Medicare Mental Health Workforce Coalition

Medicare 301:

Navigating the Medicare Provider Enrollment Process and Physician Fee Schedule: A Primer for Counselors and MFTs

Sponsored by the Medicare Mental Health Workforce Coalition / **Presented by** NBCC

June 29, 2023

Meeting Details

1. **Closed Captioning** is enabled and attendees can turn CC on or off as they desire.

2. **Interpreter Phone Number:** 305-224-1968 **Webinar ID:** 862 6451 2157 **Passcode:** 684539

3. **Session Evaluation** / **Take Our Evaluation Survey** (CE credit for live attendance only)

4. Webinar will be posted on NBCC website a few days following the webinar.

View Medicare 101 Video **View Medicare 201 Video**

5. **Q&A:** Please add your questions in the Q&A box at any time during the meeting.

Medicare Mental Health Workforce Coalition Members

- American Association for Marriage and Family Therapy
- American Counseling Association
- American Mental Health Counselors Association
- Association for Behavioral Health and Wellness
- California Association of Marriage and Family Therapists
- Centerstone
- Center for Medicare Advocacy
- Michael J. Fox Foundation for Parkinson's Research
- National Association for Rural Mental Health
- National Association of Community Health Centers
- National Association of County Behavioral Health and Developmental Disability Directors
- National Board for Certified Counselors
- National Council for Mental Wellbeing
- National Council on Aging
- Network of Jewish Human Service Agencies
- The Jewish Federations of North America

Learning Objectives

Attendees will hear from experts on the key implementation features of Medicare Part B coverage, including provider implications, in preparation for the proposed Medicare program regulatory process and rules scheduled for public comment in July.

Review steps and actions to enroll in the traditional Medicare fee-for-service program (Parts A and B) prior to Jan. 1, 2024.

Identify actions providers will take to engage Medicare Advantage (Part C) behavioral health insurance plans to secure participation on individual networks and panels.

Describe key components of the Medicare Physician Fee Schedule, how reimbursement rates are determined, and implications for practitioners.

Respond to enrollment questions, the Medicare Physician Fee Schedule, and potential next steps in the implementation of Medicare Part B coverage.

Gina Mendola, MSW

Gina Mendola serves as business function lead with the Provider Enrollment and Oversight Group in the Center for Program Integrity at the Centers for Medicare & Medicaid Services (CMS). She is responsible for providing operations and policy guidance related to Medicare provider enrollment. She works with multiple Medicare Administrative Contractors, including Noridian Healthcare Solutions; First Coast Service Options, Inc.; and Novitas Solutions, Inc.

She also works with the National Site Visit Contractors, Deloitte SVS West PMO, and Palmetto GBA. Prior to joining CMS in 2019, she was a social worker, and she has over 10 years of experience in the health care field. Mendola received both a Bachelor of Arts in community and mental health with a minor in counseling and a Master of Social Work from the University at Buffalo.

Jeanne L. Vance, JD

Jeanne Vance is a health care transactions and regulatory attorney who is a partner with the Sacramento-based law firm of Weintraub Tobin. Vance has expertise in Medicare and Medicaid payment and enrollment matters, health care operations, and health care mergers. She provides outside counsel regulatory support to implement large-scale corporate reorganizations, name and branding changes, and change of control transactions for California-based health care providers. Vance advises health care professional groups and associations regarding health care licensing and payment requirements for compliant business structures. She advises on ongoing health care compliance obligations as a condition of participating in government payment programs.

Vance is currently the Chair of the Regulation, Accreditation, and Payment Practice Group of the American Health Law Association (AHLA) and was previously the president of the Sacramento Health Law Committee and a vice chair of the California State Bar Health Law Committee. Vance received her law degree from the University of California Law, San Francisco, and her undergraduate degree from Mills College, in Oakland, California.

Provider Enrollment 101

Medicare Mental Health Workforce Coalition

June 29, 2023

Presented by

Gina Mendola

Health Insurance Specialist

Division of Enrollment Policy & Operations
Provider Enrollment & Oversight Group
Centers for Medicare & Medicaid Services

Overview

- Introduction to Medicare
- Provider Enrollment Overview
- Processing, Screening, and Verification
- Other Submission Types

Introduction to Medicare

What Is Medicare?

Medicare is a federal health insurance program for:

- People 65 and older
- Certain younger people with disabilities
- People of any age with End-Stage Renal Disease

Different parts of Medicare help cover specific services (A, B, C, and D).

Medicare Part B (Medical Insurance)

Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

- Physician/Non-Physician Practitioner Services
- Clinic/Group Practices
- Independent Diagnostics Testing Facilities (IDTF)
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers
- Medicare Diabetes Prevention Program (MDPP) suppliers

Mental Health Counselors & Marriage and Family Therapists

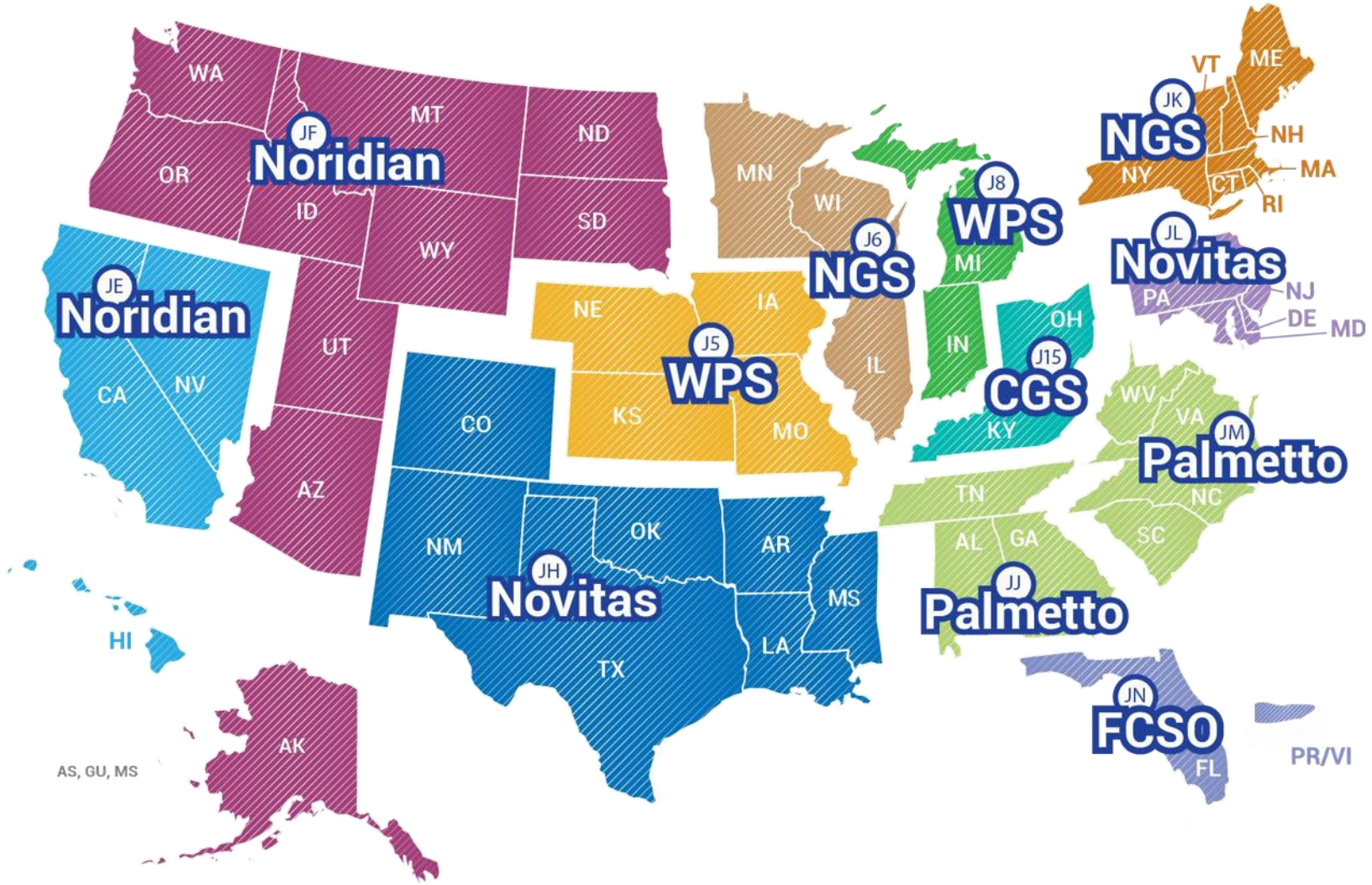
- Effective January 1, 2024
- Requirements:
  - Master's or doctoral degree qualifies for license
  - Licensed and/or certified by state in which services are furnished
  - 2 years of clinical supervision
  - Meets other requirements set by the Secretary
- Payment: 80% of the lesser of the actual charge for the services or 75% of the amount determined for payment of a psychologist

What Is a Medicare Administrative Contractor (MAC)?

A private health care insurer that has been awarded a geographic jurisdiction to:

- Enroll providers in the Medicare program
- Process Medicare claims (Part A/B and DME)
- Respond to provider inquiries
- Educate providers about Medicare billing requirements

A / B MACs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DE
MD
HI
AK
AS, GU, MS
PR/VI
JE
Noridian
JF
Noridian
JH
Novitas
J5
WPS
J6
NGS
J8
WPS
J15
CGS
JJ
Palmetto
JM
Palmetto
JK
NGS
JL
Novitas
JN
FCSO

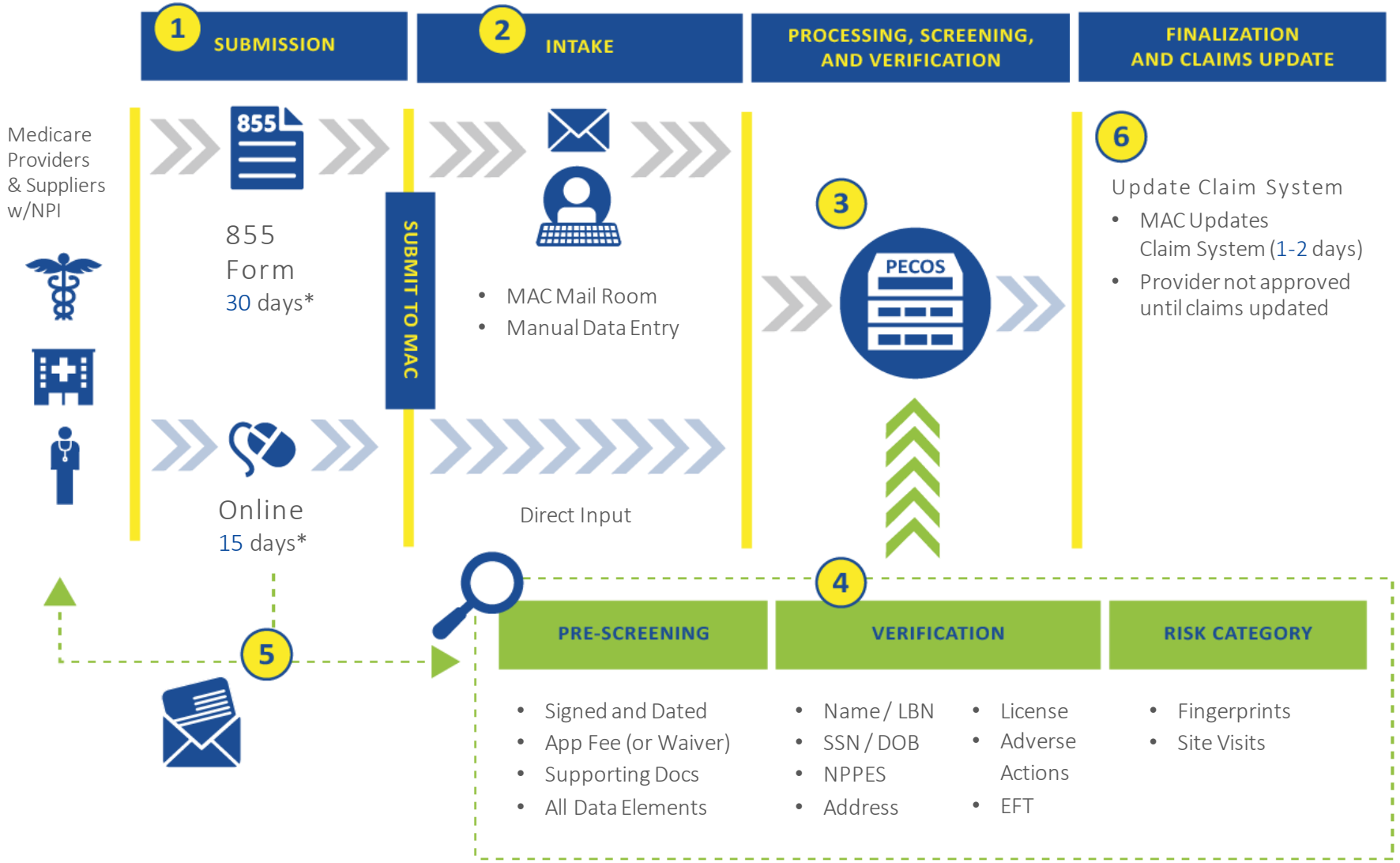
Provider Enrollment Overview

Provider Enrollment Regulations / Statutes

Establishes enrollment requirements, conditions for participation, and payments

- The Social Security Act (1861)
- Federal regulations (42 CFR 424)
- Program Integrity Manual 100-08, Chapter 10

How Enrolling Works



Identity & Access Management System (I&A)

Create an account in I&A to access and manage access to different programs

- **National Plan & Provider Enumeration System (NPPES) -** apply for an NPI
- **Provider Enrollment Chain and Ownership System (PECOS)** – enroll, revalidate, and report changes to your enrollment information
- **Electronic Health Record (EHR)** - register to receive EHR incentive payments

National Provider Identifier

- **Type 1**
  Individual health care providers (i.e., physicians, dentists, chiropractors, physical therapists)
- **Type 2**
  Organizational health care providers (i.e., hospitals, home health agencies, clinics, labs, group practices, suppliers of durable medical equipment)

Providers must obtain an NPI prior to enrolling in the Medicare Program.

Health care providers can apply for NPIs in one of three ways:

- Online via National Plan & Provider Enumeration System (NPPES)
- Paper NPI Application/Update Form (CMS-10114)
- Electronic File Interchange (EFI) whereby an approved EFI Organization can submit the health care provider's application on their behalf (i.e., through a bulk enumeration process)

NPPES Registry (for online queries):
https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do

Taxonomy Codes vs. Specialty Types

Taxonomy Codes

- Providers select a taxonomy code when applying for an NPI
- Uniquely identifies providers in order to assign them NPIs, not to ensure that they are credentialed or qualified to render health care
- May or may not be the same category used by Medicare for enrollment purposes

Specialty Types

- Self-designated on the CMS-855 application
- Describes the specific type of medical practice or services provided
- Used by CMS for enrollment and claims processing

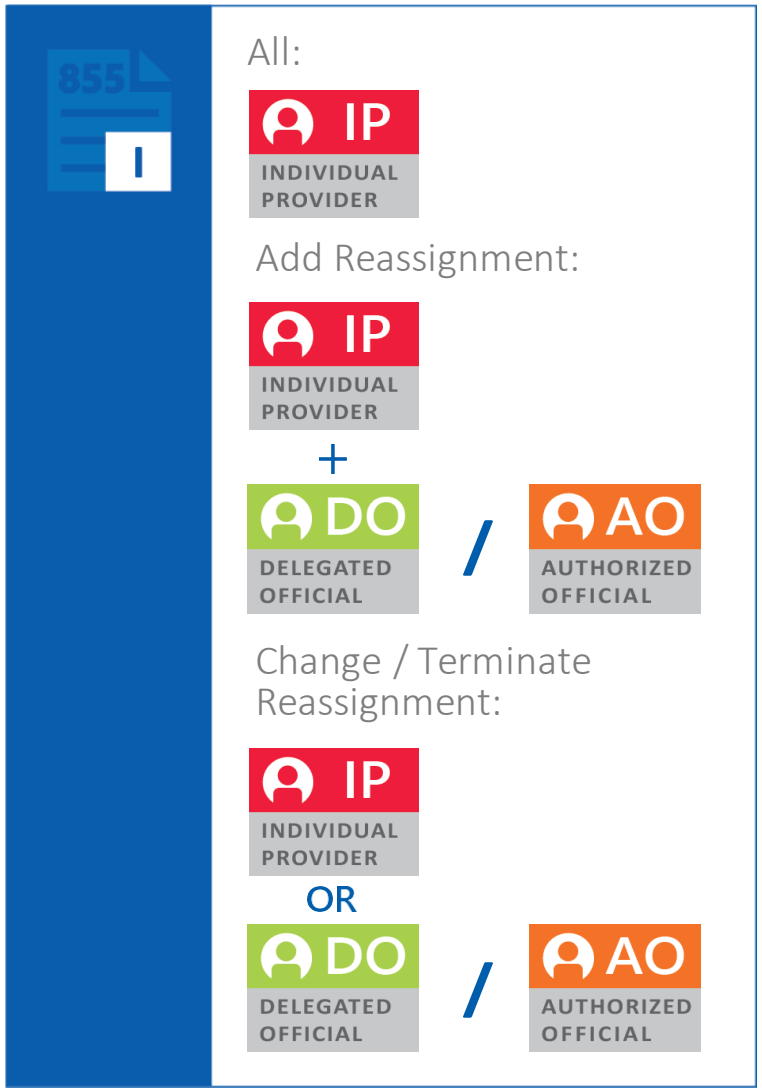
Taxonomy / Specialty Crosswalk

- CMS crosswalks the types of providers/suppliers who are eligible to enroll in Medicare with the appropriate taxonomy codes
- Can be accessed at data.cms.gov/Medicare-Enrollment/CROSSWALK-MEDICARE-PROVIDER-SUPPLIER-to-HEALTHCARE/j75i-rw8y
- Updated on a quarterly basis

CMS-855 Enrollment Applications

- **CMS-855I** Physicians and Non-Physician Practitioners
  (Part B, non-DME Individuals)
- **CMS-855R** Reassignment of Medicare Benefits
  (Supplemental to CMS-855I form)
- **CMS-855B** Clinics/Group Practices and Certain Other Suppliers
  (Part B, non-DME Suppliers)

Who Can Sign the Enrollment Application?



CMS-855 Submittal Reasons

- New Enrollee (Initial)
- Change of Information
- Revalidation
- Reactivation
- Voluntary Withdrawal

CMS-588 Electronic Funds Transfer (EFT) Agreement

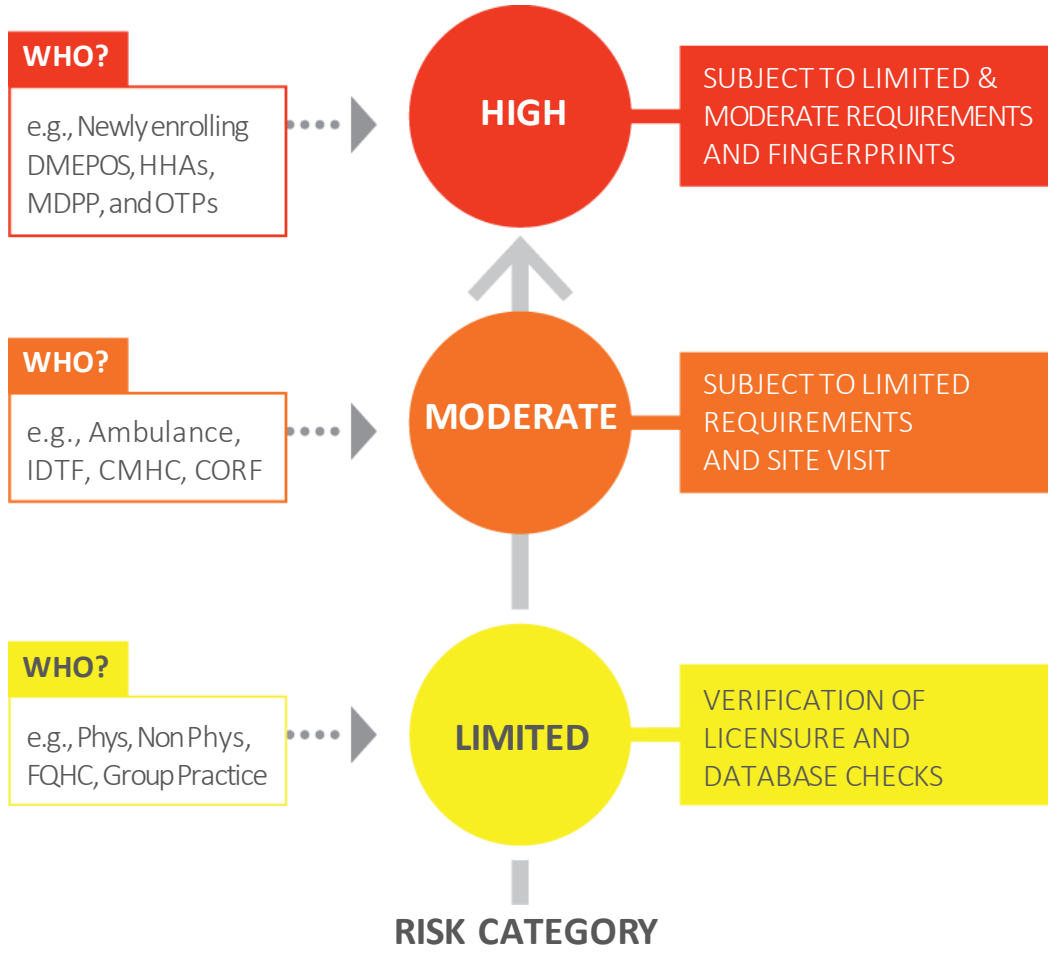
- All providers must receive Medicare payments via EFT
- Must include a copy of a voided check or bank letter verifying account information
- Once an EFT is established, any changes in EFT information will be verified by the MAC with an authorized/delegated official or contact person
- Providers who reassign all their benefits to a group are *not* required to submit an EFT agreement

Processing, Screening, and Verification

Screening Levels

Screening level may be elevated to "high" if:

- Excluded from Medicare/other Federal Health Care program
- Terminated from Medicaid
- Applied for Medicare within 6 months after temporary moratorium
- Within the last 10 years, you had:
  - Medicare payment suspension
  - Medicare billing privileges revoked
  - Final adverse action(s)



What Causes Delays?

need at least
1 round of corrections

- Missing Documents

  CMS 588 EFT, voided check,
  bank letter, education documentation,
  par agreement, cert term page

- Missing Fields (missing signature/date)
- Wrong Signature (paper)
- Incorrect Information

How the MAC develops for missing information

Contacts the…

1. Contact person (sec 13)
2. Individual provider (sec 2)
3. Authorized or Delegated Official (sec 15/16)

By…

- email
- fax
- phone
- letter

30
days to respond

No response?

- delays
- rejections
- later effective date

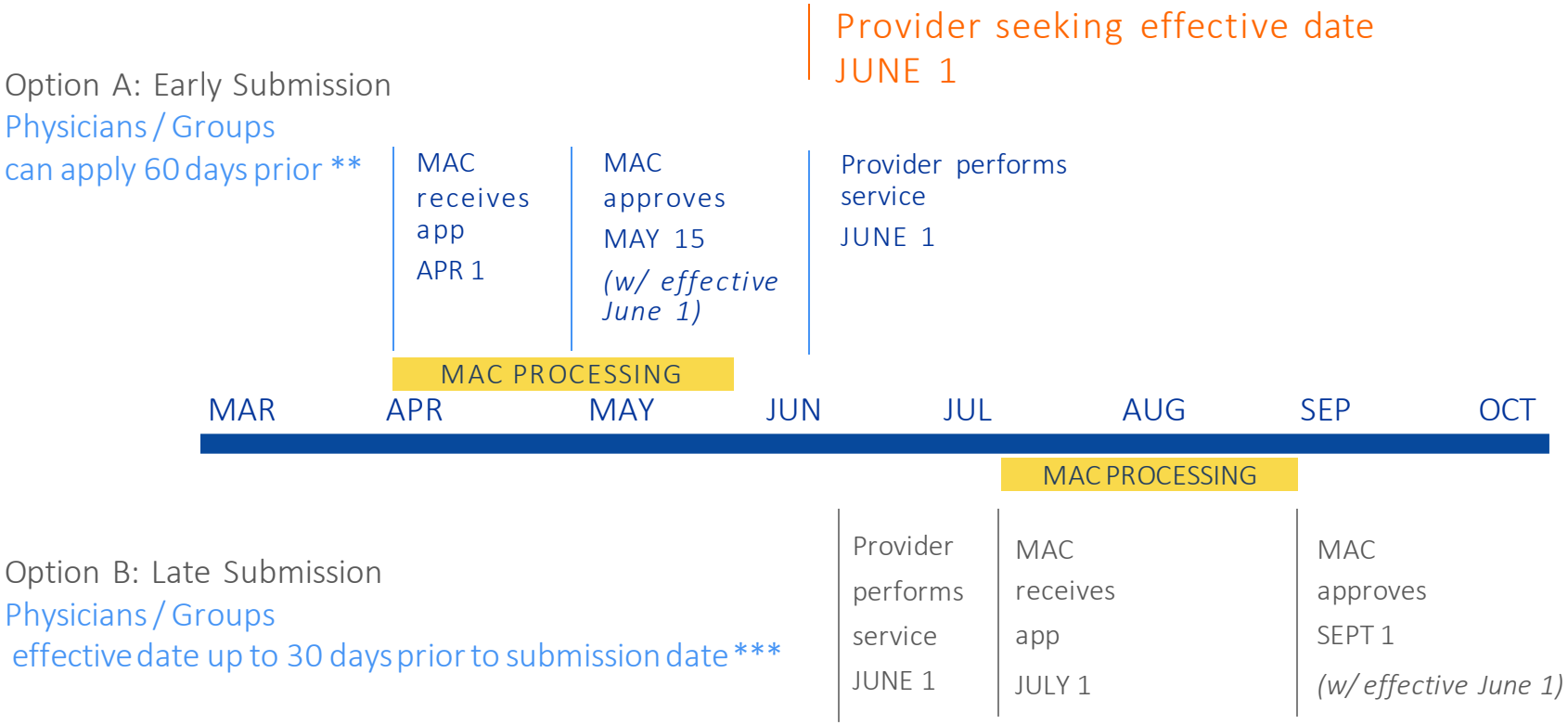
Approved

- The enrolling provider/supplier has been determined to be eligible under Medicare rules and regulations to be granted Medicare billing privileges
- Provider is not approved until claims system is updated (within 1 – 2 days)
- Approval letter is sent to the contact person. If no contact person is listed, the letter is sent to the provider at their correspondence address.

Medicare Effective Dates

Effective date is the later of:

- Application Receipt Date
- Date of first services at a new location (up to 30 days prior to application receipt)



** Must be in compliance at requested effective date (operational, licensed)

What Is a PTAN?

- A Medicare-only number issued to providers upon enrollment to Medicare
- Used to authenticate the provider when using the Interactive Voice Response (IVR) phone system, internet portal, or on-line application status
- The PTAN's use should generally be limited to the provider's contact with their MAC
- The NPI must be used to bill the Medicare program

Physician / Non-Physician PTANs

- Individuals are assigned PTANs based on their private practice and group affiliations (i.e., sole proprietor, reassignment of benefits)
- Individuals who reassign their benefits receive a member PTAN for each group PTAN they reassign to
- A sole owner would have a Group PTAN assigned for the business and a member PTAN for themselves

Group / Supplier PTANs

- PTANs are assigned per EIN, per state
- An existing provider would require a new PTAN if:
  - Adding a new location in a different payment locality in the same state
  - Enrolling a different provider type
  - Exception: Hospitals that receive a PTAN per department

Other Submission Types

Changes of Information

- You are submitting an enrollment application to notify Medicare of a change(s) to your enrollment information

CHANGE OF PRACTICE LOCATION

CHANGE OF CORRESPONDENCE ADDRESS

CHANGE OF OWNERSHIP

Changes of Information continued

- **Within 30 days**
  - Change of ownership or control, including changes in authorized or delegated official(s)
  - Adverse Legal Action (e.g., suspension or revocation of any state or federal license)
  - Change in practice location (includes any new reassignments)
- **Within 90 days**
  - All other changes to enrollment

Note: *Timeframes may vary by provider type.*
Refer to SE1617 on CMS.gov for more information

Revalidation

- Verify the accuracy of your enrollment information that exists on file with Medicare
- DME suppliers revalidate every 3 years and all other providers/suppliers every 5 years

Resources

cms.gov

- CMS-855 processing guides
- MAC contacts: (search for Medicare enrollment contact")

888-734-6433

PECOS Help Desk (EUS)

cms.gov/Revalidation

- search all records online
- view and filter online spreadsheets
- export to Excel, or connect to with API

PECOS.cms.hhs.gov account creation, videos, providers resources , FAQs

ProviderEnrollment@cms.hhs.gov

Provider Enrollment contact

FFSProviderRelations@cms.hhs.gov "ListServ" sign-up: Notice of program and policy details, press releases, events, educational material

888-734-6433

PECOS Help Desk (EUS)

cms.gov MLN Matters® Articles

articles on the latest changes to the Medicare Program and enrollment education products



Overview of the Medicare Physician Fee Schedule

Jeanne Vance, Esq.

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Medicare Physician Fee Schedule
(MPFS)

Process: Published in the Federal Register as a draft in **July** of each year. Constituents have a period (a bit over 30 days last year) of time to *submit comments*. The final rule is published around **November** 1 of each year. It is effective on the next **January** 1 after the final rule is published.

It has the **force of law**.

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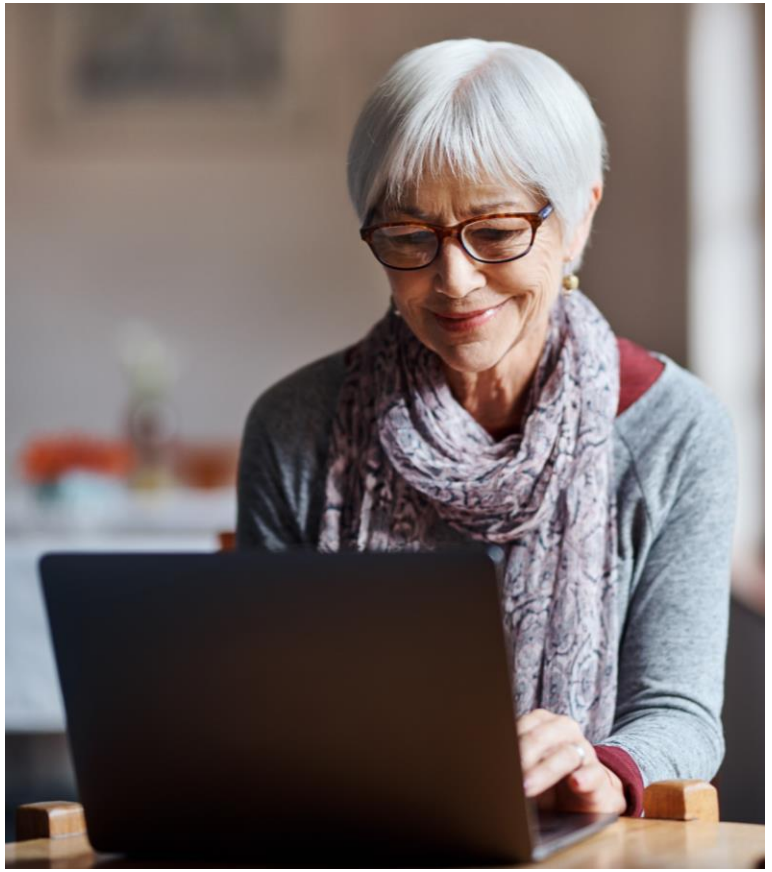
What Is in the MPFS?

1. Hundreds of pages in very fine print. Complete with table of contents and subject headings.

2. Updates to the Physician Fee Schedule, which provides the basis for fee-for-service payment to physicians and other individual health care practitioners, to include marriage and family therapists and counselors.

3. Updates to Medicare rules for Part B suppliers—each year is different.
   1. Implementation of new laws; and
   2. Updates to payment policies.



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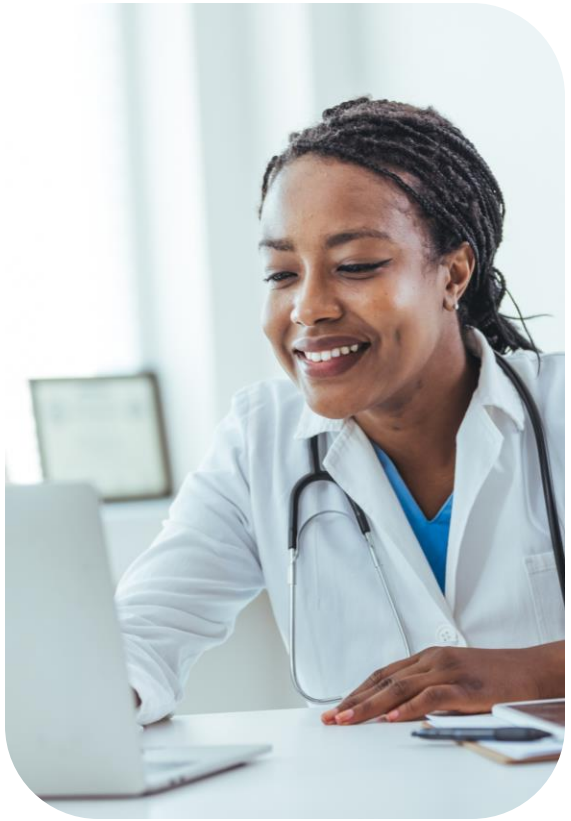
Key Information in the MPFS Rule

Contact information at CMS for the person who is responsible for substantive issues within the MPFS.

Comment period is available before proposals are final. Deadline and manner of submission is set forth in the MPFS.



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Physician Fee Schedule

This methodology is used for reimbursing practitioners for services delivered in all kinds of settings, including:

- Offices
- Hospitals
- Skilled nursing facilities
- Hospices
- Beneficiary homes

The fee schedule is expressed in dollars and sets forth the maximums for payment under Medicare for physicians and other practitioners.

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Physician Fee Schedule

Global billing under PFS.

Medicare pays a single rate for the full range of resources involved in providing the service. This includes reimbursement for the office space, utilities, supplies, malpractice insurance, the person, etc.

Professional billing only under PFS.

Where the practitioner provides the "person services" in a facility that is owned by someone else that may separately bill the Medicare program, then the practitioner receives a reduced amount for the professional billing only, with the facility billing separately for reimbursement for the space, the utilities, the supplies, the reception staff, etc.

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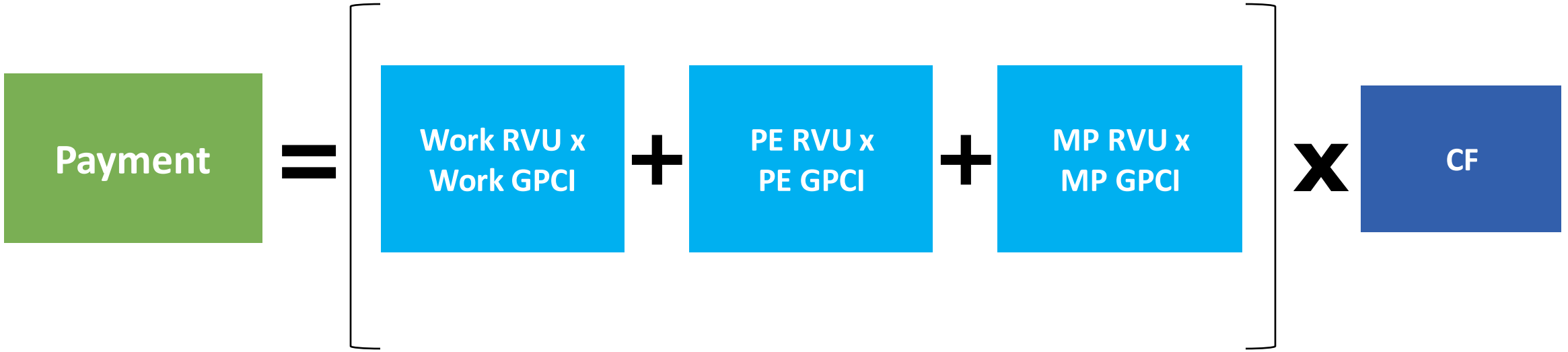
Physician Fee Schedule Formula



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Relative Value Units (RVU)

Work RVU—shows the Medicare PFS service's relative time and intensity.

Practice Expense RVU—shows the costs of supporting a practice (office rent, staff costs, etc.).

Malpractice RVU—shows the cost of malpractice insurance.

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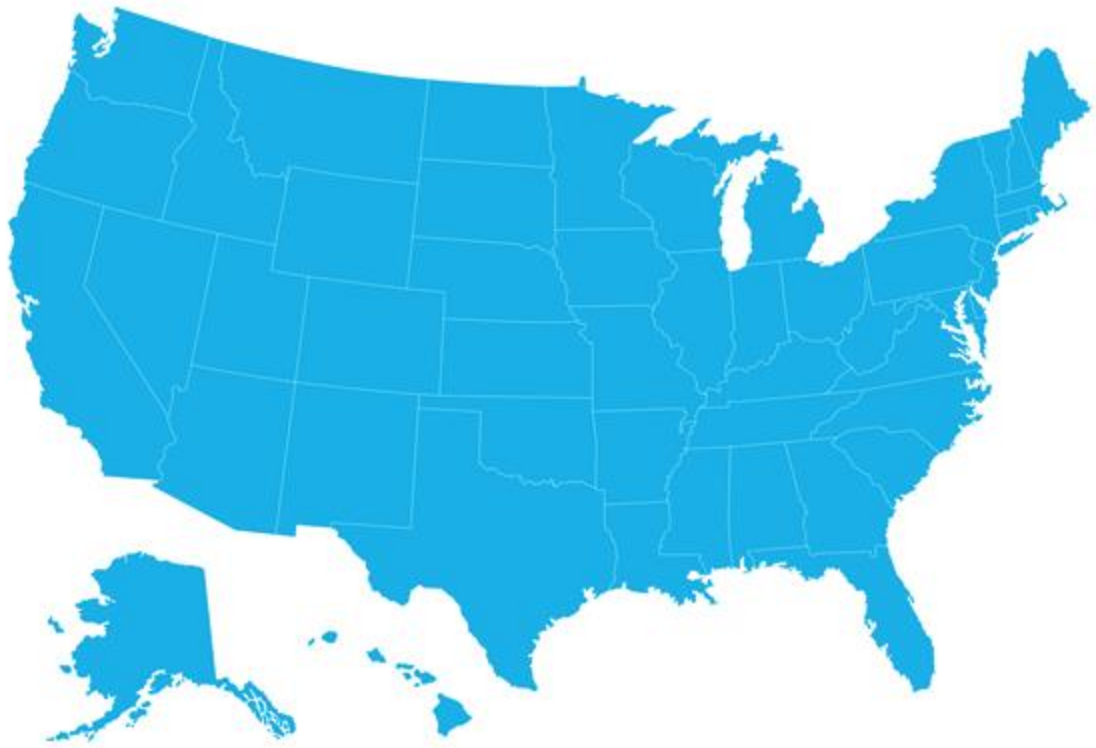
Geographic Practice Cost Indices (GPCI)

Each RVU is adjusted to account for geographic variations in the cost of practicing medicine in different parts of the country.



$ **Conversion Factor:** Expressed in dollars. There is a formula for updating the conversion factor each year in the Social Security Act.

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Fee Schedule Amounts

Include the patient co-pay. Practitioners are required to collect the co-pay, and **Medicare will generally pay 80%** of the allowed amount.

PFS Look-Up Tool:
www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched

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Example of CMS PFS Pricing Tool

HCPCS Code	Modifier	Short Description	Proc Stat	Mac Locality	Non-Facility Price	Facility Price	Non-Facility Limiting Charge	Facility Limiting Charge	Conv Fact	NA Flag for Trans Non-FAC PE RVU
90837		Psytx w pt 60 minutes	A	0111205	$166.82	$142.61	$182.25	$155.80	33.8872	
90837		Psytx w pt 60 minutes	A	0111206	$166.82	$142.61	$182.25	$155.80	33.8872	
90837		Psytx w pt 60 minutes	A	0111207	$166.82	$142.61	$182.25	$155.80	33.8872	
90837		Psytx w pt 60 minutes	A	0111209	$169.65	$144.82	$185.34	$158.22	33.8872	
90837		Psytx w pt 60 minutes	A	0111251	$160.00	$137.71	$174.80	$150.45	33.8872	
90837		Psytx w pt 60 minutes	A	0111252	$166.92	$142.71	$182.36	$155.91	33.8872	
90837		Psytx w pt 60 minutes	A	0111253	$159.93	$137.64	$174.73	$150.37	33.8872	
90837		Psytx w pt 60 minutes	A	0111254	$151.81	$132.80	$165.86	$145.08	33.8872	
90837		Psytx w pt 60 minutes	A	0111255	$150.83	$131.81	$164.78	$144.01	33.8872	
90837		Psytx w pt 60 minutes	A	0111256	$150.83	$131.81	$164.78	$144.01	33.8872	

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Physician Fee Schedule Pricing Tool; RVUs

HCPCS Code	Modifier	Short Description	Proc Stat	PCTC	Not Used for Medicare	Work RVU	NA Flag for Trans Non-FAC PE RVU	Transitioned Non-FAC PE RVU	NA Flag for Fully IMP Non-FAC PE RVU	Fully Implen Non-F RVU
90837		Psytx w pt 60 minutes	A	0		3.31		0.95		0.95

	NA Flag for Fully IMP Non-FAC PE RVU	Fully Implemented Non-FAC PE RVU	NA Flag for Trans Facility PE RVU	Transitioned Facility PE RVU	NA Flag for Fully IMP FAC PE RVU	Fully Implemented Facility PE RVU	MP RVU	Non-FAC PE Used for OPPS PMT AMT	Facility PE Used for OPPS PMT AMT	Malpractice Used for OPPS PMT AMT
		0.95		0.43		0.43	0.08	0.00	0.00	0.00

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Annual Updates

The PFS formula does not change, but the values can change each year.

Issues are corrected, such as misvalued codes, re-weighting of codes between specialties, etc.

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Policy Matters/Regulatory Updates in the MPFS

Known and unknown.

Cannot change the statute, but may provide additional clarification or interpretations on statutory requirements.

These may directly or indirectly impact a particular practitioner.

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Examples of Policy Changes/New Law Implementation From Last Year's MPFS

1. ***Changes to Medicare Telehealth List.*** Add services to the list of things that can be provided by telehealth (included consideration of certain therapy codes).

2. ***Changes to Policies for Opioid Use Disorder Treatment.*** Medicare payment policy changes for Medicare conditions for the payment for Opioid Use Disorder treatment services furnished by opioid treatment programs.

3. ***Medicare Provider Enrollment Changes.*** Expansion of authority to deny or revoke a Medicare provider enrollment based upon an OIG exclusion or felony conviction.

Looking Ahead to 2024 MPFS

- Changes implementing the expansion of Medicare payment to MHCs and MFTs.
- 2024 rates will be included by adjustments to the RVUs, conversion factor, etc.
- Potentially other items of interest to MHCs, MFTs, and their employers.
- The data here may also be used by non-Medicare payors because the data for calculation of RVUs is respected.

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Questions and Answers!


Thank you
for attending!
Medicare Mental Health
Workforce Coalition