



Part B Provider Enrollment

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Part B



IMPORTANT



The information provided in this manual was current as of July 2010. Any changes or new information superseding the information in this manual, provided in newsletters/eBulletins, MLN articles, listserv notices, Local Coverage Determinations (LCDs) or CMS Internet-Only Manuals with publication dates after July 2010, are available at:

<http://www.trailblazerhealth.com/Medicare.aspx>

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INTRODUCTION

The provider/supplier enrollment process is a critical function that assures only qualified and eligible provider/suppliers are enrolled in the Medicare program and receive reimbursement for services rendered to beneficiaries. All regulations regarding Medicare provider enrollment can be found in the Medicare Program Integrity Manual, Chapter 10, at <http://www.cms.gov/manuals/downloads/pim83c10.pdf>.

Providers/suppliers who wish to be certified for participation in the Medicare program or are requesting a change of information/address must complete the applicable provider enrollment application (CMS-855). A CMS-855 application is also required when a Change of Ownership (CHOW) has occurred.

Provider Enrollment, Chain Ownership System (PECOS)

Provider Enrollment, Chain Ownership System (PECOS) is a national database that supports the provider enrollment function. CMS launched this new enrollment system in 2003 for Medicare contractors.

This database is used to house all provider information that can be used to verify provider information, add new providers into the system or make changes to existing Medicare providers during the enrollment process.

This system is a critical part of the Medicare business world, as it houses provider eligibility to the Medicare program and is key to a successful relationship between the provider/supplier and Medicare.

Enrollment Applications

- CMS-855B (Clinics/Group Practices and Certain Other Suppliers):
<http://www.cms.gov/CMSforms/downloads/cms855b.pdf>
- CMS-855I (Physicians and Non-Physician Practitioners):
<http://www.cms.gov/CMSforms/downloads/cms855i.pdf>
- CMS-855R (Reassignment of Medicare Benefits):
<http://www.cms.gov/CMSforms/downloads/cms855r.pdf>
- Internet-based PECOS:
<http://www.cms.gov/MedicareProviderSupEnroll>

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Submitting an Application

Mail the completed paper application and all supporting documentation to:

Colorado	Provider Enrollment – Medicare Part B –Colorado TrailBlazer Health Enterprises, LLC P.O. Box 650710 Dallas, TX 75265-0710
New Mexico	Provider Enrollment – Medicare Part B – New Mexico TrailBlazer Health Enterprises, LLC P.O. Box 650709 Dallas, TX 75265-0709
Oklahoma	Provider Enrollment – Medicare Part B – Oklahoma TrailBlazer Health Enterprises, LLC P.O. Box 650711 Dallas, TX 75265-0711
Texas/Indian Health	Provider Enrollment – Medicare Part B – Texas/Indian Health/Virginia TrailBlazer Health Enterprises, LLC P.O. Box 650544 Dallas, TX 75265-0544

Internet-Based PECOS

Physicians and **non-physician practitioners** can choose to complete the application (CMS-855) via the Internet. There are three basic steps to completing an enrollment application using Internet-based PECOS. Physicians and non-physician practitioners must:

1. Have a National Plan and Provider Enumeration System (NPPES) user ID and password to use Internet-based PECOS:
<https://nppes.cms.hhs.gov/NPPES/Welcome.do>
2. Go to Internet-based PECOS at <https://pecos.cms.hhs.gov/> and complete, review and submit the electronic enrollment application via Internet-based PECOS.
3. Print, sign and date the Certification Statement (blue ink recommended) and mail the Certification Statement and all supporting paper documentation to the Medicare Contractor, Provider Enrollment – Medicare Part B, P.O. Box 650626, Dallas, TX 75265-0626.

Physician or Non-Physician Practitioner Limitations

A physician or non-physician practitioner **cannot** use Internet-based PECOS to:

- Change his name or Social Security number.
- Change an existing business structure. For example:
 - A sole owner of an enrolled professional association, professional corporation

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or LLC cannot change the business structure to a sole proprietorship.

Or,

- An enrolled sole proprietorship cannot be changed to a solely owned professional association, professional corporation or LLC.
- Reassign benefits to another supplier if that supplier does not have a current Medicare enrollment record in PECOS.

Providers and supplier organizations can choose to complete the application (CMS-855) via the Internet. There are several steps to completing an enrollment application using Internet-based PECOS. Providers and supplier organizations must:

- The first step is taken by the Authorized Official (AO) of the provider or supplier organization. This is done only one time. The individual will register in the Internet-based PECOS Identification and Authentication System (PECOS I&A) by going to <https://pecos.cms.hhs.gov/>. CMS will verify the information provided and the CMS EUS Help Desk will notify the AO of the verification.
- An individual who will use Internet-based PECOS to submit enrollment applications for the provider or supplier organization will also register in PECOS I&A. This individual may be an employee of the provider or supplier organization, or an employee of a separate organization. CMS will verify the information provided and the permission of the AO for that individual to use Internet-based PECOS on behalf of the provider or supplier organization. The individual will complete the Security Consent Form and have it signed by an official of the employer and by the AO of the provider or supplier organization. The individual will mail the signed and dated Security Consent Form to the CMS EUS Help Desk. The AO will need to periodically log on to Internet-based PECOS to see if there is a pending request for permission to access Internet-based PECOS on behalf of the provider or supplier organization. More than one person may be approved to use Internet-based PECOS on behalf of a given provider or supplier organization, but the Security Consent Form is completed only one time.
- Once the registration and verification processes are completed, the CMS EUS Help Desk will notify the AO of the establishment of the relationship between the provider or supplier organization and the organization that will be using Internet-based PECOS on its behalf.
- It may take several weeks for the registration and verification processes to be completed. Therefore, CMS encourages the AO of a provider or supplier organization to begin the registration process now, before the provider or supplier organization has the need to use Internet-based PECOS to submit a Medicare enrollment application or enrollment update.
- If a provider or supplier organization has an immediate need to submit a Medicare enrollment application to enroll or to report a change in enrollment information and the steps above have not be successfully completed, the provider or supplier organization should complete and submit the paper version of the Medicare enrollment application (CMS-855).

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After the steps above are successfully completed, the individual who will be using Internet-based PECOS is considered a PECOS user.

Provider and Supplier Organization Limitations

A provider and supplier organization **cannot** use Internet-based PECOS for the following:

- Make changes in ownership, acquisitions and mergers and consolidations. These must be done using the paper enrollment application (CMS-855).
- Make changes to a Taxpayer Identification Number (TIN). These must be done using the paper enrollment application (CMS-855).
- Change a Legal Business Name (LBN). This must be done using the paper enrollment application (CMS-855).
- An enrolled Medicare Part A provider or supplier organization wants to enroll with a Medicare carrier or A/B Medicare Administrative Contractor (MAC) to bill for Part B services. This must be done using the paper enrollment application (CMS-855).
- Initial applications submitted by Federal Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and End Stage Renal Disease (ESRD) facilities.

Navigating Through Internet-Based PECOS to Initiate an Enrollment Application

A PECOS user/physician/non-physician practitioner would follow these steps when using Internet-based PECOS to submit an enrollment application:

1. The PECOS user/physician/non-physician practitioner logs on to Internet-based PECOS at <https://pecos.cms.hhs.gov>.
2. From the My Home or My Enrollments pages in Internet-based PECOS, the user/physician/non-physician practitioner initiates an enrollment application by selecting an existing enrollment or an initial enrollment. Since Internet-based PECOS is scenario-driven, the system will present a series of questions to gather only the information needed to process the specific enrollment scenario.
3. Once Internet-based PECOS determines the scenario, the Enrollment Overview page summarizes the task the user/physician/non-physician practitioner is about to begin and allows the user/physician/non-physician practitioner to confirm that it is the correct task. To complete the task, the user/physician/non-physician practitioner enters the required information by moving through the screens that are presented.
4. At the end of the data entry process, Internet-based PECOS:
 - Ensures all required data have been entered.
 - Gives the provider the option of printing a copy of the enrollment application (TrailBlazer Health Enterprises® suggests a copy is made for the provider's records).

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- Displays a list of any required paper documentation that must be mailed to the contractor (e.g., the Internal Revenue Service (IRS)-generated CP-575, the CMS-588 Electronic Funds Transfer Agreement).
 - Prompts the user/physician/non-physician practitioner to print the two-page Certification Statement. The Certification Statement must be printed and signed (an original signature with blue ink recommended) and dated by the AO or the physician/non-physician practitioner, whichever is applicable. **(Certification Statement should be mailed no later than seven days after submitting the application over the Internet.)**
 - Displays the name and mailing address of the appropriate Medicare contractor.
5. The user/physician/non-physician practitioner submits the application.
 6. The user/physician/non-physician practitioner receives an e-mail from Internet-based PECOS indicating the enrollment application was successfully submitted to the Medicare contractor.

Note: The contractor will not process an Internet-submitted enrollment application until it has received the signed and dated Certification Statement. Failure to send the signed and dated statement to the contractor in a timely manner may result in the application being rejected or its processing delayed.

- Once the Internet-based PECOS application is electronically submitted, it is “locked,” meaning the data cannot be edited by the user/physician/non-physician practitioner until the Medicare contractor processes it or returns it electronically through Internet-based PECOS for corrections.

Internet-based PECOS – “Getting Started” along with “Enrollment Examples” complete with Web screen shots may be accessed at:

http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp

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PECOS Web Screen Examples

Welcome

Notifications

Welcome to PECOS.

Manage Medicare and Account Information

MY ENROLLMENTS >>

- Enroll in Medicare for the first time
- View and update existing Medicare information
- Continue working on saved applications

ACCOUNT MANAGEMENT >>

- Update your user account information, request or remove access to organizations
- Manage access to Medicare enrollments

Help

- + [User Account](#)
- + [Manage Access](#)

My Enrollments

New Application

To enroll in the Medicare program for the first time or to create a new enrollment, please click the "New Application" button below.

NEW APPLICATION >>

Existing Associates

There are no Associates currently present for the details provided.

Help

- + [Medicare Part A Services](#)
- + [Medicare Part B Services](#)
- + [Legal Business Name](#)
- + [National Provider Identifier \(NPI\)](#)

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Application Questionnaire

(*) Red asterisk indicates a required field.

Applicant Description

Please select the description that best matches the provider.*

Sole Owner of a PA, PC or LLC
The applicant provides practitioner services through an incorporated business of which he/she is the only owner (the practitioner and business are legally distinct).

X Self-Employed
The applicant provides healthcare services from a facility that he/she owns/leases/rents (the practitioner and business are legally the same).

Group Member Only
The applicant provides healthcare services only as an employee of another provider.

Group Member and is Self-Employed
The applicant is self-employed and provides healthcare services as an employee of another provider.

Help

- + [Sole Owner](#)
- + [Professional Corporation \(PC\)](#)
- + [Professional Association \(PA\)](#)
- + [Limited Liability Company \(LLC\)](#)

PREVIOUS PAGE **NEXT PAGE**

Note: These screen shots were obtained from the CMS Internet-PECOS Web site at <http://www.cms.gov/MedicareProviderSupEnroll/Downloads/PECOSWebScreenExample.pdf>. National Government Services developed the information and shared with CMS.

Since Internet-based PECOS is a scenario-driven process, you will only see the enrollment screens necessary to complete your initial enrollment or your change of information action. The information collected using the Internet-based PECOS enrollment process is the same as the information collected through the paper application submission process.

It takes approximately 20 minutes to complete an enrollment application via Internet-based PECOS.

An External User Services (EUS) help desk can assist physicians and non-physician practitioners with Internet-based PECOS enrollment applications.

- EUS Help Desk – (866) 484-8049.

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Reporting Changes

After enrolling in the Medicare program, all physicians/suppliers are responsible for maintaining and reporting changes in their Medicare enrollment information to their designated Medicare contractor. By reporting changes as soon as possible, physicians/suppliers will help ensure their claims are processed correctly. The reportable events listed below may affect claims processing, a payment amount or a physician's eligibility to participate in the Medicare program.

CMS requires **physicians/non-physicians** to notify Medicare on the following reportable events as soon as possible but no later than **30** days after the reportable event:

- Change in practice location.
- Change in final adverse action.
- Change in ownership or managing interest control.

Physicians/non-physicians are required to report the following reportable events as soon as possible but no later than **90** days after the reportable event:

- Change of business structure.
- Change in organization legal business name/Tax Identification Number (TIN).
- Change in practice status.
- Change in authorized or delegated officials.
- Change in banking arrangements or any payment information.
- Change in reassignment of benefits.

CMS requires **physician group practices** to notify Medicare on the following reportable events as soon as possible but no later than **30** days after the reportable event:

- Change in ownership or managing interest.
- Change in practice location.
- Change in final adverse action.

Physician group practices are required to report the following reportable events as soon as possible but no later than **90** days after the reportable event:

- Change of legal business name/tax identification number.
- Change in authorized or delegated officials.
- Change in banking arrangements or any payment information.
- Change in reassignment of benefits.

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Independent Diagnostic Testing Facilities (IDTFs) are required to report the following events within 30 calendar days of the change:

- Changes in ownership.
- Changes of location.
- Changes in general supervision.
- Change in adverse legal actions.

All other changes to the enrollment application must be reported within 90 days.

All other providers with the exception of those listed above must submit the following changes within 30 days:

- Authorized or delegated official change.
- Changes in ownership.

All other changes to the enrollment application must be reported within 90 days.

The contractor should be notified promptly of the death of a physician/non-physician practitioner participating in the Medicare program.

The contractor should also be notified promptly of the death of an owner, managing employee, director, officer, authorized/delegated official, etc., of a group organization.

Contractors receive a monthly file from CMS that lists individuals who have been reported as deceased to the Social Security Administration. If the deceased person is associated with a group organization such as an individual listed in the above paragraph, TrailBlazer notifies the group organization with whom the individual was associated and asks for a CMS-855 change request that deletes the individual from the group's enrollment record.

A response must be received within 90 days of notification. If no response is received, the group Provider Transaction Access Number (PTAN) will be deactivated.

By reporting changes as soon as possible, physicians, non-physician practitioners and group practices can ensure the claims filed will be processed correctly.

Below are links to fact sheets on reporting changes:

- <http://www.cms.gov/MedicareProviderSupEnroll/Downloads/PhysicianReportingResponsibilities.pdf>
- <http://www.cms.gov/MedicareProviderSupEnroll/Downloads/non-PhysicianReportingResponsibilities.pdf>
- <http://www.cms.gov/MedicareProviderSupEnroll/Downloads/GroupPracticeReportingResponsibilities.pdf>

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All providers/suppliers requesting a change of information must submit the changes on the appropriate Medicare enrollment paper application (Form CMS-855) or via the Internet (if applicable). Letterhead is not permitted. The change data must be furnished in the application section of the CMS-855 form, and the certification statement must be signed and dated. Failure to report a change in a provider's or supplier's information may result in the deactivation of Medicare billing privileges.

All paper applications must be filed using the most current version of the CMS-855 (02/2008) (EF 07/09) and contain all supporting documentation necessary to process the enrollment application.

Note: If a provider is enrolled in Medicare, but has not submitted a CMS-855 since 2003 and is requesting a change of information, the provider is required to submit a complete application. Providers and suppliers should follow the instructions for completing an **initial** enrollment application.

Prescreening

All applications are prescreened within 15 days of receipt to ensure providers/suppliers submit all required supporting documentation and a complete enrollment application. If an application is received that contains at least one missing required element, or the provider/supplier fails to submit all required supporting documentation:

- Provider Enrollment will send a letter to the provider (where appropriate, the letter can be sent via e-mail or fax) that documents and requests the missing information. (Note: If application was submitted via the Internet, the Medicare contractor will return the application electronically through Internet-based PECOS.)
- The letter must be sent to the provider within the 15-day prescreening period.
- Provider Enrollment is not required to make any additional request for the missing data elements or documentation after the initial letter.

Supporting Documents

- Tax documents (Internal Revenue Service (IRS) CP-575).
- CMS-588 (Electronic Funds Transfer (EFT) authorization).
- Copies of any state licenses or certifications.
- If applicable, copies of Clinical Laboratory Improvement Amendments (CLIA), Food and Drug Administration (FDA) and/or diabetes program certifications.
- Copy of attestation for government and tribal organizations.

Returned Applications

Provider enrollment applications may be immediately returned to the provider in many instances. The most common reasons are:

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- No signature on the CMS-855 application.
- Application contains a copied or stamped signature.
- Signature on the application is not dated.
- The CMS-855I application was signed by someone other than the individual practitioner applying for enrollment.
- Applicant completed the form in pencil.
- Application was faxed or e-mailed.
- Contractor received the application more than 30 days prior to the effective date listed on the application (this does not apply to certified providers, Ambulatory Surgical Centers (ASC) or portable X-ray suppliers).

Application Processing

Once a paper application or the Certification Statement for an Internet application is received the provider/supplier will receive an acknowledgement letter and the application starts the different phases of verification, validation and final processing.

The acknowledgement letter will include a tracking number. The tracking number will allow the provider/supplier to track the application through the various phases.

If the application was submitted through Internet-based PECOS, the provider will receive an e-mail from Internet-based PECOS indicating the enrollment application was successfully submitted to the Medicare contractor.

Providers/suppliers are encouraged to periodically monitor the progress of the pending application and act accordingly if there are requests for additional information.

Checking the Status of an Enrollment Application Submitted on Paper

Access the provider tracking tool using the below link. The link opens the home page for Provider Enrollment and the Tracking tool is the first item on the page. Enter the tracking number and click the Search button. Status of the application will be displayed.

Part B Enrollment Status Inquiry Tool	
Tracking Number: <input type="text"/>	<input type="button" value="Search"/>
TrailBlazer Average Processing Days for CMS-855 Applications	<ul style="list-style-type: none">• Learn more about this tool.• How do I obtain a tracking number?

<http://www.trailblazerhealth.com/Provider Enrollment>

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If additional information is needed during these phases, the provider could receive an e-mail, fax or letter requesting information.

The e-mail, fax or letter will be directed to the contact person listed in Section 13 of the CMS-855 form.

The provider/supplier has 30 days to reply to the request. If no reply is received and it is an initial application, the application will be denied. The provider/supplier will be notified by letter of the denial. If the application is a change request and a reply is not received, the current PTAN can be deactivated/ revoked, suspending the provider's/supplier's billing privileges.

Checking the Status of an Enrollment Application Submitted Using Internet-Based PECOS

If desired, 15 days or more after the electronic submission of the enrollment application, the user/physician/non-physician practitioner may log on to the Internet-based PECOS to check the status of the application. One of these statuses will be displayed:

- **“Submitted”** – An application has been submitted electronically.
- **“In-Process”** – The Medicare contractor is reviewing the enrollment application.
- **“Returned for Corrections”** – The Medicare contractor has returned the application to the provider for corrections. The provider should respond to any request from the contractor as soon as possible (within 30 days of the request).
- **“Resubmitted”** – The Medicare contractor has returned the enrollment application for corrections and the provider has made the corrections and resubmitted the enrollment application to the contractor.
- **“Final Status”** – The Medicare contractor has processed the enrollment application and the final status will be displayed. Final status includes “Approved,” “Denied,” “Rejected,” “Withdrawal of Application in Process,” “Voluntary Withdrawal from Medicare.”

Once an initial application has been completed, the provider/supplier will receive a confirmation letter notifying him of the PTAN information. On a change request application, a change notification letter will be sent advising the changes have been completed.

If an additional copy of either letter is needed, the provider may send a fax request for a duplicate letter. Only a valid request will be accepted.

Valid Request

A valid request:

- Must be on letterhead of the group or individual provider.
- Must be signed by the individual provider if request is for the doctor.

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- Must be signed by the authorized or delegated official if the request is for the group/clinic/organization.
- Should contain the TIN or Social Security Number (SSN).

Fax Number: (903) 463-0613

Application Time Frames

Initial Paper Applications – 60 to 90 days

Initial Paper Application – IDTFs – 90 to 180 days

Change Request Paper Applications – 45 to 90 days

Initial and Change Request Internet Applications – 45 to 90 days

These time frames are based on whether the application has any errors and the response time of providers in sending all requested information to the contractor.

Additional Forms

The following forms are routinely submitted with an application:

- EFT Authorization Agreement (Form CMS-588).
- Medicare Participating Physician or Supplier Agreement (Form CMS-460).

All forms can be downloaded from the CMS Web site or the TrailBlazerSM Web site.

NATIONAL PROVIDER IDENTIFIER (NPI)

The NPI is a standard “unique” health identification number used by providers/suppliers billing health insurance companies.

The purpose of the NPI is to:

- Simplify billing.
- Replace multiple provider numbers.
- Help with coordination of benefit payments.

An NPI must be obtained before submitting an initial application to Medicare. The Medicare application must contain the NPI.

There are two types of NPIs:

- Type 1 – The individual’s NPI (obtained using an SSN).
- Type 2 – Group/organization NPI (obtained using a TIN).

Providers/suppliers can obtain an NPI at <https://nppes.cms.hhs.gov>.

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WHAT IS DEACTIVATION?

Deactivate means that the provider's or supplier's billing privileges were stopped but can be restored upon the submission of updated information

Reasons for Deactivation

The contractor may deactivate a provider's or supplier's Medicare billing privileges when:

- A provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12-month period begins on the first day of the first month without a claim submission through the last day of the 12th month without a submitted claim.

Providers and suppliers deactivated for non-submission of a claim are required to complete and submit a Medicare enrollment application to recertify that the enrollment information currently on file with Medicare is correct and must furnish any missing information as appropriate. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation.

- A provider or supplier fails to report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services.
- Or,
- A provider or supplier fails to report a change in ownership or control within 30 calendar days.

Providers and suppliers that fail to promptly notify the contractor of a change (as described above) must submit a complete Medicare enrollment application to reactivate their Medicare billing privileges or, when deemed appropriate, recertify that the enrollment information currently on file with Medicare is correct. Reactivation of Medicare billing privileges does not require a new state survey or the establishment of a new provider agreement or participation agreement.

WHAT IS REVOCATION?

Revocation means that the provider's or supplier's billing privileges are terminated.

Reasons for Revocation

Listed below are reasons for possible revocation based on non-compliance.

The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section or in the enrollment application applicable to its provider or supplier type, and has not submitted a plan of corrective action as outlined in

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42 CFR, Part 488.

- Non-compliance includes, but is not limited to, the provider or supplier no longer having a physical business address or mobile unit where services can be rendered and/or does not have a place where patient records are stored to determine the amounts due such provider or other person and/or the provider or supplier no longer meets or maintains general enrollment requirements.
- The provider or supplier has lost its license(s) or is not authorized by the federal/state/local government to perform the services it intends to render.
- The provider or supplier no longer meets CMS regulatory requirements for the specialty for which it has been enrolled.
- The provider or supplier (upon discovery) does not have a valid Social Security Number (SSN)/employer identification number for itself, an owner, partner, managing organization/employee, officer, director, medical director, and/or delegated or authorized official.

Revocations based on provider or supplier conduct include:

- The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is:
 - Excluded from the Medicare, Medicaid and any other federal health care program.
 - Is debarred, suspended or otherwise excluded from participating in any other federal procurement or non-procurement program or activity in accordance with the Federal Acquisition Streamlining Act of 1994 (FASA) implementing regulations and the Department of Health and Human Services non-procurement common rule at 45 CFR, Part 76.

Revocations based on felony:

- The provider, supplier or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a federal or state felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries to continue enrollment.
 - Offenses include:
 - Felony crimes against persons, such as murder, rape, assault and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.
 - Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.
 - Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of

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criminal neglect or misconduct.

- Any felonies that would result in mandatory exclusion under Section 1128(a) of the Act.

Revocations based on false or misleading information:

- The provider or supplier certified as “true” misleading or false information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current laws and regulations.)

Revocations based on misuse of billing number:

- The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers who enter into a valid reassignment of benefits or a change of ownership as outlined.

Additional revocation reasons:

- The CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of, or to provide Medicare covered items or services for, Medicare patients. Upon on-site review, CMS determines that:
 - A Medicare Part B supplier is no longer operational to furnish Medicare covered items or services or the supplier has failed to satisfy any or all of the Medicare enrollment requirements or has failed to furnish Medicare covered items or services as required by the statute or regulations.
- The provider or supplier fails to furnish complete and accurate information and all supporting documentation within 30 calendar days of the provider’s or supplier’s notification from CMS to submit an enrollment application and supporting documentation.
- The physician, non-physician practitioner, physician organization or non-physician organization failed to comply with the reporting requirements that pertain to the reporting of changes in adverse actions and practice locations, respectively, within 30 days of the reportable event.

After a provider, supplier, delegated official, or authorizing official has had his billing privileges revoked, he is barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar.

The re-enrollment bar is a minimum of one year, but not longer than three years depending on the severity of the basis for revocation. The re-enrollment bar is in accordance with the following:

- One year – License revocation/suspension that a deactivated provider (i.e., is

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enrolled, but is not actively billing) failed to timely report to CMS; provider failed to respond to revalidation request.

- Two years – The provider is no longer operational.
- Three years – Medical license revocation/suspension and the practitioner continued to bill Medicare after the license revocation/suspension; felony conviction and the practitioner continued to bill Medicare after the date of the conviction; falsification of information.

Once the provider has been revoked, if he believes he is able to correct the deficiencies and establish eligibility to participate in the Medicare program, he may submit a Corrective Action Plan (CAP) within 30 calendar days after the postmarked date of the revocation letter. The request for a CAP must be in the form of a letter signed by the physician, non-physician practitioner, legal representative, delegated official or authorized official for the entity and should provide evidence that the provider is in compliance with Medicare requirements. The submission of a CAP addressing the issues that resulted in the denial or revocation of billing privileges will expedite the enrollment process and prompt a faster determination. Mail or fax the CAP request to:

TrailBlazer Health Enterprises, LLC
Corrective Action Plan
P.O. Box 650400
Dallas, TX 75265-0400
Fax: (903) 463-0387

If the provider believes the CAP determination is not correct, he may request a reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. The request for a reconsideration must be in the form of a letter signed by the physician, non-physician practitioner, legal representative, delegated official or authorized official for the entity.

The reconsideration must be requested in writing to this office within 60 calendar days of the postmarked date of the revocation letter. The request for reconsideration must state the issues or the findings of fact with which you disagree and the reasons for disagreement. You may submit additional information with the reconsideration request that you believe may have a bearing on the decision. Pursuant to 42 CFR 498.56(c), the Administrative Law Judge (ALJ) may not consider new issues that were not considered as part of the reconsideration determination. Failure to request a reconsideration in a timely manner is deemed a waiver of all rights to further administrative review. Send the request for reconsideration to:

TrailBlazer Health Enterprises, LLC
Enrollment Reconsiderations
P.O. Box 650400
Dallas, TX 75265-0400

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OPT-OUT GUIDELINES FOR PHYSICIANS/PRACTITIONERS

Overview

Normally, physicians and practitioners are required to submit claims on behalf of beneficiaries for all items and services they provide for which Medicare payment may be made under Part B. They are not allowed to charge beneficiaries in excess of the limits on charges that apply to the item or service being furnished.

However, a physician or practitioner (as defined in Internet-Only Manual (IOM) Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 40.4) may opt out of Medicare. A physician or practitioner who opts out is not required to submit claims on behalf of beneficiaries and also is excluded from limits on charges for Medicare-covered services.

Only physicians and practitioners that are listed in Section 40.4 may opt out:

- The only situation in which non-opt-out physicians or practitioners or other suppliers are not required to submit claims to Medicare for covered services is when a beneficiary or his legal representative refuses, of his own free will, to authorize the submission of a bill to Medicare. In this situation, the bill would not be submitted on behalf of the beneficiary. However, the limits on what the physician, practitioner or other supplier may collect from the beneficiary continue to apply to charges for the covered service, notwithstanding the absence of a claim to Medicare.*
- If an item or service is one that Medicare may cover in some circumstances but not in others, a non-opt-out physician/practitioner or other supplier must still submit a claim to Medicare. However, the physician, practitioner or other supplier may choose to provide the beneficiary, prior to the rendering of the item or service, an Advance Beneficiary Notice of Noncoverage (ABN) as described in IOM Pub. 100-04, Medicare Claims Processing Manual, Chapter 30. An ABN notifies the beneficiary that Medicare is likely to deny the claim and that if Medicare does deny the claim, the beneficiary will be liable for the full cost of the service. When a valid ABN is given, subsequent denial of the claim relieves the non-opt-out physician/practitioner or other supplier of the limitations on charges that would apply if the services were covered.*

Note: *Opt-out physicians and practitioners should not use ABNs because they use private contracts for any item or service that is or may be covered by Medicare (except for emergency or urgent care services (see IOM Pub. 100-02, Chapter 15, Section 40.28)).*

When a physician/practitioner or other supplier fails to submit a claim to Medicare on behalf of a beneficiary for a covered Part B service within one year of providing the service, or knowingly and willfully charges a beneficiary more than the applicable

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charge limits on a repeated basis, he may be subject to civil monetary penalties under Sections 1848(g)(1) and/or 1848(g)(3) of the Social Security Act (SSA). Application of these requirements cannot be negotiated between a physician/practitioner or other supplier and the beneficiary except when a physician/practitioner is eligible to opt out of Medicare under IOM Pub. 100-02, Chapter 15, Section 40.4, and the remaining requirements of Sections 40.1–40.38 are met.

Agreements with Medicare beneficiaries that are not authorized as described in these sections and that purport to waive the claims filing or charge limitations requirements or other Medicare requirements have no legal force and effect. For example, an agreement between a physician/practitioner or other supplier and the beneficiary to exclude services from Medicare coverage or to excuse mandatory assignment requirements applicable to certain practitioners is ineffective.

This subsection does not apply to non-covered charges.

Section 1802 of the SSA, as amended by Section 4507 of the Balanced Budget Act (BBA) of 1997, permits a physician/practitioner to opt out of Medicare and enter into private contracts with Medicare beneficiaries if specific requirements of this instruction are met.

Definition of Physician/Practitioner

For purposes of this provision, the term “physician” is limited to doctors of medicine and doctors of osteopathy; doctors of dental surgery or of dental medicine; doctors of podiatric medicine; and doctors of optometry who are legally authorized to practice dentistry, podiatry, optometry, medicine or surgery by the state in which such function or action is performed; no other physicians may opt out. For purposes of this provision, the term “practitioner” means any of the following to the extent that they are legally authorized to practice by the state and otherwise meet Medicare requirements:

- Physician assistant.*
- Nurse practitioner.*
- Clinical nurse specialist.*
- Certified registered nurse anesthetist.*
- Certified nurse midwife.*
- Clinical psychologist.*
- Clinical social worker.*
- Registered dietitians.*
- Nutrition professionals.*

The opt-out law does not define “physician” to include chiropractors; therefore, they may not opt out of Medicare and provide services under private contract. Physical therapists in independent practice, occupational therapists in independent practice and

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audiologists cannot opt out because they are not within the opt-out law's definition of either a physician or practitioner.

When a Physician or Practitioner Opts Out of Medicare

When a physician/practitioner opts out of Medicare, Medicare covers no services provided by that individual and no Medicare payment can be made to the physician or practitioner directly or on a capitated basis. Additionally, no Medicare payment may be made to a beneficiary for items or services provided directly by a physician or practitioner who has opted out of the program.

Exception: *In an emergency or urgent care situation, a physician/practitioner who opts out may treat a Medicare beneficiary with whom he does not have a private contract and bill for such treatment. In such a situation, the physician/practitioner may not charge the beneficiary more than what a non-participating physician/practitioner would be permitted to charge and must submit a claim to Medicare on the beneficiary's behalf.*

Payment will be made for Medicare-covered items or services furnished in emergency or urgent situations when the beneficiary has not signed a private contract with that physician/practitioner (see IOM Pub. 100-02, Chapter 15, Section 40.28).

Under the statute, the physician/practitioner cannot choose to opt out of Medicare for some Medicare beneficiaries but not others or for some services but not others. The physician/practitioner who chooses to opt out of Medicare may provide covered care to Medicare beneficiaries only through private agreements.

Medicare will make payment for covered, medically necessary services that are ordered by a physician/practitioner who has opted out of Medicare if the ordering physician/practitioner has acquired a National Provider Identifier (NPI) and provided that the services are not furnished by another physician/practitioner who has also opted out. For example, if an opt-out physician/practitioner admits a beneficiary to a hospital, Medicare will reimburse the hospital for medically necessary care.

When Payment May Be Made to a Beneficiary for Service of an Opt-Out Physician/Practitioner

Payment may be made to a beneficiary for services of an opt-out physician/practitioner in two cases:

- If the services are emergency or urgent care services furnished by an opt-out physician/practitioner to a beneficiary with whom he has a previously existing private contract (see IOM Pub. 100-02, Chapter 15, Section 40.28, for further discussion of emergency and urgent care services by opt-out physicians and practitioners).*

Or,

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- *If the opt-out physician/practitioner failed to privately contract with the beneficiary for services that he provided that were not emergency or urgent care services. Payment of these claims would only be made in the course of a request for reconsideration of a denied claim or as a result of a complaint from a beneficiary or his legal representative. The beneficiary must be notified that the physician/practitioner who has opted out must privately contract with the beneficiary or the beneficiary's legal representative for services the physician/practitioner furnished and that no further payment will be made to the beneficiary for services furnished by the opt-out physician/practitioner after 15 days from the postmark of the notice.*

Definition of a Private Contract

A private contract is a contract between a Medicare beneficiary and a physician or other practitioner who has opted out of Medicare for two years for all covered items and services the physician/practitioner furnishes to Medicare beneficiaries. In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician/practitioner and to pay the physician/practitioner without regard to any limits that would otherwise apply to what the physician/practitioner could charge. Once a physician/practitioner files an affidavit notifying the Medicare contractor that he has opted out of Medicare, the physician/practitioner is out of Medicare for two years from the date the affidavit is signed (unless the opt-out is terminated early according to IOM Pub. 100-02, Chapter 15, Section 40.35, or unless he fails to maintain opt-out (see Section 40.11)).

After those two years are over, a physician/practitioner could elect to return to Medicare or to opt out again.

Please note that a beneficiary who signs a private contract with a physician practitioner is not precluded from receiving services from other physicians and practitioners who have not opted out of Medicare.

Physicians or practitioners who provided services to Medicare beneficiaries enrolled in the new Medical Savings Account (MSA) demonstration created by the BBA of 1997 are not required to enter into a private contract with those beneficiaries and to opt out of Medicare under Section 1802 of the SSA.

General Rules of Private Contracts

The following rules apply to physicians/practitioners who opt out of Medicare:

- *A physician/practitioner may enter into one or more private contracts with Medicare beneficiaries for the purpose of furnishing items or services that would otherwise be covered by Medicare (provided the conditions in IOM Pub. 100-02, Chapter 15, Section 40.1, are met).*

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- *A physician/practitioner who enters into at least one private contract with a Medicare beneficiary (under the conditions of Section 40.1) and who submits one or more valid affidavits in accordance with Section 40.9, opts out of Medicare for a two-year period unless the opt-out is terminated early according to Section 40.35 or unless the physician/practitioner fails to maintain opt-out (see Section 40.11). The physician's or practitioner's opt-out may be renewed for subsequent two-year periods.*
- *Both the private contracts described in the first bullet of this section and the physician's or practitioner's opt-out described in the second bullet of this section are null and void if the physician/practitioner fails to properly opt out in accordance with the conditions of these instructions.*
- *Both the private contracts described in the first bullet of this section and the physician's or practitioner's opt-out described in the second bullet of this section are null and void for the remainder of the opt-out period if the physician/practitioner fails to remain in compliance with the conditions of these instructions during the opt-out period.*
- *Services furnished under private contracts, which meet the requirements of these instructions, are not covered services under Medicare and no Medicare payment will be made for such services either directly or indirectly.*

Requirements of a Private Contract

A private contract under this section must:

- *Be in writing and in print sufficiently large to ensure the beneficiary is able to read the contract.*
- *Clearly state whether the physician/practitioner is excluded from Medicare under Sections 1128, 1156 or 1892 of the SSA.*
- *State that the beneficiary or his legal representative accepts full responsibility for payment of the physician or practitioner charge for all services furnished by the physician/practitioner.*
- *State that the beneficiary or his legal representative understands that Medicare limits do not apply to what the physician/practitioner may charge for items or services furnished by the physician/practitioner.*
- *State that the beneficiary or his legal representative agrees not to submit a claim to Medicare or to ask the physician/practitioner to submit a claim to Medicare.*
- *State that the beneficiary or his legal representative understands that Medicare payment will not be made for any items or services furnished by the physician/practitioner that would have been otherwise covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.*
- *State that the beneficiary or his legal representative enters into the contract with the knowledge that the beneficiary has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of*

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Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

- *State the expected or known effective date and expected or known expiration date of the opt-out period.*
- *State that the beneficiary or his legal representative understands that Medigap plans do not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.*
- *Be signed by the beneficiary or his legal representative and by the physician/practitioner.*
- *Not be entered into by the beneficiary or the beneficiary's legal representative during a time when the beneficiary requires emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with IOM Pub. 100-02, Chapter 15, Section 40.28.)*
- *Be provided (a photocopy is permissible) to the beneficiary or his legal representative before items or services are furnished to the beneficiary under the terms of the contract.*
- *Be retained (original signatures of both parties required) by the physician/practitioner for the duration of the opt-out period.*
- *Be made available to CMS upon request.*
- *Be entered into for each opt-out period.*

For a private contract with a beneficiary to be effective, the physician/practitioner must file an affidavit with all Medicare contractors to which the physician/practitioner would submit claims, advising that the physician/practitioner has opted out of Medicare. The affidavit must be filed within 10 days of entering into the first private contract with a Medicare beneficiary. Once the physician/practitioner has opted out, such a physician/practitioner must enter into a private contract with each Medicare beneficiary to whom the physician/practitioner furnished covered services (even when Medicare payment would be on a capitated basis or where Medicare would pay an organization for the physician's or practitioner's services to the Medicare beneficiary) with the exception of a Medicare beneficiary needing emergency or urgent care.

If a physician/practitioner has opted out of Medicare, the physician/practitioner must use a private contract for items and services that are or may be covered by Medicare (except for emergency or urgent care services (see Section 40.28)). An opt-out physician/practitioner is not required to use a private contract for an item or service that is definitely excluded from coverage by Medicare.

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Requirements of the Opt-Out Affidavit

Under Section 1802(3)(B) of the SSA, a valid affidavit must:

- *Be in writing and signed by the physician/practitioner.*
- *Contain the physician's or practitioner's full name, address, telephone number, NPI or billing number (if one has been assigned), or if an NPI has not been assigned, the physician's or practitioner's Tax Identification Number (TIN).*
- *State that, except for emergency or urgent care services (as specified in IOM Pub. 100-02, Chapter 15, Section 40.28), during the opt-out period, the physician/practitioner will provide services to Medicare beneficiaries only through private contracts that meet the criteria of Section 40.8 for services that, but for their provision under a private contract, would have been Medicare-covered services.*
- *State that the physician/practitioner will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will the physician/practitioner permit any entity acting on physician's/practitioner's behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary except as specified in Section 40.28.*
- *State that, during the opt-out period, the physician/practitioner understands that the physician/practitioner may receive no direct or indirect Medicare payment for services that the physician/practitioner furnishes to Medicare beneficiaries with whom the physician/practitioner has privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare+Choice plan.*
- *State that a physician/practitioner who opts out of Medicare acknowledges that, during the opt-out period, the physician/practitioner services are not covered under Medicare and that no Medicare payment may be made to any entity for his services, directly or on a capitated basis.*
- *State on acknowledgment by the physician/practitioner to the effect that during the opt-out period, the physician/practitioner agrees to be bound by the terms of both the affidavit and the private contracts that the physician/practitioner has entered.*
- *Acknowledge that the physician/practitioner recognizes the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by the physician/practitioner during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom the physician/practitioner has not previously privately contracted) without regard to any payment arrangements the physician/practitioner may make.*
- *With respect to a physician/practitioner who has signed a Part B participation agreement, acknowledge that such agreement terminates on the effective date of the affidavit.*

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- *Acknowledge the physician/practitioner understands that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of Section 40.28 apply if the physician/practitioner furnishes such services.*
- *Identify the physician/practitioner sufficiently so the contractor can ensure no payment is made to the physician/practitioner during the opt-out period.*
- *Be filed with all contractors who have jurisdiction over claims the physician/practitioner would otherwise file with Medicare and be filed no later than 10 days after the first private contract to which the affidavit applies is entered into.*

Failure to Properly Opt Out

A physician/practitioner fails to properly opt out for any of the following reasons:

- *Any private contract between the physician/practitioner and a Medicare beneficiary that was entered into before the affidavit described in IOM Pub. 100-02, Chapter 15, Section 40.9, was filed does not meet the specifications in Section 40.8.*
- Or,*
- *The physician/practitioner fails to submit the affidavit(s) in accordance with Section 40.9.*

If a physician/practitioner fails to properly opt out in accordance with the preceding two bullets, the following will result:

- *The physician's/practitioner's attempt to opt out of Medicare is nullified and all of the private contracts between the physician/practitioner and Medicare beneficiaries for the two-year period covered by the attempted opt-out are deemed null and void.*
- *The physician/practitioner must submit claims to Medicare for all Medicare-covered items and services furnished to Medicare beneficiaries, including the items and services furnished under the nullified contracts. A non-participating physician/practitioner is subject to the limiting charge provision. For items or services paid under the physician fee schedule, the limiting charge is 115 percent of the approved amount for non-participating physicians or practitioners. A participating physician/practitioner is subject to the limitations on charges of the participation agreement the physician/practitioner signed.*
- *The practitioner may not reassign any claim except as provided in the IOM Pub. 100-04, Chapter 1, Sections 30.2.12 and 30.2.13.*
- *The physician/practitioner may neither bill nor collect an amount from the beneficiary except for applicable deductible and coinsurance amounts.*
- *The physician/practitioner may make another attempt to properly opt out at any time.*

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Failure to Maintain Opt-Out

A physician/practitioner fails to maintain opt-out if, during the opt-out period, one of the following occurs:

- The physician/practitioner has filed a valid affidavit in accordance with IOM Pub. 100-02, Chapter 15, Section 40.9, and has signed private contracts in accordance with Section 40.8, but the physician/practitioner knowingly and willfully submits a claim for Medicare payment (except as provided in Section 40.28).*
 - Receives Medicare payment directly or indirectly for Medicare-covered services furnished to a Medicare beneficiary (except as provided in Section 40.28).*
 - The physician/practitioner fails to enter into private contracts with Medicare beneficiaries for the purpose of furnishing items and services that would otherwise be covered by Medicare or enters into private contracts that fail to meet the specifications of Section 40.8.*
 - The physician/practitioner fails to comply with the provisions of Section 40.28 regarding billing for emergency care services or urgent care services.*
- Or,*
- The physician/practitioner fails to retain a copy of each private contract that the physician/practitioner has entered into for the duration of the opt-out period for which the contracts are applicable or fails to permit CMS to inspect them upon request.*

If a physician/practitioner fails to maintain opt-out in accordance with the above bullets of this section and fails to demonstrate, within 45 days of a notice from the contractor of a violation of the first bullet of this section, that the physician/practitioner has taken good-faith efforts to maintain opt-out (including by refunding amounts in excess of the charge limits to the beneficiaries with whom he did not sign a private contract), the following will result, effective 46 days after the date of the notice, but only for the remainder of the opt-out period (however, if the physician/practitioner did not privately contract and refunds coverage, he may still maintain the opt-out):

- All of the private contracts between the physician/practitioner and Medicare beneficiaries are deemed null and void.*
- The physician/practitioner opt-out of Medicare is nullified.*
- The physician/practitioner must submit claims to Medicare for all Medicare-covered items and services furnished to Medicare beneficiaries.*
- The physician/practitioner or beneficiary will not receive Medicare payment on Medicare claims for the remainder of the opt-out period, except as stated above.*
- The physician/practitioner is subject to the limiting charge provisions as stated in Section 40.10.*
- The practitioner may not reassign any claim except as provided in IOM Pub. 100-04, Chapter 1, Section 30.2.13. The practitioner may neither bill nor collect any*

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amount from the beneficiary except for applicable deductible and coinsurance amounts.

- The physician/practitioner may not attempt to once more meet the criteria for properly opting out until the two-year opt-out period expires.*

Non-Participating Physicians or Practitioners Who Opt Out of Medicare

A non-participating physician or practitioner may opt out of Medicare at any time in accordance with the following:

- The two-year opt-out period begins the date the affidavit meeting the requirements of IOM Pub. 100-02, Chapter 15, Section 40.9, is signed, provided the affidavit is filed within 10 days after he signs his first private contract with a Medicare beneficiary.*
- If the physician or practitioner does not file timely any required affidavit, the two-year opt-out period begins when the last such affidavit is filed. Any private contract entered into before the last required affidavit is filed becomes effective upon the filing of the last required affidavit, and the furnishing of any items or services to a Medicare beneficiary under such contract before the last required affidavit is filed is subject to standard Medicare rules.*

Note: *For a physician/practitioner who has never enrolled in the Medicare program and wishes to opt out of Medicare, the physician/practitioner must provide the contractor with the full name, address, license number, TIN and an NPI.*

Excluded Physicians and Practitioners

An excluded physician or practitioner may opt out of Medicare by submitting the required documentation in accordance with IOM Pub. 100-02, Chapter 15, Section 40.9. When determining effective dates of the exclusion versus the opt-out, the date of exclusion always takes precedence over the date the physician or practitioner opts out of Medicare.

Participating Physicians and Practitioners

Participating physicians and practitioners may opt out if they file an affidavit that meets the criteria and is received by the contractor at least 30 days before the first day of the next calendar quarter showing an effective date of the first day in that quarter (i.e., January 1, April 1, July 1, October 1). They may not provide services under private contracts with beneficiaries earlier than the effective date of the affidavit.

Participating physicians or practitioners may sign private contracts only after the effective date of the valid affidavit filed in accordance with IOM Pub. 100-02, Chapter 15, Section 40.9. They may not provide services under private contracts with beneficiaries earlier than the effective date of the affidavit. It is necessary to treat non-participating physicians or practitioners differently from participating physicians or

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practitioners to assure that participating physicians or practitioners are paid properly for the services they furnish before the effective date of the affidavit.

Participating physicians or practitioners are paid at the full fee schedule for the services they furnish to Medicare beneficiaries. However, the law sets the payment amount for non-participating physicians or practitioners at 95 percent of the payment amount for participating physicians or practitioners.

Participating physician/practitioners who opt out are treated as non-participating physicians or practitioners as of the effective date of the opt-out affidavit. When a participating physician/practitioner opts out of Medicare, the reimbursement for the physician/practitioner will be at the higher participating physician/practitioner rate for the period before the effective date of the opt-out. However, participating physicians or practitioners who opt out are treated as non-participating physicians or practitioners as of the effective date of the opt-out affidavit.

Therefore, participating physicians or practitioners must provide 30 days' notice that they intend to opt out at the beginning of the next calendar quarter for par status.

Physicians or Practitioners Who Choose to Opt Out of Medicare

If a physician/practitioner chooses to opt out of Medicare, it means he opts out for all covered items and services he furnished. Physicians and practitioners cannot have private contracts that apply to some covered services they furnish but not to others.

For example, if a physician or practitioner provides laboratory tests or durable medical equipment "incident to" his professional services and chooses to opt out of Medicare, the physician/practitioner has opted out of Medicare for payment of lab services and Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) as well as for professional services. If a physician or practitioner who has opted out refers a beneficiary to a non-opt-out physician or practitioner for medically necessary services such as laboratory, DMEPOS or inpatient hospitalization, Medicare would cover those services. In addition, because suppliers of durable medical equipment, independent diagnostic testing facilities, clinical laboratories, etc., cannot opt out, the physician or practitioner owner of such suppliers cannot opt out as such a supplier.

Therefore, the participating physician or practitioner becomes a non-participating physician or practitioner for purposes of Medicare payment for emergency and urgent care services on the effective date of the opt-out (see IOM Pub. 100-02, Chapter 15, Section 40.28).

Relationship to Non-Covered Services

Because Medicare rules do not apply to items or services that are categorically not covered by Medicare, a private contract is not needed to furnish such items or services to Medicare beneficiaries, and Medicare's claims filing rules and limits on charges do

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not apply to such items or services. For example, because Medicare does not cover hearing aids, a physician or practitioner or other supplier may furnish a hearing aid to a Medicare beneficiary and would not be required to file a claim with Medicare; further, the physician, practitioner or other supplier would not be subject to any Medicare limit on the amount he could collect for the hearing aid.

If the item or service is one that Medicare has not categorically excluded from coverage by Medicare but may be non-covered in a given case (for example, it is covered only when certain clinical criteria are met and there is a question as to whether the criteria are met), a non-opt-out physician/practitioner or other supplier is not relieved of his obligation to file a claim with Medicare.

If the physician/practitioner or other supplier has given a proper ABN, he may collect the full charge from the beneficiary if Medicare denies the claim.

When a physician/practitioner has opted out of Medicare, he must provide covered services only through private contracts that meet the criteria specified in IOM Pub. 100-02, Chapter 15, Section 40.8 (including items and services that are not categorically excluded from coverage but may be excluded in a given case). An opt-out physician or practitioner is prohibited from submitting claims to Medicare (except for emergency or urgent care services furnished to a beneficiary with whom the physician or practitioner did not have a private contract) (see Section 40.12).

Organizations That Furnish Physician or Practitioner Services

The opt out applies to all items or services the physician or practitioner furnishes to Medicare beneficiaries regardless of the location where such items or services are furnished.

When a physician/practitioner opts out and is a member of a group practice or otherwise reassigns his rights to Medicare payment to an organization, the organization may no longer bill Medicare or be paid by Medicare for services the physician or practitioner furnishes to Medicare beneficiaries. However, if the physician or practitioner continues to grant the organization the right to bill and be paid for the services he furnishes to patients, the organization may bill and be paid by the beneficiary for the services provided under the private contract. The decision of a physician/practitioner to opt out of Medicare does not affect the ability of the group practice or organization to bill Medicare for the services of physicians and practitioners who have not opted out of Medicare.

Corporations, partnerships or other organizations that bill and are paid by Medicare for the services of physicians or practitioners who are employees, partners or have other arrangements that meet the Medicare reassignment-of-payment rules cannot opt out because they are neither physicians nor practitioners. Of course, if every physician and practitioner within a corporation, partnership or other organization opts out, then such corporation, partnership or other organization would have, in effect, opted out.

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The Difference Between ABNs and Private Contracts

An ABN allows a beneficiary to make an informed consumer decision by knowing in advance that he may have to pay out of pocket. An ABN is not needed when the item or service is categorically excluded from Medicare coverage or outside the scope of the benefit. An ABN is used when the physician/practitioner believes Medicare will not make payment, while private contracts are used for services covered by Medicare and for which payment might be made if a claim were to be submitted.

Private Contracting Rules When Medicare Is the Secondary Payer

The opt-out physician/practitioner must have a private contract with a Medicare beneficiary for all Medicare-covered services (see IOM Pub. 100-02, Chapter 15, Section 40.7), notwithstanding that Medicare would be the secondary payer in a given situation. No Medicare primary or secondary payments will be made for items and services furnished by a physician/practitioner under the private contract.

Emergency and Urgent Care Situations

Payment may be made for services furnished by an opt-out physician/practitioner who has not signed a private contract with a Medicare beneficiary for emergency or urgent care items and services furnished to, or ordered or prescribed for, such beneficiary on or after the date the physician opted out.

When a physician or a practitioner who has opted out of Medicare treats a beneficiary with whom he does not have a private contract in an emergency or urgent situation, the physician/practitioner may not charge the beneficiary more than the Medicare limiting charge for the service and must submit the claim to Medicare on behalf of the beneficiary for the emergency or urgent care. Medicare payment may be made to the beneficiary for the Medicare-covered services furnished to the beneficiary.

In other words, when the physician or practitioner provides emergency or urgent services to the beneficiary, the physician/practitioner must submit a claim to Medicare and may collect no more than the Medicare limiting charge in the case of a physician or the deductible and coinsurance in the case of a practitioner. This implements Section 1802(b)(2)(A)(iii) of the SSA, which specifies the contract may not be entered into when the beneficiary is in need of emergency or urgent care. Because the services are excluded from coverage under Section 1862(a)(19) only if they are furnished under private contract, CMS concludes they are not excluded in the case where there is no private contract, notwithstanding that they were furnished by an opt-out physician or practitioner. Hence, they are covered services furnished by a non-participating physician or practitioner and the rules in effect, absent the opt-out, would apply in these cases.

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Specifically, the physician or practitioner may choose to take assignment (thereby agreeing to collect no more than the Medicare deductible and coinsurance based on the allowed amount from the beneficiary) or not to take assignment (and to collect no more than the Medicare limiting charge), but the practitioner must take assignment (Section 1842(b)(18)).

Therefore, in this circumstance, the physician/practitioner must submit a completed Medicare claim on behalf of the beneficiary with the appropriate HCPCS code and HCPCS modifier that indicates the services furnished to the Medicare beneficiary were emergency or urgent and the beneficiary does not have a private agreement with the physician or practitioner. If the physician or practitioner did not submit the national HCPCS modifier GJ, then the contractor must deny the claim so the beneficiary can appeal.

Modifier GJ – Opt-Out Physician/Practitioner Emergency or Urgent Services

This modifier must be used on claims for services rendered by an opt-out physician/practitioner for an emergency/urgent service. The use of this modifier indicates the service was furnished by an opt-out physician/practitioner who has not signed a private contract with a Medicare beneficiary for emergency or urgent care items and services furnished to or ordered or prescribed for such beneficiary on or after the date the physician/practitioner opted out.

In the emergency and urgent care situation where an opt-out physician or practitioner renders emergency or urgent service to a Medicare beneficiary (e.g., a fractured leg) who has not entered into a private agreement with the physician/practitioner, as stated above, the physician or practitioner is required to submit a claim to Medicare with the appropriate modifier (GJ and 54 as later discussed) and is subject to all the rules and regulations of Medicare, including limiting charge. However, if the opt-out physician or practitioner asks the beneficiary, with whom he has no private contract, to return for a follow-up visit (e.g., return within five to six weeks to remove the cast and examine the leg), the physician or practitioner must ask the beneficiary to sign a private contract. In other words, once a beneficiary no longer needs emergency or urgent care (i.e., non-urgent follow-up care), Medicare cannot pay for the follow-up care and the physician/practitioner can and must, under the opt-out affidavit agreement, ask the beneficiary to sign a private agreement as a condition of further treatment.

The way this would occur in the fractured leg example is the physician or practitioner would bill Medicare for setting the fractured leg with the emergency opt-out CMS modifier (GJ) and the surgical-care-only modifier (54) to ensure CMS does not pay the evaluation and management that is the global fee for the procedure. The physician or practitioner would then either have the beneficiary sign the private contract or refer the beneficiary to a Medicare physician or practitioner who would bill Medicare using the postoperative-only modifier to be paid for the postoperative care in the global period.

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If the beneficiary continues to be in a condition that requires emergency or urgent care (e.g., unconscious or unstable after surgery for an aneurysm), the follow-up care would continue to be paid under emergency or urgent care until the beneficiary no longer needed such care.

Definition of Emergency and Urgent Care Situations

Emergency services are defined as services furnished to an individual who has an emergency medical condition as defined in Section 42 CFR 424.101. CMS has adopted the definition of emergency medical condition in that section of the Code of Federal Regulations (CFR). However, it seems clear that Congress intended the term “emergency” or “urgent care services” to not be limited to emergency services since they also included urgent care services. Urgent care services are defined in 42 CFR 405.400 as services furnished within 12 hours to avoid the likely onset of an emergency medical condition. For example, if a beneficiary has an ear infection with significant pain, CMS would view that as requiring treatment to avoid the adverse consequences of continued pain and perforation of the ear drum. The patient’s condition would not meet the definition of an emergency medical condition because immediate care is not needed to avoid placing the health of the individual in serious jeopardy or to avoid serious impairment or dysfunction.

However, although it does not meet the definition of emergency care, the beneficiary needs care within a relatively short period of time (which CMS defines as 12 hours) to avoid adverse consequences and the beneficiary may not be able to find another physician or practitioner to provide treatment within 12 hours.

Mandatory Claims Submission

Section 1848(g)(4) of the SSA, regarding mandatory claims submission, does not apply once a physician/practitioner signs and submits an affidavit to the Medicare contractor opting out of the Medicare program for the duration of the physician’s or practitioner’s opt-out period unless the physician or practitioner knowingly and willfully violates a term of the affidavit.

Renewal of Opt-Out

A physician/practitioner may renew an opt-out without interruption by filing an affidavit with each contractor to which an affidavit was submitted for the first opt-out (as specified in IOM Pub. 100-02, Chapter 15, Section 40.9) and to each contractor to which a claim was submitted under Section 40.28 during the previous opt-out period, provided the affidavits are filed within 30 days after the current opt-out period expires.

Early Termination of Opt-Out

If a physician/practitioner changes his mind after the contractor has approved the affidavit, the opt-out may be terminated within 90 days of the effective date of the affidavit. To properly terminate an opt-out, a physician or practitioner must:

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- *Not have previously opted out of Medicare.*
- *Notify all Medicare contractors with which the physician or practitioner filed an affidavit of the termination, of the opt-out no later than 90 days after the effective date of the opt-out period.*
- *Refund to each beneficiary with whom the physician or practitioner has privately contracted, all payment collected in excess of:*
 - *The Medicare limiting charge (in the case of physicians/practitioners).*
 - Or,
 - *The deductible and coinsurance (in the case of practitioners).*
- *Notify all beneficiaries with whom the physician or practitioner entered into private contracts, of the physician's or practitioner's decision to terminate opt-out and of the beneficiaries' right to have claims filed on their behalf with Medicare for services furnished during the period between the effective date of the opt-out and the effective date of the termination of the opt-out period.*

When the physician or practitioner properly terminates opt-out in accordance with the second bullet above, the physician or practitioner will be reinstated in Medicare as if there had been no opt-out, and the opt-out provision of IOM Pub. 100-02, Chapter 15, Section 40.3, must not apply unless the physician or practitioner subsequently properly opts out.

Appeals

A determination by CMS that a physician/practitioner has failed to properly opt out, failed to maintain opt-out, failed to timely renew opt-out, failed to privately contract or failed to properly terminate opt-out is an initial determination for purposes of 42 CFR 405.803.

A determination by CMS that no payment can be made to a beneficiary for the services of a physician who has opted out is an initial determination for purposes of 42 CFR 405.803.

For additional information on appeals, see IOM Pub. 100-04, Chapter 29, at:

<http://www.cms.gov/manuals/downloads/clm104c29.pdf>

For complete instructions, see IOM Pub. 100-02, Chapter 15, at:

<http://www.cms.gov/manuals/Downloads/bp102c15.pdf>

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Contact Numbers

Provider Enrollment	
<i>Colorado, New Mexico, Oklahoma, Texas/Indian Health</i>	<i>(866) 539-5596</i>
<i>Virginia</i>	<i>(866) 697-9670</i>

Provider Contact Center	
<i>Colorado, New Mexico, Oklahoma, Texas</i>	<i>(866) 280-6520</i>
<i>Virginia</i>	<i>(866) 717-0010</i>
<i>Indian Health</i>	<i>(866) 448-5894</i>

NPPES (NPI)
<i>(800) 465-3203</i>

EUS Help Desk
<i>(866) 484-8049</i>

Provider Enrollment can be contacted via phone at the above number or via the appropriate Web form at:

[http://www.trailblazerhealth.com/Provider Enrollment/EmailProviderEnrollment.aspx](http://www.trailblazerhealth.com/Provider%20Enrollment/EmailProviderEnrollment.aspx)

DEFINITIONS

Below is a list of commonly used provider enrollment terms.

- **Applicant** means the individual (practitioner/supplier) or organization who is seeking enrollment into the Medicare program.
- **Approve/Approval** means the enrolling provider or supplier has been determined to be eligible under Medicare rules and regulations to receive a Medicare billing number and be granted Medicare billing privileges.
- **Authorized Official** means an appointed official (e.g., chief executive officer, chief financial officer, general partner, chairman of the board or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.
- **Billing Agency** means a company that the applicant contracts with to prepare, edit and/or submit claims on its behalf.
- **Change of Ownership (CHOW)** is defined in 42 CFR, Section 489.18 (a), and generally means, in the case of a partnership, the removal, addition or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable state law. In the case of a corporation, the term generally

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means the merger of the provider corporation into another corporation or the consolidation of two or more corporations resulting in the creation of a new corporation. The transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership.

- **Corrective Action Plan (CAP)** is a type of provider enrollment appeal.
- **Deactivate** means that the provider's or supplier's billing privileges were stopped but can be restored upon the submission of updated information.
- **Delegated Official** means an individual who is delegated by the "Authorized Official" the authority to report changes and updates to the enrollment record. The delegated official must be an individual with an ownership or control interest in (as that term is defined in Section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of, the provider or supplier.
- **Deny/Denial** means the enrolling provider or supplier has been determined to be ineligible to receive Medicare billing privileges.
- **Enroll/Enrollment** means the process that Medicare uses to grant Medicare billing privileges.
- **Enrollment Application** means a CMS-855 enrollment application or an electronic Medicare enrollment process approved by the Office of Management and Budget (OMB).
- **Final adverse action means** one or more of the following actions:
 - A Medicare-imposed revocation of any Medicare billing privileges.
 - Suspension or revocation of a license to provide health care by any state licensing authority.
 - Revocation or suspension by an accreditation organization.
 - A conviction of a federal or state felony offense (as defined in Section 424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation or re-enrollment.
 - An exclusion or debarment from participation in a federal or state health care program.
- **Legal Business Name** is the name that is reported to the Internal Revenue Service (IRS).
- **Managing Employee** means a general manager, business manager, administrator, director or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider or supplier.
- **Medicare Identification Number** is the generic term for any number, other than the National Provider Identifier, used by a provider or supplier to bill the Medicare program. (For Part A providers, the Medicare Identification Number (MIN) is the CMS Certification Number (CCN). For Part B suppliers other than suppliers of

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Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), the MIN is the Provider Identification Number (PIN). For DMEPOS suppliers, the MIN is the number issued to the supplier by the National Supplier Clearinghouse (NSC).

- **National Provider Identifier** is the standard unique health identifier for health care providers (including Medicare suppliers) and is assigned by the National Plan and Provider Enumeration System (NPPES).
- **Operational** means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care-related services, is prepared to submit valid Medicare claims and is properly staffed, equipped and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty or the services or items being rendered) to furnish these items or services.
- **Owner** means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of, the provider or supplier as defined in Sections 1124 and 1124(A) of the Social Security Act.
- **PECOS (Provider Enrollment, Chain and Ownership System)** is a national database that supports the provider enrollment function.
- **Physician or Non-Physician Practitioner Organization** means any physician or non-physician practitioner entity that enrolls in the Medicare program as a sole proprietorship or organizational entity.
- **Prospective Provider** means any entity specified in the definition of “provider” in 42 CFR, Section 498.2, that seeks to be approved for coverage of its services by Medicare.
- **Prospective Supplier** means any entity specified in the definition of “supplier” in 42 CFR, Section 405.802, that seeks to be approved for coverage of its services under Medicare.
- **Provider** is defined at 42 CFR, Section 400.202, and generally means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or hospice that has in effect an agreement to participate in Medicare; or a clinic, rehabilitation agency or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.
- **Reassignment** means that an individual physician or non-physician practitioner, except physician assistants, has granted a clinic or group practice the right to receive payment for the practitioner’s services.
- **Reconsideration** is the appeal process when the provider feels the determination on the CAP was incorrect.
- **Reject/Rejected** means that the provider’s or supplier’s enrollment application

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was not processed due to incomplete information or that additional information or corrected information was not received from the provider or supplier in a timely manner.

- **Revoke/Revocation** means that the provider's or supplier's billing privileges are terminated.
- **Supplier** is defined in 42 CFR, Section 400.202, and means a physician or other practitioner or an entity other than a provider that furnishes health care services under Medicare.
- **Sole Owner** can be defined as the only owner of a Professional Corporation (PC), Professional Association (PA) or Limited Liability Company (LLC).
- **Sole Proprietor** can be defined as the individual provider such as John Smith, MD, working in an office by himself. John Smith is not an entity such as a corporation, professional association or limited liability company.
- **Tax Identification Number** means the number (either the SSN or Employer Identification Number (EIN)) the individual or organization uses to report tax information to the IRS.

RESOURCES

- Medicare Provider-Supplier Enrollment:
http://www.cms.gov/MedicareProviderSupEnroll/01_overview.asp
- TrailBlazer Provider Enrollment Web Page:
<http://www.trailblazerhealth.com/Provider Enrollment>
- NPPES:
<https://nppes.cms.hhs.gov>
- Opt-Out Provider Listing:
<http://www.trailblazerhealth.com/Provider Enrollment/Opt-Out Providers>

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REVISION HISTORY

Date	Section	Revision
January 2009	Submitting an Application	<ul style="list-style-type: none"> Updated 90 days for changes to 30 days for certain criteria and also added information about deceased providers. Added Internet PECOS Information.
April 2009	Submitting an Application	<ul style="list-style-type: none"> Added limitations to physician and non-physician practitioners submitting via Internet-based PECOS. Added instructions and limitations for provider and supplier organizations for Internet-based PECOS.
May 2009	Supporting Documents	Removed NPI notification bullet.
	Checking the Status of an Enrollment Application Submitted on Paper	Due to CR 6310 changed reject application to deny application.
June 2009	Navigating Through Internet-Based PECOS to Initiate an Enrollment Application	Updated CMS Web link.
August 2009	Reporting Changes	Added information for reporting changes for deceased individuals associated with a group organization. CR 6194.
	Application Time Frames	Added time frames for Internet applications.
September 2009	Navigating Through Internet-Based PECOS to Initiate an Enrollment Application	Added screen shot examples for Internet applications.
	Reporting Changes	Updated the current application requirement.
January 2010	Reporting Changes	Updated the 30- and 90-day time frame; separated physician/Non-Physician Practitioner (NPP) and group practices.

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Date	Section	Revision
April 2010	Application Time Frames	Revised time frames on initial applications based on CR 6807.
May 2010	Valid Request	Updated the fax number to request a confirmation letter.
June 2010	Contact Numbers	Updated contact number for Virginia.
	What Is Deactivation?	New section.
	What Is Revocation?	New section.
	Definitions	New section.
<i>July 2010</i>	<i>Opt-Out Guidelines</i>	<i>New section.</i>