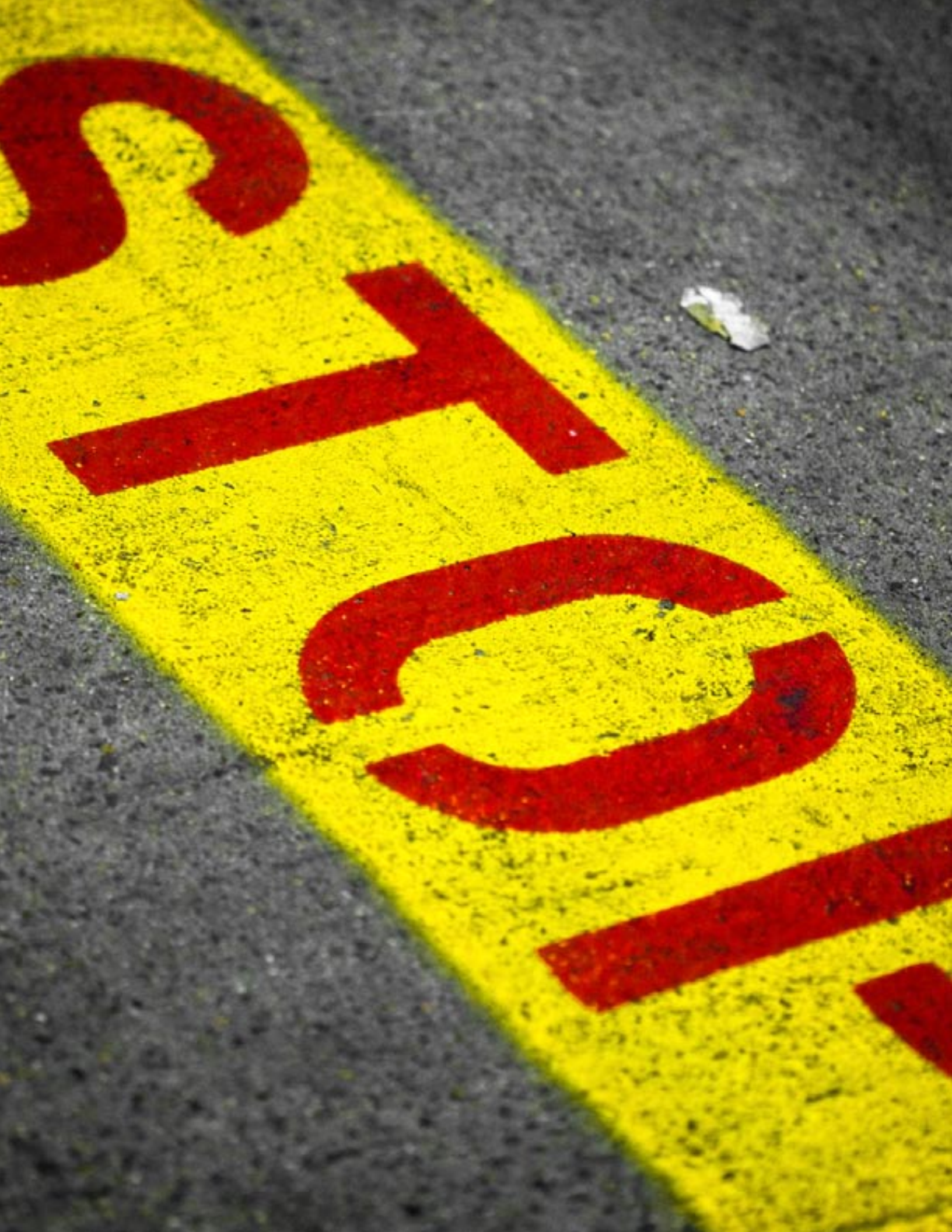

Could Your Medicare Billing Privileges Be Revoked?

In today's ever-changing health care climate, health care providers are looking for some type of stability. In the past, that stability was participation in the Medicare program. Despite the fact that the benefits of participating in the Medicare program have become increasingly murky, maintaining participating status remains a hallmark for most health care providers.

However, as Medicare moves to maintain costs more policies and procedures are being instituted which may put a health care provider's billing provider status in jeopardy. Here are some steps that can be taken to ensure that you remain in good standing with Medicare as both a billing provider and referring health care provider.

1. Update Your Enrollment When Necessary

Many health care providers simply "forget" to update their Medicare enrollment. However, a failure to update could cause you to have your Medicare billing provider status revoked. Pursuant to long-standing Medicare rules and regulations, health care providers are required to provide Medicare with certain updates. Within thirty (30) days of occurrence, a provider must notify Medicare of: (i) changes in ownership; (ii) changes in practice location; and/or (iii) final adverse actions. Within ninety (90) days of occurrence, a provider must notify Medicare of: (i) change in practice status; (ii) change in business structure, legal business name or taxpayer identification number; (iii) change in banking arrangements or payment information; and/or (iv) change in the correspondence for special payments address.

In April of 2010, the Centers for Medicare and Medicaid Services (CMS) issued a transmittal setting forth its updated process for conducting site verifications. CMS is permitted, when it deems necessary, to perform on-site inspections of a health care provider to verify that the enrollment information submitted to CMS is accurate and to determine compliance with Medicare enrollment requirements. If CMS visit a practice location that is no longer being used, but had not been removed from the health care provider's Medicare enrollment, that health care provider's ability to bill Medicare may be revoked.

Similar to the site verifications, CMS

may undertake other actions with regard to determining compliance with Medicare enrollment requirements. It is incumbent upon each health care provider to ensure that his, her or its Medicare enrollment is up-to-date with any changes that may have occurred.

2. Be Aware of Revalidation Efforts and Respond Accordingly

In September of 2009, CMS issued a transmittal setting forth a plan for provider revalidations. The revalidation effort was to focus on the top 50 Part B individual practitioner supplier billers within each State. Each of these health care providers were to be sent a request for revalidation by CMS. Pursuant to the Medicare rules and regulations, the Medicare Administrative Contractor (MAC) is permitted to request revalidation from participating health care providers at any time.

To the extent you receive a request for revalidation, it is imperative that you take all appropriate actions to complete the revalidation. A failure to do so could result in a revocation of billing privileges. Already, we have seen revocations stemming from a failure to respond. In some cases the revocations are a result of the health care provider's failure to receive the notice due to misdirected mailings to practice locations or addresses that had not been updated as required. In other cases, it is uncertain as to how a request for revalidation failed to reach the health care provider. Regardless of the reason for the failure to respond, the revocation that results from this failure remains devastating to a practice. As such, health care providers must remain vigilant in responding to any inquiries received from CMS regarding Medicare enrollment.

3. Enroll in PECOS

CMS had set forth a plan with regard to ordering, referring and providing certain Part B Medicare services requiring those ordering and referring providers to enroll in the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). As proposed, during phase 1, October 5, 2009 – January 2, 2011, if a billed item or service was not ordered or referred by a provider with an active PECOS enrollment, the claim would be processed and the provider would receive a warning message on the Remittance Notice indicating that the provider must enroll in PECOS. During phase 2, which was to begin on January 3, 2011, if a billed item or service was ordered or referred by a provider without an active PECOS enrollment, the claim would be denied.

However, in the interim final rule set forth with regard to the new Patient Protection and Affordable Care Act (PPACA), those deadlines were accelerated. As of July 6, 2010, ordering and referring health care providers must be enrolled in PECOS as of the date of the order or referral to enable the MAC to verify the provider's enrollment (or Medicare opt-out status, if applicable). If the MAC is unable to verify the ordering or referring health care provider's enrollment using PECOS, the MAC may deny claims for such services.

Recognizing the inevitable chaos that would ensue with this changed deadline, CMS set forth a June 30 news release indicating that "CMS will, for the time being, not implement changes that will automatically reject claims based on orders, certifications and referrals made by providers that have not yet had their applications approved by July 6." It is anticipated that the original deadline of January 2, 2011, will be re-instated when the final rule is issued this fall.

To remain in compliance with the new rules and to remain on the good side of those who provide Part B services for your patients, you need to take the appropriate steps to enroll in PECOS prior to the implementation of the deadline, whenever that may be. In addition, once you enroll in PECOS, you will be able to update your Medicare enrollment with regard to many

of the required enrollment updates mentioned herein.

What Is Revocation?

Some of you may be thinking, how much could revocation really affect me? If it is an innocent overlook, wouldn't I be able to fix it relatively easily? The short answers to those questions are (1) a lot and (2) no. If your Medicare billing privileges are revoked, in most casts the revocation is effective 30 days after CMS or the MAC mails the notice of its determination. Once revoked, you are barred from billing or participating in the Medicare program until the end of the re-enrollment bar. The re-enrollment bar is established by the MAC in accordance with the following:

> "1 year – License revocation/suspension that a deactivated provider (i.e., is enrolled by is not actively billing) failed to timely report to CMS; provider failed to respond to revalidation request.
> 2 years – The provider is no longer operational.
> 3 years – Medical license revocation/suspension and the practitioner continued to bill Medicare after the license revocation/ suspension/ felony conviction and the practitioner continued to bill Medicare after the date of the conviction; falsification of information." (Medicare Program Integrity Manual, Chapter 10, Section 13.2)

As such, a failure to respond to a revalidation request will revoke billing privileges for at least one year and a failure to update information such as a site location could result in a two-year revocation. Therefore, a simple mistake could have lasting implications on your practice, as your patients will be forced to seek other care during your revocation period and your income will likely decrease with your decreased patient volumes. Additionally, once your billing privileges are reinstated, your Medicare patients who have sought care elsewhere may not return.

With the penalties associated with revocation being so high, it is in each Medicare health care provider's best interest to be aware of the ever-changing Medicare landscape and remain in compliance with the rules and regulations related thereto. Think of your Medicare enrollment and compliance the same way you think of the medical care you provide – prevention is the best treatment and solution!

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