MPC, Inc.
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MEDICAL PRACTICE CONSULTANTS, INC.

Protecting Your Practice

Overview
This brochure highlights some of the steps Medicare physicians and other suppliers can take to protect their practice from inappropriate Medicare business interactions.

Obtaining a National Provider Identifier (NPI)
To bill Medicare, physicians and other suppliers must first obtain a National Provider Identifier (NPI) and enroll with the designated Medicare fee-for-service contractor. The application and request for an NPI does not replace the enrollment process for health plans. Enrolling in health plans authorizes you to bill and be paid for services.

To obtain an NPI, a physician or other supplier may apply for an NPI at https://nppes.cms.hhs.gov or by calling the Enumerator at 1-800-465-3202 or TTY 1-800-692-2326.

To enroll in the Medicare program, visit the CMS provider enrollment web site at http://www.cms.hhs.gov/MedicareProviderSupEnroll/ to access and download the appropriate Medicare enrollment application, find responses to commonly asked questions, or to find telephone and mailing address information for the fee-for-service contractor serving your area. Any misuse of your NPI should be reported immediately.

Closing, Relocating, Change in Status, or Changes in Members
Physicians, non-physician practitioners and physician and non-physician practitioner organizations are required to contact the Medicare contractor to update records, if they decide to close or move their practice or change members of a group within 30 days of the change.

Additional information regarding Medicare enrollment process, including information about the Internet-based Provider Enrollment, Chain and Ownership System, adding/deleting group members, or changes to address is available through the CMS website at www.cms.hhs.gov/MedicareProviderSupEnroll or can be obtained by contacting the designated Medicare fee-for-service contractor.

Reassignment of Benefits
Generally speaking, Medicare pays the individual physician or non-physician practitioner who performed the service. In certain situations, however, Medicare will allow the individual who performed the service to reassign their Medicare payments to another qualified physician or entity.

This is called reassignment of benefits and requires that a CMS-855R be completed, signed, and submitted to the Medicare contractor. A fully executed CMS-855R, Reassignment of Medicare Benefits, is powerful because it allows another qualified person or entity to bill Medicare on behalf of a physician or non-physician practitioner and receive payment that otherwise would have been sent directly to the individual practitioner. If an individual has authorized someone else to bill and be paid by Medicare for services that he or she renders, both the individual and the entity receiving payment are jointly responsible for ensuring that such billings are appropriate and reflect services actually performed.

Terminating Reassignment Agreements
Individual practitioners should notify Medicare as soon as reassignment agreements are terminated, since failure to do so allows the previous entity to continue billing Medicare. Individual practitioners and/or suppliers can terminate a reassignment agreement by completing and submitting a CMS-855R to their designated Medicare fee-for-service contractor.

Hiring Someone to Prepare Claims
Some physicians and suppliers find it helpful to obtain the assistance of a billing service or consultant to submit their Medicare claims.

While such entities can provide valuable services, physicians/suppliers must clearly understand that delegating this process does not relieve them from responsibility for overpayments received due to claims filed on their behalf.

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Therefore, physicians/suppliers should get involved and oversee their billing service or staff. Additionally, before hiring a service or consultant, physicians/suppliers should carefully check references and ensure that the service or consultant:

- Provides periodic reports of claims billed on the physician's behalf and, if the billing service receives the Medicare payments, it should be able to provide data regarding how much Medicare paid.
- Protects the physician's NPI and any other information used to act on the physician's behalf.
- Does not change procedure codes, diagnosis codes, or other information furnished by the physician without the physician's knowledge and consent.
- Keeps the physician informed of all correspondence received from Medicare.

Physicians should review information submitted by a billing service or consultant regularly to ensure consistency with their records. They should also keep complete administrative records for the claims a billing service files on their behalf.

Hiring Employees
The physician is responsible for the actions of his or her billing staff. Therefore, physicians should consider performing background checks before hiring new employees and conduct periodic quality checks of sensitive processes, such as the posting of account receivables.

Contractual Arrangements
Numerous legal and compliance factors must be considered when contracting with individuals, other entities, billing services, or consultants. The following questions should be considered when planning contractual arrangements:

- What types of agreements and paperwork must be executed between the physician and the other parties?
- Are any agreements/paperwork required between the physician and the insurance companies?
- Do the agreements made between the physician and the other parties conform to ethical standards?

Contracts must be examined in light of confidentiality obligations, including those defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Therefore, physicians should consult with a healthcare attorney when considering a contractual arrangement. Additionally, physicians may obtain information on contractual arrangements by reviewing requirements published by the Medicare Contractor, CMS or the SSA.

Referral of Patients and Ordering of Services/Items
Physicians or other authorized non-physician practitioners sometimes need to refer patients for specialized medical care or to receive certain diagnostic tests or supplies.

In such cases, physicians should consider the following:

- Implement a process to ensure that only the ordered services or tests were rendered. For example, when reviewing the results of diagnostic tests, note whether the other provider performed additional or more complex tests than those ordered.
- Whenever possible, specify the reason for ordering the services. If diagnostic tests are ordered as part of a routine physical exam, include that fact with the referral. Physicians should not empower the other provider who files the Medicare claim to determine why the tests were needed.
- Never sign blank certification forms that are used by other providers to justify Medicare payment for oxygen, home health services, wheelchairs, hospital beds, prosthetic devices, etc. Be sure to personally complete all medical information on such forms. Demographic information, such as patient name and address should be fully completed by the supplier or physician.
- Medical services, supplies, and devices are sometimes aggressively marketed to beneficiaries, with little regard for the medical condition, examples include: transcutaneous electrical nerve stimulator devices and power operated scooters. While these devices are helpful for some beneficiaries, physicians should use extreme caution when prescribing or ordering them, due to the creative ways they are sometimes marketed.
- Medicare can pay for items or services that are reasonable and medically necessary.
- Certification forms include helpful information about eligibility for the service or product being prescribed.