

New enrollment appeals rule contains three bombshells

An enrollment and billing revocation appeals rule that increases your carrier's ability to revoke your billing privileges and gives you less time to respond to requests for additional enrollment documentation will finally take effect August 26 (PBN 3/5/07). "This rule has been in the pipeline for over 10 years," says William Maruca, health care attorney with Fox Rothschild LLP in Pittsburgh.

Three things that stand out in the rule:

1. **You'll only have 30 days to respond to a request for additional information from your carrier.** Currently you have 60 days to act if you forget to include all of the necessary documentation when you submit a CMS-855 form. Keep in mind that the 30 days begins when your carrier sends the letter. Normally this shouldn't be a problem, but some documentation can be difficult to obtain if you don't have it on hand, says **Belinda Holmes CPC, senior medical business consultant with Kerkering, Barberio of Sarasota, Fla.**

Example: You may not have the letter the IRS sent when it granted your organization an Employer Identification Number (IRS CP-575), "You won't be able to get it in 30 days," Holmes says. Her firm uses extensive checklists to make sure the application is complete before they submit it to the carrier.

CAVEAT: The 30 day deadline does not apply to enrollment and reenrollment applications your carrier receives before August 26. Stephanie Fiedler, senior healthcare consultant with Loeb & Troper in New York, says she is used to seeing requests with a 30 day deadline, which have also cropped up in Florida. "I tell the carrier that this is incorrect and they give us more time," she says.

If your carrier invokes the new rule as the reason for the shorter time period, "Tell them this is for the date the new rule goes into to effect and be firm," she says. But keep in mind that your carrier might take a few days to stamp your enrollment application as received.

Your carrier is also able to stop the clock on processing your enrollment whenever it has a problem with your application – a powerful incentive to do it right the first time. The new rule requires carriers to process 90% of enrollments, reenrollments and revalidations in 45 days, 95% in 60 days and 99% in 90 days with 180 days being the absolute maximum.

2. **Your carrier will have more latitude in revoking your billing privileges.** "You'll be kicked out if you submit claims that cannot have been performed," warns Maruca. **Example:** Claims for services performed well after the date of a patient's death.

The change makes it easier to kick out fraudulent billers, not people who make occasional errors, CMS points out. But it's up to your carrier to define a pattern. "I've seen people who bill office services when they occurred in an [ambulatory surgery center]," Holmes says. "Is it accidental? Yes. Is it a pattern? Yes."

A revocation of privileges can last from one to three years and it “will stop you dead in your tracks,” Holmes says. Unlike a claims appeal or even an audit, you won’t be able to bill Medicare at all until you’ve won an appeal.

3. **Carriers might pull your billing privileges if don’t revalidate in a timely fashion.** In 2006 CMS stated it would require doctors to revalidate enrollment data every five years (PBN 5/1/06). The agency has said you should wait for the carrier to approach you, but this final rule opens the door to **voluntary** revalidation.

Holmes points to language in the regulation which states you “may voluntarily complete and submit a Medicare enrollment application and the necessary supporting documentation prior to our formal request for revalidation.” It goes on to say that you could see billing privileges revoked if you fail to revalidate either voluntarily or by carrier request.

Because the regulation mentions voluntary compliance you might not be able to raise the lack of a letter from your carrier as a defense if it decides to pull your billing privileges, Holmes says.

NOTE: A revalidation letter may not be clear. “We had a doctor who received a letter that asked for a copy of his license and other documents,” Holmes says. It did not mention form CMS-855.

You will get 60 days to appeal any move to deny your enrollment or revoke your billing privileges, according to the rule. — *J. Kyles*

On the Internet:

- Appeals of CMS or CMS Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges: <http://edocket.access.gpo.gov/2008/pdf/E8-14440.pdf>.

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