Demystifying the Medicare Provider Enrollment Process

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Overview

- Context
- Overview of the Medicare Enrollment Process
- Adverse Enrollment Actions
- Appealing Adverse Enrollment Actions
- Common Enrollment Issues

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Context

- Enrollment is first and base principle in OIG's Five Principle Strategy for combating fraud, waste, and abuse:
- OIG Five Principle Strategy
  - **Enrollment**: Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment or reenrollment in the health care programs.
  - Other principles: **Payment; Compliance; Oversight: Response**.
- DOJ/OIG South Florida/HEAT project has also focused attention on enrollment issues.

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Overview of the Medicare Enrollment Process

- Initial Enrollments
  - Application
  - Supporting documentation
    - NPI enrollment letter
    - CMS 588 (electronic funds transfer)
    - CMS 460 (Medicare participation agreement)
    - DMEPOS surety bond
    - IRS forms
    - State licenses
    - Accreditation requirements
  - Screening and Site Visits

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Overview of the Medicare Enrollment Process (cont.)

- Change of Information
- Two ways to enroll:
  - Paper-based
  - PECOS
- PECOS is supplanting paper-based enrollment. (Accessible to DMEPOS suppliers 10/4/2010)
- Reenrollment/Revalidation (now every 3 years for DMEPOS suppliers)

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Overview: Types of Enrollments

1. **CMS 855A**--Medicare Enrollment Application for Institutional Providers
2. **CMS 855B**--Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers
3. **CMS 855I** --Medicare Enrollment Application for Physicians and Non-Physician Practitioners
4. **CMS 855R**--Medicare Enrollment Application for Reassignment of Medicare Benefits
5. **CMS 855S**--Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

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Referring / Ordering Only Providers

- Current Process – detailed in http://www.cms.gov/MLNMattersArticles/downloads/MM7097.pdf
- Include cover letter stating enrolling for the sole purpose of ordering and referring items or services for a Medicare beneficiary and cannot be reimbursed by the Medicare program for services that you may provide to Medicare beneficiaries.

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Referring / Ordering Only Providers (cont.)

- Modified Enrollment Process for Physicians and Non-Physician Practitioners who are Enrolling Solely to Order and Refer
  - Complete the following sections paper of form CMS-855I ("Medicare Enrollment Application for Physicians and Non-Physician Practitioners"):
    - Section 1 – Basic Information (you would be a new enrollee
    - Section 2 – Identifying Information (section 2A, 2B, 2D and if appropriate 2H and 2K);
    - Section 3 – Final Adverse Actions/Convictions;
    - Section 13 – Contact Person; and
    - Section 15 - Certification Statement (must be signed and dated—blue ink recommended).

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Referring/Ordering Only Providers
(cont.)

- Mail the completed enrollment application and cover letter to your designated Medicare enrollment contractor
- CMS has an 8550 form currently in review by Office of Management and Budget

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PECOS

- Internet-based "Provider Enrollment, Chain and Ownership System" for:
  - Initial enrollment
  - View or changing enrollment information
  - Tracking enrollment application
  - Withdrawing from the Medicare Program
- CMS touts advantages of PECOS:
  - Faster processing time (45 versus 60 days)
  - Tailored application process
  - Easier to check and update enrollment information
  - Less staff time and administrative costs for providers/suppliers

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Statistics from CMS

- CMS is monitoring supplier/provider enrollment. On a call 1/12/11, CMS personnel noted
  - There are ~74,000 providers that are enrolled in local systems (*i.e.,* currently billing Medicare) that are not yet in PECOS
  - There are an additional ~54,000 providers that have ordered DME that are not enrolled in any system (*i.e.,* not currently billing Medicare directly but do order items for Medicare patients)

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Overview: Change of Information

- Notification of change to enrollment information required, often within 30 days:
  - Adverse legal actions
  - Location
  - Change of ownership or managing control information
- For physicians, non-physician practitioners, and their organizations; IDTFs, and institutional providers, all other changes must be reported within 90 days.
- For DMEPOS suppliers, all changes must be reported within 30 days.
- Potential sanctions include: revocation of billing privileges and/or assessment of overpayment.

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Provider Screening Requirements - PPACA

- Medicare – 42 C.F.R. Part 424 [Conditions for Payment]
  - Tiered risk system depending on type of provider/supplier ("categorical risk")
  - Risk category increases to "high" with history of individualized sanctions or adverse actions
    - Payment suspension; exclusion; revocation.
  - Revalidation every 5 years (3 for DMEPOS suppliers), with initial off-cycle revalidations

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Provider Screening Requirements - PPACA

- Limited Risk
  - *E.g.,* physician or non-physician practitioners, ASCs, ESRD facilities, hospitals, pharmacies, SNFs
- Moderate Risk
  - *E.g.,* ambulance providers, CMHC, IDTF, labs, hospice, PTs, revalidating HHAs or DMEPOS suppliers
- High Risk
  - *E.g.,* new HHAs or DMEPOS suppliers.

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Provider Screening Requirements – PPACA (cont.)

- Limited Risk
  - Verification that meets enrollment standards
  - License verification
  - Database checks to confirm continues to meet enrollment standards
- Moderate Risk
  - Plus on-site visit
- High Risk
  - Plus fingerprints for 5% owners, and criminal history record check based on fingerprints

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Adverse Enrollment Actions

- Denial
- Revocation
- Rejection
- Deactivation
- Corrective Action Plans

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Enrollment Denials

- Bases include not being in compliance with Medicare enrollment requirements or failing to pay application fee after notification that hardship waiver not approved.
- Some overlap with OIG exclusion bases
- Effective 30 days from notification of denial
- Opportunity to submit corrective action plan
- Decision may be appealed

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Revocation of Enrollment

- Bases include not being in compliance with Medicare enrollment requirements and failure to furnish complete and accurate re-verification information
- Some overlap with OIG exclusion bases
- Effective 30 days from notification of denial
- Opportunity to submit corrective action plan
- Decision may be appealed.
- Terminates provide agreement
- 1- 3 year re-enrollment bar

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Rejection

- Bases include when enrollment application was incomplete, application fee not paid (or hardship waiver not requested) or additional or corrected information was not received in a timely manner.
- Contractor has discretion to extend period of time to supply information if supplier is “actively working with the contractor to resolve any outstanding issues.”
- Must complete and submit new enrollment application and all supporting documentation.
- Decision may not be appealed.

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Deactivation

- Bases includes failure to report changes of information in timely fashion.
- Reactivation requires new enrollment application or recertification of existing enrollment information.
- Does not affect provider agreement
- Rebuttal is permitted, but there are no appeal rights.
- In some circumstances, provider/supplier may obtain a retrospective billing date, but it is not common.

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Deactivation

- Currently ~25,000 deactivated each month with 1/4 to 1/3 re-enrolling. Common with certain specialties (pediatric specialties, reproductive medicine, etc.) and teaching institutions
- If provider has not billed in previous 12 months - automatically deactivated
- Reporting that some providers receiving new numbers after deactivation because if same number immediately deactivates because no billing within prior 12 months
  - Need to ensure that effective dates cover entire time period (*i.e.,* no gaps)

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Corrective Action Plans

- May submit CAP for consideration and negotiation
- Verifiable evidence of compliance and sufficient assurances of intent to comply
- Reinstatement after CAP is accepted is typically effective date CMS approves the CAP and compliance is determined (i.e. prior items / services non-billable)

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Appealing Adverse Enrollment Actions

- 42 C.F.R. Section 498.5:
  - Initial Determination
  - Revised Initial Determination
  - Reconsideration
  - ALJ Hearing
  - Departmental Appeals Board Review
  - Judicial review – Federal district court

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Common enrollment issues

- State Licensing Issues
- Implications for corporate structure
- Issues Arising in Acquisitions
- Inclusion on UB-04 of prescriber NPI number
- IRS Forms
- Legal versus DBA names
- Date of Birth Discrepancies
- Authorized officials

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State Licensing Issues

- Particular issue for DMEPOS providers
- National Supplier Clearinghouse (NSC) addresses state licensing requirements on its website, but not complete or definitive.
  http://www.palmettogba.com/palmetto/statelicensure.nsf
  - Entitled to rely on NSC database (for enrollment purposes?)
  - Supplier Standard - 'a supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.'
- Can be basis for deactivation by NSC.

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Other State Licensing Issues

- Not all states license all types of entities / practitioners
  - Fellows
  - Certified Clinical Nurse Specialist
  - Therapists

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Implications for corporate structure

- In DMEPOS, separate enrollments for separate business lines may make sense:
  - Isolate effects of adverse licensing actions to relevant business unit.
- Separate enrollments, however, implicate:
  - Cross-marketing issues through Telemarketing Statute and supplier enrollment standards
  - Co-location prohibitions

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Issues arising in acquisitions

- Asset Sales
- Changes of Ownership
- Chicken and egg game
  - Coordination of corporate transfer requirements with enrollment, licensing, and other regulatory requirements

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Inclusion on claim of prescriber NPI number

- Claims must include NPI and legal name of prescriber
- UB-04
  - *E.g.,* Hospital outpatient imaging
  - Field 78 and 79, Qualifier Code DN
- CMS-1500
  - *E.g.,* Independent clinical laboratories
  - Field 17 a and b
- To look up if a provider is in PECOS go to http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp#TopOfPage

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IRS Forms

- PECOS application requires a written confirmation from IRS with tax ID and legal business name
  - IRS Form CP 575 - notification form the Internal Revenue Service uses to send a unique entity employer identification number (EIN), also known as a federal tax identification number. If you need to, you can photocopy the original form, but you cannot get a duplicate from the IRS.
  - Tax Determination Letter – regarding tax-exempt status

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Legal Business Name vs. DBAs

- During provider enumeration process, incorrect legal names may have been used for registration
  - Verify legal names versus “doing business as” names on licenses, NPIs, EIN, etc.
  - If requires correction could have implications on cash flow for organization
  - Must include legal name on claim form

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Issue – Date of Birth Discrepancies

- PECOS pre-populates certain fields based upon the NPI number, including date of birth
  - There is a comparison to information on file with social security administration (SSA). If discrepancy (*i.e.,* the application will be denied)
    - If NPPES is incorrect, provider can correct
    - If SSA is incorrect, provider must request SSA to change

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Authorized Official

- Certification statements for PECOS application require Authorized Official Signature
- Can look up at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do
- During provider enumeration some organizations may have put incorrect people as authorized official (*e.g.,* billing manager, coordinator – who likely completed entry) so may want to correct before completion

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Upcoming Enrollment Issues

- Final Rule (to replace interim final rule from May 5, 2010 on “Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements")
- Temporary enrollment moratoria
- Mandatory Compliance Plans
- Requirement that ordering/referring prescribers be enrolled (implementation delayed)

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Resources

- CMS
  - http://www.cms.gov/MedicareProviderSupEnroll/
- National Supplier Clearinghouse
  - http://www.palmettogba.com/nsc
- Medicare Administrative Contractor information
  - http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf

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Questions?

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