July 2020

2019-Novel Coronavirus (COVID-19) Medicare Provider Enrollment Relief Frequently Asked Questions (FAQs)

1. How is CMS using its authority under Section 1135 of the Social Security Act to offer flexibilities with Medicare provider enrollment to support the 2019-Novel Coronavirus (COVID-19) national emergency?

CMS is exercising its 1135 waiver authority in the following ways:

- Establish toll-free hotlines to enroll and receive temporary Medicare billing privileges
- Waive the following screening requirements for temporary billing privileges established and all enrollment applications received on or after March 1, 2020:
    - Application Fee – 42 C.F.R. 424.514 (to the extent applicable)
    - Criminal background checks associated with fingerprint-based criminal background checks (FCBC) – 42 C.F.R. 424.518 (to the extent applicable)
- Expedite any pending or new applications
    - All clean web applications will be processed within 7 business days and all clean paper applications in 14 business days
- Postpone all revalidation actions

2. What are the Medicare Provider Enrollment Hotlines?

CMS has established toll-free hotlines at each of the Medicare Administrative Contractors (MACs) to allow certain providers and suppliers to initiate temporary Medicare billing privileges:

- Physicians
- Non-physician practitioners
- Medicare-approved Ambulatory Surgical Centers (ASCs) converting to a Hospital
- Independent Freestanding Emergency Departments (IFEDs) enrolling as a hospital
- Medicare-approved hospitals establishing skilled nursing facility swing beds to patients unable to find placement in a Skilled Nursing Facility (SNF)
- Pharmacies (e.g. DME suppliers or Mass Immunizers) enrolling as Independent Clinical Laboratories
- New providers establishing temporary locations for the following provider types: Hospitals, End-Stage Renal Disease (ESRD) facilities, Skilled Nursing Facilities (SNFs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) (Refer to FAQ #7 for more details on temporary locations).
    - **Note:** Temporary locations associated with a currently enrolled and certified Medicare provider or supplier who intends to bill Medicare for the services provided under the main provider are not required to be reported to CMS via the Medicare Provider Enrollment Hotline or via the CMS-855 enrollment application.

Physicians and non-physician practitioners may also contact the Medicare Provider Enrollment Hotline to report a change in practice location. The hotlines should also be used if providers and suppliers have questions regarding the other provider enrollment flexibilities afforded by the 1135 waiver.

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3. What are the Medicare Provider Enrollment Hotline numbers and hours of operation?

Providers and suppliers should only contact the Medicare Provider Enrollment Hotline for the MAC that services their geographic area. To locate your designated MAC refer to https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/MACs-by-State-June-2019.pdf.

The hotlines are operational Monday – Friday and at the specified times below.

CGS Administrators, LLC (CGS)
The toll-free Hotline Telephone Number: 1-855-769-9920
Hours of Operation: 7:00 am – 4:00 pm CT

First Coast Service Options Inc. (FCSO)
The toll-free Hotline Telephone Number: 1-855-247-8428
Hours of Operation: 8:30 AM – 4:00 PM EST

National Government Services (NGS)
The toll-free Hotline Telephone Number: 1-888-802-3898
Hours of Operation: 8:00 am – 4:00 pm CT

National Supplier Clearinghouse (NSC)
The toll-free Hotline Telephone Number: 1-866-238-9652
Hours of Operation: 9:00 AM – 5:00 PM ET

Novitas Solutions, Inc.
The toll-free Hotline Telephone Number: 1-855-247-8428
Hours of Operation: 8:30 AM – 4:00 PM EST

Noridian Healthcare Solutions
The toll-free Hotline Telephone Number: 1-866-575-4067
Hours of Operation: 8:00 am – 6:00 pm CT

Palmetto GBA
The toll-free Hotline Telephone Number: 1-833-820-6138
Hours of Operation: 8:30 am – 5:00 pm ET

Wisconsin Physician Services (WPS)
The toll-free Hotline Telephone Number: 1-844-209-2567
Hours of Operation: 7:00 am – 4:00 pm CT

4. What information should I have available when I call the Medicare Provider Enrollment Hotline?

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Individuals will be asked to provide limited information, including, but not limited to, Legal Name, National Provider Identifier (NPI), Social Security Number, a valid in-state or out-of-state license, address information and contact information (telephone number).

Organizations will be asked to provide limited information, including, but not limited to, Legal Business Name, NPI, Tax Identification Number (TIN), address information, contact information and any information pertaining to compliance with conditions of participation as appropriate. See specifics in the questions below.

Note: Where applicable, providers and suppliers are required to submit their Electronic Data Interchange (EDI) information to their servicing MAC to ensure payment. Questions regarding the EDI process should be directed to your MAC.

5. How long will it take the MAC to approve a physician or non-physician practitioner's temporary Medicare billing privileges?

The MAC will screen and enroll the physician or non-physician practitioner over the phone and will notify the physician or non-physician practitioner of their approval or rejection of temporary Medicare billing privileges during the phone conversation.

The MAC will follow up with a letter via email to communicate the approval or rejection of the physician or non-physician practitioner's temporary Medicare billing privileges. Note: Physicians and non-physician practitioners who do not pass the screening requirements will not be granted temporary Medicare billing privileges and cannot be paid for services furnished to Medicare beneficiaries.

6. As a physician or non-physician practitioner, what will be the effective date of my temporary Medicare billing privileges?

Physicians and non-physician practitioners will be assigned an effective date as early as March 1, 2020. They may bill for services furnished on or after the effective date and until the public health emergency is lifted.

7. Can Medicare Part A providers and suppliers establish temporary locations to operate during the COVID-19 Public Health Emergency (COVID-19 PHE)?

Yes. Hospitals, End-Stage Renal Disease (ESRD) facilities, Skilled Nursing Facilities (SNFs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs), may establish temporary locations for the purpose of responding to the COVID-19 PHE in accordance with their state pandemic response plan. These locations include but are not limited to isolation facilities, temporary expansion locations, alternative care sites, convention centers, warehouses, etc.

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If the temporary location is associated with a currently certified and enrolled Part A Medicare provider who intends to bill Medicare for the services provided under the certified and enrolled provider, no additional enrollment actions are required (e.g., the location does not need to be reported on the CMS-855 enrollment application and you are not required to contact the Medicare Provider Enrollment Hotline).

If the location is not associated with a Part A certified and enrolled Medicare provider, the new entity may initiate temporary Medicare billing privileges via the Medicare Provider Enrollment Hotline (see FAQ #3) and will subsequently be certified as a temporary provider, if it meets all applicable, non-waived requirements.

Applicants will be asked to provide limited information, including, but not limited to, Legal Business Name, National Provider Identifier (NPI), Tax Identification Number (TIN), state license, address information and contact information (telephone number). CMS is waiving the following screening requirements:

- Application Fee – 42 C.F.R. 424.514
- Criminal background checks associated with the fingerprint-based criminal background checks (FCBC) – 42 C.F.R. 424.518 (to the extent applicable)

The MAC will screen the Part A provider over the phone, however, temporary Medicare billing privileges will not be established during the phone conversation since additional certification actions are required to be completed that involve the CMS Location Offices (formerly CMS Regional Offices). Once final approval is received from the CMS Location Office, the MAC will notify the Part A provider of their temporary Medicare billing privileges and effective date via email.

8. How long will it take to approve temporary Medicare billing privileges for a Medicare Part A provider?

The MAC will screen the applicant over the phone. Temporary Medicare billing privileges will not be established during the phone conversation for any Medicare Part A providers since additional certification actions are required to be completed that involve the CMS Location Offices (formerly the CMS Regional Offices). Providers who do not pass the screening requirements or the additional certification actions that are required will not be granted temporary Medicare billing privileges and cannot be paid for services furnished to Medicare beneficiaries. Once final approval is received from the CMS Location Office, the MAC will notify the Part A certified provider or supplier of their temporary Medicare billing privileges and effective date via email.

9. How can a hospital add swing-bed services for patients unable to find placement in a Skilled Nursing Facility (SNF) during the COVID-19 PHE?

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Under the COVID-19 PHE blanket waiver entitled, "Expanded ability for hospitals to offer long-term care services ("swing-beds") for patients that do not require acute care but do meet the skilled nursing facility (SNF) level of care criteria as set forth at 42 CFR 409.31", all Medicare enrolled hospitals (except psychiatric and long term care hospitals) that need to provide post-hospital SNF level swing-bed services for non-acute care patients in hospitals can apply for swing bed approval to provide these services, so long as the waiver is not inconsistent with the state's emergency preparedness or pandemic plan.

Under the swing bed waiver during the COVID-19 PHE, hospitals must call the Medicare Provider Enrollment Hotline to add swing bed services.

When calling the Medicare Provider Enrollment Hotline, the hospital must attest verbally to CMS that:

- They have made a good faith effort to exhaust all other options;
- There are no skilled nursing facilities within the hospital's catchment area that under normal circumstances would have accepted SNF transfers, but are currently not willing to accept or able to take patients because of the COVID-19 PHE;
- The hospital meets all waiver eligibility requirements; and
  They have a plan to discharge patients as soon as practicable, when a SNF bed becomes available, or when the COVID-19 PHE ends, whichever is earlier.

These facilities are still required to receive final approval through CMS Locations; therefore, temporary Medicare billing privileges will not be established during the phone conversation and may take additional time since additional certification actions are required to be completed that involve the CMS Location Offices. Once final approval is received from the CMS Location Office, the MAC will notify the hospital of their temporary Medicare billing privileges for the swing beds and effective date via email.

For more information refer to https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf and https://www.cms.gov/files/document/se20018.pdf.

10. Can we convert our Ambulatory Surgical Centers (ASCs) to a hospital during the COVID-19 PHE?

CMS is allowing Medicare-approved ASCs to temporarily enroll as hospitals to help address the urgent need to increase hospital capacity to take care of patients. ASCs can initiate temporary Medicare billing privileges via the Medicare Provider Enrollment Hotline for the MAC that serves their area. ASCs will be asked to provide limited information, including, but not limited to, Legal Business Name, National Provider Identifier (NPI), Tax Identification Number (TIN), state license, address information, signed attestation statement, and contact information (telephone number).

CMS is waiving the following screening requirements:

- Application Fee – 42 C.F.R. 424.514 (to the extent applicable)
- Criminal background checks associated with the fingerprint-based criminal background checks (FCBC) – 42 C.F.R. 424.518 (to the extent applicable)

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The MAC will screen the ASC over the phone, however, temporary Medicare billing privileges will not be established during the phone conversation since additional certification actions are required to be completed that involve the CMS Location Offices (formerly CMS Regional Offices). Once final approval is received from the CMS Location Office, the MAC will notify the ASC of their temporary Medicare billing privileges and effective date via email.

Refer to https://www.cms.gov/files/document/qso-20-24-asc.pdf for more information.

11. How long will it take to approve temporary billing privileges for an ASC converting to a Hospital?

The MAC will screen the ASC over the phone, however, temporary Medicare billing privileges will not be established during the phone conversation and may take up to two business days since additional certification actions are required to be completed that involve the CMS Location Offices. Once final approval is received from the CMS Location Office, the MAC will notify the ASC of their temporary Medicare billing privileges and effective date via email. Note: ASCs who do not pass the screening requirements will not be granted temporary Medicare billing privileges and cannot be paid for services furnished to Medicare beneficiaries.

It should be noted that the ASC cannot be certified/enrolled both as an ASC and hospital at the same time. Therefore, any ASC that is enrolled as a hospital will have its ASC billing privileges deactivated for the duration of the time it is enrolled as a hospital.

12. Are licensed Independent Freestanding Emergency Departments (IFEDs) permitted to enroll as hospitals during the COVID-19 PHE?

Currently, IFEDs can coordinate with an existing Medicare-approved hospital to become a provider-based location and receive reimbursement, through the main hospital. In this case, no additional enrollment actions are required (e.g., hospitals do not need to submit an updated CMS-855A enrollment form for the provider-based location).

Alternatively, IFEDs may temporarily enroll in Medicare as hospitals to provide inpatient and outpatient services to help address the urgent need to increase hospital surge capacity by calling the Medicare Provider Enrollment Hotline. IFEDs in those states that license them (Texas, Colorado, Rhode Island and Delaware) may initiate temporary Medicare billing privileges via the Medicare Provider Enrollment Hotline. IFEDs will be asked to provide limited information, including, but not limited to, Legal Business Name, National Provider Identifier (NPI), Tax Identification Number (TIN), state license, address information, signed attestation statement, and contact information (telephone number).

CMS is waiving the following screening requirements:

- Application Fee – 42 C.F.R. 424.514 (to the extent applicable)

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- Criminal background checks associated with the fingerprint-based criminal background checks (FCBC) – 42 C.F.R. 424.518 (to the extent applicable)

The MAC will screen the IFED over the phone, however, temporary Medicare billing privileges will not be established during the phone conversation since additional certification actions are required to be completed that involve the CMS Location Offices (formerly CMS Regional Offices). Once final approval is received from the CMS Location Office, the MAC will notify the IFED of their temporary Medicare billing privileges and effective date via email. Note: IFEDs who do not pass the screening requirements will not be granted temporary Medicare billing privileges and cannot be paid for services furnished to Medicare beneficiaries.

Refer to https://www.cms.gov/files/document/qso-20-27-hospital.pdf for more information.

13. How can Pharmacies that are currently enrolled in Medicare as DME suppliers or Mass Immunizers enroll to increase COVID-19 testing during the COVIS-19 PHE?

Pharmacies that are currently enrolled in Medicare as a DME supplier or Mass Immunizer and have a valid CLIA certificate can temporarily enroll as Independent Clinical Laboratories to help address the urgent need to increase COVID-19 testing. Pharmacies can initiate temporary Medicare billing privileges via the Medicare Provider Enrollment Hotline.

Pharmacies will be asked to provide limited information, including, but not limited to, Legal Business Name, National Provider Identifier (NPI), Tax Identification Number (TIN), state license, CLIA certificate number, address information, and contact information (telephone number).

CMS is waiving the following screening requirements:

- Application Fee – 42 C.F.R. 424.514 (to the extent applicable)
- Criminal background checks associated with the fingerprint-based criminal background checks (FCBC) – 42 C.F.R. 424.518 (to the extent applicable)

The MAC will screen the pharmacy over the phone, however, temporary Medicare billing privileges will not be established during the phone conversation. The MAC will notify the pharmacy of their temporary Medicare billing privileges and effective date via email within 2 business days.

If the pharmacy is not currently enrolled in Medicare either as a DME supplier or Mass Immunizer and wants to enroll as an Independent Clinical Laboratory, they must submit a CMS-855 enrollment application to their MAC.

Refer to https://www.cms.gov/files/document/qso-20-21-clia.pdf-0 for more information.

14. How long will the Medicare Provider Enrollment Hotline be operational?

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The Medicare Provider Enrollment Hotline will be providing Medicare temporary billing privileges and addressing questions regarding the other provider enrollment flexibilities afforded by the 1135 waiver until the public health emergency declaration is lifted.

15. Can I use the Medicare Provider Enrollment Hotline to submit my initial enrollment or change of information if I am not a provider or supplier type listed above?

All other providers and suppliers, including DMEPOS suppliers, not previously identified, are required to submit initial enrollments and changes of information via the appropriate CMS-855 application. All clean web applications received on or after March 18, 2020, will be processed within 7 business days, and all clean paper applications received on or after March 18, 2020, will be processed in 14 business days. CMS encourages providers and suppliers to submit their applications via Internet-Based PECOS at https://pecos.cms.hhs.gov/pecos/login.do.

16. Will my temporary Medicare billing privileges be deactivated once the public health emergency is lifted?

Medicare billing privileges established via the Medicare Provider Enrollment Hotline are being granted on a provisional basis as a result of the public health emergency declaration and are temporary. Upon the lifting of the COVID-19 PHE declaration, providers and suppliers, with the exception of Ambulatory Surgical Centers (ASCs), will be asked to submit a complete CMS-855 enrollment application in order to establish full Medicare billing privileges. Failure to respond to the MAC's request within 30 days of the notification, will result in the deactivation of your temporary billing privileges. No payments can be made for services provided while your temporary billing privileges are deactivated.

For ASCs that converted to a hospital during the COVID-19 PHE, once the Secretary determines there is no longer a PHE due to COVID-19, the CMS Location Offices will terminate the hospital CCN and send a tie-out notice to the applicable MAC. The MAC will deactivate the hospital's billing privileges and reinstate the ASC billing privileges effective on the date the ASC terminates its hospital status.

For more information on ASCs refer to https://www.cms.gov/files/document/qso-20-24-asc.pdf.

17. Can Medicare fee-for-service rules regarding physician State licensure be waived in an emergency?

The HHS Secretary has authorized 1135 waivers that allow CMS to waive the Medicare requirement that a physician or non-physician practitioner must be licensed in the State in which s/he is practicing for individuals for whom the following four conditions are met: 1) the physician or non-physician practitioner must be enrolled as such in the Medicare program, 2) the physician or non-physician practitioner must possess a valid license to practice in the State which relates to his or her Medicare

enrollment, 3) the physician or non-physician practitioner is furnishing services – whether in person or via telehealth – in a State in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity, and 4) the physician or non-physician practitioner is not affirmatively excluded from practice in the State or any other State that is part of the 1135 emergency area.

In addition to the statutory limitations that apply to 1135-based licensure waivers, an 1135 waiver, when granted by CMS, does not have the effect of waiving State or local licensure requirements or any requirement specified by the State or a local government as a condition for waiving its licensure requirements. Those requirements would continue to apply unless waived by the State. Therefore, in order for the physician or non-physician practitioner to avail him- or herself of the 1135 waiver under the conditions described above, the State also would have to waive its licensure requirements, either individually or categorically, for the type of practice for which the physician or non-physician practitioner is licensed in his or her home State.

18. Can the distant site practitioner furnish Medicare telehealth services from their home? Or do they have to be in a medical facility?

There are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home during the COVID-19 PHE. The practitioner is not required to update their Medicare enrollment to list the home location. For more information on telehealth refer to https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf.

19. I am due to revalidate. Will my due date be extended?

CMS is temporarily ceasing revalidation efforts for all Medicare providers or suppliers. During the COVID-19 PHE , CMS will not issue any new revalidation notices, deactivate providers who fail to respond to revalidation requests, or update the Medicare Revalidation Tool at https://data.cms.gov/revalidation with new revalidation due dates. Revalidation applications submitted to your MAC will continue to be processed but not in an expedited manner. Upon the lifting of the public health emergency, CMS will resume revalidation activities.

20. Will the Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) accreditation and reaccreditation requirements be waived?

Effective July 6, 2020, CMS is resuming all accreditation and reaccreditation activities for DMEPOS suppliers, to include surveys. Surveys may be conducted onsite, virtually or a combination of both depending on the state's reopening plan. All survey activities will be conducted in accordance with the Center for Disease Control (CDC) and local guidelines.

New DME suppliers enrolled after 3/1/2020 without the appropriate accreditation shall

submit a completed application to the Accrediting Organization (AO) with all required supporting documentation within 30 days of notification from the National Supplier Clearinghouse (NSC), to apply for accreditation. Failure to obtain accreditation, will result in the deactivation of your Medicare billing privileges

Similarly, DME suppliers who originally received an extension of their expiring supplier accreditation due to the Public Health Emergency will be contacted by the NSC to begin the reaccreditation process.

21. Are there any flexibilities related to the DMEPOS supplier standards?

The following DMEPOS supplier standards are being waived for newly enrolling DMEPOS suppliers:

- Supplier standard #9 - Business Phone, maintains a primary business telephone that is operating at the appropriate site listed under the name of the business locally or toll-free for beneficiaries.
- Supplier standard #30 - Minimum hours of operation, except as specified in paragraph (c)(30)(ii) of this section, is open to the public a minimum of 30 hours per week.

Effective July 6, 2020, CMS is resuming all DMEPOS provider enrollment site visits and will no longer be waiving supplier standard #7 - *Physical access, maintains a physical facility on an appropriate site*. The inspector will follow all state and local requirements regarding the use of appropriate personal protective equipment (PPE) when conducting the site visit (i.e., masks will be worn in public buildings if required by the state).

22. Has CMS resumed provider enrollment site visits?

Effective July 6, 2020, CMS is resuming all provider enrollment site visits in accordance with 42 C.F.R. 424.517 and 424.518, if applicable to the provider or supplier. For those site visits that require the inspector to enter the premises, the inspector will follow all state and local requirements regarding the use of appropriate personal protective equipment (PPE) when conducting the site visit (i.e., masks will be worn in public buildings if required by the state).

23. I have an application pending with the MAC that was submitted prior to March 1, 2020. When will it be approved?

Pending applications for all providers and suppliers received prior to March 1, 2020 are being processed in accordance with existing processing timeframes. Generally, web applications are processed within 45 days and paper applications within 60 days.

24. I am currently opted-out. Can I cancel my opt-out status early and enroll in Medicare?

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Under the 1135 waiver authority, the opt-out requirements can be waived to allow practitioners to cancel their opt-out early and enroll in Medicare. Opted-out physicians and practitioners can contact their MAC through the Medicare Provider Enrollment Hotline to cancel their opt-out and establish temporary Medicare billing privileges. Opt-out cancellations can also be submitted through mail, email or fax. Temporary Medicare billing privileges will not be established during the phone conversation and may take up to 2 business days since additional actions are required to cancel your opt-out status. Once your opt-out status has been canceled and temporary Medicare billing privileges established, the MAC will notify you via email.

Your Medicare billing privileges are being granted on a provisional basis as a result of the public health emergency declaration and are temporary. Upon the lifting of the COVID-19 PHE declaration, you will be asked to submit a complete CMS-855 enrollment application in order to establish full Medicare billing privileges. Failure to respond to the MAC's request within 30 days of the notification, will result in the deactivation of your temporary billing privileges. No payments can be made for services provided while your temporary billing privileges are deactivated.