Medicare enrollment application

EFT authorizations must be reviewed

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IIs your Medicare enrollment data current?

Providers should check their Medicare enrollment applications (CMS 855S) to make sure the information reported on the application (i.e. their enrollment data) is current. Recently, there has been an increase in providers whose billing privileges have been revoked because their enrollment data is incorrect. Providers are required to report changes in their enrollment data to the Centers for Medicare & Medicaid Services (CMS). The changes that must be reported include changes in ownership, changes in practice location and adverse legal actions.

The deadline for reporting changes to enrollment data depends on the type of provider and the data being changed. For example, an independent diagnostic testing facility (IDTF) must report changes in ownership, changes of location, changes in general supervision and adverse legal actions within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 days. With the exception of changes in general supervision, a similar rule applies to physicians, non-physician practitioners and physician and non-physician practitioner organizations. All other providers and suppliers must report ownership changes within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 days.

Providers who fail to report changes in their enrollment data can have their billing privileges or Medicare number revoked. In some cases, the revocation can be retroactive, which gives rise to a potential overpayment obligation. Providers who believe they have missed a deadline for reporting a change to CMS should contact legal counsel.

Read EFT authorizations from commercial payers carefully

Ohio House Bill 1 requires third party payers to pay claims for health care services to a provider electronically under Ohio's Prompt Payment Law when the third party payer receives the claim electronically. Providers need to read carefully the electronic funds transfer (EFT) forms from the payers. Currently, a large commercial payer is demanding that its participating health care providers execute a form "authorizing" the payer to make both EFT deposits to and withdrawals from the participating provider's bank accounts. Buried in the form is a provision that the provider authorizes the payer to "correct inadvertent duplicate payment information." In essence, the payer is extracting from each of its participating providers the right to access the provider's bank accounts and the funds on deposit.

To avoid having a third party payer deplete a provider's account at any time without notice, the provider could revise the "authorization" form to eliminate any authoization to make withdrawals from the account and/or direct the provider's bank to institute a full and complete direct debit zero block on the bank account. The latter involves a small bank fee and will eliminate the possibility that anyone, including third party payers, will be able to withdraw funds electronically from the account without the provider's consent.

For questions about Medicare enrollment applications or EFT authorizations, please contact Robert Cochran at 614.462.2248 or rcochran@szd.com or any member of SZD's Health Care Practice Group.

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