Medicare Provider Enrollment Update and Enforcement Strategies

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Today's Presenters

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Topics to be Addressed

- Introduction/Overview
- Enrollment/Reenrollment Process
- Rejection
- Changes of Ownership/Successor Liability
- Medicaid Specific Enrollment Issues
- Revocation of Billing Privileges

Overview

- Enrollment Process as an Enforcement Tool
- OIG's Five Principle Strategy for Healthcare Integrity (6/2009) – Enrollment, Payment, Compliance, Oversight, and Response
- Medicaid Program Integrity Review Annual Summary – May 2009 – focus on enrollment best practices

OIG's Views on Enrollment

- Providers and suppliers applying for enrollment in Medicare or Medicaid should be screened before they are granted billing privileges.
- Heightened screening measures for high-risk items and services could include requiring providers to meet accreditation standards, requiring proof of business integrity or surety bonds, periodic recertification and onsite verification that conditions of participation have been met, and full disclosure of ownership and control interests.
- The cost of this screening could be covered by charging application fees.
- New providers and suppliers should also be subject to a provisional period during which they are subject to enhanced oversight, such as prepayment review and payment caps.
- *Testimony of Daniel R. Levinson, HHS Inspector General, "Health Care Reform: Opportunity to Address Waste, Fraud and Abuse" (June 25, 2009)*

Enrollment Procedures: When to Enroll

- To obtain Medicare billing privileges
- Must re-enroll every 5 years (will be contacted by the Centers for Medicare and Medicaid Services (CMS) to initiate process)
- In the case of a change of ownership (CHOW)
- To change Medicare information or report adverse legal action

Options to Enroll

- Complete, sign and submit the appropriate CMS-855 form *or*
- Use the Provider Enrollment, Chain and Ownership System (PECOS) to enter information over the internet (http://pecos.cms.hhs.gov), and mail a signed certification

Options to Enroll (cont'd)

- CMS-855 forms differ by provider type
  - CMS-855A: Institutional providers (*e.g.*, hospitals) that furnish Medicare Part A services
  - CMS-855B: Supplier organizations (*e.g.*, ambulance companies) that bill Medicare for Part B services. Not for individuals

Options to Enroll (cont'd)

- CMS-855I (letter, not number): Individual practitioners (physician and non-physician) who provide Medicare Part B services. Includes sole owners of business entities who bill Medicare through the entity
- CMS-855R: Individuals who render Medicare Part B services and seek to reassign their benefits to an eligible entity. The individual must be enrolled prior to reassignment of benefits
- CMS-855S: Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers

Options: PECOS

- PECOS can currently be used in place of t CMS-855 forms, except:
  - Not available for DMEPOS suppliers
  - Not available for CHOW, acquisitions and mergers, and consolidations
  - Both are expected in the near future
- CMS has awarded a contract to expand PECOS to allow states to use the system for Medicaid enrollment (One-Stop Shop)

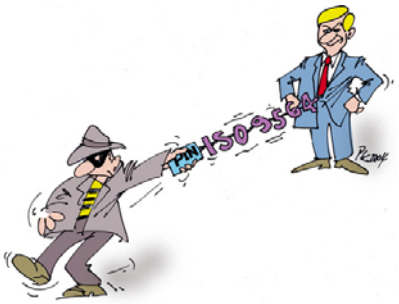
Options: PECOS (cont'd)

- CMS encourages providers/suppliers to use PECOS
  - CMS recently announced an initiative to re-validate the top 50 billing organizational suppliers, individual practitioners, and skilled nursing facilities (SNFs) who do not have a record in PECOS in each state

- Advantages of PECOS:
  - Faster processing times (average: 25 days)
  - No need to fill out entire form to enroll or make a change (scenario driven)

Options: PECOS (cont'd)

- To use PECOS, providers must have a National Provider Identifier (NPI) and a login/ID for the National Plan and Provider Enumeration System (NPPES)



Authorized Individual (AO)

- An official to whom an organization has granted the legal authority to enroll it in Medicare
  - The AO must be a director/officer, managing employee, partner, or an owner with greater than 5% share. The AO's name and SSN must be given in the application
  - The AO must sign initial applications or periodic reenrollments but may delegate authority for updates or changes

Authorized Individual (AO) (cont'd)

- PECOS requires authentication of an organization's AO, and requires the AO to approve the individual who will complete the enrollment application (if not the AO)
  - These steps could take several weeks. For provider/supplier organizations, the CMS-855 forms may be faster than PECOS

Pre-Screening

- Once the Medicare contractor receives a complete application, it determines whether the applicant has completed all the necessary data elements and supplied all necessary documentation
  - Within 15 days of receipt of application
  - If data/documents are missing, the Medicare contractor will send a letter/email/fax that requests the information within a specified timeframe

Pre-Screening (cont'd)

- Each required entry must be completed, even if the information is available elsewhere
- Failure to provide all missing information may lead to rejection or denial of the application

Verification

- Complete applications are reviewed to determine if any of the data conflicts with available sources, such as:
  - Supporting documentation
  - Qualifier.net
  - IRS data
  - Information from State licensing boards
  - Phone calls or visits to listed addresses

- Medicare contractors may request additional information. Failure to respond may lead to rejection or denial

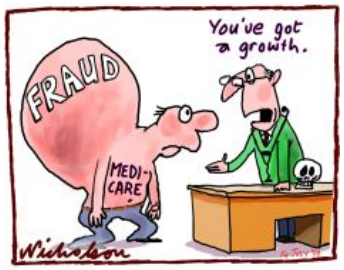
Verification (cont'd)

- Additional procedures (such as verification of signatures, request of copies of driver's licenses or other identification, and visits to sites) are required for CMS-855A, CMS-855B, and CMS-855I applicants in certain situations:

  - Changes in practice location address or in correspondence or special payments address
  - Changes in electronic funds transfer (EFT) information
  - Applications for reactivation or revalidation
  - Reassignment of all benefits

Potential Fraud

- If the Medicare contractor believes a case of fraud likely exists, the contractor must refer the matter to a Professional Standards Commission (PSC) or a Zone Program Integrity Contractor (ZPIC)



Verification (cont'd)

- The Taxpayer Identification Number (TIN) will be verified against Qualifier.net and IRS data to ensure it has not already been used and that the provider is not using multiple TINs
  - The TIN is either an Employer Identification Number or a Social Security Number
  - Make sure spelling matches exactly
  - Recently changed name?
    - Request an IRS verification letter and attach with an explanation

Verification (cont'd)

- Correspondence Address
  - Must be where the Medicare contractor can directly contact the applicant. Can be a P.O. Box or a home address
  - Do not give the number/address of a management company, attorney, billing agency, etc.
  - The Medicare contractor may call/visit to verify that the applicant can be reached there

Practice Locations

- List all locations where services will be furnished
  - Do not include clinics or entities that are separately enrolled
- If the location listed does not appear on Qualifier.net, the Medicare contractor may request more information

Practice Locations (cont'd)

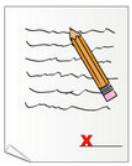
- The phone number listed must be one where patients/customers can reach the applicant to ask questions or file complaints
  - The Medicare contractor will call the listed number

Contact Person

- The Medicare contractor will use the contact person for all communications specifically related to the submission of the enrollment (*e.g.,* requests for additional information and approval/denial letters)
- Other matters will be directed to the correspondence address

Certification Statement

- Must be signed and dated by an appropriate person
  - For CMS-855I: Must be the individual practitioner
  - For CMS-855A and B: Must be an AO or a person delegated by the AO
- Must be printed and mailed if PECOS is used to enroll
- Use blue or black ink
- The signature must be original (*i.e.*, not faxed or photocopied or emailed)



Required Supporting Documents

- When a provider wants to make a change, submit only the documents applicable to that change
- Licenses, certifications, and registrations required by Medicare or State law
- Federal, State, and/or local (city/county) business licenses, certifications and/or registrations required to operate a health facility
- Written confirmation from the IRS that shows that the TIN and the Legal Business Name are consistent

Required Supporting Documents (cont'd)

- Completed Form CMS-588 (Authorization for Electronic Funds Transfer)
- Copy of any adverse legal action documentations (notifications, resolutions, and reinstatement letters)
- For home health agencies (HHAs), must demonstrate that they meet capitalizations requirements
- For CHOWs, Acquisitions/Mergers, and Consolidations, copies of all bills of sale or sales agreements

- Other documents requested by the Medicare contractor

Tips to Complete the Application

- Use PECOS or choose the appropriate version of the CMS-855
- Determine who is your Medicare contractor
- Complete all information and submit all supporting documentation
- Submit a copy of the authorization agreement for EFT, CMS-588
- Sign and date the application in blue or black ink. Even if PECOS was used, need to sign, date, and mail the certification statement [with evidence of delivery available]
- Comply with any requests from the Medicare contractor

Incomplete Applications

- Within 15 days of receipt of an application, the Medicare contractor must send a letter to the applicant that lists any missing information or documentation (pre-screening)
- Failure to supply all the information within 30 days may lead to *rejection* or *denial*
  - The Medicare Contractor may extend the time period if the applicant is actively working to resolve issues
  - If the applicant supplies only some of the missing information, the Medicare contractor has no obligation to make another request

Incomplete Applications (cont'd)

- Incomplete applications for the following will be *denied*:
  - Physicians
  - PAs
  - NPs
  - Clinical Nurse Specialists
  - Certified registered nurse anesthetists
  - Certified nurse-midwives
  - Clinical social workers
  - Clinical psychologists
  - Registered dietitians or nutrition professionals
  - Physician and Non-physician Practitioner Organizations (*e.g.*, group practices which consist of individuals identified above)

Incomplete Applications (cont'd)

- Incomplete applications for all individuals or entities not listed on the previous slide will be rejected, *e.g.*:
  - Hospitals
  - Clinics
  - Dentists
  - Nursing homes
  - DMEPOS suppliers

Rejections and Denials

- Rejections: The application was not processed
  - No appeal rights
    - Language in a recent CMS transmittal (299) suggested appeal rights would be granted, but no changes were made
  - The application may be resubmitted at any time
- Denials: the applicant has been determined to be ineligible for Medicare billing privileges
  - Appeal rights
  - May not reapply until notice is received that the appeal was unsuccessful or until the right to appeal has lapsed

Rejections and Denials (cont'd)

- For the individuals and organizations to whom denial applies, the effective Medicare billing date is the later of: the date the ultimately successful application was filed and the date they first began to furnish services at a new practice location
  - Denials and the appeal process allow physicians and other practitioners to maintain the date of their initial application
- These same individuals may also bill up to 30 days prior to the effective date if circumstances precluded enrollment in advance

Change of Ownership (CHOW)

- What constitutes a CHOW?
  - Any "transfer of Medicare participation"
  - Partnerships: Adding, removing, or substituting a partner
  - Corporations: The merger of the provider corporation into another, or the consolidation of corporations resulting into a new corporation
  - Unincorporated sole proprietorship: Transfer of title to the enterprise
  - Leasing: The lease of all or part of a provider facility (constitutes a CHOW for the leased portion)

Change of Ownership (CHOW) (cont'd)

- What does NOT constitute a CHOW?
  - The transfer of corporate stock
  - Changes in corporate membership
  - The merger of another corporation into the provider corporation
  - Hiring a management company to run operations, subject to the owner's general approval
  - There is no CHOW if, after the change, no functioning provider enterprise exists

Change of Ownership (CHOW) (cont'd)

- Reporting CHOWs
  - Both Buyer and Seller report the CHOW on the appropriate CMS-855 form, or through PECOS
  - Include a copy of the bill of sale. The final sales agreement must be submitted once the sale is executed
  - The CHOW will not be processed until the CHOW is complete
- Many events that do NOT qualify as CHOWs must be reported as "changes of information"

Change of Ownership (CHOW) (cont'd)

- When a provider undergoes a CHOW, the new owner must choose whether to accept assignment of the Medicare provider agreement
  - Assignment is *automatic*, but may be rejected
  - CMS-855 forms now ask whether the purchaser intends to participate in Medicare, and, if so, whether the new owner will accept the provider agreement

Change of Ownership (CHOW) (cont'd)

- Successor Liability
  - No *statutory* provision that provider obtaining another provider's provider agreement in a CHOW is liable for seller's Medicare overpayments
  - No *statutory* provision on CHOWs at all
  - Regulations: 42 CFR 489.18
  - Manual provisions: State Operations Manual
  - Other non-regulatory guidance

Change of Ownership (CHOW) (cont'd)

- Successor Liability
  - In a CHOW, existing provider agreement is automatically assigned to new owner unless provider voluntarily terminates Medicare participation
  - If new owner does not accept existing provider agreement, Medicare overpayment liabilities do not transfer to new owner
  - Refusal of assignment: provider must wait for resurvey, certification, issuance of new billing number: 6-12+ months

Change of Ownership (CHOW) (cont'd)

- Successor Liability
  - Most transactions are structured as CHOWs to avoid break in Medicare reimbursement
  - Courts upheld automatic transfer of liability for Medicare overpayments to new owner
  - 8th Circuit extended rule to apply to civil monetary penalties

Change of Ownership (CHOW) (cont'd)

- Other forms of successor liability
  - Individuals or entities might be held liable under state "piercing the corporate veil" doctrine

Change of Ownership (CHOW) (cont'd)

- Voluntary termination of Medicare participation
  - Provider files written notice of its intention to the State Agency or Regional Office (RO). There is no required form
  - RO will accept proposed termination date (last day business will be opened) or set a new one
    - Notice must be less than 6 months from the termination date, and must give enough time to notify all parties
  - Provider must notify the public at least 15 days before the business closes through publication in the local paper with the widest circulation

Change of Ownership (CHOW) (cont'd)

- Deactivation of provider number:
  - Done by filling an 855, or through PECOS
  - This step may not be necessary, but is recommended
    - Alternatively, a provider's billing number is terminated automatically if no claims are submitted for 4 consecutive quarters
    - Termination ensures the number is not used fraudulently

Change of Ownership (CHOW) (cont'd)

- Reapplication
  - If Buyer does not accept Seller's provider agreement, Buyer must apply for a new agreement in order to provide Medicare services
  - The process takes time
  - Buyer cannot bill Medicare until its effective date of Medicare billing privileges

Medicaid Requires Enrollment, Too!

- Federal Medicaid requirements for states to collect and verify basic information on potential providers, including whether the providers meet state licensing requirements and are not excluded from participation in the federal healthcare programs (e.g. 42 CFR §§ 455.105 – 106)
  - SMDL 08-003 (June 12, 2008) – Reminds states of responsibilities with respect to excluded providers
- One-stop Shopping – single enrollment for both Medicare and Medicaid contemplated as part of Medicaid Integrity Program efforts

Medi-Cal (California Medicaid)

- Requires completion of Provider Agreement as part of enrollment package
- Includes provider's agreement to several pages of terms, such as access for record inspection, payment suspensions, notice to DHCS within 10 days of learning it is under investigation, etc.

Revocation of Billing Privileges – Cites

- Final Rule: 71 Fed. Reg. 20,776 (April 21, 2006)
- Medicare Regulations: Revocation of Enrollment and Billing Privileges at 42 C.F.R. § 424.535; Deactivation of Medicare Billing Privileges at 42 C.F.R. §424.540; Appeals at 42 C.F.R. §§ 405.874; 424.545
- Program Integrity Manual, Chap. 10, Section 13

Deactivation of Billing Privileges

- The contractor may deactivate a provider or supplier's Medicare billing privileges when:
  - A provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12-month period begins on the first day of the first month without a claims submission through the last day of the 12th month without a submitted claim
  - A provider or supplier fails to report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services
  - A provider or supplier fails to report a change in ownership or control within 30 calendar days

Revocation of Billing Privileges

- Note 12 grounds for revocation which contractor can initiate without further approval – Program Integrity Manual, Chap. 10, Section 13.2
  - Revocation 1 – Not in compliance with enrollment requirements (includes not having a physical business address)
  - Revocation 2 – Provider/supplier lost its license
  - Revocation 3 – Provider/supplier no longer meets CMS requirements for specialty for which enrolled
  - Revocation 4 – Provider/supplier does not have a valid SSN/EIN for itself, owner, partner, etc.
  - Revocation 5 – Provider/supplier excluded, debarred, suspended
  - Revocation 6 – Provider/supplier or any owner within 10 years preceding enrollment or revalidation was convicted of Federal or State felony offense that CMS has determined to be detrimental to best interests of the program and its beneficiaries to continue enrollment, e.g., felony crimes against persons, financial crimes, malpractice suite that results in conviction of criminal neglect or misconduct

Grounds for Revocation (cont'd)

- Revocation 7 – Misleading or false information on the enrollment application certified as true
- Revocation 8 – Knowing misuse of billing number
- Revocation 9 – Provider/Supplier no longer operational
- Revocation 10 – Provider/Supplier fails to furnish complete and accurate information within 30 calendar days of notification from CMS to submit an enrollment application
- Revocation 11 – Provider/Supplier failed to comply with the reporting of changes in adverse actions and practice locations within 30 days of the reportable event
  - limited application
- Revocation 12 – Provider/Supplier/DMEPOS supplier submits a claim for services that could not have been furnished to a specific individual on the date of services, e.g., beneficiary is deceased, directing physician or beneficiary not in State or country when services were furnished, or when equipment necessary for testing is not present where testing is said to have occurred
  - Special procedures required before imposition

Appeals

- Final Rule 73 Fed. Reg. 36448 (June 27, 2008)
  - 42 C.F.R. § 424.545(a) – when billing privileges revocation also results in termination of provider agreement – Part 498 rules for both
  - 42 C.F.R. § 424.545(b) discusses rebuttal in accordance with 42 C.F.R. § 405.374;
  - Program Integrity Manual, Chap. 10, Section 19 discusses corrective action plan and administrative appeal opportunities

Reapplying after Revocation

- Provider/Supplier whose privileges are revoked is barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar
  - Generally barred for 1 – 3 years (see examples)
  - Applies only to revocations, not denials of applications

Questions and Answers

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