Community Based Organization Medicare Enrollment Workshop Forms CMS-855B, CMS-588, CMS-855I and CMS-855R

Mental Health- CBO

Medicare Enrollment

CMS-855B/CMS-855I/CMS-855R

March 2011

Training Topics

- Responsibility for claiming the client's primary insurance plan, insurance verification
- Medicare Policy
- Medicare Clinic/Group Practices Enrollment CMS-855B
- Electronic Funds Transfer (EFT) Authorization Agreement CMS-588
- Medicare Physician, Non-Physician Practitioners Enrollment Application CMS-855I
- Medicare Reassignment of Medicare Benefits CMS-855R
- Medicare Service Codes
- Medicare Exempt services
- Provider Resources

What is a CBO's responsibility in claiming to the client's Medicare plan?

It has always been the responsibility of BHCS-contracted CBO's to bill to a client's primary insurance plan(s) prior to claiming to Medi-Cal. Primary insurance includes Medicare and Private Insurance. In February 2010, DMH implemented a new state software system called Short-Doyle Medi-Cal Phase 2. The new system edits claims to ensure prior billing of eligible services to all Other Health Coverages (OHC), including Medicare. This enhanced edit ability results in a denial of a claim that is not claimed to the primary insurance plan.

Importance of Primary Insurance Payment

- It is essential that primary insurance reimbursement be obtained in order to bill to Medi-Cal.
- To ensure this revenue CBO's must include the following in their process:
  - Verify your clients' primary insurance
  - Work with your clients' primary insurance plans to obtain prior authorization of services
  - Provide requested documentation of client records to the insurance plans to secure payment
  - Meet documentation standards as required by the primary plan

Medicare Enrollment Requirement

- On 2/17/11, DMH issued Information Notice No. 11-04, which requires the Medicare enrollment of contracted Medi-Cal providers.
- As a result, Alameda County BHCS is requiring all Medi-Cal CBO's not currently enrolled with Medicare to apply immediately.
- Providers denied Medicare certification must submit the denial notice to BHCS to be eligible for Medi-Cal reimbursement and reapply for Medicare enrollment annually.

Medicare Provider Policy

- CBO's are required to enroll their agency and all eligible clinicians who are not currently enrolled as Medicare providers. CBO's must submit their Medicare enrollment applications immediately. This includes individual provider applications for the following:
  - Psychiatrist
  - Psychologist
  - Clinical Social Worker
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - Physician Assistant

Potential Loss of Revenue

- CBO services provided by Medicare eligible staff who are not enrolled in Medicare are not claimable to Medicare and will be denied by Medi-Cal, resulting in a significant loss of revenue. BHCS cannot afford this loss of revenue.
- Due to the high volume of Medicare clients served by our CBO's, BHCS must recoup all possible revenue.

Medicare Enrollment

There are three Medicare Enrollment Application documents required for enrollment with Medicare. They are:

- Clinics/Group Practices and Certain Other Suppliers CMS-855B
- Physician and Non-Physician Practitioner CMS-855I
- Reassignment of Medicare Benefits CMS-855R. This allows payment to be made to the CBO for services provided by your staff.

It is essential that the applications be completed appropriately and submitted timely. BHCS Administration has requested the applications be submitted to Palmetto GBA immediately.

Medicare Provider Enrollment Notification

- All CBO's must notify BHCS upon submission of agency and staff enrollment applications. A form for reporting this information is included in your packet today and is available on the BHCS Providers website. Forward the completed form to Provider Relations by Fax to (510) 567-8081 as soon as applications are mailed. CBO's are also required to forward enrollment approval and denial letters to Provider Relations upon receipt.

Medicare Electronic Enrollment Process

Centers for Medicare and Medicaid Services (CMS) has established an Internet-based Provider Enrollment, Chain and Ownership System (PECOS) as an alternative to the paper enrollment process.

Internet-based PECOS will allow the enrollment of :

- Clinics/Group Practices and Certain Other Suppliers CMS-855B
- Physicians, Non-Physician Practitioners CMS-855I
- Reassignment of Medicare Benefits CMS-855R

PECOS Medicare enrollment can be found through the following web site:
http://www.PalmettoGBA.com/j1B (CLICK ON PROVIDER ENROLLMENT APPLICATIONS)
or
http://www.cms.hhs.gov/MedicareProviderSupEnroll

Medicare Electronic Enrollment Process

Prior to using PECOS please read the following two documents which are included in your packet today, see PECOS Information:

1. Guidance on Using Internet-based Provider Enrollment, Chain and Ownership System (PECOS)

2. Medicare Provider and Supplier Organizations: Internet-based Medicare Enrollment is Available in All States and the District of Columbia.

Only individuals whose identities have been verified by CMS and who have been approved by a provider or supplier organization's Authorized Official (AO) may use Internet-based PECOS on behalf of that provider or supplier organization. PECOS may also be used to check on the status of a Medicare enrollment application, make changes in your Medicare enrollment, or view your Medicare enrollment information on file with Medicare.

Medicare Paper Enrollment Process

Because PECOS may not be the best method for most providers, Provider Relations is providing you with a copy of the paper CMS enrollment forms. We will review each of the forms today and some of the required attachments.

The required Medicare Enrollment Application forms are:

- Clinics/Group Practices and Certain Other Suppliers CMS-855B
- Physicians, Non-Physician Practitioners CMS-855I
- Reassignment of Medicare Benefits CMS-855R

Medicare Paper Enrollment Process

- Electronic versions of these forms (pdf format) can be found on the CMS web site: http://www.cms.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp
- We suggest that you complete the forms electronically, print the completed form, and sign in blue ink. Please note that completed CMS-855B, CMS-588, CMS-460 and CMS-855I forms cannot be saved on your computer.
- If you complete the applications manually, we suggest that you use a blue pen.

Completing Clinics/Group Practices CMS-855B

Page 1: Who Should Submit This Application

Clinic/Group Practice

- Complete and submit this application if you are an organization/group that plans to bill Medicare and you are:

  A medical practice or clinic that will bill for Medicare Part B services (e.g. group practices, clinics, independent laboratories, portable x-ray suppliers)

Completing CMS-855B

Page 2: Instructions For Completing and Submitting This Application

- Review this section for relevant information before initiating the application. It is suggested to read the application thoroughly prior to entering data and to be aware of any required supporting documentation. It is very important to complete sections completely and accurately. If a date field asks for mm/dd/yyyy be sure and indicate all fields requested in this format such as 02/01/2011.

Completing CMS-855B

Page 2: Avoid Delays In Your Enrollment

- Read this Section
- Mail your paper application to the California Fiscal Intermediary, Palmetto GBA:

  Palmetto GBA

  Provider Enrollment

  P. O. Box 1508

  Augusta, GA 30903-1508
- We recommend applications be sent certified mail with return receipt to track and confirm delivery date.

Completing CMS-855B Section 1: Basic Information

Page 3: Section 1 - Basic Information Instructions

- This section describes the types of new enrollees and the reasons for the application entered in Section 1A. Once enrolled as a Medicare provider this section also describes the type of changes you may need to make in the future.

Page 4: Section 1A

- The first column allows you to identify the reason for this application. Mark the appropriate box. For the purpose of this application:

  "You are a new enrollee in Medicare"
- Columns 2 and 3 provide you with informational requirements.

Completing CMS-855B Section 1: Basic Information

Page 5-6: Section 1B

- On Page 5, Check all that apply to your situation:
  - ❑ Identifying Information
  - ❑ Final Adverse Actions/Convictions
  - ❑ Practice Location Information, Payment Address & Medical Record Storage Information
  - ❑ Ownership Interest and /or Managing Control Information (Organizations)
  - ❑ Ownership Interest and /or Managing Control Information (Individual)
  - ❑ Billing Agency Information (if applicable)
  - ❑ Authorized Official (s)
  - ❑ Delegated Official (s) (Optional)

- Attachments 1 & 2 on Page 6 do not apply. DO NOT COMPLETE THESE ATTACHMENTS.

Completing CMS-855B Section 2: Identifying Information

Page 7: Sections 2A and 2B1

- Section 2A - Type of Supplier (check one box only)
  CLINIC/GROUP PRACTICE
  - Check "Multi-Specialty Clinic" if your staff includes more than one specialty (e.g., Psychologist, Social Worker, Nurse, Physician, etc.)
  - Check "Single Specialty Clinic" if you employ only one specialty and specify that specialty

- Section 2B1 - Supplier Identification Information
  - Enter your Legal Business Name (The name must match the name reported to the IRS)
  - Tax ID#
  - Other Name, Type of Other Name
  - Identify the type of organizational structure of your agency and your incorporation date and state where incorporated, if applicable

Completing CMS-855B Section 2: Identifying Information

Page 8: Sections 2B2, 2B3 and 2C

- In Section 2B2, enter your agency's State License Information or Certification information, if applicable.
- In Section 2B3, enter your Correspondence Address, the location where you want information directed to your agency. We suggest that this would be directed to the person responsible for the coordination of enrollment and receipt of payment.
- Section 2C is for Hospital providers only.

Completing CMS-855B Section 2: Identifying Information

Page 9: Sections 2D, 2E and 2F

- In Section 2D, enter Comments/Special Circumstances as needed
- Section 2E is applicable to PT and OT Groups only
- Section 2F is applicable to Accreditation for Ambulatory Surgical Centers

Page 10: Section 2G Termination of Physician Assistants (Only)

- This section is not applicable to a new enrollment application

Completing CMS-855B
Section 3: Final Adverse Actions/Convictions

Pages 11-12: Section 3

- Final Adverse Actions/Convictions

  All providers must read the information on Page 11 concerning any Final Adverse Actions That Must Be Reported for your organization or owner.
- Answer the questions on Page 12. If you answer "Yes" to question 1, continue to question 2 and provide the requested Final Adverse History documentation and resolution.

Completing CMS-855B Section 4: Practice Location Information

Pages 13-14: Section 4

- Read the "Instructions" on Page 13 including "Mobile Facility and/or Portable Unit" if applicable

- If you see patients in more than one practice location, copy and complete Section 4A on Page 14 for every unique location/NPI number.
  - Check box "ADD", provide a date (use 02/01/2011) and enter address for each location
  - Enter the Practice Location Name. The name must match your Legal Business Name with the IRS. If you use a different name for the location, enter your Legal Business Name followed by "dba" and the name of the site.
  - Enter the address and contact information
  - Enter the Date you first started rendering services to Medicare clients
  - Enter "Pending" for Medicare identification Number
  - Enter the NPI for the location (Note: You must ensure that the NPI address on NPPES is the same as the address you supply in 4A). If you have multiple NPI numbers for the same location, enter the additional NPI numbers on the lines that follow.
  - Check the Practice Location Type box (Group practice office/clinic) at the bottom of the page

Completing CMS-855B
Section 4: Practice Location Information

Page 15: Section 4B - Where Do You Want Remittance Notices or Special Payments Sent?

- All Medicare payments will be made via electronic funds transfers (you will be completing a CMS-588 EFT Authorization Agreement). This address will be the location where the remittance advice, or special payments will be mailed.
- Check box "ADD" and provide a date (mm/dd/yyyy use 02/01/2011). You can indicate that the address is the same as the practice location or you can indicate a different address by selecting the second box and entering the address below.

Completing CMS-855B
Section 4: Practice Location Information

Pages 15-16: Section 4B - Where Do You Keep Patients' Medical Records?

- If you store patients' medical records (current or former patients) at a location other than the location in Section 4A or 4E, complete Section 4C on Page 16.
- Check box "ADD" and provide a date (mm/dd/yyyy) and enter the address of the storage location. There is space for two locations. If you have more than two locations, attach an additional Page 16 to list your other locations.

Completing CMS-855B
Section 4: Practice Location Information

Page 17: Section 4D - Rendering Services in Patients' Homes

- If you provide services in a client's home, check the "ADD" box and provide a date (mm/dd/yyyy use 02/01/2011). BHCS recommends that you indicate the "Entire State of California" so you will not have to add additional cities if your service provider goes outside of the cities listed on your enrollment.

Completing CMS-855B
Section 4: Practice Location Information

Page 18: Section 4E and 4F

- Complete Section 4E, Base of Operations Address for Mobile or Portable Suppliers, if you have a mobile vehicle in which you are providing services. Check box "ADD", provide a date (mm/dd/yyyy use 02/01/2011) and indicate the "Base of Operations" address. If the address is the same as Section 4A you may skip this section.

- Complete Section 4F, Vehicle Information, if you have a mobile vehicle in which you are providing services. Check the "ADD" box, provide an effective date (use 02/01/2011), enter the Type of Vehicle and Vehicle Identification Number. (Note: You must submit a copy of all health care related permits/licenses/registrations.)

Completing CMS-855B Section 4: Practice Location Information

Page 19: Section 4G - Geographic Location for Mobile or Portable Suppliers Where the Base of Operations and/or Vehicle Renders Services

- Complete this section if you provide services in a mobile vehicle. Otherwise, skip.
- If you provide services, BHCS recommends that you indicate the "Entire State of California" so you will not have to add additional cities if your service provider goes outside of the cities listed on your enrollment.
- Deletions are not applicable on this new provider enrollment application.

Completing CMS-855B
Section 5: Ownership Interest and/or Managing Control Information (Organizations)

Pages 20-22: Section 5

- All providers must read Page 20. This section is used for reporting organizations only, not individual clinicians. If you are a Non-Profit organization pay attention to the section on "Non-Profit, Charitable and Religious Organizations" information.
- On Page 21, complete Section 5A, Organization with Ownership Interest and/or Managing Control Identification Information.

  Complete this section as required as it relates to your agency.

  Note: Your Tax ID number is required in Section 5A. In the Medicare Identification Number(s) area indicate "pending".
- Complete Section 5B regarding Final Adverse History of the Organization.

Completing CMS-855B
Section 6: Ownership Interest and/or Managing Control Information (Individuals)

Pages 23-24: Section 6

- All providers must read Page 23.
- On Page 24, complete Section 6A. This section is requiring you to report at least one owner and/or managing employee. If you have additional individuals to identify, copy Page 24 for each individual. Please read this carefully and report as needed for your agency.
- Complete Section 6B regarding Final Adverse History for each individual reported in Section 6A. Check "Change" and enter the effective date if you are making a change to previously reported information for this individual. Provide the requested Final Adverse History documentation and resolution.

Completing CMS-855B
Section 8: Billing Agency Information

Page 25: Section 8

- A billing agency is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf. This question relates to the billing of Medicare services. Do not list ACBHCS as your billing agent. We only bill your Medi-Cal services not Medicare.
- If your agency will bill on your own behalf, then check the box indicating "Check here if this section does not apply and skip to Section 13." Otherwise complete the requested information.

Completing CMS-855B
Section 13: Contact Person
Section 14: Penalties for Falsifying Information

Pages 26-28: Sections 13 and 14

- Section 13: Provide your contact person's information. If this person is identified as your Authorized Official or Delegated Official, then indicate that in the appropriate box. This is the person Palmetto will contact in the event that they need to clarify information on your application.

- All providers must read Section 14 on Pages 27 and 28 regarding Penalties for Falsifying Information

Completing CMS-855B Section 15: Certification Statement

Page 29 IMPORTANT – READ PAGES 29 AND 30

- This section explains who an Authorized Official (AO) and a Delegated Official (DO) are, and establishes the importance/significance of their role on behalf of your agency. The AO and DO must also be identified in Section 6A. ACBHCS would like to suggest that you appoint at least 2 AOs and 2 DOs. The AO and DO must read Section 15A Certification Statements on Page 30.

- NOTE: Section 15 states (at the bottom of Page 29) that "each Authorized and Delegated Official must have and disclose his/her social security number". Although Sections 15 and 16 do not have a dedicated field to record the AO or DO social security number, please make sure to report the AO and DO social security number in these sections.

Completing CMS-855B Section 15: Certification Statement

Pages 30-31: Sections 15A, 15B and 15C

- The Authorized Official must read Section 15A on Page 30 which contains a Certification Statement
- Complete Sections 15B and 15C on Page 31 with the Authorized Official information and obtain the signature (blue ink preferred) of the appointed Authorized Official.
- All signatures must be original. Stamped, faxed or copied signatures will not be accepted in the processing of your application.

Completing CMS-855B
Section 16: Delegated Official (optional)

Page 32: Section 16

- This section reports your agency's Delegated Official. Although this is optional, ACBHCS highly recommend that you appoint one or more Delegated Officials. Complete 16A and 16B and obtain the appointed Delegated Officials signature (blue ink preferred). All signatures must be original. Stamped, faxed or copied signatures will not be accepted in the processing of your application. The Delegated Official must read Section 15/A Certification Statement.

- NOTE: Section 15 states (at the bottom of Page 29) that "each Authorized and Delegated Official must have and disclose his/her social security number". Although Sections 15 and 16 do not have a dedicated field to record the AO or DO social security number, please make sure to report the AO and DO social security number in these sections.

Completing CMS-855B Section 17: Supporting Documents

Pages 34-46: Section 17

- This section lists the documents that, if applicable, must be submitted with this enrollment application. Please read this carefully and provide all necessary documentation. Check all the appropriate supporting documents for your application on Page 34.
- The CMS-588, Electronic Funds Transfer Authorization Agreement is a required document. A CMS-588 form is included in this training packet.
- The CMS-460, Medicare Participating Physician or Supplier Agreement, must be completed if your organization wants to be a participating provider. CBO's should research the benefits of the participation options before deciding upon your participation status.
- Attachments 1 & 2 on Pages 35 to 46 are not relevant to your application

Completing CMS-855B

Page 47

- CBO's must read the Medicare Supplier Enrollment Application Privacy Act Statement on Page 47.

  You have now completed the Clinics/Group Practices CMS-855B application.

- Please make a copy of this application for your records prior to mailing to Palmetto (Palmetto's mailing address is on slide 16 of this presentation). We suggest that the CMS-855B be sent with the CMS-855I and CMS-855R forms when possible, but you should not delay the submission of the CMS-855B.

Completing the Electronic Funds Transfer (EFT) Authorization Agreement CMS-588

- All payments from Medicare will be processed as an electronic funds transfer. See the CMS-588 Instructions for completion of this form. The form and instructions have been provided in your packet today.

Completing CMS 855I

Page 1: Who Should Complete This Application

- An eligible individual practitioner who will provide services in a group setting should complete the CMS-855I. Providers who will render all of their services in a group setting will complete Sections 1-4 and skip to Sections 13-17 of this application.
- The following are eligible practitioners:
  - Psychiatrist
  - Psychologist
  - Clinical Social Worker
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - Physician Assistant

Completing CMS 855I
Section 1: Basic Information

Page 4: Section 1A

- Physician Assistants enter their Medicare Identification Number (PTAN) and NPI at the top of Page 4. All others skip this line.
- Complete the next section: "If you are reassigning all of your Medicare benefits per Section 4B1 of this application, furnish your Medicare Identification Number (if issued) and your individual (Type 1) NPI here:"

  Medicare Identification Number(s): "Pending" NPI: your individual NPI #
- Reason for Application
  - Check the box indicating "You are a **new enrollee** in Medicare"

Completing CMS 855I
Section 1: Basic Information

Page 5: Section 1B

- Check all that apply
  - Identifying Information
  - Final Adverse Actions/Convictions
  - Practice Location Information, Payment Address and Medical Record Storage Information
  - Individuals Having Managing Control
  - Billing Agency Information

Completing CMS 855I
Section 2: Identifying Information

Page 6: Sections 2A and 2B

- Complete Section 2A, Personal Information, and review for accuracy.

  Note: The provider's name should be coordinated between his/her License, NPI and employee name with your agency.
- Provide all of the information requested, including:
  - Other names used
  - Date and place of birth
  - Social Security Number
  - License information

- Complete Section 2B, Correspondence Address, by entering the provider's clinic site address and contact information.

Completing CMS 855I
Section 2: Identifying Information

Page 7: Section 2C

- Answer the questions of Section 2C, Resident/Fellow Status.
- Check the appropriate boxes for Item 1: "Are you currently in an approved training program as:
  a. A resident?
  b. In a fellowship program?"
  - If the answer to both questions 1a and 1b is "NO", skip questions 2 through 4 and go to Section 2D.
  - If 1a or 1b is "YES", complete items 2 through 4.

Completing CMS 855I
Section 2: Identifying Information

Pages 8-9: Section 2D1 and 2D2

- Section 2D1 is for Physician Only. Check all appropriate medical specialties and write "P" or "S" in front of the box to indicate the following:

  P= primary specialty (one only)

  S= secondary specialty (multiples are allowed)

- Non-Physicians complete Section 2D2 on Page 9 by checking **one** box to indicate the practitioner's non-physician specialty.

Completing CMS 855I
Section 2: Identifying Information

Pages 10-11: Sections 2E, 2F, 2G, 2H, 2I, 2J and 2K

- Complete Sections 2E, 2F and 2G for Physician Assistants only. All others skip to Section 2H on Page 11
- Section 2H is required for Clinical Psychologists only. If "YES", indicate the field of study and attach a copy of the psychology degree.
- Section 2I is for Psychologists billing independently and is not applicable to this application.
- Section 2J is for Physical Therapists and Occupational Therapists only.
- Section 2K is to be completed for Nurse Practitioners and Certified Clinical Nurse Specialists only. Answer the question and provide the information requested if "YES".

Completing CMS 855I

Section 3: - Final Adverse Actions/Convictions

Page 12 and 13: Section 3

- **All providers must read Page 12**, Final Adverse Actions That Must Be Reported: Convictions and Exclusions, Revocations or Suspensions.

- Complete items 1 and 2 as appropriate. If the Answer to item 1 is “YES”, you must attach a copy of the final adverse action documentation and resolution to the application.

Completing CMS 855I
Section 4: Practice Location Information

Pages 14-15: Section 4A and 4B

- Section 4A does not apply to a clinician who is completing this on behalf of the CBO. Do not complete 4A.
- Complete Section 4B on Page 15 to link the individual with all appropriate practice locations. For each location, provide the Organization Name (must match name with the IRS), the Medicare Identification Number ("pending" if not yet enrolled), and the site's NPI.
- Clinicians enrolling on behalf of the CBO must reassign their benefits to the CBO by completing the CMS-855R form. This allows the payment of services to be paid to the agency and not the individual provider.
- Skip to Section 13, Page 22.

Completing CMS 855I
Section 13: Contact Person

Page 22: Section 13

- We recommend that a CBO contact person be identified in Section 13 for all of your organization and individual Medicare enrollment applications. Palmetto will send requests for additional information, and approval and denial letters to the contact person. Identifying the same contact person on all applications will allow the CBO to better monitor the status of the application process and to assist the individual providers as needed.

Completing CMS 855I

Section 14: Penalties for Falsifying Information
Section 15: Certification Statement

Page 23-26: Sections 14 and 15

- All individual providers must read Pages 23 and 24, Penalties for Falsifying Information.

- All individual providers must read Page 25, Certification Statement, and sign and date (mm/dd/yyyy) in the Practitioner Signature Area on Page 26. (use blue ink)

Completing CMS 855I
Section 17: Supporting Documents

Page 27: Section 17

- Check the boxes and attach the required supporting documents:
  - "Mandatory For All Provider/Suppler Types" - It is not necessary to check this box. The CBO will complete the CMS-588 for the EFT.
  - "Mandatory, If Applicable" – Check the first box if you have final adverse actions to report. You must check the third box to indicate you are also completing the CMS-855R form.
- All non-Physicians should attach a copy of their diploma or a degree verification document. If not included, Palmetto will likely request this information when the application is reviewed.
- Applicants born outside of the United States should attach a copy of their passport, permanent resident card, or both a driver's license and Social Security card to verify legal status. If not included, Palmetto will likely request this information when the application is reviewed.

Completing CMS 855I
Privacy Act Statement

Page 28

All providers must read the Privacy Act Statement on Page 28.

You have now completed the 855I application.

Make a copy of the completed application for your records.

Hold the original application for completion of the Reassignment Of Medicare Benefits CMS-855R form.

Completing the CMS-855R

- The Reassignment of Medicare Benefits CMS-855R form allows the CBO to submit your services to Medicare and to receive payment for Medicare Part B services that you have provided.
- The completion of the CMS-855R for each individual provider is required.
- Prior to completing the Reassignment of Medicare Benefits CMS-855R you should have completed the CMS-855I application.

Completing the CMS-855R Section 1: Basic Information

Page 3

- Check the first box under Reason for Application, "You are enrolling or are currently enrolled in Medicare and will be reassigning your benefits to this supplier for the first time." Enter the effective date of 02/01/2011 (mm/dd/yyyy).

Completing the CMS-855R
Section 2: Organization Receiving the Reassigned Benefits
Section 3: Individual Practitioner Who is Reassigning Benefits

Page 4: Sections 2 and 3

- Section 2: Organization Receiving the Reassigned Benefits

  Enter your legal business name, Tax ID#, Medicare Identification Number(s) (pending) and NPI for the respective clinic site(s).

- Section 3: Individual Practitioner Who is Reassigning Benefits

  Enter your name, Social Security Number, "pending" for your Medicare Identification Number and the staff NPI number.

Completing the CMS-855R Section 4: Authorization Statements

Page 5: Section 4

- Read the information in Section 4 regarding authorization statements.
- In Section 4A, enter the practitioner's name, have practitioner sign in the box labeled "Individual Practitioner Signature" and enter the date (mm/dd/yyyy). All signatures must be original (blue ink is preferred). Stamped, faxed or copied signatures will not be accepted in the processing of your application.
- In Section 4B, the CBO Authorized Official or Delegated Official for Medicare must sign and date the form. All signatures must be original (blue ink is preferred). Stamped, faxed or copied signatures will not be accepted in the processing of your application.

Completing the CMS-855R Section 7: Contact Person

Page 6: Section 7

- We recommend that a CBO contact person be identified in Section 7 for all of your organization and individual Medicare enrollment applications. Palmetto will send requests for additional information, and approval and denial letters to the contact person. Identifying the same contact person on all applications will allow the CBO to better monitor the status of the application process and to assist the individual providers as needed.

- All providers must read the Privacy Act Statement on Page 7.

You have now completed the 855R application.

Completed documents

You have now completed the following:

- Clinics/Group Practices Application (CMS-855B)
- Electronic Funds Transfer Authorization Agreement (CMS-588)
- Medicare Participating Physician or Supplier Agreement (CMS-460) OPTIONAL
- Physicians and Non-Physician Practitioners Application (CMS-855I)
- Reassignment of Medicare Benefits Application (CMS-855R)

Note: All signatures must be original (blue ink is preferred). Stamped, faxed or copied signatures will not be accepted in the processing of your application.

Medicare Application Confirmation

- Palmetto GBA will send a letter to the Contact Person confirming receipt of your application.
- A Correspondence Control Number (CCN) will be assigned to each application. The CCN is a reference number that is used to follow-up on the status of your application. You can find the status by entering the CCN at Palmetto's website:

http://www.palmettogba.com/palmetto/IVR.nsf/IVR_Display?openform&Code=J1A

Medicare Enrollment Response

- Medicare will send a letter to the identified Contact Person when the application process has been approved or denied. Palmetto will send separate letters for your agency and each enrolled clinician.
- The letters will include a start date, and Medicare Identification Number (PTAN). BHCS Provider Relations must be informed of this information.
- Please fax a copy of each letter, with your agency name on the fax cover sheet, to Provider Relations (510) 567-8081.

Medicare Enrollment Response

- Forward letters to Provider Relations for the following responses:
  - Your agency is approved as a Medicare provider. The letter will include your start date and agency Medicare Identification Number.
  - Your application is rejected. The letter will include the reason for the rejection.
  - Your agency is denied enrollment as a Medicare provider. The letter will include the reason for denial and options for appeal.
  - Your clinician is enrolled as a Medicare provider. The letter will include the clinician's PTAN, effective date and the Group PTAN(s) the clinician is linked to. Also complete and fax a completed Request for Clinician Staff Number form updating the clinician's Medicare Identification Number (PTAN). (A sample form is included in the packet and available on the BHCS Providers website.)

Service Code

- When the clinicians are enrolled as Medicare providers, the use of additional service codes will be required as well as the codes they currently use. A list of Medi-Cal and Medicare procedure codes has been provided as a separate handout.

Medicare Exempt Services

- When Medicare is the primary insurance plan, the state has adopted an exempt list of staff disciplines, service codes, and service locations that do not require Medicare claiming.
- InSyst has been programmed to bypass the Medicare claiming requirement for these services only.

Medicare Exempt Staff

- DMH has implemented a new edit based on the rendering staff's taxonomy code reported with each service.

- Services billed with taxonomy code prefix's other than those listed below are exempt from Medicare billing:
  - 103 Psychologist
  - 104 Clinical Social Worker
  - 207 Physician
  - 208 Physician
  - 363 Nurse Practitioner
  - 363 Physician Assistant
  - 364 Nurse Specialists

SERVICES EXEMPT FROM MEDICARE CLAIMING

Services excluded from billing to Medicare					
Mode of Service	Service Function	Proc Code	Service Procedure Codes Name	HCPC Code	Medi-Cal Claim Name
05	20 - 29	121	PHF Contract Day	H2013	Psychiatric Health Facility (PHF)
05	40 49	141	Crisis Residential Day	H0018	Adult Crisis Residential
05	65 - 79	165	Adult Residential Day	H0019	Adult Residential
10	20 - 24	221	Crisis Stabilization	S9484	Crisis Stabilization
10	81 - 84	281	Day Care Intens Half Day	H2012	Day TX Intensive Half Day
10	81 - 84	282	Day Care Intens AB3632 Half	H2012	Day TX Intensive Half Day
10	85 - 89	285	Day Care Intens Full Day	H2012	Day TX Intensive Full Day
10	85 - 89	286	Day Care Intens Full-AB3632	H2012	Day TX Intensive Full Day
10	91	291	Day Care Rehab Half Day	H2012	Day TX Habilitative Half Day
10	91	292	Day Care Rehab Half-AB3632	H2012	Day TX Habilitative Half Day
10	95	295	Day Care Rehab Full Day	H2012	Day TX Habilitative Full Day
10	95	296	Day Care Rehab Full-AB3632	H2012	Day TX Habilitative Full Day
15	70 - 78	371	Crisis Intervention	H2011	Crisis Intervention
15	70 - 78	372	Crisis Intervention-AB3632	H2011	Crisis Intervention
15	70 - 78	374	Crisis Intervention FFS	H2011	Crisis Intervention
15	40	381	Individual Rehabilitation	H2017 *	Individual Rehabilitation
15	40	382	Individual Rehab - AB3632	H2017 *	Individual Rehab - AB3632
15	50	391	Group Rehabilitation	H2017 *	Group Rehabilitation
15	50	392	Group Rehab - AB3632	H2017 *	Group Rehab - AB3632
15	58	498	THERAPEUTIC BEHAVIORAL SVCS	H2019	TBS
15	01-08	571	Brokerage Services	T1017	Linkage/Brokerage
15	01-08	572	Brokerage Svs-AB3632	T1017	Linkage/Brokerage
15	09	574	Case Mgmnt Brokerage FFS	T1017	Linkage/Brokerage
15	30	581	Plan Development	H0032 *	Plan Development
15	30	582	Plan Development - AB3632	H0032 *	Plan Development - AB3632
15	70 - 78	690	CCRP Mobile Team Outreach Svs	H2011	Crisis Intervention

*Indicates HCPC Codes were recently changed.

Medicare Exempt Service Locations

- DMH has also identified other instances where Medi-Cal can be billed directly based on the service location. The following service locations are exempt from Medicare claiming:
    - School (Location = 5)
    - Mobile unit (Location = 16)
    - Community (Location= 2, 13, 18)
    - Phone (Location = 3)

Monthly MHS 696 report

The MHS 696 report has been enhanced to indicate all insurance plans on the clients account in InSyst as of 7-1-2010. The report now includes the following insurance information:

INSYST INSURANCE/MEDI-CAL INFORMATION:

Medi-Cal Elig Record for 7/2010 : 12345678A
Insurance Policy Record in InSyst : No Active Policy Record in InSyst
Medicare Policy Record in Insyst : Yes

This enhancement will assist the provider in determining what accounts will not appear on the Medi-Cal Test Claim until a payment or acceptable denial from the primary insurance plan is reported and entered on the clients account in InSyst by ACBHCS

Chart Documentation

Provider Relations is in consultation with BHCS Quality Assurance department to determine if additional training will be required for enrolled Medicare providers on service codes and chart documentation. You will be contacted if training is offered.

Provider Resources

Provider assistance

- Palmetto Provider Contact Center (7 AM to 5 PM) (866) 931-3901
- Eligibility call center to assist providers with basic Medi-Cal benefit questions 1 (888) 346-0605
- Provider Relations assistance 1 (800) 878-1313