CMS 855: An Essential Requirement for Medicare Billing Privileges

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In an initiative designed to reduce misuse and abuse of Medicare billing numbers, the Centers for Medicare and Medicaid Services (CMS) published a final rule on April 21, 2006. The rule impacts both providers that plan on enrolling in the Medicare program and currently enrolled providers. The rule also provides CMS further access to information about enrolled providers.

The Enrollment Process
Providers enrolling in the Medicare program will be required to complete the CMS 855 in order to obtain billing privileges. A key element in accurate completion of the 855 is the inclusion of the providers National Provider Identifier (NPI). It is important to note that all providers are required to begin using their NPIs by May 23, 2007. For more information on obtaining your NPI go to:www.cms.hhs.gov/NationalProvIdentStand/04_education.asp.

In completing the 855 providers are being asked to certify that they are in compliance with all applicable federal and state licensure requirements, including certifying that they do not employ or contract with individuals or entities that are excluded from the Medicare or Medicaid program. Also the Anti-Kickback and Stark Laws are prominently mentioned. As a result providers should make themselves familiar with these provisions prior to submitting the 855. Additionally the 855 requires that the provider agree to re-coupment of Medicare overpayments.

Signing the 855 binds the provider both legally and financially. As a result it must be done by someone within the organization that has this type of authority. The signature is attesting to the accuracy of the information provided on the 855. Due to this, the individual signing the document assumes a great deal of responsibility. Providers should review and if necessary revise their policies and procedures related to the information that is being provided on the 855 prior to submission.

Enrollment Information Changes
Providers are required to submit changes in enrollment information within 90 days of the change. Supporting documentation related to the change must accompany the information submitted. In the case of a change of ownership the provider must submit changes within 30 days.

Failure to comply with these timelines can lead to the deactivation or revocation of Medicare billing privileges.

Denial or Rejection of Application
CMS has the authority to deny enrollment in the Medicare program for several reasons. Among those reasons;

- The provider failed to comply with the enrollment process, was notified by CMS, and did not develop and submit a corrective action.
- A provider or owner's conviction for a felony that CMS has determined is "detrimental to the best interests of the program".

As noted previously, submission of the 855 without the NPI or other required information will cause the initial application to be returned. CMS will inform the provider of the deficiencies in a timely manner. It is incumbent upon the provider to correct the information and re-submit the application within 60 days. Failure to do so will lead to a denial of the application. **Note:** The 60 day window can be extended if the provider shows that they are actively working with CMS to resolve the issues.

Enrollment Information Validation
The Final Rule calls for providers to revalidate enrollment information every 5 years. This begins on a very limited basis during Fiscal Year 06 and increases at the beginning of Fiscal Year 08. CMS will contact each provider directly. Legacy providers will be asked to provide a significant amount of information not previously given to CMS. This information must be provided to CMS within 60 days of receiving notification.

Site Visits
The Final Rule allows for CMS to conduct site visits for newly enrolled providers. These visits are designed to verify

the existence of the providers. These visits should not be confused with survey and certification visits that CMS conducts to ensure compliance with Medicare conditions of participation. Of concern to many legacy providers is the provision that allows CMS to conduct these site visits as part of the re-validation process.

In conclusion, the Final Rule will force both new and legacy Medicare providers to analyze their policy and procedures and compliance programs in order to ensure they are in compliance with all information they will be attesting to on the CMS 855.

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