Understanding the Fundamentals of Medicare Provider Enrollment

CMS ITU Portland

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NOVITAS SOLUTIONS

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Your Presenters

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Today's Presentation

- Agenda:
  - Novitas Solutions
  - Provider Enrollment Basics
  - Provider Enrollment Application Submission Options
  - Enrolling Part A Institutional Providers and Health Care Organizations
  - Enrolling Part B Clinics/Group Practices and Certain Other Suppliers Applications
  - Enrolling Physician/Non-Physician Practitioners
  - Additional Forms
  - Enrollment Requirements for Indian Health Services (IHS), Tribal and Urban Indian Hospitals and Provider Based Clinics
  - Enrollment Requirements for IHS, Tribal and Urban Indian Non-Provider Based Clinics
  - Enrollment Requirements for Federally Qualified Health Centers (FQHCs) and Historically Excepted Tribal FQHCs
  - IHS Specific Information
  - Maintaining and Revalidating the Enrollment Record

Acronym List

Acronym	Definition
CMS	Centers for Medicare & Medicaid Services
CCN	CMS Certification Number
DME	Durable medical equipment
FQHC	Federally qualified health centers
HH+H	Home Health and Hospice
IHS	Indian Health Services
MAC	Medicare Administrative Contractor
NPI	National Provider Identifier
PECOS	Provider Enrollment, Chain and Ownership System
REH	Rural emergency hospital
UB-04	Uniform Billing Form

Novitas Solutions

Who We Are and What We Offer

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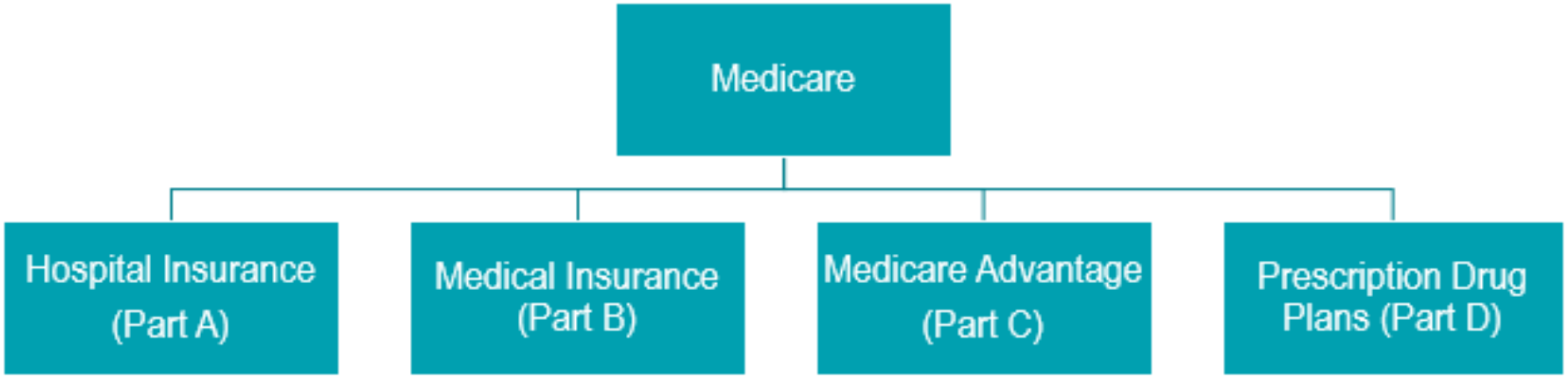
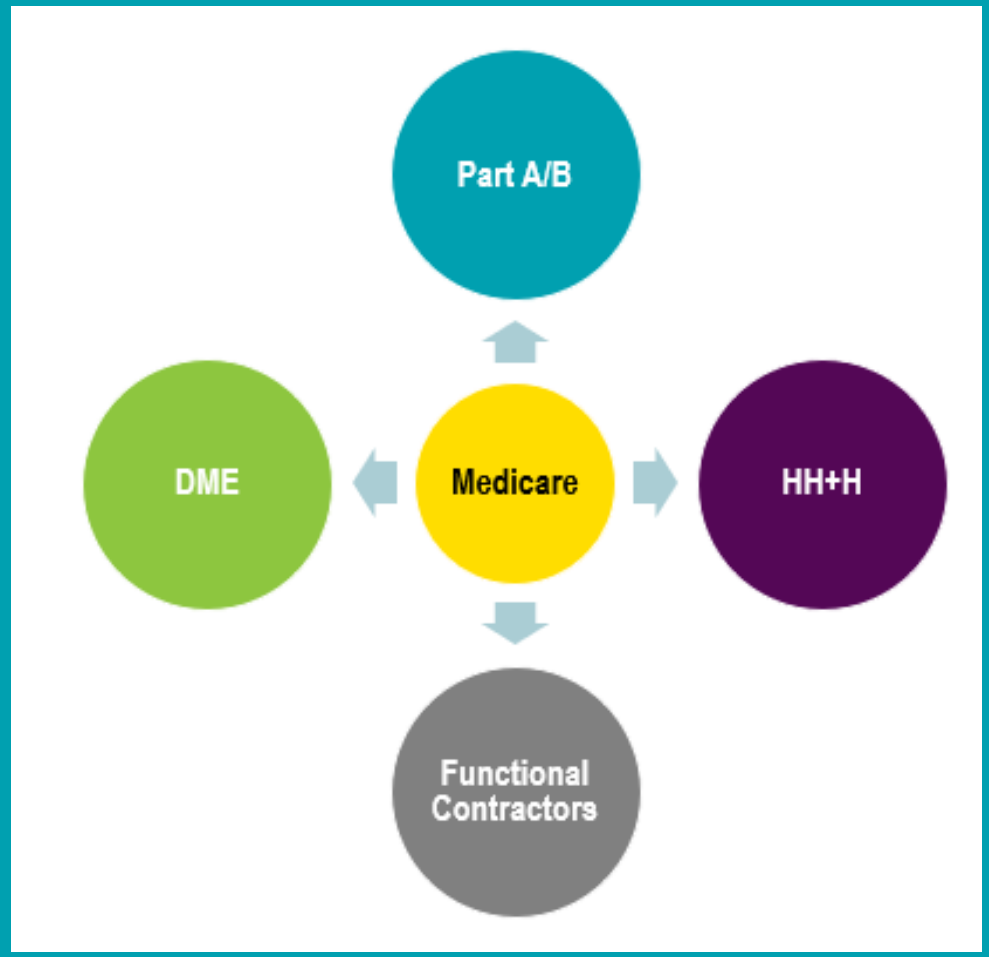
Medicare Program



- Background:
  - CMS is the federal agency responsible for providing health coverage for the Medicare program
  - Medicare program is the largest health insurance program in the United States
- Purpose:
  - Provides insurance coverage to individuals eligible 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 (Part C) or Prescription Drug plan (Part D)
- 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

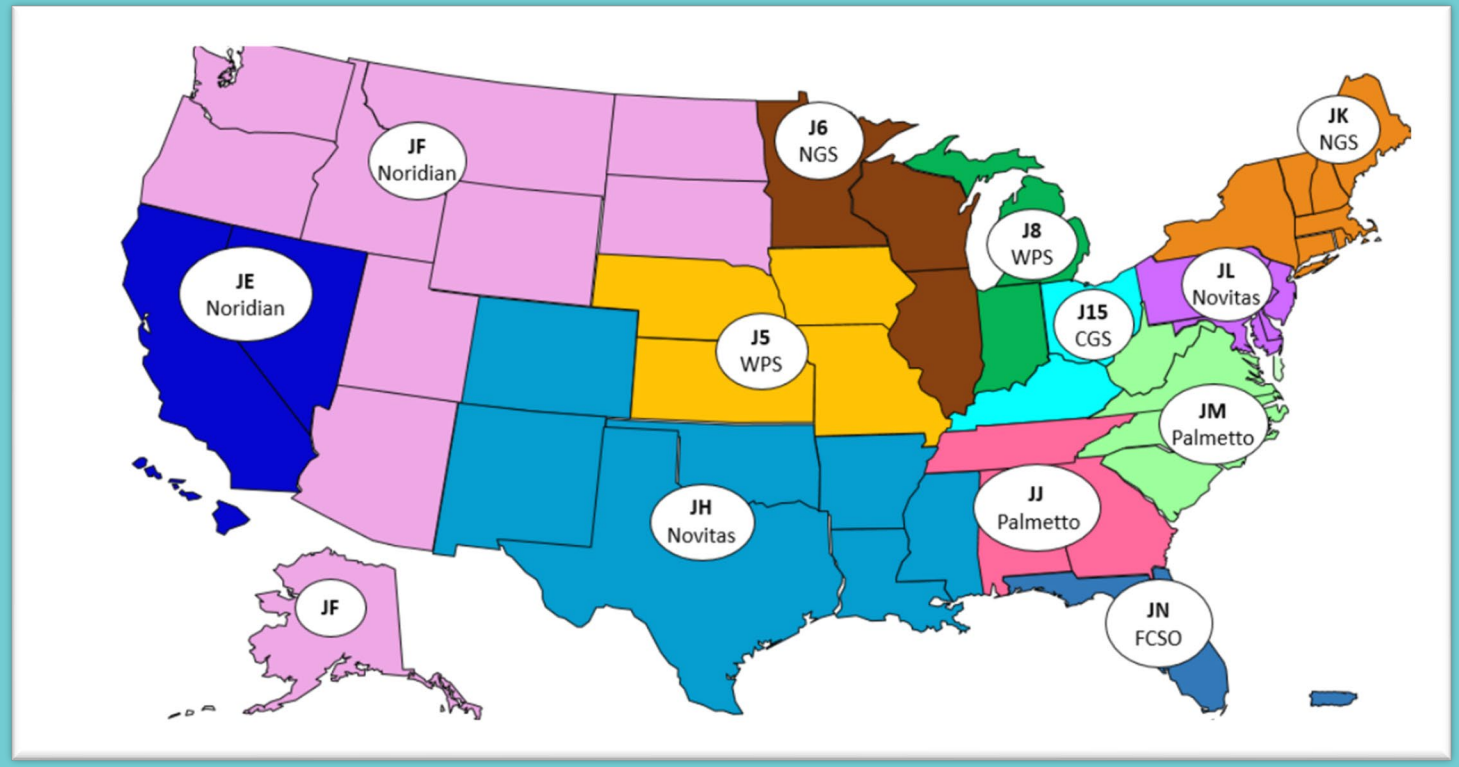


What MACs Do


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

MAC Jurisdictions: Part A/B

- Novitas Solutions:
  - Part A/B Jurisdiction H (JH):
    - Arkansas (AR), Colorado (CO), Louisiana (LA), Mississippi (MS), New Mexico (NM), Oklahoma (OK), and Texas (TX)
  - Indian Health Services (IHS)
  - Veterans Affairs
  - Part A/B Jurisdiction L (JL):
    - District Colombia (DC), Delaware (DE), Maryland (MD), New Jersey (NJ), Pennsylvania (PA)
- Two main office locations:
  - Jacksonville, FL
  - Mechanicsburg, PA

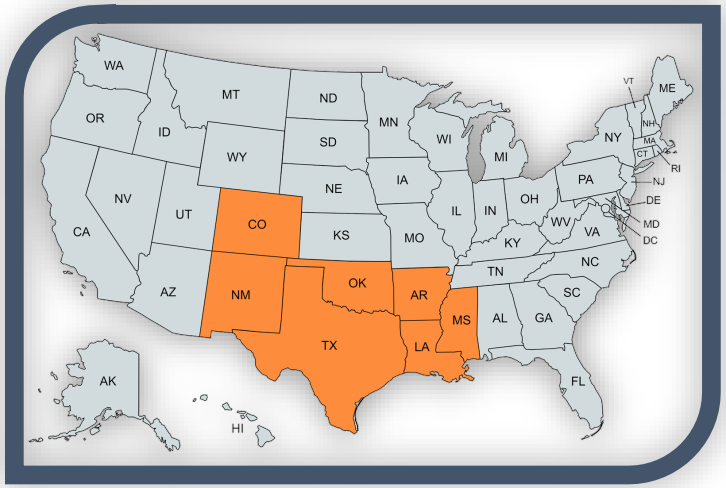


Novitas Solutions

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 **free** secure internet portal available to providers, billing services, and clearinghouses
- 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
- Reference:
  - Novitasphere (JH)

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
  - StayConnected Workshop Series
  - Medicare Navigator Series
  - Educational Event Calendar (JH)
- Full repository of On-Demand Learning (JH) educational resources available convenient viewing:
  - Click-and-play videos
  - Webinar recordings
- **Free:**
  - All educational opportunities are free

Provider Enrollment Basics

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Enrolling Under Novitas as an IHS Provider

- Novitas is the designated IHS MAC for Indian Health Service, which includes IHS, Tribal and Urban Indians
  - IHS providers and supplier's enrollment records and claims are processed in the Texas system
- IHS, Tribal and/or Urban facilities/providers must enroll with the designated IHS MAC (Novitas) for specialty provisions offered by Centers of Medicare & Medicaid (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

Enrolling Under Novitas (cont.)

- This includes provider types (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 surgical center (ASC)
- 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 and processes it in the correct system
- Reference:
  - Medicare Claims Processing Manual, Pub. 100-04, Chapter 19 - Indian Health Services

Provider Enrollment Into The Medicare Program

- Enrollment overview:
  - To be eligible to treat Medicare beneficiaries, submit claims and receive reimbursement for covered services provided to Medicare patients, providers/suppliers must be enrolled in the Medicare program
- Provider enrollment is the process of credentialing a provider/supplier for admission into Medicare:
  - Allowing them to render services to beneficiaries and receive reimbursement
  - Assuring only qualified and eligible providers/suppliers enroll in the Medicare program through validation and screening of the Medicare enrollment application and other supporting documentation
- Provider enrollment records are housed in the Provider Enrollment, Chain, and Ownership System (PECOS):
  - Web-based platform managed by the CMS to facilitate the enrollment process
- References:
  - Become a Medicare Provider or Supplier
  - Enrollment Center
  - Medicare Program Integrity Manual, Pub. 100-08, Chapter 10 - Medicare Enrollment

Enrollment Information Release

- Throughout the application process:
  - CMS authorizes the release of enrollment-related information to authorized individuals listed on the application
- Authorized individuals to whom we may release enrollment or application information:
  - Provider/supplier
  - Authorized official
  - Delegated official
  - Contact person
- For general questions regarding the enrollment process, the application, etc., contact:
  - Provider Enrollment Help Desk:
    - JH: 1-855-252-8782

Provider Enrollment Application Submission Options

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Enrollment Application Submission Option - PECOS

- PECOS is the CMS-established, internet-based online enrollment processing system:
  - Provides a scenario-driven application
  - Asks questions to obtain the required information for the provider's specific enrollment scenario
- Allows physicians, non-physician practitioners, organizations and/or facilities and their staff to:
  - Enroll initially
  - Update existing enrollment information
  - Revalidate/reactivate the enrollment record
- Paperless process including:
  - Electronic signature
  - Digital Documentation Repository (DDR)
- Faster processing time than paper enrollment applications
- Track status of the application
- PECOS offers resources and tutorials
- CMS and the MACs encourage the use of PECOS instead of paper Medicare enrollment applications
- References:
  - Welcome to the Medicare Provider Enrollment, Chain, and Ownership (PECOS)
  - Provider Enrollment, Chain, and Ownership System (PECOS) Fact Sheet
  - Who Should I Call? CMS Provider Enrollment Assistance Guide

Enrollment Application Submission Option – Paper Application

- If electronic submission isn't the preferred method, the same 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 paper applications
  - Download an application each time to avoid using an out-of-date version
  - Type or write legibly with blue ink (preferably) within the prescribed boxes of the application
  - Retain a copy of the application for the provider's files
- 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 application:
  - 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
  - Provider Enrollment Gateway User Guide
  - Mailing Addresses for Enrollment Forms

Medicare Enrollment Application Fee

- There is an application fee to cover costs associated with screening and conducting other program integrity activities associated with the provider enrollment process
- 2026 Application fee - $750.00:
  - 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))
  - FQHC
  - Historically accepted Tribal FQHCs
  - Ambulance
  - ASC
  - Durable medical equipment (DME) supplier
- Fee can be paid using PECOS Application Fee Information or Pay.gov
- References:
  - Provider Enrollment Application Fee: CY 2026
  - Application Fee Requirements for Institutional Providers

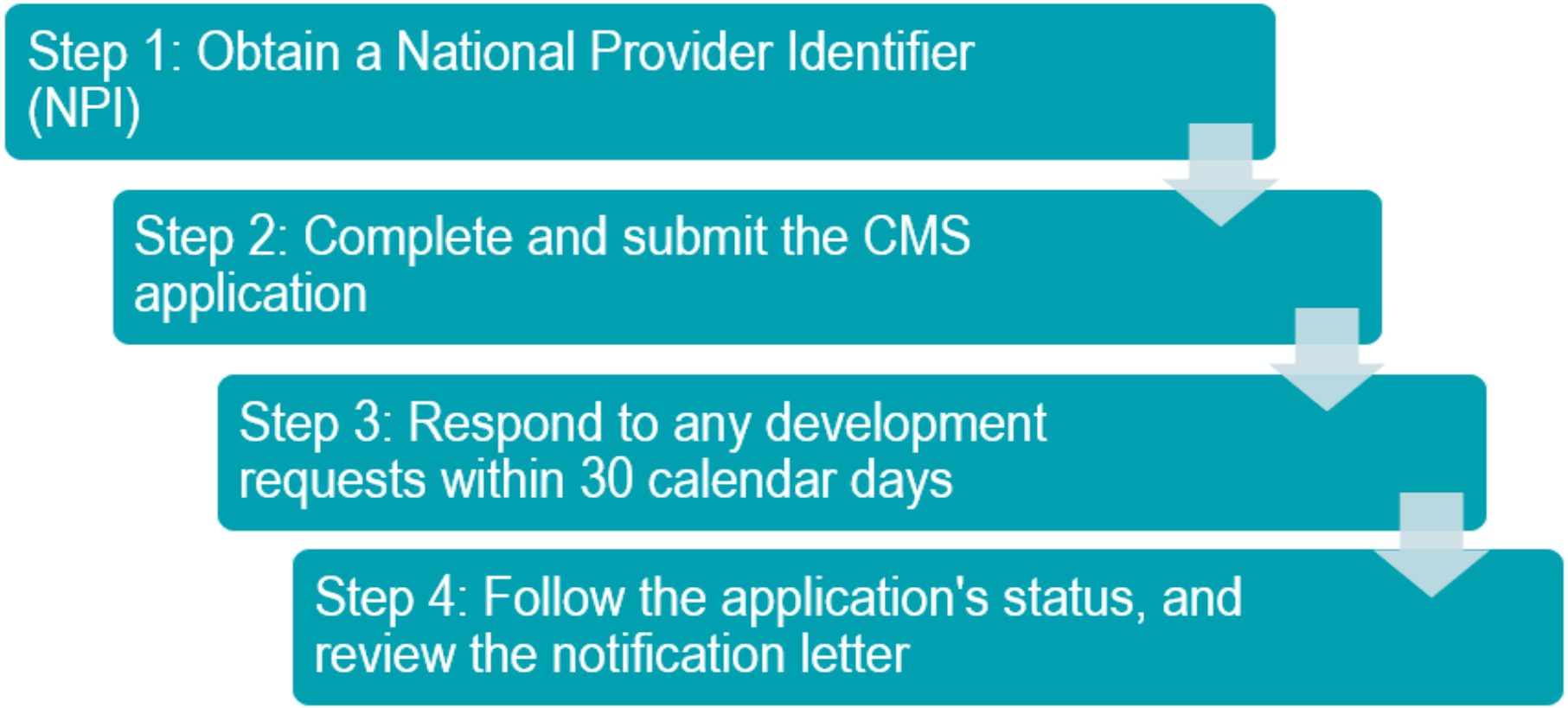
Application Fee Requirement Chart

- 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

Medicare Provider Enrollment Steps

- Physician, non-physician practitioner, organization and/or facility will take these steps to enroll in the Medicare program



Step 1: Obtain a National Provider Identifier (NPI)

- An NPI is a unique 10-digit identification number assigned to health care providers, required by health plans (including Medicare, Medicaid, and private health plans) for administrative and financial transactions:
  - Individual's first and last names must match between the NPI, the Medicare enrollment application, and the Social Security Administration
  - Organization's legal business name must match between the NPI, the Medicare enrollment application, and the Internal Revenue Service (IRS) document
- Providers must obtain the NPI prior to applying for enrollment with Medicare through the National Plan & Provider Enumeration System (NPPES)
- NPI applications are **not** processed by the MAC
- References:
  - NPPES FAQs
  - The National Provider Identifier (NPI) Fact Sheet
  - NPI Helpdesk phone:
    - 1-800-465-3203 (Toll-Free)
  - NPI Helpdesk email:
    - customerservice@npienumerator.com

Type 1 Individual

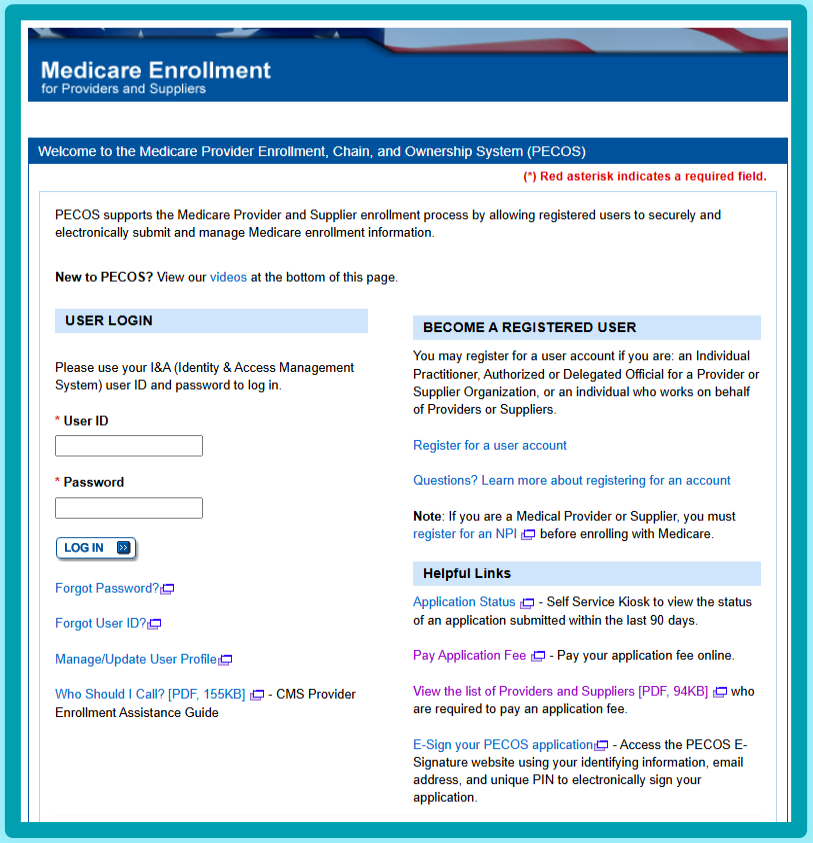
- Individuals who render health care services or furnish health care supplies to patients
- Obtained with first/last name and Social Security Number

Type 2 Organization

- Organizations that render health care services or furnish health care supplies to patients
- Obtained with legal business name and tax identification number

Step 2: Complete and Submit the CMS PECOS or Paper Application

Enrollment applications may be submitted electronically using PECOS



Enrollment applications may be submitted using paper CMS-855 form

Step 3: Application Review and Development

- 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 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:
    - Exception for requests for supporting documentation only

Step 5: Finalization and Notification

- Once all required information is received, the MAC finalizes the application information and enters it into PECOS
- A notification letter is sent once processing is complete providing important details, including whether the enrollment has been approved or denied, furnishing the Medicare billing number and effective date, relating any reassignment information, and outlining any appeal rights (if applicable)
- A best practice is to review the notification letter for accuracy

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

- 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

Enrolling Part A Institutional Providers and Health Care Organizations

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Part A Medicare Eligible Organizations

- Eligible Indian Health Services Part A enrollment options:
  - IHS facility, which includes:
    - Hospitals
  - FQHC:
    - This includes the historically excepted tribal FQHCs
  - CAH
  - IHS REH

Part A Institutional Providers Applications

- Hospitals and other health care organizations planning to bill Medicare for Part A medical services have 2 options for application submission
- PECOS:
  - Application questionnaire:
    - Select **Institutional Provider**, this will populate the CMS-855A facility application
    - Select the type of facility that will be enrolling or updating information
    - Select Novitas as the fee-for-service contractor
- Paper CMS-855A Medicare Enrollment Application Institutional Providers application:
  - Section 1(A): check the box indicating the reason the application is being submitting and following the instructions on completing the required sections
  - Section 2(A)(1): check the type of provider that will be enrolling or updating information
  - Indian Health Service Part A Provider Enrollment Application Coversheet must be submitted with the application
- 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
- References:
  - Welcome to the Medicare Provider Enrollment, Chain, and Ownership (PECOS
  - Completing the Medicare Enrollment Application - Institutional Providers (CMS-855A) application

Enrolling Part B Clinics/Group Practices and Certain Other Suppliers Applications

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Part B Clinics/Group Practices and Certain Other Suppliers

- Eligible IHS Part B enrollment options:
  - Ambulance service supplier
  - ASC
  - Clinic/group practice

Part B Clinics/Group Practices and Certain Other Suppliers Applications

- Groups and organizations who plan to bill Medicare for Part B medical services have 2 options for application submission
- PECOS:
  - Application questionnaire:
    - Select Clinic/Group Practice and Certain Other Suppliers this will populate the CMS-855B
    - Select type of supplier that will be enrolling or updating
    - Select Novitas as the fee-for-service contractor
- Paper CMS-855B Medicare Enrollment Application Clinic/Group Practice and Other Suppliers:
  - Section 1(A): check the box indicating the reason for submitting the application and following the instructions on completing the required sections
  - Section 2(B): check the type of supplier that will be enrolling or updating
  - Indian Health Service Part B Provider Enrollment Application Coversheet must be submitted with the application
- 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
- References:
  - Welcome to the Medicare Provider Enrollment, Chain, and Ownership (PECOS)
  - Completing the Medicare Enrollment Application - Clinics/Group Practices and Other Suppliers (CMS-855B) application

Enrolling Physician/Non-Physician Practitioners

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Enrolling Physician/ Non-Physician Practitioners Applications

- Physician/non-physician practitioners who plan to bill Medicare for Part B medical services or to reassign their benefits have 2 options for application submission
- PECOS:
  - Application questionnaire:
    - Select Individual Physician or Non-Physician Practitioner, this will populate the CMS-855I
    - Select type of physician specialty that will be enrolling or updating
    - Select Novitas as the fee-for-service contractor
- Paper CMS-855I Medicare Enrollment Application: Physicians and Non-Physician Practitioners application:
  - Section 1(A): check the box indicating the reason for submitting the application and following the instructions on completing the required sections
  - Section 2(G): check the type of physician specialty that will be enrolling or updating
  - Section 4 (F): "Individual/Organization/Group Receiving the Reassigned Benefits"
- Reassigned benefits:
  - An individual practitioner reassigning the right to bill Medicare and receive payments for services rendered to an eligible provider, such as a clinic, group practice, or organization
- Enrollment applications contain a question asking if the application is an IHS facility:
  - All IHS, 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
- References:
  - Welcome to the Medicare Provider Enrollment, Chain, and Ownership (PECOS)
  - Enrollment Guide: Chapter 8 - Additional Enrollment Information for Part B, provides a listing of eligible providers/non-practitioners who can enroll in Medicare
  - Completing the Medicare Enrollment Application – Physicians and Non-Physician Practitioners (CMS-855I) application

Additional Forms

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Part B Medicare Participating Physician or Supplier Agreement CMS-460

- Part B providers have the options to become a participating provider by completing the CMS-460 during enrollment or open enrollment:
  - This means the provider/supplier agrees to accept claims assignment for all Medicare-covered services and accept Medicare-allowed amounts as payment in full
- Becoming a participating provider/supplier, agreement is to:
  - Accept Medicare-allowed amounts as reimbursement in full
  - Expect reimbursement 5% higher than non-participating amount
  - Recognize inability to charge for items and services covered by the health insurance program other than the Medicare allowable charges and deductibles and coinsurance amounts
  - Return any money incorrectly collected from the individual or other person on his/her behalf or make sure other disposition that would cause a termination of the provider's agreement
  - Acknowledge placement in Medicare Participating Physicians and Suppliers Directory (MEDPARD):
    - Contains the names, addresses, telephone numbers and specialties of Medicare Participating physicians and suppliers
- Must be submitted:
  - With enrollment package, or within 90 days of initial enrollment
  - During annual open enrollment period (end of calendar year):
    - If keeping current participation status, there is no need to submit any documentation
- The CMS-460 paper form, if applicable, must be submitted even when enrolling electronically via PECOS
- Providers who reassign benefits to a clinic/group practice inherit the participation status established by the clinic/group practice, therefore reassigning practitioners do not submit the CMS-460
- References:
  - Annual Medicare Participation Announcement
  - Enrollment Guide: Chapter 4 – Medicare Participation
  - Welcome to the Medicare Provider Enrollment, Chain, and Ownership (PECOS)
  - CMS-460 Medicare Participating Physician or Supplier Agreement
  - Completing the Medicare Enrollment Application – Medicare Participating Physician or Supplier Agreement (CMS-460) application

Electronic Funds Transfer (EFT) Form

- CMS requires all providers/suppliers enrolling in Medicare use EFT method:
  - It is a direct deposit of Medicare payments into the provider's designated bank account
- The CMS-588 EFT Authorization form must be submitted with the enrollment request for any newly enrolling provider, or any existing provider not already enrolled in EFT
- Submitting an EFT form:
  - EFT can be submitted using PECOS or the paper CMS-588 Electronic Funds Transfer Authorization Agreement form, for initial enrollment and change of information applications
  - Submit one supporting document with the EFT form:
    - A voided check
    - Bank letterhead which includes:
      - Name on account
      - Account number
      - Routing number
      - Account type
      - Bank officer's name and signature
- References:
  - Welcome to the Medicare Provider Enrollment, Chain, and Ownership (PECOS)
  - CMS-588 Electronic Funds Transfer EFT Authorization Agreement
  - Completing the Medicare Enrollment Application – Electronic Funds Transfer (EFT) Authorization Agreement (CMS-588) application

Enrollment Requirements for IHS, Tribal and Urban Indian Hospitals and Provider Based Clinics

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Enrollment Requirements for IHS or Tribal Hospitals

- IHS or Tribal acute care and CAH hospitals are required to enroll in Medicare to provide services to beneficiaries and obtain reimbursement
- Enrollment application submission options:
  - PECOS:
    - Application questionnaire:
      - ❑ Select Institutional Provider, this will populate the CMS-855A facility application
      - ❑ Select the type of facility that will be enrolling or updating information
      - ❑ Select Novitas as the fee-for-service contractor
  - Paper CMS-855A Medicare Enrollment Application Institutional Providers application:
    - Section 1(A): check the box indicating the reason the application is being submitting and following the instructions on completing the required sections
    - Section 2(A)(1): check the type of provider that will be enrolling or updating information
    - Indian Health Service Part A Provider Enrollment Application Coversheet must be submitted with the application
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    - It assures Novitas receives the application from PECOS and the application is processed in the correct system
- Reference:
  - Welcome to the Medicare Provider Enrollment, Chain, and Ownership (PECOS)

Provider–Based Hospital Off-Campus Practice Location Address

- Provider-based departments are defined as a Medicare designation that allows hospitals to treat certain departments and facilities located outside of the main hospital as part of the hospital for billing purposes including:
  - Clinics
  - Departments
  - Remote locations
  - Satellite locations not separately enrolled or certified under Medicare
  - All locations must be listed in the enrollment records
- Operated under the ownership, administrative, and financial control of the main hospital
- Treated as departments of main provider (hospital) for Medicare purposes
- Located on-campus or off-campus
- All locations must be reported on the enrollment records:
  - Indian Health Service hospital off-campus outpatient department reporting requirements
- Providers must ensure all enrollment information is up to date:
  - Submit claims with practice locations exactly as they appear in 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:
      - Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE) Manual
  - Ensure the practice locations are linked to the NPI that is being reported on the claim submission

Enrollment Requirements Provider-Based Clinic

- IHS or Tribal hospital provider-based clinics are required to enroll in Medicare to provide services to beneficiaries and obtain reimbursement
- Provider-based clinics are associated with the hospital
- Enrollment application submission options:
  - PECOS:
    - Application questionnaire:
      - Select Clinic/Group Practice and Certain Other Suppliers this will populate the CMS-855B
      - Select type of supplier that will be enrolling or updating
      - Select Novitas as the fee-for-service contractor
  - Paper CMS-855B Medicare Enrollment Application Clinic/Group Practice and Other Suppliers:
    - Section 1(A): check the box indicating the reason for submitting the application and following the instructions on completing the required sections
    - Section 2(B): check the type of supplier that will be enrolling or updating
    - Indian Health Service Part B Provider Enrollment Application Coversheet must be submitted with the application
- 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:
  - Welcome to the Medicare Provider Enrollment, Chain, and Ownership (PECOS)

Enrollment Requirements for Physicians/Non-Physicians Providing Services to a Provider-Based Clinic

- Purpose:
  - Physicians and non-physicians must enroll in Medicare and reassign benefits to the clinic to render services to beneficiaries and receive reimbursement
  - Each provider providing services to this clinic/group will submit a new (if not enrolled under Novitas IHS) or updated application, to enroll and/or reassign benefits to the clinic
- Enrollment application submission options:
  - PECOS:
    - Application questionnaire:
      - Select Individual Physician or Non-Physician Practitioner, this will populate the CMS-855I
      - Select type of physician specialty that will be enrolling or updating
      - Select Novitas as the fee-for-service contractor
  - Paper CMS-855I Medicare Enrollment Application: Physicians and Non-Physician Practitioners application
    - Section 1(A): check the box indicating the reason for submitting the application and following the instructions on completing the required sections
    - Section 2(G): check the type of physician specialty that will be enrolling or updating
    - Section 4 (F): complete this section when reassigning benefits
- Reassigned Benefits:
  - Assignments of benefits to a group/clinic must be submitted in the Paper CMS-855I Medicare Enrollment Application: Physicians and Non-Physician Practitioners application or PECOS equivalent application
- 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:
  - Welcome to the Medicare Provider Enrollment, Chain, and Ownership (PECOS)

Enrollment Requirements for IHS, Tribal and Urban Indian Non-Provider Based Clinics

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Enrollment Requirements for IHS, Tribal or Urban Non-Provider-Based Clinic

- Purpose:
  - IHS or Tribal non-provider-based clinics are not associated with a hospital
  - These clinics must enroll in Medicare to provide services to beneficiaries and obtain reimbursement
- Enrollment application submission options:
  - PECOS:
    - Application questionnaire:
      - Select Clinic/Group Practice and Certain Other Suppliers this will populate the CMS-855B
      - Select type of supplier that will be enrolling or updating
      - Select Novitas as the fee-for-service contractor
  - Paper CMS-855B Medicare Enrollment Application Clinic/Group Practice and Other Suppliers:
    - Section 1(A): check the box indicating the reason for submitting the application and following the instructions on completing the required sections
    - Section 2(B): check the type of supplier that will be enrolling or updating
    - Indian Health Service Part B Provider Enrollment Application Coversheet must be submitted with the application
- 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:
  - Welcome to the Medicare Provider Enrollment, Chain, and Ownership (PECOS)

Enrollment Requirements for Physicians/Non-Physicians Providing Services to a Non-Provider-Based Clinic

- Purpose:
  - Physicians and non-physicians must enroll in Medicare and reassign benefits to the clinic to render services to beneficiaries and receive reimbursement
  - Each provider providing services to this clinic/group will submit a new (if not enrolled under Novitas IHS) or updated application, to enroll and/or reassign benefits to the clinic
- Enrollment application submission options:
  - PECOS:
    - Application questionnaire:
      - Select Individual Physician or Non-Physician Practitioner, this will populate the CMS-855I
      - Select type of physician specialty that will be enrolling or updating
      - Select Novitas as the fee-for-service contractor
  - Paper CMS-855I Medicare Enrollment Application: Physicians and Non-Physician Practitioners application:
    - Section 1(A): check the box indicating the reason for submitting the application and following the instructions on completing the required sections
    - Section 2(G): check the type of physician specialty that will be enrolling or updating
    - Section 4 (F): complete this section when reassigning benefits
- Reassigned benefits:
  - Assignments of benefits to a group/clinic must be submitted in the PECOS application or paper application
- 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:
  - Welcome to the Medicare Provider Enrollment, Chain, and Ownership (PECOS)

Enrollment Requirements for Federally Qualified Health Centers (FQHCs) and Historically Excepted Tribal FQHCs

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FQHCs and Historically Excepted Tribal FQHCs

- FQHCs were established in 1990 by section 4161 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 and were effective beginning October 1, 1991:
  - To be eligible as a historically excepted Tribal FQHC the qualifications in Change Request (CR) 9267 must be met
- FQHCs are facilities that are primarily engaged in providing services that are typically furnished in an outpatient clinic
- FQHCs must meet statutory requirements to qualify for the Medicare benefit in section 1861(aa)(4) of the Social Security Act (the Act)
- FQHCs are reimbursed by the Part B Medicare trust fund and file claims with MAC:
  - FQHC facilities bill on the Part A Uniform Billing (UB-04) claim form or electronic equivalent
- References:
  - Provider Specialty: Federally Qualified Health Centers
  - Medicare Learning Network (MLN) Booklet: MLN006397 - Federally Qualified Health Center
  - Historically Excepted Tribal FQHCs (formerly known as Grandfathered Tribal FQHCs)
  - Change Request (CR) 9267 - Payment for Grandfathered Tribal Federally Qualified Health Centers (FQHCs) that were Provider-Based Clinics on or Before April 7, 2000

Enrollment Requirements for an FQHC and Historically Excepted Tribal FQHCs

- An FQHC must enroll in Medicare Part A to receive the facility encounter rate reimbursement
- Enrollment application submission options:
  - PECOS:
    - Application questionnaire:
      - Select Institutional Provider, this will populate the CMS-855A facility application
      - Select the type of facility that will be enrolling or updating information
      - Select Novitas as the fee-for-service contractor
  - Paper CMS-855A Medicare Enrollment Application Institutional Providers application:
    - Section 1(A): check the box indicating the reason the application is being submitting and following the instructions on completing the required sections
    - Section 2(A)(1): check the type of provider that will be enrolling or updating information
    - Indian Health Service Part A Provider Enrollment Application Coversheet must be submitted with the application
- 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
- References:
  - Medicare Benefits Policy Manual, Pub. 100-02, Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services, Section 60.1, "Description of Non RHC/FQHC Services"
  - Welcome to the Medicare Provider Enrollment, Chain, and Ownership (PECOS)

Enrollment Requirements for Non-FQHC Services

- The Part A encounter rate does not include non-FQHC services
- Reimbursed for non-FQHC services requires the FQHC to enroll under Medicare Part B to submit services on the Part B CMS-1500 claim form or the electronic equivalent
- A clinic/group application is required and each provider providing services to this clinic/group will need to submit a new (if not enrolled under Novitas IHS) or updated application, to enroll and/or reassign benefits to the clinic
- Clinic enrollment application submission options:
  - PECOS:
    - Application questionnaire:
      - Select Clinic/Group Practice and Certain Other Suppliers this will populate the CMS-855B
      - Select type of supplier that will be enrolling or updating
      - Select Novitas as the fee-for-service contractor
  - Paper CMS-855B Medicare Enrollment Application Clinic/Group Practice and Other Suppliers:
    - Section 1(A): check the box indicating the reason for submitting the application and following the instructions on completing the required sections
    - Section 2(B): check the type of supplier that will be enrolling or updating
  - Indian Health Service Part B Provider Enrollment Application Coversheet must be submitted with the application
- 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:
  - Welcome to the Medicare Provider Enrollment, Chain, and Ownership (PECOS)

Enrollment Requirements for Non-FQHC Services (cont.)

- Physicians/Non-physicians enrollment application submission options:
  - PECOS:
    - Application questionnaire:
      - Select Individual Physician or Non-Physician Practitioner, this will populate the CMS-855I
      - Select type of physician specialty that will be enrolling or updating
      - Select Novitas as the fee-for-service contractor
  - Paper CMS-855I Medicare Enrollment Application: Physicians and Non-Physician Practitioners application:
    - Section 1(A): check the box indicating the reason for submitting the application and following the instructions on completing the required sections
    - Section 2(G): check the type of physician specialty that will be enrolling or updating
    - Section 4 (F): complete this section when reassigning benefits
- Reassigning benefits:
  - Assignments of benefits to a group/clinic must be submitted in the PECOS application or paper application
- Enrollment applications contain a question asking if the application is an IHS facility:
  - All IHS, 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:
  - Welcome to the Medicare Provider Enrollment, Chain, and Ownership (PECOS)

FQHCs and Historically Excepted Tribal FQHCs Adding a Location

- FQHCs and historically excepted tribal FQHCs location requirement:
  - FQHCs cannot have multiple sites or practice locations:
    - Each location must be separately enrolled and will receive its own Medicare number
  - FQHCs cannot share a practice location:
    - There must be a suite number, floor, etc. to distinguish it from another facility that shares the same building address
- New location:
  - When adding a new FQHC/historically excepted tribal FQHCs location, the location must meet the requirements of an FQHC:
    - According to the regulatory provisions at 42 Code of Federal Regulations (CFR) 491.9(2) and (c)(1), FQHCs must be primarily engaged in primary services
  - Example:
    - If the only services being rendered at the new location will be behavioral health, then this would not meet the requirements of an FQHC/historically excepted tribal FQHCs

FQHCs and Historically Excepted Tribal FQHCs New Location Meets the Requirements

- If the new location does meet the requirements of an FQHC/historically excepted tribal FQHCs):
  - A new Part A CMS-855A Medicare Enrollment Application Institutional Providers or PECOS equivalent application must be submitted
- Best practice is to obtain a new NPI for the new location to prevent billing issues
- Enrollment application fee will need to be paid prior to submitting the application
- Non-FQHC services outside of the Part A encounter rate, require providers to enroll under Medicare Part B:
  - A new CMS-855B Medicare Enrollment Application Clinic/Group Practice and Other Suppliers application or PECOS equivalent must be submitted for this location:
    - Each provider providing services to this clinic/group will need to submit a new (if not enrolled under Novitas IHS) or update the CMS-855I Medicare Enrollment Application: Physicians and Non-Physician Practitioners application or PECOS equivalent
    - Reassigning benefits:
      - Assignments of benefits to a group/clinic must be submitted in the PECOS application or paper application
- Providers who will be providing services at a multiple FQHC/historically excepted tribal FQHCs locations will need to comply with the commingling guidelines:
  - Medicare Benefit Policy Manual, Pub. 100-02, Chapter 13-Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services, Section 100, "Commingling"

FQHCs and Historically Excepted Tribal FQHCs New Location Does Not Meet the Requirements

- The new location **does not meet** the FQHC and/or historically excepted tribal FQHCs requirements:
  - A new CMS-855B Medicare Enrollment Application Clinic/Group Practice and Other Suppliers application or PECOS equivalent must be submitted for this location:
    - Each provider providing services to this clinic/group will need to submit a new (if not enrolled under Novitas IHS) or update the CMS-855I Medicare Enrollment Application: Physicians and Non-Physician Practitioners application or PECOS equivalent
    - Reassigning benefits:
      - Assignments of benefits to a group/clinic must be submitted in the PECOS application or paper application
- Best practice to obtain a new NPI for the new location/clinic to prevent billing issues
- Billing will only be on the Medicare Part B side and the allowed amount will be based on the physician's fee schedule
- Claims must be submitted with place of service (POS) 11, when the patient is being seen in this clinic location:
  - Place of Service Codes
- Providers who provide services at a FQHC/historically excepted tribal FQHCs and a free-standing clinic will need to comply with the commingling guidelines:
  - Medicare Benefit Policy Manual, Pub. 100-02, Chapter 13-Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services, Section 100, "Commingling"

IHS Specific Information

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License

- IHS provider can be licensed in any state when enrolling under Novitas
- License:
  - The Patient Protection and Affordable Care Act (PL 111-148) amended Section 221 of the Indian Health Care Improvement Act (IHCIA) as follows:
    - Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any state, from the licensing requirements of the state in which the tribal program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (ISDEAA) (25 U.S.C. 450, et seq.)
  - Reminder:
    - Provider does not renew license in the state that Novitas has on file, however, the provider obtained a license in a new state:
      - Provider will need to update enrollment application with new license information
    - Failure to submit the updated license can cause provider deactivation

Certifications

- IHS providers must maintain current certifications and report any updated certifications to Novitas
- Renewals must be submitted to Novitas to prevent claim denials
- Example of certifications include:
  - Clinical Laboratory Improvement Amendments (CLIA) Program
  - Mammography facilities
  - Dietitian or nutrition professional
  - Registered dietitian credential with the Commission on Dietetic Registration (CDR)
- Email updated certifications to:
  - Part A updates: JHPEPartACerts@novitas-solutions.com
  - Part B updates: JHPEPartBCerts@novitas-soltuions.com

Clinical Pharmacist

- IHS Clinical pharmacist are not entitled to enroll in the Medicare program
- Clinical pharmacist encounter:
  - Clinical pharmacist services are not covered by Medicare
  - Clinical pharmacist cannot bill services as:
    - IHS clinic visit (the all-inclusive rate (AIR)) billed on the UB-04 claim form when this was the only service rendered (e.g., there was no covered service that day, such as a physician visit)
    - Qualifying visit by a Tribal/Urban FQHC or historically excepted Tribal FQHCs when this was the only service rendered (e.g., there was no covered service that day, such as a physician visit)
- Provider-based and non-provider-based (free-standing ambulatory) clinic may bill for the clinical pharmacist services if the incident to guidelines are met:
  - If incident to guidelines are met the physician/non-physician practitioner who is providing the direct supervision may bill on the Part B CMS-1500 claim form for the 99211, 5-minute exam:
    - Clinical pharmacist cannot provide an evaluation and management service (E/M) above the 99211 as incident to since the E/M services are not within the scope of practice for clinical pharmacists, based on the E/M policy set by CMS
- Medication therapy management (MTM) is covered under Medicare Part D sponsor and not covered under Medicare Part A and Part B
- References:
  - Provider Specialty: "Incident to" services
  - Medication Therapy Management (MTM)

Enrolling Contracted Radiologist

- IHS can enroll contracted non-IHS physicians as an employee of facility and/or clinic
- Each provider providing services to a clinic/group will need to submit a new or updated application
- Physicians/Non-Physicians Enrollment application submission options:
  - PECOS:
    - Application questionnaire:
      - Select Individual Physician or Non-Physician Practitioner, this will populate the CMS-855I
      - Select type of physician specialty that will be enrolling or updating
      - Select Novitas as the fee-for-service contractor
  - Paper CMS-855I Medicare Enrollment Application: Physicians and Non-Physician Practitioners application:
    - Section 1(A): check the box indicating the reason for submitting the application and following the instructions on completing the required sections
    - Section 2(G): check the type of physician specialty that will be enrolling or updating
    - Section 4 (F): complete this section when reassigning benefits
  - Reassigning benefits:
    - Assignments of benefits to a group/clinic must be submitted in the PECOS application or paper application
- 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:
  - Welcome to the Medicare Provider Enrollment, Chain, and Ownership (PECOS)

Enrollment for Mobile Unit

- Mobile units:
  - Entity providing the service must bill for the service unless the service is provided under contractual arrangements
  - Contracting entity performs services on space that the IHS facility owns or leases, the IHS facility, provider-based or non-provider-based clinic can bill under arrangements
- Owned/leased by a hospital, FQHC or historically excepted Tribal FQHCs:
  - The CMS-855A Medicare Enrollment Application Institutional Providers or PECOS equivalent application Section 4, must be updated with the mobile information:
    - Indian Health Service Part A Provider Enrollment Application Coversheet must be submitted with the paper application
  - The CMS-855B Medicare Enrollment Application Clinic/Group Practice and Other Suppliers application or PECOS equivalent Section 4, must be updated with the mobile information:
    - Indian Health Service Part B Provider Enrollment Application Coversheet must be submitted with the paper application
- Owned/leased by a non-provider-based (free-standing ambulatory) clinic:
  - The CMS-855B Medicare Enrollment Application Clinic/Group Practice and Other Suppliers application or PECOS equivalent Section 4, must be updated with the mobile information:
    - Indian Health Service Part B Provider Enrollment Application Coversheet must be submitted with the paper application

Reporting Requirements for Ownership Interest and/or Managing Control Information Government/Tribal Organizations

- Providers must report and update ownership interest and/or management control information for government tribal organizations
- Applies to the CMS-855A Medicare Enrollment Application Institutional Providers or PECOS equivalent application and the CMS-855B Medicare Enrollment Application Clinic/Group Practice and Other Suppliers PECOS equivalent application:
  - Section 5A: Organization with ownership interest and/or managing control - Identification information:
    - This section only applies to organizations
    - Any organization that exercised operational or managerial control over the provider or conducts the day-to-day operations, is a managing organization
    - Examples of organizations:
      - Governmental, tribal, non-profit charitable, religious organizations, corporations (including non-profit), partnerships, LLCs, etc.
- If a federal, state, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments):
  - The name of that government or Indian tribe must be reported as “other ownership or “other control/interest”
- The provider must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization, which attests that the government or tribal organization will be legally and financially responsible in the event there is any outstanding debt owed to CMS
- This letter must be signed by an “authorized official” of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare:
  - Section 15 of the CMS-855A and B contain information on authorized officials

Maintaining and Revalidating the Enrollment Record

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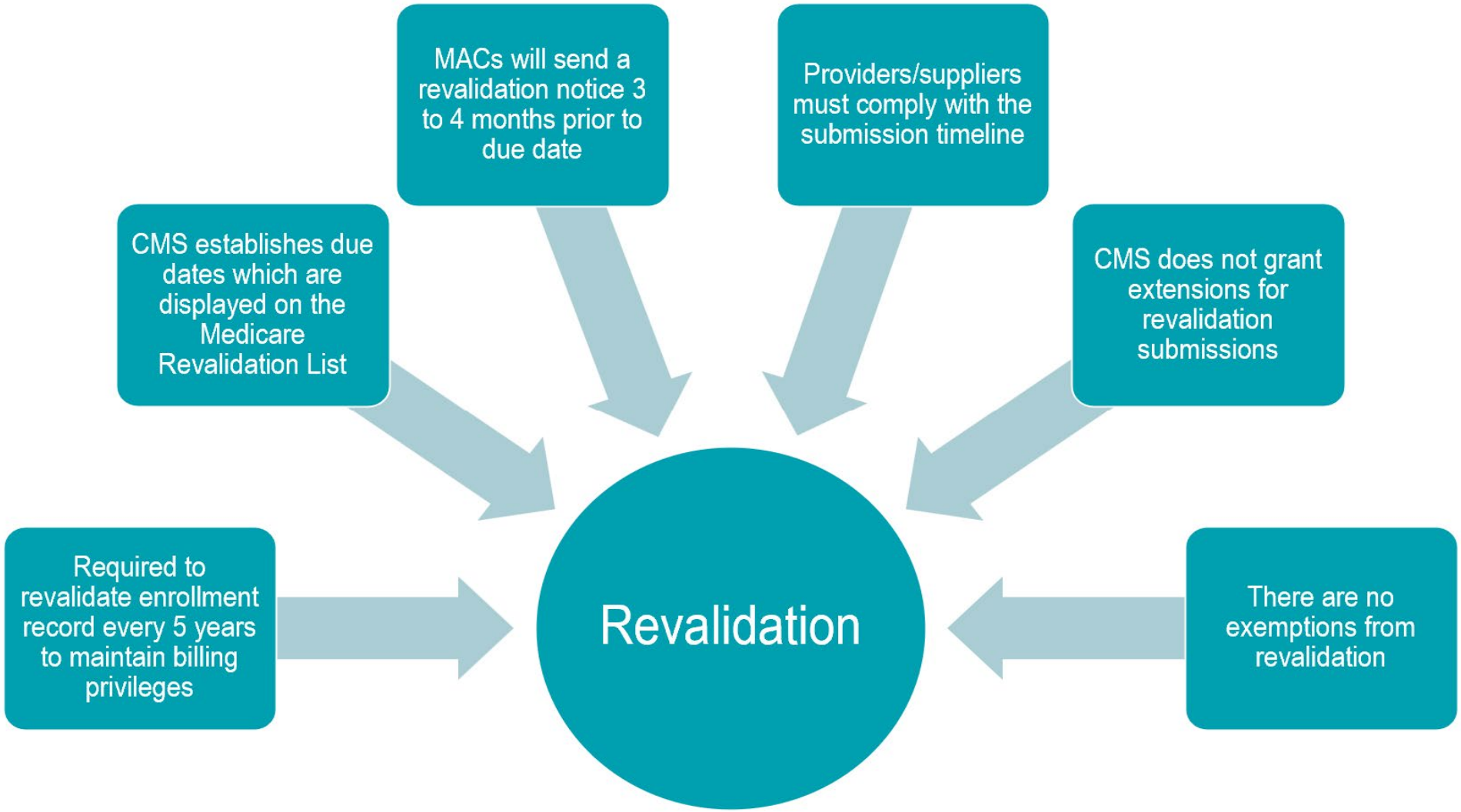
Reporting Requirements for Maintaining the Enrollment Record

- Once enrolled, providers/suppliers are responsible for keeping information current on the Medicare enrollment record
- Changes can be reported via PECOS or paper enrollment applications
- 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
- 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"

Revalidation of the Medicare Enrollment Record

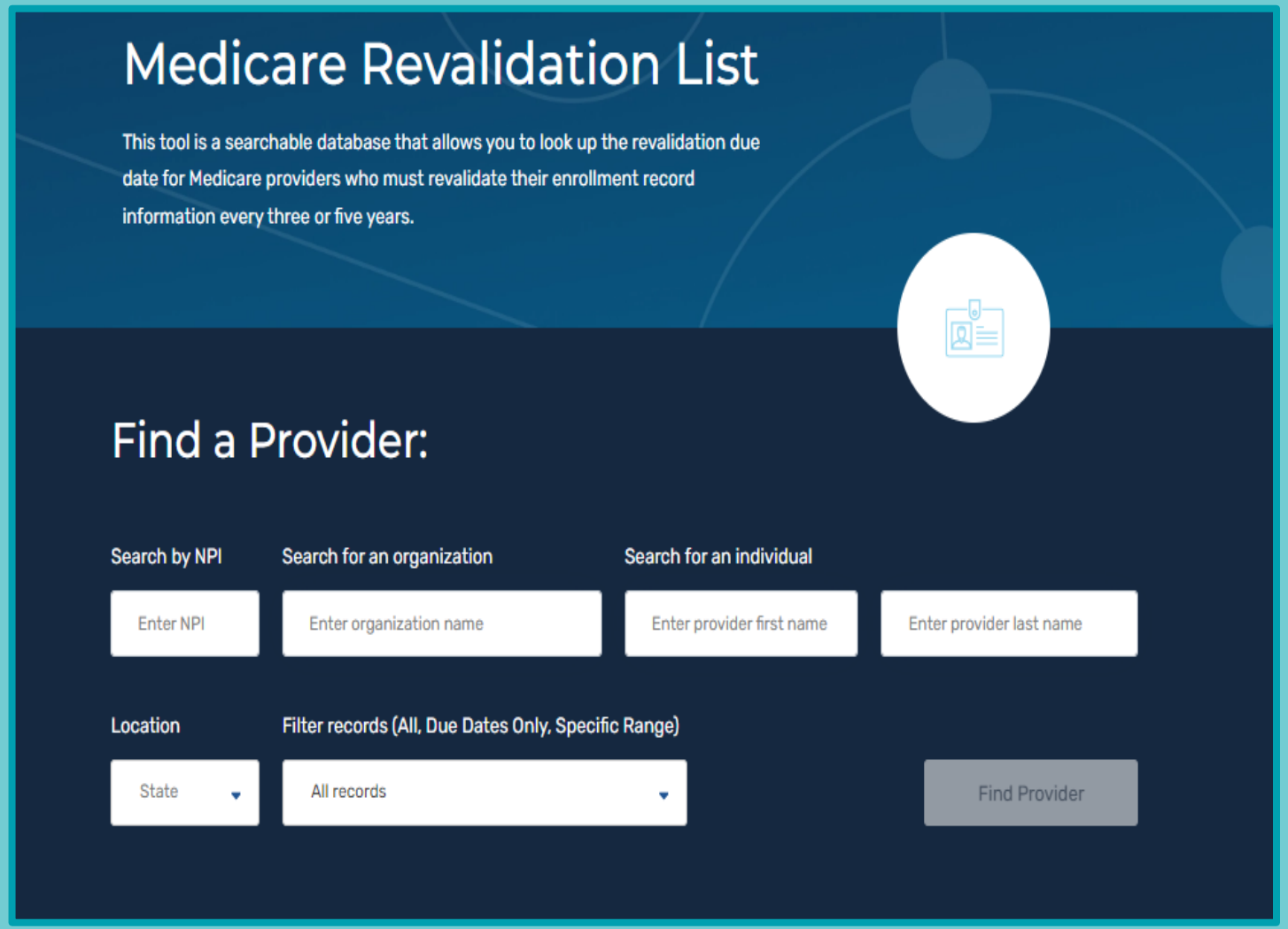
- Revalidation:
  - Certifies that Medicare has the most up-to-date information on file
  - Confirms all enrollment requirements are being met
- Medicare enrollment record revalidation is a requirement of the Patient Protection and Affordable Care Act, Section 6401
- All enrolled providers/suppliers must revalidate or renew the enrollment record periodically to maintain billing privileges:
  - Medicare requires revalidation every 5 years
  - CMS may conduct off-cycle revalidations for certain program integrity purposes
- References:
  - Revalidations (Renewing Your Enrollment)
  - Revalidation

Revalidation Timeliness Requirements



Medicare Revalidation List

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

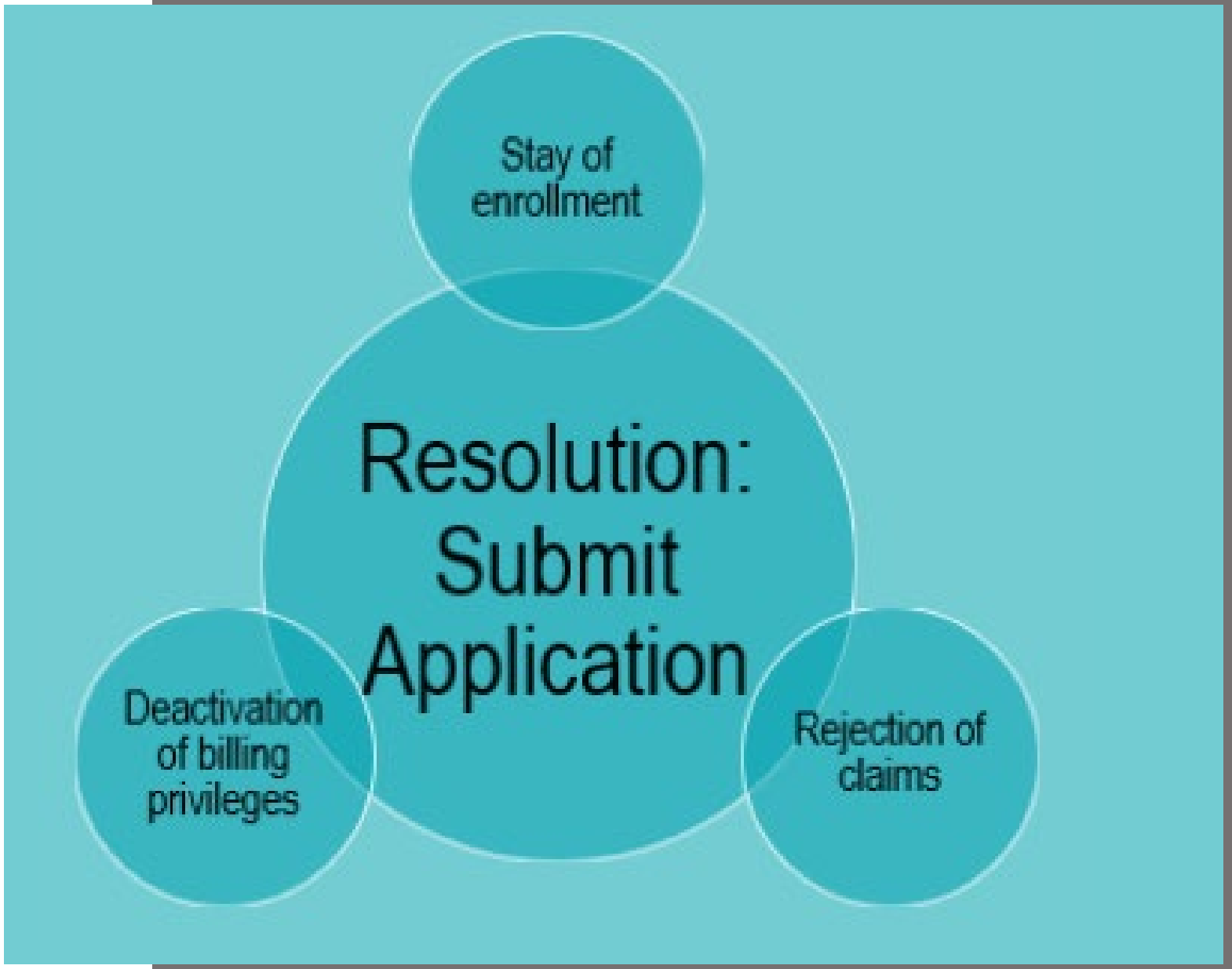


Failure to Report Changes or Respond to Revalidation

- Failure to report changes resulting in non-compliance with Medicare regulations or failure to respond to a revalidation request by the due date will result in a stay of enrollment:
  - A stay of enrollment (or stay) is a preliminary, interim status representing a pause in enrollment
  - The 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
- A stay of enrollment notification will be sent indicating the time frame in which a change of information or revalidation application must be received:
  - Providers/suppliers have 30 days to submit the required 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 the application request by the due date will result in deactivation of billing privileges
- Deactivated status may result in a gap in billing coverage (no payments) between the date of deactivation and the new Medicare effective date:
- References:
  - Stay of Enrollment
  - Medicare Learning Network (MLN) Matters Article: MM13449 "Stay of Enrollment"

Resolving a Stay or Deactivation of Billing Privileges

- To resolve a stay of enrollment, submit the revalidation application within the required 30-day timeframe
- Novitas will end the stay of enrollment and there will be no impact to the enrollment record:
  - Please note any rejected claims must be resubmitted
- To resolve a deactivation of billing privileges, submit the revalidation application as soon as possible:
  - Reactivation date will be the receipt date of the new, full, and complete application
  - CMS Certification Number (CCN)/ Provider Transaction Access Number (PTAN) will remain the same but there will be a gap in billing privileges
  - Medicare will not reimburse for services during the period of deactivation (billing gap)



Key Takeaways

- Reviewed the basic steps of the Medicare provider enrollment process including obtaining an, NPI, application submission, development, and finalization
- Examined the different methods available to submit provider enrollment applications
- Summarized the enrollment process for Part A and Part B (organizations and individuals) from receipt/initial screening, through review/development, and finalization of the application process
- Reviewed the IHS specific enrollment requirements:
  - Questionnaire 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
  - IHS Part A or Part B coversheet must be submitted with paper application
- Identified compliance requirements for maintaining the enrollment record and the revalidation process, including timeframes, how to find the due date, and resolutions for a stay of enrollment or deactivation of billing privileges

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IHS Contact Information

- Visit our websites:
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