CARLTON FIELDS

Advance Preparation for Medicare Revalidation Requests: Good Decision for the Bottom Line

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The 2009 Affordable Care Act (ACA) has provided no shortage of new regulations for health care providers of every shape and size. One such item is the requirement that providers that enrolled in Medicare prior to March 25, 2011 (the effective date of the Act) submit complete Medicare enrollment revalidation information after a request from the Centers for Medicare and Medicaid Services (CMS). Unfortunately, since CMS began policing this process, many providers (without regard to type) have faced penalties from CMS for not meeting the required deadlines resulting in significant financial implications. In most situations, CMS has pursued the deactivation of billing privileges for noncompliance. In egregious cases, typically involving more heavily regulated suppliers such as home health agencies and independent diagnostic testing facilities, there have also been occurrences of revocation. Reporter Charles Fiegl reported in *American Medical News* that, as of June 2012, "Medicare [had] revoked or deactivated the billing privileges of more than 23,000 health professionals and equipment suppliers" as a result of the revalidation process. As such, all Medicare providers should prepare in advance for the revalidation process and should actively monitor the status of a request when received. The revalidation process requires a provider to certify accuracy with existing Medicare enrollment information. The ACA requires that most providers revalidate every five years (Durable Medical Equipment (DME) providers must revalidate every three years). CMS is also permitted to pursue "off-cycle" revalidations as a result of random checks, complaints, national initiatives and the high probability of fraud for a particular provider. As a result, providers should always be on the lookout for revalidation requests. Staff that sorts mail at both the "special payments" and correspondence addresses on file with Medicare should be informed of where to direct the requests for prompt attention. It should be noted that preemptive attempts to revalidate, prior to a formal request from CMS, will not be accepted and, therefore, should not be pursued. To make things easier on providers, Medicare Administrative Contractors (MACs) have been instructed to send the notification letters in colored envelopes to differentiate the letters from other mail.

MACs have also been known to call providers up to two times to remind them of upcoming deadlines and notify them that a revalidation request has been sent. The revalidation process will continue through March 2015. CMS has posted on its website a list of all providers with the last four digits of their corresponding National Provider Identifiers that have been issued a revalidation request. It is highly recommended that providers check this website on a periodic basis. Once the request is received, the provider has approximately 60 days to complete and submit the required enrollment forms. Provided that the information is submitted on time, there is typically no lapse in billing privileges. If the provider is deactivated as a result of a failure to respond, it can become reactivated if the information is submitted within 120 days of the postmark of the original revalidation notice. The consequence of revocation, which is used sparingly by CMS, is far more serious and can lead to disastrous consequences for providers. Revocation requires Medicare payments to be halted until a corrective action plan or request for reconsideration is received. If the plan or request is not approved, the provider can be barred from participating in Medicare from the effective date of the revocation until the end of the reenrollment bar, which is a minimum of one year. Providers in Florida that see Medicare patients as a large percentage of their overall case load may be disproportionately disadvantaged by a revocation. It is not uncommon for a provider that has been revoked to pursue creditor protection as a result of the negative financial impact that results from the inability to seek reimbursement from Medicare during the reenrollment bar. To ensure a timely and comprehensive response, providers should review the appropriate CMS 855 enrollment form that will be used with the revalidation to ensure that all requested information about the appropriate staff is provided. For instance, most forms require a Social Security Number as well as date and place of birth for each of the directors and officers, and failure to provide all of this information would delay reenrollment. While these are not new requirements, CMS has ramped up enforcement when gathering information – expecting providers to be fully transparent in this regard. Providers should also be prepared to answer questions regarding revalidation information that is different from information provided during the initial enrollment process. Specifically, CMS is likely to ask questions regarding changes in ownership, practice location addresses and payment information. Those staff members responsible for preparing and submitting the information must be educated regarding the importance of the revalidation process and the significant penalties that can be imposed as a result of providing incorrect or insufficient information and the subsequent delay. If revalidation is not completed through the Internet-based PECOS system, forms should be mailed with a tracking function. Copies of all correspondence with CMS should be maintained in a specifically identified location in case the provider is required to refute any claim of non-receipt by CMS. Providers can avoid the costly consequences of failing to revalidate on time if they prepare in advance by gaining a working knowledge of what is required and educate their staff on the gravity of timely compliance. However, upon receipt of a notice of deactivation (or revocation) due to a failure to revalidate before the deadline, a provider should immediately consult with an experienced health care attorney regarding next steps. *Originally published by Florida Medical Business (November/December 2013).*

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