



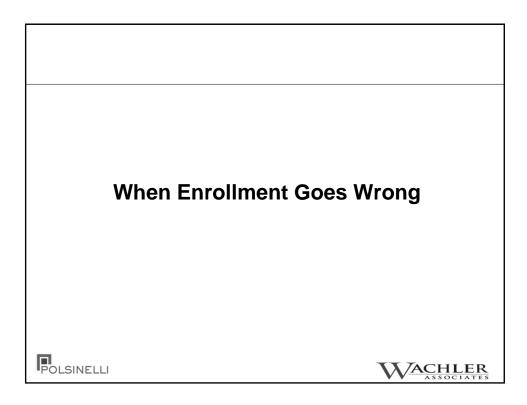
- Required as condition of participating in Medicare to provide timely updates to any changes in information encompassed in your 855.
- Need to design a tracking mechanism of what was reported, and what/when that information changes.

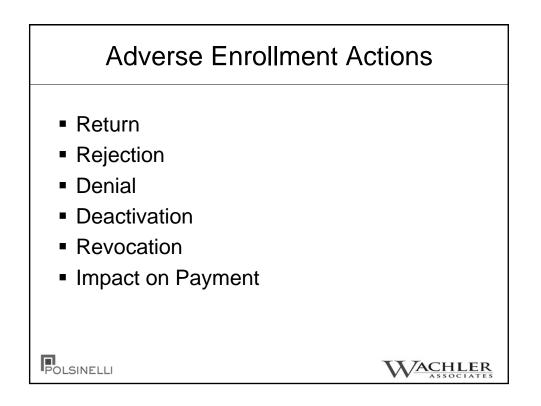
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Need to understand timelines.

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**Reporting Changes Provider Type 30-Day Reporting** 90-Day Reporting Certified Providers and 1) Change of ownership or control All other Suppliers (e.g., hospice, (including changes in AOs or DOs) HHA, hospital, etc.) 2) Air ambulance - revocation or suspension of state/federal license Physicians, NPPs, Phys. 1) Change of ownership All other Organizations 2) Adverse legal actions 3) Change in practice location IDTF All other 1) Change of ownership 2) Change in location 3) Adverse legal actions 4) Changes in general supervision DMEPOS All changes N/A POLSINELLI ACHLER



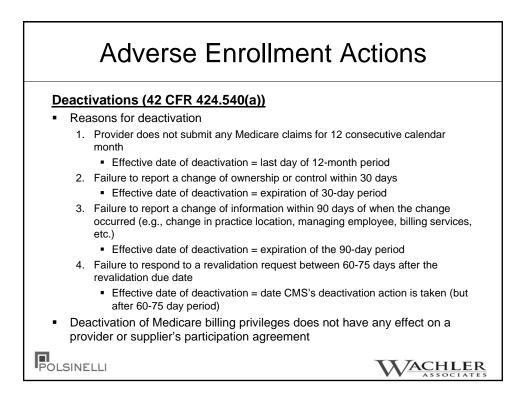


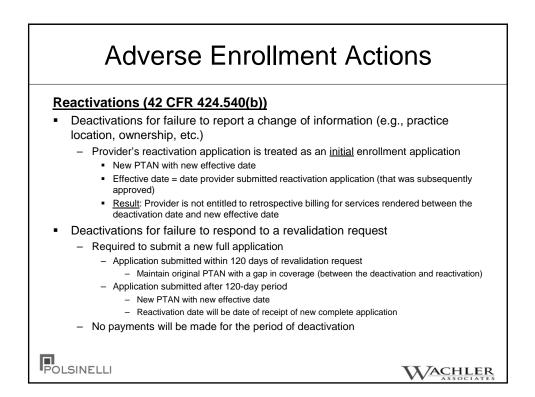
## Adverse Enrollment Actions

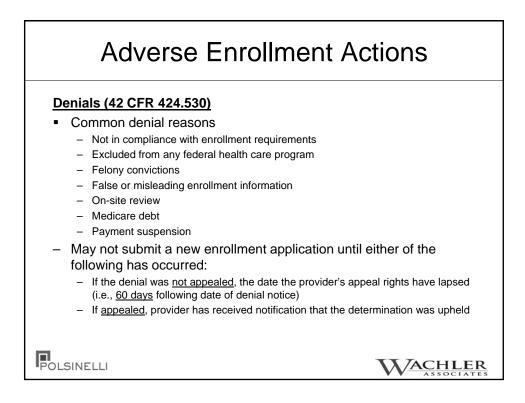
#### **Rejections**

- CMS may reject a provider's application if the provider fails to furnish complete information on the enrollment application <u>within 30 calendar days</u> from the date the contractor's request for missing information
- Common mistakes
  - Certification statement unsigned/undated
  - Certification statement signed 120 days prior to the date on which the contractor received the application
  - Failure to complete all required section of the application
  - Failure to submit all supporting documentation
  - Wrong application was submitted (e.g., Form CMS-855B was submitted for Part A enrollment)
- Enrollment applications rejected by CMS will require the provider to resubmit the application as a <u>new</u> application.
  - <u>Result</u>: The effective date will be the date in which the resubmitted application was filed because it was the resubmitted application "that was subsequently approved by CMS" instead of the initial application.

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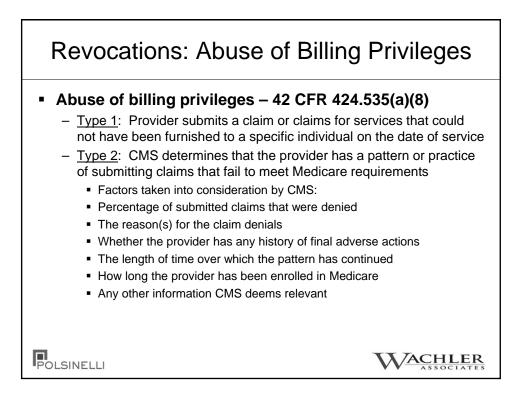
## **Adverse Enrollment Actions**

#### Revocations (42 CFR 424.535)

- Common revocation reasons
  - Noncompliance with enrollment requirements
  - Excluded from any federal health care program
  - Felony convictions
  - On-site review
  - Failure to report
  - Abuse of billing privileges
  - Medicaid termination
  - Failure to document or provide CMS access to documentation

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- Suspension/revocation of DEA Certification or Registration
- Improper prescribing practices

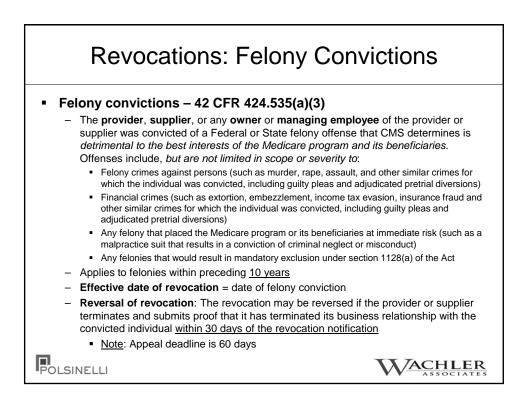


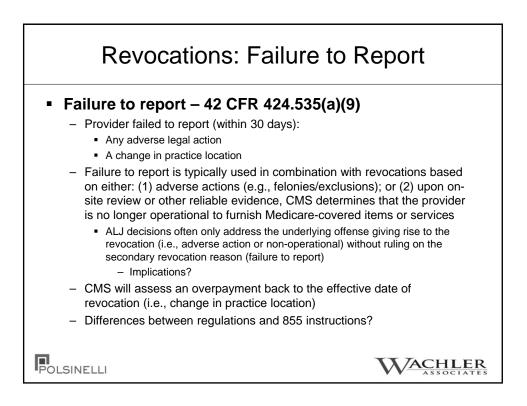
#### Revocations: Abuse of Billing Privileges

#### Interplay Between Revocations, Audits, and FCA Liability

- Abuse of Billing Privileges (42 C.F.R. § 424.535(a)(8)(ii))
  - CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement if CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements.
- 60-Day Overpayment Final Rule
  - "A provider or supplier's claim denial that has been both—(1) fully (rather than partially) overturned on appeal; and (2) finally and fully adjudicated will be excluded from our consideration in determining whether the provider or supplier's Medicare billing privileges should be revoked under § 424.535(a)(8)(ii)."
  - "Finally and fully adjudicated" means that—(1) the appeals process has been exhausted; or (2) the deadline for filing an appeal has passed.
  - Impact of ALJ audit appeals backlog?
  - "[W]e do not believe a claim denial that fails to meet both of these requirements should be excluded from our review for two reasons. First, excluding claims that are currently being appealed could encourage providers and suppliers to file meritless appeals simply to circumvent the application of § 424.535(a)(8)(ii). Second, merely because a claim is under appeal does not necessarily mean it will be overturned."

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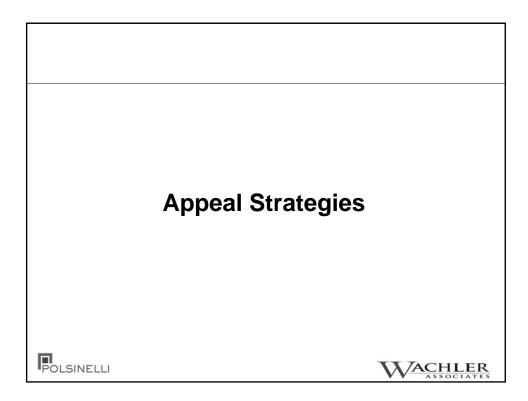


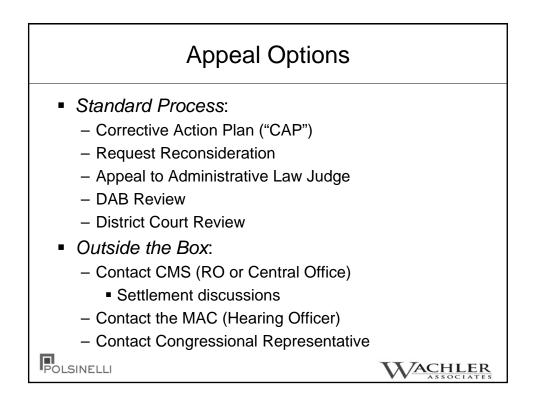
# What Can you do When Enrollment Goes Wrong?

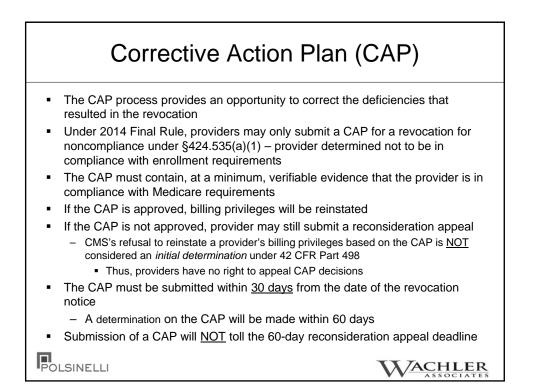
- Return Nothing, start over. Considered a "nonapplication"
- Rejection Fix the deficient sections within 30 days from the date the "Development Letter" is mailed by MAC (but be mindful of CHOW/CHOI timelines)
- Deactivation File to reactivate, no appeal rights.
- Denial Corrective Action Plan, Request for Reconsideration, Appeal
- Revocation Appeal, appeal, appeal...

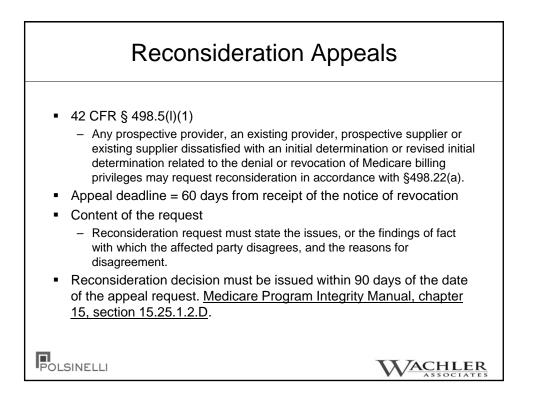
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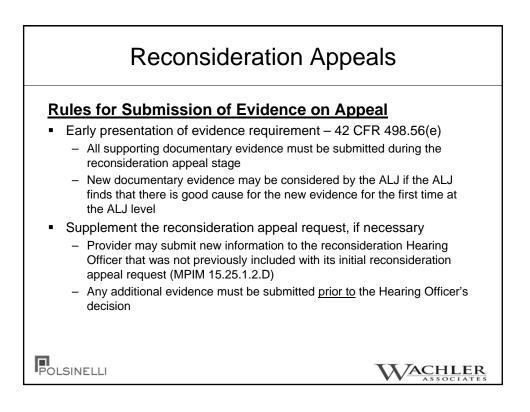
### **Reconsideration Appeals**

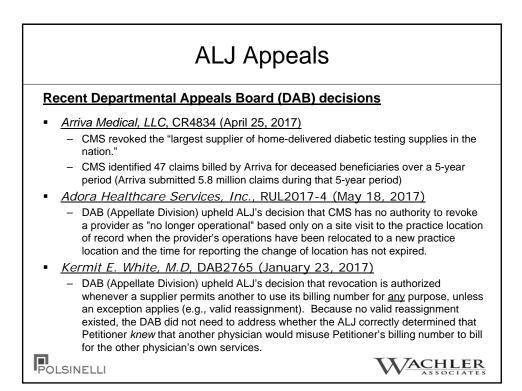
#### Key Considerations

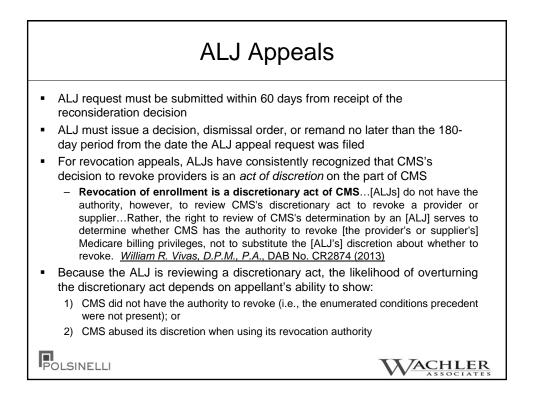
- Open communications with CMS and/or its contractors
   Request opportunity to discuss findings via telephone conference
- CMS (rather than its contractors) will make all determinations pertaining to revocations for abuse of billing privileges
- Timing issues
  - Revocation becomes effective 30 days after the date of revocation notice
    - Exception: Revocations based on adverse actions (e.g., felony conviction, license suspension, federal exclusion) will be effective the date of the adverse action
    - <u>Exception</u>: Revocation based on practice location determined not to be operational by CMS will be effective the date on which CMS made such a determination (e.g., date of on-site visit)

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Provider likely to be revoked while reconsideration appeal is pending review







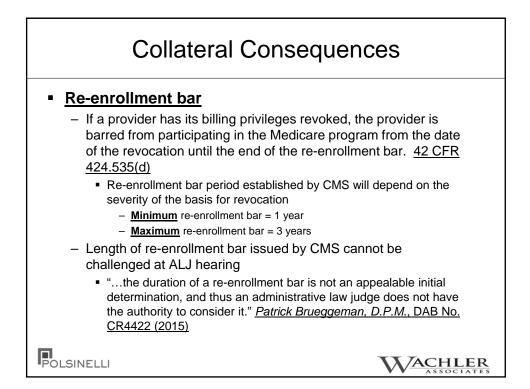
### **ALJ** Appeals

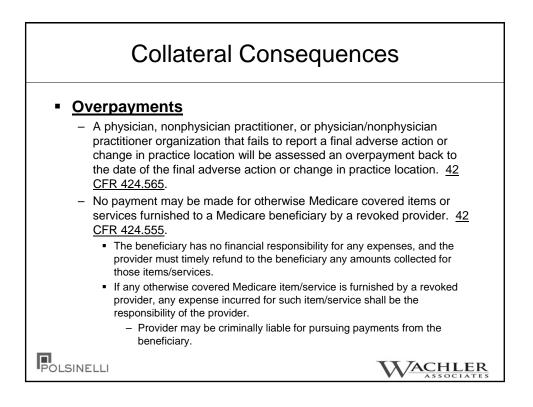
#### Additional ALJ/DAB case excerpts

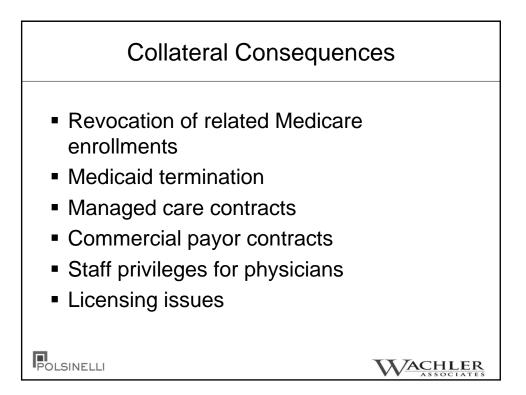
- I must sustain CMS's determination and may not second guess CMS's judgment if a legitimate basis for the revocation exists and where the facts established noncompliance with one or more of the regulatory standards at the time of the revocation. <u>ASAP Home Oxygen, Inc., DAB No. CR2364 (2011)</u>.
- The statements in the preamble, however, are an articulation of enforcement policy rather than a rule establishing essential elements that must be proven to uphold a revocation under section 424. 535(a)(8).... CMS's decision to revoke billing privileges is, after all, discretionary. <u>Louis J. Gaefke</u>, D.P.M., DAB No. CR2785 (2013).
- I am required to follow the Act and regulations, and I have no authority to declare statutes or regulations invalid.... Thus, even though I accept for purposes of summary judgment that Petitioner's owner and employee did not understand either the regulations or the CMS-855I, that fact is not a basis on which I may conclude that the regulations are invalid and that Petitioner's failure to comply with the regulations is not a basis for revocation. <u>Lf Med. Servs. of Ny, P.C., DAB No. CR4350 (2015)</u>.

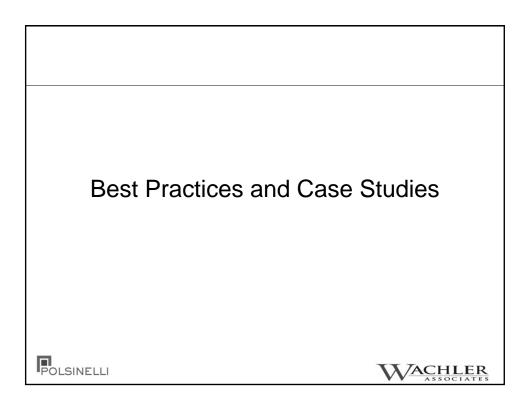
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ALJ Appeals
Additional ALJ/DAB case excerpts
Petitioner argues that 42 C.F.R. § 424.535(a)(9) is unconstitutionally vague and that the CMS-855I provides inadequate instructions about how to report a change in practice location My authority is limited to determining whether there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges I am required to follow the Act and regulations, and I have no authority to declare statutes or regulations invalid Thus, even though I accept for purposes of summary judgment that Petitioner's owner and employee did not understand either the regulations or the CMS-855I, that fact is not a basis on which I may conclude that the regulations are invalid and that Petitioner's failure to comply with the regulations is not a basis for revocation. <u>Lf Med. Servs. of Ny, P.C., DAB No. CR4350 (2015)</u>
<ul> <li>the duration of a re-enrollment bar is not an appealable initial determination, and thus an administrative law judge does not have the authority to consider it. <u>Patrick Brueggeman, D.P.M.</u>, DAB No. CR4422 (2015)</li> </ul>
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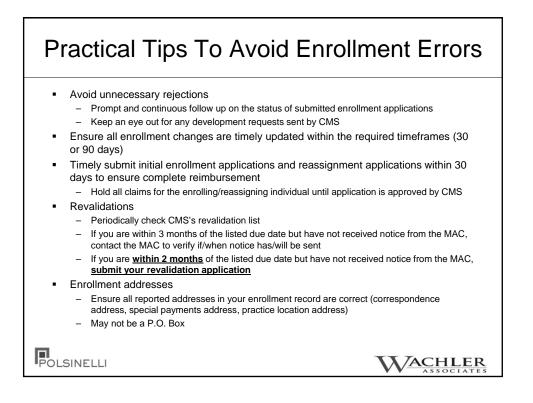


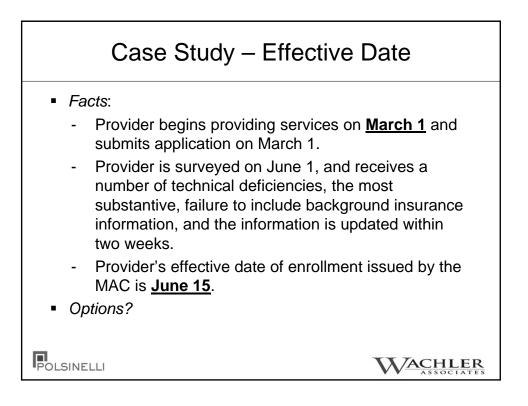
#### Practical Tips To Avoid Enrollment Errors

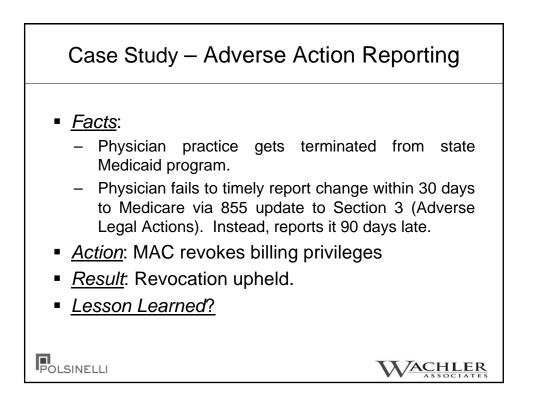
- Ownership of the Process Whose job is this?
- Develop checklists to review prior to any filing going out the door (e.g., right form/version, correct address, paid application fee, NPI, dated application, signed application, postage, fed ex tracking)
- Form Completion Tips
  - Tricky sections (Sec. 4, 5, 6)
  - Must get SSNs, not optional
  - Must know date ownership/control began and report accurately

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- Exact percentages of ownership needed
- Watch for MAC transitions



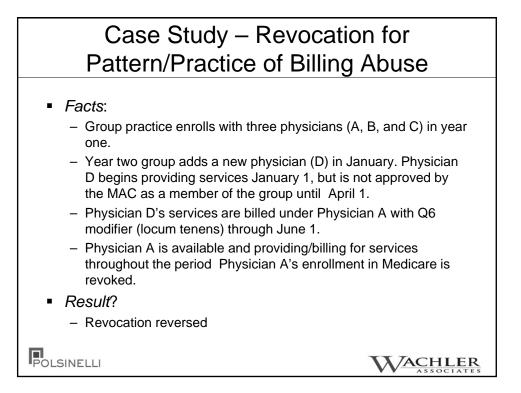




#### Case Study – Untimely Updates

- <u>Facts</u>: Supplier fails to implement system to monitor and track changes of information reported in its 855B. Supplier recognizes failure to timely update information. Supplier comes to you, the compliance officer asking for advice. What do you tell him?
- <u>Obligation</u>: File updated 855B notifying MAC/CMS of changes, even if not timely, and accurately. Consider implications of revalidation timing.
- <u>Risk</u>: MAC can revoke billing privileges.
- <u>Ever seen it happen?</u> Yes, but only recently, and still on appeal. Prior history demonstrated revocation limited to failure to report more sensitive changes.
- <u>Lesson Learned?</u> Track, monitor, timely report, audit, catch the changes before they are caught by CMS or the MAC

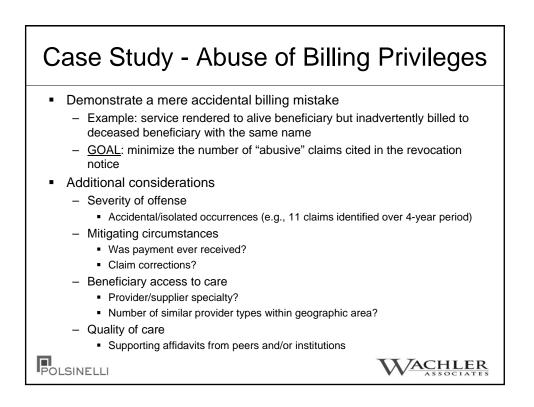
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### Case Study - Abuse of Billing Privileges

- Provider revoked under 42 CFR 424.535(a)(8)(i) for allegedly billing for deceased beneficiaries for 11 claims over a 4 year time period
- Revocations based on billing for deceased beneficiaries (424.535(a)(8)(i))
  - This revocation authority is not intended to be used for isolated occurrences or accidental billing errors. Rather, this basis for revocation is directed at providers and suppliers who are engaging in a pattern of improper billing. <u>73 Fed. Reg. 36488 at 36455</u>.
  - ...[CMS] will not revoke billing privileges under § 424.535(a)(8) unless there are multiple instances, at least three, where abusive billing practices have taken place. Id.
  - In considering whether to revoke enrollment and billing privileges in the Medicare program, we would consider the severity of the offenses, mitigating circumstances, program and beneficiary risk if enrollment was to continue, possibility of corrective action plans, beneficiary access to care, and any other pertinent factors. <u>71 Fed. Reg. 20754 at 20761</u>.

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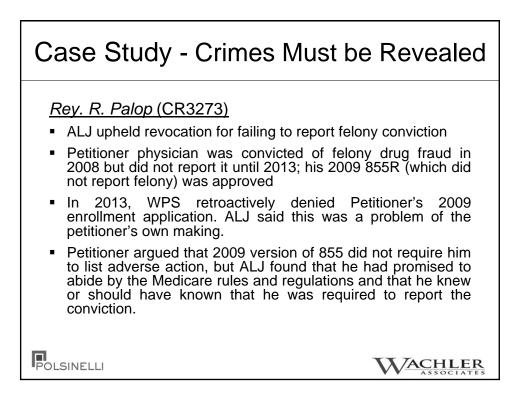


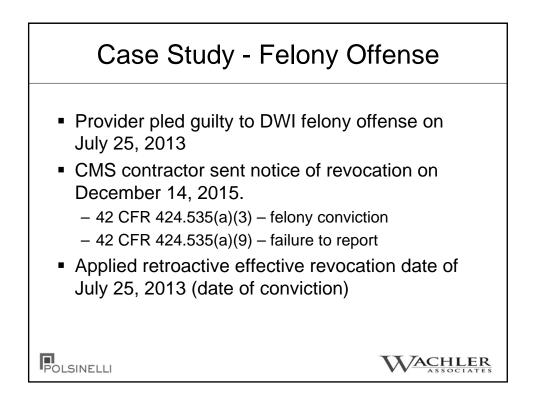
#### Case Study - Non-Operational

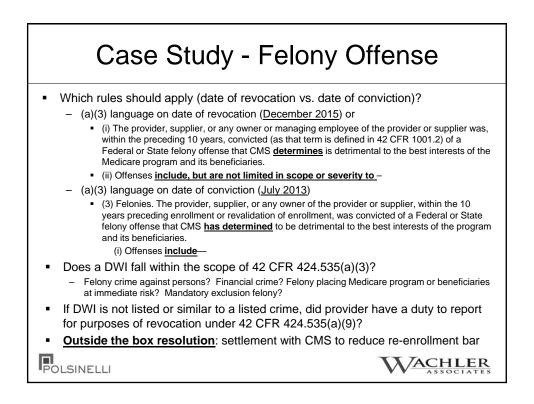
#### Facts:

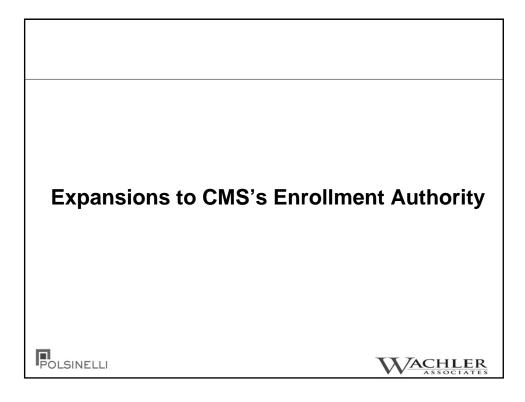
- DMEPOS supplier operates at 123 Main St. for 10 years.
- DMEPOS supplier relocates next door to 456 Main St.
- DMEPOS supplier is concurrently revalidating its enrollment information with CMS/NSC
- NSC Site Visit Contractor shows up at 123 Main St. and nobody is there.
- NSC Site Visit Contractor calls 123 Main Street and even comes out again.
- DMEPOS supplier files its CHOI to notify NSC of its new address location.
- Result?
  - Supplier gets revoked for being "non-operational" and failing to report CHOI timely.

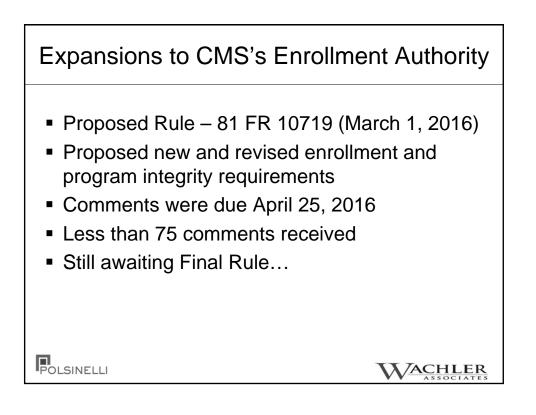
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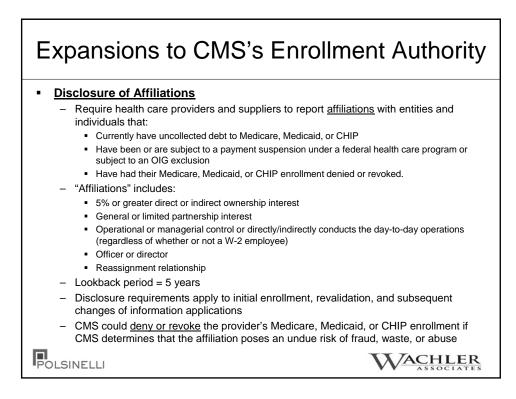


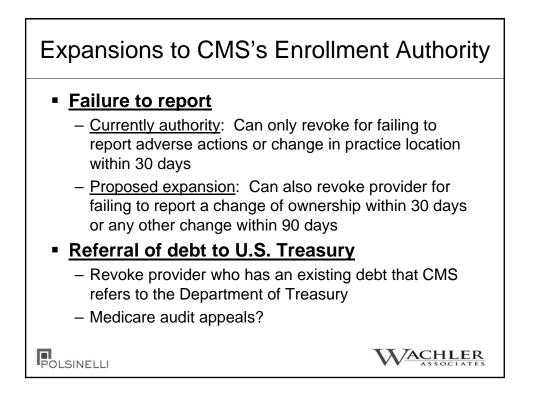








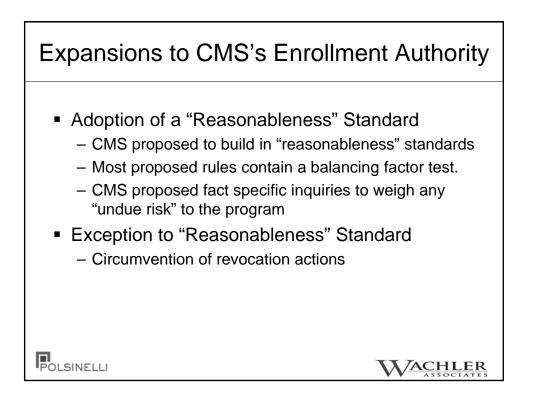


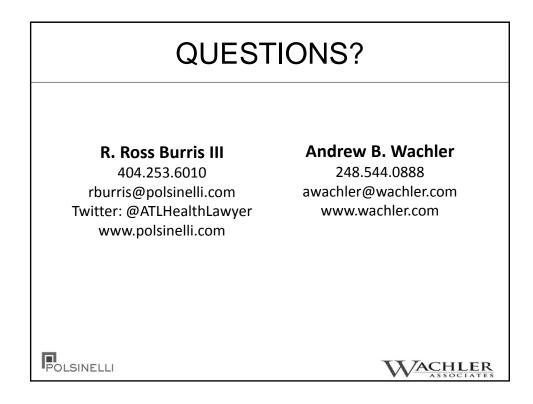


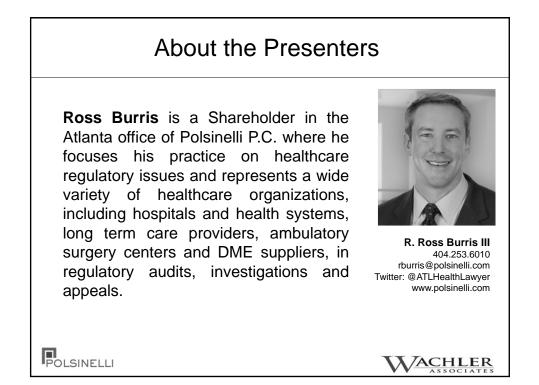
### Expansions to CMS's Enrollment Authority

- Deny or revoke a provider's Medicare enrollment if CMS determines that the provider is currently revoked under a different name, numerical identifier, or business identity.
- Increased re-enrollment bars
  - Raise maximum re-enrollment bar from 3 years to 10 years
     Maximum of 20-year re-enrollment bar for second revocation
  - Allow CMS to add an additional 3 more years to re-enrollment bar if the provider attempts to re-enroll under a different name, numerical identifier, or business entity
- Reapplication bar
  - Prohibit a provider from enrolling in Medicare for 3 years if an enrollment application is denied because the provider submitted false or misleading information with its application

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#### About the Presenters

Andrew B. Wachler has been counseling healthcare providers and organizations nationwide in a variety of health care legal matters for over 30 years on RAC and Medicare appeals, the Stark law, fraud and abuse, enrollment and revocation and other topics.



Andrew B. Wachler 248.544.0888 awachler@wachler.com www.wachler.com

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