Medicare Enrollment

By
Dr. Ron Short, DC, MCS-P

October Medicare News

New MAC Contracts

- On September 17, 2012, CMS announced that Novitas was awarded the contract for Jurisdiction L.
    - Jurisdiction was formerly Jurisdiction 12 and covers Pennsylvania, Delaware, Maryland, New Jersey, and Washington D.C.
    - Novitas was formerly Highmark.
    - Since Highmark had the contract for Jurisdiction 12, there essentially will be no change.
- On September 20, 2012, CMS announced that Noridian was awarded the contract for Jurisdiction E.
    - Jurisdiction E was formerly Jurisdiction 1 and covers California, Nevada, Hawaii, American Samoa, Guam, and the Northern Mariana Islands.
    - The transfer will take place over the next several months.
- On September 27, 2012, CMS announced that National Government Services was awarded the contract for Jurisdiction 6.
    - Jurisdiction 6 cover Illinois, Wisconsin, and Minnesota.
    - The contract was for one base year and four option years.
    - The transfer will take place over the next six months.

Medicare Maintenance Fees

- Last month I mentioned an interpretation of Medicare regulations regarding the fees that we can charge to maintenance patients.
- I have had rather extensive discussions with some other consultants and conducted some further research.
- We have come to the conclusion that other regulations and sections of the Social Security Act apply in this case.
- The end result is that you can charge full price after you have billed the service without the AT modifier, given the patient an ABN and placed a GA modifier on the claim, and received a denial for that claim.
- There is still some question about discounting maintenance care so we still recommend a Medical Discount Plan such as CHUSA.

Monetary Thresholds for Appeals

- The 2013 monetary thresholds for appeals were announced.
- For appeal to the Administrative Law Judge level the minimum amount in dispute must be $140.00.
- For appeal to the Federal District Court level the minimum amount in dispute must be $1,400.00.

Mechanism of Trauma

- Part of the required information in the initial visit history is the mechanism of trauma.
- If there is no mechanism of trauma or if the record indicates an insidious onset, Medicare will consider the care to be maintenance in nature.
- Medicare has no mechanism to pay for a case that does not have a clear mechanism of onset.

The Physician Quality Reporting System (PQRS)

- Starting in 2015 Medicare will place a Payment Adjustment (read cut) on the fees of any doctor not reporting measures through the Physician Quality Reporting System (PQRS).
- This cut will be applied to the reporting year 2013.In other words, if you do not report measures through the PQRS in 2013 you will receive a cut in the amount that Medicare will pay you in 2015.

Medicare for Chiropractors Special Offer

- The good folks at ChiroCode are offering my book Medicare for Chiropractors at a substantial savings this week.
- Use the promo code MED22 and receive $100.00 off of the current price.
- This special will last for this week only, so act quickly.

Why Enroll in Medicare?

- This is one of the most common questions that I am asked.
- You are required by law to bill Medicare for covered services rendered to a Medicare beneficiary.
- You must be enrolled with Medicare as a provider to bill Medicare.The penalty for not billing Medicare for a covered service is up to $10,000 fine per occurrence.
- They always start at $10,000.
- Additionally, the Medicare Program Integrity Manual, Chapter 15, Section 15.1 States:
- "No provider or supplier shall receive payment for services furnished to a Medicare beneficiary unless the provider or supplier is enrolled in the Medicare program. Further, it is essential that each provider and supplier enroll with the appropriate Medicare fee-for-service contractor."

Steps to Enrolling in Medicare

- There are several steps in enrolling in Medicare.
- Each step requires completion before you can take the next step.
- Take these steps out of order and you will greatly prolong the enrollment process.
- Before you start the enrollment process you will need:

- IRS documentation showing business name and taxpayer identification number
- State and/or local business license if applicable
- State license to practice
- Physical Practice Location
- Practice Telephone Number You do not need to be in practice to begin the enrollment process.

- After you have the above information you will need to employ the following forms.
- National Provider Identifier (NPI) Application
- CMS-855I
- Electronic Data Interchange (EDI) Enrollment Form
- EDI Registration Form
- Electronic Funds Transfer (EFT) Authorization Agreement
- Medicare Participating Physician or Supplier Agreement
- CMS-855R
- CMS-855B You can treat Medicare patients up to 30 days prior to the official receipt of your application.
- Your application is official on the date that it was received by the MAC and date stamped.
- According to Medicare Program Integrity Manual, Chapter 15, Section 15.17
- "In accordance with 42 CFR §424.520(d), the effective date for the individuals and organizations identified above (these include physicians and group practices *ed.*) is the later of the date of filing or the date they first began furnishing services at a new practice location.
- Note that the date of filing for Internet-based PECOS applications for these individuals and organizations is the date that the contractor received an electronic version of the enrollment application and a signed certification statement.
- Because of this it is important that you send all application materials by certified mail with a return receipt requested.

National Provider Identifier (NPI)

- The purpose of the NPI is to have a single universal identification number for all healthcare providers in order to "improve the efficiency and effectiveness of the electronic transmission of health information". "Every provider that submits an enrollment application must furnish its NPI(s) in the applicable section(s) of the CMS-855."
- "The provider need not submit a copy of the NPI notification it received from the National Plan and Provider Enumeration System (NPPES) unless requested to do so by the contractor."To obtain an NPI online go to https://nppes.cms.hhs.gov/NPPES/Welcome.do
- The process is straightforward and you should get your number by e-mail notification in a few days.
- You can also submit the application on paper using form CMS-10114, but this will take longer to receive your number.

- There are two types of entity classifications for NPIs:
  - Type 1: This classification is for individuals and sole proprietorships. Everyone needs a type 1 NPI and if you are a sole proprietorship, it is the only NPI that you will need.
  - Type 2: This classification is for organizations. If you have a corporation or partnership, you will need a type 2 NPI also.

CMS-855 Enrollment Form

- There are three CMS-855 enrollment forms that will concern the chiropractor.
  - CMS-855I
  - CMS-855B
  - CMS-855R
- You can submit these applications on paper.
- Or you can go to http://www.cms.hhs.gov/MedicareProviderSupenroll/ to access these applications and to access the internet-based PECOS system.

CMS-855I

- This form should be completed by individual practitioners, including physicians and non-physician practitioners, who render Medicare Part B services to Medicare beneficiaries.
- This includes a physician or practitioner who: (1) is the sole owner of a professional corporation, professional association, or limited liability company, and (2) will bill Medicare through this business entity.
- All doctors should enroll as individuals.

CMS-855B

- This application should be completed by a supplier organization (e.g., ambulance company) that will bill Medicare for Part B services furnished to Medicare beneficiaries.It is not used to enroll individuals.
- Any organization that will have multiple owners (e.g., partnerships, corporations with multiple shareholders, etc.) should use this form to enroll the organization in Medicare.

CMS-855R

- An individual who renders Medicare Part B services and seeks to reassign his or her benefits to an eligible entity should complete this form for each entity eligible to receive reassigned benefits.
- The person must be enrolled in the Medicare program as an individual prior to reassigning his or her benefits. Your associate would use this form to reassign his billing rights to you.
- Also, any doctor working for an entity that would use the CMS-855B to enroll should use this form to reassign their benefits to the entity.
- February 8, 2012 the OIG issued a special alert regarding form CMS-855R.

- Physicians who reassign their right to bill the Medicare program and receive Medicare payments by executing the CMS-855R application may be liable for false claims submitted by entities to which they reassigned their Medicare benefits.
- Even if someone else may be doing the billing, you are responsible to see that it is done properly.
- Therefore, you must learn the procedures and periodically check to ensure that they are carried out properly.Avoid an associate contract that requires you to have nothing to do with the billing.
- You should know what the billing department is doing regarding claims for services that you performed.
- The CMS-855R application must be completed for any individual who will (1) reassign his/her benefits to an eligible entity, or (2) terminate an existing reassignment.
- The CMS-855R and CMS-855I can be submitted concurrently.
- The effective date of a reassignment is the date on which the individual began or will begin rendering services with the reassignee. Note that benefits are reassigned to a supplier, not to the practice location(s) of the supplier. As such, the carrier shall not require each practitioner in a group to submit a CMS-855R each time the group adds a practice location. If the individual is initiating a reassignment, both he/she and the group's authorized or delegated official must sign section 4 of the CMS-855R.
- If the person or group is terminating a reassignment, either party may sign section 4 of the CMS-855R; obtaining both signatures is not required. In situations where the supplier is both adding and terminating a reassignment, each transaction must be reported on a separate CMS-855R. The same CMS-855R cannot be used for both transactions.

CMS-855 Enrollment Form

- The contractors have deadlines that they are supposed to meet.
- The contractor is obligated to process 80% of paper-based applications within 60 calendar days.
- They are obligated to process 90% of web-based applications within 45 calendar days.

CMS-588 Electronic Funds Transfer Form

- For new enrollees and revalidating providers, all payments must be made via EFT.
- The contractor shall thus ensure that the provider has completed and signed the CMS-588.If an enrolled provider that currently receives paper checks submits a CMS-855 change request – no matter what the change involves – the provider must also submit:
- A CMS-588 that switches its payment mechanism to EFT. The change request cannot be processed until the CMS-588 is submitted.

- An updated section 4 that identifies the provider's desired "special payments" address. Once a provider changes its method of payment from paper checks to EFT, it must continue using EFT. A provider cannot switch from EFT to paper checks.
- The "special payment" includes payment of incentive bonuses for such thing as practicing in a Healthcare Provider Shortage Area (HPSA). Remember that electronic funds transfer works both ways.
- As part of the agreement you are agreeing to allow Medicare to deduct funds from your account if they should find that you have been overpaid. To limit this risk you should open a separate account that is reserved just for EFT payments from Medicare and keep only $100.00 in it.
- When a payment comes in withdraw all but the original $100.00. In this way, you limit your risk of your account being raided.

Par vs. Non-Par

- Much has been made about whether or not to be a participating provider.
- Some go so far as to state that you will not be reviewed if you are a non-par provider.
- This is false.What does it actually mean to be a participating provider.
- Close examination of the Medicare Participating Physician or Supplier Agreement (Form CMS-460) indicates that you are agreeing to four things: That you will
  accept assignment (direct payment to you instead of the beneficiary) on all Medicare claims filed for the calendar year.
  - That the Medicare approved charge for the service will be the full charge for covered services.
  - That you will collect only the applicable deductible and coinsurance.
  - That the agreement will automatically renew annually unless you take specific action to cancel it.

Revalidation

- Per 42 CFR § 424.515, Medicare providers and suppliers (other than DMEPOS suppliers) must resubmit and recertify the accuracy of their enrollment information every five years in order to maintain Medicare billing privileged.
- Currently, most MACs are sending out revalidation letters.Per 42 CFR § 424.515, a provider whom the contractor requested to furnish all requested information (as part of the revalidation) must do so within 60 calendar days after the date the contractor notified the provider of the need to revalidate.
- If the provider fails to do so, the contractor shall revoke the providers billing privileges using existing revocation procedures.The provider must submit all required documentation with its application, even if such documentation is already on file with the contractor.
- There have been several cases of doctors ignoring revalidation letters and loosing their billing privileges.