HCCA
HEALTH CARE COMPLIANCE ASSOCIATION

COMPLIANCE TODAY

Volume Fourteen
Number Two
February 2012
Published Monthly

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Medicare revalidation survival guide

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The Centers for Medicare & Medicaid Services (CMS) have launched a massive effort to revalidate the enrollment information of providers and suppliers in the Medicare program. New enrollment screening criteria, in accordance with the Patient Protection and Affordable Care Act (PPACA), imposes heightened screening and enforcement measures for initial Medicare enrollment, revalidation, and billing in an effort to proactively prevent fraud and abuse in federal health care programs.

Approximately 1.4 million health care providers and suppliers in the Medicare program, including 750,000 physicians, are required to revalidate their enrollment information with CMS between now and March 2015. Providers and suppliers should not begin the revalidation process, however, until receiving a revalidation request letter from CMS or a Medicare Administrative Contractor (MAC). Providers and suppliers who submitted enrollment applications on or after March 25, 2011 will not be required to undergo revalidation, as their applications were processed under PPACA's new enrollment screening criteria.

Initially, CMS announced a much more compressed timeframe for completion of its revalidation effort and indicated that revalidation letters would be sent to providers and suppliers between August 2011 and March 23, 2013. After reevaluating the revalidation requirement under PPACA, however, CMS concluded that PPACA allows for a more flexible timeframe. CMS has since announced that it will extend its revalidation effort through March 2015. Importantly, this extension does not affect those providers who have already received a revalidation notice.

Revalidation process

CMS began its revalidation effort in September 2011 by sending 89,000 revalidation request letters to providers and suppliers. This first set of letters was sent to providers and suppliers that bill the Medicare program but are not currently in Medicare's Provider Enrollment, Chain and Ownership System (PECOS). A sample revalidation notice letter is posted on CMS's website (www.cms.gov). Between now and March 2015, MACs will intermittently send out revalidation request letters on a regular basis. This phased approach will allow the MACs to better manage the additional workload created by the revalidation applications.

Providers and suppliers must revalidate their Medicare enrollment information either by submitting a paper revalidation application (CMS-855 form) or by electronically submitting a revalidation application online using PECOS. Providers and suppliers have 60 days from the date of their revalidation request letter to submit the requested enrollment forms and all supporting documentation for revalidation. Institutional providers and suppliers who submit an enrollment application for revalidation will be required to pay a fee for revalidation processing, but physicians, physician group practices, non-physician practitioners, and non-physician practitioner organizations are exempt from this fee. For calendar year 2011, the application fee was $505, but the fee increases to $523 for 2012.

Failure to complete revalidation enrollment forms as requested may result in deactivation of the provider or supplier's Medicare billing privileges. CMS has instructed its MACs to make at least two phone calls to alert providers or suppliers of a pending revalidation request before deactivating privileges. Once a provider or supplier's billing privileges have been deactivated for failure to timely revalidate, CMS has indicated that it will reinstate billing privileges if it receives the appropriate revalidation documents within 120 days of the postmark of the original revalidation request.

PECOS improvements

CMS has started taking steps to improve PECOS to allow providers and suppliers to more easily update their information and submit revalidation applications. For example, providers and suppliers using PECOS can pay the application fee (if any) online when submitting their revalidation enrollment application. Other planned improvements to PECOS include: fewer screens and more prompts to notify providers when information is incomplete, a search function for enrollment applications to assist providers to more easily manage their enrollment applications, a simplified registration process for authorized representatives, and use of digital document upload for supporting documents to eliminate the need to separately mail supporting documents. Providers and suppliers can expect to see some of these planned updates and changes to PECOS as early as January 2012.

Paper applications and the revised CMS-855 forms

Providers and suppliers who plan to submit a paper revalidation application (CMS-855 form) should be aware that in July 2011, CMS published new versions of the Medicare enrollment applications (CMS-855A, 855B, 855S, 855R, 855O and 855I). The revised forms contain several changes, including requiring all providers and suppliers to provide more detailed information about individuals or organizations that have ownership or managing control of the provider or supplier. These changes have also been incorporated into the PECOS system. When responding to a request for revalidation, providers and suppliers who plan to submit paper applications should use the most current version of the applicable CMS-855 form.

Revalidation survival tips

1. Watch for a revalidation request letter from your local CMS contractor. According to CMS, the letter will arrive in a colored envelope and will be clearly marked as a "Revalidation Request."
2. CMS has posted on its website a list of all providers and suppliers who were mailed a revalidation letter. Check this list to confirm whether a letter was sent to your organization.
3. According to CMS, for providers that are not in PECOS, the revalidation request letter will be sent to the special payments or primary practice address. For providers in PECOS, the revalidation request letter will be sent to both the special payments and correspondence addresses. If both of those addresses are the same, a revalidation request letter will also be sent to the primary practice address. If you are not sure of the address where your organization's revalidation letter may be directed, call your MAC directly.
4. Your organization should not begin the revalidation process until a revalidation request letter is received from your MAC.
5. Do not delay your response or ignore a revalidation request letter. Begin processing your revalidation application as soon as your organization receives the request to revalidate your information. Providers and suppliers have only 60 days to submit a revalidation application with all supporting documentation.

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Failure to timely submit a revalidation application can result in deactivation of Medicare billing privileges.

6. The revalidation process can be tedious and time-consuming. Consider appointing a single person within your organization to gather the necessary revalidation information and documentation and to otherwise oversee the revalidation process.
7. The process for Medicare enrollment and revalidation has become increasingly complex. Further, the CMS-855 forms are not "one size fits all." If, after reviewing the instructions for the 855 form, you still have questions about how to accurately complete the form, do not hesitate to call your MAC for further guidance.
8. Providers and suppliers should continue to submit necessary updates regarding any changes of information or change in ownership. The obligation to do so is not affected by the revalidation effort.
9. Once you receive a revalidation request letter, track and document the steps you take to complete the revalidation process. If you submit a CMS-855 form or any supporting documentation by mail, use certified mail or other similar means to ensure the documents are traceable. Make and maintain copies of everything you submit to Medicare, as well as all of the correspondence you receive, to evidence your timely processing of CMS's revalidation request. After submitting payment of any applicable revalidation fee, print the confirmation screen for your records.
10. Promptly respond to communications and follow-up requests from your MAC. Educate those within your organization who may receive correspondence or answer phones to ensure that CMS's requests reach the appropriate person and are handled correctly. ■