

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Medicare Provider & Supplier Enrollment

April 30, 2009

2:00PM – 3:30PM ET

The Centers for Medicare & Medicaid Services (CMS) will hold a Special Open Door Forum (ODF) to discuss the availability of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) and the implementation of regulatory provisions. During this call CMS staff will discuss the:

- Internet-based PECOS for physicians, non-physician practitioners and provider and supplier organizations
- Provider and supplier reporting responsibilities
 - Final Adverse Actions
 - Change of Practice Locations
 - Change of Ownership
 - Other Reportable Events
- Effective date of Medicare billing privileges and retrospective billing for physicians, certain non-physician practitioners, and physician and non-physician practitioner organizations
- Revalidation Efforts

Afterwards, there will be an opportunity for the public to ask questions.

We look forward to your participation.

Open Door Forum Instructions:

Capacity is limited so dial in early. You may begin dialing into this forum as early as 1:45 PM ET.

Dial: 1-800-837-1935

Reference Conference ID 94109369

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880 and for Internet Relay services click here

<http://www.consumer.att.com/relay/which/index.html> . A Relay Communications Assistant will help.

An audio recording of this Special Forum will be posted to the Special ODF website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning Monday May 11, 2009 and available for 30 days.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at:

<http://www.cms.hhs.gov/OpenDoorForums/>

Thank you.

Audio file for this transcript:

<http://media.cms.hhs.gov/audio/SpcFrmODFMedicareProviderEnrollment.mp3>

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Moderator: Natalie Highsmith

April 30, 2009

2:00 pm ET

Operator: Good afternoon my name is (Christie) and I will be your conference facilitator today. At this time I would like to welcome everyone to the Centers for Medicaid and Medicare Services and it's the Medicare Provider Enrollment and Supplier Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers remarks there will be a question and answer session. If you would like to ask a question during this time simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question press the pound key.

Thank you, you may begin.

Natalie Highsmith: Thank you, (Christie) and good day to everyone and thank you for joining us for our Special Open Door Forum on the availability of Internet-based provider enrollment, chain and ownership system and the implementation of regulatory provisions.

Today CMS staff will discuss Internet-based PECOS for physicians, non-physician practitioners and provider and supplier organization, provider and supplier reporting responsibilities, effective date of Medicare billing privileges and retrospective billing and revalidation efforts.

And also we will have an open Q&A session at the end. I will now turn the call over to Miss Pat Peyton who is in our Division of Provider and Supplier Enrollment within our Office of Financial Management, Pat.

Patricia Peyton: Hello everyone.

The Centers for Medicare and Medicaid Services wants to ensure that all providers and suppliers with the exception of the suppliers of durable medical equipment, prosthetics, orthotics and supplies are aware that they can use the Internet to enroll in Medicare, to update their existing enrollment information, to view their existing enrollment information or to voluntarily terminate their Medicare enrollment.

We talked about Internet-based PECOS, which is the online Medicare providers/supplier enrollment system, at a Physician Open Door Forum on April 7. Hopefully providers and suppliers who were unable to dial into that Open Door Forum are able to dial into this one.

Information about Internet-based PECOS can be found on the CMS Medicare provider/supplier enrollment web page. When you click on “Internet-based PECOS” on the left-hand side of that page, you're taken to the Internet-based PECOS web page where we are making this information available to you.

There are five documents already there for downloading for physicians and non-physician practitioners. We will post information for provider and supplier organizations as soon as possible. I'll describe these new documents at the end of the presentation. And at the bottom of that web page there's a direct link to Internet-based PECOS.

Internet-based PECOS has been available to physicians and non-physician practitioners since December 2008. The system is set up so that a physician or

non-physician practitioner can log-on to Internet-based PECOS with his or her NPPES user ID and password and take any of the enrollment actions that I described earlier.

On April 1, 2009 CMS announced the availability of Internet-based PECOS to provider and supplier organizations. Provider and supplier organizations are those whose Taxpayer Identification Numbers are EINs, employer identification numbers. Generally, these would include physician group practices, hospitals, skilled nursing facilities, mammography centers and many others.

They can now conduct their enrollment transactions online with the exception of changes of ownership, acquisitions and mergers, and consolidations. They'll need to continue to use paper for those actions at this time. Internet-based PECOS will be able to accommodate those actions in the near future. And we'll make an announcement about that at the appropriate time.

Enrolling over the Internet is faster than the paper enrollment process. Our contractors have processed more than 2100 Internet submitted enrollments and the average processing time is about 25 days.

Our processing timelines for contractors for Internet-submitted enrollment applications are more stringent than those for paper. Contractors must process 90% of web-based applications (that is, initial enrollments and changes in information) within 45 days of receipt of the signed and dated Certification Statement and the supporting documentation.

For paper applications, they must process 80% of initial applications within 60 days and 80% of changes within 45 days.

Internet-based PECOS is scenario driven so the user goes through the screens and answers question by entering the requested information.

A Help icon is visible on all the screens or a user can contact the CMS External User Services help desk with questions about navigating through the system.

At the end of the process, the user submits the enrollment application. The system displays a list of the paper documentation that also needs to be mailed to the contractor. And this list includes the Certification Statement, which I'll talk about in a minute.

And it also displays the name and mailing address of the contractor. The user can print the completed enrollment application if he or she so desires. We recommend this be done and the copy retained by the physician, non-physician practitioner or the provider/supplier organization.

If you do print the copy, do not mail it to the contractor. The contractor will receive the application electronically after the user submits it. Mailing the printed copy just to be on the safe side may only cause confusion, which could slow the process.

After the application is submitted to the contractor via Internet-based PECOS, the user receives an email confirming that the application was successfully transmitted.

Mailing the signed and dated Certification Statement to the contractor is of major importance when using the Internet to submit enrollment applications to Medicare.

This is because the Internet-submitted enrollment application will not be processed by a contractor until the contractor receives the signed and dated Certification Statement from the provider or supplier.

The processing time for the web-submitted enrollment application begins on the day the signed and dated Certification Statement is received by the contractor--not the day of the user hits the "Submit" button in Internet-based PECOS. The contractor will do nothing with that application until it receives the signed and dated Certification Statement.

The Certification Statement is a two-page form that is generated by Internet-based PECOS and requires the signature and date of signature of the physician or the non-physician practitioner or, for organization providers and suppliers, of the Authorized Official. We suggest blue ink be used, so that the contractor can see that the signature and date are not photocopied.

Do not use stamps for signatures or dates. Providers and suppliers need to ensure that they mail the signed and dated Certification Statements just as soon as possible after submitting the applications over the Web. We strongly urge that this be done within seven days of the day the web-based application is submitted.

Even though Internet-based PECOS prompts the user to download the Certification Statement, it might be a good idea to stick a note or a reminder on the computer when first logging on to Internet-based PECOS to be sure to remember to get this form signed and dated and in the mail. Any other required paper documentation may be put in the same envelope.

Users can check the status of an Internet-submitted enrollment application beginning approximately 15 days after submitting it to the contractor. Waiting 15 days before checking allows time for the signed and dated Certification

Statement to reach the contractor and be associated with the web-based application so that processing can begin and the status can be available when the user wants that information.

Getting access to Internet-based PECOS by provider and supplier organizations is very different from the process used by physicians and non-physician practitioners. For provider and supplier organizations, the access process begins with the Authorized Official.

Even though we do not think an Authorized Official will actually be submitting enrollment applications, although they might, he or she still must be registered in and authenticated by the PECOS Identity and Access system, which we call PECOS I&A.

The Authorized Official, once authenticated and registered in PECOS I&A, must also sign the Security Consent Form when it is presented for signature. The Security Consent Form conveys the Authorized Official's approval for another organization to do the Medicare enrollment work or the provider/supplier organization.

The Authorized Official must also approve the individual who will be submitting the enrollment application on behalf of the provider or supplier organization--this person of course would be the PECOS user.

After the Authorized Official is authenticated and registered in PECOS I&A, he or she needs to be sure to watch for an email from the CMS External User Services Help Desk that will be requesting his or her approval of this individual.

And all these processes could very easily take several weeks. Therefore we encourage the Authorized Official of a provider or supplier organization to

begin the registration process now, before the provider or supplier organization has an immediate need to send in an enrollment application and would like to use Internet-based PECOS to do so.

The Authorized Official begins this process by going to Internet-based PECOS-- and I'll give you the URL in a minute—or he or she can click on that link from the Medicare provider/supplier enrollment web page.

If a provider or supplier organization has an immediate need to submit a Medicare enrollment application--either to enroll or report a change in enrollment data--and the Authorized Official and the end user have not both successfully completed the PECOS I&A process and the user has not yet been approved, the provider or supplier organization should complete and submit the paper version of the Medicare enrollment application (the CMS 855), because in that type of situation, paper would be faster.

Three documents about Internet-based PECOS for provider and supplier organizations will soon be available—hopefully today--on the CMS Medicare provider/supplier enrollment web page. These are:

The first one is an “Overview of Internet-based PECOS” which gives a broad picture of the system and the process of creating and submitting an Internet application. It includes information about applications statuses (the things that you can check on after you wait 15 days) and the limitations of the system, at this time, for provider and supplier organizations.

Then there's the “Getting started with Internet-based PECOS” document, which is about 9 pages long. This document references the regulation that defines provider and supplier organizations, describes the access process in more detail than I just did, and contains questions and answers that we believe

address most of the issues people will want to know about. And we can add to these questions and answers as necessary.

And then there's a one-page "Contact Information" document that tells the provider and supplier organizations who to call if they have problems with the system or if they have enrollment policy questions.

And here are the URLs and a phone number for you. Internet-based PECOS can be found at <https://pecos.cms.hhs.gov> or you may go to the CMS Medicare provider/supplier enrollment web page and click on the link.

And the Medicare provider/supplier enrollment web page is www.cms.hhs.gov/MedicareProviderSupEnroll. And the CMS External User Services Help Desk phone number is 1-866-484-8049. And their email address is eussupport@cgi.com.

That takes care of my presentation.

Jim Bossenmeyer: My name is Jim Bossenmeyer; I'm Director of the Division of Provider and Supplier Enrollment. And I'd like to provide some information to you today about changes that were recently published in CR6310, which contained information about changing some practice locations and ownership, other recordable events and also talk about revalidation.

But before I do that, CMS manuals can be found at cms.hhs.gov and when you go into that website, which is the main CMS website, if you select manuals and you go to publication 100-8 under the Internet-Only manuals, that will bring you to the Provider Integrity Manual.

And if you select Chapter 10 of that Manual you will go to the provider enrollment section for Medicare. And that manual is frequently updated, so

checking that document on a regular basis is one source of very valuable information.

Also, as Pat stated, the website for Medicare provider and supplier enrollment can be found at www.hhs.gov/MedicareProviderSupEnroll. Just a couple quick enrollment tips before we get started.

Make sure that providers do not mail an application to CMS in Baltimore or a CMS Regional Office. We strongly request that you consider using Internet-based PECOS which Pat talked about to enroll, make a change, or view your enrollment.

Submit the current version of the paper application if you're planning to submit use a paper application. That can be found on the CMS website. Submit the correct application for your provider type to your designated contractor.

Make sure that you sign and date the application. Blue ink is preferred. And if you are going to use the electronic submission, be sure that you submit the 2-page Certification Statement as soon as possible.

Be sure that the information that you're submitting to Medicare is consistent, that the information on your tax identification number from the IRS is consistent with the information on the Medicare enrollment application, as well as on the electronic funds transfer authorization agreement.

Physicians, non-physician practitioners, and other providers and suppliers should carefully review Section 14, which relates the penalties for falsifying information, and Section 15, which is the Certification Statement.

These documents are printed out on Internet-based PECOS for your review. We also encourage you to keep a copy of your Medicare enrollment application when you submit it into your Medicare contractor. We're going to talk a little bit today about some terminology that we'll be using.

And first will be the term “certain non-physician practitioners.” And what I mean by that term is that it refers to physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists and registered dietitian or nutrition professionals.

We'll also be talking about or using the term “final adverse action,” which means one or more of the following: a Medicare-imposed revocation of Medicare billing privileges, suspension or revocation of a license to provide healthcare by any State licensing authority, the revocation or suspension by an accreditation organization, a conviction of a federal or State felony offense within the last ten years preceding enrollment, revalidation or reenrollment, or an exclusion or debarment from participation in a federal or State healthcare program.

Now I'll move on to some of the recent changes that were published as part of the November 19, 2008 Medicare physician fee schedule and were effective July 1 of this year. CMS began implementing this policy on April 1 of this year.

The final rule with comment published in the Federal Register established an effect of date of billing privileges for physicians, certain non-physician practitioners and physician and physician practitioner organization as the later of the filing of a Medicare enrollment application that was subsequently approved by the Medicare contractor, or the date the enrolled physician or non-physician practitioner first started furnishing services at a new practice

location. This rule also permits physicians and certain non-physician practitioners to retrospectively bill for services rendered up to 30 days prior to the effective date if the physician or non-physician practitioner met all program requirements.

In addition, this regulation permits physician and non-physician practitioners to retrospectively bill for services furnished up to 90 days prior to the effective date when there was a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act.

This regulation also requires physicians and non-physician practitioners and physician and non-physician practitioner organizations to notify Medicare contractors of any change in ownership, final adverse action or change in practice location within 30 days of the reportable change.

Failure to notify the designated contractor of these changes may result in a revocation and/or an overpayment from the date of the reportable change.

This regulation prohibits physician and non-physician practitioners, as well as owners, authorized officials, delegated officials of a physician or non-physician practitioner organization, from attaining additional billing privileges if their current billing privileges are actively suspended or an overpayment is pending.

This regulation requires that all providers and suppliers including individual practitioners maintain ordering and referring documentation for seven years of the date of service.

This regulation establishes an effective revocation date as the date of federal exclusion, debarment, federal conviction or license suspension or revocation

or the date that the practice location is determined to be not operational by CMS or its contractor.

So with these types of revocations, physicians or certain non-physician practitioners would not be allowed to bill for services after the date of the reportable event.

With the implementation of these new changes regarding the effective billing date for physician certain non-physician practitioners and physician and non-physician organizations, CMS has revised its policy with respect to processing incomplete applications. If Medicare contractors receives incomplete applications, they're required to request that the provider or supplier provide the information - developmental information to the contractor --within 30 days.

If that does not occur, the Medicare contractor will now begin to deny those applications, affording an individual appeal right and preserving the individuals filing date on their initial application.

It is incumbent that the applicant use their appeal rights either by submitting a corrective action plan or an appeal in order to preserve the date of filing. Medicare contractors will not reject an application for incomplete information for a physician, those non-physician practitioners that I mentioned earlier, or physician or non-physician practitioner organizations.

The physician and non-physician practitioner organizations have reporting responsibilities. The reporting responsibilities include the notification of Medicare of changes of ownership that requirement that they must submit that change of ownership information to us within 30 days.

The physician/non-physician practitioner must also report the following events within 30 days any final adverse action or a change in practice location. If a provider physician/non-physician practitioner submits an enrollment application to change their practice location after the 30 days, Medicare will not revoke your billing privileges.

We want to have compliance and we want to make sure that we're providing correct payments to you.

However, if Medicare conducts an onsite evaluation or inspection and the practice location is not located at the address provided to Medicare and there's been no change of address reported within the prior 30 days, Medicare may revoke those billing privileges.

So it's important that you submit changes of address or practice location information or if there's been a change - if there's been a final adverse action - or change in ownership.

A special note to speech language pathologists: speech language pathologists can begin to receive payment for services provided independently effective July 1 of this year.

That means that they can submit - these individuals may submit an enrollment application to their Medicare contractor no earlier than June 2 of this year. Applications that are submitted earlier than June 2 will be denied as - denied or returned to the practitioner.

So the speech language pathologists should only submit their enrollment applications after June 2 to the Medicare contractor.

Moving to revalidation: revalidation is a process that occurs when a Medicare contractor requests that a provider/supplier submit an enrollment application to Medicare.

With revalidation, providers and suppliers are required to submit a complete enrollment application either via Internet-based PECOS or on paper within 60 days of the contractor's request.

Providers and suppliers must submit a complete enrollment application, including the electronic funds transfer authorization agreement (the CMS-588).

And if the individual or organization has not updated their information since November of 2003, that individual or organization will be required to submit the application as if it were an initial application.

Contractor revalidation priorities are that we obtain updated or current enrollment information for providers and suppliers who've not updated their Medicare enrollment record within the last 5 years.

We expect to begin revalidation activities early this summer. And our Medicare contractors will also be conducting onsite evaluations later this year to ensure that practitioners are operating at the locations that they've given to Medicare.

So we certainly encourage practitioners and organizations to update their Medicare enrollment information. We would especially encourage the use of Internet-based PECOS to facilitate the enrollment process.

That's all that I have and I think we'd like to open it up to questions.

Natalie Highsmith: Okay (Christie) if you can just remind everyone on how to get into the queue to ask their question. And everyone please remember when it is your turn to restate your name, what state you are calling from, what provider or organization you are representing today.

And also since we do have little over a 1000 people on the phone lines today I ask that you please ask one question. Or give one comment. And if you have further question or further comments that you get back into the queue to state your question or to give your second or third comment.

(Christie)?

Operator: At this time if you would like to ask a question please press star followed by the number 1 on your telephone keypad. If you'd like to withdraw your question press the pound key.

Our first question comes from Angela Richardson's line, your line is open.

Angela Richardson: Hi my name is Angela Richardson I'm calling from Meddata Service Bureau. I guess one of our biggest questions is, is the carrier going to tell us who is already enrolled PECOS systems?

Jim Bossenmeyer: Well the practitioner can - the individual practitioner - can check their enrollment record in PECOS. If there is a question regarding revalidation the Medicare contractor will mail a letter to the practitioner requesting that they revalidate their information.

Angela Richardson: So we don't have to do it unless they ask for revalidation?

Jim Bossenmeyer: You're not required to update your information, of course, unless there's been a change - a reportable change. Certainly if there are any of the reportable

changes that I mentioned earlier you'd want to go ahead and do that as soon as possible- within the 30 days after the reportable event.

We also encourage individuals in organizations to keep their enrollment information up to date with Medicare since, especially some Part B suppliers including physicians, payments are made based on the location of the practice location. So it's beneficial to the physician or the organization to maintain current information with Medicare.

Angela Richardson: Okay, well, I guess, what I'm asking is, is all that information already going to be in PECOS? Or when they ask for revalidation am I going to have to go in PECOS and reenter all the information?

Jim Bossenmeyer: If we request a revalidation, if there's - if the provider had not updated their enrollment information since prior to November 2003 - PECOS (the Provider Enrollment, Chain and Ownership system) does not have information. So that individual will need to submit a complete initial application.

Operator: And our next question comes from the line of Alexandra Bennewitch your line is open.

Alexandra Bennewitch: Yes, hello, thank you. I may have missed a little bit of the intro. I'm with the American Association for Homecare here in Virginia and it's Alexandra Bennewitch, did you say that durable medical equipment providers are not included in this option to do Internet?

Patricia Peyton: Hi, this is Pat Peyton. That's right, at this time they - they're not in PECOS and they can't use PECOS yet. But we think, probably, next year—2010-- they'll be able to.

Alexandra Bennewitch: Thank you very much.

Operator: And our next question comes from GiGi Washington your line is open.

GiGi Washington: Hello, I'm sorry can I get that website again?

Patricia Peyton: Which one? Provider enrollment?

GiGi Washington: Yes.

Patricia Peyton: It's www.cms.hhs.gov/MedicareProviderSupEnroll.

GiGi Washington: Thank you.

Patricia Peyton: You're welcome.

Operator: And our next question comes from the line of Francesca Beickert your line is open.

Francesca Beickert: Yes, hi, thank you, Francesca Beickert from Halifax Medical Center, Daytona Beach, Florida. My question is this, for an addition to a practice location meaning an addition to the, from the original submission on the 855I I am looking at it right now.

The form states that we can just photocopy and complete the section for each location. However someone is already enrolled and active with a number, do we have to complete the entire I to add an additional practice location, also getting another signature from the practitioner?

Sandra Olson: Hi this is Sandee Olson.

You will need to complete Sections 1, 3 and the additional practice location and yes you will need a signature from the authorized official if you need it and also of the individual practitioner who you're adding the practice location to.

Francesca Beickert: Okay. And that is for each additional practice location.

Sandra Olson: No you can just fill out one CMS 855I or go onto PECOS and do this and you can do all the additional locations for that one individual all at one time on one application.

Francesca Beickert: Okay and that would be the I&S or re-signature for somebody already active.

Sandra Olson: Yes.

Francesca Beickert: Okay thank you.

Operator: Our next question comes from Jana Stump your line is open.

Jana Stump: Hi. So if we don't, I'm adding a new position very soon. We don't have to send the original application in, just the signature pages?

Sandra Olsen: If he is PECOS web or Internet based PECOS? You will only need to send in a signature page.

Jim Bossenmeyer: It's a two-page certification statement that you'd send in for that individual practitioner.

Jana Stump: Okay thank you.

Operator: Our next question comes from the line of Andrea George your line is open.

Andrea George: Hi, I'm calling from Gosnold, Inc; it's a Rehab on Cape Cod in Massachusetts. And my question is how do you know, for instance, we have many sites and many behavioral health clinicians.

I'm wondering how we would know if somebody has not updated their profile since November of '03 or is just their submission of claims since then enough?

Jim Bossenmeyer: Well Medicare deactivates the Medicare billing privileges if there's been no submission of claims for more than a 12-month period. So the, what I would suggest is that the individual practitioner review their records to determine whether or not they're seeing Medicare patients.

If they have been and there's an ongoing payment to that individual from Medicare, they can also check to make sure. They can look at Internet-based PECOS to see whether or not they have a record in PECOS.

If they're not and if they have not updated their enrollment since 2003, PECOS would not have a record for them and they would have to go ahead and complete an initial application.

Andrea George: Okay.

Sandra Olson: Provider enrollments in Internet-based PECOS are associated together by either the provider's social security number or his tax number if that's any help.

Andrea George: Okay. Thank you.

Operator: Our next question comes from Denise Nack your line is open.

Denise Nack: Yes hi I'm calling from Capital Cardiovascular Specialists in Austin, Texas. And I just had an application rejected because I went online and I did the PECOS for one of our physicians that has opened a new location in El Paso, Texas. And I filled out the 855B. I sent it in as I was supposed to.

I even got a confirmation saying that they had received my online PECOS and I had confirmed that the doctor was registered with the PECOS. I'm not understanding this; they rejected it because they said they didn't get a paper 855R and an 855I. I sent in the signed, dated, certification papers in blue ink from this physician so you tell me.

Now I have to go and I have to fill out this whole application all over again. They said it's because the doctor had not had a group enrolled in the El Paso location so therefore you cannot do anything on PECOS until you have done an 855B and they have completed that. So that makes no sense to me.

Sandra Olson: This is Sandee Olson.

Can you give me your name and phone number and I'll give you a call after this call.

Denise Nack: Yes, it's Denise Nack, Nack, 5-1-2-3-3-4-7-8-5-5 and I spoke with four different people at Medicare telling me that I could go onto PECOS and I could do this and I would not have to send in any paperwork except for the certification, the signed dated certifications for the 855R and the 855I.

The only paper that I would need to send in was any documentation that they had requested like the, the MPI.

Sandra Olson: Denise, I'll give you a call back as soon as this call is over.

Denise Nack: Okay and what is your name.

Sandra Olson: My name is Sandee Olson.

Denise Nack: Sandy Olson. Okay thank you.

Sandra Olson: You're welcome.

Operator: Our next question comes from Robin Nelson your line is open.

Robin Nelson: My question is we have one Medicare number for several sites, I have ten different sites. How do I delete one site that we're closing?

Sandra Olson: Hi this is Sandee again.

If you go out into Internet-based PECOS and you're enrollment record is in PECOS you can apply a termination date to that practice location you want to end it.

You would then complete or print the certification statement, have your authorized official or individual whoever's submitting it sign the certification statement and send it to the contractor. You can end a practice location in PECOS.

Robin Nelson: Okay the, we have just submitted the application for the authorized person for PECOS and I haven't gotten anything back yet. So then should I then submit paper to terminate this site until I get the authorization back?

Sandra Olson: Yes. I would go ahead and submit the papers so you can get that site off of your enrollment records.

Robin Nelson: Okay.

Sandra Olson: And you would do that as a change of information.

Robin Nelson: Thank you very much.

Sandra Olson: You're welcome.

Operator: Our next question is from Karen Topale your line is open.

Karen Topale: Thank you for taking my call.

I with ENT & Allergy Associates we're a group of 100 physicians in three states. We deal with two different contractors does this mean that my authorized official for each state must register individually?

Jim Bossenmeyer: What two states are you working within?

Karen Topale: I'm working in New York, New Jersey and Connecticut. So in Connecticut and New York we use NGS Medicare and in New Jersey we have Highmark. Each of those contractors have different authorized officials.

Sandra Olson: This is Sandee again.

If you have different authorized officials per site yes each one of them would have to enroll in the EUS (unintelligible) enrollment records.

Karen Topale: Okay, okay thank you.

Operator: Our next question comes from the line of Lisa Dollen your line is open.

Lisa Dollen: Yes we had a question, we were, when we, the PECOS system first came out last in December or so we were told ambulance services were not able to be entered through the PECOS system has that changed?

Jim Bossenmeyer: Yes that has. All organizations except for DMEPOS suppliers are able to use Internet-based PECOS.

Lisa Dollen: Okay. I just had one other quick question hopefully you can answer.

When you're talking about the I&A process where we're getting the authorized signer, you know, set up so that we can add those, I'm calling from the EMS billing services and we're an organization that bills for about 200 different ambulances all having separate ownership.

Each one of those would have to have this authorized signer set up in your system? I was looking at the manual, I'm not quite sure where I see that because I understand that I&A, but I'm not sure if it's an acronym or, you know, what I need to be looking for to get information on just that part of the system.

Sandra Olson: The information is not on our website yet. We're trying to get it uploaded this week.

Lisa Dollen: Okay.

Sandra Olson: And it'll tell you how to contact EUS and get into PECOS.

Lisa Dollen: Now since each of those ownerships are separate we would have to have that set up for each individual ambulance first and then submit the form correct?

Jim Bossenmeyer: The Authorized Official is going to have to make the determination about whether or not he/she wants to handle the enrollment activities themselves, delegate it to somebody within their organization, or delegate it to an outside entity. And so if they do that that individual authorized official will need to make those decisions.

Lisa Dollen: Okay. And by them doing that...

Natalie Highsmith: I'm sorry Lisa, I'm sorry we do have to move on to the next question, if you can get back into the queue to ask your other questions please.

Lisa Dollen: Thanks.

Sandra Olson: Thank you.

Operator: Our next question comes from Barbara Hall your line is open.

Barbara Hall: Yes my name is Barbara Hall from the State of Missouri with the Department of Mental Health and one of my question is you just stated the authorized official can delegate this process of adding stuff in PECOS.

Is that a onetime delegation in the system and then all the subsequent emails and everything else can be handled by somebody else?

Patricia Peyton: Right. This is Pat Peyton. The Authorized Official registers in PECOS, does, you know, what he or she is supposed to do, signs the Security Consent Form which is generated from PECOS by the entity or organization to which the Authorized Official is going to give permission, you know, to do the Medicare work for that provider.

And then, lastly, the actual person who's going to be using PECOS goes into PECOS I&A. It is all tied together by the Help Desk behind the scenes and the Authorized Official approves that other organization and the individual person.

Jim Bossenmeyer: But it's also important to note that the authorized official can discontinue that relationship...

Patricia Peyton: Definitely.

Jim Bossenmeyer: ...with the person who's working on his or her behalf, so if the authorized official decides that they no longer would, they no longer want an individual or organization to work on their behalf that is their decision and they are the responsible person for making that decision.

Patricia Peyton: Right. And then they can disassociate at any time they want.

Operator: Our next question comes from Berise Woods your line is open.

Berise Woods: Yes I was just wondering if there is any potential outlook to add the 855R's to the PECOS web system.

Sandra Olson: The PECOS web system already handles an 855R. It's not actually like the application when you're working in PECOS. It just asks you if you're going to be reassigning your benefits. It does print two applications and the certification statements if you're completing an 855 I&R.

Berise Woods: Okay.

Jim Bossenmeyer: It's important to know that the PECOS web system does not replicate the paper application so you're not going through and completing it; it's a scenario driven application.

So you'll only respond to those questions that are needed to complete the application. If you're doing an initial, you'll complete a little bit more information.

If you're making a change, you're only going to see those types of questions and respond to those questions that give us the information we need to process that specific change.

Sandra Olson: So if you were to print those applications out of PECOS web it would print you an R application.

Operator: Our next question comes from Donna Cobb your line is open.

Donna Cobb: Hi this is Donna Cobb and I'm calling on behalf of Boston Emergency Physician Foundation in Boston. And I have a question. I submitted a paper application which was an I and an R for a provider on 04/13 with a 05/01 effective date.

And I received a demand letter back stating that I needed to submit a copy of the claim that the provider has seen. Then about another hour later I received another application for a demand letter back stating that the applicant signature didn't match what was on file.

So when I called them I was told that the provider had to see a patient before they would finish the application.

Jim Bossenmeyer: We...

Donna Cobb: And I was also given 15 days to complete this request.

Jim Bossenmeyer: If you provided us, can you provide me with your telephone number ma'am and we'll get back with you.

Donna Cobb: Okay its 6-1-6-4-6-4-0-0-9-8 and who will be calling me back.

Sandra Olson: If it's Part A or Part B...

Donna Cobb: It's a Part B.

Jim Bossenmeyer: I will be giving you call back and this is Jim Bossenmeyer.

Donna Cobb: Okay. Thank you.

Operator: Our next question comes from the line of Ben Parefsky your line is open.

Ben Parefsky: Yes thank you.

I'm calling from Golden, Colorado and our agency represents a number of providers that provide mental health services in nursing homes.

So they're all essentially sole proprietors, there's no group number they're all basically enrolled with Medicare under individual P10's and generally their social security number or the few that have a tax ID.

So my question is, you know, we are privy to their basically to their user name and password for MPI, which I've used to get onto PECOS for a new applicant that we were working with.

But is it formally necessary for us to then have an official representative deemed or if these people give us, you know, as part of our relationship with them this information to get on to PECOS is that acceptable?

Patricia Peyton: Well, sole proprietors are individuals who should be using their NPPES User IDs and passwords to, you know, do their enrollment themselves.

Ben Parefsky: Right.

Jim Bossenmeyer: Physicians or individual practitioners are responsible for anybody who's working on their behalf, so we certainly encourage individuals to review their own record and submit those applications on their behalf.

There are some complex issues when we use the term sole proprietor. That has a legal meaning. There is a difference in being incorporated versus being a sole proprietorship in the filing of taxes; since that they're filing their taxes as a sole proprietor, they need to make sure that they're reviewing those documents--that they're not just signing the 2-page Certification Statement-- if information goes in, and they sign that certification statement, it becomes their responsibility if there's missing information or if there's information that's not complete.

If there was an adverse legal action and it was determined that there was an adverse legal action that is actionable by CMS that will result or could result in a revocation at some point, it could preclude the individual from participating in Medicare.

So certainly encourage the individual practitioners to review their enrollment records; but if they chose to use another person to do that, they (the physicians) take full responsibility for that action.

Ben Parefsky: Okay so then basically because then that's the service part, that's one of the services we provide is the credentialing, so they're not actually burdened themselves with...

Jim Bossenmeyer: But at the end of the day, Medicare does not have a relationship with a billing agent or a clearinghouse. Our relationship is with the individual practitioner or the organization that is enrolling in the Medicare program. Your individual relationships between that physician and yourself need to be worked out independently of the Medicare enrollment process.

Ben Parefsky: Okay, okay thank you very much.

Operator: Our next question comes from the line of Suzanne Spicz your line is open.

Suzanne Spicz: Hi, hello?

Natalie Highsmith: Hello.

Suzanne Spicz: Hi yes. I have a question regarding something you stated about every five years the doctors have to update if they don't get EFT payments. My doctors all bill under a group so they never directly get a payment assigned to them.

So when I had a group situation that I was setting up and I had just to an 855R I was told that I had to do a reenrollment do an 855I because they weren't active.

They have been seeing Medicare patients, they never stopped but they don't get a group, I mean a check sent directly to them because the group gets the check.

So does this mean now that every five years every doctor who bills under a group has to get reenrolled if their situation changes.

Jim Bossenmeyer: I would encourage that each practitioner makes sure that they submit updates as they occur. If it's a reenrollment situation, the Medicare contractor will notify the practitioner when he/she needs to revalidate his/her information.

Suzanne Spicz: So it's going to be an every five-year situation.

Jim Bossenmeyer: It could be and we encourage you to submit changes as required under the reporting responsibilities. If there is no contact with an individual in five years in the organization, Medicare may conduct a revalidation so that we ensure that the information is still accurate.

Suzanne Spicz: Right but if they're doing business under a group my concern is that they're considered inactive because they're not getting a payment made to them directly even though they're very active the information is being updated. But you're not like the fact that it's associated with a payment EFT situation.

Jim Bossenmeyer: But EFT payments are made to the institution, at which your physicians are working. Are they continuing to bill through the group practice today?

Suzanne Spicz: Right but when I spoke with Medicare on the individuals they specifically said, "Oh, we don't see this doctor as being active even though they've been billing under the group." They're not recognizing them as being active because the checks are being made to the group not to the individual.

Sandra Olson: Medicare probably has your physicians enrolled in our claims system, but since we went to PECOS in 2003 some physicians who hadn't had an update to their enrollment aren't in PECOS.

So we have made a requirement that our contractors request an 855I along with the R you've already submitted to be sent in so we can put accurate information into PECOS.

((Crosstalk))

Sandra Olson: For the 855I.

Suzanne Spicz: So this should go away once this whole transition happens, this shouldn't come up again in five years if there's another group situation or something like that.

Sandra Olson: There may not be; right.

Suzanne Spicz: Okay thank you.

Operator: Our next question comes from the line of Linda Craig your line is open.

Linda Craig: Yes my name is Linda Craig I'm with Truxton Radiology Group.

My question is that I have 12 radiologists that I've enrolled. A few of them I've gotten their approval letters from and the other 1/2 I haven't and this has been since November of '08.

Not some of them are, we collapsed our (unintelligible) panel to one number for this group. How do I get some approved and some of them I still getting issues on as far as billing goes.

Sandra Olson: Linda this is Sandee can you give me your phone number and I'll give you a call back.

Linda Craig: Area code 6-6-1-6-1-6-1-4-8-0.

Sandra Olson: Okay I'll give you a call back.

Linda Craig: Okay thank you.

Jim Bossenmeyer: One of the things as we go into the last hour of this call we're not going to be able to respond to specific casework type of issues. We'll have to get in touch with our contractors to do that. But if you tell us that there's a specific issue, we will do that. But we won't be able to respond to any kind of casework on this national call.

Operator: Our next question comes from Nancy Beckley your line is open.

Nancy Beckley: Hi, good afternoon.

I heard mentioned the aspects of the speech language pathologists, so I'm assuming that they can apply online and my follow up on that is can physical therapists in private practice and occupational therapists in private practice also complete the Internet PECOS both as individual providers and as group practices?

Jim Bossenmeyer: The answer to that is yes.

Speech language pathologists, physical therapists, and occupational therapists can enroll. But as I said earlier, speech language pathologists cannot enroll until after June 2. So they should not submit an enrollment application until June 2 or later because their effective date for filing independently is July 1.

Nancy Beckley: Thank you so much for that clarification.

Operator: Our next question comes from Michele Hurst your line is open.

Michele Hurst: Hi thank you.

Michele Hurst with Medrium Incorporated, in California. We have kind of a two-part question. The first part is we wanted to know when the notifications went out originally for the effective date, the change.

Jim Bossenmeyer: Well the Federal regulation was published on November 19, 2008.

Michele Hurst: And was that notification sent to the providers or?

Jim Bossenmeyer: That was published in the Federal Register after a notice and comment rulemaking process. CMS discussed the effective date of billing on previous Physician Open Door Forums and there has been information that has been released regarding this change through our Medlearn Matters articles.

Michele Hurst: Okay and the next part of my question is regarding an application that we sent in on a provider who's been seeing patients since November that some information was requested back and so her effective date is actually a March 26 date. And we're wondering how we could appeal that date.

Jim Bossenmeyer: Let us give you a call. What is your number please?

Michele Hurst: It's area code 661-846-3716.

Jim Bossenmeyer: But if an individual disagrees with the effective date of their Medicare billing, that is an appealable action and it can be appealed by notifying the Medicare contractor after you receive your approval letter.

Michele Hurst: Okay great. And then you guys will call us back and we can...

Jim Bossenmeyer: Yes, absolutely, and talk about the specifics for your case.

Michele Hurst: Okay thank you so much.

Operator: Our next question comes from the line of Clara Gomez your line is open.

Clara Gomez: Hi this is Clara Gomez I'm calling from a billing company in South Florida by the name of Avisena.

I've got a question concerning I heard that starting this summer Medicare will start doing random site visits.

And I was wondering for those physicians that have multiple locations in the Medicare files and for what reason they're not servicing patients at one particular location.

Are there certain aspects of how Medicare will pick a location that they'll be site visits on or it always advisable that that physician should delete that location from the files?

Jim Bossenmeyer: That the physician should delete that information from the files.

Clara Gomez: Definitely should delete and when it comes to the random onsite visits?

Jim Bossenmeyer: It is the physician's responsibility to keep their reassignment information current with Medicare. That's easily done looking at the Internet-based PECOS product, which has been available since December of last year. Our random onsite inspections will be focused in some cases—"focused" meaning that they will look at a specific provider or supplier grouping such as

ambulance suppliers or another type of supplier. Or they may look at specific areas where we think we have specific concerns.

Operator: Our next question comes from the line of Linda Guerra your line is open.

Linda Guerra: Hi this is Linda Guerra from Beth Israel Ceacoss Physician Organization in Boston, Mass. Could you just speak a little bit about the effective date, the 30 days now just clarify that for us.

We've heard that the 30 days is the latter of the receipt of the application or when the doctor first saw a Medicare patient and the actual claim in order to update the file by the 30 days.

Jim Bossenmeyer: Yes ma'am.

The - ideally the Medicare enrollment application will be sent in prospectively, meaning that before the practitioner or , the physician begins work at a new clinic or a new practice location they would send in the application prior to starting to see patients at that location.

If that is done, there is no claim retrospectively involved because the application was submitted prior to the physician/practitioner seeing Medicare patients.

Linda Guerra: But that usually does happen, we send them in 30 days before the physician start date, but if the application's rejected for any reason you don't take 45 to 60 days to process the app then if there's a rejection for any reason, you know, we're concerned about the backdating.

Jim Bossenmeyer: If your application is submitted in advance, we will deny applications versus rejecting applications for physicians and non physician practitioners that I discussed earlier that will preserve your data filing.

You will need to then submit a corrective action plan providing the Medicare contractor with the information that was needed in order to fully complete your application.

Linda Guerra: Okay that's helpful thank you. And then just one other question what happens if two separate affiliations are applying at the same time in PECOS for a doctor for example Mass General in Boston (unintelligible).

Jim Bossenmeyer: If the individual has responsibility for their provider enrollment record--not a third party. So an organization such as the hospital that you describe would not have access to that individual's enrollment record.

So if that physician wanted to submit two reassignments at the same time they would be permitted to do so.

Operator: Our next question comes from Tammy Ruiz from California your line is open.

Tammy Ruiz: Hi there thank you so much for taking my call.

My name is Tammy Ruiz; I'm calling from the County of Monterey, Clinic Services Division. We have a situation here in Northern California where we had a change in Medicare for the MAC; we went from NHIC to Palmetto.

The situation we have with the - with a few of our providers is the transition from the NHIC to Palmetto. We had to revalidate probably about 130 of our providers. Several we did not have to revalidate because they were currently linked to the appropriate clinic and we have several clinics.

My question is we have two - three providers that we were previously getting paid from the old MAC. We were getting paid from the current MAC in the latter part of 2008.

And now the current MAC is saying that they have been deactivated since 2006. And that was not the information that we initially got from any other contractor or a MAC.

Jim Bossenmeyer: Well, we would need to take your name and number ma'am. Because...

Tammy Ruiz: Thank you.

Jim Bossenmeyer: ...obviously we're not going to be able to sort this one out over the phone.

Tammy Ruiz: 8-3-1-7-2-8-8-0-8-4. And who will be calling me back?

Sandra Olson: Sandy Olson.

Tammy Ruiz: Thank you.

Sandra Olson: You're welcome.

Operator: Our next question comes from the line of Cheryl West. Your line is open.

Cheryl West: Hi. I have a question about reactivations.

Because my physicians are radiologists and they rotate among many sites, we have found that we are getting denial notices based on a reactivation. But we never receive a reactivation notice. Is there a way that I can get a handle on this so we don't have denials?

Jim Bossenmeyer: Okay. So you're getting claims denials?

Cheryl West: Yes, we're getting claims denials and then with the change in the reactivation process we can only go back 30 days.

Jim Bossenmeyer: Your radiologists should update their enrollment information with Medicare for the different practices where they are planning to work.

Cheryl West: Well we do that. And because they're radiologists and they may not work at a site...

Jim Bossenmeyer: Right.

Cheryl West: ...for a year. Then we submit the claim and we get the deactivation notice or the claim denial.

Jim Bossenmeyer: We are working on a process so that we can send a letter to you when there's a deactivation so that you'd receive notice on that.

Cheryl West: Okay. Because it's a huge problem in trying to get appeal then get the new (P10) within 30 days.

Jim Bossenmeyer: Right. Understood.

Cheryl West: Yes. So we really - do you have a timeline for when this might be corrected?

Jim Bossenmeyer: It's something that we have in our system's queue right now. I can't give you a specific timeline at this moment.

Cheryl West: And can we appeal the denials?

Jim Bossenmeyer: The claims denials?

Cheryl West: Yes. Because what we're getting - because of this new change on April 1, it used to be with reactivations you could go back to the effective date of the enrollment.

Jim Bossenmeyer: You can appeal the effective date of the enrollment. Yes.

Cheryl West: Okay. That helps me. Thank you.

Operator: Our next question comes from Lisa Bortoloni. Your line is open.

Lisa Bortoloni: Hi, this is Lisa Bortoloni from MedBest Medical Management in New York. Can someone please give me the explanation or the details as to when a provider actually signs the application, when Medicare receives the application, what date is actually going to be used as the providers effective date?

Jim Bossenmeyer: The effective date of filing is the date that the Medicare contractor receives the paper application - the 855I that's signed and dated. Or, if it is an Internet-based application, it is the date that the Medicare contractor receives both the electronic submission and the signed and dated application from the provider.

So, on a paper application it's pretty simple. The application is sent to the contractor, it gets stamped with the date that they receive it in their mailroom - that's going to be the beginning date. And so, if you're doing things prospectively, there's no limitation of retrospectively.

And an electronic application, if you submit the application electronically and put the signed and dated Certification Statement in the mail the same day, the

contractor receives it two or three days later: the date that they receive that application and the signed and dated Certification Statement and it gets stamped in, that will be the effective date.

Lisa Bortoloni: So it really doesn't matter on the application on the paper one, where it says date provider started with group or - that's really not going to matter because it all depends on when the contractor receives the application?

Jim Bossenmeyer: Unless it is a future date, yes ma'am.

Lisa Bortoloni: Okay. Thank you.

Operator: Our next question comes from the line and Michelle Butcher your line is open.

Michelle Butcher: Yes, hello. I'm calling from Eye Associates of New Mexico, Ophthalmologist and Optometry. And we've been a Medicare provider for 30 years so obviously there's been multiple versions of the application, et cetera and various authorized officials.

Now last May, May 2008 a revalidation application was sent for the group because we - all our doctors and all our providers bill under the same tax ID number. Whether it's our supplier aspect, medical or optical.

My question is, for this revalidation application I sent May 2008, is that the authorized official that will then register for the PECOS - for all of our Medicare whether it's supplier, whether it's the supplier or the group or the physicians?

Jim Bossenmeyer: The current authorized official that is associated with that practice and the tax identification number would be the s going into PECOS I&A through PECOS, Internet-based PECOS for identification and registration.

Michelle Butcher: But we currently have an Authorized Official for (NS Mado) and a different Authorized Official for TrailBlazer.

Jim Bossenmeyer: As we said earlier, Internet-based PECOS for DMEPOS suppliers is not active at this time.

Michelle Butcher: Oh.

Jim Bossenmeyer: And that will not be available until sometime next year.

Michelle Butcher: Okay.

Jim Bossenmeyer: So, for your purposes right now, you would need the Authorized Official who is on file with TrailBlazers.

Michelle Butcher: And does that person go into this PECOS website you gave me to register?

Patricia Payton: Yes, the Authorized Official is the beginning of the process. Pardon me?

Michelle Butcher: That person will go into that PECOS website you gave me previously and register to give me the authorization to complete the application?

Patricia Payton: Well, he or she registers and there is an entire process that follows. It's not he puts your name in there and bingo you get it. You will eventually go in too. You will download the Security Consent Form, he has to sign it, you need to make sure he signs it, you mail it back in.

One of the documents that we're going to have posted very soon on our website does go through some detail about how that works.

Michelle Butcher: Okay.

Patricia Payton: So you will have something that you can look at that can help you once we get this document up there, it's a nine-pager.

Michelle Butcher: Okay. So if we have a new provider coming like in the next month or two it's probably a better idea to do paper?

Jim Bossenmeyer: Well, the individual practitioner can sign on into PECOS and do that themselves. Or they can choose to do the paper process. Certainly as Pat mentioned earlier today, with Internet-based PECOS, the Medicare contractor can process that much faster.

Right now they're averaging about 25 days for an application after they've received the signed and dated Certification Statement. So it also eliminates many of the common errors that we find in the paper-based application process. So it will be easier for the practitioner to use the Internet-based PECOS process.

Michelle Butcher: And if the practitioner does for him or herself can then the delegated person at a later time go in and make changes and updates for that particular practitioner?

Jim Bossenmeyer: Well, the individual is always responsible for their Medicare enrollment information. So that individual is responsible for updating that information or ensuring that that information that's being updated for themselves is correct and accurate.

Natalie Highsmith: Next question please.

Operator: Our next question comes from the line of Addie Smithel your line is open.
Miss Smithel, are you on the line?

Woman: Addie, you on mute?

Natalie Highsmith: We can hear you.

Addie Smithel: Yes, I'm calling from Fairfax, Virginia. And...

Natalie Highsmith: We can barely hear you it sounds like you're on another phone.

Addie Smithel: Can you hear me?

Natalie Highsmith: There you go.

Addie Smithel: Okay. I'm calling from Inova Physicians in Fairfax, Virginia. I do most of the credentialing for all of our physicians here at the hospital since they are hospitalists. Would I be considered the official delegated person to go in and register all these physicians?

Jim Bossenmeyer: No ma'am you are not. The...

Addie Smithel: I cannot - so someone else - a delegated person has to do it?

Jim Bossenmeyer: No, no. What we've said is that is the individual's responsibility for maintaining their enrollment information. You will not be able to access their enrollment record without their consent.

Addie Smithel: So the physicians have to do it their selves?

Jim Bossenmeyer: They can - we encourage physicians to do it themselves. Or if they choose to use another person they have to take full responsibility for the actions of that individual who is working on their behalf. The physician will still be required to sign and date the Certification Statement.

Addie Smithel: Yes.

Jim Bossenmeyer: And that if their information in that enrollment record that is submitted is incorrect or missing, then the physician is ultimately responsible for the information that is submitted on his or her behalf.

Addie Smithel: Well, previously, you know, we have been letting them complete the paper applications and have them sign. And we submit all the attachments and everything. And anything that has to be updated, you know, we have been doing it. So you're saying that I can no longer do that, they have to be responsible?

Jim Bossenmeyer: No, I'm saying if you - if the physician chooses to have the application submitted by paper-- that process that you have currently can continue. If the physician chooses to submit the Internet application for themselves, Medicare certainly encourages that individual to look at their record and view their enrollment information, making sure that the reassignments are correct and that the information that somebody submitted for them previously is accurate. If they choose to allow somebody else to submit their enrollment application for them, they have to take full responsibility for that.

Operator: Okay, our next question - I'm sorry?

Natalie Highsmith: No, I'm sorry. Go ahead.

Operator: Our next question comes from Gwen Davis. Your line is open.

Gwen Davis: Hi, my name is Gwen Davis I work for the South Carolina Department of Health. In South Carolina we have public health departments in 46 counties across the state.

We have been told by the - I'm not sure if it was the intermediary or the carrier but whoever we were supposed to call. But we cannot be enrolled as a Medicare provider because our services that we would be billing for are provided by nurses rather than physicians.

And - but we are getting rejects from our state Medicaid agency saying that clients have Medicare primary to Medicaid. Do we have to go through the enrollment process to receive a denial of our provider enrollment or is there's some type of documentation or somebody I can email to show the Medicaid agency that we are unable to enroll as a Medicare provider?

Sandra Olson: Gwen, this is Sandy.

Can you give me your phone number so I can give you a call back on this situation?

Gwen Davis: Sure, 8-0-3-4-6-3-6-8-1-3.

Sandra Olson: Okay, thank you, Gwen.

Jim Bossenmeyer: But Gwen, one thing I'd like to - provide some information on you. Medicare will only enroll those providers or suppliers that are eligible to participate in the Medicare program.

So if your organization is not eligible to participate in the Medicare program (perhaps because you're not providing the services directly or you have

individuals that Medicare would not otherwise enroll providing the service), Medicare would deny your enrollment application.

Certainly you always have a right to submit an enrollment application to Medicare to have a formal determination made. But you must be eligible to participate in order to be approved in the Medicare program.

Gwen Davis: Right. What I'm trying to do is see if there's some way I can get that in writing rather than go through the enrollment process. Because our state Medicaid agency wants something from Medicare confirming that we are unable to enroll in order to remove the software restrictions that deny our claims.

Jim Bossenmeyer: Okay.

Gwen Davis: Okay. So Sandee you'll call me back?

Sandra Olson: I will.

Gwen Davis: Thank you.

Operator: And our next question comes from the line of Gary Pulfus. Your line is open. Mr. Pulfus, your line may be on mute. Okay, we'll move on to the next question. Debra Farley your line is open.

Debra Farley: Yes, my name's Debra Farley of Bill Pro Management Systems in Ohio. And we confirmed with (DMS) Regional that a practice location is a location where the provider/supplier renders services to Medicare beneficiary.

Now we take this to mean it's not just an office location but if a provider is seeing patients in a hospital or nursing facility. Are we correct that those

locations must be enrolled also? Or added as a location to the providers already enrolled in Medicare?

(Frank Whelan): Hi, this is (Frank Whelan). I wanted to get a little bit more information. Could I call you offline after this call?

Debra Farley: Yes, my number is 4-4-0-8-5-4-0-2-0-5.

(Frank Whelan): And I'm sorry your name was Debra?

Debra Farley: Yes.

(Frank Whelan): Okay. I will call you this afternoon.

Debra Farley: I thank you.

(Frank Whelan): Sure.

Operator: Our next question comes from the line of Patti Mason, your line is open.

Patti Mason: Hi, my name is Patti Mason. And I handle the credentialing for about over 1000 providers in various different states. And we've been recently informed by our provider enrollment that there's a new ruling that enrollment needs to speak to the provider directly to verify the correspondent's address.

And that the number provided in the correspondent's address has to directly connect to the physician. And I'm wondering where I could find a copy of this ruling or if this is actually correct?

Jim Bossenmeyer: Actually this information is contained in our manuals. And it's in Chapter 10 of the Program Integrity Manual. You can find...

Patti Mason: Well Andrew - I'm sorry. Andrew Finnegan listed our contact at PMS and he had stated that that it's actually a newer ruling. And he did direct me to the manual that for, that was issued in - said was in 2007.

But enrollment is stating that this is actually a new rule and that they actually have to speak to the physician. So even if the physician is not available at that time that they'd have to call back to actually talk to the doctor.

(Frank Whelan): Yes, that is - okay, this is (Frank Whelan).

That's a provision that is currently in Section 5.7 of our provider enrollment instructions. But you can give me your email address; I can email you a copy of that provision.

Patti Mason: Okay. My email is patricia.mason@mckesson.com.

(Frank Whelan): Okay. I will send it to you.

Patti Mason: Great.

And my other question was, is that are billing agencies able to be - I know how you had said the INA, which could be the outside organization or other entity. Now would a billing agency be able to become the INA for a group or is that not allowed?

Jim Bossenmeyer: Well, the...

Patricia Peyton: That's up to the Authorized Official as to who would be doing his provider's enrollments.

Jim Bossenmeyer: And this represents an opportunity for providers and supplier organizations, now that we've simplified the enrollment process using Internet-based PECOS, those Authorized Officials need to make the determination about whether or not they want to do the enrollment process in-house within their own organization, or whether or not they would like to continue to use a billing agent or a clearinghouse or another third party to perform those services for them.

Operator: Our next question comes from Tenna Behm. Your line is open.

Tenna Behm: Hello, I'm calling from Phoenix Physicians, we're emergency medicine providers.

And back about 18 months ago we were told to - that I'm the authorized official for our organizations, we were told to go to IACS and that that's how the electronic enrollment would be done in the future.

And I did that with all of our entities. I set myself up, got approval; have my user ID and password. And now my question is, I have to go through a different process in order to be set up to do electronic enrollment, is that correct?

Jim Bossenmeyer: Yes, you - I think you - 18 months ago you were doing that as part of the physician quality reporting initiative.

Tenna Behm: No, sir, I was doing it because I was told that's how electronic enrollment would be set up.

We did utilize it for PQRI because we needed those reports and I was later told, oh, well, that's how we can get them.

But initially what I was told is that I had to be set up as the security officer for our organizations, we have several organizations. And that that is how we would enter electronic enrollment.

That took a great deal of administrative time. And I don't understand why that information can't be cascaded into your PECOS system, so that many more hours aren't utilized.

I mean I respect that you want to do it electronically and we definitely want that. And as the authorized official I definitely would prefer it because it cuts down on our enrollment time.

But there were hours spent on the phone with the help desk at IACS about electronic enrollment. So, no, sir, if you go back in your communication, electronic enrollment it was going to be done this way. And now it's being changed.

Jim Bossenmeyer: No, the information that you're providing is correct. And due to limitations that we encountered after we released those communications, we were required to establish a separate I&A solution for the Provider Enrollment, Chain and Ownership System. So I understand your concerns.

Operator: Our next question comes from the line of Barb McKitrick. Your line is open.

Barb McKitrick: Hi, this is Barb McKitrick with Southeast Radiation Oncology Group in Charlotte.

And my concern as was voiced earlier, is the reactivation of physicians that only go to centers, you know, periodically. And I tried to reactivate a provider in February and I sent in the 855I because that's all I usually ever sent in to reactivate.

And it was received by our carrier on February 20. And then I got a communication asking for a claim and an 855R. And I asked for clarification on that because I didn't understand why they needed the R because it was reactivating with that group. And that number was tied to that group before.

And so we got it all completed, I got the R and a claim to them the end of March or it might have been April 1 when they actually got to them. And they used a March 1 effective date. And the claims were for January.

Jim Bossenmeyer: Okay.

Barb McKitrick: And I had started this before the new thing started and...

Jim Bossenmeyer: Did...

Barb McKitrick: ...so there was confusion as to what is really required to be sent in. I sent it as fast I understood it. But they didn't abide by the original application date of the February date. They did - when they got every...

Jim Bossenmeyer: Ma'am.

Barb McKitrick: ...they needed...

Jim Bossenmeyer: Ma'am.

Barb McKitrick: ...(unintelligible) and backdated it 30 days.

Jim Bossenmeyer: If you can provide me with your name and number, we'll have somebody get in touch with you and get this resolved for you.

Barb McKitrick: I appreciate that very much. It's Barb McKitrick. The number is 7-0-4-3-3-3-7-3-7-6, extension 2-1-4.

Jim Bossenmeyer: Okay, thank you ma'am.

Barb McKitrick: Thank you.

Operator: Our next question comes from the line of Tanya Matthews. Your line is open.

Miss Matthews, your line may be on mute.

Tanya Matthews: Yes, my question is, once you enroll and you send the certification form back in, is there any other document that you have to send with your application?

Jim Bossenmeyer: Internet-based if you're doing it, are you doing it through the Internet or...

Tanya Matthews: That's through the Internet.

Jim Bossenmeyer: Okay. If the practitioner is going to receive payments directly, so if they have - it's an individual practitioner or a group and they're going to be receiving payments directly, then they're going to be required to submit the Electronic Funds Transfer Authorization Agreement. It's the CMS-855.

Tanya Matthews: Right. But if they're primarily all going to be grouped practitioners.

Jim Bossenmeyer: Okay. If they're all reassigning - if individuals are reassigning to the group - PECOS will also notify you of the other information that you need to submit as part of that application.

Tanya Matthews: And one other - one last thing. How long do you have to send the certification form in once you receive it from...

Jim Bossenmeyer: As we said earlier, you want to get that signed and dated Certification Statement in as soon as possible because that affects your date of filing. So we certainly encourage you to get that in, to submit your enrollment application prospectively before the physician or non-physician practitioner starts to work at the new practice location.

Submit that signed and dated Certification Statement within a few days, no more than seven days of filing that application, because you want to make sure that you're getting the effective date of filing.

Operator: Our next question comes from Nicole Fine. Your line is open.

Nicole Fine: Yes, my name is Nicole Fine. I'm calling from Florida Cancer Specialists.

And my question is, when we're applying for a supplier number for DME do the same rules apply for the effective date that they do when filing a B?

Jim Bossenmeyer: With the DMEPOS supplier, and that actually brings up a good point. The DMEPOS suppliers actually operate under a different set of rules and they can be found in the Federal Register 42 CFR 424.57. They're also in the back of the Medicare enrollment application for DMEPOS suppliers and that's the CMS-855S.

The effective date of filing for a DMEPOS supplier is the date that the National Supplier Clearinghouse approves your Medicare billing privileges. When you submit your application as a DMEPOS supplier, you're required to have - and the national supplier clearinghouse will conduct - a site visit.

There are also new requirements for DMEPOS suppliers, or for certain DMEPOS suppliers, that they will be required to have a surety bond in the

amount of \$50,000. And there's also accreditation that is going to be implemented on October 1 of 2009.

So you want to make sure that you look at the supplier standards found at 422.57. And there are 26 supplier standards. And the effective date of billing is the date NSC National Supplier Clearinghouse approves your enrollment record.

Nicole Fine: Thank you.

Operator: Our next question comes from Melissa Rice. Your line is open.

Natalie Highsmith: Okay, after Melissa we will go ahead and end the call. Go ahead Melissa.

(Gina Hillers): Hi, this is actually Gina Hillers from Health Plus Regional. And we were advised that CMS has recently made a ruling that there's only to be one Medicare group number per tax ID number.

So what we've had to do is actually add our new practices to existing group numbers. And some of these new groups have different remit addresses. And we were told that CMS doesn't have the capability to administer their multiple remit addresses under one existing group number.

I was just wondering, are there any plans in the future to correct this so we can have multiple remit addresses under one group number? And if not, how do you recommend that we sort our payments?

Jim Bossenmeyer: Well, the National Provider Identifier, which was implemented May 23, 2008, establishes the NPI that you will be using for the submission of claims for that organization. It is your choice to have one or more than one NPI's for your organization.

So you need to take a look at that. Medicare will only issue the number of internal billing numbers, or PTANs, that are necessary to effectuate a correct payment. Your claim will come in with an NPI the remittance will go out with that NPI.

(Gina Hillers): Okay.

What we have about 50 to 60 locations and each one has their own individual NPI number. But we've had to; we were told that we had to link them to existing group numbers.

And even though they have different remit addresses we were told that we'd have to use the main one just one remit for each and every one of those locations with those sub-NPI numbers.

Sandra Olson: Can I get your name again, this is Sandee. I'm going to have to give you a call back.

(Gina Hillers): Okay. It's (Gina Hillers). And my phone number is 8-6-4-5-6-0-6-4-5-7.

Sandra Olson: Okay, (Gina), thanks.

(Gina Hillers): Thank you.

Natalie Highsmith: Okay, (Christy) we are past our 3:30 hour here on the east coast. I'm going to turn the call over to Jim Bossenmeyer for closing remarks.

Jim Bossenmeyer: I'd like to thank everybody who participated in today's call. We appreciate the information that was provided to us. And we'll be getting back to those individuals that we said we would either today or tomorrow. So thank you.

Natalie Highsmith: Okay, (Christie), can you tell us how many people joined us on the phone lines.

Operator: Yes, ma'am one moment. This concludes our conference call, you may now disconnect.

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