Health Law Alert: CMS Focus on Medicare Enrollment: What Providers Need to Know

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CMS is taking a number of steps to tighten up its rules on Medicare enrollment. To an already burdensome enrollment process, CMS is now imposing shorter timeframes, additional penalties, and an emphasis on keeping enrollment current. The following provides an overview of some of these key changes to the Medicare enrollment rules and what providers can do now to respond.

Current Enrollment Status in PECOS

In late 2008, CMS rolled out its Internet-based PECOS, which allows providers to enroll in Medicare, check the status of an application, or make changes to their enrollment information. CMS is now emphasizing the importance of keeping a current enrollment record in PECOS by imposing penalties for not doing so. Providers will have a tighter timeframe—only 30 days from the previous 90-day window—to correct mistakes and supply additional information to keep their enrollment status updated. Specifically, providers will need to report final adverse legal actions, practice address changes, and ownership changes within 30 days of the change, or risk the possibility of having their billing privileges for all of their PTANs revoked. If this occurs, the provider will not be able to bill with any of their PTANs for a minimum of one year, and up to three years. Additionally, if a provider does not submit an adverse legal action within 30 days, the contractor may assess an overpayment back to the date of the action or change.

Providers should verify that their PECOS enrollment record is current, and update it as necessary. They may do so by accessing the PECOS system at https://pecos.cms.hhs.gov/pecos/login.do. Providers should be certain to update their PECOS record if any of the above three changes occur within 30 days of the change to avoid the risk that their billing privileges will be revoked.

Revalidation Efforts by Carriers

CMS recently directed Medicare contractors to begin a series of revalidation efforts focused on certain Medicare Part B physicians, nonphysician practitioners, and group/organizational suppliers. Most of the revalidation letters were mailed between October 2009 and January 2010. Revalidation efforts are not new, and these targeted efforts will affect a relatively small percentage of providers and suppliers. However, it is imperative that those who receive a letter requesting a revalidation application respond to it in a timely manner.

Providers and suppliers who receive a revalidation letter have 60 days from the date of the request to submit a revalidation application to the Medicare contractor. If an application is not received within 60 days, the contractor will revoke the billing privileges of the provider/supplier and will bar the provider/supplier from participating in Medicare for one year from the date of revocation. Revocation is effective 30 days after the notification of revocation is mailed. A provider or supplier may appeal a revocation.

Providers and suppliers who do not receive a revalidation letter do not have to take any action. CMS is emphasizing that providers and suppliers should refrain from proactively submitting an application for revalidation. Providers or suppliers who wish to verify whether they have been issued a revalidation letter can contact their appropriate MAC.

Ordering and Referring Providers

CMS is imposing stricter rules on ordering and referring providers for Part B claims. In order for physicians to bill for items or services that are the result of an order or referral, the claim must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider, the ordering/referring provider must be in PECOS or in the Medicare carrier's or Part B MAC's claims system, and the ordering/referring provider must be eligible to order/refer in the specialty for that item or service.

This policy is being implemented in two phases. During Phase 1, which has been extended until January 2, 2011, if a billed service requires an ordering/referring provider and none is provided, or if the ordering/referring provider is not in PECOS or in the claims system of the carrier or Part B MAC, the claim will continue to process and the Part B provider or supplier will receive a warning message on the remittance advice.

During Phase 2, which will begin on January 3, 2011, a claim will be rejected if the ordering/referring provider is not in PECOS or the claim system. Similarly, if the billed service requires an ordering/referring physician and none is present, the claim will be denied. A claim will also not be paid if the ordering/referring provider is not of the specialty to order or refer that item or service.

All physicians who order and refer items or services for Medicare beneficiaries should verify that they have a current enrollment record in PECOS and that all information is up-to-date. They may do so by accessing the PECOS system at https://pecos.cms.hhs.gov/pecos/login.do. Any physicians who enrolled prior to the implementation of PECOS in 2003 will be required to re-enroll if they want to refer and order in the future.

Updated CMS-855 Forms

CMS has updated its CMS-855 Medicare enrollment application forms. The new forms must be used as of December 1, 2009. Providers should check the effective date in the lower left corner of the Form 855 to ensure they are using the most current form, designated "(EF 07/09)."

Signatures on Dictated Medical Records

Several Medicare contractors have recently released guidance describing strict signature requirements for dictated patient records. After a physician's dictated notes are transcribed into a final record, the physician must review the transcribed note to correct any errors and affirm the contents of the note. Once affirmed, the physician must affix a handwritten or electronic signature to the note and it becomes the final record of the service. Failure to sign dictated notes may result in the denial of services or in a request that the provider complete an attestation statement to validate the note.

If an electronic signature is used, it must be readily identifiable as a valid electronic signature proving that the physician affirmed the transcribed note. It is not sufficient that the provider is designated as dictating the note, or that the provider's name is present in the record. If the provider uses a handwritten signature, it should be legible. If the signature is not easily identifiable or is not signed on or over the provider's printed name, a sample signature should be submitted with any documentation requested by CMS or the contractor.

Effective Billing Date Rules and Retrospective Billing

CMS has dramatically shortened the allowable timeframe to retroactively bill for Medicare services. The 2009 Medicare Physician Fee Schedule limits a provider's ability to retroactively bill for services to no more than 30 days prior to the effective date, rather than the 23 months previously allowed under the regulations. The effective billing date will be the later of (1) the date of filing of a Medicare enrollment application that is able to be processed to approval, or (2) the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location.

Physicians and nonphysicians should consider proactively submitting enrollment applications prior to, or as soon as they begin to, provide services to Medicare beneficiaries. This will help avoid claim denials for services furnished prior to the billing effective date.

Contact Us

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