Medicare Expanded Services for 2025

CMS ITU

Nashville Virtual

June 17, 2025

NOVITAS SOLUTIONS

Disclaimer

- GuideWell Source, First Coast Service Options, and Novitas Solutions' employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide. Any views and opinions expressed either during or after the presentation are those of my own and are not those of GuideWell Source, First Coast Service Options, Inc., and Novitas Solutions, Inc. In addition, I, alone, assume the responsibility for the accuracy of information contained in the oral presentation and any written materials or aids created and/or used for this presentation.
- This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.
- This presentation is a general summary that explains certain aspects of the Medicare Program but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference
- This content is protected. Any use of images or likenesses for AI-generated purposes is strictly prohibited. By accessing, viewing, or attending this live presentation, you agree to refrain from using AI tools (including audio recording and/or videotaping) to manipulate or replicate any visual elements without explicit permission. Unauthorized reproduction, modification or distribution using artificial intelligence technology is prohibited and may result in legal action. For any inquiries regarding permissible use, please contact First Coast Service Options, Inc., and/or Novitas Solutions, Inc., directly.

Copyright Notices

- Current Procedure Terminology (CPT) codes, descriptions, and other data only are copyright 2024 American Medical Association (AMA). All rights reserved. Applicable Federal Acquisition Regulation (FARs)/Health and Human Services Acquisition Regulations (HHSARs) apply. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
- Copyright © 2024 the American Hospital Association (AHA), Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution, or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312- 893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. The AHA has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. The Centers for Medicare and Medicaid Services (CMS) and its products and services are not endorsed by the AHA or any of its affiliates.

Agenda

1. Novitas Solutions
2. Updates and Reminders
3. Provider Enrollment Basics
4. Stay of Enrollment Overview
5. Revalidation

Acronym List

Acronym	Definition
AIR	All-inclusive rate
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CY	Calendar year
DDE	Direct Data Entry
DME	Durable Medical Equipment
FFS	Fee-for-service
FISS	Fiscal Intermediary Shared System
FQHC	Federally qualified health centers
HCPCS	Healthcare Common Procedure Coding System
HH+H	Home Health and Hospice
IHS	Indian Health Services

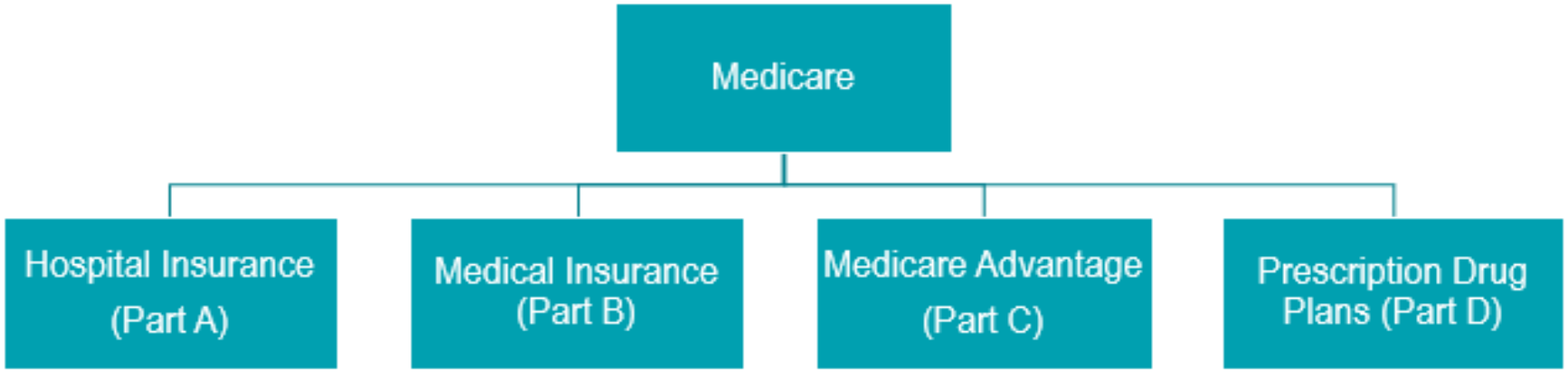
Acronym List Two

Acronym	Definition
MAC	Medicare Administrative Contractor
NPI	National Provider Identifier
PECOS	Provider Enrollment, Chain and Ownership System
UB-04	Uniform Billing Form 04

Novitas Solutions

Who We Are and What We Offer

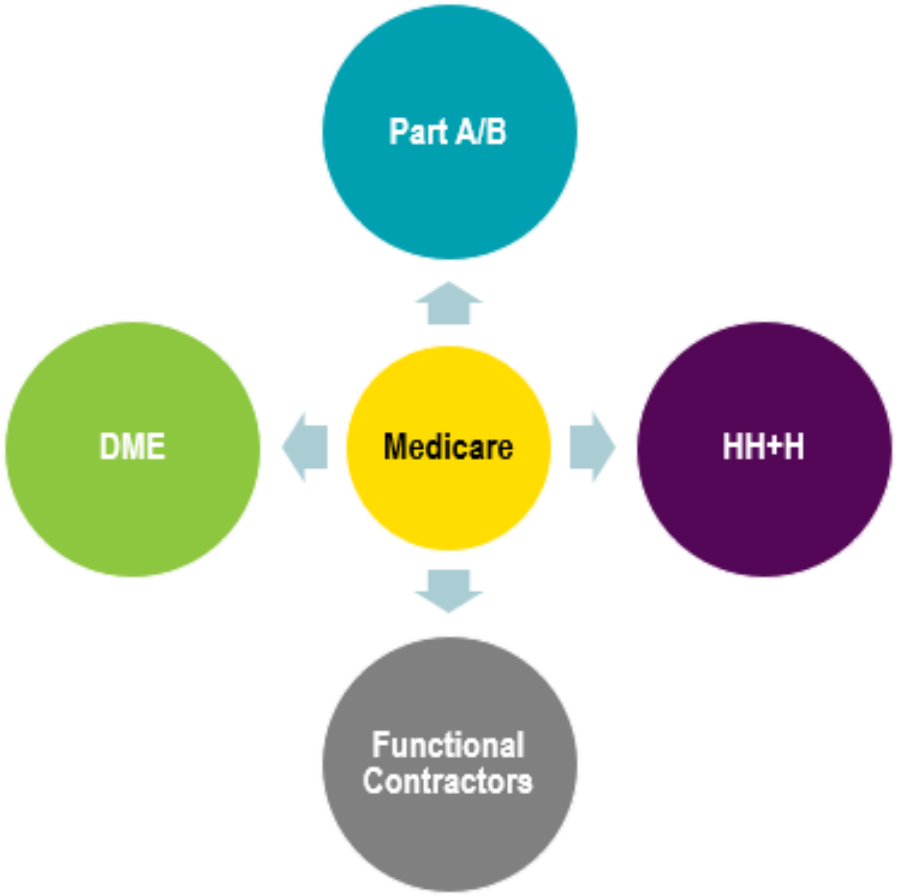
Medicare Program



- Background:
  - CMS is the federal agency that provides health coverage for the Medicare program
  - The Medicare program is the largest health insurance program in the United States
- Purpose:
  - Provides insurance coverage to individuals able to enroll:
    - Age 65 and older
    - Disabled individuals under the age of 65
    - Individuals with permanent kidney failure (End Stage Renal Disease)
- Note: MACs do not have information or answer questions on Medicare Advantage plans
- References:
  - Centers for Medicare & Medicaid Services
  - What Medicare Part A Covers
  - What Medicare Part B Covers
  - Medicare Advantage Plan Directory
  - Prescription Drug Plan Directory

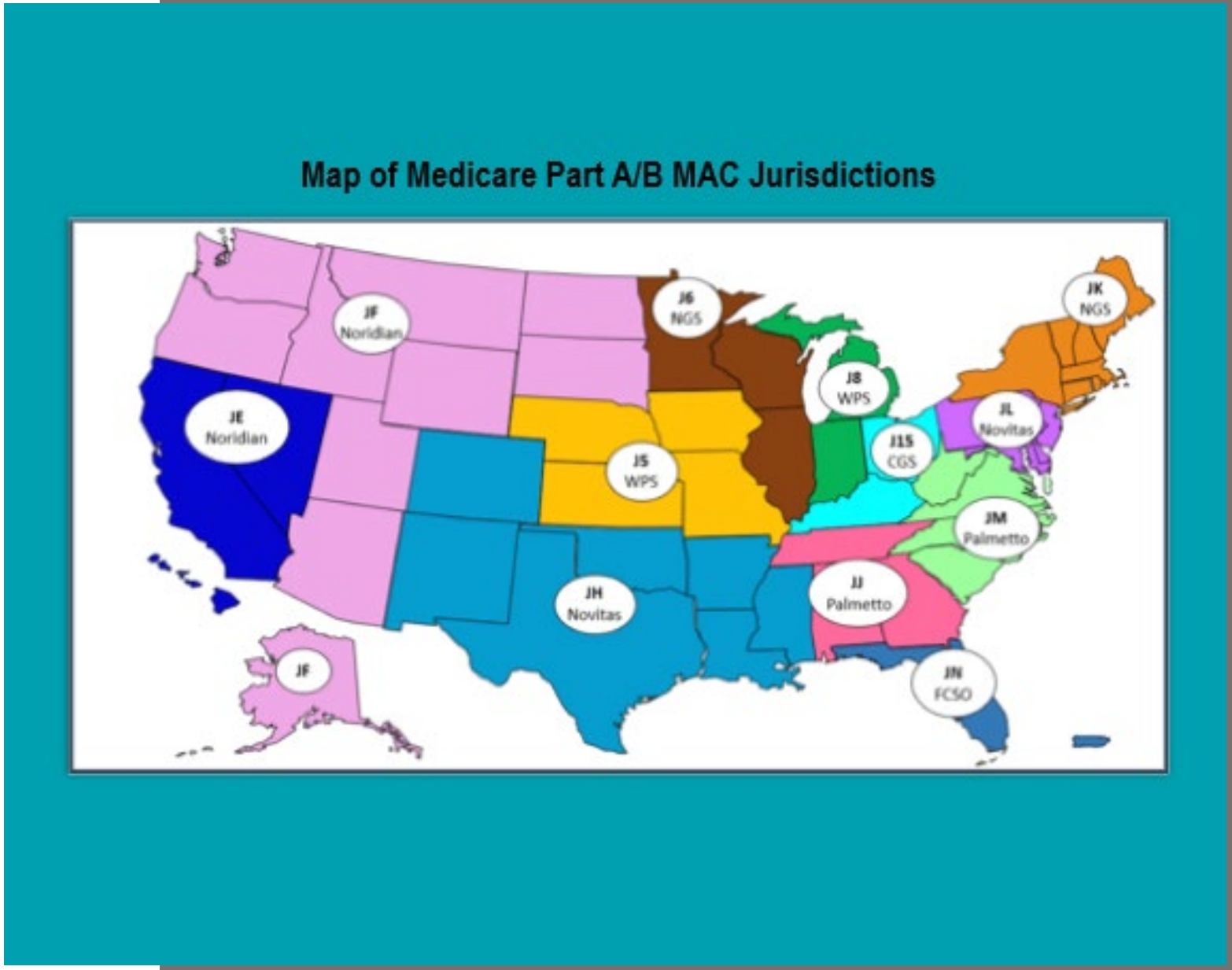
CMS Contractors

- Medicare Administrative Contractor (MAC) definition:
  - MACs are multi-state, regional contractors responsible for processing Medicare claims for a defined geographic area or “jurisdiction”:
    - Part A: hospital insurance
    - Part B: medical insurance
    - Durable Medical Equipment, Orthotics, and Prosthetics (DMEPOS)
    - Home Health and Hospice (HH+H)
- Functional Contractors definition:
  - Other CMS contractors who assist with:
    - Facilitating program integrity activities
    - Performing administrative functions
    - Promoting equitable access to high quality and affordable health care
- Reference:
  - What’s a MAC



MAC Jurisdictions: Part A/B

- Novitas Solutions:
  - Part A/B Jurisdiction H (JH):
    - AR, CO, LA, MS, NM, OK, and TX
  - Indian Health Services (IHS)
  - Part A/B Jurisdiction L (JL):
    - DC, DE, MD, NJ, PA
- Two main office locations:
  - Jacksonville, FL
  - Mechanicsburg, PA
- [CMS jurisdiction maps]



What MACs Do


Enforce program integrity
Enroll providers and suppliers
Coordinate with CMS and other Medicare contractors
Process claims
Issue decisions regarding appeal requests (redeterminations)
Reconcile Medicare reimbursement
Facilitate outreach and education
Respond to provider inquiries

Novitas Solutions

Medicare Administrative Contractor

Jurisdiction H (JH)

Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas, and includes Indian Health Service (IHS) and Veterans Affairs (VA) nationally

www.novitas-solutions.com

Provider Resources

Assistance is available!

Education

Events and Registration
On-Demand Learning

Provider Enrollment

Enrollment Application Forms
Tutorials
Submission Options

Novitasphere Portal

Portal Enrollment
Features and Functionality

Electronic Billing – EDI

EDI Enrollment
PC-ACE Software
Electronic Remittance Advice

Additional Help

New Provider Roadmap
Self-Service Tools
Fee Schedules

Contact Us

Get connected!

Customer Contact Center

1-855-252-8782
Monday – Friday 8 a.m. – 4 p.m. ET/CT/MT
Phone numbers and mailing addresses

Electronic Mailing List

Latest news and updates

Social Media

Follow us on:
YouTube
LinkedIn

Indian Health Services

IHS Educational Events
Indian Health Services Reference Manual
Mailing Addresses
Electronic Mailing List

Novitas Portal - Novitasphere

- Novitasphere is a secure internet portal that is available to providers, billing services, and clearinghouses for FREE! (JH)
- Novitasphere provides numerous tools to help prevent billing errors and other compliance concerns including (not an all-inclusive list):
  - Patient eligibility details
  - MBI lookup tool
  - Claim status
  - Appeals
  - Claim corrections (Part B only)
  - Comparative billing reports (Part B only)
  - Submit/Retrieve Documents
- Live Chat feature
- Dedicated Help Desk- 1-855-880-8424

Educational Opportunities

- Live webinars focused on specialty specific and widespread topics incorporating real-time Medicare requirements, processes, and instructions regarding how to prevent frequent and costly errors:
  - Topics change monthly
  - Workshop series:
    - StayConnected:
      - Series of topic/service-related events focused on outlining CMS requirements, including coverage, billing, etc.
    - Medicare Navigator:
      - Series of events focused on assisting providers navigate to, identify, perform, submit, etc., necessary Medicare tasks
  - Event Calendar (JH)
- We developed a full repository of on-demand educational resources available when it is most convenient to you:
  - Click-and-play videos (JH)
  - Webinar recordings (JH)
- **Free**:
  - All educational opportunities are free

Updates and Reminders

NOVITAS SOLUTIONS

2025 Indian Health Services (IHS) Hospital Payment Rates

What

- Indian Health Services (IHS) Hospital Payment Rates for Calendar Year 2025

When

- Effective: January 1, 2025
- Implementation: June 13, 2025

Who

- Indian Health Service facilities

Lower 48 States	Calendar year (CY) 2025
Outpatient all-inclusive rate (AIR)	$718.00
Inpatient ancillary	$1,074.00

Alaska	CY 2025
Outpatient AIR	$1,193.00
Inpatient ancillary	$1,567.00

- Rates have been updated as of March 27, 2025,and adjustments will be completed by June 13, 2025
- Reference:
  - Change Request (CR) 13972 - Indian Health Services (IHS) Hospital Payment Rates for Calendar Year 2025

All-Inclusive Rate (AIR) Add-On Payment for High-Cost Drugs Provided by Indian Health Service (IHS) and Tribal Hospitals

- Add-on payment for high-cost drugs for IHS and tribal hospitals

- Effective Date: January 1, 2025
- Implementation Date: January 6, 2025

- Indian Health Services (IHS)

- Key Points:
  - CMS is defining a high-cost drug as any drug covered under Medicare Part B and payable under the Outpatient Prospective Payment System (OPPS) whose per-day cost exceeds $1,334.00 (2 times the annual lower 48 states' AIR CY 2024)
  - CMS will pay the Average Sales Price (ASP):
    - For an encounter featuring one or more high-cost drugs, the hospital will receive the AIR payment for the encounter plus an add-on payment (ASP)
    - CMS will provide the CY 2025 payment amounts for drugs with per-day costs that exceed the threshold in the CY 2025 final OPPS rule and the January 2025 quarterly update to the hospital outpatient prospective payment system transmittal:
      - A list of drugs whose costs exceeds two times the lower 48 AIR was included as Addendum Q in the CY 2025 OPPS/Ambulatory surgical center (ASC) final rule
    - List being updated on a quarterly basis using existing drug compendia and CMS ASP quarterly reporting to account for newly introduced drugs and changes in drug prices
  - Does not apply to Critical Access Hospitals (CAH)
- References:
  - Change Request (CR) 13698 - All-Inclusive Rate (AIR) Add-On Payment for High-Cost Drugs Provided by Indian
  - Addendum Q:
    - Hospital Outpatient Prospective Payment- Notice of Proposed Rulemaking with Comment Period (NPRM)

Add-On Payment for High-Cost Drug Billing

- Billing add-on high-cost drug(s) with encounter:
  - Revenue code 0636
  - Appropriate Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) (using the appropriate Addendum Q for the date of service)
  - Ensure units of drugs administered are accurately reported in terms of dosage specified in CPT/HCPCS descriptor
  - Encounter (revenue code 0510 and appropriate CPT/HCPCS)
  - Valid type of bills:
    - 12X
    - 13X
- Note:
  - Not an all-inclusive list

Addendum Q - CY 2025 Final Rule Payment Rates for Drugs Qualifying for Add-on Payment to IHS and Tribal Hospitals Based on CY 2024 AIR

*The HCPCS codes in Addendum Q represent drugs and biologicals with a per day cost (cost per unit * units per day) above our final threshold of two times the CY 2024 AIR ($1,334).*

CPT codes and descriptions only are copyright 2024 American Medical Association. All rights reserved. Applicable FARS/DFARS Apply.

HCPCS Code	Short Descriptor	Payment Rate
90375	Rabies ig im/sc	$264.50
90376	Rabies ig heat treated	$347.32
90377	Rabies ig ht&sol human im/sc	$236.34
90396	Varicella-zoster ig im	$2,124.80
A9513	Lutetium lu 177 dotatat ther	$279.48
A9515	Choline c-11	$2,062.94
A9517	I131 iodide cap, rx	$23.13
A9530	I131 iodide sol, rx	$20.88
A9543	Y90 ibritumomab, rx	$14,774.74
A9572	Indium in-111 pentetreotide	$1,914.61
A9582	Iodine i-123 iobenguane	$2,074.81
A9584	Iodine I-123 ioflupane	$1,388.02
A9586	Florbetapir f18	$2,194.62
A9587	Gallium ga-68	$51.09
A9588	Fluciclovine f-18	$268.42
A9591	Fluoroestradiol f 18	$498.67
A9592	Copper cu 64 dotatate diag	$595.10
A9593	Gallium ga-68 psma-11 ucsf	$534.91
A9594	Gallium ga-68 psma-11, ucla	$372.17
A9595	Piflu f-18, dia 1 millicurie	$332.44
A9596	Gallium illuccix 1 millicure	$978.69
A9600	Sr89 strontium	$1,740.72
A9601	Flortaucipir inj 1 millicuri	$3,500.00
A9602	Fluorodopa f-18 diag per mci	$470.40
A9604	Sm 153 lexidronam	$4,314.91
A9606	Radium ra223 dichloride ther	$159.16
A9607	Lutetium lu 177 vipivotide	$227.55
A9608	Flotufolastat f18 diag 1 mci	$614.78
A9615	Inj, pegulicianine, 1 mg	$35.39
A9800	Gallium locametz 1 millicuri	$824.00
C9067	Gallium ga-68 dotatoc	$4.05
C9257	Bevacizumab injection	$1.73
C9482	Sotalol hydrochloride iv	$21.49
J0129	Abatacept injection	$41.32
J0139	Inj, adalimumab, 1 mg	$86.53
J0172	Inj, aducanumab-avwa, 2 mg	$5.64
J0175	Inj, donanemab-azbt, 2 mg	$3.98
J0178	Aflibercept injection	$755.72
J0179	Inj, brolucizumab-dbll, 1 mg	$319.71
J0180	Agalsidase beta injection	$210.87
J0202	Injection, alemtuzumab	$2,276.75
J0206	Inj allopurinol sodium 1 mg	$4.15
J0208	Inj sodium thiosulfate 100mg	$90.57

Add-On Payment for High-Cost Drug Addendum Q

- Billing for CPT/HCPCS qualify as an add-on drug from the Addendum Q (updated quarterly):
  - CPT/HCPCS is not listed on Addendum Q:
    - It does not meet criteria to be billed separately and would be combined with encounter
- Billing for codes that are not on Addendum Q prevents claim from processing and will return to provider (RTP)
  - RTP 31872:
    - The drug submitted is not eligible for an add-on payment. This service will need to be removed as a line item since it is not able to be paid separately
- Note:
  - All other charges are billed as an all-inclusive AIR with a face-to-face visit into one line item:
    - Exceptions are therapies, preventative vaccines and administrations (influenza, pneumococcal, COVID-19 and/or hepatitis B), telehealth originating site fee and/or hospital-based ambulance services

All Inclusive Rate (AIR) Requirements

- Requirements for billing AIR:
  - A face-to-face encounter/visit with a physician or non-physician practitioner (this must be a physician or non-physician who is eligible to enroll in the Medicare program) is required for an encounter/visit to count as a billable encounter
- AIR services:
  - All fees (except for therapies, telehealth originating site facility fee, pneumococcal, influenza, hepatitis B vaccine, and COVID-19 vaccines and administrations, and hospital-based ambulance services) are combined and billed on the Uniform Billing Form 04 (UB-04):
    - Report under revenue code 0510
    - Type of bill (TOB) 13X or 85X

AIR Billing for Return Visit

- Return visits for follow-up care ordered by the physician or non-physician practitioner during the initial visit:
  - When a physician or non-physician practitioner orders a specific procedure or test that cannot be performed until a later date after the date of the initial visit with the physician or non-physician practitioner, and the procedures or tests are medically necessary, then it is appropriate for the return encounter/visit to be billed on the date the procedure or test is furnished and for the provider to receive an additional AIR payment even if the beneficiary did not interact with a physician or non-physician practitioner during the return visit
  - Patient's medical record will need to be documented with a medically necessary reason for the return visit
- Examples of medically necessary reasons include:
  - A requirement for the beneficiary to fast for 12 hours before a scheduled test,
  - A chest X-ray needed 2 weeks after starting antibiotic treatment for pneumonia
  - A beneficiary needs to return on a different day for a medically necessary test that was ordered during an initial visit, due to unavoidable constraints on either the provider or patient side, that return visit will be deemed medically necessary

AIR Billing for Multiple Visits

- Definition:
  - More than one encounter/visit involving multiple health professionals or multiple visits with the same health professional on the same day; a single location within the hospital (including the hospital-based satellite):
    - All encounters/visits are added together for one single visit
- Exception:
  - Encounter/visit is allowed for an additional reimbursement an illness or injury occurs subsequent to the initial visit:
    - Submit 1 claim with two detail lines:
      - Clinic visit CPT/HCPCS code and emergency room (ER) CPT/HCPCS code
    - Condition code G0 (zero)
    - Include diagnoses for clinic and emergency room visit
    - Indicate in remarks reason for more than one visit
- If the services are billed separately on two claims, one claim will be rejected as a duplicate bill:
  - An adjustment to the paid claim is necessary to ensure proper reimbursement

Repetitive Services

- Definition:
  - Repetitive services are defined as those provided multiple times over a period and billed using designated revenue codes:
    - Chemotherapy and radiation therapy do not fall under the revenue codes that must be billed on a monthly basis
    - For repetitive Part B services delivered to an individual by providers submitting institutional claims, billing will need to occur monthly until treatment is completed:
      - If the treatment duration is less than one month, the entire treatment would be billed on a single claim
- Reference:
  - Medicare Claims Processing Manual, Pub. 100-04, Chapter 1 – General Billing Requirements, Section 50.2.2, "Frequency of Billing for Providers Submitting Institutional Claims With Outpatient Services"

Billing Repetitive Therapy

- Therapy Part B services furnished to an individual by IHS providers are billed monthly
- For therapy and encounter/visit (AIR) services rendered in same month:
  - Separate claims submitted:
    - Therapy services on one claim for all dates within month
    - Encounter/visit (AIR) services on individual claim(s)
- Inpatient stay during the month when repetitive services are provided:
  - Utilize occurrence span code 74 with dates of inpatient stay

Telehealth

- Definition:
  - Visit with provider that uses telecommunication system to mean multimedia communications equipment that includes, at a minimum, audio and video equipment permitting 2-way, real-time interactive communication between the patient and distant site physician or practitioner
- Purpose:
  - Use of audio-only equipment to furnish services described by the codes for audio-only telephone E/M services and behavioral health counseling and educational services
- Must use interactive audio and video telecommunications system permitting real-time communication:
  - Distant site is the location where a physician or practitioner provides telehealth
  - Originating site is the location where a patient located and receives medical service via telehealth
- All distant site telemedicine services are billed on the CMS-1500 claim form:
  - Including provider-based and freestanding providers/facilities/clinics
  - Billing on the UB-04 is not permitted
- Utilize appropriate telehealth list for date of service
- References:
  - Medicare Learning Network (MLN) Booklet: MLN901705 Telehealth & Remote Patient Monitoring
  - List of Telehealth Services
  - Telehealth FAQ Calendar Year 2025

Credit Balance Updates

- Effective December 1, 2024, Credit Balance Reports (PDF) (CMS-838) are no longer required to be submitted for zero-balance certifications:
  - Facilities are still required to report self-identified overpayments:
    - Adjustments would be submitted for any claims that are overpayments
- In the event adjustments are not finalizing to recoup overpayments, then submit the credit balance report for Novitas to handle:
  - Report those to Novitas as a credit balance; include the corrected UB-04 claim form with submission
- References:
  - Quarterly Credit Balance Reports No Longer Required
  - 2024-12-19 MLN Connects Weekly Edition Newsletter: Quarterly Credit Balance Reports No Longer Required

Provider–Based Hospital Off-Campus Practice Location Address

- Definition:
  - Medicare allows hospitals to have additional locations, on or off campus, outside of the main hospital as part of the hospital for billing purposes which include:
    - Clinics
    - Departments
    - Remote locations
    - Satellite locations not separately enrolled or certified under Medicare
  - All locations must be listed in the enrollment records
- Purpose:
  - Ensure all enrollment information is up to date:
    - Submit claims with practice locations exactly as it appears from the practice location address screen:
      - Received from PECOS and can be viewed in Fiscal Intermediary Shared System (FISS) Direct Data Entry (DDE) under shortcut 1D provider practice address
  - Ensure the practice locations are linked to the NPI that is being reported on the claim submission

Hospital Location Address Systematic Validation Edit

- Systematic validation edit:
  - CMS implemented systematic validation edits to enforce requirements for hospitals with multiple locations to include off-campus provider-based department location
- If a hospital submits a claim with a location not listed in the enrollment record or the reported location on the claim does not match exactly what is listed in the enrollment record the claim will return to provider (RTP) for reason code 34977:
  - Claim service facility address does not match provider practice file address
- Resolving reason code 34977:
  - Ensure the service facility address reported in DDE MAP F matches provider enrollment information in PECOS:
    - Compare to the Provider Practice Address Query Menu selection D from the Inquiry Menu available in DDE:
      - This is the practice location screen received from the PECOS
- Update practice locations using either:
  - PECOS
  - Paper CMS-855A Institutional Providers application
- Enrollment application fee is required when adding a practice location
- References:
  - Indian Health Service Hospital Off-Campus Outpatient Department Reporting Requirements
  - Enrollment Contact Center

FISS Edit To Validate Attending Physician NPI

- CMS implemented a consistency system edit that validates the attending provider NPI on institutional claims
- Institutional providers must indicate the attending provider name and NPI for the patient's medical care and treatment on institutional claims for any services other than nonscheduled transportation claims:
  - Refer to MLN Matter Article (MM) 12889 New Fiscal Intermediary Shared System Edit to Validate Attending Provider NPI – Phase 2 for a list of physician and non-physician practitioner (NPP) specialties eligible as an attending physician and who must be enrolled in PECOS in an approved status
- Claims will return with reason code 34963: Attending Physician is Invalid, for one of the following reasons:
  - The attending physician on claim page 03 is invalid
  - The attending physician NPI is present, but the first four digits of the last name do not match PECOS
  - The claim has a through date of service equal or greater than the termination date of the physician
- References:
  - New Fiscal Intermediary Shared System (FISS) Consistency Edit to Validate Attending Physician NPI
  - Reason Code 34963
  - Resolve Claim Return Reason Code 34963 for Outpatient Therapy Services

Provider Enrollment Basics

NOVITAS SOLUTIONS

Enrolling Under Novitas as an IHS Provider

- IHS, Tribal and/or Urban facilities/providers must enroll with the designated IHS MAC (Novitas) for specialty provisions offered by CMS under IHS guidelines:
  - Specific enrollment qualifications
  - Specific education for IHS
- This applies to:
  - IHS-owned and operated facilities
  - IHS-owned, Tribally operated facilities
  - Tribal-owned, IHS-operated facilities
  - Tribal facilities electing to bill like IHS (e.g., hospitals using the AIR)
- This includes provider types (this is not an all-inclusive list):
  - Hospital
  - Provider-based clinic
  - Non-provider-based clinic (free-standing clinic)
  - Federally qualified health centers (FQHC)
  - Historically accepted Tribal FQHCs (formerly grandfathered Tribal FQHC)
  - Ambulance
  - Ambulatory surgery center (ASC)
- Note: Enrollment applications contain a question asking if the application is an IHS facility:
  - All Indian Health Service, Tribal and Urban Indian providers/suppliers must always select “yes” when enrolling with Novitas
  - This question does not affect the laws the provider/supplier goes by:
    - It assures Novitas receives the application from PECOS and the application is processed in the correct system
- Reference:
  - Medicare Claims Processing Manual, Pub. 100-04, Chapter 19 - Indian Health Services

Provider Enrollment Into The Medicare Program

- Enrollment purpose:
  - Assures only qualified and eligible providers/suppliers enroll in the Medicare program through validation and screening of the Medicare enrollment application and other supporting documentation
  - Providers/suppliers must be enrolled in Medicare to render services to beneficiaries and receive reimbursement
- National Provider Identifier (NPI) purpose:
  - NPI serves as the identification number assigned to health care providers for billing and other purposes
  - Provider must apply for a NPI prior to requesting enrollment with Medicare through the National Plan and Provider Enumeration System (NPPES):
    - NPPES helpdesk:
      - Phone: 1-800-465-3203 (NPI Toll-Free)
      - Email: customerservice@npienumerator.com
- Timeframe for MACs to process applications:
  - The time required to process an application varies based on the specific type of application submitted:
    - CMS-855 Enrollment Application Processing Timeframes
- References:
  - Novitas Enrollment Center
  - Medicare Program Integrity Manual, Pub. 100-8, Chapter 10 - Medicare Enrollment

Enrollment Application Submission Options - PECOS

- CMS established internet-based online enrollment processing system
- Provider Enrollment, Chain and Ownership System (PECOS):
  - Most efficient way to submit Medicare enrollment applications
  - Allow physician, non-physician practitioner, organization and/or facility to:
    - Enroll
    - Make changes
    - Track status of the application
  - Offers resources and tutorials:
    - PECOS CMS External User Services (EUS) help desk:
      - Toll-Free Phone: (866) 484-8049
      - New email address effective, March 31, 2025:
        - ✓ Email: EUS_Support@cms.hhs.gov
- References:
  - Welcome to the Medicare Provider Enrollment, Chain, and Ownership (PECOS)
  - "Who should I call?" CMS Provider Enrollment Assistance Guide
  - Enrollment Applications

Enrollment Application Submission Options – Paper Application

- Enrollment tasks can be facilitated through the submission of paper Medicare enrollment applications:
  - Best practices:
    - Refer to CMS Enrollment Applications page for the most current version of the 855 applications
    - Download an application each time to avoid using an out-of-date version
    - Type or write legibly with ink within the prescribed boxes of the application
  - Indian Health Service provider enrollment application coversheet must be submitted with the Paper CMS-855A Medicare Enrollment Application Institutional Providers application and the Paper CMS-855B Medicare Enrollment Application Clinic/Group Practice and Other Suppliers applications:
    - Indian Health Service Part A Provider Enrollment Application Coversheet
    - Indian Health Service Part B Provider Enrollment Application Coversheet
- Submission methods:
  - Provider Enrollment Gateway allows for paper applications to be uploaded and submitted online
  - Enrollment applications (hard copies) can also be submitted through mail or another courier service
- References:
  - Provider Enrollment Gateway (JH)
  - Provider Enrollment Gateway User Guide (JH)
  - Mailing Addresses for Enrollment Forms (JH)

Medicare Enrollment Application Fee

- Background:
  - Section 6401(a) of the Affordable Care Act (ACA) requires a fee on each “institutional provider of medical or other items or services and suppliers”
- Purpose:
  - Fee used to cover the cost associated with screening and conducting other program integrity activities associated with related provider enrollment process
- 2025 Application Fee - $730.00:
  - Must be paid before submitting the application
  - Fee is subject to change each calendar year
- Fee applies to:
  - Initial enrollment
  - Revalidation
  - Adding a new practice location
- Applicable providers/suppliers (not an all-inclusive list):
  - IHS hospitals (acute and critical access hospital (CAH)
  - Federally qualified health centers (FQHC)
  - Historically accepted Tribal FQHCs
  - Ambulance
  - Ambulatory surgical center (ASC)
  - Durable medical equipment (DME) supplier
- Fee can be paid using PECOS Application Fee Information or Pay.gov
- References:
  - Provider Enrollment Application Fee: CY 2025
  - Application Fee Requirements for Institutional Providers

Application Fee Requirement Chart

- Examples of provider/supplier types who may have application fee requirements depending on the type of application submitted (not an all-inclusive list)
- Reference:
  - Application Fee Requirements for Institutional Providers

Provider/Supplier Type	Initial Enrollment	Revalidation	Change of Ownership	Change of Information	Additional Practice Location
Clinic/group practice	No	No	No	No	No
Physician/non-physician	No	No	No	No	No
Ambulance	Yes	Yes	No	No	Yes
Critical access hospital (CAH)/IHS acute hospital	Yes	Yes	No	No	Yes
Rural emergency hospital (REH)	No	Yes	No	No	Yes
FQHC/historically excepted tribal FQHCs	Yes	Yes	No	No	N/A FQHCs are not allowed to add additional practice address

Timely Reporting of Provider Enrollment Information Changes

- If changes occur between revalidation cycles, these changes must be reported within CMS timeliness requirements
- Change of information:
  - Physicians, non-physician practitioners, and physician/non-physician organizations must report the following changes within 30 days:
    - Ownership
    - Adverse legal action
    - Practice location
  - Providers and suppliers not previously identified above must report the following changes within 30 days:
    - Ownership
    - Authorized/delegated officials
    - Practice location
- All other informational changes must be reported within 90 days
- Changes can be reported via PECOS or paper enrollment applications
- If changes are not reported, a stay of enrollment, revocation or deactivation may be implemented:
  - This may cause claim rejections or payment suspension
- Reference:
  - Medicare Program Integrity Manual, Pub. 100-08, Chapter 10 - Medicare Enrollment, Section 10.4.4, "Changes of Information"

Enrollment Information Release

- Throughout the application process:
  - CMS authorizes the release of enrollment-related information to authorized individuals listed on the application
- Authorized individuals:
  - Provider/supplier
  - Authorized official
  - Delegated official
  - Contact person:
    - No limit on the number of contacts per enrollment application
    - A primary contact can be designated when multiple contacts are listed on the application
- General questions regarding the enrollment process, application, etc.:
  - Provider Enrollment Help Desk:
    - 1-855-252-8782

Application Review and Development Letter

- Purpose:
  - Providers/suppliers will receive a development letter/email for additional information if sections of the application are missing, incomplete or incorrect:
    - Not all applications will receive a development letter
  - The development letter will outline:
    - Information required to process the application
    - Methods available to respond
    - Due date for response
- Development timeframe:
  - Response is required within 30 calendar from the date of the development letter
  - Failure to respond timely and completely will result in the rejection of the application:
    - Rejected applications do not have appeal rights
    - Rejected applications require a new completed application to restart the enrollment process
- Required response:
  - All development responses must be accompanied with a newly signed and dated signature page:
    - Except for requests for supporting documentation only

Finalization and Notification

- Once all required information is received, the MAC documents the application information in PECOS:
  - Certified providers/suppliers:
    - If enrolling in Part B as a state certified ambulatory surgical center or portable x-ray supplier, etc., or enrolling as a Part A provider, the application will be forwarded to the state survey agency/CMS for final approval
- A notification letter will be sent once the processing the application is complete and will provide important details, including whether the enrollment has been approved or denied:
  - A revalidation notification letter may be comprised of any of the examples below

Initial approval letter

- Name/legal business name (LBN)
- NPI(s)
- Provider Transaction Access Number (PTAN)/CMS Certification Number (CCN
- Effective date
- Appeal rights

Change of information approval letter

- Information that was changed
- Appeal rights

Non-approved application

- Reason for non-approval
- Appeal rights

Enrollment Application Status Tools

- Definition:
  - Application status tools are free, online, quick and easy options to check the status of processing enrollment applications
- Status tools available:
  - Novitas Provider Enrollment Status Inquiry Tool:
    - Web-based status tool provides history of:
      - PECOS applications and paper–submitted applications
      - Opt outs
      - Rebuttals
      - Part B corrective actions plans for denials and revocations
      - Part B reconsideration requests for denials, revocations and Medicare effective date determinations
      - Status tool also includes revalidation applications along with the date of issuance of the revalidation request:
        - Typical timeframes for revalidation applications to be available is approximately 10 - 15 business days after receipt
  - PECOS Self Services Application:
    - CMS web-based status tool for providers/suppliers to run simple search queries to retrieve and view the status of their PECOS application submitted within the past 90 days
  - Novitas Provider Enrollment Gateway:
    - Web-based status tool for providers/suppliers to check the status of a previously uploaded paper application via the Gateway only

Stay of Enrollment Overview

NOVITAS SOLUTIONS

Stay of Enrollment

- Background:
  - Calendar Year 2024 Physician Fee Schedule final rule (CMS-1784-F) established a new provider enrollment status labeled a “stay of enrollment”
  - Affects physicians, suppliers, and other providers billing MACs for services they provide to Medicare patients
  - Effective May 30, 2024
- Definition:
  - A stay of enrollment (or “stay”) is a preliminary, interim status representing a pause in enrollment
- Purpose:
  - Stay of enrollment is a CMS action that’s less burdensome for providers and suppliers to resolve than a deactivation or revocation of the Medicare enrollment record
- Reference:
  - Medicare Learning Network (MLN) Matters Article: MM13449 “Stay of Enrollment”

Requirements for Implementation of a Stay of Enrollment

- There are two conditions for implementing a stay per 42 CFR 424.541:
  - The provider:
    - Is non-compliant with at least one Medicare enrollment requirement
    - Can remedy the non-compliance by submitting, as applicable, CMS enrollment form using the CMS-855, CMS-20134, or CMS-588:
      - We refer to these forms as applicable CMS forms (ACFs)
  - If the type of non-compliance involved can't be corrected by the submission of an ACF, a stay can't be imposed, and other sanctions may be applied
- Examples of how the 2 conditions relate to non-compliance to revalidation include:
  - A provider/supplier didn't respond to a revalidation request
  - A revalidation application was submitted, but ultimately rejected due to failure to respond to a development request
- Both examples can be remedied by submitting a revalidation application, therefore, a stay of enrollment would be appropriate to implement

Stay of Enrollment Details

- Key elements of a “stay”:
  - Enrollment is temporarily paused while the provider takes action to come into compliance prior to imposing a deactivation or revocation
  - Provider remains enrolled in Medicare during the stay
  - Claims submitted with dates of service within the stay period will be rejected
  - A stay ends on the earlier of the following dates:
    - The date on which the MAC determines the provider resumes compliance with all Medicare enrollment requirements
    - The day after the imposed stay period expires (up to 60 days)
  - A stay isn’t considered a sanction or an adverse legal action of any kind
  - **A stay that is not resolved by submission of an application will result in deactivation of Medicare billing privileges**

Notification and Rebuttals

- Notification letters:
  - MACs will send a stay of enrollment notification letter by hard-copy mail to the correspondences address and an email to the correspondence e-mail address if a valid email address is available:
    - Providers have reported that stay of enrollment letters have been found in their spam folder when sent via email, therefore, please ensure the spam folder is monitored for any provider enrollment correspondence
  - The notification alerts providers that “Failure to submit a revalidation application within 30 days of this notice may result in a deactivation of the providers/suppliers Medicare enrollment”
- Rebuttal:
  - A rebuttal is an opportunity for the provider to demonstrate all applicable enrollment requirements were met if the provider believes the stay of enrollment was implemented in error:
    - The provider may submit only 1 rebuttal request per stay of enrollment
  - If an applicable CMS form is received for a stay while a rebuttal submission is pending or during the rebuttal submission timeframe, the MAC will process the ACF consistent with current instructions

Revalidation

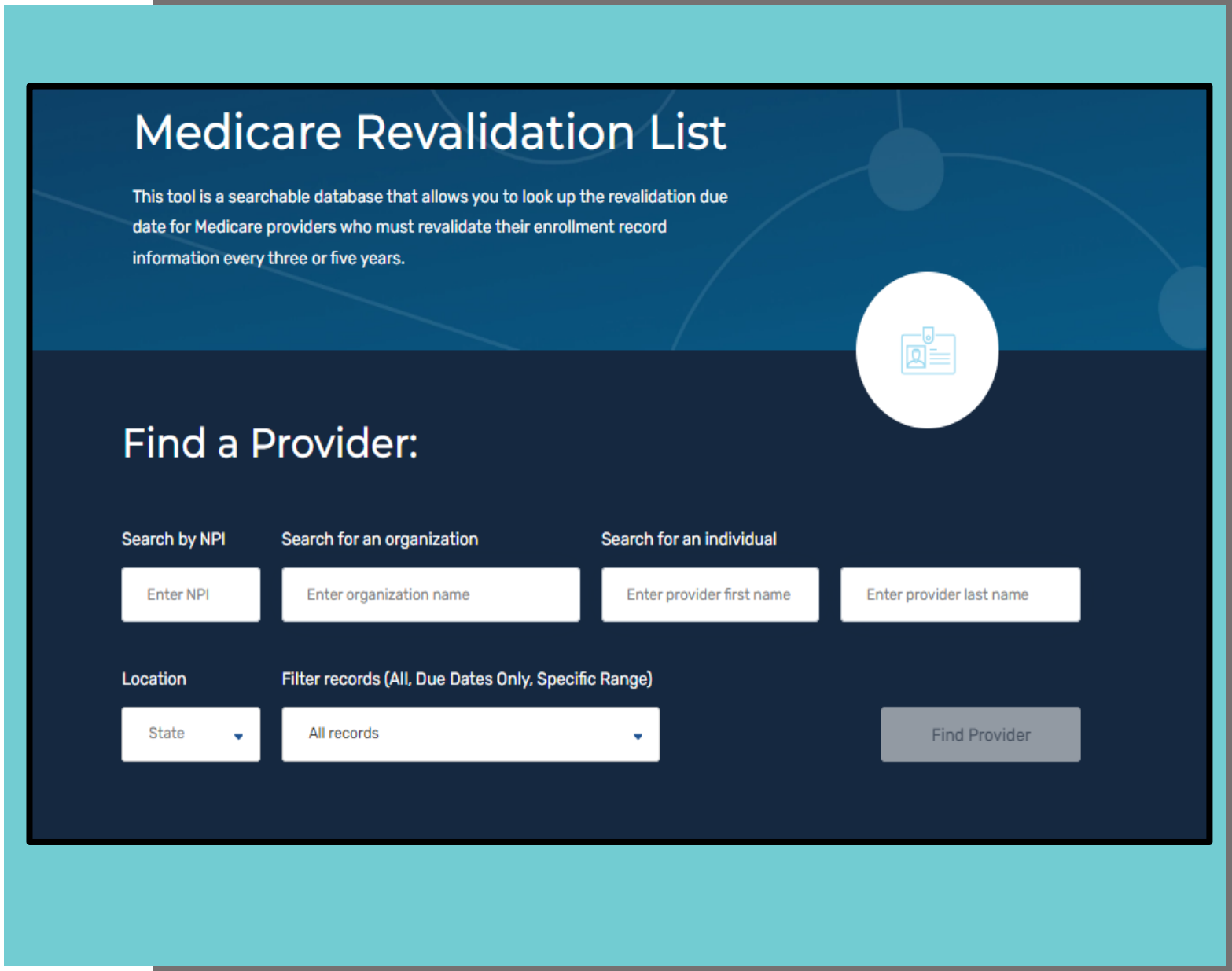
NOVITAS SOLUTIONS

Revalidation of the Medicare Enrollment Record

- Background:
  - Revalidation is a requirement of the Patient Protection and Affordable Care Act, Section 6401
- Definition:
  - All existing enrolled providers/suppliers must revalidate – or renew – periodically to maintain billing privileges
- Purpose:
  - Certifies that Medicare has the most up-to-date information on file
  - Confirms all enrollment requirements are being met
- Frequency:
  - Medicare requires revalidation every 5 years (3 years for durable medical equipment, prosthetic devices, prosthetics, orthotics, and supplies (DMEPOS)
  - CMS may conduct off-cycle revalidations for certain program integrity purposes
- References:
  - Revalidations (Renewing Your Enrollment)
  - Revalidation (JH)

Medicare Revalidation List

- How will provider/suppliers know when to revalidate?
- CMS posts revalidation due dates on the Medicare Revalidation List, if revalidation is due within 6 months
- Search by National Provider Identifier (NPI), organization legal business name, or individual first and last name, then click 'Find Provider'
- Revalidate if within 3 months of the due date, even if a notification letter has not been received:
  - Due date listed as TBD (to be determined); unsolicited revalidations will be returned



Revalidation Notification Letter

- The Medicare Administrative Contractor (MAC) will send notification of the requirement to revalidate
- Novitas sends a revalidation notice 3 - 4 months in advance of the due date listed on the Medicare Revalidation:
  - Correspondence and special payments address on file
- Sample letter available on the MAC Revalidation center:
  - Revalidation (JH)

Dear [Provider/Supplier Name],

Every five years, CMS requires you to revalidate your Medicare enrollment record. You need to update or confirm all the information in your record, including your practice locations and reassignments.

We need this from you by **[Due date, as Month dd yyyy].** If we don't receive your response by then, we may stop your Medicare billing privileges.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating by [Due date, as Month dd yyyy]

[Name] | **NPI** [NPI] | **PTAN** [PTAN]

Reassignments: <Only include this title if the record has any reassignments>

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]

<Repeat for other reassignments>

CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

What you need to do

Revalidate your Medicare enrollment record, through https://pecos.cms.hhs.gov/pecos/login.do or [form CMS-855 or Form CMS-20134].

Failure to Respond to Revalidation

- Failure to respond to revalidation request by the due date:
  - Results in a stay of enrollment status
- A stay of enrollment notification will be sent indicating the time frame the revalidation application must be received:
  - Providers/suppliers have 30 days to submit the revalidation application
- During this timeframe claims will reject and must be resubmitted once reinstated:
  - Part A UB-04 claim form or electronic equivalent claim rejection message:
    - Reason code 39998 – "The provider has a stay of enrollment. The provider can remedy the non-compliance via the submission of, as applicable to the situation, a form CMS -855, form CMS-20134, or form CMS-588 change of information or revalidation application."
  - Part B CMS-1500 claim form or electronic equivalent claim rejection messages:
    - Claim Adjustment Reason Code (CARC): 16 "Claim/service lacks information or has submission/billing error(s)."
    - Remittance Advise Remark Code (RARC): N257 "Missing/incomplete/invalid billing provider/supplier primary identifier."

Failure to Respond to Stay of Enrollment

- Failure to respond to the stay of enrollment revalidation request by the due date or failure to respond to a development request within 30 days, will result in be deactivation
- Deactivated status:
  - May result in a gap in coverage (no payments) between the date of deactivation and the new Medicare effective date:
    - New reactivation date will be based on the receipt date of the new, full, and complete application
    - Original Provider Transaction Access Number (PTAN) and/or CMS certification number (CCN) will remain the same
    - Medicare will not reimburse for any services during the period of deactivation

Key Takeaways

1

- Discussed updates and reminders

2

- Reviewed basic enrollment process

3

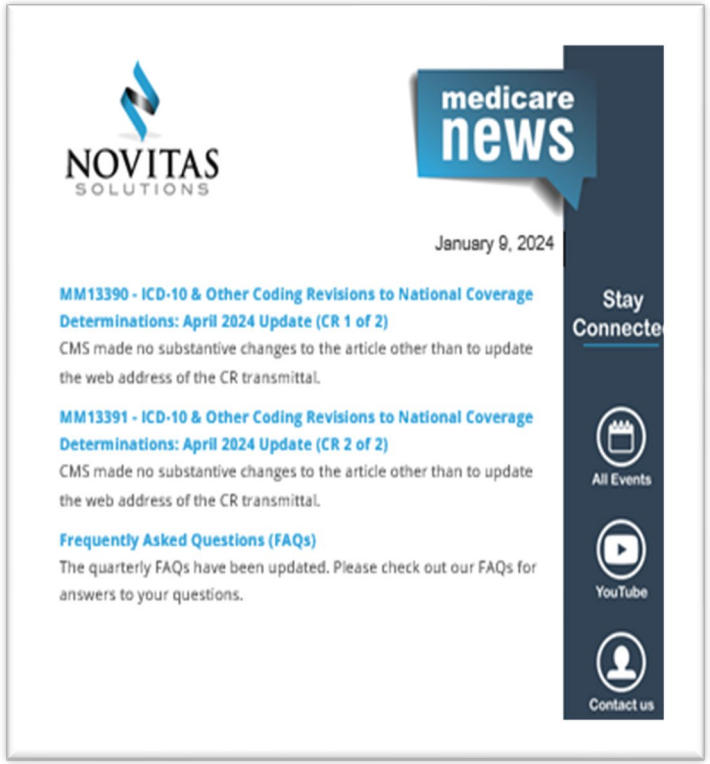
- Reviewed the Stay of Enrollment guidelines

4

- Discussed the revalidation requirements

Join eNews Email

- Novitas Solutions eNews:
  - Receive current updates directly via email:
    - Part A and Part B News
    - Issued weekly
    - CMS MLN Connects issued Thursdays
  - Subscribing is quick and easy:
    - Click the Join E-Mail List from our website tool bar
  - Didn't receive verification or stopped receiving email notifications?
    - Follow these simple steps to allow emails



mlnconnects
Official CMS news from the Medicare Learning Network®

- CMS MLN Connects Newsletter:
  - National fee-for-service news from across CMS:
    - Program and policy details
    - News and announcements
    - Press releases
    - Claim, pricer, and code information
    - Updates on new and revised MLN Matters Articles and publications

IHS Contact Information

- Visit our websites:
  - www.novitas-solutions.com
- Call our Customer Contact Center:
  - 1-855-252-8782
- Gail Atnip
  Education Specialist, Provider Outreach and Education
  Gail.Atnip@novitas-solutions.com
  214-356-4210
- Kim Robinson
  Education Specialist, Provider Outreach and Education
  Kim.Robinson@novitas-solutions.com
  214-399-0444
- Stephanie Portzline
  Manager, Provider Engagement
  Stephanie.Portzline@novitas-solutions.com
  717-947-5749

Join Our eNews Email List!

- Receive current updates directly via email:
  - Part A and Part B News
  - Issued weekly
  - CMS MLN Connects issued Thursdays
- Subscribing is quick and easy:
  - Click the Join Our E-Mail List from our website left navigation bar
  - Subscribe to Our Mailing List (JH)
- Didn't receive verification or stopped receiving email notifications?
  - Follow the simple steps to allow emails in the IP Addresses article