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CMS Pursues 'Enforcement by Enrollment,' Inviting a Change in 'Mindset' About Enrollment

When an orthopedic surgery practice opened a durable medical equipment (DME) business, it inadvertently set in motion a rejection of its Medicare enrollment. Because the physicians referred to each other as partners, the employee preparing the DME enrollment form checked the box for general partners even though the medical group wasn't a partnership. Mislabeling the physicians activated the fingerprint requirement for enrollment in a high-risk category—in this case DME suppliers.

"That's a mistake people make," said Gretchin Heckenlively, a partner at Eide Bailly. "We have seen those practitioners refuse to get fingerprinted and their enrollment gets rejected."

Sometimes it's the nuances that get you, with CMS increasingly policing Medicare through stays of enrollment, applicant denials, deactivations and revocations of provider enrollment. The administration is doing "enforcement by enrollment," said attorney Judy Waltz, with Foley & Lardner LLP. "They're focusing on tools to avoid the submission of claims that suggest fraud, waste and abuse from 'suspect' providers that, because of CMS's prior experience, they know are out there." In response, providers and suppliers may want to revisit their oversight of enrollment forms.

Getting Away from Pay and Chase

CMS is trying to move away from pay and chase—i.e., recovering ill-gotten gains from providers and suppliers after the fact. "Instead of pay and chase, they're hoping to revert that to keeping bad players from enrolling in Medicare right out of the gate," Heckenlively said. CMS also has made recent enrollment changes that affect the way providers file their 855 enrollment forms (e.g., 855A for institutions, 855B for group practices).

Enrollment of telehealth providers adds another dimension. "A great dilemma is how to enroll with Medicare if you're a completely virtual telehealth practice," said Steve Lokensgard, with Faegre Drinker Biddle & Reach LLP.

'Changing Your Mindset'

Providers and suppliers enroll in Medicare using the CMS Provider Enrollment, Chain and Ownership System (PECOS). They're required to timely update PECOS when they make certain changes, such as adding a practice location or changing an address, and to do a full-blown revalidation (i.e., re-enrollment) every five years (three years for DME suppliers). Getting it wrong can interfere with enrollment and lead to claim denials and possibly revocation of the provider's billing number. For example, tiny discrepancies in the address of an off-campus provider-based department (PBD) between the claim and PECOS will stop payment in its tracks.

Reducing the compliance risks with enrollment requires "changing your mindset that these are forms that just need to be completed," Heckenlively said. "You can't just hand it off to the person who has the most time available." Enrollment forms are "a compliance tool, and there's a lot you need to sit down and go through before you actually touch the form." She noted that every time providers and suppliers sign an update or revalidation, they're not just attesting to the accuracy of the change they're making. "You're signing to the accuracy of the enrollment every time." Even if the provider is just updating a board member change, "you need to review the entire enrollment for accuracy," Heckenlively said.

PBD Enrollment Errors Hit Hospital Wallets

Minor errors can cause major reimbursement damage. For example, hospitals lose the full outpatient prospective payment system (OPPS) payment for services at an off-campus PBD if they report its relocation on the 855A, said Amy Gendron, director of clinical and regulatory compliance at Michigan-based Trinity Health. But redesigning a PBD's layout wouldn't change the OPPS payment, she said. For example, if a hospital reconfigures an orthopedic PBD to make room for a cardiology suite, it doesn't need to update the 855A because the whole floor is considered a PBD, Gendron said.

Misunderstandings about this could cost the hospital big bucks because PBDs that open after Nov. 2, 2015, are reimbursed at 40% of the OPPS rate, and the same goes for relocated or converted PBDs.

"We have unfortunately had updates to our 855A that have slipped through the cracks and jeopardized grandfathered locations," Gendron said.

Data on 855 forms and PBD claims must also align to protect payment. CMS requires hospitals to put all practice locations on their enrollment forms, including PBDs, and their address in PECOS should be an exact match to the address on the claim form. If it's not, Medicare will deny the claim. CMS gets finicky about this: the spelling of "street" in an address must be the same on both PECOS and claims (i.e., not Street on one and St. on the other). CMS implemented validation edits in 2023 to enforce this requirement, and it rejects claims without a perfect match. The requirement is designed to ensure Medicare payment is correct for grandfathered versus non-grandfathered PBDs.

To oversee enrollment, Trinity Health has a "complex sign-off process that runs all the way up through the compliance and integrity leadership at the vice president level," Gendron said. "Part of why we started our whole process of having everyone sign off on any changes to the 855 was because of address matching. We have experienced some significant pains in the past trying to get everything aligned and connected."

The stakes may soon be higher, because the 2026 Consolidated Appropriations Act (CAA) that passed the U.S. House Jan. 22 and is pending in the U.S. Senate requires hospitals to get separate identifiers for their off-campus PBDs and attest to their compliance.[1] "Regular enrollment of PBDs is a challenge," Gendron said. "Now we will add another layer of administrative complexity."

SNFs Are Now Required to Bare All

Enrollment forms have seen their fair share of changes. A biggie: Since Jan. 16, 2024, skilled nursing facilities (SNFs) and nursing homes have been required to report far more information about owners, investors and managers, Waltz said. Although SNFs have always had to report owners and certain managers, CMS wants more visibility into the people and companies behind the scene—namely private equity and real estate investment trusts.

"The degree of disclosures that are required are so much higher for SNFs than any other type of provider," Waltz said. "It's very burdensome." SNFs are required to report "additional disclosable parties," which refer to a person or entity with operational or financial control. "The overarching goal is trying to understand where all the decision points are being made as it relates to the management and care of patients," Heckenlively said.

In another change, starting Jan. 1, 2026, CMS requires DME suppliers undergoing a majority change in ownership to file a new enrollment application instead of a change of ownership, Heckenlively said. "It shows you there's a continued emphasis on ownership for high-risk providers and suppliers."

There have also been helpful revisions. PECOS was updated to allow providers and suppliers to enter information on foreign owners, effective Jan. 1, 2026, Heckenlively said. "This is good," she explained. "We're required to report owners, and from a compliance perspective, you're trying to give them information, but they didn't have the ability to accept it."

Clarifying the Reasons for Revocation

Another revision focused on revocation of Medicare billing numbers. CMS in a September 2025 transmittal (13,415) addressed when a reenrollment bar would extend to all of a provider's enrollments, or just the Medicare Provider Transaction Access Number (PTAN) that was revoked, Lokensgard said.[2] If revocation is based on more administrative grounds (e.g., evidence from on-site visits indicates that the provider or supplier isn't operational), the reenrollment bar will only apply to the revoked PTAN. But if revocation is based on a more substantive reason that's "closer to fraud" (e.g., the provider is excluded from Medicare), the reenrollment bar applies to all enrollments associated with the provider's tax ID, he said.

It's harder to pin down the effect of a Medicare revocation on a provider's Medicaid enrollment, or whether the provider will be placed on the CMS Preclusion List for Medicare Advantage and Part D, Lokensgard said. "The clarification from CMS in September was helpful, but it's still more difficult than it should be to understand the impact of a Medicare revocation."

Revocations are virtually impossible to reverse, Lokensgard said. Although HHS administrative law judges will hear revocation cases, "they're only reviewing whether CMS had a legitimate basis to revoke the enrollment and it's a difficult thing to fight. Your intent or good faith doesn't matter. The revocation will stand," he said.

Telehealth Opens a Can of Worms

Telehealth has opened another enrollment can of worms. One of them is reporting practice locations on the 855. While physicians and other practitioners who deliver telehealth services from their home but also have a brick-and-mortar practice location don't have to report their home addresses, the same isn't true of telehealth practitioners who work exclusively from home, CMS explained in November FAQs.[3] They're required to enroll their home address as a practice location, sacrificing their privacy in the process, said attorney Thomas Ferrante, with Foley & Lardner LLP. But CMS has given practitioners some grace. They have the option of suppressing their address on the Care Compare website by either marking the address as a "Home office for administrative/telehealth use only" location in their enrollment application or asking CMS to suppress their address and phone number by emailing qpp@cms.hhs.gov.

That apparently hasn't inspired enough confidence in some quarters. In a Jan. 20 letter, the Alliance for Connected Care asked CMS to stop requiring telehealth practitioners working from home "to report their private residence to the federal government for purposes of enrollment or billing."

Another wrench in the works is that practitioners are required to bill the Medicare administrative contractor (MAC) for the jurisdiction where they're physically located, Ferrante said. If the physician is in Tampa, Florida, but delivers telehealth to a patient in Los Angeles, the physician bills the MAC for Florida. That may require the practice or hospital to add a new practice location to the enrollment form for every physician who delivers telehealth services, he said.

Telehealth-only providers may lose business because of the enrollment burden, Ferrante said. For example, a hospital and affiliated medical practice considering a telepsychiatry vendor "may say, 'We'd love to, but don't want to have to enroll in all MAC locations.'"

Medicaid Version of Fingerprint Glitch

Medicaid enrollment also looms large. "It's very unforgiving," Lokensgard said. He recounted the experience of a DME supplier when it was revalidating. The state told the supplier to get new fingerprints from owners with more than a 5% stake. Prodded by the Affordable Care Act, CMS has implemented fingerprint-based background checks for people who own more than 5% of high-risk providers and suppliers in certain categories (Medicare Diabetes Prevention Programs, home health agencies, DME suppliers, opioid treatment programs, hospices and SNFs). This was easier said than done with one owner, a 93-year-old woman in a nursing home. "They didn't get it done in time," Lokensgard said. "It was an automatic revocation."

To get back in Medicaid's good graces, the supplier was required to submit a new enrollment application. "They had to go through the whole enrollment process for initial Medicaid," he said. "We submitted documents and got them to agree it wasn't a serious fraudulent matter." But the damage was done because the state had placed the supplier on the Data Exchange System (DEX), which tracks Medicare and Medicaid enrollment terminations and revocations when they're "for cause." That led to five other states revoking the DME supplier's enrollment. As soon as the supplier reenrolled, Medicaid took it off DEX. But it was still annoying because revocations under appeal aren't supposed to be added to DEX.

The Trump administration also is amping up the use of moratoria on Medicaid enrollment as an anti-fraud strategy, Waltz said. In a letter to Minnesota's governor, CMS directed the state Department of Human Services to freeze enrollment of 13 provider categories and revalidate existing providers in those categories. Other states may see similar moves as CMS's way to keep potential bad apples out of Medicare.

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Endnotes

1 Consolidated Appropriations Act, 2026, H.R. ___, 119th Cong. (2d Sess. 2026), https://bit.ly/3YUGCII.

2 Centers for Medicare & Medicaid Services, "Provider Enrollment Updates to Chapter 10 of CMS Publication (Pub.) 100-08, Program Integrity Manual (PIM)," Trans. 13,415, September 18, 2025, https://go.cms.gov/4ahUgMp.

3 Centers for Medicare & Medicaid Services, "Telehealth FAQ Calendar Year 2026," updated November 14, 2025, https://go.cms.gov/4teIjPd.