

## Important Information Regarding Upcoming Part B Provider Enrollment Activities

**PLEASE READ THIS ARTICLE IN ITS ENTIRETY TO AVOID A SITUATION THAT COULD BE DETRIMENTAL TO YOUR PRACTICE.**

Over the course of the upcoming months there are several Provider Enrollment activities taking place under the direction of the Centers for Medicare & Medicaid Services (CMS). The purpose of this article is to highlight those activities and outline potential impacts.

### Revalidation

The CMS recently issued a series of Change Requests (CRs) directing Medicare contractors to undertake a series of revalidation efforts focused on a cross-section of **select** Medicare Part B physicians, non-physician practitioners and group/organizational suppliers. Revalidation activities are not new and are rooted in existing regulations. The revalidation efforts associated with these CRs is very limited and affects a very small percentage (approximately 2,900) of providers and suppliers in our jurisdiction. The bulk of the revalidation letters will be mailed between the months of October 2009 and January 2010 and will be sent to the current practice location address recorded in our master provider file. As mailings are initiated, we will provide notification via List Serv.

To review the transmittals specific to revalidation efforts, please visit the CMS' website at <http://www.cms.hhs.gov/Transmittals/2009Trans/list.asp>. Your review should focus on CRs 6485, 6574 and 6666.

### ***Prompt Action Required – Implications for Non-Responsiveness***

If you receive a letter from us requesting a revalidation application, it is imperative you submit the application in a timely manner. As stated in 42 CFR § 424, if an application is not received within 60-calendar days from the date of the request, we must revoke your billing privileges and impose a 1-year re-enrollment bar. This means you will be barred from participating in the Medicare program for 1-year from the effective date of the revocation. It is important to note that a revocation, in this situation, will be effective 30-days after the notification of such action is mailed. The notice of revocation will also include your right to appeal. All appeals must be submitted in a timely manner to allow a re-examination of the revocation.

If you do not receive a letter requesting a revalidation application, no action is required. Please do not proactively submit an application for revalidation. If you question whether you will, or should have received a revalidation letter, please utilize our "Revalidation Inquiry Tool" on our Enrollment Center at <http://www.highmarkmedicare.com/enrollment/index.html> under "Tips, Tools and Tutorials for Enrollment". The tool will be available no later than October 27, 2009 and you will need to know your PTAN to perform a search. For each PTAN entered, a message will display advising whether or not a revalidation letter has been issued. If a revalidation letter has been issued, the date of the HMS request and revalidation application due date will be provided. The tool will be updated periodically as revalidation letters are issued in November through January; we will provide notice on our website via a systems alert when the updates occur.

### New Ordering/Referring Edits

Effective October 5, 2009, the CMS expanded the scope of editing for ordering and referring providers in conjunction with Change Requests 6417 and 6421.

**CR 6417** instructs A/B Medicare Administrative Contractors (A/B MACs) to implement system edits to ensure Part B providers and suppliers bill for ordered or referred items or services only when those items or services are ordered or referred by physician and non-physician practitioners who are eligible to order/refer such services. Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider **and the ordering/referring provider must be in the Provider Enrollment Chain and Ownership System (PECOS) or in the A/B MAC's master provider file.**

This CR is being implemented in two phases:

- During Phase 1 (October 5, 2009-January 3, 2010): If the ordering/referring provider is on the claim, A/B MACs will verify that the ordering/referring provider is enrolled in Medicare (in the PECOS, or on the master provider file) and is eligible to order/refer. If the ordering/referring provider is not enrolled, the claim will continue to process and the Part B provider or supplier will receive a **warning message** on the Remittance Advice. If the ordering/referring provider is enrolled, but is not of the specialty to order or refer, the claim will continue to process and the Part B provider or supplier will receive a **warning message** on the Remittance Advice.
- During Phase 2, (January 4, 2010 and thereafter): If the billed item or service requires an ordering/referring provider and the ordering/referring provider is not in the claim, the claim will not be paid. **It will be rejected.** If the ordering/referring provider is on the claim, the A/B MAC will verify that the ordering/referring provider is enrolled in Medicare (is in the PECOS or on the master provider file) and is eligible to order and refer. If the ordering/referring provider is not enrolled, the claim will not be paid. **It will be rejected.** If the ordering/referring provider is enrolled, but is not of the specialty to order or refer, the claim will not be paid. **It will be rejected.**

For Part B claims, if you are not enrolled in the Medicare program, you will need to submit a CMS-855 application to HMS if you are a J12 provider.

We encourage you to refer to the following MLN Matters Articles at:  
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6417.pdf>.

**CR 6421** instructs Durable Medical Equipment Medicare Administrative Contractors (DME MACs) to implement more restrictive edits affecting claims from suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Comparable to CR 6417, the new system edits ensure DMEPOS suppliers bill for items or services only when those items or services are ordered or referred by physician and non-physician practitioners who are eligible to order/refer such services. Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider **and the ordering/referring provider must be in the PECOS.**

Please note that when the DME MAC is editing the ordering/referring provider on the claim, the edits are relying solely on whether or not the ordering/referring provider **is in the PECOS.**

This CR is being implemented in two phases:

- During Phase 1 (October 5, 2009-January 3, 2010): If the ordering/referring provider is on the claim, the DME MAC will verify that the ordering/referring provider is in the PECOS and is eligible to order/refer. If the ordering/referring provider is not in the PECOS or is in the PECOS but is not of the type/specialty to order or refer, the claim will continue to process.
  - If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a **warning message** on the Common Electronic Data Interchange (CEDI) GenResponse Report.
  - If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier **will not receive a warning and will not know that the claim did not pass these edits.**

- During Phase 2, (January 4, 2010 and thereafter): If the ordering/referring provider is not on the claim, the claim **will not be paid**. If the ordering/referring provider is on the claim, the DME MAC will verify that the ordering/referring provider is in the PECOS and eligible to order and refer. If the ordering/referring provider is not in the PECOS or is in the PECOS but is not of the specialty to order or refer, the claim will not be paid. **It will be rejected.**
  - If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a rejection message on the CEDI GenResponse Report.
  - If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will see the rejection indicated on the Remittance Advice.

For DMEPOS, even if you are enrolled in the Medicare program, you may be required to submit the appropriate application(s) to the A/B MAC in your jurisdiction to establish a record in the PECOS. You can confirm whether or not you have a record in the PECOS by using Internet-based PECOS. Information related to using Internet-based PECOS can be found on the CMS' web site at: [http://www.cms.hhs.gov/MedicareProviderSupEnroll/04\\_InternetbasedPECOS.asp#TopOfPage](http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage). If you are unable to use Internet-based PECOS, you can call your A/B MAC to verify if you do or do not have a record in the PECOS. You can reach our Provider Enrollment Department by calling 1-866-488-0549 between the hours of 8:00 a.m. and 3:30 p.m. (EST) Monday through Friday.

We encourage you to refer to the following MLN Matters Articles at: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6421.pdf>.

## **Mass Mailing for Individual Practitioners**

The CMS recently issued CR 6278 instructing A/B MACs to issue a one-time mailing to all active Part B individual physician and non-physician practitioners. The purpose of the mailing is to act as a reminder of the requirements for reporting changes to enrollment information. There will be two mailings:

- On November 30, 2009, a mailing will be sent to every practice location of every actively practicing physician
- On December 31, 2009, a mailing will be sent to every practice location of every actively practicing non-physician

## **What You Need to Know – Potential Impact to Payments**

All letters will be mailed in "Return Service Requested" envelopes. This means all undeliverable letters will be returned to us by the Post Office. In accordance with the instructions in CR 6278, if a letter is returned by the Post Office, A/B MACs are required to deactivate the billing privileges of all practice locations associated with the PTAN on the letter (if the physician/non-physician does not already have a change of address request pending) and mail a revalidation letter to that physician/non-physician at another address. Billing privileges will remain deactivated until the revalidation application is received and processed. **Important:** Claims for services rendered from the date of the deactivation until the date of reactivation **will not be payable** (unless the returned mail is determined to be an error on behalf of the Post Office). If a revalidation application is not received within 60-calendar days from the date of the request, we must revoke your billing privileges and impose a 1-year re-enrollment bar. This means you will be barred from participating in the Medicare program for 1-year from the effective date of the revocation. It is important to note that a revocation, in this situation, will be effective 30-days after the notification of such action is mailed. The notice of revocation will also include your right to appeal. All appeals must be submitted in a timely manner to allow a re-examination of the revocation.

If you question whether a letter was sent that you did not receive, there will be a tool available on our Enrollment Center at <http://www.highmarkmedicare.com/enrollment/index.html> under "Tips, Tools and Tutorials for Enrollment". The tool will be available no later than November 30, 2009 and you will need to know your PTAN to perform a search.

***Advance Warning – Individual Physicians and Non-Physician Practitioners receiving ERA and EFT***

Due to the fact paper correspondence is rarely sent, if at all, to your practice location address, you may be most vulnerable to the returned mail situation described above. If the practice location address we have on our master provider file is inaccurate, it behooves you to submit your application to update your address information before, or no later than the end of November 2009. As described above, there are penalties associated with returned mail. At a minimum, there will be a period of time you will not be able to recoup payments for services rendered.

To confirm the practice location address on our master provider file, you can call our Customer Contact Center at 1-877-235-8073 between the hours 8:00 a.m. and 4:00 p.m. (EST) Monday through Friday.