Health Care Compliance Association's 18th Annual Compliance Institute

Medicare Enrollment Application, Revocation and Appeals

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Objectives

- Learn tips to ensure enrollment success and avoid enrollment deficiencies that can result in denial or revocation of billing privileges
- Discuss how proposed regulations expanding Medicare's authority to deny enrollment and revoke Medicare participation will affect your company
- Understand appeal rights for enrollment denials and revocations of Medicare privileges.
Enrollment Basics

- Submit appropriate version of CMS Form 855 – Provider/Supplier Enrollment Application to Medicare Administrative Contractor ("MAC") or National Supplier Clearinghouse for DMEPOS Suppliers
  - 42 C.F.R. 424.510
- Must include complete, accurate and truthful information and all supporting documentation
- Signed certification statement by person with authority to bind the enrollee
- Pay fee when required or get hardship exception

Enrollment Basics: The CMS 855 Form

- Use Correct CMS Form 855
  - CMS 855A – For institutional providers (i.e. HHA, hospitals, SNF, Rural Health Clinics)
  - CMS 855B – For clinics/group practices, IDTFs, ASCs, and other entities (non-individuals billing under Part B), not DMEPOS suppliers
  - CMS 855I – For individuals (physicians, NPPs) billing under Part B
  - CMS 855O – For registration of ordering/referring physicians and NPPs.
  - CMS 855R Reassigning benefits under Part B
  - CMS 855S For DMEPOS suppliers
Enrollment (Cont’d.)

- Things to know about the 855 forms:
  - Each particular version of 855 has instructions and definitions, some of which are peculiar to that version
  - Instructions are not always instructive regarding item reported
  - The forms are forms and do not fit all situations (particularly complex CHOWs) well.

Enrollment Basics (Cont’d.)

- Things to know about the 855 forms:
  - They can be downloaded from CMS’s website
  - CMS changes the forms from time to time:
    - If you do not use the right version, your enrollment will be delayed! Important because enrollment is effective beginning on the date that the MAC receives an 855 that can be processed to conclusion, and generally suppliers (and to a lesser extent providers) are not allowed to bill for services furnished before the enrollment date.
Enrollment Basics (Cont'd.)

- Update changes to information on CMS Form 855 within required time frames
  
  - 42 C.F.R 424.516(e) and 42 C.F.R. 424.540(a)(2)

- Update CHOWs, location, adverse legal actions (i.e. loss of license or certification) within 30 days

- All other changes within 90 days (non-CHOW ownership changes like stock transfers, change in billing services, managing employees)

Enrollment Basics (Cont'd.)

- Complete accreditation, survey or on-site review requirements for provider type
  
  - 424 C.F.R 510(d) (5) and (8)

- On-site review is for purpose of verifying enrollment information is accurate and determining compliance with Medicare enrollment requirements.
  These onsite reviews do "not affect those site visits performed for establishing compliance with COPs."
  
  - 424 C.F.R 510(d) (8)
Enrollment Basics (Cont’d.)

- MAC is required to screen all initial applications (including new location and revalidation request responses) based on CMS assessment of risk levels.
  - 42 C.F.R. 424.518
- Levels are "limited," "moderate," or "high."

Enrollment Basics (Cont’d.)

- Examples of "limited"—physicians, ASCs, end-stage renal disease centers, hospitals, SNFs, pharmacies
  - Verification of licenses & post-enrollment verifications
- Examples of "moderate"—Ambulances, CMHCs, Hospices, IDTFs, physical therapists, revalidating HHAs and DMEPOS
  - Includes on-site review
- Examples of "high"—only newly enrolling HHA and DMEPOS in this category
  - Includes fingerprinting/criminal history check
Enrollment Basics (Cont’d.)

- PPACA (Section 6401) requires CMS to implement requirements that providers and suppliers establish compliance programs as a condition of enrollment
  - Regulations not yet published
- Also 6102 of PPACA makes compliance programs mandatory for enrollment of nursing home providers (NF and SNF)
  - Effective March 23, 2013

PECOS

What is PECOS?
- Provider Enrollment Chain and Ownership System
- It is a secure Web site that providers and suppliers can access to submit an application to enroll or change information
- PECOS can be access at:
Results After Filing 855

- Follow-up Communication
- Rejection of Application
- Denial of Enrollment
- Revocation of Associated Providers
- Acceptance and Enrollment

Results After Filing 855 (Cont'd.)

- Rejection of Application
  - Reasons
    - Incomplete form
    - Failure to submit requested information within 30 days
    - Failure to pay application fee
  - No appeal rights for rejection of form.
  - Must resubmit new 855
  - 42 C.F.R. 424.525
Results After Filing 855 (Cont'd.)

Denial of Enrollment

- 42 C.F.R. 424.530

Many reasons, including:

- Non-compliance with enrollment requirements
- False/misleading information on CMS 855
- Current owner, physician or non-physician practitioner has an existing overpayment
- Provider (or owner, managing employee, medical director, supervising physician, authorized/delegated official) conduct—excluded, debarred or suspended from federal programs.

Denial of Enrollment (Cont’d.)

Reasons:

- Felonies (within 10 years) by provider or any owner (crimes against persons like rape, murder and financial crimes like tax fraud, embezzlement etc.)
  - CMS determines if conduct is "detrimental to best interests of program"
- Current owner, physician or non-physician practitioner on Medicare payment suspension
- Fails on-site review (not operational)
- HHA fails to maintain required initial reserve operating funds
Results After Filing 855 (Cont’d.)

Denial of Enrollment for Overpayment

- CMS Transmittal 479 (August 1, 2013) CR 8039
  - revised Program Integrity Manual, Ch. 15 regarding denial of an 855 when an existing or delinquent overpayment exists
  - MAC required to get CMS approval first
- October 17, 2013 MLN Matters Article MM8039 "Enrollment Denials When Overpayment Exists"
  - clarified several points with examples of overpayments that would result in denial

Results After Filing 855 (Cont’d.)

- Revocation of Associated Provider

Denial or Enrollment can result in adverse action (e.g. revocation) of associated providers (i.e. providers with same manager, owners or authorized officials)
Results After Filing 855 (Cont’d.)

- Acceptance
- Will receive letter from MAC with date of effective enrollment and additional forms, including provider agreement, to sign

Revocation of Enrollment and Billing Privileges

- When enrolled provider fails to comply with condition of continued enrollment
  42 CFR 424.535
- Many reasons, including many of the reasons for denial, plus:
  - Misuse of billing number (sells, allows another to use)
  - Abuse of billing privileges (beneficiary is deceased, out of country)
  - Failure to report information (i.e. CHOW, changes in location)
  - Medicaid termination by State (exhaust appeals first).
Revocation of Enrollment and Billing Privileges (Cont’d.)

- CMS will also terminate Medicare provider agreement if revokes enrollment.

Deactivation of Medicare Billing Privileges

- 42 C.F.R. 424.540
  - Deactivation means provider's billing privileges were stopped, but can be restored upon the submission of updated information 42 C.F.R. 424.502
  - No effect on provider's participation agreement/can reactivate is most cases
  - Reasons
    - Fails to submit claims for 12 consecutive months
    - Fails to report changes to enrollment information
    - HHA 36-month rule related to CHOWs.
Proposed Enrollment Regulations

- Dramatically expands CMS authority to deny enrollment and revoke Medicare provider numbers (PTANs) and billing privileges
- Gives CMS much discretion
- As of February 2014, rules are still in rulemaking stage; comments were due on June 28, 2013
- Many proposed changes

Proposed Enrollment Regulations (Cont’d.)

- Two of the onerous proposals:
  - Denial of enrollment if the enrolling provider, supplier or owner has an existing overpayment (current rules do not apply to all providers and suppliers)
    - Must repay in full or have repayment plan
  - Revocation of Medicare enrollment and billing privileges when the provider or supplier has "abused" its Medicare billing privileges
Proposed Enrollment Regulations (Cont’d.)

- Revocation for "abuse" of its Medicare billing privileges
  - Current rule is limited (i.e. deceased beneficiary, out of country)
  - For a "pattern or practice" of submitting claims for services that fail to meet the Medicare requirements

- Preamble says "a common scenario warranting such revocation would be when a provider or supplier is placed on pre-payment review and a significant number of claims are denied for failing to meet the medical necessity requirements (78 Fed Reg. at pg. 25022)

- CMS will use discretion to revoke privileges, including factors such as the reasons for the claims denial, % of denials and length of time over which the pattern has continued.
Appeals of Enrollment Actions

- Covered by 42 CFR Part 498 but also see 42 CFR Part 405 Subpart H
- Triggered by an unfavorable "initial determination" related to enrollment
  - 42 CFR §498.3(h)

Denial or Revocation of Enrollment: The Appeals Process

- **Four steps:**
  - Reconsideration before the MAC
    - Also Corrective Action Plan
  - ALJ Hearing
  - Departmental Appeals Board (DAB) Review
  - District Court/Judicial Review
Appeals Process – Reconsideration

- Must be requested within 60 days of receipt of Initial Determination
  - For list of "Initial Determinations" that can be appealed see 42 C.F.R. 498.3
- Request for reconsideration must identify any error made by MAC
  - 42.C.F.R. 498.22

Corrective Action Plan (CAP)

- Submit when provider receives notice that CMS will revoke its billing privileges
- Must be submitted within 30 days (not a month)
- Use in addition to Request for Reconsideration
- For some MACs, provider must use the form on the MAC website
Corrective Action Plan (CAP) (Cont’d.)

- MAC/CMS required to process within 60 days.
  - Much discretion in terms of review, approval and processing
  - Get to know the people processing your CAP.
- Rejection of CAP is not appealable
  (Medicare Program Integrity Manual CMS-100-08, Ch. 15 §25 1.1.B.)

Corrective Action Plan (CAP) (Cont’d.)

- To correct deficiencies that resulted in the proposal to revoke
  - Identify what was wrong and how it was corrected
  - Carefully consider how you "agree to improve" something without agreeing that you are at fault
- Provider must establish that it is in compliance with Medicare requirements
Corrective Action Plan (CAP) (Cont’d.)

- Submitting a CAP does not substitute for submitting a request for reconsideration and does not toll the time for submitting a request for reconsideration.
  - If you choose to submit a CAP and miss the appeal deadline, you are out.
  - File reconsideration request at same time you file CAP, but it may not be processed at same time.

Appeals Process – ALJ Hearing

- 42.C.F.R. 498.40
- Request for hearing must be made within 60 days of notice of reconsideration determination
- ALJs are bound by statute, regulations and CMS Rulings (but not manual instructions)
- DAB sends out prehearing order within about 10 days after the request is filed.
Appeals Process – ALJ Hearing  
(Cont’d.)

❖ OGC Regional Counsel has 30 days put case together  
➢ OGC attorneys generally have been reasonable to deal with and settle many of the cases  
❖ Better chance of favorable ruling at ALJ level than below

Appeals Process – ALJ Hearing  
(Cont’d.)

❖ The ALJ hearing is an adversarial process.  
❖ Parties may present oral arguments, question and cross-examine witnesses, and file briefs or other written statement.  
❖ The ALJ, upon his or her own motion or at the request or a party, may issue subpoenas.
Appeals Process – DAB Review

- Either party may request DAB review of the ALJ's decision or dismissal.
  - 42 C.F.R. 498.80; 42 C.F.R. 498.82
- 60-day deadline

Appeals Process – DAB Review

- The DAB may grant, deny or dismiss a request for review.
- Upon request by the DAB, the parties will be permitted to file briefs or other written statements and (rarely) an opportunity to present to the DAB oral arguments and evidence.
Appeals Process – ALJ Hearing (Cont’d.)

- Upon taking review, the DAB may issue a decision, or it may remand the case back to the ALJ either for a hearing and decision or for a recommended decision (in which case, the final decision will be issued by the DAB).

Appeals Process – District Court

- Following a final decision by the Secretary "made after a hearing" a party can seek review in the district court
- This generally means that one must receive a DAB "decision," or an ALJ "decision" (if the DAB declines review)
  - A "dismissal" does not count – one must have a "decision" in order to get into court
  - Exhaustion of remedies generally required, but if no right to administrative appeal (e.g., deactivation), there may be federal question jurisdiction. See Bowen v. Michigan Academy of Family Physicians, 476 U.S. 557 (1986).
Another Type of Enrollment: Ordering and Referring Physicians/Practitioners

> Affordable Care Act requires that physicians and "other eligible professionals (OEP)" be enrolled in Medicare to order or refer certain items or services for Medicare beneficiaries.

"OEPs" are:
- Physician Assistants
- Clinical Nurse Specialists
- Nurse Practitioners
- Clinical Psychologists
- Interns, Residents, and Fellows
- Certified Nurse Midwives
- Clinical Social Workers

Ordering and Referring Physicians/Practitioners

- For claims from:
  - Part A HHAs
  - Clinical Laboratories for ordered tests
  - Suppliers of DMEPOS
  - Imaging Centers (Technical portion only)
Ordering and Referring Physicians/Practitioners (Cont'd.)

- Effective January 6, 2014, CMS turned on the edits to deny Part B clinical lab and imaging, DMEPOS, and Part A HHA claims that fail the ordering/referring provider edits.
  - MLN Matters SE 1305 Revised (November 6, 2013); and
  - MLN "Medicare Enrollment Guidelines for Ordering/Referring Providers" ICN 906223 (December 2013).

How to Check Enrollment Record

- Providers & suppliers may check the Ordering Referring Report or Internet-based PECOS to verify their enrollment records
  - The Ordering Referring Report is published by CMS
  - Report shows all physicians & OEPs who have an approved record in PECOS to order and refer and those who have an application that has been received and is pending approval
  - Report is available at: http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandRefering.asp#TopOfPage
APPENDIX OF STATUTORY AND REGULATORY AUTHORITIES

Enrollment Authorities

Provider and Supplier Enrollment Regulations
- 42 CFR Part 424, Subpart P (the 424.500’s) – establishing and maintaining Medicare billing privileges (including rules for denying, revoking and deactivating billing privileges, and special rules on HHA changes in majority ownership)
- 424.57 – DMEPOS supplier standards
- 424.58 DMEPOS accreditation procedures
- 410.33 IDTF Standards
- 42 CFR, Part 498 – appeals procedures (see also 42 CFR Part 405, Subpart H (the 424.800’s))


PECOS Guide
**Enrollment: Recent Final Rules**

- April 27, 2012 – final rule in furtherance of May 5, 2010 interim final rule with comment period (see below), on enrollment requirements for ordering/referring physicians and NPI requirements (77 FR 25284)

- March 14, 2012 – further changes to DMEPOS supplier standards, including changes to patient anti-solicitation provision (77 FR 14989)

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**Enrollment: Recent Final Rules (Cont’d.)**

- February 2, 2011 – implementing provision of PPACA on screening requirements, application fees, temporary enrollment moratoria, payment suspensions, and Medicaid terminations of providers and suppliers that have been terminated or that had their billing privileges revoked (76 FR 5682)

- August 27, 2010 – additional DMEPOS supplier standards (75 FR 166).
Enrollment: Recent Final Rules (Cont'd.)

- May 5, 2010 – implementing provisions of PPACA to require all providers and suppliers that qualify for an NPI to include their NPI on all applications to enroll in the Medicare and Medicaid programs and on all claims for payment submitted under the Medicare and Medicaid programs (75 FR 24437)
- January 2, 2009 – surety bond requirement for DMEPOS suppliers (74 FR 166)

Enrollment: Recent Final Rules (Cont'd.)

- November 19, 2008 – established the re-enrollment bar of 1 to 3 years on providers and suppliers that have had their billing privileges revoked, and placed limitations on retroactive billing by providers and suppliers (73 FR 69726)
- June 27, 2008 – "Appeals of CMS or CMS Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges" (73 FR 36448).
Enrollment: Recent Final Rules (Cont’d.)

- November 27, 2007 – changes to IDTF provisions in 410.33 (72 FR 66222)
- December 1, 2006 – established performance standards for IDTFs (71 FR 69624)
- April 21, 2006 – "Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment,” implementing section 1866(j)(1)(A) of the Act (71 FR 20754)
- October 11, 2000 – additional standards for DMEPOS suppliers (65 FR 60366).

QUESTIONS???