Enrollment guide: Chapter 3 - Overview of the Medicare enrollment process

Provider enrollment

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3.1 Overview of Part A enrollment

The NPI is assigned by the National Plan and Provider Enumeration System (NPPES), which is a separate process from applying for Medicare enrollment. You must obtain your NPI prior to enrolling in Medicare. You may apply for an [NPI](https://NPPES.cms.hhs.gov) online.

The following institutional providers/health care organizations must enroll to be eligible to receive Medicare payment for covered services provided to Medicare beneficiaries:

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

Part A providers are referred to as “certified providers”. The usual process for becoming a certified Medicare provider is as follows:

* The applicant completes and submits the Medicare enrollment application (Form CMS-855A) to Novitas Solutions.
* We review the application and makes a recommendation for approval or denial to the applicable State Agency (SA) or CMS Regional Office.
* Once we make a recommendation to approve enrollment, SA or, if applicable, a CMS recognized accrediting organization conducts a survey. Based on the survey results, the SA makes a recommendation for approval or denial (a certification of compliance or noncompliance) to the CMS Regional Office.
* The CMS Regional Office makes the final decision regarding program eligibility. The CMS Regional Office also works with the Office of Civil Rights to obtain the necessary Civil Rights clearances. If approved, the provider must typically sign a provider agreement.

In addition to completing and submitting an enrollment application (CMS-855A) and all of the required supporting documentation to Novitas Solutions, new providers must also simultaneously contact their local SA

Note: Certain provider types may elect voluntary accreditation by a CMS-recognized accrediting organization in lieu of a SA. The survey process is used to determine whether a provider meets the requirements for participation in the Medicare Program.

Failure to contact your SA or Medicare-approved accreditation organization in a timely manner may delay your enrollment into the Medicare Program.

CMS maintains oversight for compliance with the Medicare health and safety standards for laboratories, acute and continuing care providers (including hospitals, nursing homes, HHAs [home health agencies], ESRD (end-stage renal disease) facilities, hospices, and other facilities serving Medicare and Medicaid beneficiaries), and makes available to beneficiaries, providers/suppliers, researchers and State surveyors information about these activities.

The survey (inspection) for this determination is done on behalf of CMS by the individual SAs. The functions the states perform for CMS under the agreements in Section1864 of the Social Security Act (the Act) are referred to collectively as the certification process. This includes, but is not limited to:

* Identifying potential participants - Payment for health services furnished in or by entities that meet stipulated requirements of the Act. Identification includes those laboratories seeking to participate in the Clinical Laboratory Improvement Amendments (CLIA) program.
* Conducting investigations and fact-finding Surveys - Verifying how well the health care entities comply with the conditions of participation (CoPs) or requirements. This is referred to as the "survey process".
* Certifying and recertifying - Certifications are periodically sent to the appropriate Federal or State agencies regarding whether entities, including CLIA laboratories, are qualified to participate in the programs.
* Explaining requirements - Advising providers and suppliers, and potential providers and suppliers in regard to applicable Federal regulations to enable them to qualify for participation in the programs and to maintain standards of health care consistent with the CoPs and Conditions for Coverage (CfC) requirements.

When you are ready to enroll, visit the [CMS provider enrollment web site](http://www.cms.gov/SurveyCertificationGenInfo/) to find additional information helpful in the enrollment process for certified providers. In addition, the web site provided immediately above contains information about the SAs that are responsible for certifying your provider type.

3.2 Overview of Part B enrollment

The NPI is assigned by NPPES, which is a separate process from applying for Medicare enrollment. You must obtain your NPI prior to enrolling in Medicare. You may apply for an [NPI online](https://nppes.cms.hhs.gov./).

The following suppliers must enroll to be eligible to receive Medicare payment for covered services provided to Medicare beneficiaries:

* Ambulance Service Supplier
* Ambulatory Surgical Center
* Clinic/Group Practice
* Home Infusion Therapy (HIT)
* Hospital Department(s)
* Independent Clinical Laboratory
* Independent Diagnostic Testing Facility (IDTF)
* Intensive Cardiac Rehabilitation
* Mammography Center
* Mass Immunization (Roster Biller Only)
* Medicare Diabetes Prevention Program (MDPP)
* Opioid Treatment Program (OTP)
* Pharmacy
* Physical/Occupational Therapy Group in Private Practice
* Portable X-ray Supplier
* Radiation Therapy Center

Note: Ambulatory Surgical Centers and Portable X-ray Suppliers are considered certified Part B suppliers. For more information related to the certification process, please refer to the Part A enrollment section immediately above.

The following physicians must enroll to be eligible to receive Medicare payment for covered services provided to Medicare beneficiaries:

Doctors of:

* Medicine
* Osteopathy
* Dental surgery or dental medicine
* Chiropractic
* Podiatric medicine, or
* Optometry

The following non-physician practitioners must enroll to be eligible to receive Medicare payment for covered services provided to Medicare beneficiaries:

* Anesthesiology Assistant
* Audiologist
* Certified Nurse Midwife
* Certified Registered Nurse Anesthetist
* Clinical Nurse Specialist
* Clinical Social Worker
* Mass Immunization Roster Biller
* Nurse Practitioner
* Occupational Therapist in Private Practice
* Physical Therapist in Private Practice
* Physician Assistant
* Psychologist, Clinical
* Psychologist Billing Independently
* Registered Dietitian or Nutrition Professional
* Speech Language Pathologist
* Marriage and Family Therapist
* Mental Health Counselor
* Any other practitioner as may be specified by the Secretary as defined in 1842 (b) (4) (I) of the Social Security Act.

Specialty codes are self-designated and they describe the kind of medicine physicians, non-physician practitioners or other healthcare providers/suppliers practice. For a complete listing of physician and non-physician specialties, refer to the [Centers for Medicare and Medicaid Services’ Internet Only Manual System](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf#page=76).

3.3 Ineligible Suppliers

The following is a list of suppliers who frequently attempt to enroll in Medicare but are not eligible to do so; no statute permits them to bill Medicare. Note that this list is not exhaustive:

* Acupuncturist
* Assisted Living Facilities
* Birthing Centers
* Certified Alcohol and Drug Counselor
* Certified Social Worker
* Drug and Alcohol Rehabilitation Counselor
* Hearing Aid Center/Dealer
* Licensed Alcoholic and Drug Counselor
* Licensed Massage Therapist (LMT)
* Licensed Practical Nurse (LPN)
* Licensed Professional Counselor
* Masters of Social Work
* National Certified Counselor
* Occupational Therapist Assistant
* Physical Therapist Assistant
* Registered Nurse
* Speech and Hearing Center
* Substance Abuse Facility

3.4 Provider Enrollment Administrative Appeals

Part A

A provider or supplier whose Medicare enrollment is denied or whose Medicare billing privilege is revoked can request an appeal of that determination. This appeal process applies to all providers and suppliers and ensures that all applicants receive a fair and full opportunity to be heard. All providers and suppliers that wish to appeal will be given the opportunity to request an appeal of a reconsideration decision to an administrative law judge (ALJ) of the Department of Health and Human Services (DHHS). Providers and suppliers then can seek review by the Departmental Appeals Board (DAB) and then may request judicial review.

If a Medicare contractor reviews an enrollment application for a provider or certified supplier and finds that the application should be denied, the Medicare contractor will deny or recommend denial to the CMS regional office (RO) and notify the provider or certified supplier by letter. Details related to the decision to deny, as well as further appeal rights, will be provided.

Similarly, if a Medicare contractor discovers that there is a basis for revoking a provider or certified supplier’s billing privileges, the Medicare contractor will revoke billing privileges and notify the provider or certified supplier by letter with a copy to the appropriate State agency and CMS RO. Details related to the decision to revoke billing privileges, as well as further appeal rights, will be provided.

Corrective actions plan (CAP)

A CAP is the process that gives the provider or certified supplier an opportunity to correct the deficiencies (if possible) that resulted in the denial or revocation of billing privileges. The CAP must provide evidence that the provider or certified supplier is in compliance with Medicare requirements. The CMS RO or CMS Central Office (CO) will accept the submission of a CAP for denied or revoked billing privileges if the CAP is submitted within 30 days from the date of the denial or revocation letter. The appropriate CMS address will be provided in the denial or revocation letter. Submission of a CAP must contain, at a minimum, verifiable evidence of the provider or certified supplier’s compliance with enrollment requirements.

If a CAP is approved by the CMS RO/CO, billing privileges can be issued. The effective date is based on the date the provider or certified supplier came into compliance with all Medicare requirements. That is, once the provider or certified supplier has passed the state survey and been issued a certification date.

A decision for the approval or denial of the CAP will be provided by the CMS RO/CO within 60 days from the submission date.

Reconsiderations

If a provider or certified supplier did not submit a CAP, or the CAP was not approved, the next course of action is to request a reconsideration with the CMS RO or CMS CO. The appropriate CMS address to use for submission of a reconsideration request will be provided in the denial or revocation letter.

A provider or certified supplier that wishes to request a reconsideration must file its request in writing with the CMS RO/CO within 60 days after the postmark of the notice to be considered timely filed. The date the request is received by the RO/CO is treated as the date of filing. The request may be signed by the authorized official within the entity. Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

ALJ Hearing

The CMS, a Medicare contractor, or a provider or certified supplier dissatisfied with a reconsidered determination is entitled to a hearing before the ALJ. The ALJ has delegated authority from the Secretary of the DHHS to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such an appeal must be filed, in writing, within 60 days from the receipt of the reconsideration decision. Failure to timely request an ALJ hearing is deemed a waiver of all rights to further administrative review. Details for filing a request for a hearing before an ALJ are provided in the reconsideration determination letter.

DAB hearing

The CMS, a Medicare contractor, or a provider or certified supplier dissatisfied with the ALJ hearing decision may request Board review by the DAB. Such request must be filed within 60 days after the date of receipt of the ALJ’s decision. Failure to timely request a Review by the DAB is deemed a waiver of all rights to further administrative review.

Judicial review

A provider or certified supplier dissatisfied with DAB review has a right to seek judicial review by timely filing a civil action in a United States District Court. Such request shall be filed within 60 days from receipt of the notice of the DAB’s decision.

Part B

A provider or supplier whose Medicare enrollment is denied or whose Medicare billing privilege is revoked can request an appeal of that determination. This appeal process applies to all providers and suppliers and ensures that all applicants receive a fair and full opportunity to be heard. All providers and suppliers that wish to appeal will be given the opportunity to request an appeal of a reconsideration decision to an ALJ of the DHHS. Providers and suppliers then can seek review by the DAB and then may request judicial review.

If a Medicare contractor finds a basis for denying an application, or similarly, a basis for revoking a currently enrolled provider or supplier’s billing privileges, details related to the decision to deny or revoke will be provided by letter. The denial/revocation letter will contain information related to further appeal rights. Appeal rights are explained below.

Corrective Actions Plan (CAP)

A CAP is the process that gives the provider or supplier an opportunity to correct the deficiencies (if possible) that resulted in the denial or revocation of billing privileges. The CAP must provide evidence that the provider or supplier is in compliance with Medicare requirements. The Medicare contractor will accept the submission of a CAP for denied or revoked billing privileges if the CAP is submitted within 30 days from the date of the denial or revocation letter. Submission of a CAP must contain, at a minimum, verifiable evidence of compliance with enrollment requirements.

If the CAP is approved by the Medicare contractor, billing privileges can be issued. The effective date of billing privileges is the date the provider/supplier came into compliance with all Medicare requirements. A decision for the approval or denial of the CAP will be provided by the Medicare contractor within 60 days from the submission date.

CAPs are sent to Novitas Solutions at the following address:

Jurisdiction L (JL): (Delaware, Maryland, New Jersey, Pennsylvania, Washington, D.C.)

Novitas Solutions
Corrective Action Plan Submission
P.O. Box 3326
Mechanicsburg, PA 17055-1839

 Jurisdiction H (JH): (Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas, Indian Health Service/Tribal Providers and Veterans Affairs Providers)

Novitas Solutions
Corrective Action Plan Submission
P.O. Box 3096
Mechanicsburg, PA 17055-1814

Reconsiderations (formerly Medicare contractor Hearings)

If a provider/supplier did not submit a CAP, or the CAP was not approved by the Medicare contractor, the next course of action is to request a reconsideration of the Medicare contractor’s initial denial or revocation determination.

A provider/supplier that wishes to request a reconsideration must file its request, in writing, with the Medicare contractor within 60 days after the postmark of the denial/revocation notice (not withstanding submission of a CAP) to be considered timely filed. The date the request is received by the Medicare contractor is treated as the date of filing. The request must be signed by the physician, non-physician practitioner, or any responsible authorized official within the entity, and sent to:

Jurisdiction L (JL): (Delaware, Maryland, New Jersey, Pennsylvania, Washington, D.C.)

Novitas Solutions
Medicare Reconsideration Request
P.O. Box 3326
Mechanicsburg, PA 17055-1839

Jurisdiction H (JH): (Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas, Indian Health Service/Tribal Providers and Veterans Affairs Providers)

Novitas Solutions
Medicare Reconsideration Request
P.O. Box 3096
Mechanicsburg, PA 17055-1814

Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

Medicare contractor reconsiderations are conducted by a Hearing officer (HO) or senior staff having expertise in provider enrollment and who was independent of the initial decision to deny or revoke enrollment. If a timely request for a reconsideration is received, the HO (or senior staff) will acknowledge receipt of the request and will then hold an on-the-record reconsideration. The reconsideration determination will be issued within 90 days from the receipt date of the request. The final determination letter will be sent via certified mail.

ALJ Hearing

CMS, a Medicare contractor, or a provider or supplier dissatisfied with a reconsidered determination is entitled to a hearing before an ALJ. The ALJ has delegated authority from the Secretary of the DHHS to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such an appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. Failure to timely request an ALJ hearing is deemed a waiver of all rights to further administrative review. Details for filing a request for a hearing before an ALJ are provided in the reconsideration determination letter.

DAB hearing

CMS, a Medicare contractor, or a provider or supplier dissatisfied with the ALJ hearing decision may request Board review by the DAB. Such request must be filed within 60 days after the date of receipt of the ALJ’s decision. Failure to timely request a review by the DAB is deemed a waiver of all rights to further administrative review.

Judicial review

A provider or supplier dissatisfied with a DAB decision has a right to seek judicial review by timely filing a civil action in a United States District Court. Such request shall be filed within 60 days from receipt of the notice of the DAB’s decision.

Part A and Part B administrative appeals guidelines can be found in [Publication. 100-8, Chapter 15, Section 25](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf).