

Medicare Enrollment

By

Dr. Ron Short, DC, MCS-P

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. While the CMS-855 forms have thorough instructions and additional assistance can be secured from your Medicare Administrative Contractor or Carrier, a few suggestions are: Have the following in hand prior to submitting an enrollment application;
 - State professional license.
 - Any required state or local business licenses.
 - Documentation of Taxpayer Identification Number.
 - Physical practice location.
 - Practice telephone number. You may check only one reason for submittal of the application form. If you have more than one reason you must submit multiple applications.
- If you are enrolling for the first time, you may enter "pending" when asked for your Medicare Identification Number. You may use a P.O. Box as your correspondence address.
- Solely owned practitioner organizations (professional corporation, professional association, or limited liability company) need only complete the CMS-855I application.
- Sole proprietorships need not complete section 4A of the CMS-855I application form.
- Only the individual practitioner must sign the CMS-855I.

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).
- The "special payment" address may only be one of the following:
 - One of the provider's practice locations.
 - A P.O.BoxThe provider's billing agent.
 - The chain home office address.
 - Correspondence address 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. In return for agreeing to this, Medicare will give you some goodies.
- Among these are:
 - You are paid 5% more.
 - If you file electronically, you will receive your money within 2 weeks.
 - You will receive a Medicare Remittance Notice within a few days of being paid.
 - You are listed in the Provider Directory.
 - You are a party to a denial and, as such, you can initiate an appeal.
 - You can bill your full price to Medicare.
 - Claims are automatically forwarded to secondary insurance. If you do not participate, circumstances are a little different:
 - You are paid at 95% of the allowed fees.

- You can charge the patient up to the “limiting charge” which is set at 115% of the allowed charge.
- If you charge any amount over the limiting charge you risk a \$10,000 per occurrence fine. You are not listed in the Provider Directory.
- You collect from the patient but, by law, you must submit claims anyway.
- You can accept assignment, but it is on a claim-by-claim basis.
- You will receive a Medicare Remittance Notice quarterly.
- Under some circumstances you will not be able to initiate an appeal without receiving an Assignment of Appeal Rights from the beneficiary.
- These requirements apply whether you elect to participate or not participate:
 - You are required to submit the claim for the patient.
 - You are subject to review by Medicare.
 - You are required to document medical necessity for all care for it to be paid by Medicare. You are required to deliver an ABN to the patient when you believe that Medicare will not pay for the service.
 - You are required to adhere to all Medicare regulations. The only “advantage” to not participating is that you get to charge the Medicare patients 15% more.
- This is offset by the fact that the Medicare patient is paying more out-of-pocket and will see your office as less desirable than the office that takes assignment where they just walk-in, get adjusted, and walk out. Medicare wants you to participate because it is easier for them.
- Therefore, they will make it easier for you if you participate.

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 losing their billing privileges.

Changes to Medicare Enrollment

- On September 23, 2010 CMS published some proposed rules in the Federal Register for comment.
- The comment period ended November 15, 2010.
- The final rules were published February 2, 2011.
- These rules were effective March 25, 2011.

- The rules are as follows: Screenings to include:
 - Verification of Medicare specific requirements.
 - License verification.
 - Database checks.
 - Unscheduled/unannounced site visits.
 - Criminal background checks.
 - Fingerprinting.
- There are three categories of screenings.
 - Limited.
 - Moderate.
 - High.
- “Physician and non-physician practitioners and medical groups and clinics” are to be placed in the limited category. The limited category includes:
 - “Verification of any provider/supplier specific requirements established by Medicare.”
 - “Conduct license verifications (may include licensure checks across states)”.
 - “Database Checks.”
 - Database checks are: “to verify Social Security Number (SSN), the National Provider Identifier (NPI), the National Practitioner Data Bank (NPDB) licensure, an OIG exclusion, taxpayer identification number, tax delinquency, death of an individual practitioner, owner, authorized official, delegated official, or supervising physician.” A specific provider type can be moved from “limited” category to “high” category.
- For two reasons:
 - If CMS believes that the specific provider type poses a greater risk of fraud, waste or abuse.
 - If the specific provider type has been under a temporary moratorium.
- In the final rule Physical Therapists were moved from the “limited” category to the “moderate” category. Temporary moratoria on enrollment of Medicare Providers and Suppliers, Medicaid and CHIP Providers.
 - The Secretary of Health and Human Services may impose temporary moratoria on the enrollment of new Medicare, Medicaid or CHIP providers and suppliers, including categories of providers and suppliers if the secretary determines such moratoria are necessary to prevent or combat fraud, waste or abuse under the programs. The moratorium will be imposed for 6 months and extended in 6 month increments as CMS deems necessary.
 - The moratorium can be appealed through the Departmental Appeals Board level.
 - Moratoria will be announced in the Federal Register and through the Medicare listserv. Suspension of payments.

- CMS can suspend payments to a provider when there is a credible allegation of fraud.
 - CMS will consult with the OIG and/or the Department of Justice to determine if there is a credible allegation of fraud.
 - For the purpose of the Affordable Care Act, CMS has determined that physicians are exempt from the payment of application fees.
 - If a provider or supplier is terminated from Medicare they will now be terminated from Medicaid and CHIP.
 - It also works the other way.
 - If a provider is terminated from Medicaid or CHIP then they will also be terminated from Medicare.
- These provisions were effective March 25, 2011.
- They applied to new enrollees and revalidating enrollees at that time.
- They will apply to existing enrollees on March 25, 2012.

Reportable Changes

- Once you are enrolled in Medicare, you are required to keep the Medicare carrier informed as to changes in your status or information.
- The following changes are for individual physicians and can be reported on the CMD-855I form or on the PECOS online system. The following reportable events are required to be reported as soon as possible but no later than 30 days after the reportable event:
 - Change in Practice Location
 - Change in Final Adverse Action Physicians are required to report the following reportable events as soon as possible, but no later than 90 days after the reportable event:
 - Change of Business Structure.
 - Change in Organization Legal Business Name/Tax Identification Number.
 - Change in Practice Status.
- Other reportable changes include:
 - Change in Reassignment of Benefits.
- Change in Banking Arrangements or any Payment Information occurs when a physician changes his or her bank or bank account or makes other payment information changes. This type of change should be reported immediately to the Medicare contractor. Physician group practices must report the following on the CMS-855B.
 - Physician group practices are required to report the following reportable events as soon as possible, but no later than 30 days after the reportable event:
 - Change in Ownership or Managing Interest Control.
 - Change in Practice Location.
 - Change in Final Adverse Action. Physician group practices are required to report the following reportable events as soon as possible, but no later than 90 days after the reportable event: Change in Legal Business Name/Tax Identification Number.

- Change in Authorized or Delegated Officials.
- Change in Reassignment of Benefits. Change in Banking Arrangements or any Payment Information occurs when a physician group practice changes its bank or bank account or makes other payment information changes. This type of change should be reported **immediately** to the Medicare contractor. A physician group practice can update his or her electronic funds transfer information by submitting the Electronic Funds Transfer Authorization Agreement (CMS-588) to his or her Medicare Contractor.

Opting Out of Medicare

- There is a procedure for physicians to opt out of Medicare and work private contract arrangements with their patients. Some consultants are currently selling opt-out programs for chiropractors.
- The problem is that chiropractors cannot opt out of Medicare.
- Quoting Medicare Benefits Policy Manual, Chapter 15, section 40.4:
- For purposes of this provision, the term “physician” is limited to doctors of medicine; doctors of osteopathy; doctors of dental surgery or of dental medicine; doctors of podiatric medicine; and doctors of optometry who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the State in which such function or action is performed; **no other physicians may opt out.** Anyone promoting that there is a way for chiropractors to opt out Medicare is promoting something that, in all probability, will get doctors in trouble.