**Palmetto GBA Frequently Asked Questions - Medicare Enrollment Requirement for Dentists Ordering Part D Medicare Drugs Teleconference**

Q1. I am trying to decide whether to opt-out of Medicare or to complete the CMS 855O enrollment application. What are the benefits of one over the other?

A. The decision is an individual decision that each practice must make and therefore the advantages of one option over the other may differ.

| **Opt-Out Affidavit** | **CMS 855O Enrollment Form** |
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| Opting-out will allow the provider to be listed as a provider eligible to prescribe Part D prescription drugs covered under a patient's Medicare drug plan. | Completing and submitting the CMS 855O will allow the provider to be listed as a provider eligible to prescribe Part D prescription drugs covered under a patient's Medicare drug plan. |
| A valid opt-out affidavit will automatically renew every two years unless the provider cancel the renewal by notifying all Medicare Administrative Contractors with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period. | Completed only once unless CMS regulations change and require the provider to revalidate their 855O at some point in the future. |
| Must enter into a private contract with patients for ***covered Medicare services*** prior to the service being performed (exception for emergency care services as defined by CMS). | Can become an **active billing Medicare provide at any time** by submitting the CMS 855I enrollment application (and any additional information or enrollment forms required). |
| Provider or patient is prevented from billing Medicare or a Medicare Advantage plan for covered Medicare services provided by an opt-out provider for the opt-out period. | |
| Opt-out affidavit may not be revoked after 90 days and provider is prevented from enrolling as an active billing Medicare provider during the opt-out period. | |
| If a physician or practitioner changes his or her mind after the Medicare contractor has approved the affidavit, the opt-out may be terminated within 90 days of the effective date of the affidavit. | |

Q2. Does this new regulation make any changes to the services currently covered when performed by a dentist?

A. No. There are no changes in dental service coverage. CMS Medicare Dental Coverage

Q3. How does this new requirement affect Medicare coverage of dental services covered by a Medicare Advantage Plan (i.e. Humana, Delta Dental) and if I opt-out of Medicare, am I still able to bill a patient's Medicare Advantage plan for covered dental services?

A. CMS addresses this question in question # 11 of the CMS-4159 Frequently Asked Questions.

Q4. If I am already enrolled with Medicare as a durable medical equipment (DME) provider or with Palmetto GBA and have an **active Medicare billing number** (Provider Transaction Number (PTAN)), do I need to take action?

A. No.

Q5. When submitting an initial opt-out affidavit, when does the two year period begin?

A. The two-year opt-out period begins the date the affidavit is signed, provided the affidavit is filed within ten days after he or she signs his or her first private contract with a Medicare beneficiary.

Q6. What if I am uncertain as to whether I will ever render a covered Medicare service that I want to bill Medicare for and be reimbursed?

A. Each dentist will need to make an individual business decision that best fits their business needs. Refer to table in question one.

Q7. Where can I find a list of services that Medicare covers when performed by a dentist?

A. The CMS does not provide a list of covered dental CPT/HCPCs codes. Currently, Medicare will pay for dental services that are an integral part either of a covered procedure (e.g., reconstruction of the jaw following accidental injury), or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Medicare will also make payment for oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances. Such examination would be covered under Part A if performed by a dentist on the hospital's staff or under Part B if performed by a physician. More information outlining covered dental services can be found on the CMS Medicare Dental Coverage webpage.

Q8. If I only render services that are statutorily excluded (never covered) do I need to enroll with Medicare to be an “active” provider for billing purposes?

A. No. However, in order to have prescription drugs covered by a patient’s Medicare prescription drug plan you must be an enrolled Medicare provider for purposes of billing covered services, complete the CMS 855O enrollment form to be classified as a provider eligible to order services for a Medicare patient or submit an opt-out affidavit.

Q9. If I am an endodontist or orthodontists how do I complete the CMS 855O enrollment form?

A. Under the 'Specify' section of the CMS 855O form, indicate your specialty designation.

Q10. What happens if I choose to do nothing and I am not enrolled as an active billing Medicare provider, have not opted-out of Medicare or have not completed the CMS 855O enrollment form when this regulation is implemented?

A. Failure to take one of the three actions listed in your question will result in any covered Part D prescription drugs prescribed by you being denied by the patient's prescription drug plan. The patient would then be responsible for paying out of pocket for a prescription drug that would otherwise likely be covered by their prescription drug plan.

Q11. If I do nothing as listed in the question above and I prescribe a drug for a Medicare patient on or after implementation of this requirement, can I then take one of the above actions and make them retroactive so that patient's prescription drug order by me can be covered?

A. There is currently no regulation allowing an opt-out affidavit or 855O enrollment form to be submitted and made retroactive.

Q12. If I submit an opt-out affidavit, what is the effective date of my two year opt-out period?

A. The two-year opt-out period begins the date the affidavit is signed, provided the affidavit is filed within ten days after he or she signs his or her first private contract with a Medicare beneficiary.

Q13. Is there a period in which I can revoke my opt-out affidavit?

A. If a physician or practitioner changes his or her mind after the Medicare contractor has approved the affidavit, the opt-out may be terminated within 90 days of the effective date of the affidavit.

Q14. If I opt-out of Medicare and then decide I want to bill for covered services can I complete an enrollment application and begin billing Medicare?

A. If more than 90 days have passed since the effective date of an opt-out affidavit, a provider may not enroll as an active billing Medicare provider of covered services until the current two year opt-out period ends. During your opt-out period if you are going to render a covered Medicare service you must enter into a private agreement with a patient for the patient to be liable for the covered charges. Opt-out Affidavid

Q15. I need help determining which option is best suited for my practice. What should I do?

A. Review the information provided in the answer to question #1 and decide whether you are comfortable with a decision that cannot be revoked for two years (opt-out option), review the FAQs in this document and make the decision that best fits your business need.

Q16. Why is Medicare making me take action when none of my services are covered by Medicare anyway?

A. CMS addresses this requirement in question two in the CMS-4159 Frequently Asked Questions.

Q17. Which option is best for me if I don't know if I will ever want or need to bill for a covered Medicare service?

A. The option selected is an individual business decision for each practice. It is suggested that providers review the options carefully and select the option they feel is the least restrictive for their business needs.

Q18. If I opt-out of Medicare and see a patient with a Medicare Advantage Plan that covers dental services, would I need to enter into a private agreement with the patient to make the patient liable

for the service?

A. Yes.

Q19. Can I be held liable for the patient's prescription drug charges if I order a prescription drug and have not taken steps to be considered a provider eligible to order prescriptions drugs for purposes of drug coverage by Medicare?

A. CMS will provide direction to the prescription drug plans regarding financial liability when prescriptions are denied due to the new requirement.

Q20. What is the worst thing that will happen if I don't take action?

A. Drugs covered under your patient's Medicare prescription drug plan will not be covered and the patient will not be able to use their prescription drug coverage for drugs you prescribe. Pharmacies and patients may contact you with questions and concerns because they must pay out of pocket for covered Medicare drugs you prescribe.

Q21. If I am currently enrolled as a durable medical equipment (DME) provider and I submit an opt-out affidavit can I still bill Medicare for DME supplies?

A. No. The submission of an opt-out affidavit opts a provider out of being able to bill Medicare for any service and requires you enter into a private agreement with your patient for the equipment.

Q22. If I opt-out of Medicare do I have to provide written notification that I have opted out of Medicare to my Medicare patients even when I am not rendering a service that is billable to Medicare?

A. An opt-out physician/practitioner is not required to use a private contract for an item or service that is excluded from coverage by Medicare.

**Glossary**

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| Active Provider | Active providers are those providers that are organizations (e.g., hospitals, medical groups, skilled nursing facilities) and those who are individuals (e.g., physicians, nurse practitioners, physician assistants etc.) who have an ACTIVE status in their record in the Provider Enrollment, Chain and Ownership System (PECOS) **for Medicare billing purposes** |
| Centers for Medicare and Medicaid Services (CMS) | An agency within the US Department of Health & Human Services responsible for direction and administration of the Medicare program |
| CMS 855I Form | The CMS enrollment application for an individual to complete to enroll in Medicare if they plan to bill Medicare for covered services |

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| CMS 855O Form | The CMS enrollment application physicians and non-physician practitioners complete to register in the Medicare program for the sole purpose of ordering or referring items or services for Medicare beneficiaries. These physicians and non-physician practitioners do not and will not send claims to a Medicare Administrative Contractor for the services they furnish |
| DME MAC | Durable Medical Equipment Medicare Administrative Contractor - Medicare Part B contractor responsible for administering durable medical equipment benefits in a specific jurisdiction |
| Eligible to Refer or Order a Medicare Service | Only Medicare-enrolled individual physicians and non-physician practitioners of a certain specialty type may order/refer for Part B (including Portable X-Ray services) and DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) Medicare beneficiary services |
| MAC | Medicare Administrative Contractors - administer the Medicare program in one or more geographic jurisdictions |
| Medicare Health Plan | CMS contracts with public or private organizations to offer a variety of health plan options for beneficiaries as an alternate to traditional Medicare coverage. These plans may include coordinated care plans (such as health maintenance organizations (HMOs), provider sponsored associations (PSOs), and preferred provider organizations (PPOs)), Medicare Medical Savings Account (MSA) plans, private-fee-for-service (PFFS) plans, and Religious Fraternal Benefit (RFB) plans. These health plans provide all Medicare Parts A and B benefits, and most offer additional benefits beyond those covered under the Original Medicare program |
| Medicare Part D Plan | Medicare coverage of prescription drugs |
| Medicare Prescription Drug Plan | Medicare Part D – Medicare coverage of prescription drugs – may be part of a Medicare Advantage Plan or a stand-alone Medicare drug plan |
| NPI | National Provider Identifier - The NPI is a unique identification number for covered health care providers |
| Opt-In | There is no such term associated with Medicare |
| Opt-Out | A choice a provider makes that means that neither the physician, nor the beneficiary submits the bill to Medicare for services rendered. Instead, the beneficiary pays the physician out-of-pocket and neither party is reimbursed by Medicare. A private contract is signed between the physician and the beneficiary that states, that neither one can receive payment from Medicare for the services that were performed. The physician or practitioner must submit an affidavit to Medicare expressing his/her decision to opt-out of the program |
| Ordering/Prescribing Provider | An entity that orders or prescribes a service or supply for a patient with Medicare benefits |
| Out of Network Provider | A Medicare Advantage Plan may negotiate terms and conditions with a specific provider or group of providers and require patients in most cases, for full benefits to be treated by providers within the plan's network. (Refer to individual plans for their network details) |
| Palmetto GBA | The Medicare Administrative Contractor – Medicare Part A and B contractor responsible for administering Medicare benefits in Virginia, West Virginia, and North and South Carolina as well as the home health and hospice benefits in 16 states |
| Private Contract | A "private contract" is a contract between a Medicare beneficiary and a physician or other practitioner who has opted out of Medicare for two years for **all** covered items and services the physician/practitioner furnishes to Medicare beneficiaries. In a private |

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| | contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician/practitioner and to pay the physician/practitioner without regard to any limits that would otherwise apply to what the physician/practitioner could charge.<br><br>An opt-out physician/practitioner is not required to use a private contract for an item or service that is definitely excluded from coverage by Medicare. |
| PTAN | Provider Transaction Access Number - A PTAN is a Medicare-only number issued to providers by MACs upon enrollment to Medicare as an active billing provider |
| Rendering Provider | The entity that provides a service to a patient with Medicare benefits |
| Statutorily Non Covered Service | Also referred to as statutorily excluded care or services - items or services that are never covered by Medicare and do not meet the definition of any Medicare benefit<br>Items or Services Not Covered By Medicare Booklet |