RURAL HEALTH WORKSHOP

CMS Provider Enrollment: Knowing When to Report Changes and How

WELL-AHEAD

LOUISIANA RURAL HEALTH ASSOCIATION

Speaker

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CMS Provider Enrollment:

Knowing When to Report Changes and How

Louisiana Rural Health Workshop
June 20-22, 2023

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Objectives

- Understanding CMS Provider Enrollment
- Understanding the Workflow of Provider Enrollment
- Understanding When a Change of Information is Required
- Understanding When a Change of Ownership is Required
- Understanding the CMS-29 Form for RHCs

Types of Provider Enrollment

INDIVIDUAL, GROUP AND INSTITUTIONAL

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CMS Resources

https://www.cms.gov/medicare/provider-enrollment-and-certification

Medicare Enrollment for Providers & Suppliers

Information for Physicians, Practitioners, Suppliers, & Institutional Organizations

Access PECOS - the Medicare Enrollment System

Become a Medicare Provider or Supplier

Pay the Medicare Application Fee

Revalidations (Renewing Your Enrollment)

PECOS or Paper?

- Initial Provider enrollment can be done through PECOS or the applications can be dropped to paper.
- Changes in information or a COI can be made on PECOS or by sending hard copy forms.
- Changes in ownership or a CHOW can be made on PECOS or by sending hard copy forms.
- CHOWs which involve a buyer and seller who have different MACs is better done on paper.
- Keep paper copies or print PECOS screens.

Types of Medicare Enrollments

INDIVIDUAL PROVIDER ENROLLMENT

855-0

This type of enrollment is for an individual provider who will only be an ordering or referring provider. This provider will not actually bill services to Medicare.

855-I

This type of enrollment is for an individual provider who will be billing services to Medicare as either an individual or as part of a group. Individual enrollment is made first before reassignment to a group

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https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms855o.pdf

MEDICARE ENROLLMENT APPLICATION

ENROLLMENT FOR ELIGIBLE ORDERING/CERTIFYING PHYSICIANS AND OTHER ELIGIBLE PROFESSIONALS

CMS-855O

See page 1 to determine if you are completing the correct application and page 2 for information on where to mail this completed application.

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855-O: Ordering and Referring Only Providers

Most physicians and eligible professionals (as defined in section 1848(k)(3)(B) of the Social Security Act) enroll in the Medicare program to be reimbursed for the covered services they furnish to Medicare beneficiaries.

However, with the implementation of Section 6405 of the Affordable Care Act, CMS requires certain physicians and eligible professionals to enroll in the Medicare program for the sole purpose of ordering/certifying items or services for Medicare beneficiaries. These physicians and eligible professionals do not and will not send claims to a Medicare Administrative Contractor (MAC) for the services they furnish. The physicians and eligible professionals who may enroll in Medicare solely for the purpose of ordering/certifying include, but are not limited to, those who are:

- Employed by the Department of Veterans Affairs (DVA)
- Employed by the Department of Defense (DOD)/Tricare (moved from list below so the first two bullets are military related while the rest of the bullets are from HHS (ASPE))
- Employed by the Public Health Service (PHS)
- Employed by the Indian Health Service (IHS) or a Tribal Organization
- Employed by Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) or Critical Access Hospitals (CAH)
- Licensed Residents (as defined in 42 C.F.R. section 413.75(b)) in an approved medical residency program
- Dentists, including oral surgeons
- Pediatricians
- Retired physicians who are licensed

Once enrolled, you will be listed on a CMS database and will be deemed eligible to order/certify services and items for Medicare beneficiaries.

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855i.pdf

MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS

CMS-855I

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

SEE SECTION 12 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION.

TO VIEW YOUR CURRENT MEDICARE ENROLLMENT RECORD GO TO: HTTPS://PECOS.CMS.HHS.GOV

855-I: Individual Providers who will bill Medicare

WHO SHOULD COMPLETE AND SUBMIT THIS APPLICATION

All physicians, as well as all eligible professionals as defined in section 1848(k)(3)(B) of the Social Security Act must complete this application to enroll in the Medicare program and receive a Medicare billing number.

Physicians and non-physician practitioners can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper CMS-855I enrollment application. Be sure you are using the most current version.

For additional information regarding the Medicare enrollment process, including Internet-based PECOS and to get the current version of the CMS-855I, go to **http://www.cms.gov/MedicareProviderSupEnroll**.

Complete this application if you are an individual practitioner or eligible professional who plans to bill Medicare and you are:

- Currently enrolled in Medicare to order and certify and want to enroll as an individual practitioner to submit claims for services rendered.
- An individual practitioner or eligible professional who has formed a professional corporation, professional association, limited liability company, etc., of which you are the sole owner.
- Currently enrolled in Medicare and you received notice to revalidate your enrollment.
- Previously enrolled in Medicare and you need to reactivate your Medicare billing number to resume billing.
- Currently enrolled in Medicare and need to enroll in another Medicare Administrative Contractor's (MAC's) jurisdiction (e.g., you have opened a practice location in a geographic territory serviced by another MAC).
- Currently enrolled in Medicare and need to make changes to your enrollment information (e.g., you have added or changed a practice location).
- Voluntarily terminating your Medicare enrollment.

Types of Medicare Enrollments

GROUP PROVIDER ENROLLMENT

855-B

This type of enrollment Is used for a practice that will have multiple individual providers who will bill professional services as a group. Individual providers reassign their individual Medicare payments to the group.

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https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms855b.pdf

MEDICARE ENROLLMENT APPLICATION

Clinics/Group Practices and Other Suppliers

CMS-855B

SEE PAGE 1–2 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

SEE SECTION 12 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION.

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Refer to the complete 855-B Instructions to determine if this type of enrollment or application form is appropriate for what you need to do.

When does an RHC or Hospital need an 855-B Enrollment?

- A new clinic that intends to become an RHC may first open as a fee-for-service clinic and will need an 855-B enrollment when first opening.
- An independent RHC needs an 855-B Enrollment for Medicare Split Billing
- RHC Providers may need to be part of an 855-B group when they bill professional services outside the RHC. For example: surgeries, inpatient rounding, working in the Emergency Department, working for another practice or group.
- Hospitals will usually have one or more 855-B enrollments which are used to bill hospital-based professional services.
- A Critical Access Hospital can elect Method II billing for professional services of hospital-based providers.

Types of Medicare Enrollments

REASSIGNMENT OF INDIVIDUAL BENEFITS TO A GROUP

855-I

This type of enrollment is for an individual provider who will be billing services to Medicare as either an individual or as part of a group. Individual enrollment is made first before reassignment to a group.

855-R

855-B

This type of enrollment Is used for a practice that will have multiple individual providers who will bill professional services as a group. Individual providers reassign their individual Medicare payments to the group.

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https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms855r.pdf

MEDICARE ENROLLMENT APPLICATION

REASSIGNMENT OF MEDICARE BENEFITS

CMS-855R

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

855-R: Reassignment of 855I payments to an 855-B professional group

WHO SHOULD COMPLETE AND SUBMIT THIS APPLICATION

Complete this application if you are reassigning your right to bill the Medicare program and receive Medicare payments for some or all of the services you render to Medicare beneficiaries, or are terminating a currently established reassignment of benefits. Reassigning your Medicare benefits allows an eligible organization/group to submit claims and receive payment for Medicare Part B services that you have provided as a member of the organization/group. Such an eligible organization/group may be an individual, a clinic/group practice or other health care organization.

Physicians and non-physician practitioners, other than physician assistants, can reassign Medicare benefits or terminate a reassignment of Medicare benefits after enrollment in the Medicare program or make a change in their reassignment of Medicare benefit information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper CMS-855R application. Be sure you are using the most current version.

Both the individual practitioner and the eligible organization/group must be currently enrolled (or concurrently enrolling via submission of the CMS-855B for the eligible organization/group and the CMS-855I for the individual practitioner) in the Medicare program before the reassignment can take effect. Generally, this application is completed by the organization/group, signed by the Delegated/Authorized Official of the organization/group and the individual practitioner, and submitted by the organization/group. When terminating a current reassignment, either the organization/group or the individual practitioner may submit this application with the appropriate sections completed and signed.

NOTE: A separate CMS-855R must be submitted for each organization/group where a reassignment is being established or terminated.

Types of Medicare Enrollments

FACILITY PROVIDER ENROLLMENT

855-A

This type of enrollment Is used for a FACILITY that will submit institutional Part A claims to Medicare for facility charges.

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https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms855a.pdf

MEDICARE ENROLLMENT APPLICATION

INSTITUTIONAL PROVIDERS

CMS-855A

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION

SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 52 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

Who is an institutional provider?

WHO SHOULD COMPLETE THIS APPLICATION

Institutional providers can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper enrollment application process (e.g., CMS 855A).

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to *www.cms.gov/MedicareProviderSupEnroll*.

Institutional providers who are enrolled in the Medicare program, but have not submitted the CMS 855A since 2003, are required to submit a Medicare enrollment application (i.e., Internet-based PECOS or the CMS 855A) as an initial application when reporting a change for the first time.

The following health care organizations must complete this application to initiate the enrollment process:

- Community Mental Health Center
- Comprehensive Outpatient Rehabilitation Facility
- Critical Access Hospital
- End-Stage Renal Disease Facility
- Federally Qualified Health Center
- Histocompatibility Laboratory
- Home Health Agency
- Hospice
- Hospital
- Indian Health Services Facility
- Organ Procurement Organization
- Outpatient Physical Therapy/Occupational Therapy /Speech Pathology Services
- Religious Non-Medical Health Care Institution
- Rural Health Clinic ★
- Skilled Nursing Facility

If your provider type is not listed above, contact your designated fee-for-service contractor before you submit this application.

Complete this application if you are a health care organization and you:

- Plan to bill Medicare for Part A medical services, or
- Would like to report a change to your existing Part A enrollment data. A change must be reported within 90 days of the effective date of the change; per 42 C.F.R. 424.516(e), changes of ownership or control must be reported within 30 days of the effective date of the change.

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RHCs are Institutional Facility Providers

- Not just paid a different way
- Certified Facility Type
- Can Be Accredited
- Is Assigned a new, distinct CCN or CMS Certification Number
- A group practice becoming an RHC becomes a facility.
- A provider-based RHC is not considered by CMS to be a department of the hospital.
- PBRHCs may function as departments but it is important to realize that RHCs have different conditions of certification, are assigned an RHC CCN, and are accountable as a separate facility.
- Four states also license Rural Health Clinics in addition to CMS certification.
- Louisiana is the ONLY state that has a licensing option which does consider the RHC as a department of the hospital (Type 3). In Louisiana, an RHC may be subject to requirements which supersede CMS.

Reportable Changes

How to make changes or updates to information originally or previously submitted on a Medicare enrollment

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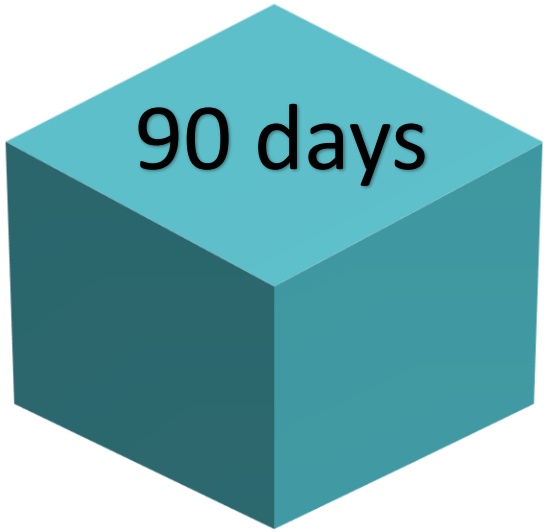
Timeframe for Reporting Changes

- Changes in Ownership (CHOW)
- Changes in Ownership (non-CHOW)
- Changes in Managing Control
- Changes in Authorized or Delegated Officials
- Change in Practice Location/Relocation (Individuals, Groups and Institutions)
- Adverse legal actions/revoked licenses



All other changes, such as:

- Name changes
- Mailing Address
- Billing Company
- Vehicle Information
- Medical Records Storage

Individuals and Groups: Reporting Changes to CMS

§ 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program

(d) ***Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.*** Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes:

(1) Within 30 days—

(i) A change of ownership;

(ii) Any adverse legal action; or

(iii) A change in practice location.

(2) All other changes in enrollment must be reported within 90 days.

Other providers and suppliers: Reporting Changes to CMS

§ 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program

(e) ***Reporting requirements for all other providers and suppliers.*** Reporting requirements for all other providers and suppliers not identified in paragraphs (a) through (d) of this section, with the exception of MDPP suppliers whose reporting requirements are established at § 424.205(d), must report to CMS the following information within the specified timeframes:

(1) Within 30 days for a change of ownership or control, including changes in authorized official(s) or delegated official(s);

(2) All other changes to enrollment must be reported within 90 days.

(3) Within 30 days of any revocation or suspension of a Federal or State license or certification including Federal Aviation Administration certifications, an air ambulance supplier must report a revocation or suspension of its license or certification to the applicable Medicare contractor. The following FAA certifications must be reported:

Changes in Information

- Verify the current enrollment information.
- Know what was first or most recently submitted.
- Correct the information either through PECOS or by submitting a hard copy enrollment form.
- The reason for the application is to change information.

☒ You are **changing** your Medicare information	Medicare Identification Number *(if issued):*	**Go to Section 1B**
	NPI:	

- An authorized or delegated official must certify the changes by signing the application.
- Submit or attach any required documentation.

Change in Ownership (CHOW)

Change of Ownership (CHOW)

A CHOW typically occurs when a Medicare provider has been purchased (or leased) by another organization. The CHOW results in the transfer of the old owner's Medicare Identification Number and provider agreement (including any outstanding Medicare debt of the old owner) to the new owner. The regulatory citation for CHOWs can be found at 42 C.F.R. 489.18. If the purchaser (or lessee) elects not to accept a transfer of the provider agreement, then the old agreement should be terminated and the purchaser or lessee is considered a new applicant.

☒ There has been a **Change of Ownership (CHOW)** of the Medicare-enrolled provider You are the: ☐ Seller/Former Owner ☐ Buyer/New Owner	Tax Identification Number:	**Seller/Former Owner: 1A, 2F, 13,** and either **15** or **16** **Buyer/New Owner: Complete all** sections except **2G** and **2H**

In a CHOW transaction, both the Buyer and the Seller submit an 855 to report the change. The information on both 855s must be consistent.

Change in Ownership (CHOW)

§ 489.18 Change of ownership or leasing: Effect on provider agreement.

(a) *What constitutes change of ownership* —

(1) ***Partnership.*** 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, constitutes change of ownership.

(2) ***Unincorporated sole proprietorship.*** Transfer of title and property to another party constitutes change of ownership.

(3) ***Corporation.*** 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 constitutes change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership.

(4) ***Leasing.*** The lease of all or part of a provider facility constitutes change of ownership of the leased portion.

Change in Ownership (CHOW)

(b) ***Notice to CMS.*** A provider who is contemplating or negotiating a change of ownership must notify CMS.

(c) ***Assignment of agreement.*** When there is a change of ownership as specified in paragraph (a) of this section, the existing provider agreement will automatically be assigned to the new owner.

(d) ***Conditions that apply to assigned agreements.*** An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to, the following:

(1) Any existing plan of correction.

(2) Compliance with applicable health and safety standards.

(3) Compliance with the ownership and financial interest disclosure requirements of part 420, subpart C, of this chapter.

(4) Compliance with civil rights requirements set forth in 45 CFR parts 80, 84, and 90.

Mergers, Acquisitions and Consolidations

Acquisition/Merger

An acquisition/merger occurs when a currently enrolled Medicare provider is purchasing or has been purchased by another enrolled provider. Only the purchaser's Medicare Identification Number and tax identification number remain.

Acquisitions/mergers are different from CHOWs. In the case of an acquisition/merger, the seller/former owner's Medicare Identification Number dissolves. In a CHOW, the seller/former owner's provider number typically remains intact and is transferred to the new owner.

Consolidation

A consolidation occurs when two or more enrolled Medicare providers consolidate to form a new business entity.

Consolidations are different from acquisitions/mergers. In an acquisition/merger, two entities combine but the Medicare Identification Number and tax identification number (TIN) of the purchasing entity remain intact. In a consolidation, the TINs and Medicare Identification Numbers of the consolidating entities dissolve and a new TIN and Medicare Identification Number are assigned to the new, consolidated entity.

> Because of the various situations in which a CHOW, acquisition/merger, or consolidation can occur, it is recommended that the provider contact its fee-for-service contractor or its CMS Regional Office if it is unsure as to whether such a transaction has occurred. The provider should also review the applicable federal regulation at 42 C.F.R. 489.18 for additional guidance.

Effective Date/Approval Date

- You must submit the bill of sale or legal agreements for CHOWs, Mergers, Acquisitions and Consolidations.
- CMS must approve the transfer of the provider number to the receiving party. This may take weeks or months between the legal transaction and the finalized CMS approval.
- The regional office of CMS will grant final approval.
- The regional office of CMS has the discretion to require a new certification survey.

Revalidations

Revalidation
CMS may require you to submit or update your enrollment information. The fee-for-service contractor will notify you when it is time for you to revalidate your enrollment information. Do not submit a revalidation application until you have been contacted by the fee-for-service contractor.

- The revalidation process ensures that the provider information is periodically reviewed and updated.
- Failure to respond to a revalidation request can jeopardize your enrollment status and your reimbursement.

Provider Enrollment Workflow

Understanding the Process

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FOR ALL PROVIDER ENROLLMENT TYPES

Provider submits 855 to MAC

→

MAC analyzes the application (Development)

→

MAC requests additional information or corrections (30-day window)

→

Provider submits additional information if required

NEXT STEPS FOR INDIVIDUALS AND GROUPS

APPLICATION APPROVED OR REJECTED

IF APPROVED, ENROLLMENT IS FINALIZED

PROVIDER NUMBER ASSIGNED

PROVIDER CAN SUBMIT CLAIMS BASED ON EFFECTIVE DATE

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NEXT STEPS FOR INSTITUTIONAL PROVIDERS

APPLICATION APPROVED OR REJECTED

→

IF APPROVED, MAC FORWARDS THE ENROLLMENT TO THE STATE AGENCY

→

SURVEY MAY BE REQUIRED BY STATE AGENCY OR ACCREDITOR

→

SURVEY FINDINGS SUBMITTED TO REGIONAL OFFICE OF CMS BY STATE AGENCY

→

CCN IS ASSIGNED BY CMS REGIONAL OFFICE

→

TIE-IN NOTICE SENT TO MAC

OTHER FORMS

MAY BE NEEDED WITH 855

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FORM #	FORM NAME	REQUIRED FOR
588	Electronic Funds Transfer (EFT) Authorization Agreement	All initial 855s and for CHOWs; changes in banking information
420	MEDICARE PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT	All Part B providers and suppliers
1561	HEALTH INSURANCE BENEFIT AGREEMENT	Institutional Part A providers except RHCs
1561-A	HEALTH INSURANCE BENEFIT AGREEMENT-RURAL HEALTH CLINIC	Rural Health Clinics on Initial enrollment
CMS-29	VERIFICATION OF CLINIC DATA RURAL HEALTH CLINIC PROGRAM	Required initially, at subsequent surveys or when clinic data changes

CMS-29

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB N0. 0938-0074

VERIFICATION OF CLINIC DATA – RURAL HEALTH CLINIC PROGRAM

Medicare program must complete this form and return it to the State agency that is handling the certification process. If a return envelope is not provided, the name and address of the State agency may be obtained from the Center for Medicare & Medicaid Services (CMS) regional office at **http://www.cms.hhs.gov/RegionalOffices/**.
This form is also to be completed when the State agency surveys a participating RHC.

CMS CERTIFICATION NO. (RH1)

STATE/COUNTY (RH2)

STATE REGION (RH3)

I. **IDENTIFYING INFORMATION** (TO BE COMPLETED FOR EACH CLINIC SITE)

NAME OF CLINIC	STREET ADDRESS	
CITY, COUNTY AND STATE	ZIP CODE	TELEPHONE NO. *(Including Area Code)* (RH4)

NAME AND ADDRESS OF CLINIC OWNER(S) (RH5)

II. **MEDICAL DIRECTION**				
III. **CLINIC PERSONNEL** (FULL TIME EQUIVALENTS)	(A) PHYSICIAN (RH6)	(B) NURSE PRACTITIONER (RH7)	(C) PHYSICIAN ASSISTANT (RH8)	(D) OTHER (RH9)

IV. **TYPE OF CONTROL** (check one)	A. INDIVIDUAL	B. CORPORATION	C. PARTNERSHIP	D. GOVERNMENT
1. PROFIT				STATE 3. LOCAL 4. FEDERAL 5.
2. NON- PROFIT				

Is the RHC a provider-based entity to a hospital or critical access hospital (CAH)? Yes ◯ No ◯ (check one) (RH11)

(RH10) If yes, please indicate the CMS Certification Number of the hospital/CAH _____ (RH12)

I certify that this information is true, correct, and complete. I agree, if approval is granted, that all services rendered by the clinic shall be in conformity with Federal, State, and local laws. I further understand that a violation of such laws will constitute grounds for withdrawal of approval under the regulations. If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

SIGNATURE OF AUTHORIZED OFFICIAL	TITLE	DATE
		(RH13)

Form CMS-29 / OMB Approval Expires 05/31/2025

Form Page 1

Completing the CMS-29

- Complete a new CMS-29 to report:
  - New RHC enrollment
  - Subsequent survey or when request by State Agency
  - Change in RHC medical director
  - Change in ownership or entity structure
  - Change in provider composition
- Submitted to the State Agency
- Forwarded to CMS Regional Office
- Do not include with 855A for RHC enrollment. Correction of 855 provider enrollment data is a separate action.
- May be requested by an accreditor
- Be consistent with reporting information

Completing the CMS-29

- Make sure the person completing the form understands the legal ownership and type of entity.
- Include legal name and dba name.
- Make sure the information is consistent with the provider enrollment data.
- Read the directions.
- Report FTEs in .25 increments. FTEs are based on 2,080 worked hours a year.
- For provider-based RHCs, the parent entity's CMS number is entered under the Type of Control section in fields RH 11 and RH 12. This is how the provider-based relationship is connected.
- The information on the CMS-29 is used to populate the QCOR database.

Recap of Provider Enrollment

Types of Provider Enrollment/Forms

855O

Individual Ordering or Referring Provider

855I

Individual Billing Provider

855B

Part B Group Practice

855A

Part A Institutional Provider

https://www.novitas-solutions.com/webcenter/portal/Enrollment_JH/Enrolling

Enrolling & Reporting Changes

Everything you need to know about initially enrolling or reporting changes to your Medicare enrollment, such as address changes or opting out. Find out which forms you need to complete, where to send them, and our current processing time frames.

- **Enrollment Forms & Assistance**
  - Correspondence / Practice Address Additional Information
  - Enroll in Medicare Online (Using PECOS)
  - Enrollment Forms (CMS-855, CMS-588, CMS-460)
  - Which Enrollment Forms Do I Need to Complete?
  - Tips for Completing Enrollment Forms Correctly
  - Medicare Participating Physician or Supplier Agreement (CMS-460) Form *(Instructions)*
  - Clinical Lab Questionnaire Form
  - Individual, Sole Proprietor / Disregarded Entity, Sole Owner, Group Practice Decision Tree
  - Determining your Medicare Effective Date
  - Required Sections on CMS Applications

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https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00004864

Provider Enrollment Status Inquiry Tool

This tool provides the status history of:

- PECOS applications
- Paper–submitted CMS-855/588/20134 applications
- Opt outs
- Rebuttals
- Part B corrective actions plans for denials and revocations
- Part B reconsideration requests for denials, revocations and Medicare effective date determinations

This tool also includes the status of Cycle 2 revalidation applications along with the date of issuance of the revalidation request. **Note:** the typical timeframe for Cycle 2 revalidation applications to be available is approximately 10-15 business days after receipt.

Click to proceed with Your Enrollment Status Inquiry *

Enrollment Status

Search with DCN

Value

Document Control Number (DCN) - The 9-11 character number provided on any correspondence generated by Novitas Solutions related to the application.**Note:** This may also be referred to as the "Reference #".

SUBMIT QUERY

Consistency for EINs with Multiple Enrollments

MACs are now attempting to reconcile provider enrollment identifying data when a legal entity (EIN) has multiple enrollments. You may have received a letter or may have received a letter if your organization has discrepancies in the identifying information as reported on any of your active enrollments.

It is very important that the individual completing the provider enrollment understands what information is needed and has access to other provider enrollment data.

Novitas began sending these letters out about two months ago.

Questions/Comments

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Patty Harper is CEO of InQuiseek Consulting, a healthcare consulting company based in Louisiana. She has over 25 years of healthcare experience in the areas of healthcare finance & reimbursement, health information management, compliance, and practice management. She began her healthcare career as a hospital controller and reimbursement analyst. Patty holds a B.S. in Health Information Administration (cum laude) from Louisiana Tech University. She is credentialed through AHIMA as a RHIA, CHTS-IM, and CHTS-PW. Patty successfully completed AHIMA's ICD-10 Academy in 2011 and was previously been recognized as an ICD-10 Trainer. She is also Certified in Healthcare Compliance (CHC®) thorough the Compliance Certification Board. Patty is a frequent speaker and contributor for national, state and regional and rural healthcare associations on these and other reimbursement-related topics. Patty currently serves on the Board of NARHC.

Questions?

We want to hear from you!

https://www.surveymonkey.com/r/BW59S9F

RURAL HEALTH WORKSHOP

Break with Exhibitors: 2:00 – 2:30 p.m.

WELL-AHEAD

LOUISIANA RURAL HEALTH ASSOCIATION