

MEDICARE PROVIDER ENROLLMENT: 10 Do's and Don'ts

Don't risk having your reimbursement for Medicare services delayed—or even worse—denied

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APPLYING for a Medicare provider number can be a daunting process. Medicare has very strict rules which, if not followed, can cause the issuance of your number to be delayed or even denied and prevent you from billing and collecting for the services you render to your Medicare patients. To help you avoid this costly error, here are 10 key “do’s and don’ts” you should follow to make the enrollment process as smooth as possible.

1 Don't wait to file your Medicare enrollment application. In the 2009 Medicare Physician Fee Schedule, the Centers for Medicare and Medicaid Services announced new enrollment rules for physicians, non-physician practitioners and physician and non-physician practitioner groups. Effective April 1, 2009, a provider that enrolls or re-enrolls with Medicare may only bill for services provided up to 30 days prior to the “effective date” of the application. The “effective date” of the application is the later of the date you filed a Medicare enrollment application that was subsequently approved by a Medicare carrier or the date you, as an enrolled provider, first begin providing services at a new practice location.

Be aware, however, that you only qualify for the 30-day leeway if circumstances prevented you from enrolling *before* providing services to Medicare patients. The only exception is if a Presidentially-declared emergency prevents enrollment; in that case you have up to 90 days prior to the effective date to bill for services. Previously, you could bill for services rendered up to a

whopping 27 months earlier.

If you are hiring a new provider, make sure you take the following steps on or before his or her start date so that you will be ready to submit the appropriate Medicare enrollment application:

- Obtain, or verify that the provider has obtained, a National Provider Identifier number;
- Verify his or her enrollment information (for example, status of license, DEA certificate, etc.);
- Perform an appropriate background check (for example, make sure he or she is not on CMS’ list of individuals excluded from Medicare); and
- Gather all documentation requested in the application.

If you delay submitting the application, reimbursement will be denied for services provided more than 30 days prior to the effective date. *Never, ever* allow a new provider who does not yet have his or her Medicare number to bill using another provider’s number. Except in certain limited circumstances, this is absolutely prohibited and can constitute billing fraud.

If you have not enrolled or updated your Medicare enrollment since November 2003, you will need to complete a new enrollment application. You will receive a letter from the carrier requiring you to submit a new enrollment application, or you may do so prior to receiving the letter. Once you submit your new application, the carrier will create an online enrollment record for you in the Internet-based Provider Enrollment, Chain and Ownership System. CMS is now requiring all providers to be enrolled

in PECOS by January 3, 2011, or face Medicare payment problems.

2 Report changes within the applicable time period. You must notify your Medicare carrier of the reportable events listed below no later than 30 days after the event. You must report such events by filing the appropriate Medicare enrollment paper application (CMS Form 855) by mail or through PECOS.

- A change in practice location.
- A “final adverse action,” which means any of these items:
- A Medicare-imposed revocation of any of the provider’s Medicare billing privileges;
- Suspension or revocation of the provider’s license to furnish health care by any State licensing authority;
- Revocation or suspension of the provider by an accreditation organization;
- The provider’s conviction of certain felony offenses; or
- The provider is excluded or debarred from participation in any Federal or State health care program.
- A change in ownership.

You must also notify Medicare of other reportable events (for example, a change in business structure; a change in an authorized or delegated official; a change in banking arrangements; or a change in reassignment of benefits) as soon as possible but no later than 90 days after the event.

Make sure you have a system in place so that the CMS is notified of reportable events within the applicable time periods. The CMS has made it clear that it is going to “incentivize” you to report changes. To this end, there are now real

consequences if you fail to comply with the new reporting requirements—except for a failure to report a change in ownership, your Medicare billing privileges can be revoked and/or the carrier may try to recover overpayments for services rendered after the date the CMS should have been notified of the reportable event. In addition, Medicare carriers recently have been instructed to send letters to providers reminding them of their reporting responsibilities. If a letter is returned to the carrier by the post office as undeliverable and the carrier does not already have a change of address enrollment application pending, the carrier will deactivate the billing privileges for that practice location and may take additional actions with respect to other practice locations if the appropriate CMS 855 form is not submitted.

3 Obtain or file all necessary permits and licenses before submitting your application. You must meet all Medicare program requirements before you can bill Medicare for services. For example, providers must have all necessary state and local licenses, including city business licenses, county fictitious business name statements and Medical Board fictitious name permits. Although you may submit an enrollment application while awaiting the issuance of a particular license or permit, a Medicare carrier may not allow you to bill prior to the date the license or permit was issued. Since certain licenses and permits can take several weeks to process (for example, it may take six weeks to obtain a Medical Board of California fictitious name permit), make sure you apply for all required licenses and permits well before you submit your enrollment application.

4 If you have multiple practice locations, check to see if you need to file applications with more than one carrier. If you have more than one practice location, it is possible that the offices may be in different Medicare carriers' jurisdictions. If this is the case, you need to file a separate enrollment form for each location in a separate jurisdiction. It may not always be obvious that a location is in a particular jurisdiction. For example, Palmetto GBA's "Northern California" jurisdiction includes locations in San Bernardino and Riverside Counties. If you are unsure about whether your practice locations are in different carrier

jurisdictions, contact the carrier *before* you file your enrollment application.

5 Submit the right application form. The CMS revises its enrollment forms from time to time. Don't assume that the form you downloaded two months ago is still the current version—check the carrier's website to see what date is listed on the current version. Even if the form has been revised only slightly, the carrier will return an application submitted on an outdated form after a specified grace period.

Also, make sure you are submitting the correct CMS 855 form. For example, the CMS used to require sole shareholder professional corporations to submit CMS Form 855B, which is generally used for groups. That rule has changed—a sole shareholder professional corporation must now submit CMS Form 855I. If you're in doubt, check with the carrier.

6 Understand all terms in the application. The meaning of important terms used in the CMS 855 forms is not always obvious. This is why you must read and understand the definition of each term before answering a question. For example, Section 6 of CMS Form 855B, "Ownership Interest and/or Managing Control," asks you to list your "managing employee." You might assume that a managing employee means a W-2 employee; but the definition is broader than that. It includes any individual who exercises operational or managerial control over your day-to-day operations, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee or independent contractor.

7 Include all requested and updated documentation. Make sure you review the checklist of documents the application form asks you to supply, and that the documents you supply are up to date. For example, don't send an expired license or malpractice insurance certificate.

8 Carefully review the application before you sign it. Although it may seem obvious, enrollment mistakes can often be avoided simply by taking the time to review the enrollment application before you sign it. Often an office manager or billing company completes the enrollment applications; but that will not excuse a mistake. Remember, you are certifying to the CMS that all of the information

contained in the enrollment application is true. Deliberately providing false information is a criminal act. Further, at a minimum, mistakes will result in requests for clarification or additional information, and delay the processing of your application. Therefore, it is imperative that you take the time necessary to personally review the form or forms you are submitting to verify that all information is accurate and complete. Also, make sure the form contains an original signature. If the form is unsigned or has a stamped signature, the carrier will return it to you.

9 Promptly respond to any requests for additional information. Frequently the carrier will determine that it needs additional information or documents in order to process the application. Make sure you have a system in place so that requests are not ignored or delayed. The carrier will generally give you 30 days to respond to requests for additional or missing information or documentation; if you do not respond within 30 days, your application may be rejected and you will have to submit a new application with a later effective date. Thus, it is extremely important to try to get it right the first time.

10 Follow up with the carrier and document all contacts. Although carriers discourage you from contacting them directly to check on the status of an enrollment application, it is important for you to do so to make sure you haven't missed a request for additional information from the carrier. You should be aware, however, that carrier representatives are very busy, and multiple representatives will likely be involved in the processing of your application. Therefore, it is easy for misunderstandings or miscommunications to occur. To protect yourself, you should follow-up on all conversations or correspondence with Provider Enrollment by documenting these encounters by letter or fax.

If you follow these tips, you will greatly increase the likelihood that your enrollment application will be processed as quickly as possible and that you will be approved on a timely basis.

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