National Provider Enrollment Conference

San Diego, CA (April 24 – 25, 2018)
Frequently Asked Questions (FAQs)

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR PROGRAM INTEGRITY

National Provider Identifier (NPI)

1. **Is an owner required to have an NPI?**

   An owner is only required to have an NPI if they are also a healthcare provider.

2. **Does a psychologist who is employed by a group need a separate NPI for both the group & individual.**

   Yes a separate NPI for both the psychologist (type 1) and the group (type 2) is required. The NPIs are required to be submitted on the CMS-855B, CMS-855I/R applications.

3. **Do I need a separate NPI if I provide Part A & B services?**

   No. You may utilize the same NPI for Part A and B. However, you will be issued a separate Provider Transaction Access Number (PTAN) for each. To learn more about the differences between an NPI and PTAN refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1216.pdf

Policy

4. **Is there a consolidated Medicare Administrative Contractor (MAC) listing with contact information?**

   Yes, it is available on the CMS.gov at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf.

5. **I'm a Part A provider with 2 locations that are enrolled with 2 separate MACs and want all my enrollments to be maintained by the same MAC. What should I do?**

   Your provider is considered an Out-of-Jurisdiction Provider (OJP). An OJP is a provider that is not currently assigned to an A/B MAC in accordance with the geographic assignment rule and the qualified chain exception. For example, a hospital not part of a qualified chain located in Maine, but currently assigned to the A/B MAC in Jurisdiction F would be an OJP.

   Each A/B MAC will initially service some OJPs until CMS undertakes the final reassignment of all OJPs to their destination MACs based on the geographic assignment rule and its exceptions.

   CMS has not set a timetable for moving OJP's but will make this process as seamless as possible to avoid provider burden.

6. **Can providers have more than 60 days to submit applications in advance?**

At this time CMS maintains the current policy of allowing providers to submit their applications 60 days (Part B) or 180 days (Part A) in advance of their effective date.

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

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

8. **What is a retrospective billing date?**

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

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

9. **Can approval letters be sent via secure fax or email?**

   Yes, MACs are currently sending approval letters via email or fax. Please notify CMS at providerenrollment@cms.hhs.gov if your MAC is not.

10. **Do the MAC approval letters list all Provider Transaction Access Number (PTANs)?**

    Yes.

11. **How do I remove a Delegated Official (DO) from my enrollment record?**

    You can submit a CMS-855B, 855A, or 855S to remove a DO. An authorized official is required to sign off on this change.

12. **Where can we find Local Coverage Determinations (LCDs)?**

    LCDs are MAC specific and can be found on your MAC's website.

13. **If we need to update our lockbox and correspondence address do we have to submit a CMS-855?**

Yes. The appropriate CMS-855 application should be submitted to report a change in your lockbox or correspondence address.

14. **What does it mean to be Participating vs Non-Participating and can you switch this designation?**

    Participating means that you agree to always accept claims assignment for all covered services furnished to Medicare beneficiaries. By agreeing to always accept assignment, you agree to always accept Medicare-allowed amounts as payment in full and not to collect more than the Medicare deductible and coinsurance or copayment from the beneficiary.

    Non-participating means that you accept Medicare but do not agree to take assignment in all cases (determined on a case-by-case basis). This means that while non-participating providers have signed up to accept Medicare insurance, they do not accept Medicare's approved amount for health care services as full payment.

    To participate in the Medicare Program as a participating provider/supplier, submit the Medicare Participating Physician or Supplier Agreement (Form CMS-460). You have 90 days from when you enroll to decide if you want to be a participating provider or supplier otherwise your PAR status defaults to non-participating. The only other time you may change your participation status is during the open enrollment period, generally from mid-November through December 31 of each year.

15. **Does CMS intend to remove the ability to submit a paper application?**

    No. CMS will continue to permit providers to submit paper applications.

16. **If an FQHC enrolls in Part B, do they receive a separate Part B PTAN?**

    Yes. A part B PTAN would be issued upon processing of the enrollment application.

17. **If the Nurse Practitioner was not enrolled in Medicare before 2003 and refuses to obtain a master's degree, will the application be denied?**

    Yes. Per 42 CFR §410.75(b), a nurse practitioner must be a registered professional nurse who is authorized by the state to practice and must also meet one of the following criteria:

    (1) Obtained Medicare billing privileges as a nurse practitioner for the first time on or after January 1, 2003, and meets the following requirements:

    (i) Is certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

    (ii) Possesses a master's degree in nursing or a Doctor of Nursing Practice (DNP) doctoral degree.

    (2) Obtained Medicare billing privileges as a nurse practitioner for the first time before January 1, 2003, and meets the standards in (1)(i) above.

(3) Obtained Medicare billing privileges as a nurse practitioner for the first time before January 1, 2001.

18. **When will CMS be revising the CMS-855A application?**

    CMS anticipates the revised CMS-855A being released in September 2019.

19. **Can a power of attorney sign the CMS-855 enrollment application on behalf of the individual provider or AO/DO?**

    No. Only the individual provider, or the Authorized or Delegated Official can sign the enrollment application.

20. **Can I submit a CMS-855B to report a tax ID change via PECOS web?**

    Yes. A change in tax identification is considered a new enrollment, therefore the provider will need to voluntary withdraw their current enrollment and create a new enrollment under the new tax identification number.

21. **Does the Legal Business Name (LBN) listed on the CMS-855 enrollment application need to match the Internal Revenue Services (IRS) documentation?**

    Yes.

Clinic/Group Practice

22. **The providers within my group provide services at nursing homes, foster homes, etc. Would each location need to be reported on the group's enrollment application?**

    Yes, providers must list all addresses where he/she furnishes services.

23. **If we have a new Legal Business Name (LBN) do we need to add it to the group's enrollment?**

    Yes, a change of information should be submitted to report the LBN change.

24. **My organization's partners change daily. What is CMS' expectation for reporting these changes?**

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

MLN/MLNMattersArticles/downloads/SE1617.pdf for the timeframes for reporting changes to your enrollment information.

Telehealth

25. If the provider performing the readings (professional component) is located in Florida but the group performing the service (technical component) is located in Georgia, how do I complete the individual and group enrollments?

If the group will be billing for both services (professional and technical components), the following enrollment actions are required:

- The individual provider must be properly licensed or otherwise authorized to perform services in the state in which he/she has his/her practice location. The practice location can be an office or even the individual's home (for example, a physician interprets test results in his home for an independent diagnostic testing facility).

- The individual provider is not required to enroll in the group's MAC jurisdiction nor be licensed/authorized to practice in the group's state.

- The group must enroll in the MAC jurisdictions in which (1) it has its own practice location(s), and (2) the individual provider has his/her practice location(s). In Case (2), the group:

    - Shall identify the individual provider's practice location as its practice location on its Form CMS-855B
    - In Section 4A of its Form CMS-855B shall select the practice location type as "Other health care facility" and specify "Telemedicine location."
    - Need not be licensed/authorized to perform services in the individual provider's state.

If the provider and the group plan to bill the services separately, the individual provider would enroll with the MAC in Florida and the group would only enroll with the MAC in Georgia.

Independent Diagnostic Testing Facility (IDTF)

26. Can a physician be opted out of Medicare and still be listed as a supervising physician for an IDTF?

No. The supervising physician must be Medicare enrolled. The physician need not necessarily be Medicare-enrolled in the State where the IDTF is enrolled; moreover, the physician need not be

furnishing medical services outside of his/her role as a supervising physician (i.e., he/she need not have his/her own medical practice separate from the IDTF).

27. Can an IDTF share space with a clinic/group practice?

IDTFs are able to lease space from a clinic but clinics are not able to lease space from an IDTF. The clinical space shared amongst the IDTF and clinic and used for furnishing services to Medicare beneficiaries must be separate, however, they are permitted to share common areas such as bathrooms, waiting rooms, hallways, etc.

28. Can a supervising physician providing general supervision be a regular doctor versus a radiologist?

Yes, as long as the provider is appropriately credentialed to provide the procedures for which they are supervising.

29. We are not currently using our radiology equipment but will in the future. Can we enroll as a group and then change to an IDTF?

If you are not currently billing for IDTF services, you may enroll as a group. However, in the future should you decide to begin billing Medicare for IDTF services that you provide to patients outside of your group practice you will be required to enroll separately as an IDTF.

<u>Certified Providers/Suppliers</u>

30. Can you provide a definition for the following: CAH, HHA, OPT, RHC and ASC?

Critical Access Hospital (CAH), Home Health Agency (HHA), Outpatient Physical Therapy (OPT), Rural Health Clinic (RHC) and Ambulatory Surgery Center (ASC).

31. What does RO stand for?

CMS Regional Office (RO). The ROs play a role in the survey and certification process for Part A certified providers/suppliers.

32. Why is it that an application can take 45-60 days and then the State/RO can take another 6-9 months? What is the reason for the delay?

The MAC processes the CMS-855 enrollment applications submitted by certified providers/suppliers and makes a recommendation for approval to the CMS Regional Offices (RO) who determines whether the certified provider/supplier meets all applicable enrollment requirements and conditions of participation/coverage to participate in the Medicare program. In many cases a survey is required to be conducted by the State Agency (SA) before the RO can make their final determination which adds additional time to the enrollment process. The timeframes for the survey by the SA and the certification by the RO varies by provider type and

the enrollment action. CMS is actively working to streamline the enrollment process for certified providers/suppliers.

33. What is the difference between Qualified Chain Provider (QCP) and a Chain Home Office (CHO)? Is there a difference in the certification process?

A QCP is a chain provider comprised of—

(1) 10 or more eligible providers collectively totaling 500 or more certified beds; or

(2) 5 or more eligible providers collectively totaling 300 or more certified beds, with eligible providers in 3 or more contiguous States.

A CHO is the entity that provides centralized management and administrative services to the individual providers or suppliers under common ownership and common control, such as centralized accounting, purchasing, personnel services, management direction and control, and other similar services.

The main difference between a QCP and a CHO is that a CHO does not get certified.

Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS)

34. Does the early submission of applications (i.e., 60 days) apply to DME submissions?

Yes, DME suppliers can submit their applications up to 60 days prior to the opening of the business.

35. Are we required to obtain certification if we are distributing DME products? Or can we just bill Part B?

You must enroll as a DME supplier and bill through the National Supplier Clearinghouse (NSC). This process requires you to obtain accreditation for the products and services you are distributing.

36. If you are an accredited DME supplier in one product category, can you bill for products from another DME category as long as you meet all licensure requirements?

No. You must obtain accreditation for all products and services you intend to bill and meet all licensure requirements. You must also update your enrollment information to reflect all products and services for which you are accredited in order for you to receive payment for those specific products and services.

37. **I have a physician office in a rural area where DME services area are limited. My doctor has been providing crutches and similar items for free. Do we have to become a DME supplier in order to be reimbursed?**

    Yes. To be reimbursed for the DME items and services provided you must enroll as a DME supplier.

Application Fees

38. **Do we pay one or multiple application fees for pharmacy enrollment (i.e., chain provider)?**

    An application fee is required for institutional providers that are newly-enrolling, re-enrolling/re-validating, or adding a new practice location. Pharmacies that enroll as a DME supplier are required to pay an application fee per location. For more information on application fees refer to https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareApplicationFee.html.

39. **If you submit one application to enroll 3 additional practice locations is only one fee required?**

    If all 3 locations are submitted on one application then only one fee is required. If you add these locations at separate intervals and on separate applications, then a fee would be required for each location submission.

40. **When completing a revalidation application for FQHCs, do we have to pay a fee for each?**

    Yes, because FQHCs cannot have multiple sites or practice locations on one enrollment. Each location must be separately enrolled which requires a separate fee.

Revalidation

41. **When did revalidation cycle 2 start?**

    March 2016.

42. **Why do I have to revalidate every 5 years if nothing has changed?**

    Federal regulations require DME suppliers to revalidation every 3 years and all other providers/suppliers every 5 years to verify the accuracy of the enrollment information CMS has on file.

43. **Who can sign the revalidation application?**

    The individual provider or the authorized or delegated official. Currently the delegated official is not permitted to sign the CMS-855S revalidation application in PECOS, however PECOS will be updated in January 2019 to allow the DO to sign.

44. What happens if I am enrolled with two Medicare Administrative Contractor (MACs) (A/B and DME) and I submit a revalidation application to the wrong MAC?

Your application will be returned.

45. Are providers required to check the revalidation look up tool for their revalidation due date or will notices continue to be sent?

MACs will continue to mail revalidation notices within 3-4 months prior to your revalidation due date. The notices are mailed to the provider's correspondence and special payment addresses and/or practice location address.

46. How is the 3 and 5 year revalidation due dates determined?

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

47. Once I am reactivated after deactivation due to non-response to revalidation will I receive a new Provider Transaction Access Number (PTAN)?

After a provider has been deactivated for non-response to revalidation a full application is required to reactivate the enrollment. The Medicare Administrative Contractor (MAC) will process the application as a reactivation and establish a gap in billing based on the receipt date of the application. The provider/supplier will maintain their original PTAN but the MAC will reflect a gap in coverage (between the deactivation and reactivation of billing privileges) on the existing PTAN. The provider will not be reimbursed for dates of service in which they were not in compliance with Medicare requirements (deactivated for non-response to revalidation or non-response to a development request).

48. A provider has begun working for a new organization. The provider is due for revalidation, however, the new organization was unaware and the provider was deactivated for non-response to revalidation. How can this be avoided in the future?

Groups can utilize the revalidation look up tool located at https://data.cms.gov/revalidation to determine due dates for their group members. In addition, groups can contact the provider's MAC to obtain revalidation status information. The MACs will provide the following revalidation status information over the phone to callers who are able to provide a provider' name, PTAN, TIN/SSN and NPI number. The caller does not need to be listed on the provider's enrollment record as a contact person:

- Revalidation status (i.e., whether or not a provider/supplier has been revalidated),
- Revalidation due date,
- Revalidation approval date,
- The specific information related to a revalidation development request, and
- The date a provider was deactivated due to non-response to a revalidation or non-response to a development request

49. Is CMS still issuing notices to large groups when their members are due to revalidate?

Yes. Large groups (200+ members) accepting reassigned benefits from providers identified on the CMS list will receive a letter from their MACs listing the providers linked to their group that are required to revalidate for the upcoming 6 month period. We encourage all groups to work together as only one application from each provider is required, but the provider must list all groups they are reassigning to on the revalidation application submitted for processing. MACs will have dedicated provider enrollment staff to assist in the large group revalidations.

If you are a large group with 200+ members and haven't received a letter please email providerenrollment@cms.hhs.gov.

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

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

51. Are extensions still granted for revalidation?

Extensions will only be granted if a provider was not given the full six months advance notice prior to their revalidation due date as a result of the revalidation list being untimely posted to the CMS website.

52. When revalidating an individual provider's CMS-855I enrollment do I need to revalidate all of his/her reassignments and practice locations?

Yes. Failure to do so could result in termination of his/her reassignments and/or deactivation of his/her Medicare billing privileges.

53. Am I required to submit the CMS-460 (Participation Agreement) with my revalidation?

No.

54. Am I required to revalidate my CMS-855O enrollment?

Providers who submit a CMS-855O application to enroll solely to order or certify are not required to revalidate.

55. Can CMS align the revalidation due dates for providers who are enrolled in multiple MAC jurisdictions?

CMS will consider this change as a future enhancement.

Reassignments

56. How do I remove a reassignment?

A CMS-855R can be submitted to terminate a reassignment. Only one signature is needed to effectuate this change, either the Authorized/Delegated Official or the individual provider.

57. Do I need to complete a CMS-855R to reassign my provider to an FQHC?

No, a reassignment is not needed for Part A billing. If the FQHC needs to bill for Part B services, they would enroll as a clinic/group practice and then they would submit CMS-855Rs to reassign to the organization.

58. Why can't Physician Assistants (PAs) reassign their benefits?

Payment for the PA's services may only be made to the PA's employer, not to the PA directly. The PA cannot individually enroll in Medicare and receive direct payment for his or her services. This also means that the PA does not reassign his or her benefits to the employer, since the employer must receive direct payment.

59. Is there a limit to the number of providers that can reassign to my group?

There is no limit.

60. Who needs to sign the CMS-855R? The Authorized or Delegated Official?

Initial CMS-855R applications must be signed and dated by the physician/non-physician practitioner and the authorized official or delegated official of the provider.

CMS-855R applications submitted to change and/or update the provider's enrollment information, to include updates to the primary practice location or termination of a reassignment, must be signed by either the physician/non-physician practitioner or the authorized or delegated official of the provider.

Ownership

61. Do we need to submit IRS documentation for the owning/managing organizations we list in section 5/6 of the CMS-855 enrollment application?

Owning/managing organizations are not required to furnish IRS CP-575 documentation unless requested by the MAC (e.g., the contractor discovers a potential discrepancy between the organization's reported legal business name and tax identification number).

62. When submitting a board member change will we always receive notification that it has been approved?

Yes. MACs will issue an approval letter to the provider when the change has been processed.

63. Do we have to report social security numbers (SSN) for our authorized and delegated officials?

Yes. Section 1124(a)(1)(B) of the Social Security Act requires each person/entity with an ownership or control interest in the provider to disclose their employer identification number or social security account number.

64. Can a seller continue to bill until the change of ownership (CHOW) is approved?

Yes. The most common example of a CHOW occurs when a provider's CMS Certification Number (CCN) and provider agreement are transferred to another entity as a result of the latter's purchase of the provider. To illustrate, suppose Entity A is enrolled in Medicare, but Entity B is not. B acquires A. Assuming all regulatory requirements are met, A's provider agreement and CCN number will transfer to B.

Upon accepting the provider agreement, the new owner accepts the terms and conditions under which it was originally issued. Once the CHOW processes and the MAC: 1) receives the tie-in notice from the CMS Regional Office; and 2) updates the Provider Enrollment Chain and Ownership System (PECOS), claims will only be paid under the new owner's tax identification number, National Provider Identifier and CCN, or provider transaction number.

MACs will no longer have the ability to update the crosswalk in order for the Seller to complete their billing. Therefore, the old and new owners are responsible for working together on payment arrangements for claims for services furnished during and before the CHOW is processed.

65. Do we need to list all board members on the CMS-855A or is it just the board president?

Yes, if the applicant is a corporation, ALL officers and directors/board members of the enrolling provider must be reported. Board members of the provider's indirect owners need not be disclosed to the extent they are not otherwise required to be reported (e.g., as an owner or managing employee) in section 6. However, there may be situations where the officers and directors/board members of the enrolling provider's corporate owner/parent also serve as the enrolling provider's officers and directors/board members. In such cases – and again assuming that the provider is a corporation – the indirect owner's officers and directors/board members would have to be disclosed as the provider's officers and directors/board members in section 6.

Electronic Funds Transfer (EFT)

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

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

67. The EFT form in PECOS is outdated and when I submit it to the MAC it gets rejected because it's not the current form. When will this be updated?

CMS will be updating PECOS to reflect the current version of the EFT form in July 2018. In the meantime, CMS will provide instructions to the MACs to develop for the missing information and not reject the outdated EFT form.

68. Is a deposit slip acceptable to submit with the EFT form to validate account information?

No, MACs may only accept a voided check or bank letter.

69. I have 3 PTANs, am I able to have 3 separate EFTs?

MACs will issue the minimum number of PTANs possible to ensure claims process correctly. If the MAC has to issue multiple PTANs based on payment localities, then you are permitted to have multiple EFTs.

70. Can a Delegated Official sign the initial EFT form?

Yes as long as they are established as a DO on the enrollment.

Release of Information

71. Who can obtain denial/revocation letters? Currently the MACs are not providing letters to the contact person listed?

Revocation letters may be released to the individual provider or the authorized or delegated official unless the individual provider or authorized or delegated official: (1) furnishes a signed written letter on the provider's letterhead stating that the release of the provider data is authorized, and (2) the MAC has no reason to question the authenticity of the person's signature. The letter can be mailed, faxed, or emailed to the MAC.

72. Will the MAC provide revalidation status information to the delegated official?

Yes, the delegated official, if listed on the provider's enrollment record should be able to obtain all information listed in the provider's enrollment record.

73. How can I obtain the PTAN if I'm not listed on the enrollment?

The individual provider or authorized or delegated official must furnish a signed written letter on the provider's letterhead stating that the release of the provider data is authorized. The letter can be mailed, faxed, or emailed to the MAC. The MAC will furnish the PTAN information if it has no reason to question the authenticity of the person's signature.

Ordering and Certifying

74. Is the CMS 855O required for providers in addition to a CMS 855I/R to order/certify?

If the provider intends to bill the Medicare program they would complete the CMS 855I and/or the CMS-855R which also allows them to order/certify. If the provider wants to enroll solely to order/certify then they would complete the CMS 855O.

75. Can a practitioner order/certify if they have opted out?

Yes. A practitioner must be enrolled in an approved status or opted out to order/certify.

76. If a provider is currently located in Puerto Rico as an ordering/certifying provider, does the provider need to submit another application if he relocates?

No, the 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.

77. Do locum tenens need to submit a CMS 855O if they will only be certifying services?

No. Generally, locum tenens (substitute physician or physical therapist) need not enroll via the CMS 855 enrollment forms because they will not be providing the services to Medicare patients over a continuous period of longer than 60 days. If the substitute physicians or physical

therapists will be providing services beyond 60 days, they would need to enroll via the CMS-855O in order to certify services.

Opt-Out

78. How is the opt-out effective date determined?

The initial 2-year opt-out period begins the date the affidavit is signed, provided the affidavit meets the requirements and is filed within 10 days after the physician or practitioner signs his or her first private contract with a Medicare beneficiary.

79. Can a physician or practitioner terminate their opt out early?

Physicians or practitioners who have not previously opted out may terminate their opt-out period early no later than 90 days after the effective date of the initial 2-year opt-out period. Notification must be provided to the MAC(s) within this timeframe.

80. Is opt-out national and is it automatically renewed?

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

Valid opt-out affidavits signed on or after June 16, 2015, will automatically renew every 2 years. If physicians and practitioners who file affidavits effective on or after June 16, 2015, do not want their opt-out to automatically renew at the end of a 2 year opt-out period, they may cancel the renewal by notifying all contractors with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period.

81. Can we bill facility services for surgery if a practitioner has opted out?

No. As required by the Medicare statute and regulations, Medicare will not cover any services provided by a physician or practitioner who chooses to opt-out of Medicare, and no Medicare payment can be made to that physician or practitioner directly, except in an emergency or urgent care situation.

82. Can a provider who opts out of Medicare still be an owner of a group? What about the providers that work for him?

Yes. The owner cannot bill for services as a physician, however, he/she would be permitted to order and certify items and services to Medicare beneficiaries. The group, for which he/she is

the owner of, can bill the Medicare program. The group can bill for services provided by the physicians/non-physician practitioners that reassign their benefits to the group, provided they are not opted out.

83. How do you enroll in Medicare once you have opted out?

You must notify your MAC in writing no later than 30 days prior to the start of your next 2-year opt-out period that you no longer wish to opt-out. In order to enroll in Medicare you would submit a CMS-855I and a CMS-855R (if applicable).

84. What is the difference between a voluntary termination and opting out?

A voluntary termination means you are withdrawing your current enrollment with Medicare and will no longer be rendering services to Medicare beneficiaries.

Opt out means you will continue to render services to Medicare beneficiaries but have chosen not to enroll in Medicare. You and the beneficiary agree not to submit a bill for reimbursement by Medicare for services rendered (beneficiary pays out-of-pocket). A private contract is signed between the physician and the beneficiary. In addition, the physician submits an affidavit to Medicare to opt-out of the program.

Identity & Access Management System (I&A)

85. Is there a training account in I&A that we can use to demonstrate to providers how to create an account or approve surrogacy requests?

There is currently not a training account available in I&A. However, there are tutorials and user guides available at https://nppes.cms.hhs.gov/IAWeb/register/startRegistration.do.

86. If you are a surrogate for a provider and enter an enrollment on their behalf, do you still need to print the application for the provider's wet signature?

The provider is still required to sign the application and can do so via e-signature or printing the certification statement and mailing it into their Medicare Administrative Contractor (MAC).

87. Can a Third Party be an Authorized Official (AO) or Delegated Official (DO) in I&A?

A third party can be an AO or DO for their own Employer Identification Number (EIN).

88. Do you need to be a surrogate if you are a DO?

No.

89. Is it faster to get associated as an AO for a new legal entity by e-mailing a copy of the 147C letter or attaching directly on I&A? Sometimes I have had to submit it via e-mail because I was not receiving any response after attaching directly on I&A.

We recommend you attach the document in I&A. However, depending on the current workload it may take a few days to approve.

90. Can an AO or DO electronically sign an application without creating an I&A account?

Yes.

91. The AO and DO roles in I&A differ from that in PECOS and are very confusing. Has CMS given any consideration to changes the terms in I&A?

CMS acknowledges that the terms are confusing to the users and has revised the I&A AO definition to be consistent with PECOS. CMS will revisit making changes to other terms (e.g., DO) in the future. If the individual is an AO/DO in PECOS, they are automatically approved as an AO/DO in I&A.

92. Can there be multiple AOs in I&A?

Yes.

93. Can EUS approve an AO?

Yes with the CP-575.

94. Can there be the same surrogate across multiple tax identification numbers (TINs)?

Yes, as long as the AO or DO has approved them.

95. Can an I&A user list their personal email address?

Yes.

Provider Enrollment Chain and Ownership System (PECOS)

96. Can signatures be accepted thru docusign if the application is submitted online?

Docusign is not acceptable method for submitting signatures. Currently providers have the option to e-sign or print, sign/date, and mail the paper certification statement.

97. How does the Provider Enrollment Chain and Ownership System (PECOS) determine which MAC to send my web application?

Based on the practice location entered, PECOS will submit your application to the MAC that services that geographic area. The PECOS logic is based on the geographic assignment rules found at https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs.html#MapsandLists.

98. Are the questions in PECOS web the same as the questions on the paper CMS-855 application?

Yes, however, PECOS is a scenario-driven application and presents a series of questions to retrieve only the information needed to process your specific enrollment scenario.

99. When will Physician Assistants (PAs) be able to enroll online?

Currently PAs are able to enroll online.

100. Can I complete DME applications on PECOS?

Yes.

101. Do I have to use the United States Postal Service (USPS) verified address in PECOS?

No. PECOS validates the addresses entered with USPS and displays the standardized version of the address. The system will prompt the provider to enter a comment when the standardized version of the address is not accepted.

102. Why is the subsequent adverse legal action (ALA) questions automatically answered after you answer the first ALA question?

This is a PECOS bug and we will be fixing this issue in our June 2018 release.

103. Can a filter be added in PECOS to display providers in alphabetical order?

Currently PECOS can be sorted alphabetically by Last Name, First Name, and Organization Name.

104. How do I submit documents via PECOS (e.g. accreditation documentation)?

On the PECOS log in page located at https://pecos.cms.hhs.gov/pecos/help-main/faq.jsp is a PECOS FAQ document (in the footer). It contains an FAQ that walks the user through which documents need to be submitted with an enrollment application and how to upload those documents in PECOS.

105. The web application tracking number and the MACs internal tracking number do not match which makes it difficult for the provider to identify the status of the application in PECOS.

We will take this into consideration for a future enhancement.

106. Will PECOS be updated to allow the contacts to be selected for applications being submitted? Or can the order be updated in PECOS when submitting an application so the letters go the correct contacts?

CMS will take this into consideration as a future PECOS enhancement.

107. The physician has completed their residency. How can I remove the residency information in PECOS?

The information is part of the historical record in PECOS. There is no action required by the provider to update this information and this information cannot be removed.

108. MACs are faxing the application corrections instead of Return for Corrections in PECOS. The app is locked and provider has to submit via paper. How can the application be unlocked so I can submit the corrections through PECOS?

You should contact your MAC and request they return the application for corrections in PECOS. MAC contact information can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf

109. How can I ensure that the information entered into PECOS is secure?

PECOS goes through the same required CMS mandated security protocols as referenced in ARS 3.1 Publication. The publication follows the standards set by the National Institute for Standards and Technology. The link to ARS 3.1 publication can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-

Technology/InformationSecurity/Info-Security-Library-Items/ARS-31-Publication.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

110. Is there currently a way to make a single change in PECOS (e.g., add or delete owners, managing control) and it apply to multiple enrollments under the same Tax Identification Number?

Not at this time, however, CMS is considering this for a future PECOS enhancement.

111. If my provider is already enrolled in Medicare but they are unsure if they are in enrolled in the group's state how would I find this information?

The provider can log into PECOS which will display all the states the provider is enrolled and his/her current enrollment status.

Maintaining Compliance with Enrollment Requirements

112. If a Medicare enrolled physician submits an enrollment application to Medicaid and it is denied by the SMA for a reason not independently reportable to Medicare, is the Medicaid denial ITSELF a reportable Adverse Legal Action?

No, only those actions delineated in the applicable "Final Adverse Legal Actions" portions of each 855 application must be reported. Additionally, said denial is not an action which is required to be reported within particular timeframes dictated by provider/supplier type.

113. Are we required to run background checks on all of our board members at a nonprofit?

If board members are individuals who have managing control in said nonprofit entity, then, each board member *must* be reported on any applicable applications and *must* report all "Final Adverse Legal Actions", including felonies and exclusions. If CMS detects an unreported "Final Adverse Legal Action" attributable to any board member which was undisclosed, then, administrative action may be appropriate against the entity.

114. Do I need to report arrests, convictions or both on my enrollment application?

All convictions, as defined in 42 C.F.R. SECTION 1001.2, must be reported on all enrollment applications for 10 years after the conviction occurred. This is true for individuals, as well as, owners and managing employees of entities.

115. Are there any consequences if we submit our changes untimely?

Yes, if certain changes are not submitted within regulatory timeframes, based upon provider/supplier type, then administrative action is possible.

116. Once enrolled can I add a location or submit changes to my information?

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

117. If a PA or Nurse Practitioner (NP) leaves the group, is it our responsibility to terminate them from our group?

Yes, within 30 days. Refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1617.pdf for the timeframes for reporting changes to your enrollment information. The termination date will not prevent the group from submitting claims and being paid for services provided by the PA or NP prior to the termination date. In addition, future termination dates can be submitted on the enrollment application.

Appeals

118. Can corrective action plans (CAPs) and reconsiderations be initiated by the authorized official or a law firm?

Yes, however, the CAP or reconsideration must be signed and dated by the individual provider, the authorized or delegated official, or a legal representative. The provider's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a CAP or reconsideration request.

Preclusion List

119. If a prescription is rejected at point of sale due to the prescriber's inclusion on the preclusion list, can the beneficiary pay out of pocket?

There is nothing precluding the beneficiary from paying out of pocket for their prescription.

General Information

120. If I am enrolling with a Medicare Advantage (MA) plan do I need to enroll with the MAC or a private payer?

If you are billing MA, you must enroll with the MA plan. If you are billing Part A/B services, then you must enroll with the MAC.

121. Will future conferences include claims representatives?

We will submit this suggestion to determine if this is possible for the next event.