Actions and Statistical Sampling for Overpayment Estimates \[PDF, 237KB\]](#)
- [Chapter 9 - Reserved for Future Use \[PDF, 30KB\]](#)
- [Chapter 10 - Reserved for Future Use \[PDF, 113KB\]](#)
- [Chapter 11 - Fiscal Administration \[PDF, 97KB\]](#)
- [Chapter 12 - The Comprehensive Error Rate Testing Program \[PDF, 133KB\]](#)
- [Chapter 13 - Local Coverage Determinations \[PDF, 219KB\]](#)
- [Chapter 14 - Reserved for Future Use \[PDF, 25KB\]](#)
- [Chapter 15 - Medicare Enrollment \[PDF, 2MB\]](#)
- [Chapter 15.4-Processing Guide-855O \[PDF, 154KB\]](#)
- [Chapter 15.5-Processing Guide-855R \[PDF, 190KB\]](#)
- [Exhibits \[PDF, 1MB\]](#)

[www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending)  
CMS | National Provider Enrollment Conference | March 2019

# CMS-855R Processing Guide



## For Providers | For MACs

MACs shall validate that the applicant completes this section of the CMS-855R identifying the reasons for the application that must be completed.

**A - Reasons for Submission**  
This section identifies the voluntary termination of service chosen by the MAC.

**B - Reasons you are Required to Submit**  
This section identifies the reasons for the application to order and refer. Only the MAC shall send a development.

*“Verification must occur of licenses and or certifications. The only licenses that must be submitted with the application are those required by Medicare or the state to function as the supplier type in question. Licenses and permits that are not of a medical nature are not required, ...*

*If the MAC is aware that a particular state does not require license/certification and the “Not Applicable” boxes are not checked in Section 2C, no further development is needed. “*

### Section 2. Identification Information

**A - Primary Contact**  
The primary contact person is the person who is responsible for the application. The primary contact person is the person who is responsible for the application.

*“Communications regarding the processing of the CMS-855R shall be sent to the contact person listed. If multiple contact persons are listed, the MAC shall contact the first contact person listed on the application. If they are not available, the MAC shall contact the other person(s) listed, unless the individual practitioner indicates otherwise via any means.”*

# CMS-8550 Processing Guide



## For Providers | For MACs

MACs shall validate that the applicant completes this section of the CMS-8550 identifying the reasons for the application that must be completed.

### A - Reasons for Submission

This section identifies the voluntary termination of a license chosen by the MAC.

### B - Reasons you are Registered

This section identifies the reasons for registration to order and refer. Only one reason should be selected. If a reason is not selected, the MAC shall send a...

*“A physician/eligible professional need not submit a copy of his/her degree unless specifically requested to do so by the MAC. To the maximum extent possible, the MAC shall use means other than the physician’s submission of documentation- such as a State or school Web site - to validate the person’s educational status.”*

### Section 2 -

### A - Personal

The physician date of birth, Social Security information is given to the physician and...

*“If the physician/eligible professional is submitting an initial enrollment application a PTAN need not be listed, as one has not been assigned; the physician/eligible professional can enter the word “pending” in this field or leave the field blank.*

*If the 8550 enrollment is being terminated, the PTAN should be listed... The MAC may use the shared systems, PECOS, or its provider files as a resource for determining the PTAN before developing for this information.”*

# CMS-855I Processing Guide | Coming Soon



## For Providers | For MACs

MACs shall validate that the applicant completes this section of the CMS-855I identifying the reasons for the application. The MAC shall ensure that the information provided is accurate and that all required information is provided. The MAC shall ensure that the information provided is accurate and that all required information is provided.

### A - Reasons for Submitting

This section identifies the reasons for the application. The MAC shall ensure that the information provided is accurate and that all required information is provided.

### B - Reasons you are Registered

This section identifies the reasons for the physician or non-physician practitioner to register with the MAC. Only one reason should be checked. If a reason is not identified, the MAC shall send a development request to the provider contact person to obtain the missing data.

*“On the CMS-855I, the physician must indicate his/her supplier specialties, showing "P" for primary and "S" for secondary. The provider may select only one primary specialty but may select multiple secondary specialties. A physician must meet all Federal and State requirements for the type of specialty(s) checked....”*

### Section 2 - Personal Information

#### A - Personal Information

The physician or non-physician practitioner must provide accurate and complete information in this section. The date of birth and social security number must coincide with the information on the individual's Social Security record. Each block under this section must be completed if applicable. If the information is not given, the MAC shall send a development request to the provider contact person to obtain the missing data except for "Type of Other Name" and "Gender" which can be captured orally.

*“The physician assistant must furnish his/her NPI in section 1 of the application, and must list his/her employers in section 2E. Since PAs cannot reassign their benefits – even though they are reimbursed through their employer – they should **not** complete a CMS-855R.....”*



# Thank You

**March 2019** | This summary material was part of an in-person presentation. It was current at the time we presented it. It does not grant rights or impose obligations. We encourage you to review statutes, regulations, and other directions for details.

If you need more accessibility options for the material, contact [providerenrollment@cms.hhs.gov](mailto:providerenrollment@cms.hhs.gov)

Centers for Medicare & Medicaid Services

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