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## Medicare Reimbursement Restrictions/New Providers/New Practice Location

### The Centers for Medicare and Medicaid Services ("CMS")

published a modification to an earlier Change Request to the 2009 Medicare Physician Fee Schedule final rule ("**2009 PFS**"). The change applies to all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries, and/or Part A/B Medicare Administrative Contractors ("**A/B MACS**") for services provided to Medicare beneficiaries.

As provided in the 2009 PFS, carriers and A/B MACS will establish the effective date of Medicare billing privileges for the following individuals and organizations: physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse mid-wives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, and physician and non-physician practitioner organizations (e.g.,

clinics/group practices).

Carriers and A/B MACS will now establish the effective date of Medicare billing privileges for physicians, non-physician practitioners, and physician or non-physician practitioner organizations (the "**Covered Groups**"). Covered Groups will no longer be allowed to establish retrospective Medicare effective billing dates.

The effective date of Medicare billing privileges for the individuals and entities identified above is the LATER of the date of filing or the day they first begin furnishing services at a new practice location.

The individuals and Covered Groups may retrospectively bill for services when:

- The supplier has met all program requirements, including state licensure requirements; and
- The services were provided at the enrolled practice location for up to –

- 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries;

or

- 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

### WHAT DOES THIS MEAN?

Before the 2009 PFS, a new provider could bill A/B MACS retrospectively for work performed prior to his or her effective date at a new practice location. Since it could easily take up to six months to get a provider approved at a new practice location, the physician group employing the provider might be carrying that provider for some period of time with very little cash flow except from private payers. However, ultimately the checks would catch up with the claims and all would be reconciled. Under 2009 PFS the time limit for submitting retrospective claims has been shortened to thirty days. Claims for work performed prior to that thirty day period may be rejected. The good news is that the on-line processes CMS has adopted seems to have reduced the wait time by several weeks. Also, CMS has softened its position on this point by stating that claims for services rendered prior to the thirty day time period will be denied, rather than rejected. But there is no guarantee your application will be processed timely and the cash flow situation for affected clinics and providers could be serious. The point to remember in all of this is that great care should be taken as to when you bring on a new provider – pay attention to the timing. We suggest you start the process for new providers as soon as possible to avoid potential cash losses or denied claims.

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