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Medicare and Medicaid Enrollment and Revalidation: Obtaining and Maintaining Enrollment and Billing Privileges

WEDNESDAY, MAY 2, 2018

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

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Medicare and Medicaid Enrollment and Revalidation Screening Requirements

May 2, 2018

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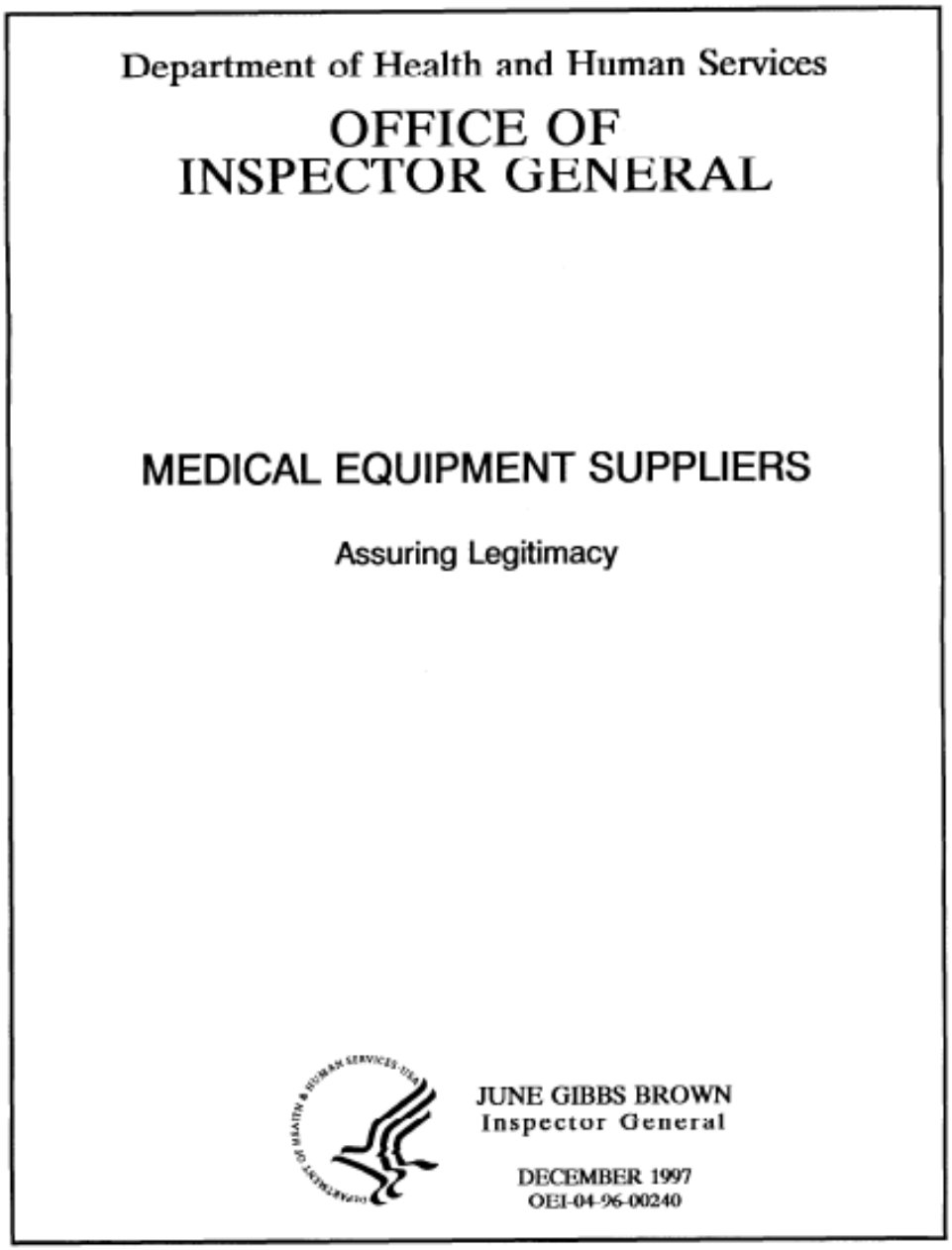
2018 CMS Fast Facts

- January 2018 – CMS Fast Facts
  - In 2016, Medicare Enrolled Providers and Suppliers Totaled:
    - **1,249,691** Providers
    - **6,146** Hospitals
    - **85,297** DMEPOS
    - **11,956** Home Health Agencies
    - **15,274** Skilling Nursing Facilities
    - **5,529** Ambulatory Surgical Centers

November 2016 GAO Report

- *Medicare: Initial Results of Revised Process to Screen Providers and Suppliers, and Need for Objectives and Performance Measures*
  - Reviewed Updated Screening Process (2016)
  - CMS used updated screening process on 2.4 million applications (2016)
  - Over 23,000 new applicants and 703,000 were denied, rejected, deactivated or revoked (2016)
  - CMS avoided estimated $2.4 billion in Medicare spending to ineligible providers

Where it all Began…



Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

MEDICAL EQUIPMENT SUPPLIERS

Assuring Legitimacy

JUNE GIBBS BROWN
Inspector General

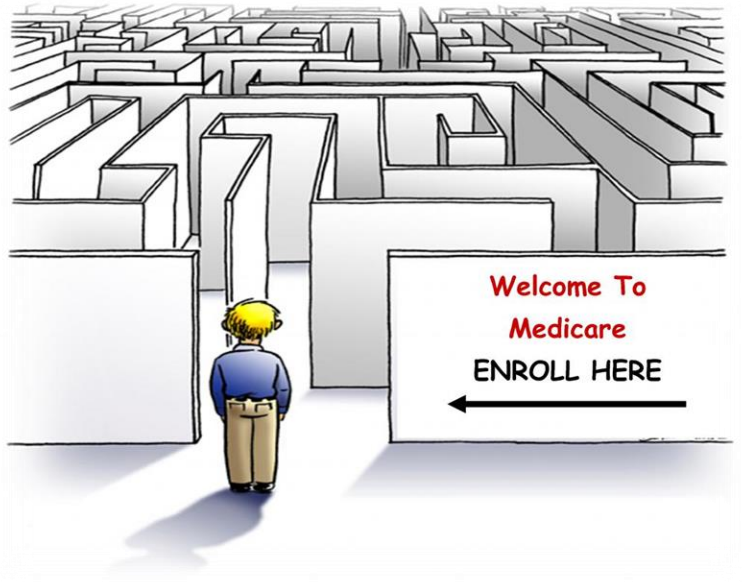
DECEMBER 1997
OEI-04-96-00240

Enrollment Regulations

- Why is this so important?
  - Program integrity v. pay-and-chase
    - OIG: in 1997, 1 of every 9 DMEPOS applicants lacked physical address
- Provider and Supplier Enrollment:
  - 42 CFR Part 424, Subpart P (Medicare)
    - Establishing and maintaining billing privileges
    - More screening requirements
      - 42 CFR 424.518
    - More reasons to deny and revoke
      - 42 CFR 424.530, 424.535

Enrollment Regulations

- Provider and Supplier Enrollment:
  - Specific requirements depending on provider/supplier type:
    - 42 CFR 410.33 (IDTFs)
    - 42 CFR 424.57 and 424.58 (DMEPOS)
  - 42 CFR Part 455 (Medicaid)



Sub-Regulatory Guidance

- Key Portions of Medicare Manuals:
  - Medicare Program Integrity Manual (CMS Pub. 100-08)
    - Chapter 15 (requirements for specific types of providers, suppliers, site verification process, appeals process)
  - Medicare State Operations Manual (CMS Pub. 100-07)
    - Chapter 2
    - Chapter 3

Regulatory Development of Key Enrollment Initiatives

- **Mar. 1 2016 (proposed)**—numerous ACA provisions, including expanded authority to revoke enrollment for failure to file changes of information (applies to all providers/suppliers and all CHOIs) (81 Fed. Reg. 10720)
- **Dec. 5, 2014** – expanding the basis for denial or revocation of a provider or supplier's enrollment (79 Fed. Reg. 72499)
- **Feb. 2, 2011—**enrollment screening, application fees, enrollment moratoria, payment suspensions and Medicaid terminations of providers/suppliers that have had billing privileges revoked (76 Fed. Reg. 5682)
- **Aug. 27, 2010**—DME standards (75 Fed. Reg. 166)

Regulatory Development of Key Enrollment Initiatives

- **May 5, 2010—**requiring all providers/suppliers that qualify for NPI to include NPI on all applications to enroll in Medicare, Medicaid and on al claims for payment submitted under Medicare, Medicaid (75 Fed. Reg. 24437)
- **Jan. 2, 2009—**surety bond requirements for DME suppliers (74 Fed. Reg. 166)
- **Nov. 19, 2008—**1-3 year re-enrollment bar for providers, suppliers that have had billing privileges revoked; placed limitations on provider, supplier retroactive billing (73 Fed. Reg. 69726)
- **Jun. 27, 2008—**appeals process for CMS, MAC decisions on provider, supplier failure to meet requirements for billing privileges (73 Fed. Reg. 36448)

Regulatory Development of Key Enrollment Initiatives

- **Nov. 27, 2007**—enhanced IDTF provisions (72 Fed. Reg. 66222)
- **Dec. 1, 2006**—IDTF "performance standards" (71 Fed. Reg. 69624)
- **Apr. 21, 2006**—requirements for providers/suppliers to establish and maintain billing privileges (71 Fed. Reg. 20754)
- **Oct. 11, 2000**—additional standards for DME suppliers (65 Fed. Reg. 60366)

Forms, Forms & More Forms

- 855A (Providers)
- 855B (Suppliers)
- 855I (Physicians & NPPs)
- 855R (Reassignment)
- 855S (DMEPOS)
- 855O (Ordering & Referring Physicians/NPPs)
- 855POH (Physician owned hospitals (Stark))
- Misc. (20134 (diabetes), 588 (EFT), 460 (Participation)

The Forms are Simple, Right?

- Enrollment complexities:
  - What kind of enrollment transaction is it?
    - Change of ownership (CHOW) v. change of information (CHOI)
    - Others
  - Filing deadlines:
    - How far in advance can forms be filed?
  - Time frames for updating enrollment:
    - Depends on type of transaction
    - Depends on provider/supplier category
  - Determining effective dates
  - Paper v. PECOS
  - What can happen when this goes wrong?

Changes of Information

Provider Type	30-day Reporting	90-day Reporting
DMEPOS Suppliers	All Changes	N/A
IDTFs	Change of ownership, location, general supervision, adverse legal actions	All other changes
Physicians, non-physician practitioners, physician organizations	Change of ownership, adverse legal actions (e.g., licensure revocation), change in practice location	All other changes
All other providers/ suppliers (hospitals, HHAs, hospices, etc.	Change of ownership or control (including changes in authorized or delegated officials), revocation/ suspension of state or federal license	All other changes

Enrollment Screening Requirements

- Medicare Enrollment
  - Screening requirements for providers and suppliers (42 CFR 424.518):
    - Tiered system depending on risk of category of provider/supplier (high, moderate, low)
    - Risk category increases with history of bad behavior
    - Specific details about screening process found in sub-regulatory guidance
  - Applies to initial enrollment (including new practice location) and revalidation

Enrollment Screening Requirements

- Medicare Enrollment
  - Expanding the Instances for Denial and Revocation of Provider or Supplier Enrollment (42 CFR 424.530, 535)
    - Applies to providers, suppliers, owners or managing employees of the provider or supplier.
    - CMS may deny enrollee if any of the applicable individuals were convicted of a felony CMS determines is detrimental to the best interest of Medicare and its beneficiaries within 10 years of applying
    - Crimes include: crimes against people, financial crimes, Medicare-related felony or any felony that would result in mandatory exclusion.

Enrollment Screening Requirements

- Medicare Enrollment
  - Re-Applying After Revocation (42 CFR 424.535)
    - Bars providers, suppliers, delegated officials, or authorizing officials from re-enrolling in Medicare for 1-3 years after revocation depending on the severity of the basis for revocation.

Provider/Supplier Risk Categories

Limited	Moderate	High
•Physician or non-physician practitioners and medical groups or clinics, with the exception of physical therapists and physical therapy groups •Ambulatory surgery centers •Competitive acquisition program/Part B vendors •ESRD facilities •FQHCs •Histocompatibility labs •Hospitals, including CAH	•Ambulance suppliers •Community mental health centers •Comprehensive outpatient rehabilitation facilities •Hospice organizations •Independent diagnostic testing facilities •Independent clinical labs •Physical therapy including physical therapy groups •Portable x-ray suppliers	•Prospective (newly enrolling) home health agencies •Prospective (newly enrolling) suppliers of DMEPOS

Provider/Supplier Risk Categories

GRAY PLANT MOOTY

Limited	Moderate	High
•Indian Health Service facilities •Mammography screening centers •Mass immunization roster billers •Organ procurement organizations •Pharmacies newly enrolling or revalidating via the CMS-855B •Radiation therapy centers •Religious non-medical health care institutions •Rural health clinics •Skilled nursing facilities	•Currently enrolled (revalidating) DMEPOS suppliers •Currently enrolled (revalidating) home health agencies	

Levels of Required Enrollment Screening

Type of Screening Required	Limited	Moderate	High
Verification of any provider/supplier requirements established by Medicare	X	X	X
Conduct license verifications (which may include licensure checks across states)	X	X	X
Database checks to verify social security number (SSN); the National Provider Identifier (NPI); the National Practitioner Data Bank (NPDB) licensure, an OIG exclusion; taxpayer identification number; death of individual practitioner, owner, authorized official, delegated official or supervising physician.	X	X	X
Unscheduled or unannounced site visits		X	X
Fingerprint-based criminal history record check of law enforcement repositories			X

Screening Requirements

Screening Requirements

- Site verification (moderate and high risk categories):
  - For most providers/suppliers, contractors will:
    - Document date/time of visit
    - Photographs (date/time stamped) for inclusion in file
    - Document observations such as facility free of furniture; notice of eviction; space occupied by another business
    - Written report required with signed declaration
  - IDTFs and DMEPOS subject to additional rules:
    - See, e.g., 42 CFR 410.33(g), MPIM, Ch. 15, Sec. 15.5.19 (“IDTF Attachment”)
    - See, e.g., 42 CFR 424.57 (DMEPOS)

Screening Requirements

- Contractor will determine whether following are met:
  - facility is open
  - personnel are at the facility
  - customers are at the facility (if applicable to provider/supplier type)
  - facility appears to be operational
- Site visits for enrollment purposes do not affect those site visits performed regarding Conditions of Participation.
  - 42 CFR 424.517

Screening Requirements

- Fingerprints and criminal background checks (high risk providers/suppliers):
  - fingerprints for national background check
  - all individuals with 5% or more direct or indirect ownership interest
  - Using FBI technology
  - Must submit fingerprints upon submission of enrollment application and within 30 days of contractor request
- Delayed and then implemented (Medicare) in 2014 and 2015 (Medicaid)

Increasing the Level of Risk

- CMS can adjust risk category from "limited" or "moderate" to "high":
  - Payment suspensions
  - Program exclusions
  - Billing privileges revoked within previous 10 years
  - Certain "final adverse actions" (e.g., license revocation or suspension)
  - Medicaid terminations
  - For 6 months after lifting temporary moratoria

Medicaid Enrollment

- Medicaid Enrollment Screening (42 CFR 455.450)
  - Tiered system for enrollment screening
  - Site visits required for moderate to high risk categories, others discretionary
  - Screening of all providers at least every 5 years

Medicaid Enrollment

- Medicaid revalidation
  - Occurs every 5 years
- Monthly checks for excluded status recommended. Required?
  - "State Medicaid agency must do all of the following… Check the LEIE and EPLS no less frequently than one month." 42 CFR 455.436(c)(2)
  - CMS guidance
    - https://oig.hhs.gov/exclusions/files/sab-05092013.pdf
    - http://www.cms.gov/smdl/downloads/SMD061208.pdf
    - http://www.cms.gov/SMDL/downloads/SMD011609.pdf
- States may have unique requirements
  - Check State Medicaid Provider Manual for current information

Enrollment Revalidation

- CMS wants record to be current:
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/RevalidationChecklist.pdf
- 2 types of revalidation:
  - Every 5 years for most providers/suppliers
    - 3 years for DMEPOS
  - Off cycle revalidation
- Revalidation does not affect requirement to timely file CHOIs:
  - In accordance with provider/supplier specific deadlines

Enrollment Revalidation

- CMS lists revalidation due dates on their website: https://data.cms.gov/revalidation
- Due Dates are updated every 60 days and listed at least 6 months in advance
- CMS encourages applicants to revalidate via Internet Based PECOS.
- Failure to revalidate?
  - Possible hold on Medicare payment
  - Deactivation of billing privileges

Enrollment Revalidation

- Revalidation timeline (example):

Action	Timeframe	Example
Revalidation list posted	Approximately 6 months prior to due date	March 30, 2017
Issue large group notifications	Approximately 6 months prior to due date	March 30, 2017
MAC sends email/letter notification	75 – 90 days prior to due date	July 2 - 17, 2017
MAC sends letter for undeliverable emails	75 – 90 days prior to due date	July 2 - 17, 2017
Revalidation due date		**September 30, 2017**
Apply payment hold/issue reminder letter (group members)	Within 25 days after due date	October 25, 2017
Deactivate	60 – 75 days after due date	7

Table from: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1605.pdf

Enrollment Application Fees

- ACA: amounts collected to fund program integrity efforts, including screening
  - 42 CFR 424.514
- $569 for CY2018
- Only required from “institutional” providers:
  - Any provider that submits a paper Medicare enrollment application using 855A, 855B, or 855S.
  - Hospitals, HHAs, community mental health centers, SNFs

Enrollment Application Fees

- Fees must be paid for:
  - Initial enrollment
  - Adding practice locations
  - Revalidation
- Limited “hardship” exception available:
  - E.g., working with underserved populations or engaged in extensive charity work

Enrollment Application Fees

Application Fee requirements for Institutional Providers	Enrollment Action				
Provider/Supplier Type	**Initial Enrollment**	**Revalidation**	**Change of Ownership ***	**Change of Information other than Addition of Practice Location**	**Addition of Practice Location**
Ambulance Service Supplier	Yes	Yes	No	No	Yes
Ambulatory Surgical Center	Yes	Yes	No	No	Yes
Clinic/Group Practice	No	No	No	No	No
Community Mental Health Center	Yes	Yes	No	No	Yes
Competitive Acquisition Program (CAP)/Part B Drug Vendor	Yes	Yes	No	No	Yes
Comprehensive Outpatient Rehabilitation Facility	Yes	Yes	No	No	Yes
Critical Access Hospital	Yes	Yes	No	No	Yes
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	Yes	Yes	No	No	Yes
End-Stage Renal Disease Facility	Yes	Yes	No	No	Yes
Federally Qualified Health Center	Yes	Yes	No	No	Yes
Histocompatibility Laboratory	Yes	Yes	No	No	Yes
Home Health Agency	Yes	Yes	No	No	Yes
Hospice	Yes	Yes	No	No	Yes
Hospital	Yes	Yes	No	No	Yes
Independent Clinical Laboratory	Yes	Yes	No	No	Yes
Independent Diagnostic Testing Facility	Yes	Yes	No	No	Yes
Indian Health Services Facility	Yes	Yes	No	No	Yes
Mammography Center	Yes	Yes	No	No	Yes
Mass Immunization (Roster Biller Only)	Yes	Yes	No	No	Yes
Non-Physician Practitioner	No	No	No	No	No
Organ Procurement Organization	Yes	Yes	No	No	Yes
Outpatient Physical Therapy/Occupational Therapy/Speech Pathology Services Provider that enroll via the CMS-855A	Yes	Yes	No	No	Yes
Outpatient Physical Therapy/Occupational Therapy/Speech Pathology Services Provider that enroll via the CMS-855B	No	No	No	No	No
Pharmacy	Yes	Yes	No	No	Yes
Physician	No	No	No	No	No
Portable X-ray Supplier	Yes	Yes	No	No	Yes
Radiation Therapy Center	Yes	Yes	No	No	Yes
Religious Non-Medical Health Care Institution	Yes	Yes	No	No	Yes
Rural Health Clinic	Yes	Yes	No	No	Yes
Skilled Nursing Facility	Yes	Yes	No	No	Yes

* For providers and suppliers reporting a change of ownership via the Form CMS-855A, the ownership change does not require an application fee if the change does not require the provider to supplier to enroll as a new provider or supplier.

Table from: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/ApplicationFeeRequirementMatrix.pdf

Enhanced Oversight for Provisional Period

- 42 USC 1395cc(j)(3)
- Minimum 30 days and up to 1 year for new providers and suppliers
- Enhanced oversight includes prepayment review, payment caps during provisional period
- HHS to establish guidelines through program instructions

Temporary Moratoria on Enrollment

- CMS can impose in a range of circumstances, including if it determines that there is significant potential for fraud, waste or abuse (42 CFR 424.570)
- Based on factors such as:
  - highly disproportionate number of providers or suppliers in a category relative to the number of beneficiaries
  - rapid increase in enrollment applications within a category.

Temporary Moratoria on Enrollment

GRAY PLANT MOOTY

- Can also be imposed:
  - State imposes moratorium on group of providers/suppliers also eligible to enroll in Medicare
  - State imposes moratorium in particular geographic area, particular provider/supplier type or both
  - CMS, in consultation with DOJ or OIG identifies either or both of following as having significant potential for fraud or abuse:
    - particular provider/supplier type
    - particular geographic area

Temporary Moratoria on Enrollment

- CMS will announce in Federal Register and include a rationale for the moratorium and the geographic areas in which it is to apply.
- No advance notice of a moratorium
- 6 month duration; can be extended

Temporary Moratoria on Enrollment

- Moratoria applies to:
  - Newly enrolling providers/suppliers
  - Establishment of new practice locations
- Moratoria does not apply to:
  - Changes in practice locations
  - Changes in information
  - Changes in ownership (except HHAs that require initial enrollment)
  - Providers whose enrollment application was approved but not yet entered into PECOS

Temporary Moratoria on Enrollment

- Enforcement Examples:
  - Jul. 2013—home health agencies (Miami-Dade (FL) and Cook (IL) Counties) and ambulance suppliers (Harris County (TX)
  - Jan. 2014—home health agencies (Dallas, Detroit, Houston, Ft. Lauderdale) and ambulance (Philadelphia)
  - 2015—extensions
  - 2016—statewide expansions for home health (FL, TX, IL, MI) and ambulance (NJ, PA, TX)
  - 2017 and 2018—extensions

Surety Bond Requirements

- Required for certain providers/suppliers (e.g., DMEPOS, HHA, CORF)
- Long list of requirements for DMEPOS suppliers (42 CFR 424.57)
  - Limited exemptions from bonding requirements
- DMEPOS suppliers obtain bonds through sureties identified by US Treasury
- Bond must be at least $50,000
  - If adverse action has occurred, the bond may be required to be higher

Surety Bond Requirements

- ACA (Sec. 6402) granted CMS authority to impose surety bond requirements on additional provider/supplier categories
  - Amount would be commensurate with provider/supplier billing volume but not less than $50,000
- CMS has considered, but failed to implement, proposed rules for surety bonds:
  - granting provisional enrollment and then setting amount of bond based on review of billing
  - Addressing surety bond non-payment

Accreditation Requirements

- DMEPOS suppliers
  - 42 CFR 424.57(c)(22)-(25); 42 CFR 424.58
  - DMEPOS suppliers must be accredited by "deemed" accreditation organization to establish/maintain billing privileges
    - Requires meeting AO "quality standards"
    - Different then CMS "supplier standards"
  - Accreditation must indicate specific products, services for which supplier is accredited in order to bill and receive payment
  - Certain suppliers are exempt from accreditation

Accreditation Requirements

- Advanced Diagnostic Imaging (42 CFR 414.68)
  - MIPPA required accreditation for suppliers of technical component of advanced diagnostic imaging services:
    - MR, CT, nuclear medicine (including PET) and other services designated by HHS
  - Three approved AOs
  - Accreditation required by Jan 1., 2012
  - Verification required in Medicare enrollment process

Questions?

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Medicare and Medicaid Enrollment and Revalidation Screening Requirements

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Enforcement Mechanisms

- Payment Suspension
- Deactivation of Billing Privileges
- Revocation of Enrollment and Billing Privileges
- Termination of Enrollment

Payment Suspension

HISTORY:

1996 – CMS regulations first authorized payment suspension

2010 - Affordable Care Act § 6402(h)

2011 – Implementing Regulations

2016 – Updated guidance to contractors

Basis of Suspension – Medicare
(42 C.F.R. 405.371)

CMS or contractor may suspend Medicare payments if:

- Reliable information of an overpayment or that payments to be made may not be correct; or
- Credible allegation of fraud (after consulting with OIG and/or DOJ).

"Good Cause" Exceptions

(42 C.F.R. § 405.371; 455.23)

Medicare recognizes "good cause" exceptions to suspension requirements, including when:

- Suspension might jeopardize an undercover investigation or expose whistleblower.
- Beneficiary access to services would be jeopardized.
- Other available remedies would more effectively or quickly protect Medicare funds.
- Determines not in the best interests of Medicare pgogram

Continuation of Suspension - Medicare
(42 C.F.R. § 405.371 and 405.372)

- Generally. Suspension is limited to 180 days.
- Extension. An intermediary, carrier, OIG, or law enforcement agency may request a one-time extension for up to an additional 180 days.
- Fraud Exception. Time limits do not apply to suspension due to fraud.
  - Every 180 days after the initiation of a suspension due to fraud:
    - Evaluate whether there is "good cause" to not continue suspension
    - Request certification from law enforcement agency (e.g., OIG) that the underlying fraud investigation continues.
  - If suspension has lasted 18 months, then "Good Cause" is deemed to exist,
  - However, CMS may continue suspension if:
    - The OIG is considering administrative action or the administrative action is pending; or
    - DOJ submits written request that suspension continue.

Notice of Suspension - Medicare (42 C.F.R. § 405.372)

- Notice. CMS or the Medicare contractor must notify the provider or supplier of the intention to suspend payments and the reasons for making the suspension, unless the suspension is due to:
  - Provider or Supplier Failing to Provide Requested Information; or
  - Allegation of Fraud.

- Rebuttal. Supplier / Provider may file rebuttal regardless of whether they are entitled to notice.

- Appeal of Deactivation (42 C.F.R. § 424.545). A provider or supplier may also file a rebuttal of a deactivation.

Rebuttal

(42 C.F.R. § 405.374)

- Timing.
  - If notice of suspension must be given, then rebuttal must be received within the time specified in the notice (generally 15 days).
  - Otherwise, provider or supplier must be given opportunity to submit rebuttal as to why suspension should be removed.

- Determination. CMS or the Medicare contractor has 15 days from the date of receipt of rebuttal to make a determination.

- No Appeal. This determination is not an "initial determination" and is not appealable.

Basis of Suspension – State Agency

(42 C.F.R. 455.23)

- Mandatory suspension: State Medicaid agency must suspend if there is credible allegation of fraud for which an investigation is pending.
  - "Credible allegations" can come from many sources, such as fraud hotlines, claims data mining, provider audits, civil FCA cases, and law enforcement investigations
- Exception: States may determine there is "good cause" not to suspend.
  - Recent OIG reports suggest that CMS believes states are being too lenient in determining that "good cause" exists, and should be imposing more payment suspensions.

Duration of Suspension - Medicaid

(42 C.F.R. § 455.23)

- Medicaid payment suspensions do not have clear time frames.
- MFCU Referral: Whenever a state suspends payment, the states are required to make a referral to the MFCU or other appropriate law enforcement agency.
  - If the referral is accepted:
    - The suspension will continue until the investigation is completed.
    - The state must request quarterly certification that the matter continues to be under investigation and that suspension is still warranted.
  - If the referral is rejected, the suspension must be lifted unless another state or federal agency accepts the investigation.

Notice of Suspension - Medicaid

(42 C.F.R. § 455.23)

- Timing of Notice. State agency must provide notice within:
  - 5 days of the taking the suspension action; or
  - 30 days if requested by law enforcement (can be extended not to exceed 90 days).
- Submission of Evidence. Notice must state that provider has right to submit written evidence for consideration.
- Appeal. Notice must set forth any appeal process under State law.

Deactivation of Billing Privileges

42 CFR 424.540

- Reasons for Deactivation.
  - Nonsubmission of Claims. No claims submitted for 12 consecutive calendar months.
  - Failure to Report. Failure to report:
    - Change in Information within 90 calendar days; or
    - Change in Ownership / Control within 30 days.
  - Failure to Respond. Failure to respond to a revalidation request within 60-75 days after the due date.

- Effect of Deactivation. Deactivation is temporary. It is not a final action. The Medicare provider agreement remains in effect and can be reactivated through proper procedures.

Reactivation of Billing Privileges

(42 C.F.R. § 424.540)

- Process for Reactivation: Submit Medicare enrollment application containing all required information or changes.

- Payment: There is no payment during the period of deactivation. Reactivation does not allow the provider to retroactively bill during that period.

- Additional Requirements: Home health agencies must under go an initial survey by state or accrediting body to confirm compliance with COPs before the number can be reactivated.

Revocation of Enrollment

Reasons for Revocation
(42 C.F.R. § 424.535)

- Noncompliance.
- Conduct.
- Felonies.
- False or Misleading Information.
- On-Site Review.
- Grounds Related to Screening Requirements.
- Misuse of Billing Number.
- Misuse of Billing Number
- Abuse of Billing Privileges.
- Failure to Report.
- Failure to Document / Provide Access to Documentation.
- Initial Reserve Operating Funds.
- Medicaid Termination.

Effect of Revocation

(42 C.F.R. § 424.540)

- Provider Agreement. The supplier's or provider's current provider agreements are also terminated.

- Effective
  - Generally. 30 days after mailing of revocation notification.
  - Immediate Revocation. Revocation is effective upon:
    - Exclusion or debarment;
    - Felony conviction;
    - License suspension or revocation; or
    - Determination that supplier, provider, or practice location not operational.

- Claims for Services Furnished Prior to Revocation. Claims must be submitted with 60 days of revocation.

Reapplying After Revocation

(42 C.F.R. § 424.540)

- Re-enrollment Bar. Generally, minimum of 1 year and a maximum of 3 years before supplier can reapply.
  - Exceptions.
    - Revocation Due to Hardship Waiver.
    - Hardship Waiver.
  - Conditions of Re-enrollment.
    - » Complete and Submit New Application.
    - » Resurveyed and Recertified by State Agency.
    - » New Provider Agreement.

- Reversal of Revocation (42 C.F.R. § 424.540). If revocation due to adverse activity of an individual (e.g., supervising physician committed a felony), revocation may be reversed if business relationship terminated within 30 days of revocation notification.

Termination of Medicaid Enrollment

- Basis (42 C.F.R. § 455.416).
  - Failure to Timely Submit Information.
  - Conviction of Criminal Offense Related to Medicare or Medicaid.
  - Terminated by Another State's Medicaid or CHIP program.
  - Failure to Permit Access to Sties.
  - Falsification of Information.
  - Cannot Verify Identity of Applicant.

- Reactivation (42 C.F.R. § 455.420). Provider must be re-screened and pay application fees.

Appeal of Revocation / Termination (42 C.F.R. § 424.545)

- Medicare (42 C.F.R. § 424.545). A revocation may be appealed in accordance with 42 C.F.R. Part 498, Subpart A.

- Medicaid (42 C.F.R. § 455.422). State must provide any appeal rights established by State law or regulations.

Medicare and Medicaid Enrollment and Revalidation Screening Requirements

Strafford Webinar

May 2, 2018

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Topics To Cover

- Corrective Action Plans (CAPs): Knowing when to use one and practical considerations when drafting a CAP.
- Rebuttals: Knowing when a rebuttal might be successful.
- Appeals:
  - What is most important to know about enrollment appeals?
  - Trends in cases and influence of outcomes.

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No Right To Appeal

- Enrollment application is rejected (42 C.F.R. § 424.525(a)):
  - Failure to submit complete application and supporting documents:
    - Within 30 days from the date a contractor requests missing information *i.e.*, date request sent by mail, fax, or e-mail, or
    - Within 30 days of the application submission. [Therefore, even with a second request the clock keeps running rather than resetting.]
  - Failure to pay application fee or request hardship waiver.

Opportunity For Rebuttal

- Deactivation of billing privileges: under 42 C.F.R. § 424.545 no appeal rights but right to rebuttal.
- Payment suspension under 42 C.F.R. § 405.371: no appeal rights but right to rebuttal.

42 C.F.R. § 405.374: Opportunity for rebuttal:

- Opportunity to submit a statement with pertinent information regarding why the action should not be put into (or maintained) in effect.
- Must be submitted within 15 days from date of notice.

Corrective Action Plan – CMS Policy

Corrective Action Plan – MPIM §§ 15.25.1.1 and 15.25.2 (Eff. 12/19/16):

- Purpose for the CAP: to give the provider or supplier an opportunity to correct the deficiencies (if possible) that resulted in the revocation.
- Intent of CMS that the submission of a CAP will expedite the decision-making process and result in the issuance of a more timely determination.
- Not a final determination to which there are further appeal rights, *i.e.*, there is no appeal to an unfavorable decision on the CAP.

Corrective Action Plan – CMS Policy

Submission of a CAP to CMS or MAC:

- Must be submitted within 30 days from the date of the denied enrollment or revocation notice, although allow "good cause" to accept late filing.
- Must provide verifiable evidence that the provider or supplier is in compliance with Medicare requirements.
- Must be signed and dated by the individual enrollee, the authorized or delegated official for an entity, or a legal representative.
- CMS or MAC may allow submission by fax or email.
- MACs have discretion to require the use of a standardized CAP form.

Corrective Action Plan – CMS Policy

Review of CAP:

- If needed information or supporting documentation was not included, the CAP is to be denied.
- 60-day period for Medicare contractor to process a CAP and issue a finding.
- If submitted with appeal, CAP is to be processed first.

Effect of Filing a CAP:

- The processing of the CAP does not toll the filing requirements associated with an appeal.
- May result in restored (as if never happened) or newly issued (creation of gap period) billing privileges.
- Decision is not appealable.

Corrective Action Plan – Case Example

- *Healthy Point Medical Care, PC v. CMS*, HHS DAB, Docket No. C-15-1614 (Sept. 29, 2015).
  - 9/23/14 site verification visit to practice location -- no longer operational.
  - Revocation under 42 C.F.R. § 424.516(d)(1)(iii) for failure to report a change in practice location within 30 days, with required two-year reenrollment bar for failed site visit.
  - Practice submitted a Corrective Action Plan enclosing CMS 855B to delete practice location effective 7/1/14 and affidavit from office manager accepting responsibility for reporting failure.
  - CMS prevailed on summary judgment motion.

Appeal Rights Under Regulations

- Medicare applicants denied enrollment and providers and suppliers with revocation of billing privileges are granted appeal rights -- 42 C.F.R. § 405.874.
- State Medicaid agency must provide appeal rights, as available under the state's statutes or regulations, to applicants denied enrollment or providers terminated from enrollment -- 42 C.F.R. § 455.422.
- However, no appeal rights granted for deactivation of billing privileges.

Appeal Steps

- Is there a notice letter?
- Carefully review the notice letter:
  - Is the content sufficient?
  - Was the supporting documentation provided?
  - Do the cited regulation/s provide grounds for the action under the particular facts?
  - Was the effective date determined appropriately?
  - If revocation, was the length of the reenrollment bar consistent with CMS's current guidance?
- Any benefit to preliminary discussion with MAC or CMS liaison or CMS PEOG?

Medicare Appeal: Reconsideration

Request for Reconsideration MPIM § 15.25.2.2:

- Must be in writing and *received within 60 days* after the postmark of the notice of denial or revocation, with 5-day grace period for mail time, *unless* granted a "good cause" exception for late filing.
- Must demonstrate that enrollment was incorrectly denied or billing privileges were erroneously revoked.
- Signed by the individual enrollee, a legal representative, or any responsible authorized official unless DMEPOS supplier then signed by the authorized representative, delegated official, owner or partner.
- Must include all evidence to be considered not only for this level appeal but for all further appeals.
- No *equitable relief* available in enrollment appeals.

Medicare Appeal: Reconsideration

Reconsideration Determination:

- Conducted by CMS or MAC Hearing Officer, independent from the initial decision to deny or revoke enrollment.
- On-the-record review, issue decision within 90 days.
- Scope of review: if the reason/s for imposing a denial or revocation at the time it did so was a correct decision:
  - May consider new evidence but must take into account facts relating to the status of the provider or supplier subsequent to the initial determination.
  - May not introduce new denial or revocation reasons or change a denial or revocation reason listed in the initial determination.

Medicare Appeals: Further Levels

ALJ Hearing:

- CMS or its contractor, or the provider or supplier dissatisfied with a Reconsideration Determination may appeal.
- Filed, in writing, within 60 days from receipt of the Reconsideration Decision.
- CMS has the initial burden to prove basis for action.

DAB Hearing:

- CMS or its contractor, or the provider or supplier dissatisfied with the ALJ Hearing Decision may appeal.
- File a request for hearing within 60 days from receipt of ALJ Decision -- brief disputing ALJ findings and conclusions.

District Court:

- Provider or supplier dissatisfied with the DAB Decision may seek judicial review in District Court – 60 days to file.

Enrollment Denied

US Ultrasound v. CMS, HHS DAB, Docket No. A-09-117 (Feb. 19, 2010).

- Denial enrollment for failure to meet enrollment requirements.
- Buyer intended to operate business post-closing through contractual arrangement.
- Contracting company, not the Buyer:
  - Owned the diagnostic testing equipment.
  - Employed the supervising physicians and technicians.
  - Was responsible for the equipment calibration and maintenance.
- Buyer paid a percentage of the net monthly collections to contractor.

Enrollment Denied

US Ultrasound v. CMS (Cont.)

- Application to enroll was initially approved by MAC with June 2008 effective date.
- In Nov. 2008, MAC notified supplier that after further review, PTANs could not be released.
- In Jan. 2009, MAC notified supplier of denied enrollment.
- CMS argued:
  - 42 C.F.R. § 400.202 defines "supplier" as an entity that "furnishes health care services," and
  - Absent authority to contrary, supplier is expected to be the entity furnishing the service.

Enrollment Denied

Wolverine State Inpatient Services v. CMS, HHS DAB, Docket No. C -12-819 (Nov. 26, 2012).

- Cited to *US Ultrasound v. CMS*, however, focused on definition of “operational” under enrollment rules.
- Case involving individual physician practices that formed a “group” and reassigned billing privileges to a related entity that provided administrative services including billing.
- Related entity submitted the enrollment application which was denied.
- CMS reasoned, the enrollee did not employ the physicians but was merely a billing agent.
- Decision to deny the enrollment was upheld.

Revocation – Failed Site Visit

AR Testing Corp. v. CMS, HHS DAB, App. Div., Doc. No. A-15-69, Dec. No. 2679 (Mar. 10, 2016).

- Revocation Basis:
  - Determination based upon on-site review that the provider is no longer "operational" to furnish Medicare covered items or services. 42 C.F.R. § 424.535(a)(5)
  - Unannounced inspection at the "practice location" listed in the mobile IDTF's revalidation application
  - Inspector unable to locate a sign identifying the practice location claiming could not find the provider in the building.

Revocation – Failed Site Visit

AR Testing Corp. v. CMS (Cont.).

- AR Testing argued a mobile IDTF is not required to have personnel at its "practice location" at the moment of site visit.
- ALJ's Findings:
  - Regulations require an IDTF to "be accessible during regular business hours to CMS and beneficiaries" 42 C.F.R. § 410.33(g)(14)(i).
  - Not "operational" under 42 C.F.R. § 424.502 if not open to the public and properly staffed.
  - "Posting a telephone number does not satisfy the requirements that a supplier be open and accessible."
  - No exception for mobile IDTF.

Requirement To Be Operational

- Operational means the provider or supplier [42 C.F.R. § 424.502]:
  - Has a qualified physical practice location,
  - Is open to the public for the purpose of providing health care related services,
  - Is prepared to submit valid Medicare claims; and
  - Is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, supplier specialty, or the services or items being rendered) to furnish these items or services.

Revocation – Failed to Update Data

Decatur Health Imaging, LLC v. CMS, HHS DAB, App. Div., Doc. No. A-17-37, Dec. No. 2805 (Jul. 24, 2017).

- Facts:
  - Physician owner with 6.7% interest died on July 9, 2015.
  - In an October 23, 2015 letter the MAC instructed the provider to report the ownership change in the next 90 days, by submitting the applicable CMS 855 form, or face deactivation.
  - On January 25, 2016, 94 days after the letter, billing privileges were deactivated.
  - On March 7, 2016, the CMS 855 update was filed
  - The MAC approved the update but set March 7, 2016 as the reactivation effective date.

Revocation – Failed to Update Data

Decatur Health Imaging, LLC v. CMS (Cont.)

- Upheld the reactivation effective date based on:
  - Medicare providers must report changes in enrollment data, including changes in their ownership or control, within required time periods. 42 C.F.R. § 424.516(a)-(e).
  - CMS may revoke billing privileges for failing to comply with these reporting requirements. 42 C.F.R. §§ 424.535(a)(1)&(9).

Revocation – Ordering And Referring

George M. Young, M.D. v. CMS, HHS DAB, Docket No. C-15-3553 (Mar. 1, 2016).

- 1/6/15 letter requesting medical records (orders, progress notes, patient information sheets) for 14 Medicare beneficiaries for whom he ordered DME.
- Physician unable to produce records since facility where he was employed, which had possession of the records, could not locate records.
- Revocation under 42 C.F.R. § 424.535(a)(10), with one-year reenrollment bar, for failure to provide access to documentation.
- Revocation upheld.

Revocation – Billing Errors

Patrick Brueggeman, D.P.M. v. CMS, HHS DAB, App. Div., Doc. No. A-16-32, Dec. No. 2725 (Jul. 26, 2016).

- Basis of revocation: "Abuse of billing privileges" 42 C.F.R. § 424.535(a)(8)(i).
  - Provider submits a claim or claims for services that could not have been furnished to a specific individual on the date of service.

  Includes but not limited to:
  - When the beneficiary is deceased,
  - The directing physician or beneficiary is not in the State or country when services were furnished, or
  - When the equipment necessary for testing is not present.

Revocation – Billing Errors

- Facts: Data analysis of over 13,595 claims for DOS between January 1, 2012 and August 31, 2014 identified 33 claims for 16 different beneficiaries who were deceased at the alleged time of service. (0.24% error rate)
- Podiatrist argued:
  - Services were provided to a living beneficiary with the same or very similar names or interchanged names reverse.
  - Unintended data entry errors -- not abusive billing practices.
  - After claims denied – resubmitted and paid.
- CMS argued:
  - Abundance of the errors after being aware of the problem when the claims were originally denied.
  - Evidence of “abuse of billing” not “clerical error or oversight.”

Revocation – No Longer in Business

Framsl Medical Equipment and Supply, LLC v. CMS, HHS DAB, Doc. No. C-17-825 (Feb. 2, 2018).

- Facts - Timeline:
  - License to Sell Used Bedding - Expired on May 18, 2016.
  - Liability Insurance Policy - Expired on July 8, 2016.
  - Surety Reported Request to Not Renew Bond as of September 30, 2016.
  - Site Visit - January 5, 2017.
  - Attempt to Call - Telephone Disconnected - January 17, 2017.
  - Revocation Letter dated January 31, 2017, Effective as of September 30, 2016, with Two-Year Reenrollment Bar Beginning 30 days from the Letter Postmark Date.