National Provider Enrollment Conference
Charleston, SC (September 6 – 7, 2017)
Frequently Asked Questions (FAQs)

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR PROGRAM INTEGRITY

CMS 855 Policy

1. **Which application do I complete to terminate a Physician Assistant (PA) from my group?**

   The organization can terminate a PA employer relationship by completing the CMS-855B. Section 2G is specific to terminating an employed PA from your group or clinic.

2. **Can a provider who is Active Duty Military bill Medicare for services provided to Medicare patients in a civilian hospital?**

   Yes as long as they meet all applicable Medicare enrollment requirements to enroll and bill for services.

3. **What documentation must be submitted to the MAC to validate the Legal Business Name of unrelated entities which have a reportable "control" interest in the provider?**

   Documentation is required to validate the organization's legal business name (LBN) and tax identification number (TIN). You may submit a CP-575, a federal tax department ticket, or any other pre-printed document from the IRS that identifies the TIN and/or LBN.

4. **What is the proper disclosure of individuals and organizations of non-profit corporations specific to indirect and direct control?**

   Non-profit organizations generally do not have owners. Thus, a non-profit organization need not list any owners in sections 5 or 6 of the Form CMS-855. The actual name of the Board of Trustees or other governing body must be listed in section 5A of the Form CMS-855 and the individuals on the Board of Trustees including officers, directors and managing employees must be listed in section 6.

5. **What is the best way to make sure all information is correct on NPPES, Part A and Part B enrollments? If information is incorrect or needs updating, how does this information need to be changed?**

   The best way to ensure your Medicare Part A and B enrollment information is correct is to use PECOS. PECOS will display all of your enrollment information and if there are

updates that need to be made you can submit them through PECOS. PECOS can be accessed at https://pecos.cms.hhs.gov/pecos/login.do. NPPES may be updated at https://nppes.cms.hhs.gov/#/.

6. **If the provider maintains their medical records electronically, does the address/location of the server need to be provided on the CMS-855 application?**

   No. If you don't identify a separate medical storage location in section 4G (855I) or 4C (855B) of the application, you are attesting that medical records are stored at your practice location. A future update to the CMS-855 forms will provide an option to identify that medical records are stored electronically.

   Section 4E of the CMS-855S does collect information on electronic storage of medical records. The supplier shall identify the website, URL, in-house software program, online service, vendor, or other platform in which patient records are stored electronically. This must be a site that can be accessed by the NSC MAC if necessary and may be verified during the on-site visit.

7. **What documentation is required to be submitted with my CMS-588 Electronic Funds Transfer (EFT) form?**

   Providers/suppliers must include a bank letter or voided check displaying the Legal Name/Legal Business Name of the enrolling provider/supplier, with their CMS-588 EFT form. MACs will not accept a deposit form as proof of the banking information.

8. **Our Legal Business Name (LBN) is really long and exceeds the character limit in PECOS. Should I abbreviate my LBN?**

   No. You should key in everything exactly as it appears with the Internal Revenue Services (IRS) until you've reached the character limit. You should include the IRS document with your application so that the MAC can determine the full LBN. The MACs will use the IRS letter to validate the full LBN.

Revalidation

9. **Why do providers who are due for revalidation not always display in the PECOS Revalidation Center?**

There is a time lag between when a provider appears on the CMS published revalidation due date list and PECOS. CMS is working towards reducing this time lag moving forward.

10. A provider's revalidation due date continues to display even after the provider has revalidated. Isn't the due date supposed to fall off?

The due date will continue to display even after the revalidation application has been processed. The revalidation due date will not be refreshed until the next cycle of revalidation.

11. We were deactivated for non-response to revalidation and have now reactivated our enrollment. Our PTAN and effective date remained the same, however, we have a gap in billing. No indication of this gap in billing was provided in the approval letter.

CMS is revising the approval letter to include information regarding the gap in billing. After a provider has been deactivated for non-response to revalidation a full application is required to reactivate their 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).

12. I have not received a revalidation letter from my MAC, however, I am listed on the revalidation look up tool with a due date. Can I submit my revalidation application?

Yes. Providers/suppliers can submit their revalidation up to 6 months in advance of their listed due dates on http://go.cms.gov/MedicareRevalidation.

13. We have not received a large group notification. 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/suppliers 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/supplier 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.

14. **A new provider has joined my group and I need to determine if they have revalidated, however, the MAC will not provide me this information. Currently I am not listed as a contact person on the provider's enrollment. How can I find out if the provider has been revalidated?**

    CMS will be providing instructions to the MACs to disclose this information even if the individual is not listed as the provider's contact person.

15. **Once documents have been uploaded in PECOS or submitted with an application (e.g., license, diploma), is the provider required to submit the same documentation to the MAC for future revalidations (if it hasn't changed)?**

    No. The MAC should not request the provider submit documentation that already exists on file with Medicare.

Site Visits

16. **I submitted my enrollment application with a future effective date for my new practice location, however a site visit was conducted prior to the effective date. Why did this occur?**

    The MACs shall not order the site visit until the effective date of the location has approached. CMS will reiterate this policy to the MACs.

17. **What is the difference between the site visits conducted by the National Site Visit Contractor (NSVC) and the State Agency/CMS Regional Office?**

    Site visits are required for all moderate/high risk providers when they initially enroll, revalidate, or add a new location. In addition, CMS has the authority to perform site visits on all providers. The NSVC is responsible for conducting all provider/supplier site visits, with the exception of Durable Medical Equipment (DME) suppliers. During the

site visit, the NSVC is verifying the provider/supplier's practice location information to determine compliance with enrollment requirements

State surveys are required for all certified providers/suppliers (e.g., Home Health Agencies, Hospitals) as a condition of participation and to determine compliance with enrollment requirements and State laws.

18. **Does the Legal Business Name and Doing Business As name listed on the application need to match exactly as listed on the building?**

    Yes. The name listed on the application and the signage on the building need to match.

Medicaid Enrollment

19. **Some SMAs are still requiring Medicare approval letters. Should I be providing the letter to the SMA?**

    SMAs should not request MAC "welcome letters" as a condition of provider enrollment. If the "welcome letter" is requested, the provider can direct the SMA to section 1.7 of the Medicaid Provider Enrollment Compendium (MPEC) which provides instructions to the SMA to directly check Medicare's enrollment record through its access to PECOS.

20. **Some SMA are requiring a marriage license or a social security card to validate my identity. Is this appropriate?**

    SMAs should only request a marriage license or social security card to validate identity if they have no other means to do so. Further, the SMA should not request original documents but may request duplicates of the original documents.

Ordering, Certifying and Prescribing

21. **A resident has been enrolled via a CMS-855O in one state and moves to another state. Is it necessary to update their PECOS enrollment to reflect the new state they're practicing in and their new license?**

    The CMS-855O is a national enrollment. The provider is not required to dis-enroll and re-enroll in the new state. The resident should, however, update their current CMS-855O enrollment with any new licenses obtained in the new state. CMS will be providing instructions to the MACs to convey this policy.

22. **Our residents have permits but are not able to enroll in Medicaid. What are Medicaid ordering and certifying requirements for residents with a permit?**

These requirements may vary depending on the state in which you are located. For example, some states will require residents to enroll with Medicaid as an "Ordering, Referring, Prescribing (ORP) Only" provider type. However, some states may accept the supervising physician or hospital's NPI in place of the resident's NPI on a claim for services that were ordered, referred, or prescribed. It is important to verify with your state's Medicaid program their ordering and certifying requirements prior to submitting claims in order to avoid payment denials or rejections.

Residents and Fellows

23. Is a practitioner in a resident program billable by Medicare?

Yes. Residents can receive Medicare reimbursement for services rendered at other facilities or practice locations that are not part of their residency program. For more information please refer to Pub. 100-02, chapter 15, section 30.3.

Provider Enrollment Chain and Ownership System (PECOS)

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

Not at this time, however, CMS is considering this enhancement for the PECOS redesign (PECOS 2.0).

25. Can the CMS-460 form (Participation Agreement) be uploaded into PECOS?

No. Currently the CMS-460 form requires an original signature. If the user indicates "Yes" for their PAR status, the CMS-460 form displays as required documentation in the Required/Supporting Documents topic list. If the user indicates "No" for their PAR status, the CMS-460 will not display on the documents list.

Please note that the PAR status topic only displays for CMS-855B, CMS-855S and CMS-855I enrollments. Note that for CMS-855I enrollments, PAR status only displays if the individual provider has private practice locations (not reassigning all benefits) or reassigning some benefits. If the individual provider is reassigning ALL benefits, the PAR status topic will not display.

26. What is e-signature?

PECOS allows providers/suppliers to electronically sign Medicare enrollment applications. Utilizing the electronic signature process will ensure faster application submission, resulting in faster application processing times. This feature does not change who is required to sign the application.

27. When entering an address in PECOS, why does it always display an error requesting us to choose the Unites States Postal Service (USPS) recommended address?

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.

28. Can I upload a signed certification statement in PECOS?

Currently providers/suppliers are not permitted to upload a signed certification statement. If the application is submitted via PECOS and the provider/supplier wishes to submit a paper CMS-855 certification statement (downloaded from www.cms.gov), it should write the tracking ID on the top of the certification statement and mail it to their MAC.

Identity and Access Management (I&A)

29. The authorized official (AO) and deleted official (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 will be revising the I&A AO definition to be consistent with PECOS. CMS will revisit making changes to other terms (e.g., DO) in the future.

30. A Delegated Official deactivated an employee in I&A that left the practice, but when we look in PECOS, she is still listed. Can we remove/delete her email and replace it with one for a current employee?

Making changes in I&A does not automatically remove the contact person from PECOS. A separate application is required to remove that contact person from PECOS.

31. Where can I find more information about the surrogacy process?

For more information on the surrogacy process refer to the NPPES surrogacy we page at https://nppes.cms.hhs.gov/webhelp/nppeshelp/SURROGACY%20PAGE.html

32. Can a DO assign another DO?

No. DO's can only assign staff end users. Only AOs can assign DOs.

33. Who, besides the provider/supplier, can submit a name change in the National Provider Plan and Enumeration System (NPPES)?

NPPES surrogacy does allow others to make changes to the provider/supplier's information.

Maintaining Compliance

34. What is the difference between a revocation and a deactivation?

A revocation is the removal of a provider/supplier's Medicare billing privileges and termination of the provider/supplier's agreement. A re-enrollment bar is applied that lasts a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation.

A deactivation means the provider/supplier's Medicare billing privileges have paused.

35. Are revocation letters required as part of adverse legal action (ALA) reporting?

No. Providers/suppliers are not required to submit a copy of their revocation letter as ALA documentation.

36. A provider was delayed in renewing his medical license. The delay lasted for 3 months. Does this have to be reported on the CMS-855 as an ALA?

If it was just a delay, it would not need to be reported. However, if the state categorizes the action as a license suspension or revocation, it must be reported.

37. What is the difference between the Office of Inspector General (OIG) exclusion authority and CMS' revocation authority?

OIG exclusions generate from an exercise of authority under Sections 1128 and 1156 of the Social Security Act. The length of the exclusion varies and is determined by the OIG.

The effect of the exclusion is that no payment shall be made by any Federal health care program for any items or services furnished, ordered or prescribed by an excluded individual or entity.

CMS has 14 revocation authorities found at 42 C.F.R. § 424.535. Each revocation authority is accompanied by a re-enrollment bar which lasts a minimum of 1 year, but not greater than 3 years. 42 C.F.R. § 424.535 (a)(2) gives CMS the authority to take revocation action for exclusions imposed by the OIG. The effect of a CMS imposed revocation is that the provider/supplier is unable to receive reimbursement for Medicare services during the period of revocation.

38. What is a re-enrollment bar?

Per 42 CFR §424.535(c)(1), after a provider, supplier, delegated official, or authorizing official has had its billing privileges revoked, it is barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar begins 30 days after CMS or its contractor mails notice of the revocation and lasts a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation. Note that an enrollment bar issued pursuant to 42 CFR §424.535(c) does not preclude CMS or its contractors from denying re-enrollment to a provider/supplier that was convicted of a felony within the preceding 10-year period or that otherwise does not meet all criteria necessary to enroll in Medicare.

39. What licensure actions are considered an adverse legal action and must be reported to Medicare?

Examples include revocation and suspension of a medical license.

General Information

40. Where will the April conference be held? Are the dates known? Will the conference provide intermediate and/or advanced regulatory and compliance information?

The dates for the next conference have not yet been determined but it will tentatively be held in New Orleans, LA. CMS will make conference information available on https://www.cms.gov/Medicare/Provider-Enrollment-and-

Certification/MedicareProviderSupEnroll/index.html. Based on feedback received, CMS is considering beginner and advanced sessions.