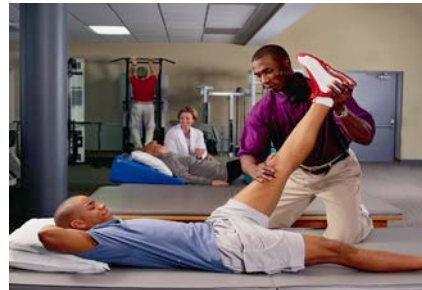

Outpatient Physical Therapy/Speech Pathology (OPT/SP) Provider Initial Application Process

What is an OPT/SP provider?

An OPT/SP provider provides an integrated interdisciplinary rehabilitation program designed to upgrade the physical functioning of disabled individuals by bringing specialized rehabilitation staff together to perform as a team and provide at a minimum the following services: physical therapy or speech-language pathology services and social or vocational adjustment services.



How do I become an OPT/SP provider?

To establish Medicare Certification of an OPT/SP provider, an applicant must complete and submit an application packet. Application materials can be found below or requested through the Bureau of Facility Standards at (208) 334 - 6626.

What is included in the Certification application packet?

The application packet includes what must be submitted and approved by the Bureau of Facility Standards prior to an initial survey (items #1 - #4) and resource information related to OPT/SP providers (items #5 - #8) as follows:

1. Request for Certification - [CMS-1856](#),
2. Health Insurance Benefits Agreement - [CMS-1561](#), (**Two Originals Required**)
3. "Office of Civil Rights Clearance for Medicare Certification" (OCR) [Request Form](#) and [Technical Assistance Packet](#). (Additional information is available at http://www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/index.html). This form may be answered and submitted, on line, via <https://ocrportal.hhs.gov/ocr/pgportal/> *If the provider chooses to submit the civil rights package on line, the*

submission will go directly into the OCR intake queue, and the provider will receive an e-mail from OCR stating that the provider completed the civil rights submission. The e-mail will contain an OCR number, which is critical to OCR's ability to access the provider's submission from the OCR intake queue. The provider will submit a copy of this e-mail to the SA, and the SA will submit it to the CMS Regional Office in lieu of the completed civil rights package.

4. Fiscal year ending date [form](#).
5. [Appendix E](#), Guidance to Surveyors: Outpatient Physical Therapy/Speech Pathology Services
6. [Appendix Q](#), Guidelines For Determining Immediate Jeopardy
7. CMS Letter, [S&C-08-03 Initial Surveys](#)
8. OPT/SP Survey Report - [CMS-1893](#),

How do I complete the Certification application?

1. The OPT/SP Survey Report - CMS-1893 (Item #8) is used by the Bureau of Facility Standards to determine whether or not the provider meets the federal regulatory requirements for OPT/SP services. It is provided as a reference. If, after you have reviewed all of the requirements listed on the CMS-1893 form, you decide to apply for certification by Medicare as an OPT/SP provider, then complete the application forms (Items #1- #4), and return them to the Bureau of Facility Standards.
2. Please ensure that all questions are answered when completing the application information indicated in items #1- #4 above. Please ensure that there are two originals of the Health Insurance Benefits Agreement - CMS-1561A (item #2 above) and that the two-page checklist at the front of the "Office of Civil Rights (OCR) Clearance for Medicare Certification" packet (item #3 above) is completed and signed. All hand-printed applications must be clearly printed and easily readable.

Where do I send my completed Certification application materials?



The application materials can be submitted by mail and/or hand delivered.

PLEASE KEEP A COPY FOR YOUR RECORDS

✚ If you are mailing the application packet, mail to:

Department of Health and Welfare
Bureau of Facility Standards
P.O. BOX 83720
BOISE, ID 83720-0009

✚ If you are hand delivering the application packet, deliver to:

Department of Health and Welfare
Bureau of Facility Standards
3232 Elder Street
Boise ID 83705

What happens after I submit my Certification application materials?

Bureau of Facility Standards staff will review the materials you submitted. If the application is incomplete or if there are questions, Bureau staff will contact you. Once the application materials have been approved and after we have received notification from the Medicare Fiscal Intermediary that the [CMS-855A](#) (Medicare Application for Health Care Providers that will Bill Fiscal Intermediaries) application has been approved, an on-site Medicare initial certification survey may be completed by an [Accrediting Organization](#) (AO). **Please see below for additional information related to the CMS-855A.**

How long will the Certification process take?

The length of the OPT/SP application for initial certification process varies dependent on multiple factors such as whether or not the application is complete, whether or not additional information needs to be submitted, current work load and availability of resources necessary to complete the application review, etc. Additionally, your initial survey will be scheduled with the AO. Therefore, it is not possible for the Bureau of Facility Standards to establish specific timeframes.

Additionally, once the AO has completed your initial Medicare *deemed* status survey; **please forward to this office a copy of 1) the AO survey along with any plan of correction submitted in response to the survey and 2) the letter from the AO to**

you verifying accreditation. Once this information has been received the Bureau of Facility Standards will process the Medicare certification on to the CMS Region X Office, Seattle, Washington, for final review and approval.

How do I get paid for providing services?

The Centers for Medicare/Medicaid Services **require new applicants for complete the form *CMS-855A, Medicare Application for Health Care Providers that will Bill Fiscal Intermediaries***, and forward it to the fiscal intermediary/carrier for approval. The form CMS-855A can be accessed on the Internet or requested directly from your fiscal intermediary/carrier:

[Medicare Provider Enrollment](#)

Read the instructions on the web site and obtain the form by clicking on the version you will need for your computer.

Noridian Administrative Services
P.O. Box 6726
Fargo, ND 58108-6726
888/608-8816

www.noridianmedicare.com

To become a Medicaid provider you must complete an enrollment application online to Molina Medicaid Solutions. To submit an Idaho Medicaid provider application, go to <http://www.idmedicaid.com> (Molina Medicaid Solutions Web site). Click on the Provider Enrollment link on the left side of the page. A step-by-step guide is located under the User Guide link on the left side of the screen. We recommend you open this guide in a separate browser window before you begin your application.

To begin your application, open a new browser window at <http://www.idmedicaid.com>, click on the Provider Enrollment link on the left side of the page and then click on the New Provider Enrollment Application link in the center of the page. The new enrollment online application is simple to navigate and online help text appears for each field when you hold your cursor over the field. Additional provider enrollment help is available at (866) 686-4272 choose option "0."

This is a completely separate process from applying for Medicare certification.

Medicare/Medicaid reimbursement is not retroactive and becomes effective only after the survey is completed and you are in compliance with all regulations or have submitted an acceptable plan of correction.

Additional information

For additional information please access the website and reference information below or contact the Bureau of Facility Standards at (208) 334-6626 or email questions to fsb@dhw.idaho.gov.

Bureau of Facility Standards Informational Letters
[OPT/SP](#)

Centers for Medicare & Medicaid Services [Outpatient Rehabilitation Center](#)



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD ARMSTRONG –
Director

BUREAU OF FACILITY STANDARDS
DEBRA RANSOM, R.N., R.H.I.T. – Chief

3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

FISCAL YEAR ENDING

FACILITY NAME: _____

FISCAL YEAR END DATE: _____

OWNER/ADMINISTRATOR

DATE