

# THE MEDICARE PROVIDER ENROLLMENT TOOLKIT



# DEAR *Practitioner/Practice,*

Before you can begin billing for services furnished to Medicare patients, you must first enroll in the Medicare program. The Medicare provider enrollment process is complex, and your ability to complete the process without error will enable you to save time and money.

The Medicare provider enrollment process has changed a great deal over the past few years. Both the American Medical Association (AMA) and the Medical Group Management Association (MGMA) have seen an increase in the confusion and difficulties experienced by practitioners and practices interested in enrolling in the Medicare program. The AMA and MGMA work closely together to advocate on your behalf on this and many other issues. As a result of our most recent efforts on this issue, the Centers for Medicare & Medicaid Services (CMS) agreed to delay implementation of the problematic changes in the 2009 Medicare physician fee schedule until April 1, 2009. Additionally, AMA and MGMA members and staff assisted CMS in testing its new Internet-based enrollment system, which is expected to help streamline the process and decrease the time it takes to become enrolled.

Despite these achievements, the Medicare provider enrollment process continues to be overly complex and burdensome. In order to assist practitioners and practices who wish to enroll in the Medicare program, we have developed a Medicare Provider Enrollment Toolkit. As a member of the AMA and/or MGMA, we are providing you with this toolkit as a benefit of your membership.

We believe that this toolkit will help you to better understand the Medicare provider enrollment process. More importantly, we hope that it provides you with the necessary information to ensure that your Medicare provider enrollment application is processed efficiently and without difficulties.

Should you have any questions or concerns, please do not hesitate to contact either the AMA or MGMA.

Sincerely,



William F. Jessee, MD, FACMPE  
President and CEO  
Medical Group Management Association



Michael D. Maves, MD, MBA  
Executive Vice President and CEO  
American Medical Association

# TABLE *of contents*

1	Introductory letter
2	Table of Contents
3	When to enroll in the Medicare program
5	Checklist for beginning a Medicare enrollment application
7	Internet-based Provider Enrollment, Chain & Ownership System (PECOS)
10	Which application should I complete?
12	Electronic funds transfers (EFT)
14	2009 changes to Medicare provider enrollment
16	Changing enrollment information
18	Common Medicare enrollment application submission errors
20	Checklist for completing a Medicare enrollment application
22	Medicare provider enrollment application outcomes
25	Medicare provider enrollment appeals process
28	Flowchart of Medicare enrollment process
30	Important provider enrollment timeframes
31	Medicare contractor provider enrollment processing requirements
32	Commonly used abbreviations & acronyms
34	Resources

# WHEN TO ENROLL *in the Medicare program*

You must notify your Medicare contractor for enrollment purposes when you encounter the following situations:

- **Initial enrollment:**
  - When you begin furnishing services to Medicare beneficiaries.
  - When you reactivate your Medicare billing privileges after not submitting claims to Medicare for 12 months.
- **Change of information:** When you change your enrollment information, including the following situations:
  - You move to a new organization.
  - You open a new location.
  - Your ownership in a medical practice changes.
  - You change practice location.
  - There is an adverse legal action.
- **Revalidation:** Five years have passed since your last enrollment activity, and you have been notified by your contractor that you are required to revalidate your information. You are required by Medicare to resubmit and recertify the accuracy of your enrollment information every five years in order to maintain Medicare billing privileges.
- **Deactivation:** CMS will deactivate your billing privileges in the following situations:
  - You have not submitted any Medicare claims for 12 consecutive calendar months. The 12-month period begins on the first day of the first month without a claims submission through the last day of the 12th month without a submitted claim. You may not reactivate your billing privileges until you are prepared to submit a new claim.
  - You did not report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred.
  - You did not report a change in ownership or control within 30 calendar days.

You must submit a complete CMS-855 form if you are changing your Medicare enrollment information and meet either of the following criteria:

- You have never completed a CMS-855 form; or
- You have not completed a CMS-855 form since 2003.

Generally, you will not have to complete a new CMS-855 form if you are only making changes to your electronic funds transfer (EFT) information. However, if you meet one of the two criteria listed above, you will be required to do so.

### Three important things to note when considering enrollment in Medicare:

1. **Revalidation:** As of April 1, 2009, this effort has not begun in earnest. However, CMS has recently instructed contractors that they may conduct revalidation efforts if there are available funds at the end of the fiscal year. Thus, at some point in the future, you should expect to be asked to revalidate your enrollment information.
2. **Changes to NPI:** Any changes to your practice information that you provided on your National Provider Identifier (NPI) application must also be provided to your Medicare contractor within 30 days. For more information on how to make these changes to your provider enrollment information, see the section of the toolkit on Changing your Medicare Provider Enrollment Information.
3. **Enrollment more than five years ago:** CMS strongly encourages practices and practitioners to resubmit their enrollment application if it has been more than five years since they last submitted one.

# CHECKLIST FOR

## *beginning a Medicare enrollment application*

One of the best and easiest ways to avoid difficulties with Medicare enrollment is to ensure that you have all of the information and documents that you need before you begin to fill out the application.

You should have the following pieces of information at your fingertips before you begin:

- Correct 855 Enrollment Form:** Have a copy of the most recent version of the CMS-855 form that you will be completing. This also applies to those individuals using Internet-based PECOS, because the information that you will need to provide and the terminology used is the same on both the paper and Internet-based applications. The applications are located on the CMS Forms section of the CMS Web site. For more information on which form(s) you should complete, read the Which Application Should I Complete? section of this toolkit.
- The start date for the practice or practitioner:** Applications can be submitted only up to 30 days before a practice or practitioner will begin furnishing services to Medicare patients.
- The appropriate National Provider Identifier (NPI) number(s):**
  - o For an organization, you will need the organization's Type II NPI and any NPIs associated with the organization's subparts.
  - o For an individual working in an organization, such as a group practice, you will need the individual's Type I NPI, the organization's Type II NPI and NPIs associated with the organization's practice locations if they have been separately enumerated.
  - o For a single, incorporated practitioner, you will need the NPI number for yourself and the NPI number for your corporation.
  - o For questions concerning NPIs, you must contact the NPI Enumerator. You can do this in the following ways:
    - Telephone:
      - 800.465.3203
      - 800.692.2326 (TTY)
    - E-mail: [customerservice@npienumerator.com](mailto:customerservice@npienumerator.com)
    - Mail:
      - NPI Enumerator
      - P.O. Box 6059
      - Fargo, ND 58108-6059
- Proof of your organization's Tax Identification Number (TIN) and legal business name (LBN):** This can be one of the following:
  - o IRS form CP-575
  - o IRS form 147C
  - o IRS form 8012 – Tax Coupon
  - o Department of Treasury form 8489

- CMS-460 form:** A copy of the most recent version of the Medicare Participating Provider Agreement (CMS-460 form).
- Banking Information:** Certainty that the name on the bank account where your money will be deposited matches the name you will be using to enroll in Medicare. For organizations, this name must be your LBN.
- CMS-588 form:** A copy of the most recent version of the Electronic Funds Transfer (EFT) Authorization Agreement (CMS-588 form). For additional information on EFT, read the Electronic Funds Transfer section of this toolkit.
- Copies of any pertinent licenses (business, medical, etc.).**
- Copies of documentation pertaining to adverse legal actions.**

# INTERNET- *based PECOS*

In late 2008, CMS launched its long-awaited Internet-based version of Provider Enrollment, Chain and Ownership System (PECOS). As of April 2009, Internet-based PECOS, or PECOS Web as it is sometimes called, is available nationwide for use by individual practitioners and group practices interested in enrolling or changing individual or group information. Group practices will not be able to use Internet-based PECOS to change ownership information until May 2009, but all other changes can be made via the system. Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) will not be able to use Internet-based PECOS until 2010 at the earliest.

## PROS

System is scenario-driven, so applicant will not see questions that do not pertain to him/her.

Contractors are able to process applications more quickly because the data have been entered directly into the system.

System has an audit function ensuring that all required information is provided.

Eliminates the problem of correct personnel not receiving notices of missing information.

E-mails the applicant if information is missing.

Provides status updates for applicant.

Eliminates data-entry errors made by contractors when processing applications.

## CONS

Contractor will not begin processing the application until a signed certification statement is sent by mail. (This corresponds to Section 15 in the paper application.)

Original signature on the certification statement and attachments still must be mailed to contractor.

Individuals using the system on behalf of an organization will still need to complete additional paper work to receive authorization to access the system on behalf of the organization.

The applicant may not be the appropriate contact person.

Contractor may still misplace documents.

### *AMA and MGMA advocacy efforts result in CMS Internet-based PECOS policy reversal*

When CMS originally launched Internet-based PECOS in December 2008, it prohibited practice staff and credentialing professionals from accessing Internet-based PECOS on behalf of individual practitioners. As a result of advocacy efforts by the AMA and MGMA, CMS has reversed this policy and will now allow those delegated by individual practitioners to perform credentialing activities to use Internet-based PECOS on their behalf. Instead of prohibiting practice staff and others from using Internet-based PECOS on behalf of individual practitioners, CMS reminds individual practitioners that they are ultimately liable for the

accuracy of the enrollment information reported to the Medicare program, as well as for any unauthorized disclosures of the information that may occur while the information is being sent to Medicare.

### *Internet-based PECOS for organizations*

As of April 1, 2009, organizations, such as group practices, are permitted to use Internet-based PECOS to complete the information contained within the CMS-855B application. As expected, this process is more complicated and cumbersome for organizations than for individual practitioners. Additional paper work must be completed and further steps must be taken in order to gain access to the system.

### **Obtaining access to Internet-based PECOS for an organization**

Before a medical practice or other organization can use Internet-based PECOS, a number of steps must be taken.

- **Step 1:** The first time the system is used for this purpose, the Authorized Official must register in the Internet-based PECOS Identification and Authentication System (PECOS I&A) by visiting <https://pecos.cms.hhs.gov>. See the CMS-855B for information on who can act as an Authorized Official. If you are changing or revalidating the organization's enrollment information, note that this person must be noted as an Authorized Official on your previous CMS-855B application. CMS will verify the information provided and the CMS External User Services (EUS) Help Desk will notify the Authorized Official of the verification.
- **Step 2:** Any individuals who need to use Internet-based PECOS on behalf of an organization will also need to register in PECOS I&A, and the Authorized Official will need to grant these individuals permission to access to the organization's enrollment information. These individuals may be employees of the organization or employees of another organization. CMS will verify the information provided by these individuals and ensure that permission has been granted by the Authorized Official for each requesting individual. The first individual (other than the Authorized Official) from an organization seeking access to Internet-based PECOS must complete the Security Consent Form and have it signed by an official of his or her employer and by the Authorized Official of the organization for whom the enrollment application is being completed. The form must then be mailed to the CMS EUS Help Desk.
  - o **Example 1:** A group practice hires a consulting company to perform the credentialing work for the practice. The first individual from that company who needs to access Internet-based PECOS on behalf of the group practice will need to complete the Security Consent Form. Additional individuals from that company that may later need access to the group practice's Internet-based PECOS enrollment information will not need to complete a new Security Consent Form.
  - o **Example 2:** The group practice has employees who are responsible for completing Medicare enrollment applications for the practice. The first employee (other than the Authorized Official) seeking access to Internet-based PECOS to conduct enrollment activities on behalf of the group (not individual practitioners) will need to complete the Security Consent Form.
- **Step 3:** The CMS EUS Help Desk will notify the Authorized Official that the approval process is complete.

Upon completion of the Internet-based PECOS application, the Authorized Official of the organization must sign, date and mail the two-page Certification Statement printed from Internet-based PECOS. The contractor will not begin processing the application until this Certification Statement has been received.

**NOTE:**

This process will take at least two to three weeks to complete. Thus, anyone who anticipates needing access to Internet-based PECOS on behalf of an organization should begin the registration and verification process well in advance of any anticipated enrollment activity. If the enrollment activity needs to occur more quickly than this process allows for, the paper applications will continue to be available.

*Resources for Internet-based PECOS*

Access Internet-based PECOS from the Provider-Supplier Enrollment section of the CMS Web site.

Request assistance for technical difficulties with Internet-based PECOS via e-mail or call the External User Services Help Desk at 866.484.8049.

Contact your contractor with questions about enrollment or the enrollment process.

# WHICH APPLICATION *should I complete?*

I should complete the **CMS-855I** application because I am a:

- Physician (including solo practitioners who are incorporated or not incorporated)
- Nonphysician practitioner
  - Anesthesiology Assistant
  - Audiologist
  - Certified Nurse Midwife
  - Certified Registered Nurse Anesthetist
  - Clinical Nurse Specialist
  - Clinical Social Worker
  - Nurse Practitioner
  - Occupational Therapist in Private Practice
  - Physical Therapist in Private Practice
  - Physician Assistant
  - Psychologist, Clinical
  - Psychologist billing independently
  - Registered Dietitian or Nutrition Professional
  - Speech Language Pathologist (beginning July 2009)

**NOTE:** Solo practitioners should complete only the 855-I.

I should complete the **CMS-855B** application because I am a(n):

- Ambulance Service Supplier
- Ambulatory Surgical Center
- Clinic/Group Practice
- Competitive Acquisition Program (CAP)
- Part B Drug Vendor
- Independent Clinical Laboratory
- Independent Diagnostic Testing Facility (IDTF)
- Mammography Center
- Mass Immunization (Roster Biller Only)
- Portable X-ray Supplier
- Radiation Therapy Center
- Slide Preparation Facility

I should complete the **CMS-855R** application because I am:

- A physician or nonphysician practitioner with the right to independently bill Medicare, and I am reassigning my benefits to an organization such as a group practice.
- Terminating the reassignment of my benefits to an organization.
- A representative of an organization terminating a physician's or nonphysician practitioner's reassignment of benefits to the organization.

For more information on the different CMS-855 applications, visit the CMS Web site. The CMS-855 enrollment forms are located on the CMS Forms section of the CMS Web site.

# ELECTRONIC

## *funds transfers*

New practices and practitioners who do not reassign their benefits, as well as those changing their Medicare enrollment information, are required to receive payment for their Medicare services electronically. The method of electronic payment Medicare uses is called electronic funds transfer (EFT). In order to receive your payments via EFT, you must complete the Electronic Funds Transfer Authorization Agreement (CMS-588). If you do not complete this form and include it with your application submission, your application will be delayed until you respond to your contractor's request for this information. If you do not respond to the request from your contractor, the contractor will deny your application. For additional information on the differences between a denial and a rejection, see the Medicare Provider Enrollment Application Outcomes section of this toolkit.

### ***Who must complete a CMS-588 form?***

- Newly enrolling practices and practitioners who are not reassigning their benefits to a group practice or other organization.
- Practices and practitioners not reassigning their billing privileges to a group practice or other organization who are changing their Medicare provider enrollment information and who have not completed a Medicare provider enrollment application since 2003.
- Practices and practitioners not reassigning their billing privileges to a group practice or other organization who are responding to a contractor's revalidation request. For additional information on revalidation, read the When to Enroll in the Medicare Program section of this toolkit.
- Practices and practitioners who are:
  - o Transitioning from a carrier or fiscal intermediary to a Medicare Administrative Contractor (MAC); and
  - o Already receiving payments via EFT.

### ***Concerns about banking privacy and reversal of Medicare electronic funds transfers***

Some practices and practitioners have expressed concerns regarding the privacy of their banking information, as well as the ability of Medicare to reach into their accounts in order to retrieve Medicare payments. There are stringent and explicit banking rules that govern the ability of any person or entity, including Medicare, to access funds from your bank account. For instance, Medicare is able to reverse electronic funds transfers where a contractor erroneously makes a duplicate payment. However, Medicare cannot, as a general rule, access your bank account and seize funds without following a set of legally prescribed steps. Seizing funds from your bank account involves a different process from garnishment, recoupment and offset, all of which involve reducing Medicare payments before an electronic fund transfer. There are benefits to receiving Medicare payments electronically, including a reduction in potential fraud and/or theft, staff time associated with making bank deposits and the possibility that payments will be lost in the mail. Most importantly, it will take less time for you to receive electronic payments than paper checks.

**NOTE:**

Because of the EFT requirement, **CMS requires that the name on the bank account matches the name on the Medicare provider enrollment application.** In the case of an individual practitioner, this means your name. For organizations such as group practices, this means the legal business name (LBN) of your organization. Your LBN may be different than your “Doing Business As” (DBA) name, but the primary name on the bank account where your Medicare funds are deposited must be your LBN.

In CMS' most recent guidance, the agency announced payments would only be made to a banking institution in the state where the practice is located. However, as a result of advocacy efforts of the AMA and MGMA, CMS withdrew this position and left the previous policy in place.

# 2009 CHANGES

## *to Medicare provider enrollment*

As part of the 2009 Medicare physician fee schedule, CMS has made significant changes to the Medicare provider enrollment regulations. Most important among them, CMS has instituted limitations on your ability to retroactively bill for services furnished to Medicare patients before you are officially enrolled in the Medicare program and eligible to bill.

Previously, you were permitted to bill for services provided up to 27 months before you were enrolled in Medicare. Under the new regulations, you are permitted to bill Medicare only for services furnished to Medicare patients up to 30 days before your billing effective date. The effective date is the later of:

- The date you filed an application that your Medicare contractor ultimately approves; or
- The date you began furnishing services at a new practice location.

Your filing date is defined as the date your Medicare contractor receives your approvable Medicare enrollment application. In the case of an application submitted using Internet-based PECOS, the filing date is the day the contractor receives both of the following:

- Your electronic enrollment application; and
- Your signed certification statement that is signed with an original signature and mailed to your Medicare contractor.

We have created some scenarios to help demonstrate what this means in practical terms.

- **Example 1:**
  - Scenario: Physician A is going to start at Practice 1 on March 1. Practice 1 submits Physician A's application, containing all of the necessary information, and it is received by the contractor on Feb. 1.
  - Answer: The filing date is Feb. 1. The effective date is March 1, the date Physician A began furnishing services at Practice 1, because it is later than the filing date. While you might think this means that you could then bill for services furnished as early as Feb. 1, keep in mind that Medicare was told that the practitioner was going to begin furnishing services on March 1. Thus, any claims submitted for services furnished before March 1 will be denied.
- **Example 2:**
  - Scenario: Physician A starts at Practice 1 on Feb. 1. Physician A's application is received by the contractor on March 1 and contains all of the necessary information.
  - Answer: The filing date is March 1. The effective date is also March 1 because this is later than the date Physician A began furnishing services at Practice 1. However, Physician A can be paid for services provided to Medicare patients as early as Feb. 1 because that is 30 days before the March 1 effective date.

- **Example 3:**
  - Scenario: Physician A starts at Practice 1 on March 1. Physician A's application is received by the contractor on March 2 and contains all of the necessary information.
  - Answer: The filing and the effective dates are both March 2, since this is later than when Physician A began furnishing services at Practice 1. You cannot bill for services provided before the physician's start date, so in this case, you would be able to bill for services furnished March 1 or later.
- **Example 4:**
  - Scenario: Physician A is starting at Practice 1 on March 1. Physician A's application is received by the contractor on Feb. 1. It is missing a copy of the physician's license. The contractor sends a letter to Practice 1 or Physician A on Feb. 15 requesting a copy of the license. Neither the physician nor the practice follows up with the contractor.
  - Answer: The filing date is not established in this case because the contractor cannot complete the processing of the application. The application is denied, and notification is sent on March 30. For additional information on enrollment application denials, read the Medicare Provider Enrollment Application Outcomes and Medicare Provider Enrollment Appeals Process sections of this toolkit. Practice 1 has the option of filing a corrective action plan, an appeal or both. If Practice 1's corrective action plan is approved, the effective date is the date the practice came into compliance. If Practice 1 wins on appeal, the filing date is established as part of the appeal decision. Alternatively, Practice 1 can wait until the appeal rights have lapsed (60 days after the postmark of the notice) and file a new application. In this case, the filing and effective dates will both be the date the new processable application is received by the contractor, and Practice 1 will be able to retroactively bill for services furnished up to 30 days before the effective date of the new application.
- **Example 5:**
  - Scenario: Physician A starts at Practice 1 on Feb. 1. Physician A's application is received by the contractor on March 1 and is missing documentation. The contractor sends a letter to Physician A on March 15 requesting a copy of the license. Physician A responds to the contractor's request by the requested deadline. Through no fault of Physician A, the contractor is unable to process the application until May 1.
  - Answer: The filing date is March 1, and the effective date is Feb. 1. Since Physician A responded to the request for information within the required time, Physician A is still permitted to bill back to Feb. 1.
- **Example 6:**
  - Scenario: Physician A's Medicare billing privileges were deactivated because Physician A did not bill the Medicare program for services for 12 consecutive months beginning on Feb. 1, 2008. Physician A's application is received by the contractor on April 1, 2009 to reactivate Medicare billing privileges.
  - Answer: Physician A's enrollment application indicates that he started seeing patients at this location on Jan. 1, 1998. Physician A's date of filing is April 1, 2009, while the effective date is March 2. Physician A is precluded from receiving payment for services rendered between Feb. 1, 2009 and March 1, 2009.

# CHANGING

## *your Medicare provider enrollment information*

**\*\*\* Report changes to your enrollment information promptly or risk termination of your billing privileges.\*\*\***

While you have always been required to alert your Medicare contractor to any changes in your Medicare provider enrollment information, some recent changes have made it even more important that you do so in a timely manner. **You could lose your Medicare billing privileges for at least a year if your contractor learns you have not made changes to your enrollment information within the required timeframe.**

You must notify your contractor of changes to your Medicare enrollment information according to the following timeframes:

<i>Type of change</i>	<i>Timeframe to notify Medicare of a change</i>
Changes in ownership (CHOW) or financial or controlling interest	30 days
Changes in practice location	30 days
Adverse legal actions (see Medicare enrollment application for a complete list)	30 days
All others	90 days

You may want to refer to the “Reporting Responsibilities Fact Sheets” found under “Downloads” on the Provider-Supplier Enrollment section of the CMS Web site.

### ***Practitioners or practices that enrolled before 2003***

If you enrolled as a Medicare provider before 2003 and have not made any changes to your enrollment information since that time, you will need to complete the entire CMS-855 application or Internet-based PECOS application in order to make any changes to that information. In the case of a practice hiring a new practitioner, this may mean that you have to complete a new CMS-855B for your practice before you can enroll the individual practitioner and reassign his/her benefits to the group. If this is the situation, the practice will have to agree to accept payment electronically via electronic funds transfer (EFT). Because of a change in regulatory interpretation, CMS will no longer pay newly enrolling practices and practices making change to their enrollment information via paper checks. For more information about EFT and the CMS-588 form, read the Electronic Funds Transfer section of this toolkit.

**If you do not notify your contractor of changes to your enrollment information, and your contractor later finds out, you could face a revocation of your Medicare billing privileges.** By regulation, revocations of Medicare billing privileges are for a minimum of one year. This means that you could not be paid for furnishing services to Medicare beneficiaries for at least a full year, which could have a detrimental financial effect on your practice.

### ***Group practices***

If you do not have a copy of your organization's original Medicare enrollment information and do not know who has been designated as your organization's "authorized official" or "delegated official," an owner of your practice must submit a written letter on the organization's letterhead to your Medicare contractor authorizing the release of that information. Medicare contractors are not allowed to release such information over the telephone or in an e-mail, and neither are they allowed to release it to practice staff.

### ***Moving from a higher-paying geographic area to lower one***

If you move from a high-paying geographic area to a lower-paying one and do not notify your contractor of the change, you could also be subject to an overpayment action. If CMS or your Medicare contractor believes you have been overpaid, you will receive a letter demanding the return of those funds plus interest. Generally, if you do not repay this money within 30 days, Medicare will begin recouping the funds from your future payments unless you challenge the recoupment by filing an appeal. Overpayments will be assessed from the date your practice location changed (although Medicare is only permitted to go as far back as Jan. 1, 2009). In many cases, you will need assistance of legal counsel. Overpayment actions can be quite costly to the practice and practitioner, and should be avoided at all costs.

### ***Understanding the "Do Not Forward" Initiative and its effects on Medicare payments***

Another reason to make sure that you notify your contractor of any changes in your Medicare provider enrollment information is the Do Not Forward (DNF) Initiative. As of 2002, if CMS or your contractor sends you mail at the address Medicare has on record and you are no longer at that address, it will not be forwarded. Instead, it will be returned to your Medicare contractor, and your Medicare payments may be suspended without notice. The only way to remove the suspension is to notify CMS of the changes in your provider enrollment information via the appropriate CMS-855 application or Internet-based PECOS and then wait until the contractor processes them. Of course, if you have not met the time constraints detailed above, you may then find yourself subject to a revocation of your billing privileges and/or an overpayment action.

# COMMON MEDICARE

## *enrollment application submission errors*

### **CMS-855I**

- CMS-855I has not been submitted along with the CMS-855R when a physician is reassigning benefits to a group practice.
- Sec. 2D: Specialties are marked with X or multiple P's.
- Sec. 4
  - o B: Questions 1 & 2 are not answered.
  - o C:
    - The date started at location is blank.
    - Is incomplete if there is more than one location.
- Proof of master's degree program information is missing on the nurse practitioner and clinical nurse specialist applications.
- Documentation of tax information is missing.

### **CMS-855B**

- An entire CMS-855B was not submitted when making a change related to a Tax Identification Number (TIN) for an established organization.
- Dates on the application do not reflect the:
  - o Start date for the organization.
  - o Start date for the business.
  - o Start date for the location.
- Sec. 6 is not completed for all:
  - o Owners and/or
  - o Nonowners listed in Sec. 16 (Authorized Officials).

### **CMS-855R**

- Sec. 1 is missing the effective date. This should be the date the individual will start reassigning his/her benefits to the group practice.
- Sec. 4B is not signed or is not signed by the appropriate official. It must be signed by an individual who is designated as an Authorized Official on the CMS-855B.
- The application is not signed by both the practitioner reassigning benefits and the Authorized or Delegated Official for the organization.
- The Authorized or Delegated Official who signed the application is not on file as an authorized signer for the group practice.

***CMS-855B & 855I:***

- o Sec. 1A:
  - Reason for application submittal is missing or completed incorrectly.
  - NPI number(s) missing.
- o Sec. 2B:
  - Legal business name (as reported to the IRS) is filled in with the Doing Business As (DBA) name.
  - Incorporation date is left blank.
- o Sec. 4A: Date practice first started rendering services to Medicare patients at this location is left blank.
- o The “Yes” and “No” boxes in the Adverse Legal History sections and throughout the applications are skipped or neither box is checked.
- o Sec. 15: The certification statement is not included with the application.
- o Sec. 17: Checklist is not marked and/or items on the checklist were not sent with the application.

***Errors common to multiple forms:***

- Application is filed more than 30 days prior to practitioner’s start date.
- Signature:
  - o Is copied or stamped.
  - o Is blank.
  - o Is not dated.
  - o Is someone other than an authorized signer or individual practitioner.
  - o Is done with black ink instead of blue ink, and contractor is unable to ascertain whether it is an original signature.

**NOTE:** Medicare considers it unacceptable to write “N/A” in response to a question that requires a “yes” or “no” answer. This is considered an incomplete response, and your contractor will send you a letter indicating that you are missing information.

# CHECKLIST FOR COMPLETING *a Medicare enrollment application*

\*\*\* Reduce your chances of problems by checking off these steps \*\*\*

- Is it more than 30 days before the practitioner or practice's start date? Remember, Medicare contractors will return applications that are received more than 30 days before the date the applicant will begin furnishing services at that location.
- In the case of a paper application:
  - Have you completed the correct version of the application? This can be verified by accessing the CMS Forms section of the CMS Web site and comparing the dates noted in the bottom left corner of the application.
  - Have you completed the application using Adobe or pen?
- In the case of an Internet-based application:
  - Have you printed out the certification statement?
  - Has the certification statement been signed with an original signature?
  - Is your certification statement and attachment package complete or will it be ready within the next 15 calendar days?
- Is every applicable space filled in?
  - Is the country of birth listed, even if it is the United States?
  - Have you checked all appropriate boxes? If you are completing an application for the first time since 2003, check "add" where it asks if you are adding, changing or deleting information.
- Have you filled in all of the required dates?
- Have you completed Sec. 4C of the CMS-855I and CMS-855B for every practice location? You are permitted to copy this page as many times as is necessary.
- Have you listed all of the appropriate individuals in Secs. 5 and 6 of the CMS-855B? You are permitted to copy these pages as many times as is necessary.
- Have you provided an original copy of the practitioner or practice's license?
- If you are filing a change of information for a practitioner or practice, has the practice or practitioner completed an application since 2003? If not, have you completed the entire application, complete with the supporting documentation?
- Is the application signed and dated in blue ink, as recommended? If not, CMS may not be able to distinguish between an original signature and a copy, and may return the application for failure to provide an original signature.
- Have you completed an Electronic Funds Transfer Authorization Agreement form (CMS-588)? Practices and physicians new to the Medicare program or making a change to their existing enrollment application are required to receive reimbursement electronically if they are not reassigning their billing privileges.
- If enrolling a new practice or practitioner, have you completed the Medicare Participating Provider or Supplier Agreement (CMS-460)?

- Have you read through Sec. 17 of the application and verified that you have copies of all of the required attachments?
- Have you obtained the address for the appropriate Medicare contractor for your jurisdiction in order to mail your applications? To locate your contractor's mailing address, visit the Provider-Supplier Enrollment section of the CMS Web site.
- Have you made a copy of the application for your records? This will be very important for making future changes to CMS-855B and CMS-855R applications because they must be signed by the same people who sign the original applications. Medicare contractors are not allowed to release information regarding the names of the Authorized Officials, which can make it difficult when there are personnel changes.

# MEDICARE PROVIDER

## *enrollment application outcomes*

There are five possible outcomes to a Medicare provider enrollment application:

- You are granted Medicare billing privileges.
- You are contacted for missing information.
- Your application is returned.
- Your application is denied.
- Your application is rejected. (As of April 1, 2009, this is no longer an option for individual practitioners or group practices.)

If there are no problems with your Medicare provider enrollment application, the contractor will process your application and you will receive a letter stating that you have been granted Medicare billing privileges. At that point, you can begin billing for services furnished to Medicare beneficiaries.

The other four possible outcomes occur in very specific circumstances and require additional work on your part before you can receive Medicare billing privileges.

### ***Missing Information***

**It is very important that you respond promptly to any communications you receive from your contractor requesting additional enrollment information. Furnishing missing information in a timely manner ensures that you retain your original filing date. If you do not respond to that request within 30 days, your application may be rejected or denied (see below for additional information).** Your contractor does have some latitude to grant you additional time if you give a reason for needing it, but you must contact your contractor to make that request.

### ***Returned applications***

If your application is returned, you must complete a new CMS-855 application. The time clock does not start, so your filing date will be the date the contractor receives your new application, assuming it is complete. For Medicare purposes, a returned application is considered a non-application. You are not entitled to appeal a returned application.

Possible reasons for a returned application:

- There was no signature on the CMS-855 application.
- You submitted an old version of the CMS-855 application.
- The application contained a copied or stamped signature.
- The signature on the application was not dated.
- The CMS-855 application was signed by someone other than the individual practitioner applying for enrollment.
- You failed to submit all of the forms needed to process a reassignment package within 15 calendar days of the contractor's receipt of your application package.

- You sent your CMS-855 to the wrong contractor (e.g., the application was sent to Contractor X instead of Contractor Y).
- You completed the form in pencil.
- You submitted the wrong application (e.g. a solo practitioner submitted an 855R instead of an 855I).
- If a Web-generated application was submitted, it did not appear to have been downloaded from the CMS Web site.
- An old owner or new owner in a change of ownership (CHOW) situation submitted its application more than three months before the anticipated date of the sale. (This applies only to inpatient applicants.)
- You faxed or e-mailed your application.
- The contractor received the application more than 30 days before the effective date listed on the application. (This does not apply to certified providers, ASCs or portable X-ray suppliers.)
- The contractor confirmed that you submitted a new enrollment application before the expiration of the time period in which you are entitled to appeal the denial of your previously submitted application.
- The contractor discovered or determined that you submitted a CMS-855 application for the sole purpose of enrolling in Medicaid; the only exception to this is when you are required to submit a Medicare cost report in order to participate in a state Medicaid program.
- The CMS-855 was not needed for the transaction in question. (A common example is an enrolled physician who wants to change his/her reassignment of benefits from one group to another group and submits a CMS-855I and a CMS-855R. Because only the CMS-855R is needed, the CMS-855I shall be returned.)
- The CMS-588 was sent in as a stand-alone change of information request, that is, without a CMS-855 form, and was:
  - o Unsigned;
  - o Undated; or
  - o Contained a copied, stamped or faxed signature.

### ***Denied applications***

If your application is denied, you are granted certain appeal rights. For more information on the appeals process, read the Medicare Provider Enrollment Appeals Process section of this toolkit. Your filing date will depend on the outcome of your appeal.

Reasons for a denied application:

- You are found to be out of compliance with the Medicare enrollment requirements applicable to you, and you have not submitted a corrective action plan (CAP). For more information on CAPs, read the Medicare Provider Enrollment Appeals Process section of this toolkit.
- As an individual practitioner or group practice or individuals required to be reported on the Medicare provider enrollment application, such as owners, managing employees, authorized or delegated officials, medical directors, supervising physicians, you are:
  - o Excluded from Medicare, Medicaid or any other federal health care program; or
  - o Debarred, suspended or otherwise excluded from participating in any other federal procurement or nonprocurement program or activity.
- You, as an individual practitioner or group practice or any owner of the group practice, were convicted within the 10 years preceding enrollment or revalidation of enrollment of a federal or state felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include:
  - o Felony crimes against persons, such as murder, rape, assault and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions;

- o Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions;
- o Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct; and/or
- o Any felonies outlined in section 1128 of the Social Security Act.
- You submitted false or misleading information on your enrollment application to gain enrollment in the Medicare program.
- CMS determines, upon onsite review or other reliable evidence, that you are not operational to furnish Medicare covered items or services, or do not meet Medicare enrollment requirements to furnish Medicare covered items or services. This includes, but is not limited to, the following situations:
  - o You do not have a license(s) or are not authorized by the federal/state/local government to perform the services that you intend to render.
  - o You do not have a physical business address or mobile unit where services can be rendered and/or do not have a place where patient records are stored to determine the amounts due such provider or other person.
  - o You do not meet CMS regulatory requirements for your specialty.
  - o You do not qualify as a provider of services or a supplier of medical and health services. An entity seeking Medicare payment must be able to receive reassigned benefits from physicians in accordance with the Medicare reassignment provisions. **NOTE:** This denial provision will be used in cases where you are not recognized by any federal statute as a Medicare provider or supplier (e.g., marriage counselors).
  - o You do not provide a valid SSN/EIN for the applicant, owner, partner, managing organization/employee, officer, director, medical director and/or delegated or authorized official.
  - o A home health agency (HHA) does not meet the capitalization requirements required by law.
- You have an existing overpayment at the time of filing an enrollment application.
- You have been placed under a Medicare payment suspension.

### ***Rejected applications***

Effective April 1, 2009, applications for individual practitioners & medical practices will no longer be rejected. Instead, applications for these types of Medicare providers will be denied, as discussed above. Rejection is a valid option for other types of Medicare suppliers.

If your application is rejected, you are not entitled to appeal the contractor's decision. You must complete a new application, and your filing date is the date your contractor receives your new, complete application.

There is only one reason for a rejected application: You failed to respond to a request from your contractor for missing or clarifying information. **It is very important that you respond promptly to any communications you receive from your contractor requesting additional enrollment information. If you do not respond to that request within 30 days, your application will be rejected.** Your contractor does have some latitude to grant you additional time if you furnish a reason for needing it, but you must contact your contractor to make that request.

# MEDICARE PROVIDER

## *enrollment appeals process*

You have the right to formally appeal the **revocation** of your Medicare provider enrollment application, as well as the **denial** of your Medicare billing privileges. Note that rejection, a possibility only until April 1, 2009 when changes affecting retroactive billing go into effect, is not appealable. For more information on the differences between revocation and denial, refer to the Medicare Provider Enrollment Application Outcomes section of this toolkit.

In the event that your Medicare billing privileges are **revoked**, the revocation is effective 30 days from date of the postmark on the envelope containing the notice that has been mailed to you, except that in the case of a **revocation** based on a federal exclusion or debarment, revocation is effective with the date of the exclusion or debarment. This date may precede the date you receive actual notice of the revocation.

Your contractor is required to notify you of a denied Medicare provider enrollment application or a revocation of Medicare billing privileges by certified mail. This notice must include:

- The reason(s) for **denial** or **revocation** with enough information for you to understand exactly what caused the denial or revocation;
- Information about your appeal rights; and
- Address to which your written appeal must be mailed.

In most cases, you will have three options when it comes to filing an appeal. You can:

- **File a formal written appeal within 60 calendar days of the notice's postmark;**
- **File a corrective action plan (CAP) within 30 calendar days of the notice's postmark; or**
- **File a formal written appeal with 60 calendar days and file a CAP within 30 calendar days.**

If you do not pursue one of these options in a timely manner, you waive all of your rights to further administrative review. This holds true throughout the appeals process.

### What is a corrective action plan?

A CAP is an informal process in which the contractor has complete discretion whether to consider additional information. It gives you an opportunity to correct the deficiencies that resulted in the **denial** or **revocation** of your billing privileges. The CAP should provide evidence that you are in compliance with Medicare requirements. You can file a CAP and a formal written appeal simultaneously. You will be notified of the decision regarding your CAP by mail. If it is approved, you will be asked to withdraw your appeal; if it is not approved, your formal appeal will provide you with another means to challenge the decision to revoke your billing privileges or deny your application.

Contractors are required to process CAPs within 60 days of receipt. You should be aware that the deadline for filing a formal written appeal is not extended because you have filed a CAP; the 60-day filing requirement includes the time for submitting and processing a CAP. **Thus, if you wish to file a formal appeal, you should not wait for the decision on your CAP to do so.**

None of this information should be construed as legal advice.  
Please be advised that this document has been created for educational purposes only.  
Note: The rules and regulations upon which this document are based are subject to change at any time.  
You should refer to those rules and regulations should any questions arise.  
If you have any questions regarding legal matters, please consult an attorney.

Filing a CAP is not an option in all circumstances. Specifically, you are not eligible to file a CAP if your Medicare billing privileges have been **revoked** based on:

- o A federal exclusion or debarment;
- o A felony conviction;
- o A license suspension; or
- o CMS has determined that your practice is no longer operational or you are not furnishing Medicare services at the location you provided on your enrollment form.

In these instances, your only option is to file a formal written appeal.

### **What is the formal appeals process?**

#### *Initial request for reconsideration*

The initial request for reconsideration is the first step in the formal appeals process. It must be handled by either your CMS Regional Office or a contractor hearing officer not involved in the initial determination to **deny** your Medicare provider enrollment application or to **revoke** your billing privileges. In most, if not all instances, it will be a hearing officer making a determination regarding your initial request for reconsideration.

#### The format

A formal written request for reconsideration must be signed by the individual physician, nonphysician practitioner or, in the case of a group practice, the organization's Authorized Official. You will receive a letter from the hearing officer acknowledging receipt of your request. This letter should also advise you that a determination will be issued within 90 days of the date of the request. The reconsideration will be considered "on the record." It is your responsibility to demonstrate that your enrollment application was incorrectly denied or that your billing privileges were revoked erroneously. Any and all evidence you wish to have considered should be submitted at the time of your request for reconsideration. If you do not submit your evidence before a decision is reached, you will not be allowed to introduce it at higher levels in the appeals process.

You should be aware that the hearing officer will review only information relevant to your contractor's reason for denying your application or revoking your billing privileges at the time the decision was made and whether it was the correct decision. Contractors cannot submit new reasons for denial or revocation.

#### Late filings

If your request for reconsideration is filed late, you may still have an opportunity to be heard. The hearing officer is required to make a finding of good cause before taking any other action on the appeal. If you can show good cause for late filing, the hearing officer can extend the filing time. The hearing officer may find good cause when the record clearly shows, or you claim and your claims are not negated by the record, that your delay in filing was due to:

- Unusual or unavoidable circumstances, the nature of which demonstrate that you could not reasonably be expected to have been aware of the need to file timely; or
- Destruction by fire, or other damage, of your records when the destruction was responsible for the

None of this information should be construed as legal advice.  
Please be advised that this document has been created for educational purposes only.  
Note: The rules and regulations upon which this document are based are subject to change at any time.  
You should refer to those rules and regulations should any questions arise.  
If you have any questions regarding legal matters, please consult an attorney.

delay in filing.

### The decision

Your decision letter from the hearing officer will be sent to you by certified mail and will include the following information:

- A restatement of the facts and findings, including the legal basis for the contractor's initial decision to deny your application or to revoke your billing privileges;
- A summary of the documentation you provided to the hearing officer; and
- A clear explanation of the hearing officer's decision, including enough information for you to understand the reasoning.

In situations where the hearing officer issues a decision in favor of the contractor, the letter will contain:

- A legal basis to support each reason for the denial or revocation;
- An explanation as to why you do not meet the enrollment criteria;
- Further appeal rights, procedures for requesting a hearing before an administrative law judge (ALJ) and the address to which the written appeal must be mailed; and
- Information you must include with your appeal, such as your name and provider/supplier number, your taxpayer identification number (TIN) and a copy of the reconsideration decision.

For those who successfully appeal, the effective date will be determined as part of the appeal decision.

### *Administrative law judge (ALJ) hearing*

If your initial request for reconsideration is denied, you have the right to request a hearing before an ALJ. **This appeal must also be in writing, and it must be filed within 60 days after you receive the reconsideration decision.** Your contractor and CMS are also granted the right to request an ALJ hearing if they are dissatisfied with the decision made during the initial request for reconsideration.

Requests for ALJ hearings must be directed to:

Department of Health & Human Services  
Departmental Appeals Board (DAB)  
Civil Remedies Division, Mail Stop 6132  
330 Independence Avenue, SW  
Cohen Building, Room G-644  
Washington, DC 20201  
ATTN: CMS Enrollment Appeal

You should receive a letter acknowledging receipt of your request from an ALJ at the Departmental Appeals Board (DAB). It will also contain information detailing a scheduled prehearing conference. CMS will be represented by an attorney from the regional office of the Office of the General Counsel of the U.S. Department of Health & Human Services.

### *DAB Hearing*

Any party to the ALJ hearing (you, CMS or the Medicare contractor acting on behalf of CMS) that is unhappy with the decision made by the ALJ may request a further review by the DAB. That request must be filed within 60 days of receipt of the ALJ's decision.

The DAB will make its determination based on information provided in time for use during the initial request for reconsideration, as well as any evidence introduced at the ALJ hearing. It may also consider additional evidence if the DAB considers the evidence relevant and material to an issue presented. You will receive notice that the DAB will consider evidence pertaining to the specified issues. The notice will provide you with reasonable time to comment and present other evidence pertinent to those issues. If evidence is presented orally, you are entitled to a copy of the transcript made during the presentation.

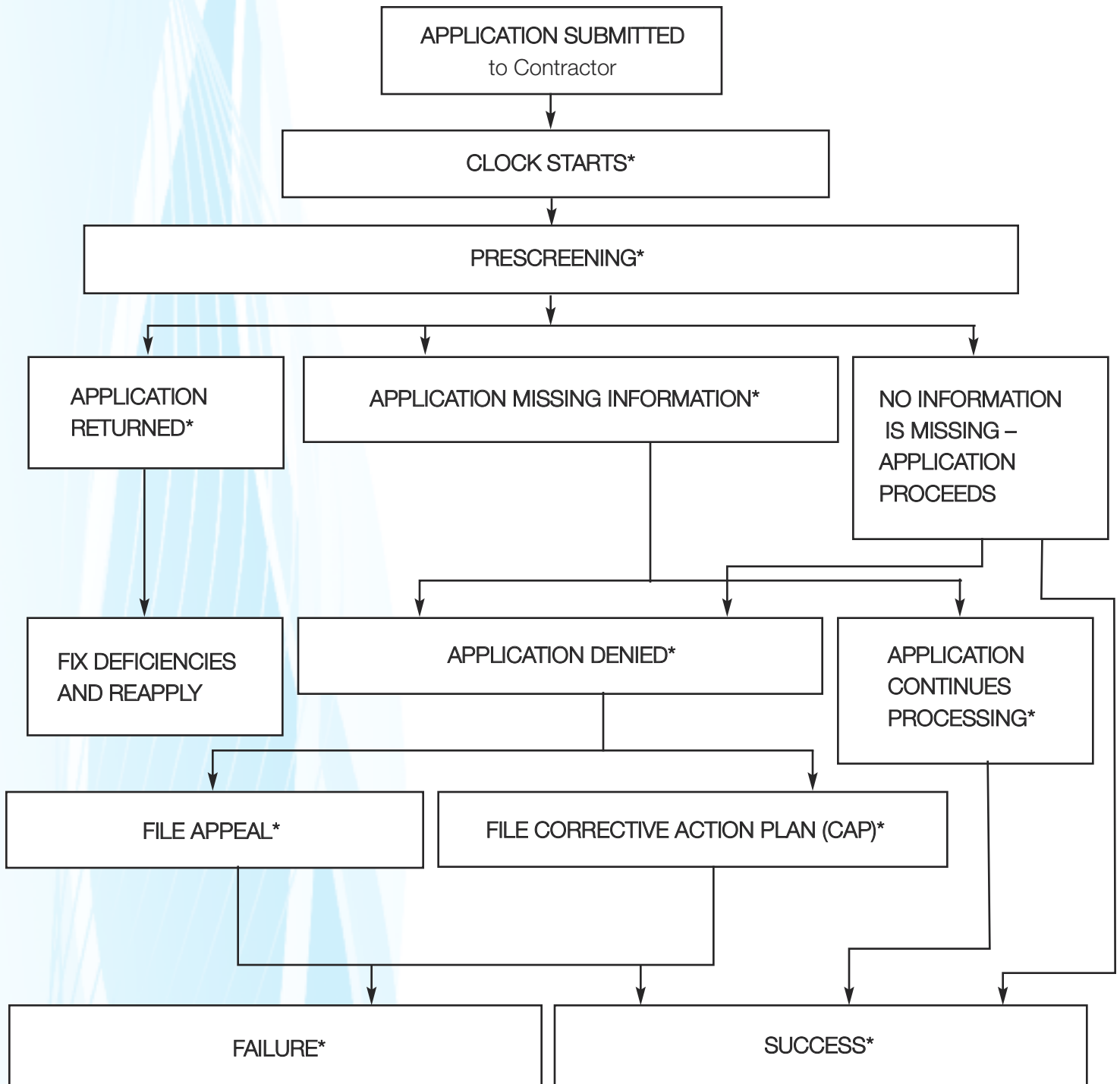
### *Judicial Review*

**If you are dissatisfied with a DAB decision, you can seek judicial review by filing a civil action in a U.S. District Court within 60 days of your receipt of the DAB's decision.** If you have not hired an attorney before this point, it is strongly recommended you do so before you file a civil action.

None of this information should be construed as legal advice.  
Please be advised that this document has been created for educational purposes only.  
Note: The rules and regulations upon which this document are based are subject to change at any time.  
You should refer to those rules and regulations should any questions arise.  
If you have any questions regarding legal matters, please consult an attorney.

# FLOWCHART of MEDICARE *enrollment process*

Understanding what happens to your application and when it happens after you submit it to Medicare.



\*See following page for detailed information.

## CLOCK STARTS

- **Paper Application:** When application is received in mailroom and stamped.
- **Internet Application:** Clock starts after application submitted online AND signed certification statement is mailed and received by contractor.

## PRESCREENING

- Contractor has 15 days to prescreen your application.
- If any information or documentation is missing, you will be contacted for the missing information. In the case of a CMS-855B, the letter will be directed to the designated "Contact person."

## APPLICATION RETURNED

- For reasons why your application may be returned, see Medicare Provider Enrollment Application Outcomes.

## APPLICATION MISSING INFORMATION

- You have 30 days to respond to the request for missing information, known as a "development request." This includes missing:
  - Information on the enrollment form (new signature required)
  - Your certification statement (new signature required)
  - Supporting documentation (no new signature required)
- Additional time to provide the missing information may be requested.

## APPLICATION DENIED

- Legal basis for denial exists.
- Missing information never supplied
- For more information on why your application could be denied, see Medicare Provider Enrollment Application Outcomes.

## APPLICATION CONTINUES PROCESSING

After missing information is supplied in a timely manner.

## FILE APPEAL

- Within 60 days of denial notice.
- For more information on filing an appeal, see Medicare Provider Enrollment Appeals Process.

## FILE CORRECTIVE ACTION PLAN (CAP)

- If your application was denied because you did not meet all the conditions for enrollment and you believe you are able to correct the deficiencies, you may be able to submit a CAP within 30 days of denial notice.
- For more information on submitting a corrective action plan, see Medicare Provider Enrollment Appeals Process.

## FAILURE

- Reapply using entirely new application after a denial or your denial was appealed and upheld.
- If you reapply after a denial, you must wait until after your appeal rights have lapsed.

## SUCCESS

For those who appealed, the effective billing date will be determined as part of the appeal decision.

# IMPORTANT PROVIDER *enrollment timeframes*

## **15 days:**

- If you have not submitted a signed certification statement and required attachments within 15 days of submitting your Internet-based provider enrollment application submission, your application will not be considered filed.
- Contractors have 15 days to prescreen Medicare provider enrollment applications for missing information and attachments.

## **30 days:**

- You can file a Medicare provider enrollment application up to 30 days before the practice or practitioner begins providing services at that location.
- Your Medicare provider enrollment application will be denied if you have not responded within 30 days to a request for missing or additional information.
- You must notify your Medicare contractor within 30 days of the following changes in your information. Otherwise, your participation in the Medicare program could be terminated:
  - Practice location
  - Change of ownership
  - Adverse legal actions
- If your Medicare provider enrollment application is denied, you have 30 days from the date of the denial notice to file a corrective action plan (CAP). For more information on corrective action plans, read the Medicare Provider Enrollment Appeals Process section of this toolkit.

## **45 days:**

- You should not expect your Medicare provider enrollment application to be processed in less than 45 days if you submit an Internet-based application, although it is possible that your contractor may process it more quickly if all of the necessary information is included.

## **60 days:**

- You should not expect your Medicare provider enrollment application to be processed in less than 60 days if you submit a paper application, although it is possible that your contractor may process it more quickly if all of the necessary information is included.
- If your Medicare provider enrollment application is denied, you have 60 days from the date of the denial notice to file a formal appeal.
- If your Medicare provider enrollment application is denied and you decide not to appeal either formally or by filing a corrective action plan, you cannot file a new Medicare provider enrollment application until your appeal rights lapse, which is 60 days after the date of the denial notice.

## **90 days:**

- Notify your Medicare contractor within 90 days of changes in your Medicare provider enrollment information **to change anything other than one of the 30-day notice changes.**

# MEDICARE CONTRACTOR

## *provider enrollment processing requirements*

Medicare contractors are required to process enrollment applications within certain specified times. If they fail to do so, they are required to provide an explanation to CMS for each individual situation that this occurs. In situations in which your application is not processed within the required time, you should notify your CMS Regional Office unless the application processing is delayed because your initial submission was incomplete. The clock does not stop if your application is missing information and the contractor has to wait for you to send it. Instead, a notation is made in your file, and the contractor has some leeway with processing your application within the times set below.

### *Initial Medicare provider enrollment application processing requirements*

<u>Paper:</u>		<u>Internet-based PECOS:</u>	
Processing time (from receipt)	Standard	Processing time (from receipt)	Standard
0 to 60 days	80 percent	0 to 45 days	90 percent
61 to 120 days	90 percent	46 to 60 days	95 percent
121 to 180 days	99 percent	61 to 90 days	99 percent

### *Change of information application processing requirements*

<u>Paper:</u>		<u>Internet-based PECOS:</u>	
Processing time (from receipt)	Standard	Processing time (from receipt)	Standard
0 to 45 days	80 percent	0 to 45 days	90 percent
46 to 60 days	90 percent	46 to 60 days	95 percent
61 to 90 days	99 percent	61 to 90 days	99 percent

**NOTE:** CMS has acknowledged that at least a few Medicare contractors have failed to meet these requirements in a number of instances over the last three years, so keep this in mind while you wait for your application to be processed.

# COMMONLY USED *abbreviations and acronyms*

**CAQH UPD:** Universal Provider Datasource, formerly known as the UCD or Universal Credentialing Data-source. It is an electronic credentialing data collection system designed, owned and maintained by CAQH, a nonprofit entity (formerly known as the Coalition for Affordable Quality Healthcare). The UPD is used by many of the national private health insurance plans for their credentialing data collection.

**CHOW:** Changes in ownership information.

**CMS:** Centers for Medicare & Medicaid Services. The government agency responsible for promulgating Medicare regulations and instructions, as well as overseeing the entire Medicare program.

**CMS-588:** The Electronic Funds Transfer (EFT) Authorization Agreement. Required as part of the Medicare provider enrollment application since May 2006.

**CMS-855:** The paper Medicare provider enrollment application. Some version of the application has been required for Medicare provider enrollment since 1996.

**Carrier:** The state-based Medicare contractors formerly responsible for Part B enrollment activities and claims payments.

**Contractor:** This generally refers to the private entity directly responsible for Medicare provider enrollment activities and claims payment. Medicare is in the process of moving from using fiscal intermediaries and carriers to Medicare Administrative Contractors (MACs), as required by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

**CAP:** Corrective Action Plan. A process that gives a Provider or Supplier an opportunity to correct deficiencies that resulted in the denial or revocation of billing privileges. A formal appeal and a CAP can be filed simultaneously. See following definitions of Provider and Supplier.

**DBA:** Doing business as. The common name of the group practice.

**DNF:** Do Not Forward Initiative.

**EFT:** Electronic funds transfer. The electronic method of claims payment used by Medicare.

**Enumerator:** See NPPES.

**FI:** Fiscal intermediaries. Formerly, the state-based Medicare contractors responsible for Part A enrollment activities and claims payments.

**LBN:** Legal business name. The name used to register the organization with the state and the Internal Revenue Service.

**MAC:** Medicare Administrative Contractor. The new, regionally based private entities responsible for Part A and Part B Medicare enrollment activities and claims payments.

**NPI:** National Provider Identifier. Unique 10-digit identifier assigned to all providers. Type I NPIs are assigned to individual practitioners, and Type II NPIs are assigned to organizations, including solo practitioners who have chosen to incorporate and their subparts, if so desired.

**NPES:** National Plan & Provider Enumeration System, also referred to as “the Enumerator.” The system used to obtain and maintain National Provider Identifier (NPI) numbers and information.

**PECOS:** Provider Enrollment, Chain and Ownership System. The Medicare provider enrollment database.

**PECOS Web:** Also known as Internet-based PECOS, it's the new Internet-version of PECOS that allows practices and practitioners to partially complete their Medicare enrollment information electronically.

**Provider:** Technically defined in the CMS regulations as any of the following entities:

- A hospital
- A transplant center
- A critical-access hospital (CAH)
- A skilled nursing facility (SNF)
- A comprehensive outpatient rehabilitation facility (CORF)
- A home health agency (HHA)
- Hospice
- A religious nonmedical health care institution (RNHCI)

Despite this technical definition, CMS frequently uses the term “provider” to include all individuals and entities that furnish services to Medicare patients. That includes physicians, nonphysician practitioners and group practices. See definition of Supplier.

**Supplier:** Technical term defined in the CMS regulations as:

- Physician or other practitioner, such as physician assistant
- An independent laboratory
- Supplier of durable medical equipment, prosthetics, orthotics or supplies (DMEPOS)
- Ambulance service provider
- Independent diagnostic testing facility
- Supplier of portable X-ray services
- Rural health clinic (RHC)
- Federally qualified health center (FQHC)
- Ambulatory surgical center (ASC)
- An entity approved by CMS to furnish outpatient diabetes self-management training
- End-stage renal disease (ESRD) treatment facility that is approved by CMS as meeting the conditions for coverage of its services.

Despite this technical definition, CMS frequently includes suppliers in its use of the term “provider.” See definition of Provider.

**TIN:** Tax identification number, as assigned by the Internal Revenue Service.

# MEDICARE PROVIDER

## *enrollment resources*

### CMS Web site areas of interest:

- Provider/Supplier Enrollment
  - o Contractor contact information
  - o Definitions of enrollment terminology
- CMS home page
- CMS Forms
- National Provider Identifier
- Medicare Program Integrity Manual, Chap. 10
- MLN Matters Article 6310

### Internal Revenue Service (IRS) Web site

### National Plan & Provider Enumeration System (NPPES):

- Telephone:
  - o 800.465.3203
  - o 800.692.2326 (TTY)
- E-mail: [customerservice@npienumerator.com](mailto:customerservice@npienumerator.com)
- Mail:
  - NPI Enumerator
  - PO Box 6059
  - Fargo, ND 58108-6059

### Medicare provider enrollment regulations:

- Appeals of contractor enrollment determinations
- Medicare provider enrollment
- 2009 Medicare physician fee schedule

### Medical Group Management Association (MGMA) Government Affairs Department

- Telephone: 877.ASK.MGMA (275.6462), ext. 1300
- E-mail: [govaff@mgma.com](mailto:govaff@mgma.com)
- MGMA Web site: [www.mgma.com](http://www.mgma.com)

### American Medical Association (AMA)

- E-mail: [MedicareProblems@ama-assn.org](mailto:MedicareProblems@ama-assn.org)
- AMA Web site: [www.ama-assn.org](http://www.ama-assn.org)