TIPS FROM OUR CONSULTANT

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NEW BENEFICIARY MEDICARE IDENTIFIERS

The Medicare Access and CHIP Reauthorization Act (MACRA) requires the Centers for Medicare and Medicaid Services (CMS) to remove Social Security Numbers from beneficiary Medicare cards to help fight identity theft and safeguard taxpayer dollars. Physicians must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number (HICN) to the randomly generated Medicare Beneficiary Identifier (MBI), the new Medicare number. CMS is calling this project the New Medicare Card.

The MBI will be:

- Clearly different than the HICN and Railroad Retirement Board (RRB) numbers
  - ► The Railroad Retirement Board will issue new cards to RRB beneficiaries
  - ► Physicians will no longer be able to distinguish RRB patients by the number on the new Medicare card. You will be able to identify them by the RRB logo on the beneficiary's card
- 11-characters in length
- Made up only of numbers and uppercase letters (no special characters)

Medicare will be mailing new Medicare cards with their unique MBI to beneficiaries between April 2018 and April 2019.

Transition Period

CMS plans a transition period where physicians can use either the HICN or the MBI to exchange data. The transition period will begin no earlier than April 1, 2018 and run through December 31, 2019.

During the transition period, CMS will monitor the use of HICNs and MBIs to see how many providers/suppliers are ready to use only MBIs by January 2020. CMS will also actively monitor the transition and adjustment to the new MBIs to make sure of their wide-spread adoption so Medicare operations are not interrupted.

After the transition period ends on January 1, 2020, physicians will need to use MBIs on claims with a few exceptions when you can use either the HICN or MBI.

Medicare Exceptions (Not All Inclusive)

- Appeals - Physicians can use either the HICN or the MBI for claims appeals and related forms.
- Adjustments - Physicians can use the HICN indefinitely for some systems (Drug Data Processing, Risk Adjustment Processing, and Encounter Data) and for all records, not just adjustments.
- Reports – Medicare will use the HICN on these reports until further notice:
  - ► Incoming to Medicare (quality reporting, Disproportionate Share Hospital data requests, etc.)
  - ► Outgoing from Medicare (Provider Statistical & Reimbursement Report, Accountable Care Organization reports, etc.)

PROVIDER ENROLLMENT REVALIDATION – CYCLE 2

§6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. This cycle of revalidation applies to those providers/suppliers that are currently and actively enrolled. Due dates are established based on the provider's/supplier's last successful revalidation or initial enrollment (approximately 3 years for DME suppliers and 5 years for all other providers/suppliers).

Check http://go.cms.gov/MedicareRevalidation for the provider/suppliers due for revalidation. This list will be refreshed periodically. Be sure to check this list regularly for updates.

If the provider/supplier has a due date listed, CMS encourages them to submit their revalidation within six months of their due date or when they receive notification from their MAC to revalidate. When either of these occur:

- Submit a revalidation application through Internet-based PECOS located at https://pecos.cms.hhs.gov/pecos/login.do, the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; or
- Complete the appropriate CMS-855 application available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html
- Physicians are not charged an application fee; however, ambulatory surgical centers and Medicare suppliers must pay an application fee by going to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do
  - ► The application fee is $560.00 for Calendar Year (CY) 2017
- Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

Medicare Administrative Contractors (MAC) will send a revalidation notice within 2-3 months prior to your revalidation due date either by email (to email addresses reported on your prior applications) or regular mail (to at least two of your reported addresses: correspondence, special payments and/or your primary practice address) indicating the provider/supplier's due date.

Revalidation notices sent via email will indicate "URGENT: Medicare Provider Enrollment Revalidation Request" in the subject line to differentiate from other emails. If all the emails addresses on file are returned as undeliverable, your MAC will send a paper revalidation notice to at least two of your reported addresses: correspondence, special payments and/or primary practice address.

Deactivations Due to Non-Response to Revalidation or Development Requests

It is important that you submit a complete revalidation application by your requested due date and you respond to all development requests from your MACs timely. Failure to submit a complete revalidation application or respond timely to development requests will result in possible deactivation of your Medicare enrollment.

If your application is received substantially after the due date, or if you provide additional requested information substantially after the due date (including an allotted time for US or other mail receipt) your provider enrollment record may be deactivated.

Providers/suppliers deactivated will be required to submit a new full and complete application to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

NOTE: The reactivation date after a period of deactivation will be based on the receipt date of the new full and complete application. Retroactive billing privileges back to the period of deactivation will not be granted. Services provided to Medicare patients during the period between deactivation and reactivation are the provider's/supplier's liability.