Non-Participating Provider Guide to Enrollment and Responsibilities in Medicare

Step-by-Step Guide

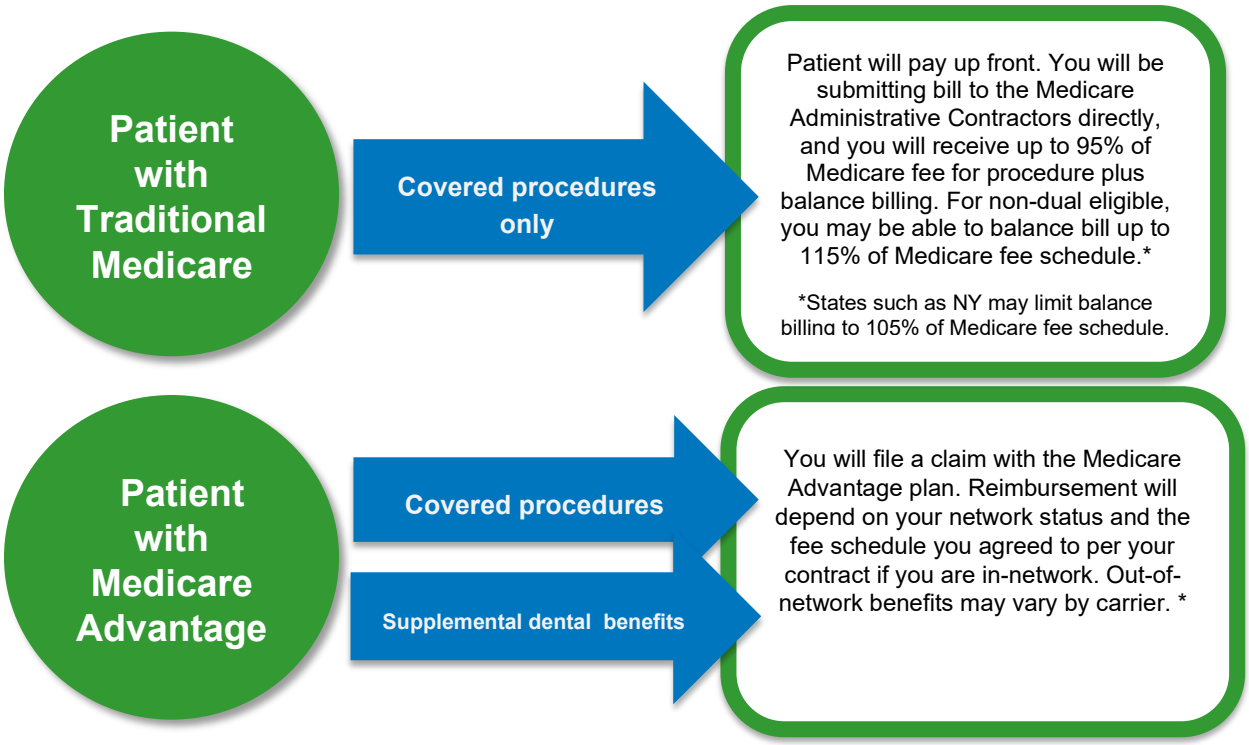

Figure: Scenarios of how billing occurs when enrolled as a Medicare Non-Participating Provider

* For "dual eligible" beneficiaries who are recipients of both Medicare & Medicaid benefits, Medicare will be the primary payer. The beneficiary cannot be balance billed due to Medicaid regulations. Because Medicare has 20 percent coinsurance, providers can be paid up to 20 percent less than the fee schedule amount when treating dual-eligible beneficiaries. Further, payments for dual eligible beneficiaries enrolled in Medicare Advantage plans may be impacted by providers network status and contractual terms.

How to Enroll in Medicare as a Non-Participating Provider

The first step in the process to enroll in Medicare is to obtain a National Provider Identifier (NPI) number if you do not already have one. An NPI is a unique identification number that health care providers, health plans, and health care clearinghouses must use for administrative and financial transactions. You can obtain your NPI online through the Department of Health & Human Services National Plan & Provider Enumeration System (NPPES), the system to apply for and manage NPIs. You should obtain a Type 1 NPI.[1]

If you are unsure if you have an NPI, you can check by searching the NPPES NPI Registry.

[1] Type I NPI is is for healthcare providers who are individuals, including physicians, dentists, and all sole proprietors. An individual is eligible for only one NPI. Type 2 are healthcare providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.

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Create an account in the CMS Identity & Access Management (I&A) System as this single account can be used to access NPPES for your NPI and PECOS for Medicare enrollment.

Use your I&A system account to obtain your NPI, if needed, through NPPES.

[You also have the option to obtain your NPI using a paper application**.** Complete, sign, and mail the NPI Application/Update Form (CMS-10114) to the address on the form.]

Once you have your NPI, use your I&A system account number to access PECOS and enroll in Medicare by completing the CMS-855I form for physician and non-physician practitioners to enroll as a provider to bill Medicare for covered dental services.

The CMS-855I form allows you to specify your specialties. In PECOS, you may select Dentistry, Oral Surgery, Maxillofacial Surgery, Dental Anesthesiology, Dental Public Health, Endodontics, Oral and Maxillofacial Pathology, Oral and Maxillofacial Radiology, Oral Medicine, Orofacial Pain, Orthodontics and Dentofacial Orthopedics, Pediatric Dentistry, Periodontics, and Prosthodontics. You may also select Unspecified Physician Specialty if one of the specialties above do not apply to your field of dentistry.

If you decide not to participate, take no further action. All newly enrolled providers are automatically non-participating. You are not considered to be participating unless you submit the CMS-460 form to your MAC.

If you decide to participate within this 90-day timeframe, complete the CMS-460 form and send it to your MAC.

You will be able to revisit your participation decision at the end of each calendar year with the decision effective the following year starting January 1. Your MAC manages participation status changes during this open enrollment period that generally runs from mid-November through December 31. This is the only period of time that providers who are currently enrolled in Medicare can change their current participation status. You can contact your MAC with questions related to changing your participation status.

Are you unsure if you enrolled previously? Check your status at CMS's Physician and Provider Look Up Tool.

Are you unsure if you opted-out previously? Check your status at CMS's Provider Opt-Out Affidavit Look Up Tool.

EXAMPLES OF RESPONSIBILITIES OF A NON-PARTICIPATING PROVIDER

1.) Maintaining enrollment within PECOS

Once you enroll in Medicare, you must update any information that might change, such as a change in practice location, billing service, or license number. These changes must be reported within 90 days of when change is occurring. Additionally, a change of ownership in a practice must be reported within 30 days. Failure to do so could result in rejection of claims, deactivation or "pause" in enrollment, or revocation of enrollment from the Medicare program for up to 3 years.

2.) Giving 90 days notice if you wish to no longer participate in Medicare

If you wish to terminate your enrollment in Medicare (for example, due to retirement or surrendering your license), you must provide 90 days' notice to CMS. You can withdraw through PECOS, which you used to enroll in Medicare, or you may withdraw your enrollment by paper application by going to page 4 of the CMS-855I Form. Please note that withdrawing from Medicare is not the same as choosing to be an opt-out provider. If you wish to opt-out of Medicare as an active provider treating Medicare beneficiaries, you must follow the instructions to opt-out.

3.) Obtaining all necessary information for billing before time of service

You must determine if Medicare is the primary or secondary payer; therefore, the beneficiary must be queried about other possible coverage that may be primary to Medicare. Failure to maintain a system of identifying other payers is viewed as a violation of the provider agreement with Medicare. Learn more about when Medicare is the primary payer and when it is the second payer.

4.) Submitting claims for services to the Medicare Administrative Contractor (MAC) or Medicare Advantage Plans.

Despite receiving the full payment from the patient for services, a provider must submit a claim to the state's assigned MAC. This must be done within 12 months after the patient's visit. This allows the patient to be reimbursed for 80% of the Medicare approved fee for non-participating providers.

Non-participating providers are required by law to accept claims assignment and submit a claim when a beneficiary has both Medicare and Medicaid (for a covered service). This concept of "mandatory assignment" also applies to provider billing for clinical laboratory services, ambulance services and drugs and biologicals.

Unlike traditional Medicare, the patient will not have to pay the full fee up-front for covered services and you will receive most of the reimbursement from submitting a claim to the Medicare Advantage plan's sponsor. Medicare Advantage plans have different time limits for submitting claims, and depends on the time limit set by the plan provider. You should contact the plan provider to learn when claims should be submitted.

5.) Ensuring that your office does not charge above balance billing limits.

Most non-participating providers are not accepting claims assignment and will only do so on a case-by-case basis. This means you can charge the patient at 115% of the approved non-participating provider Medicare rate (95% of the approved participating provider rate). Doing so will mean that you will earn a little bit more than 10% of the approved participating provider Medicare rate. However, please be aware that some states may have a limitation on how much you can balance bill, such as New York who only allows participating providers to balance bill up to 105% of the approved non-participating provider Medicare rate. Various states and the federal government can levy monetary penalties if a Medicare provider charges above the 115% limited balanced billing amount to the patient.

If you agree to claims assignment, you will accept the Medicare approved amount for non-participating providers (95% of the approved Medicare participating provider rate) as payment in full; with no ability to balance bill the beneficiary above that amount.

6.) Collecting your full payment.

In this case, the MAC will pay 80% of the non-participating approved amount (95% of the Medicare participating amount) directly to beneficiary. A non-participating provider must collect the entire approved amount, the portion Medicare pays and the beneficiary 20% coinsurance, from the beneficiary.

If you are a non-participating provider who accepts assignment, claims may be paid slower than for participating providers. However, claims are required to be paid within the window required by statute, which is no later than 28 days for electronic claims and 31 days for paper claims. Non-participating providers have fewer rights to appeal claim determinations than participating providers.

7.) Ensuring to respond and return overpayments

An overpayment for a non-participating provider occurs when a patient pays a provider more than the amount due and payable by Medicare. MACs are required by law to recover overpayments over $25. Providers have 60 days to pay back an overpayment after discovery of the overpayment or after the MAC sends a demand letter from MAC for repayment. To expediently resolve the matter, you may request immediate recoupment from the MAC for all current and future overpayments that occur, or make a one-time request for a specific overpayment. Unless you specify it as a one-time request, the immediate recoupment request applies to all current and future debts. This will allow the MAC to recover an overpayment by offsetting future payments to satisfy the overpayment amount.

If you do not believe an overpayment occurred, you must submit a rebuttal for overpayment within15 days after receiving a demand letter from a MAC for overpayment. Despite having a 60-day window to pay back an overpayment, interest on the overpayment begins accruing after 30 days. More instructions on dealing with overpayments can be found on CMS's website.

8.) Keep necessary documentation for claims and respond to records requests from CMS or MACs in a timely manner

There must be “an exchange of information” in order for a dental service to be covered by Medicare in connection with an intrinsically-linked medical procedure. “Exchange of information” can be a referral form from a physician treating the patient for the covered medical procedure. Proof of this “exchange of information” and other dental records of a Medicare patient must be kept in the patient file in case of an audit occurring from CMS or MACs. Failure to provide information within 90 days, or responding with inaccurate information, could lead CMS to revoke your status as a participating provider for up to 3 years. Your Medicare enrollment can still be revoked for up to 3 years even if you are not able to respond because you changed practice locations without updating your enrollment information in PECOS.

DISCLAIMER

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