# Participating Provider Guide to Enrollment and Responsibilities in Medicare

Step-by-Step Guide

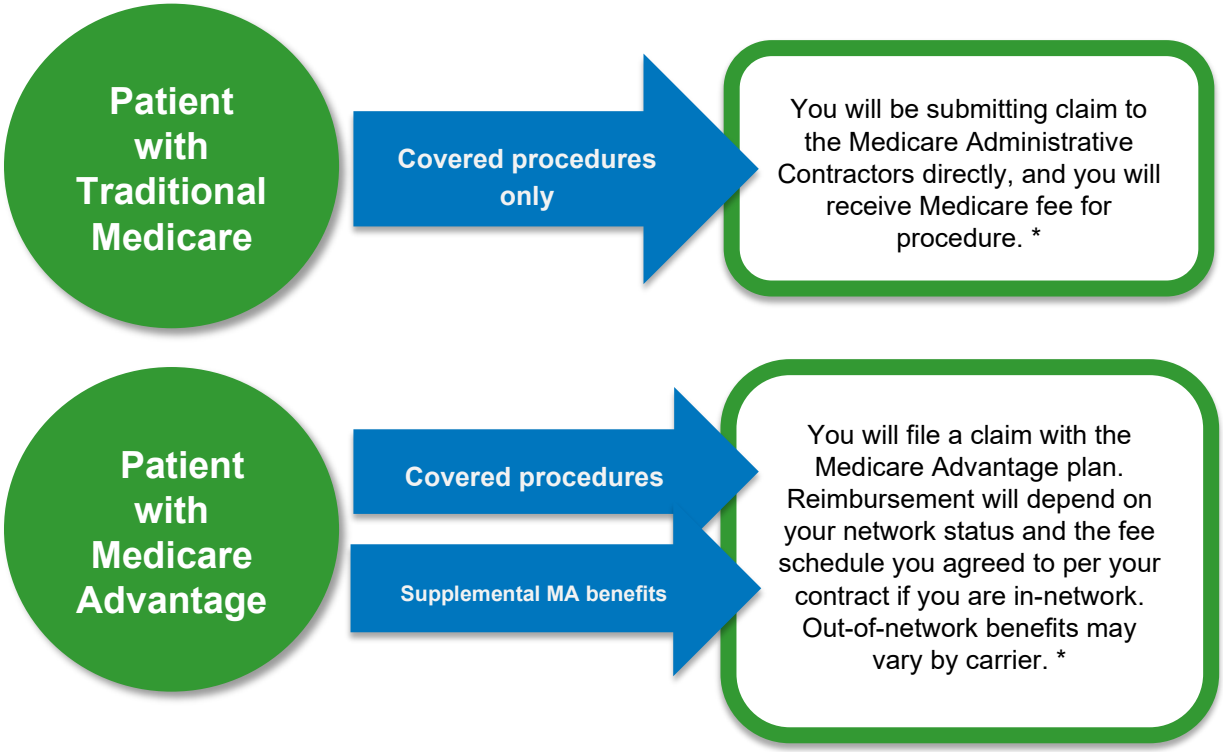


*Figure: Scenarios of how billing occurs when enrolled as a Medicare Participating Provider*

* * For “dual eligible” beneficiaries who are recipients of both Medicare & Medicaid benefits, Medicare will be the primary payer. The beneficiary cannot be balance billed due to Medicaid regulations. Because the Medicare program includes a 20 percent coinsurance provision, providers can be paid up to 20 percent less than the fee schedule amount when treating dual-eligible beneficiaries. Further, payments for dual eligible beneficiaries enrolled in Medicare Advantage plans may be impacted by providers network status and contractual terms.

## How to Enroll in Medicare

The first step in the process to enroll in Medicare is to obtain a National Provider Identifier (NPI) number if you do not already have one. An NPI is a unique identification number that health care providers, health plans, and health care clearinghouses must use for administrative and financial transactions. You can obtain your NPI online

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through the Department of Health & Human Services National Plan & Provider Enumeration System (NPPES), the system to apply for and manage NPIs. You should obtain a Type 1 NPI.[1]

If you are unsure if you have an NPI, you can check by searching the NPPES NPI Registry.

Once you have an NPI, you can enroll in Medicare through the Provider Enrollment, Chain, and Ownership System (PECOS), the system to electronically submit and manage Medicare enrollment information.

Create an account in the CMS Identity & Access Management (I&A) System as this single account can be used to access NPPES for your NPI and PECOS for Medicare enrollment.

Use your I&A system account to obtain your NPI, if needed, through NPPES.

[You also have the option to obtain your NPI using a paper application**.** Complete, sign, and mail the NPI Application/Update Form (CMS-10114) to the address on the form.]

Once you have your NPI, use your I&A system account number to access PECOS and complete the CMS-855I form for physician and non-physician practitioners to enroll as a provider to bill Medicare for covered dental services.

If you are currently enrolled in Medicare for the sole purpose of ordering or referring Medicare-covered services such as as durable medical equipment and supplies or DMEPOS (e.g. sleep apnea devices) and clinical laboratory services billed by another provider—having enrolled through the CMS-855O form, you should use PECOS to enroll using the CMS-855I form to be able to bill for covered dental services. You will not be able to treat Medicare beneficiaries without completing the CMS-855I form.

The CMS-855I form allows you to specify your specialties. In PECOS, you may select Dentistry, Oral and Maxillofacial Surgery, Dental Anesthesiology, Dental Public Health, Endodontics, Oral and Maxillofacial Pathology, Oral and Maxillofacial Radiology, Oral Medicine, Orofacial Pain, Orthodontics and Dentofacial Orthopedics, Pediatric Dentistry, Periodontics, and Prosthodontics. You may also select Unspecified Physician Specialty if one of the specialties above do not apply to your field of dentistry.

The CMS-855I also enables you to take other steps to facilitate billing and payment for services, including:

**Submitting an Electronic Funds Transfer (EFT) Authorization Agreement, to receive electronic payment for services. Visit ADA's guide to enrolling in Electronic Funds Transfer (EFT) if you have not used this before.**

[1] Type I NPI is is for healthcare providers who are individuals, including physicians, dentists, and all sole proprietors. An individual is eligible for only one NPI. Type 2 are healthcare providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.

 

**"Reassigning your benefits" to an organization or group to submit claims and receive payment for services you furnish on your behalf.**

Your Medicare Administrative Contractor (MAC) may request documentation to support or validate information reported on the CMS-855I form. Your MAC may also request documents other than those identified on the form as it determines necessary.

**Choosing to "participate" in traditional Medicare after enrollme**nt

If you want to be a participating provider, submit a completed CMS-460 form, the Medicare Participating Physician or Supplier Agreement, as supporting documentation with your initial CMS- 855I enrollment application.

If you do not submit a CMS-460 form with your initial enrollment, you will be enrolled as a non-participating provider, which is the default status. You have 90 days from your initial enrollment to submit a CMS-640 form to become a participating provider. If you decide to participate within this 90-day timeframe, complete the CMS-460 and send it to your MAC.

You will be able to revisit your participation decision at the end of each calendar year with the decision effective the following year starting January 1. Your MAC manages participation status changes during this open enrollment period that generally runs from mid-November through December 31. This is the only period of time that providers who are currently enrolled in Medicare can change their current participation status. Contact your MAC with questions related to changing your participation status.

Are you unsure if you enrolled previously? Check your status at CMS's Physician and Provider Look Up Tool.

Are you unsure if you opted-out previously? Check your status at CMS's Provider Opt-Out Affidavit Look Up Tool.

 

## RESPONSIBILITIES OF A PARTICIPATING PROVIDER

As a participating provider that is enrolled in Medicare, examples of your responsibilities include:

### 1.) Maintaining enrollment within PECOS

Once you enroll in Medicare, you must update any information that might change, such as a change in practice location, billing service, or license number. These changes must be reported within 90 days of after a change occurs. Additionally, a change of ownership in a practice should be reported within 30 days. Failure to do so could result in rejection of claims, deactivation or "pause" in enrollment, or revocation of enrollment from the Medicare program for up to 3 years.

### 2.) Giving 90 days' notice if you wish to terminate your enrollment in Medicare

If you wish to terminate your enrollment in Medicare (for example, due to retirement or surrendering your license), you must provide 90 days' notice to CMS. You can withdraw through PECOS, which you used to enroll in Medicare, or you may withdraw your enrollment by paper application by going to page 4 of the CMS-855I Form. Please note that withdrawing from Medicare is not the same as choosing to be an opt-out provider. If you wish to opt-out of Medicare as an active provider treating Medicare beneficiaries, you must follow the instructions to opt-out.

### 3.) Obtaining all necessary information for billing before time of service

Providers must determine if Medicare is the primary or secondary payer; therefore, the beneficiary must be queried about other possible coverage that may be primary to Medicare. Failure to maintain a system of identifying other payers is viewed as a violation of the provider agreement with Medicare. Learn more about when Medicare is the primary payer and when it is the second payer.

### 4.) Submitting claims for services to the Medicare Administrative Contractor (MAC) or the Medicare Advantage Plan.

If the patient is a traditional Medicare beneficiary, a provider has 12 months to submit a claim after a patient's visit. By statute, these claims will be paid out within 28 days if submitted electronically or 31 days if submitted as a paper claim.

Medicare Advantage plans have different time limits for submitting claims, and depends on the time limit set by the plan provider. You should contact the plan provider to learn when claims should be submitted.

### 5.) Accepting Medicare approved amount for all Medicare-covered services.

Agreeing to claims assignment means that you accept the Medicare approved amount as payment in full; with no ability to balance bill the beneficiary above that amount.

### 6.) Collecting your full payment.

After the beneficiary reaches the deductible, Medicare typically pays the provider 80% of the approved amount, with the beneficiary responsible for paying the provider the remaining 20% as coinsurance.

Medicare requires participating providers to make a reasonable attempt to collect any coinsurance (and any deductible) from the beneficiary that is not covered by supplemental insurance. A provider must make an individual determination on beneficiary's inability to pay to waive coinsurance. Providers are prohibited from routinely waiving coinsurance as it can be viewed as an inducement to the beneficiary to seek services from that provider.

Direct payment to the provider by the Medicare contractor and the "crossover" of the claim to Medigap or other supplemental insurance are ways that Medicare encourages providers to elect participating status. Another incentive for providers to participate is that Medicare "approved amount" is 5% higher than the approved amount for providers who decide to be non-participating. Additional incentives to encourage providers to participate are that MACs process participating providers' claims more quickly than non-participation providers' claims.

### 7.) Ensuring to respond and return overpayments

An overpayment occurs when a MAC pays a provider more than the amount due and payable by Medicare. Identified overpayments are debts owed to the federal government. MACs are required by law to recover overpayments. Providers have 60 days to pay back an overpayment after discovery of the overpayment or after the MAC sends a demand letter from MAC for repayment. To expediently resolve the matter, you may request immediate recoupment from the MAC for all current and future overpayments that occur, or make a one-time request for a specific overpayment. Unless you specify it as a one-time request, the immediate recoupment request applies to all current and future debts. This will allow the MAC to recover an overpayment by offsetting future payments to satisfy the overpayment amount.

If you do not believe an overpayment occurred, you must submit a rebuttal for overpayment within15 days after receiving a demand letter from a MAC for overpayment. Despite having a 60-day window to pay back an overpayment, interest on the overpayment begins accruing after 30 days. More instructions on dealing with overpayments can be found on CMS's website.

### 8.) Keep necessary documentation for claims and respond to records requests from CMS or MACS in a timely manner

There must be "an exchange of information" in order for a dental service to be covered by Medicare in connection with an intrinsically-linked medical procedure. "Exchange of information" can be a referral form from a physician treating the patient for the covered medical procedure. Proof of this "exchange of information" and other dental records of a Medicare patient must be kept in the patient file in case of an audit occurring from CMS or MACs. Failure to provide information within 90 days, or responding with inaccurate information, could lead CMS to revoke your status as a participating provider for up to 3 years. Your Medicare enrollment can still be revoked for up to 3 years even if you are not able to respond because you changed practice locations without updating your enrollment information in PECOS.

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***DISCLAIMER***

*This resource was current at the time it was published or uploaded onto ADA.org. Medicare laws and policy can and do occasionally change, so it is recommended to remain aware of changes.*

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