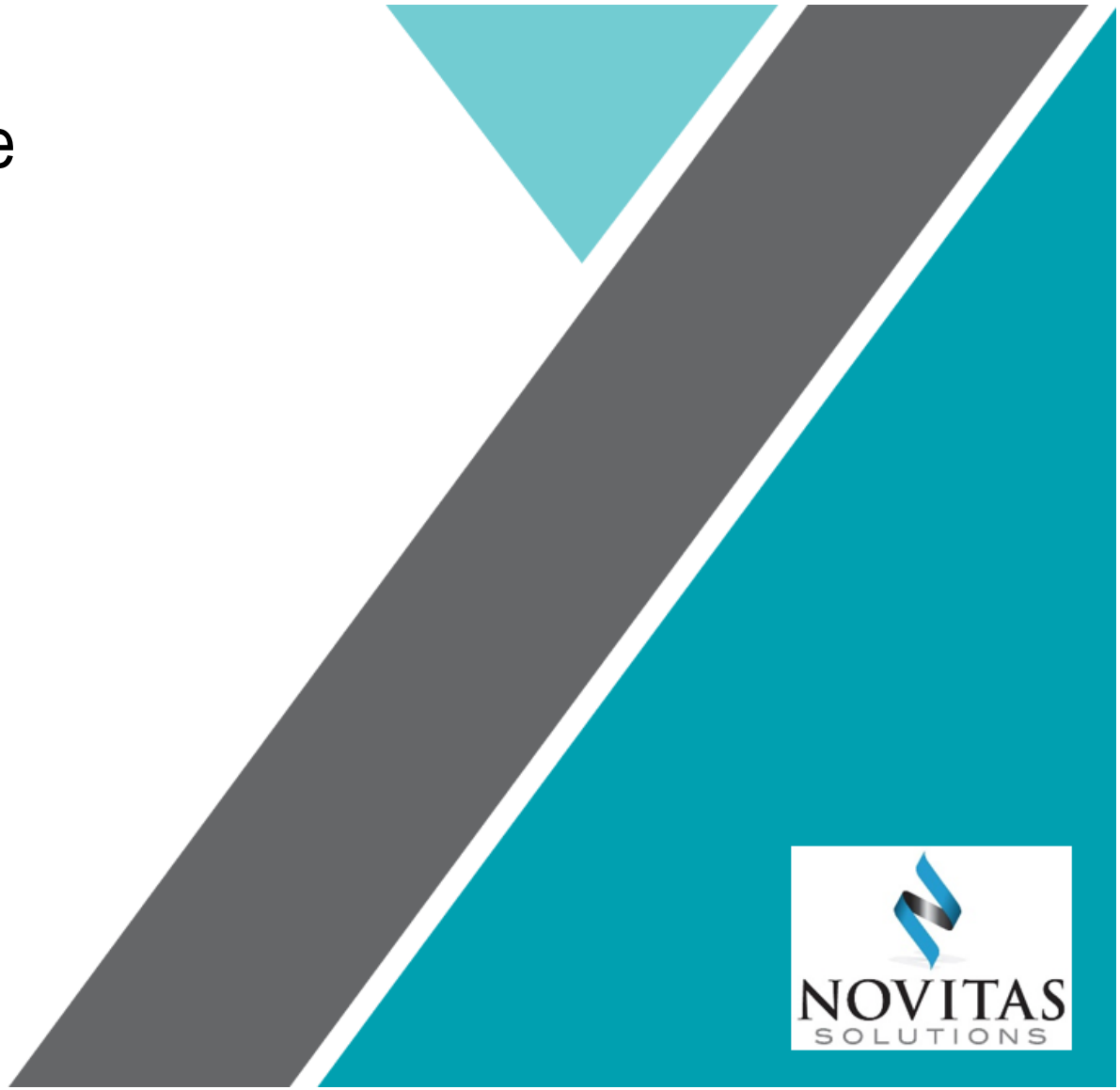
2024 Indian Health Service Partnership Conference

Provider Enrollment

August 2024



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Today's Presentation

- Agenda:
  - MAC for IHS
  - Provider Enrollment Basics
  - Enrolling Part A Institutional Providers and Health Care Organizations
  - Enrolling Part B Clinics/Group Practices
  - Enrolling Physician/Non-Physician Practitioners
  - Additional Forms
  - Applications for Indian Health Service, Tribes and Urban Indian Facilities and Providers
  - Enrollment For Mobile Unit
  - IHS Specific Information
  - Revalidation

Acronym List

Acronym	Definition
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics and Supplies
FISS	Fiscal Intermediary Shared System
FQHC	Federally Qualified Health Centers
GFT FQHC	Grandfathered Tribal FQHC
IHS	Indian Health Services
MAC	Medicare Administrative Contractor
NPI	National Provider Identifier
PECOS	Provider Enrollment, Chain and Ownership System
REH	Rural Emergency Hospital

MAC for IHS

IHS MAC

- Novitas:
  - Is the MAC for Jurisdiction H (JH), which spans Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas, and includes Indian Health Service (IHS) and Veterans Affairs (VA) nationally
  - The IHS contract includes Indian Health Services, which include IHS, Tribal and Urban Indians:
    - IHS providers and suppliers enroll in the provider enrollment system under Texas and claims are processed in the Texas system

Provider Enrollment Basic

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Provider Enrollment Into The Medicare Program

- Enrollment Purpose:
  - Providers/suppliers must be enrolled in Medicare to render services to beneficiaries and receive reimbursement
  - Provider Enrollment credentialing assures only qualified and eligible providers/suppliers can enroll in the Medicare program
- NPI Purpose:
  - Providers must apply for an NPI prior to requesting enrollment with Medicare through the National Plan and Provider Enumeration System (NPPES)
  - NPI serves as the identification number assigned to health care providers for billing and other purposes
  - Contact NPPES:
    - Phone: 1-800-465-3203 (NPI Toll-Free)
    - Email: customerservice@npienumerator.com
- Resources:
  - Novitas Enrollment Center
  - Provider Enrollment guidelines and regulations to follow:
    - Medicare Program Integrity Manual, Pub. 100-8, Chapter 10 - Medicare Enrollment

Medicare Enrollment Application Fee

- Application Fee:
  - 2024 Application Fee of $709.00 must be paid prior to submitting the application dependent on your supplier provider/supplier type:
    - IHS hospitals, FQHCs, GFT FQHCs, ambulance, Ambulatory Surgical Center (ASCs) and Durable Medical Equipment(DME) suppliers
  - Fee amounts are subject to change each calendar year
- Fee may be applied to certain provider types only:
  - Initial Enrollment
  - Revalidation
  - Addition of Practice Location
- Fee can be paid using PECOS or Pay.gov

Application Fee Requirement Chart

- This is not the full Application Fee Requirement Chart

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
FQHC/GFT FQHC	Yes	Yes	No	No	N/A
Critical Access Hospital (CAH)/IHS Hospital	Yes	Yes	No	No	Yes
REH	Yes	Yes	No	No	Yes

National Site Visit Verification and Fingerprint-Based Background Checks

- National Site Visit Verification:
  - Screening mechanism used to validate the operational capacity of a site by using pre-determined requirements
  - Prevent questionable providers/suppliers from enrolling into Medicare
  - Below are some of the most common situations where site visits are performed:
    - Provider/Suppliers in the moderate or high screening category
    - Practice location cannot be verified on United States Postal Service
- Fingerprint-Based Background Checks:
  - As part of the screening provisions in the Affordable Care Act, CMS implemented fingerprint-based background checks to be performed on individuals/suppliers:
    - Who are initially enrolling as a supplier in the high-risk screening category
    - With a five percent or greater ownership interest in a provider or supplier that falls under the high-risk category
    - Who have been elevated to the high-risk category for certain reasons identified by CMS

Timely Reporting of Provider Enrollment Information Changes

- All physicians, non-physicians, physician and non-physician organizations must report the following changes within 30 days:
  - Change of ownership
  - Change of adverse legal action
  - Change in practice location
- All other changes must be reported to your MAC within 90 days of the change
- All providers and suppliers not previously identified above must report the following changes within 30 days:
  - Change of ownership- including change in authorized/delegated officials
- All other informational changes must be reported within 90 days
- Changes can be reported via the Internet-based PECOS or the paper enrollment application
- Failure to do so could result in the revocation or deactivation of your Medicare billing privileges or payment suspension

Stay of Enrollment

Stay of Enrollment Overview

- Background:
  - The CY 2024 Physician Fee Schedule (PFS) Final Rule contains provisions about Medicare provider enrollment, including the creation of a new provider enrollment status "stay of enrollment"
- Definition:
  - Stay of enrollment is a CMS action that's less burdensome on providers and suppliers than a deactivation or revocation of your Medicare enrollment
  - A stay of enrollment (or "stay") is a preliminary, interim status representing a pause in enrollment
- Implementation date:
  - Effective May 30, 2024, providers and suppliers will begin to see notifications indicating stay of enrollment when a stay is implemented on their enrollment records
- Reference:
  - Medicare Learning Network (MLN) Matters Article: MM13449 "Stay of Enrollment"

Requirements for a Stay of Enrollment

- There are two steps for implementing a stay per 42 CFR 424.541:
  - Step one:
    - The provider is identified as non-compliant with at least one Medicare enrollment requirement
  - Step two:
    - The provider can remedy the non-compliance by submitting, as applicable, CMS enrollment form using the paper CMS-855, CMS-20134, or CMS-588 or submitting these form via PECOS
      - CMS refer to these forms as applicable CMS forms (ACFs)
  - If the type of non-compliance involved cannot be corrected by the submission of an ACF, a stay can't be imposed:
    - Normal enrollment processing guidelines will apply:
      - Deactivation or revocation will be implemented on the enrollment record

Examples of a Stay of Enrollment

- Examples of how this two-step works include:
  - A provider failed to report a change in its address from 10 Smith Street to 20 Smith Street
  - A supplier didn't respond to a revalidation request
  - A DMEPOS supplier didn't report the deletion of a managing employee
  - A physician didn't report a change in their practice location's ZIP code
  - A Medicare Diabetes Prevention Program supplier failed to report a change in the address of an organizational owner
- In these examples, the provider failed to adhere to a reporting, revalidation, or supplier standard requirement, but could resume compliance by submitting the necessary ACF
- These are merely examples, there are many more scenarios in which a stay could apply

Key Points of a Stay of Enrollment

- Key Points:
  - You remain enrolled in Medicare during the stay
  - Claims will be rejected that are submitted with dates of service within the stay period and must be resubmitted once reinstated
  - Your stay of enrollment lasts no longer than 60 days
  - The MAC can impose a stay of less than 60 days
  - A stay ends on the earlier of the following dates:
    - The date your MAC decides you resume compliance with all Medicare enrollment requirements
    - The day after the imposed stay period expires
  - A stay isn't considered an adverse legal action of any kind
  - A stay may be imposed multiple times for separate instances of non-compliance:
    - Example: A stay in June 2024 and another stay in December 2025
- If there is no response to the stay of enrollment request, normal enrollment processing rules will apply:
  - A deactivation or revocation will be implemented on the enrollment record

Notification and Rebuttals

- Notification Letters:
  - MACs will send all stay notification letters by hard-copy mail to the correspondences address and e-mail if a valid email address is available
- Rebuttals:
  - You may file a rebuttal under a stay of enrollment
  - A rebuttal is an opportunity for you to show you met all applicable enrollment requirements and that the stay shouldn't have been imposed
  - You may submit only one rebuttal request per enrollment stay

Application Inquires

- Throughout the course of application processing and once finalized, CMS authorizes the release of enrollment-related information to the following individuals listed on the application:
  - Provider/Supplier
  - Authorized Official
  - Delegated Official
  - Contact person:
    - No limit on the number of contacts per file
    - If you have multiple contacts and want to designate a primary contact for the application, please provide that on application
- If you have any questions regarding the enrollment process, your application, etc., please contact us:
  - JH: 1-855-252-8782

Review/Development

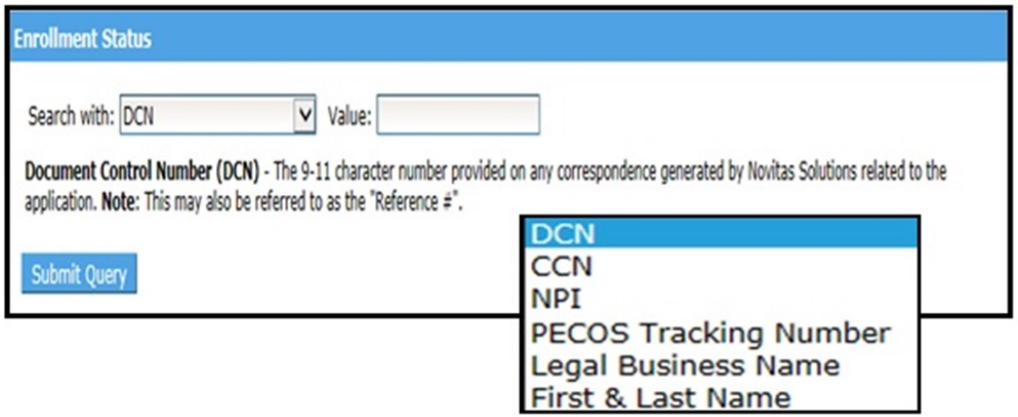
- CMS requires that all MAC contractors review each enrollment application in accordance with the Medicare Program Integrity Manual
- During review process:
  - Development (additional information or sections of the application are missing or incorrect):
    - Fax
    - Email
    - Mail
- Note: All development returned to Novitas must be accompanied with a newly signed and dated signature page, with the exception of supporting documentation:
  - PECOS signature- electronic signature/upload signature/fax signature
  - Paper application signature- fax signature

Finalization

- Once all needed information is received and complete, the MAC documents the application information in PECOS
- Once enrollment information has been exported from PECOS and received in the claims processing system, supplementary information is added to the file to ensure claims process accurately
- Application processing timeframes may vary:
  - Refer to CMS-855 Enrollment Application Processing Timeframes
- The provider/supplier should be received a letter within 7 to 10 business days after your information finalizes in PECOS:
  - This letter will provide valuable information regarding the steps you need to take to begin submitting Medicare claims
  - Approval letters will be mailed to the Contact Person's (Section 13) address
- If PECOS application was utilized, an approval letter will be emailed upon finalization and mailed to the contact person

Novitas Enrollment Status Tool

- Provider enrollment status inquiry tool:
  - Status history information is available for all applications from receipt through completion
  - Receipt date is the date we receive your Medicare application
  - Once uploaded into our system, you will receive a document control number
  - Using the dropdown menu in the field next to “Search with”, you can search using various criteria; once you have entered your search criteria, click on “Submit Query”; “**Do not hit the enter key**”



Enrollment Submission Options

- There are two options for providers/suppliers to submit an initial, update (make a change) or revalidate their enrollment applications:
  - Internet-based PECOS:
    - PECOS is a CMS established Internet-based online enrollment process system
    - Allows physicians, non-physician practitioners, and provider and supplier organizations/facilities the option of enrolling, making a change in their Medicare enrollment information, or tracking the status of their Medicare enrollment applications throughout the Internet submission process
    - PECOS offers providers and supplier resources and tutorials to assist with using PECOS
    - In order for your application to be sent to Novitas, you should select Novitas as the Fee for Service contractor
    - This option is the quickest, most efficient way to submit Medicare enrollment applications
  - Paper applications:
    - Enrollment can be facilitated through the submission of the paper CMS-855 Medicare enrollment applications
    - It is best practice not to keep paper copies of the forms in the office:
      - Blank applications are available on Novitas Solutions JH enrollment website or CMS website
    - When submitting paper applications, the IHS cover sheet should be submitted:
      - IHS Part A coversheet
      - IHS Part B coversheet
    - Once completed:
      - Upload the application using the Provider Enrollment Gateway; portal allows for paper applications to be uploaded and submitted online
      - Or the application can be mailed

Enrolling Part A Institutional Providers and Health Care Organizations

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Part A Medicare Eligible Organizations

- Community Mental Health Center (CMHC)
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- **Critical Access Hospital (CAH)**
- End-Stage Renal Disease Facility (ESRD)
- **Federally Qualified Health Center (FQHC):**
  - **This includes the GFT FQHC**
- Histocompatibility Laboratory
- Home Health Agency (HHA)
- Hospice
- Hospital
- **Indian Health Services Facility (IHS)**
- Opioid Treatment Program
- Organ Procurement Organization
- Outpatient Physical Therapy/ Occupational Therapy/ Speech Pathology Services
- Religious Non-Medical Health Care Institution
- **Rural Emergency Hospital (REH)**
- Rural Health Clinic (RHC)
- Skilled Nursing Facility (SNF)

Part A Institutional Providers Applications

- Internet-based PECOS
  - When using PECOS there is an application Questionnaire:
    - Select Institutional Provider, this will populate the CMS-855A facility application
    - Under Part A Providers of Services, select the type of facility that you will be enrolling or updating
    - There is a drop-down box for you to select Novitas as the Fee for Service contractor
- The paper CMS-855A Institutional Providers application:
  - Section 1(A): check the box indicating the reason you are submitting the application and following the instructions on completing the required sections
  - Section 2(A)(1): check the type of provider that you will be enrolling or updating
  - CMS-855A Tutorial
  - When submitting paper applications, the IHS cover sheet should be submitted:
    - IHS Part A coversheet
- When enrolling via PECOS or the paper CMS-855 applications there is an application questionnaire asking if the application is an Indian Health Service (IHS) facility:
  - All Indian Health Services, Tribes and Urban Indian providers/suppliers should always select yes when enrolling with Novitas
  - This question does not affect the laws that you go by, it just assures Novitas receives your application from PECOS and that we process your application into the correct processing system

Provider - Based Hospital Off-Campus Practice Location Address

- Hospital Location Requirements:
  - Medicare allows hospitals to have additional locations, on or off campus, outside of the main hospital as part of the hospital for billing purposes:
    - Includes clinics, departments, remote locations, and satellite locations not separately enrolled or certified under Medicare
    - These locations should be listed in the enrollment records
  - Requirements for correct provider practice location reporting was effective back in 2017, however, systematic edits were not put in place until August 1, 2023
- Systematic Validation Edits:
  - CMS implemented systematic validation edits to enforce requirements in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 1 - General Billing Requirements, Section 170, "Payment Bases for Institutional Claims", for hospitals with multiple locations to include off-campus provider-based departments location
- Hospital Provider Requirements:
  - Providers should ensure that their enrollment information is up to date, and any claim submissions reflect the practice locations exactly as it appears from the practice location address screen which is received from PECOS viewed in FISS under Short Cut 1D provider practice address
  - Providers should ensure that the practice locations are linked to the NPI that is being reported on the claim submission

Verifying and Updating a Provided - Based Hospital Off-Campus Practice Location Address

- Verifying location information:
  - PECOS:
    - You can verify the location information in PECOS, if you have access to the system
  - Direct Data Entry (DDE):
    - The practice location screen is available in DDE:
    - Provider Practice Address Query- Option 1D
    - Providers with outpatient practice locations may use this screen to verify the information available for the FISS to edit against
    - This screen will also provide the practice effective date in the field “PRAC EFF DT”
    - Refer to Indian Health Service hospital off-campus outpatient department reporting requirements for additional information
  - Contact the Novitas enrollment contact center
- Updating Practice Locations:
  - The PECOS Institutional provider or the paper CMS-855A Institutional Providers application is required in order to update practice locations
  - The enrollment application fee is required when adding a practice location

Hospital Location Address Systematic Validation Edits

- If a hospital submits a claims with a location not listed in the enrollment records or does not match exactly the claim will be reject as a return to provider (RTP)
- Reason code 34977- Claim service facility address does not match provider practice file address:
  - Location submitted was not listed in the enrollment records
  - Location submitted does not exactly match the information from the enrollment records
  - Must match, word for word, including abbreviations and punctuation:
    - For example: Road vs. Rd, Suite vs. Ste., etc.
    - Include special characters if listed in the address:
      - For example, &, (),+, *, -, etc.
  - Applies to Type of Bill (TOB) 13x and 14x

Enrolling Part B Clinics/Group Practices

Part B Clinics/Group Practices and Certain Other Suppliers

- **Ambulance Service Supplier**
- **Ambulatory Surgical Center (ASC)**
- **Clinic/Group Practice**
- Hospital Department (s)
- Independent Clinical Laboratory
- Independent Diagnostic Testing Facility (IDTF)
- Intensive Cardiac Rehabilitation Supplier
- Mammography Center
- Mass Immunization (Roster Biller Only)
- Opioid Treatment Program
- Pharmacy
- Physical/Occupational Therapy Group in Private Practice
- Portable X-ray Supplier
- Radiation Therapy Center

Part B Clinics/Group Practices and Certain Other Suppliers Applications

- Internet-based PECOS
  - When using PECOS there is an application Questionnaire:
    - Select Clinic/Group Practice and Certain Other Suppliers this will populate the CMS-855B
    - Select the type of supplier that you will be enrolling or updating
    - There is a drop-down box for you to select Novitas as the Fee for Service contractor
- The paper CMS-855B Clinic/Group Practice and Other Suppliers application:
  - Section 1(A): check the box indicating the reason you are submitting the application and following the instructions on completing the required sections
  - Section 2(B): check the type of supplier that you will be enrolling or updating
  - CMS-855B Tutorial
  - When submitting paper applications, the IHS cover sheet should be submitted:
    - IHS Part B coversheet
- When enrolling via PECOS or the paper CMS-855 applications there is an application questionnaire asking if the application is an Indian Health Service (IHS) facility:
  - All Indian Health Service, Tribes and Urban Indian providers/suppliers should always select yes when enrolling with Novitas
  - This questions does not affect the laws that you go by, it just assures Novitas receives your application from PECOS and that we process your application into the correct processing system

Enrolling Physician/ Non-Physician Practitioners

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Enrolling Physician/ Non-Physician Practitioners Applications

- Internet-based PECOS
  - When using PECOS there is an application Questionnaire:
    - Select Individual Physician or Non-Physician Practitioner, this will populate the CMS-855I
    - Select the type of physician specialty hat you will be enrolling or updating
    - There is a drop-down box for you to select Novitas as the Fee for Service contractor
- The paper CMS-855I Physician/ Non-Physician Practitioners application:
  - Section 1(A): check the box indicating the reason you are submitting the application and following the instructions on completing the required sections
  - Section 2(G): check the type of physician specialty that you will be enrolling or updating
  - CMS-855I Tutorial
- When enrolling via PECOS or the paper CMS-855 applications there is an application questionnaire asking if the application is an Indian Health Service (IHS) facility:
  - All Indian Health Service, Tribes and Urban Indian providers/suppliers should always select yes when enrolling with Novitas
  - This questions does not affect the laws that you go by, it just assures Novitas receives your application from PECOS and that we process your application into the correct processing system

Marriage and Family Therapists (MFTs)

- Section 4121 of Division FF of the Consolidated Appropriations Act, 2023 (CAA, 2023), establishes a new Medicare benefit category for MFT and MHC services furnished by and directly billed by MFTs and MHCs. Payment for MFT and MHC services under Part B of the Medicare program will begin January 1, 2024
- MFT Requirements to enroll:
  - Possesses a master's or doctorate degree which qualifies for licensure or certification as a MFT under State law of the State in which such individual furnishes marriage and family therapist services
  - Licensed or certified as an MFT by the State in which they furnish services
  - Has performed at least 2 years or 3,000 hours of clinical supervised experience in marriage and family therapy or mental health counseling after obtaining the degree referenced above
  - Meets other requirements as the Secretary of Health and Human Services (HHS) determines appropriate

Mental Health Counselors (MHCs)

- Section 4121 Division FF of the Consolidated Appropriations Act, 2023 (CAA 2023), defines MHC services as services for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital)
- An MHC is an individual who:
  - Possesses a master's or doctorate degree which qualifies for licensure or certification as a MHC, clinical professional counselor, or professional counselor under State law of the State in which such individual furnishes MHC service
  - Is licensed or certified as an MHC, clinical professional counselor, or professional counselor by the State in which they furnish services
  - Has performed at least 2 years or 3,000 hours of clinical supervised experience in marriage and family therapy or mental health counseling after obtaining the degree referenced above
  - Meets other requirements as the Secretary of Health and Human Services (HHS) determines appropriate
- Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC) Provider Enrollment Frequently Asked Questions (FAQs)

Additional Forms

Part B Medicare Participation Agreement

- Purpose:
  - A participating provider is one who voluntarily and in advance enters into an agreement in writing to provide all covered services for all Medicare Part B beneficiaries on an assigned basis
- By becoming a participating provider/supplier, you agree to:
  - Not charge any individual or other person for items and services covered by the health insurance program other than the Medicare allowable charges and deductibles and coinsurance amounts
  - Placement in Medicare Participating Physicians and Suppliers Directory (MEDPARD)
  - Reimbursement is five percent higher than the non-participating amount
- To become a participating provider, use the PECOS application, or the paper CMS-460 Medicare Participating Physician or Supplier Agreement application:
  - The agreement can be submitted, with the enrollment application, within 90 days of initial enrollment or during annual Open Enrollment period (end of calendar year):
    - ❑ If keeping current participation status, there is no need to submit any documentation
- For rules and regulations:
  - Enrollment Guide: Chapter 4 – Medicare participation
  - CMS-460 Tutorial

Electronic Funds Transfer (EFT)

- Purpose:
  - To have your Medicare payments deposited directly into your bank account
  - CMS require that all providers/suppliers enrolling in Medicare or making changes to their enrollment file use EFT
- Use this PECOS application or the paper CMS-588 Electronic Funds Transfer Authorization Agreement form, for initial enrollment and change of information
- Submit one supporting document:
  - Voided Check
  - Bank Letterhead:
    - Name on account
    - Account number
    - Routing number
    - Account type
    - Bank officer's name and signature
- Paper CMS-588 Electronic Funds Transfer Tutorial

Applications for Indian Health Service, Tribes and Urban Indian Facilities and Providers

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Applications for IHS or Tribal Hospital and Provider Based Clinic

- Indian Health Services or Tribal Hospital:
  - The PECOS Institutional provider or the paper CMS-855A Institutional Providers application is required in order to enroll with Medicare:
    - When using the paper application, the IHS Part A coversheet should be submitted
- Indian Health Services or Tribal Provider Based Clinic:
  - Provider based will be associated with a hospital:
    - The PECOS clinic/group practice or the paper CMS-855B Clinic/Group Practice and Other Suppliers application is required in order to bill the professional services as a clinic/group practice:
      - When using the paper application, the IHS Part B coversheet should be submitted
    - Each provider providing services to this clinic/group will need to submit a new (if not enrolled under Novitas IHS) or updated PECOS Individual Physicians/Non-Physicians or paper CMS-855I Physicians and Non-Physician Practitioners application, in order to enroll and/or reassign their benefits to the clinic
    - Reassigning benefits:
      - New, revisions to current, or termination of reassignment of Medicare benefits can be submitting using the PECOS application or utilize the paper CMS-855I Physicians and Non-Physician Practitioners, section 4F

REH

- Background:
  - Beginning January 1, 2024, a tribal or IHS operated hospital that converts to an REH (IHS-REH) that provides hospital outpatient services to a Medicare beneficiary may be paid for such services under the outpatient hospital All-Inclusive Rate that is established and published annually by IHS, rather than the rates for REH
- Who is eligible to convert to an REH?
  - A facility is eligible to convert to an REH if it was a Critical Access hospital (CAH) or rural hospital with 50 beds or less as of December 27, 2020
  - Including a hospital that closed after December 27, 2020
- References:
  - Provider specialty: Rural emergency hospital (REH)
  - 42 CFR Chapter IV, Subchapter G, Part 485, "CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS“
  - REH FAQs

REH Enrollment

- PECOS:
  - Select the Institutional provider Application
  - Selecting the **Create Initial Enrollment Application** button on the My Associates page or My Enrollment page:
    - To enroll as a IHS REH via PECOS, you must create an Initial Enrollment application for provider type IHS REH
  - Select "Indian Health Services Rural Emergency Hospital" under the Part A Provider Services dropdown box
  - Complete all applicable sections
  - Upload all required state licenses/certifications for operation as an REH (if available)
  - Submit application through PECOS

- Paper CMS-855A Institutional Providers Application:
  - Follow the instructions for changing your Medicare information
  - Sections to be completed:
    - Section 1(A): check the "You are changing your Medicare information" box
    - Section 2(A)(1): check the type of provider, "Other" write in "IHS rural emergency hospital"
    - Complete Sections 2(B): with REH information
    - Compete Section 3: Final Adverse Legal Actions
    - Compete Section 15: Certification Statement
  - When submitting paper applications, the IHS cover sheet should be submitted:
    - IHS Part A coversheet
  - Once completed:
    - Upload the application using the Provider Enrollment Gateway; portal allows for paper applications to be uploaded and submitted online
    - Or the application can be mailed

Indian Health, Tribal or Urban Non- Provider Based Clinic

- The PECOS clinic/group practice or the paper CMS-855B Clinic/Group Practice and Other Suppliers application is required in order to bill the professional services as a clinic/group practice:
  - When using the paper application, the IHS Part B coversheet should be submitted
- Each provider providing services to this clinic/group will need to submit a new (if not enrolled under Novitas IHS) or updated PECOS Individual Physicians/Non-Physicians or paper CMS-855I Physicians and Non-Physician Practitioners application, in order to enroll and/or reassign their benefits to the clinic:
  - Reassigning benefits:
    - New, revisions to current, or termination of reassignment of Medicare benefits can be submitting using the PECOS application or utilize the paper CMS-855I Physicians and Non-Physician Practitioners application, section 4F

Application for FQHC and GFT FQHC

- Tribal/Urban FQHC and GFT FQHC:
  - The PECOS Institutional provider or the paper CMS-855A Institutional Providers application is required in order to enroll with Medicare as a FQHC:
    - Adding a new location/address requires a new enrollment application for the new location
    - Medicare does not allow an FQHC to enroll or reassign a physician/non-physician to the PECOS Institutional provider or the paper CMS-855A Institutional Providers application:
      - Enrolling and reassigning a physician/non/physician must be obtained using the PECOS Individual Physicians/Non-Physicians or paper CMS-855I Physicians and Non-Physician Practitioners application and reassignment is linked to the Part B Group practice application (see next bullet)
  - The PECOS clinic/group practice or paper CMS-855B Clinic/Group Practice and Other Suppliers application is required in order to bill as a clinic/group practice for services that are not part of the FQHC benefit:
    - Each provider providing services to this clinic/group will need to submit a new (if not enrolled under Novitas IHS) or updated PECOS Individual Physicians/Non-Physicians or paper CMS-855I Physicians and Non-Physician Practitioners application, in order to enroll and/or reassign their benefits to the clinic
    - Reassigning benefits:
      - New, revisions to current, or termination of reassignment of Medicare benefits can be submitting using the PECOS application or utilize the paper CMS-855I Physicians and Non-Physician Practitioners application, section 4F

FQHC and GFT FQHC Adding a Location

- FQHC location requirement:
  - If an FQHC provides services in permanent units in more than one location, each unit must be separately enrolled in the Medicare program
- New Location:
  - When adding a new FQHC location, the location must meet the requirements of a FQHC:
    - According to the regulatory provisions at 42 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

FQHC and GFT FQHC New Location Meets the Requirements

- If the new location does meet the requirements of an FQHC:
  - A new PECOS Institutional provider or paper CMS-855A Institutional Providers application will need to be submitted:
    - When using a paper application, the IHS Part A coversheet should be submitted
  - It is best practice is to obtain a new NPI for the new location to prevent billing issues
  - The enrollment application fee will need to be paid prior to submitting the application
  - In order to bill for services not included in the Part A encounter rate:
    - A PECOS clinic/group practice or paper CMS- 855B Clinic/Group Practice and Other Suppliers application will need to be submitted for this location:
      - When using a paper application, the IHS Part B coversheet should be submitted
    - Each provider providing services to this clinic/group will need to submit a new (if not enrolled under Novitas IHS) or updated PECOS Individual Physicians/Non-Physicians or paper CMS-855I Physicians and Non-Physician Practitioners application, in order to enroll and/or reassign their benefits to the clinic
    - Reassigning benefits:
      - New, revisions to current, or termination of reassignment of Medicare benefits can be submitting using the PECOS application or utilize the paper CMS-855I Physicians and Non-Physician Practitioners application, section 4F
- Providers who will be providing services at a multiple FQHC 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"

FQHC and GFT FQHC New Location Does Not Meet the Requirements

- The new location does not meet the FQHC requirements:
  - This location may enroll as a free-standing clinic/group via the PECOS clinic/group practice or paper CMS-855B Clinic/Group Practice and Other Suppliers application:
    - If using a paper application, the IHS Part B coversheet should be submitted
    - Each provider providing services to this clinic/group will need to submit a new (if not enrolled under Novitas IHS) or updated PECOS Individual Physicians/Non-Physicians or paper CMS-855I Physicians and Non-Physician Practitioners application, in order to enroll and/or reassign their benefits to the clinic
    - Reassigning benefits:
      - New, revisions to current, or termination of reassignment of Medicare benefits can be submitting using the PECOS application or utilize the paper CMS-855I Physicians and Non-Physician Practitioners, section 4F
- It is 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
- Place of Service (POS) should be 11, when the patient is being seen in this clinic location
- Providers who will be providing services at a FQHC 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"

Enrollment For Mobile Unit

NOVITAS SOLUTIONS

Mobile Unit

- Mobile Units:
  - The entity providing the service must bill for the service unless the service is provided under contractual arrangements
  - If the contracted 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 GFT FQHC:
  - The PECOS Institutional provider or the paper CMS-855A Institutional Providers application, Section 4, will need to be updated with the mobile information:
    - When using the paper application, the IHS Part A coversheet should be submitted
  - The PECOS clinic/group practice or paper CMS-855B Clinic/Group Practice and Other Suppliers application section 4, will need to be updated with the mobile information:
    - When using the paper application, the IHS Part B coversheet should be submitted
- Owned/leased by a Non-Provider Based (free-standing ambulatory) Clinic:
  - The PECOS clinic/group practice or the paper CMS-855B Clinic/Group Practice and Other Suppliers application, Section will need to be updated with the mobile information:
    - When using the paper application, the IHS Part B coversheet should be submitted

Example of Paper CMS-855A and CMS-855B Paper Section 1A: Basic Information Reason for Submission

SECTION 1: BASIC INFORMATION *(Continued)*

A. Check one box and complete the required sections

☐ Your organization has **Consolidated** with another organization You are the: ☐ Former organization ☐ New organization	Medicare Identification Number of the Seller/Former Owner *(if issued)*: NPI: Tax Identification Number:	**Former Organizations: 1A, 2H, 13,** and either **15** or **16** **New Organization: Complete all** sections except **2F** and **2G**
☐ You are **changing** your Medicare information	Medicare Identification Number *(if issued)*: NPI:	**Go to Section 1B**
☐ You are **revalidating** your Medicare enrollment	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections except 2F, 2G, and 2H**

Paper CMS-855A Section 1B: Changing Information

SECTION 1: BASIC INFORMATION *(Continued)*

B. Check all that apply and complete the required sections:

	REQUIRED SECTIONS
☐ Identifying Information	**1, 2** (complete only those sections that are changing), **3, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Adverse Legal Actions/Convictions	**1, 2B1, 3, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☒ Practice Location Information, Payment Address & Medical Record Storage Information	**1, 2B1, 3, 4** (complete only those sections that are changing), **13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Ownership Interest and/or Managing Control Information (Organizations)	**1, 2B1, 3, 5, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Ownership Interest and/or Managing Control Information (Individuals)	**1, 2B1, 3, 6, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Chain Home Office Information	**1, 2B1, 3, 7, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Billing Agency Information	**1, 2B1, 3, 8** (complete only those sections that are changing), **13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Special Requirements for Home Health Agencies	**1, 2B1, 3, 12, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Authorized Official(s)	**1, 2B1, 3, 6, 13,** and **15.**
☐ Delegated Official(s) (Optional)	**1, 2B1, 3, 6, 13, 15,** and **16.**

Paper CMS-855B Section 1B: Changing Information

SECTION 1: BASIC INFORMATION *(Continued)*

Changing Information	Required Sections
☐ Address Information ☐ Correspondence Mailing Address ☐ Medicare Beneficiary Medical Records Storage Address ☒ Practice Location Address ☐ Remittance Notices/Special Payment Mailing Address ☐ Base of Operations Address for Mobile or Portable Suppliers (location of Business Office or Dispatcher/ Scheduler)	**1, 2A, 3, 12, 13 (optional)** and **15 AND sections 2A3, 2A4, 4A, 4B, 4C,** and/or **4E** as applicable for the address that is being changed and 6 for the signer if that authorized or delegated official has not been established for this supplier
☐ Billing Agency Information	**1, 2A1, 3, 8, 13 (optional)** and **15** and 6 for the signer if that authorized or delegated official has not been established for this supplier
☐ Authorized Official(s) and/or Delegated Official(s)	**1, 2A1, 3, 13, 15A1** (if you are an Authorized Official) or **15B1** (if you are a delegated official), and another **6** for the signer if that authorized or delegated official has not been established for this supplier
☐ Any other information not specified above	**1, 2A1, 3, 12 (if applicable), 13 (optional)** and **15** and the applicable section or sub-section that is changing and **6** for the signer if that authorized or delegated official has not been established for this supplier

Paper CMS-855A: Section 4D: Base of Operations

D. Base of Operations Address for Mobile or Portable Providers (Location of Business Office or Dispatcher/Scheduler)

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Check here ☐ and skip to Section 4E if the "Base of Operations" address is the same as the "Practice Location" listed in Section 4A.

Street Address Line 1 *(Street Name and Number)*			
Street Address Line 2 *(Suite, Room, etc.)*			
City/Town		State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*	

Paper CMS-855A: Section 4E: Base Vehicle Information

E. Vehicle Information

If the mobile health care services are rendered inside a vehicle, such as a mobile home or trailer, furnish the following vehicle information. Do not furnish information about ambulance vehicles, or vehicles that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor's office). If more than three vehicles are used, copy and complete this section as needed.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE FOR EACH VEHICLE	TYPE OF VEHICLE (van, mobile home, trailer, etc.)	VEHICLE IDENTIFICATION NUMBER
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		

For each vehicle, submit a copy of all health care related permits/licenses/registrations.

Paper CMS-855A: Section 4F: Geographic Location

F. Geographic Location For Mobile or Portable Providers where the Base of Operations and/or Vehicle Renders Services

For home health agencies (HHAs) and mobile/portable providers, furnish information identifying the geographic area(s) where health care services are rendered.

NOTE: If you provide mobile health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate enrollment application (CMS-855A) for each Medicare fee-for-service contractor's jurisdiction.

1. INITIAL REPORTING AND/OR ADDITIONS

If you are reporting or adding an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

Paper CMS-855 B: Section 4E: Base of Operations

E. Base of Operations Address for Mobile or Portable Suppliers (Location of Business Office or Dispatcher/ Scheduler)
The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use.

NOTE: When necessary to report more than one base of operations, copy and complete this section for each base of operations.

If you are changing information about currently reported information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

☐ Check here and skip to section 4F if the "Base of Operations" address is the same as the "Practice Location" listed in section 4A.

Base of Operations Street Address Line 1 *(Street Name and Number)*		
Base of Operations Street Address Line 2 *(Suite, Room, etc.)*		
City/Town	State	ZIP Code + 4
Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Paper CMS-855 B: Section 4F: Vehicle Information

F. Vehicle Information
If the mobile health care services are rendered inside a vehicle, such as a mobile home or trailer, furnish the following vehicle information below. Do not provide information about vehicles that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor's office) or ambulance vehicles. If more than four vehicles are used, copy and complete this section as needed.

For each vehicle, submit a copy of all health care related permits/licenses/registrations.

If you are adding or removing information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE FOR EACH VEHICLE	TYPE OF VEHICLE *(van, mobile home, trailer, etc.)*	VEHICLE IDENTIFICATION NUMBER
☐ ADD ☐ REMOVE Effective Date *(mm/dd/yyyy)*:		
☐ ADD ☐ REMOVE Effective Date *(mm/dd/yyyy)*:		
☐ ADD ☐ REMOVE Effective Date *(mm/dd/yyyy)*:		
☐ ADD ☐ REMOVE Effective Date *(mm/dd/yyyy)*:		

Paper CMS-855 B: Section 4G: Geographic Location

G. Geographic Location for Mobile OR Portable Suppliers Where the Base of Operations and/or Vehicle Renders Services
Provide the city/town, county, state/territory, and zip code for all locations where mobile and/or portable services are rendered.

NOTE: If you provide mobile or portable health care services in more than one state/territory and those states/territories are serviced by different MACs, complete a separate CMS-855B enrollment application for each MAC's jurisdiction.

1. Initial Reporting and/or Additions
If you are reporting or adding an entire state/territory, check the box below and specify the state/territory.

☐ Entire State/Territory of _____

If services are only provided in selected cities/towns or counties, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town or county.

CITY/TOWN	COUNTY	STATE/ TERRITORY	ZIP CODE

IHS Specific Information

Licenses

- Licenses:
  - The Patient Protection and Affordable Care Act (PL 111-148) amended Section 221 of the Indian Health Care Improvement Act (IHCIA) to provide 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:
    - If a provider does not renew their licenses in the state that we have on file, the provider will need to update their enrollment application with the new licenses
    - Failure to submit the updated licenses could cause provider to be deactivated

Certifications

- Certifications must be current and on file with Novitas:
  - Renewals must be submitted to Novitas to prevent claim denials
  - Example of certifications include:
    - Clinical Laboratory Improvement Amendments (CLIA) Program
    - Certification of Mammography Facilities
    - Licensed or certified as a dietitian or nutrition professional by state in which services are performed (federal employees can be licensed or certified in any state)
    - Registered dietitian credential with the Commission on Dietetic Registration (CDR) is proof that education and experience requirements are met
  - Updated certifications should be emailed to:
    - Part A updates: JHPEPartACerts@novitas-solutions.com
    - Part B updates: JHPEPartBCerts@novitas-soltuions.com

Clinical Pharmacist

- Clinical Pharmacist are not entitled to enroll in the Medicare program
- Clinical Pharmacist Encounter:
  - Medicare does not cover medical services performed or provided by a clinical pharmacist
  - These services cannot be billed as a:
    - IHS clinic visit (the all-inclusive rate (AIR) billed on the Uniform Billing 04 (UB-04) 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 GFT FQHC when this was the only service rendered (e.g., there was no covered service that day, such as a physician visit)
  - 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 1500 Claim form for the 99211, the five-minute exam:
      - Note: Clinical pharmacist cannot provide an evaluation and management service above the 99211 as incident to since the Evaluation and Management (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 not covered under Medicare Part A and Part B:
  - Bill to Medicare Part D

IHS Specific Enrollment Information

- Contracted Radiologists:
  - IHS can enroll contracted non-IHS physicians as employees of their facility
  - Each provider providing services to a clinic/group will need to submit a new (if not enrolled under Novitas IHS) or updated PECOS Individual Physicians/Non-Physicians or paper CMS-855I Physicians and Non-Physician Practitioners application, in order to enroll and/or reassign their benefits to the clinic
- Mobile Mammography Units:
  - If facility is contracting with a mobile mammography unit the enrollment records will need to be updated:
    - The PECOS Institutional provider or the paper CMS-855A Institutional Providers application is required:
      - When using the paper application, the IHS Part A coversheet should be submitted
    - The PECOS clinic/group practice or the paper CMS-855B Clinic/Group Practice and Other Suppliers application is required in order to bill the professional services as a clinic/group practice:
      - When submitting paper applications, the IHS Part B coversheet should be submitted

Section 5: Ownership Interest- Organization(s)

- Read section carefully for definitions of relationships
- If section is applicable, a flowchart is required with application

1. IDENTIFYING INFORMATION

Legal Business Name as Reported to the Internal Revenue Service		
"Doing Business As" Name *(if applicable)*		
Address Line 1 *(Street Name and Number)*		
Address Line 2 *(Suite, Room, etc.)*		
City/Town	State	ZIP Code + 4
Tax Identification Number *(required)*		
Medicare Identification Number(s) *(if issued)*	NPI *(if issued)*	

Section 5: Ownership Interest- Organization(s) Government/Tribal Organizations

- 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 an owner
- 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 that 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
- See Section 15 for further information on "authorized officials"

Reminders

- IHS Application questionnaire:
  - When enrolling via PECOS or the paper CMS-855 applications there is an application questionnaire asking if the application is an Indian Health Service (IHS) facility:
    - All Indian Health Services, Tribes and Urban Indian providers/suppliers should always select yes when enrolling with Novitas
    - This question does not affect the laws that you go by, it just assures Novitas receives your application from PECOS and that we process your application into the correct processing system
- Selecting the Fee-For-Service Contractor in PECOS:
  - When using PECOS there is a drop-down box for you to select Novitas as the Fee for Service contractor
- Novitas is the MAC for IHS, Tribes and Urban Indians, selecting Novitas and answering the question above will assure the application will be sent to Novitas and will be processed in the correct processing system
- When submitting paper applications, the IHS cover sheet should be submitted:
  - IHS Part A coversheet
  - IHS Part B coversheet

Revalidation

Revalidation Requirements

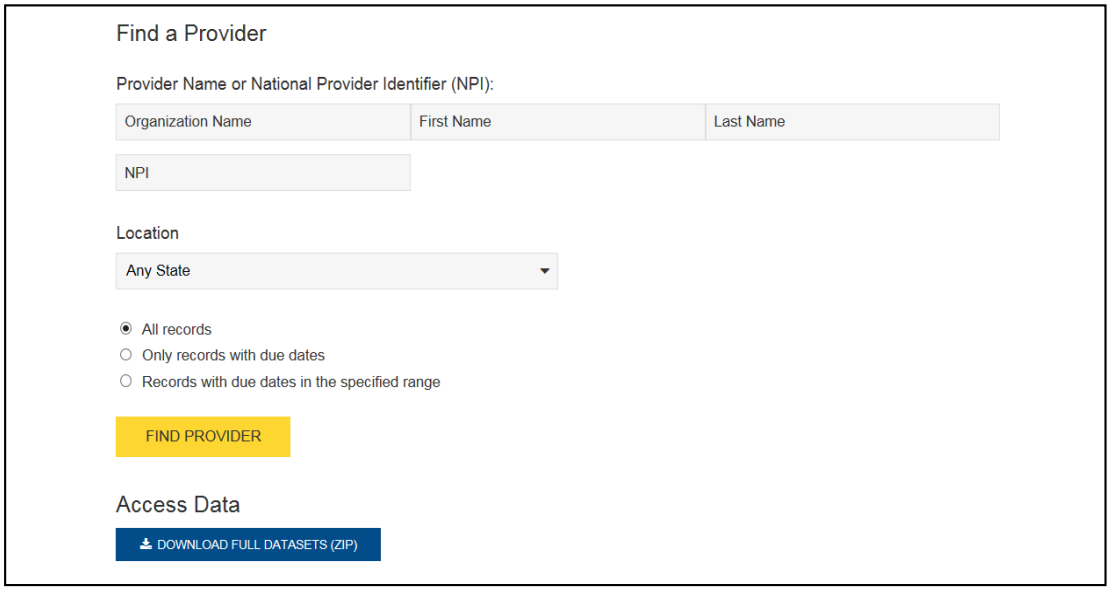
- All providers and suppliers are required to revalidate enrollment records every five years to maintain Medicare billing privileges:
  - To ensure compliance with these requirements, CMS is permitted to conduct off-cycle revalidations for certain program integrity purposes
- Due dates for revalidations are displayed on the Revalidation Lookup tool, if due within six months:
  - "TBD" (To Be Determined) displayed in the due date field for all other providers/suppliers:
    - Unsolicited revalidation submissions will be returned
- Revalidation notices:
  - MACs will send a revalidation notice three to four months prior to your revalidation due date to the correspondence and special payments address on file
- Failure to respond to revalidation request by the due date, will result in a stay of enrollment status and notification will be sent indicating the time frame we must receive the revalidation application:
  - The provider/supplier has 30 days to submit the revalidation application and during this timeframe, claims will reject

Revalidation Requirements

- 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:
    - Reactivation date after period of deactivation will be based on the receipt date of the new, full, and complete application
    - Providers/suppliers will maintain their original Provider Transaction Access Number (PTAN) and/or CMS certification number (CCN)
    - Medicare will not reimburse you for any services during the period that you were deactivated

CMS Revalidation Lookup Tool

- Medicare Revalidation Lookup Tool:
  - Tool used to determine revalidation due dates



Key Takeaways

- Reviewed the basics enrollment requirements
- Discussed the appropriate applications for Indian Health Service, Tribes and Urban Indian Facilities and Providers
- Provided IHS specific information for enrolling
- Reviewed the revalidation requirements

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  - Follow these simple steps to allow emails

IHS Contact Information

- Visit our websites:
  - www.novitas-solutions.com
- Call our Customer Contact Center:
  - JH: 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
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