MACtoberfest®

Navigating the Enrollment Process

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Provider Enrollment

Session Overview

- Role of Provider Enrollment
- When should I Submit an Application?
- Life Cycle of an Enrollment Application
- Prescreening & Verification Process
- Certified Provider Enrollment
- Clinic/Group Practice Enrollment
- Address Changes and Which Addresses are Maintained by Provider Enrollment
- Internet PECOS
- Provider Enrollment Self Service Resources
- Revalidation Policies

Role of Provider Enrollment (PE)

- Review, validate and process CMS Form 855 enrollment application, including supporting documentation, to ensure only eligible and qualified individuals and organizations participate in the Medicare program
- Ensuring CMS requirements are consistently and accurately met
- Maintain PE records in Internet-based PECOS, FISS and MCS

CMS 855 Enrollment Applications

Form	Description
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 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
CMS 588	Electronic Funds Transfer Agreement
CMS 406	Participation Agreement

When Should You Submit an Application?

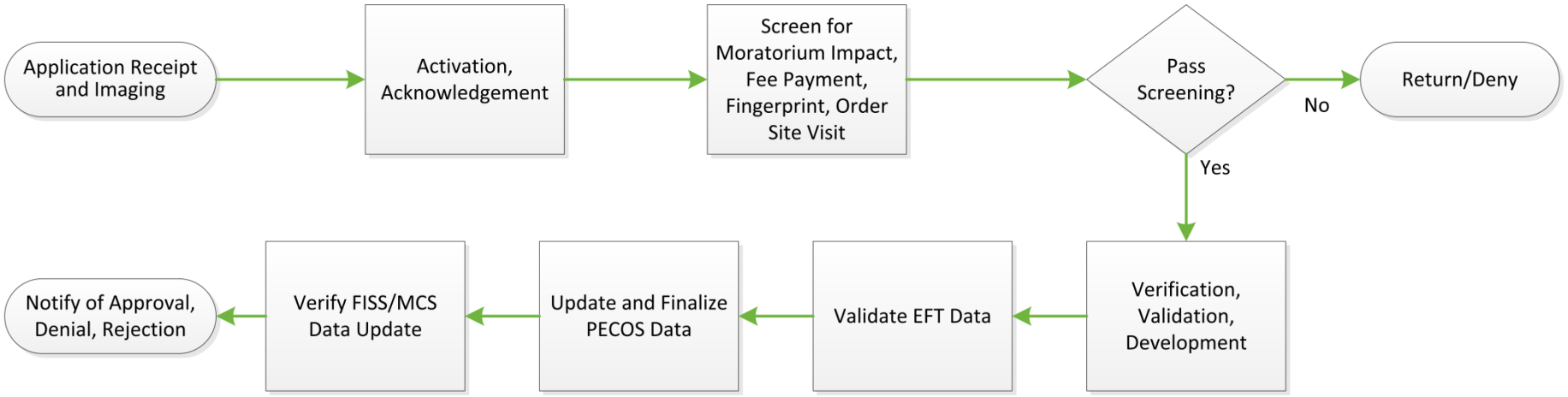
- Joining Medicare program for the first time
- Anytime something changes with your facility/practice
- Ownership Changes
  - Change of Ownership (CHOW)
  - Stock Transfer
- Joining a new group
- Enrolling for the sole purpose of ordering and/or referring services
- Revalidating

Authorized and Delegated Officials Who Can Sign the Application?

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)
Initials, Changes, & Revalidations – 855A, 855B	Changes & Revalidations – 855A, 855B
Reassignments – 855R / Individual Provider + AO/DO	

Provider Enrollment Global View

Applications



Prescreening & Verification Process

- Correct 855 application submitted & signed and dated
- Application Fee Paid if applicable
  - 2018 application fee is $569
  - Fee varies from year-to-year
  - Required for institutional providers when initially enrolling, revalidating or adding a practice location Home Health Agencies, DME supplier, Hospital, IDTF
  - Must be paid electronically via PECOS with credit or debit card (no checks)
  - Missing fees are developed for and application is rejected within 30 if fee not paid
- Supporting Documents Submitted

Prescreening & Verification Process

- Name/Legal Business Name verification
- SSN/DOB
- National Provider Identifier - NPI
  - Name used to obtain NPI is same as reported on 855
  - Type 1 – Individual (i.e. physicians, non-physicians etc.)
  - Type 2 – Organizational providers (i.e. hospitals, groups etc.)
- License
- Adverse Actions reported

Application Fees

Application Fee Paid if applicable

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- Fee varies from year-to-year
- Required for institutional providers when initially enrolling, revalidating or adding a practice location Home Health Agencies, DME supplier, Hospital, IDTF
- Must be paid electronically via PECOS with credit or debit card (no checks)
- Missing fees are developed for and application is rejected within 30 if fee not paid

Application Fee Refunds

Refunds May be Issued if

- A hardship exception request is approved
- The application was denied due to temporary moratorium
- The application was rejected prior to initiation of the screening process
- Fee not required for the transaction in question or not part of the application submission

Certified Providers/Suppliers Enrolling via the CMS 855A

- Community Mental Health Center (CMHC)
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- Critical Access Hospital (CAH)
- End-Stage Renal Disease Facility (ESRD)
- Federally Qualified Health Center (FQHC)
- Histocompatibility Laboratory
- Home Health Agency (HHA)
- Hospice
- Hospital and Hospital Units
- Indian Health Services Facility
- Organ Procurement Organization (OPO)
- Outpatient Physical Therapy/Occupational Therapy/Speech Pathology Services (OPT)
- Religious Non-Medical Health Care Initiative
- Rural Health Clinic (RHC)
- Skilled Nursing Facility (SNF)

Certified Providers/Suppliers Enrolling via the CMS 855B

- Ambulatory Surgical Center (ASC)
- Portable X-Ray Supplier (PXRS)

Certified Provider/Supplier Initial Enrollment Process

- Provider Actions
  - Obtain NPI
  - Contact State Agency for certification forms
  - Ensure you are able to meet state/federal requirements
  - Complete CMS 855A and submit it to MAC
  - Obtain civil rights clearance from the Office of Civil Rights (OCR) – applicable for all Medicare Part A providers
  - Be operational and providing services to patients at the time of survey
- Palmetto GBA Actions
  - Screen and validate the CMS 855A
  - Submit recommendation of approval to State Agency, copy to CMS RO

Certified Provider/Supplier Initial Enrollment Process

- State Survey Agency or Accrediting Organization Actions
  - On-site certification survey
  - Make certification recommendation to CMS RO
- CMS RO Actions
  - If Condition of Participation (COP) are met, RO issues provider agreement and assigns CCN
- Palmetto GBA Actions
  - Processes tie-in notice received from CMS RO
  - Update PECOS and claims systems

Note: EFT and EDI enrollment cannot be completed until after the claims system update

Initial Survey Process

- Survey can't be completed until approval recommendation is received from the MAC
- All surveys are unannounced
- Must be fully operational and serving patients
- Survey results are forwarded to the RO
  - **In compliance** – the RO proceeds with the provider/supplier's Medicare approval and issues the provider or supplier agreement and assigns a CMS Certification Number (CCN)
  - **Not in compliance** – the RO issues a denial letter. The applicant may correct the deficiencies and return

How Long is Approval Recommendation Valid?

- The MAC's recommendation on the CMS-855 is considered valid regardless of how long it takes for the State to initiate the survey process
- The provider must submit an updated CMS-855 application to the MAC if the state agency requests it

Transactions that Require SA/RO Approval

- Initial enrollment
- Change of ownership
- The following types of change of information:
  - Adding locations (all provider types except hospitals)
  - Adding swing-bed, psychiatric, or rehabilitation units to a hospital
  - Adding a transplant center to a hospital
  - Change in type of PPS-exempt unit
  - Conversion of hospital from one sub-type to another
  - Change in practice location address where a survey of the new site is required
  - Stock transfer

Change of Ownership

- The assets of the Medicare provider organization are being sold or transferred to another organization through a CHOW, Acquisition/Merger, or Consolidation

Documentation Needed:

- Copy of final sales/lease agreement
- Copy of bill of sale
- Documents must include date and be signed

Effective date of transfer on 855A application must match the effective date of the sale as noted in the sales agreement or bill of sale

Change of Ownership

Billing During and After CHOW Processing:

- Old and new owners are responsible for working together on claims for services furnished during the CHOW processing period. The bank account will not be updated to buyer's account until the CHOW is approved
- After CHOW processing is complete, only the Buyer is permitted to submit claims using the existing CCN. MACS no longer have the ability to update the crosswalk in order for the Seller to complete their billing

Examples of CHOWs

- Sale or transfer of assets
- Provider entity merges into another provider entity
- Two provider entities combine to create a new provider entity
- Lease of the provider facility
- Operator of provider facility changes
- Management contract where owner relinquishes all authority and responsibility
- Dissolution of provider entity due to removal, addition, or substitution of a partner/owner

Stock Transfers

The stock of the Medicare provider organization is being sold or transferred but the provider's assets and liabilities are still held by the same provider organization

Documentation Needed:

- Copy of the stock transfer agreement
- Document must include date and be signed

Effective date of addition/deletion/change for owners in Section 5/6 must match the effective date of the sale in the stock transfer agreement

HHA Capitalization

Factors used to determine initial reserve operating funds:

- Geographic location and urban/rural status
- Average cost per visit comparisons to similar HHAs
- Provider-based versus freestanding status
- Proprietary versus non-proprietary status

HHA Capitalization

Documentation Needed:

- Projected budget
- Document outlining number of anticipated visits for a full year broken out by month
- Copies of current bank statements
- Letter from bank officer attesting that funds are immediately available
- Attestation from the HHA certifying that at least 50% of required funds are non-borrowed
- Audited financial statements if available

HHA Capitalization

Documentation Review Points:

1. Prior to MAC making approval recommendation
2. After approval recommendation but before RO review process is completed
3. After RO review process is completed but before MAC conveys billing privileges
4. During the 3 month period after MAC conveys billing privileges

HHA Change in Majority Ownership

Occurs when an individual or organization acquires more than a 50% direct ownership interest in a home health agency (HHA) during:

- The 36 months following the HHA's initial enrollment into the Medicare program
- The 36 months following the HHA's most recent change in majority ownership

HHA Change in Majority Ownership

- Exceptions
  - The HHA has submitted 2 consecutive years of full cost reports
  - The HHA's parent company is undergoing an internal corporate restructuring
  - The HHA is changing its existing business structure and the owners remain the same
  - An individual owner of the HHA dies
- If the MAC determines that a change in majority ownership has occurred within either 36-month period and no exception applies, the HHA's billing privileges are deactivated and the HHA must enroll as an initial applicant

Elimination of HHA Subunits

New HHA Conditions of Participation (CoPs) effective 1/13/2018 no longer contain a definition for HHA subunits

Options for existing HHA Subunits:

- Elect to become a parent HHA
- Elect to become a branch of its parent HHA
- Elect to terminate it participation in Medicare

Any HHA subunits that exist on the effective date of the regulations that haven't elected to become a branch or elected to terminate will automatically be converted to parent HHAs

Part A Application (855A) Top Development Reasons

- Initial Enrollment
  - Fee Payment
  - EFT – Preprinted voided check
  - Section 6 – Missing Data or incomplete for AO/DO
- Change of Ownership
  - Bill of Sale
  - EFT – Preprinted voided check
  - 4A – Missing PTAN
  - CHOW Effective Date

Part A Application (855A) Top Development Reasons

- Change of Information
  - Section 2B1 – LBN/TIN Correction
  - Section 6 – Missing Data or incomplete for AO/DO
- Revalidation
  - Fee Payment
  - Section 5/6 – Corrections (add/delete from existing PECOS information)

Clinic/Group Practice Enrollment

- A group of physicians and/or non-physician practitioners who provide single or multiple types of medical specialty care within one organization (e.g., primary care)
- Physicians and/or non-physician practitioners are employed/contracted by the clinic/group practice and reassign their Medicare benefits allowing the clinic/group practice to submit claims and receive payment for the services they render
- Clinics/group practices submit the CMS-855B application to enroll, make changes or revalidate their enrollment

Sole Owner LLC and Corporations

- What is a sole owner?
  - 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
- Sole owners complete section 4A of the CMS-855I to initially enroll in Medicare as a solely owned group

Sole Owner LLC and Corporations

- The MAC creates a CMS-855I, CMS-855B and CMS-855R behind the scenes
- Changes of information and revalidation can generally be submitted via the CMS-855I; however, if any information involves data not captured on the CMS-855I, the change must be made on the applicable CMS form (i.e., CMS-855B, CMS-855R)

Reassignments

- At least one reassignment (CMS-855R) must be submitted with the CMS-855B to establish a clinic/group practice
- MAC will develop if a CMS-855R is not received
- Failure to respond to development could impact the Medicare effective date
- The individual must be enrolled in the Medicare program as an individual prior to reassigning his or her benefits to the clinic/group practice
- If the individual is not enrolled, the CMS-855I application is also required

Physician Assistant

Physician Assistants 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)

Physician Assistants CANNOT:

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

PA Employer Relationships

Establishing a PA Employer Relationship

- Physician Assistants (PAs) do not reassign their benefits
- PAs complete section 2E of the CMS-855I to associate to a clinic/group practice
- The clinic/group practice must be enrolled to add the employee
- MAC affiliates PA to employer's TIN and will develop for which employer PTANs to link PA

Terminating a PA Employer Relationship

- PA completes section 2F of CMS-855I or clinic/group
- practice completes section 2G of CMS-855B

Physical Therapist

- 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

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

Interns and Residents

- Interns are NOT permitted to enroll in Medicare
- Residents are permitted to enroll in Medicare
  - Must be licensed
  - 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

Tax Identification Changes

- If a provider is changing its tax identification number, the transaction is treated as a brand new enrollment
- Provider must submit two applications:
  - A CMS-855B to initially enroll as a new provider, and
  - A CMS-855B to voluntary terminate the existing enrollment

Part B Application
Top Development Reasons

855B

- Section 2 – Incorrect Provider Type, LBN, TIN
- Section 4 – Updates to Practice Location
- Section 6 – Missing Data or incomplete for AO/DO
- EFT – Preprinted voided check
- IRS Documentation

Part B Application
Top Development Reasons

- 855I
  - Section 2 – DEA, Graduation Year, SSN
  - Section 4B – Incomplete
  - Licenses / Certifications
  - NPI – Name update
  - Copy of DEA
- 855R
  - Section 6 – Correct Signature
  - Section 2 – Group LBN
  - Section 3

Part B Application
Top Development Reasons

855I / 855B Revalidation

- Section 4 – Incomplete
- Section 5/6 – Corrections (add/delete from existing PECOS information)
- DEA
- Licenses / Certifications

CMS 588 EFT Authorization Agreement

- All providers must be enrolled to receive reimbursement via EFT
- 01/17 version of the CMS-588 is the only version being accepted effective 1/1/18
- Name on Bank Account can be:
  - The provider's legal business name
  - The chain home office legal business name if payment is being made to the chain home office
  - If governmental, doesn't have to match provider's legal business name if required by law to have payments made to a specific account. Must provide copy of statute/regulation supporting this

CMS 588 EFT Authorization Agreement

Supporting Documents

- ***Pre-printed*** voided check or a letter from the bank confirming name on account, account number, and routing number
- A deposit slip is not acceptable
- If payment is being made to the chain home office, a letter authorizing EFT payments due the provider to the chain home office's bank account

Reporting Address Changes

- Addresses reported using the CMS Form 855
  - Practice Location Address
  - Special Payment Address
  - Correspondence Address
- Report address/practice location change within 30 days of the change occurring
  - 42 CFR § 424.516
- All address reported on the 855 are captured in FISS/MCS

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

2. STATE LICENSE INFORMATION/CERTIFICATION INFORMATION

Provide the following information if the provider has a State license/certification to operate as the provider type for which you are enrolling.

☐ State License Not Applicable

License Number	State Where Issued
Effective Date *(mm/dd/yyyy)*	Expiration/Renewal Date *(mm/dd/yyyy)*

Certification Information

☐ Certification Not Applicable

Certification Number	State Where Issued

C. Correspondence Address

Provide contact information for the entity listed in Section 2B1 of this section. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 *(Street Name and Number)*			
Mailing Address Line 2 *(Suite, Room, etc.)*			
City/Town		State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*	

Type of Accreditation or Accreditation Program (e.g., hospital accreditation program, home health accreditation, etc.)

E. Comments

Use this section to clarify any information furnished in this section.

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

A. Practice Location Information

Report all practice locations where services will be furnished. If there is more than one location, copy and complete this section for each. Please list your primary practice location first.

To ensure that CMS establishes the correct associations between your Medicare legacy number (if issued) and your NPI, you must list a Medicare legacy number—NPI combination for each practice location. If you have multiple NPIs associated with both a single legacy number and a single practice location, please list below all NPIs and associated legacy numbers for that practice location.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Practice Location Name *("Doing Business As" name if different from Legal Business Name)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
Medicare Identification Number *(if issued)*		NPI
Medicare Identification Number *(if issued)*		NPI

☐ Hospital Psychiatric Unit
☐ Hospital Rehabilitation Unit
☐ Hospital Swing-Bed Unit
☐ OPT Extension Site
☐ Other Hospital Practice Location:_____

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

B. Where Do You Want Remittance Notices Or Special Payments Sent?
If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Medicare will issue payments via electronic funds transfer (EFT). Since payment will be made by EFT, the "Special Payments" address will indicate where all other payment information (e.g., remittance notices, special payments) are sent.

☐ "Special Payments" address is the same as the practice location (only one address is listed in Section 4A). **Skip to Section 4C.**

☐ "Special Payments" address is different than that listed in Section 4A, or multiple locations are listed. **Provide address below.**

"Special Payments" Address Line 1 *(PO Box or Street Name and Number)*

"Special Payments" Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

DATE *(mm/dd/yyyy)*			

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Section 13 Contact Person Reporting Changes

- CMS Form 855s do not have an option to allow reporting a change to the contact person
  - Deleting a Contact Person
  - Submit via regular letter, email, or phone from the Authorized /Delegated Official or current contact person
- Section 13 Contact Person Address is not maintained in FISS/MCS – PECOS only
- All completion letters are sent to the contact person reported in Section 13 for each application submitted

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

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)

Ambulance License Update Process

- Ambulance license expiration is maintained in PECOS/MCS
- Update license certificate should be submitted prior to the current expiration date (e.g. within 45 days or as soon as new license is obtained)
- Submit new license to Palmetto GBA via regular mail or electronically via fax 803-699-2438

Revalidation Cycle 2

Section 6401 (a) of the Affordable Care Act

- Reinforces the revalidation requirements of 42 CFR §424.515 – all providers/suppliers must resubmit and recertify the accuracy of enrollment information every 5 years
- Establishes new screening requirements for new and existing providers
- Requires existing providers to be revalidated under new screening requirements

Revalidation Due Dates

- Due dates are on the last day of the month (e.g. Feb 28, March 31, April 30 etc.)
- Due dates are posted to CMS.gov “Revalidation Due Date Lookup Tool”
  - Will display all currently enrolled providers
    - Due Date
    - TBD (To be determined)
- Posted 6 months before the revalidation due date
- Include crosswalk to reassignment information

Palmetto GBA Delivery of Cycle 2 Revalidation Notices

- **Electronically for eService Users**
  - Provider's eService administrator(s) and any other individual eService user on a provider's account with the message inbox permission will receive the eLetter in their inbox on the 'Messages' tab. Email notification that a revalidation letter has been sent through eDelivery will be sent to the provider administrator(s) on the account
    - Any user with Secure Messages permission can **see** eDelivery letters, but only administrators can elect to receive **email alerts** for received letters
- **Standard USPS mail for non-eService Users**
  - Provider enrollment revalidation notifications will be sent through the U.S. Postal Service

Unsolicited Revalidations

- Unsolicited revalidations are defined as:
  - Revalidation submitted more than 6 months in advance of the due date
  - TBD listed on the CMS.gov "Revalidation Due Date Lookup Tool"
  - No notice received from Palmetto GBA requesting you to revalidate
- All unsolicited revalidations will be returned without processing
- If your intention is to submit a change to your provider enrollment record, submit a "**change of information**" application on the appropriate CMS Form 855

Deactivations

- Avoid deactivation
  - Submit revalidation application by due date and include all active practice locations and reassignments
  - Respond to all development requests within 30 days of receipt
- Failure to take these actions could result in a hold on your Medicare payments and possible deactivation of Medicare billing privileges

Reactivation

- Deactivated providers/suppliers are required to submit a complete enrollment application to reactivate
- The provider/supplier will maintain their original PTAN, but will not be paid for services rendered during the period of deactivation (resulting in a gap in coverage)
  - Note gap in coverage policy is not applicable to Part A
- Reactivation date is based on the receipt date of the new application

eCredentialing Informational Claims Edits for Revalidation Due Date

- Every five years, CMS requires providers to revalidate their Medicare enrollment record. Failure to respond to our notice to revalidate will result in a hold on Medicare payments and possible deactivation of Medicare enrollment. Palmetto GBA returns informational claims messaging for providers that are due to revalidate. The following informational message will be provided on claims that have been adjudicated if a revalidation is due

  - ***Your Medicare enrollment record is due for revalidation. Failure to respond may result in a hold on payments and possible deactivation of your enrollment***

- Please visit https://data.cms.gov/revalidation to confirm your revalidation due date

Revalidation Resources

- Visit https://data.cms.gov/revalidation Reassignment crosswalk list
- MLN Matters® SE1605 – Provider Enrollment Revalidation – Cycle 2
- Revalidation Application Checklist

SE1605

What is PECOS?

The Provider Enrollment, Chain and Ownership System (PECOS) is the system that houses all provider's enrollment and billing information. PECOS can be used in lieu of the paper CMS-855 enrollment application to:

- Submit an initial Medicare enrollment application
- Submit changes to existing Medicare enrollment information
- Revalidate your enrollment information
- Track the status of an enrollment application
- Reactivate an existing enrollment record
- Withdraw from the Medicare Program

Advantages of using PECOS

- Track your application
- Upload Digital Document
- Submit Electronic Signatures
- Submit or Update EFT (CMS-588) information
- Pay Application Fee (Pay.gov)
- Print Medicare enrollment information
- Faster than paper-based enrollment (45 day processing time vs. 60 days for paper)
- Tailored application process means you only supply information relevant to YOUR application
- More control over your enrollment information, including reassignments
- Easy to check and update your information for accuracy
- Less staff time and administrative costs to complete and submit enrollment to Medicare

Provider Enrollment Self Service Resources

- Internet-based PECOS at www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp
- Application Status Lookup Tool www.palmettogba.com
- Application Status Check via Palmetto GBA
  - IVR – 855-696-0705

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Questions?