

Medicare Part A and B Recent Changes

Implementation of Provider Enrollment Provisions in CMS-6028-FC

The Affordable Care Act (ACA) requires CMS to determine the level of screening to be conducted during provider and supplier enrollment based on the level of risk posed to the Medicare system. With the enactment of the ACA, CMS has the increased ability to focus efforts on prevention, rather than simply acting after the fact. The use of risk categories and associated screening levels will help ensure that only legitimate providers and suppliers are enrolled in Medicare, Medicaid and the Children's Health Insurance Program (CHIP), and that only legitimate claims are paid.


Effective March 25, 2011, newly enrolling and revalidating providers and suppliers will be placed in one of the following three screening categories. These categories represent the level of risk for fraud, waste and abuse to the Medicare program for the particular category of provider/supplier, and determine the degree of screening to be performed by the A/B Medicare Administrative Contractor (MAC) processing the enrollment application.

- Limited
- Moderate
- High

Effective March 25, 2011, A/B Medicare Administrative Contractors (MACs) will begin collecting application fees with certain provider/supplier enrollment applications (both paper and online applications) as described below. The fee is to be used by the Secretary to cover the cost of program integrity efforts, which includes the cost of screening associated with provider enrollment processes including those under Sections 1866(j) and 1128J of the Social Security Act. The application fee is currently \$505 for Calendar Year (CY) 2011; however, this fee will vary from year-to-year based on adjustments made pursuant to the Consumer Price Index for Urban Areas (CPI-U).

Note that these application fees do not apply to physicians, non-physician practitioners, physician organizations and non-physician organizations. All institutional providers of medical or other items or services or suppliers must pay the application fee. "Institutional provider" includes any provider or supplier that submits a paper Medicare enrollment application using:

- CMS-855A.
- CMS-855B, not including physician and non-physician practitioner organizations.
- CMS-855S.
- The associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment applications.

Providers **must** make payments electronically to <http://www.pay.gov/> . This is the **only** way that payments will be accepted by Medicare. Non-payment through Pay.gov could cause a provider's enrollment application to be denied.

IVR Medicare Number Entry Enhanced

Beginning March 10, 2011, the Interactive Voice Response (IVR) steps to enter the patient's Medicare number was enhanced. With this new change, providers are able to enter the patient's Medicare number in one easy step by simply entering the patient's Medicare number followed by # (pound key). The enhancement also allows providers to receive eligibility on all Medicare numbers except those ending in a double-letter suffix starting with the letter T. Examples: TA, TB and TD.

IVR – (877)567-9230

IHS Customer Service – (866)448-5894

Medicare Secondary Payer (MSP) Questionnaire

At any time, CMS or the Medicare contractor could schedule an audit of a hospital's MSPQ records. Prior to the Medicare contractor coming to your facility you will be sent a packet of information that contains the patients accounts that will be reviewed. The following are questions that we have received from IHS providers regarding the MSPQ:

1. Does the patient have to sign the MSPQ every time?
No, a signature is not required.

2. Can I file the Part A claim if we failed to obtain the MSPQ?
Yes. However Medicare would not expect to see this happen often. Processes should be in place to obtain this information at every inpatient admission and ensure that outpatient services have the MSPQ on file and that it was not obtained more than 90-days prior to the date of service.

3. Does CMS have an official MSPQ form?
No, but a model questionnaire is located in the CMS Internet Only Manual (IOM) MSP manual, chapter 3 section 20.2.1.
<http://www.cms.gov/manuals/downloads/msp105c03.pdf>

4. What if the patient doesn't know what his retirement date was; can we put "unknown?"
No. In accordance with IOM Pub. 100-05, Chapter 5, Section 30.1, "Further Development Is Not Necessary," it is acceptable to use today's date minus five years when the patient has been on Medicare longer than that period. In cases where the patient has not been on Medicare that long, the patient's date of Medicare entitlement can be used.