Eli's Rehab Report

Compliance: Are You on Your Revalidation Process Game?

Don't let these new Medicare provider requirements come as a surprise

If you bill Medicare at your practice or facility, it's time to get a strong handle on Medicare's "revalidation process" if you haven't already. Why? If you're not in compliance, it's only a matter of time until your carrier or fiscal intermediary can put the kibosh on your billing privileges.

Background: According to CMS ruling 42 CFR 424.515 in the April 21, 2006, Federal Register, all Medicare providers must revalidate their Medicare information on file, via a CMS-855 form, within 60 days of receiving a written revalidation request from their CMS fiscal intermediary or carrier, say **Lyndean Brick, JD,** senior vice president of Murer Consultants Inc. in Joliet, Ill.

Sounds simple enough, but many providers have never filed a complete CMS-855, which can make the revalidation process quite difficult, Brick says. And you may even receive an on-site survey if CMS discovers enough discrepancies.

But that's not all. "Generally speaking, once a provider submits a complete CMS-855, either in response to a revalidation request or otherwise, the provider must then revalidate his or her entire CMS-855 filing once every five years -- or within 90 days after any change in his or her Medicare provider information," Brick says.

Know What CMS Is Looking For

If you're not sure what kind of information you need to have lined up for CMS for revalidation, check out a copy of the Medicare enrollment form online at http://www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf.

You'll notice that the agency requires a slew of information ranging from your practice name to your licensure status. You may find that pieces of this required information are out of date for your practice or facility, and if that's the case, it's time to fix that fast and submit a fresh 855 form to CMS.

Important: As you update your information, consider consistency a top priority. Why? "One of the biggest problem areas we find is that providers aren't consistent with names, among other things in their legal documentation," Brick says. For example, a rehab practice may have opened with the name Mountain Rehab, but it bills as Mountain Sports Rehab, yet its information on file with CMS may say Mountain Pain and Rehab. And CMS won't go for that.

Critical: And now, with NPIs going into full-swing, the practice or facility name and other information you've filed on your NPI application must match your legal documentation. "Even if one little thing gets out of whack and CMS catches it, its contractors can stop reim-bursement," Brick say, "even something as small as your IRS information not matching your NPI information."

Helpful: See the article at right for a list of questions you should ask when you audit your information on file.

Keep an Eye on the Timing

The CMS revalidation process is being enforced over a five-year period that went into effect last year, and the initial revalidation effort focused on Medicare contractors' top-100 billers. But that doesn't mean you should wait for your carrier or FI to contact you. "CMS will continue to push forward with their revalidation efforts with smaller healthcare organizations as the effort phases in," Brick says. And you're much better off being prepared with your most up-to-date information on-hand than to be scrambling to get your ducks in a row and risk having your billing privileges revoked.

So long story short, Medicare providers have a lot of housecleaning to do in their legal documentation so they can turn in

a clean and up-to-date 855 form. And from here on out, anytime you have even the slightest change in your legal information, even if it's something as small as an address change, you need to notify Medicare of that change within 90 days.

Resources: See the rule's text at http://a257.g.akamaitech.net/7/257/2422/13nov20061500/edocket.access.gpo.gov/cfr_2006/octqtr/pdf/42cfr424.515.pdf.