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SPECIAL PUBLICATION

Healthcare

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Section 1135 Waiver Provider Enrollment Flexibility

As referenced in our Client Alert addressing the Section 1135 Waivers issued by the Secretary of the U.S. Department of Health and Human Services (Secretary) on March 13, 2020,[1] the Centers for Medicare and Medicaid Services (CMS) has provided certain flexibility with respect to provider enrollment matters. On March 23, 2020, CMS issued new guidance on this provider/supplier enrollment flexibility in the form of Frequently Asked Questions (FAQs).[2]

The provider/supplier enrollment flexibility can be divided into two categories based on type of provider:

- Physician/Non-Physician Practitioner Enrollment Flexibility
- All Other Providers/Suppliers Enrollment Flexibility

Each of these enrollment flexibility categories are discussed below.

Physician/Non-Physician Practitioner Enrollment Flexibility

CMS has provided two components of enrollment flexibility available to physicians and non-physician practitioners (Physicians/NPPs): Temporary Medicare Billing Privileges and Waiver of Screening Requirements. CMS also provides other notable guidance through the FAQs regarding Physician/NPP state licensure requirements and Medicare telehealth services provided from home by a Physician/NPP. Each of these topics is further discussed below.

Temporary Medicare billing privileges

CMS has established the following toll-free hotlines.

- CGS Administrators, LLC (CGS)
  Hotline Tel. No.: 1-855-769-9920
  Hours: 7:00 AM – 4:00 PM CT
- National Government Services (NGS)
  Hotline Tel. No.: 1-888-802-3898
  Hours: 8:00 AM – 4:00 PM CT
- Novitas Solutions, Inc.
  Hotline Tel. No.: 1-855-247-8428
  Hours: 8:30 AM – 4:00 PM EST
- Palmetto GBA
  Hotline Tel. No.: 1-833-820-6138
- First Coast Service Options Inc. (FCSO)
  Hotline Tel. No.: 1-855-247-8428
  Hours: 8:30 AM – 4:00 PM EST
- National Supplier Clearinghouse (NSC)
  Hotline Tel. No.: 1-866-238-9652
  Hours: 9:00 AM – 5:00 PM ET
- Noridian Healthcare Solutions
  Hotline Tel. No.: 1-866-575-4067
  Hours: 8:00 AM – 6:00 PM CT
- Wisconsin Physician Services (WPS)
  Hotline Tel. No.: 1-844-209-2567

[1] This client alert is available here.
[2] These new FAQs are available here.

Hours: 8:30 AM – 5:00 PM ET Hours: 7:00 AM – 4:00 PM CT

The hotlines are operational Monday – Friday and will be available until the Section 1135 emergency declaration has been lifted. Physicians/NPPs may only contact the hotline for the Medicare Administrative Contractor (MAC) that services their geographic area.[3]

The hotlines may be used to (i) enroll and grant temporary Medicare billing privileges to Physicians/NPPs, (ii) report a change in practice location or other changes in information with respect to Physicians/NPPs, and (iii) to have providers/suppliers (including Physicians/NPPs) ask questions regarding the Section 1135 waiver provider enrollment flexibilities.

When calling the hotlines, Physicians/NPPS, or those calling on their behalf, will be asked to provide limited information in order to initiate temporary billing privileges. This information will include, but not be limited to, the following:

- Legal Name
- National Provider Identifier (NPI)
- Social Security Number
- Valid in-state or out-of-state license
- Address information
- Contact information (telephone number)

The MAC will attempt to screen and enroll the Physician/NPP over the phone, will notify the Physician/NPP of their approval or rejection of temporary Medicare billing privileges during the phone conversation, and will follow up with a letter via email to communicate the approval or rejection of the Physician/NPP's temporary Medicare billing privileges. In the event a Physician/NPP does not pass the screening requirements, the Physician/NPP will not be granted temporary Medicare billing privileges and cannot be paid for services furnished to Medicare beneficiaries.

Physicians/NPPs who receive temporary billing privileges will be assigned an effective date as early as March 1, 2020. Physicians/NPPs may bill for services furnished on or after the effective date.

Medicare billing privileges granted to Physicians/NPPs through the hotlines are granted on a provisional basis as a result of the Section 1135 public health emergency. Upon a lifting of the emergency, the Physician/NPP will be asked to submit a complete CMS-855 enrollment application in order to establish full Medicare billing privileges, following the MAC's review of the application. Failure to respond to the MAC's request within 30 days of notification will result in the deactivation of the temporary billing privileges. No payments can be received for services rendered after such a deactivation.

Waiver of Screening Requirements

CMS has also waived certain screening requirements applicable to initial or continued Medicare enrollment. Specifically, the waived screening requirements include the following:

- Criminal background checks associated with fingerprint-based criminal background checks (FCBS) – 42 C.F.R. 424.518 (to the extent applicable)
- Site visits – 42 C.F.R. 424.517

[3] To locate your designated MAC, refer to https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-AdministrativeContractors/Downloads/MACs-by-State-June-2019.pdf.

- Postponement of all revalidation actions

Other Notable Guidance

- State Licensing Requirements

CMS comments on Physician/NPP state licensure requirements in the FAQs. Regarding state licensure requirements, CMS notes that the 1135 waivers allow CMS to waive, on an individual basis, the Medicare requirement that a Physician/NPP be licensed in the State in which s/he is practicing, provided all of the following four conditions are met:

1) The Physician/NPP is enrolled as a physician or a non-physician practitioner in the Medicare program;

2) The Physician/NPP possesses a valid license to practice in the State which relates to his or her Medicare enrollment;

3) The Physician/NPP 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/NPP is not affirmatively excluded from practice in the State or any other State that is part of the 1135 emergency area.

CMS notes, however, that CMS waiving a state licensure requirement for Medicare purposes does not have the effect of a State or local government waiving a State or local licensure requirement. In other words, any State and/or local licensure requirements would continue to apply unless waived by the State or local government. Therefore, in order for the Physician/NPP to avail him- or herself of CMS waiving a state licensure requirement, the State also would have to waive its licensure requirements, either individually or categorically, for the type of practice for which the Physician/NPP is licensed in his or her home State.

- Telehealth Services Provided by a Physician/NPP from Home

CMS notes that there are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home.

If a Physician/NPP is providing Medicare telehealth services from his or her home, the practitioner is required to update his or her Medicare enrollment with the home location. The practitioner can add his or her home address to their Medicare enrollment file by reaching out to the MAC through the provider enrollment hotline. Adding the home location through the hotline would be effective immediately so practitioners could continue providing care without a disruption. More details about this enrollment requirement can be found at 42 CFR 424.516.

If the Physician/NPP reassigns his or her benefits to a clinic/group practice, the clinic/group practice is required to update the Medicare enrollment of the Physician/NPP with his or her home location. The clinic/group practice can add the Physician/NPP's home address to its Medicare enrollment file by reaching out to the MAC through the provider enrollment hotline.

All Other Providers/Suppliers Enrollment Flexibility

All other providers/suppliers outside of physicians/NPPs, including DEMPOS suppliers (Other Providers/Suppliers), are required to submit initial enrollments and changes of information via the appropriate CMS-855 application, though the above hotlines can be used by Other Providers/Suppliers for questions regarding the 1135 waiver provider enrollment flexibilities. Encouraging Other Providers/Suppliers to submit their applications via Internet-Based PECOS, CMS states that all clean web applications 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.[4]

In addition to agreeing to the above processing timeframes, CMS is waiving the following screening requirements for all enrollment applications received on or after March 1, 2020:

- Application Fee – 42 C.F.R. 424.514
- Criminal background checks associated with the FCBC – 42 C.F.R. 424.518 (to the extent applicable)
- Site visits – 42 C.F.R. 424.517

CMS also notes that it is currently postponing the DME accreditation and reaccreditation timetables and deadlines under the Section 1135 waiver authority. DMEPOS suppliers should still comply with accreditation requirements; however, formal accreditation from an accrediting organization will be postponed. CMS will monitor all billing activity during the emergency and continue to reassess this requirement. Aberrant billing practices may be subject to further action.

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We anticipate that additional guidance in response to COVID-19 will be issued in the coming days and weeks, which may include additional waivers or modifications. Covered health care providers who are or may be affected by the consequences of the COVID-19 pandemic should monitor additional developments and announcements from the United States Department of Health and Human Services, CMS, the Office of Inspector General, the Office for Civil Rights, and various other federal and state agencies. If you have any questions about the impact of COVID-19 on health care providers or the Section 1135 provider enrollment flexibility, please contact a member of our national Healthcare practice group.

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[4] In the FAQs, CMS notes that CMS is processing pending applications for all providers and suppliers received prior to March 1, 2020 in accordance with existing processing timeframes (i.e., generally, web-based applications are processed within 45 days and paper-based applications are processed within 60 days).

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