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Obtaining and Maintaining Medicare Enrollment

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Introduction

- Medicare faces demographic hurdles.
  - Part-A trust fund is expected to run dry by 2026.
- Medicare has tried other systems to slow the flow of money out of the program:
  - MIPS.
  - E/M payment changes.
  - Other quality- and value-based payment programs.
  - Fraud and abuse laws.
- It’s more effective to control who has access to funds in the first place through enrollment controls.

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The Enrollment Process

- Original enrollment form (HCFA-1513) was a one-page application.
  - Form was retired in 2003.
  - In 2001, HCFA-855 was introduced, with two other forms.
- Current forms:
  - CMS-855A for Part-A providers.
  - CMS-855B for Part-B suppliers.
  - CMS-855S for DMEPOS suppliers.
  - CMS-855O for opted-out providers.
  - CMS-855R for reassignment
  - CMS-855I for individual enrollment.

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The Enrollment Process (Part 2)

- Forms require the submission of a broad range of information.
  - Contact information, office locations, D/B/A names, copies of licenses, information about companies and individuals with ownership/control of the enrolling entity, adverse legal histories, and copy of certification statement signed by "Authorized Official."
  - Independent Diagnostic Testing Facilities (IDTFs) must report information including types of tests performed, supervising physician, interpreting physicians, and technician credentials.

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The Enrollment Process (Part 3)

- Information submitted (continued):
  - DMEPOS supliers must report additional information such as business structures, list of products/services offered, and information about liability insurance and surety bonds.
- Initial enrollment requires being mindful of processing times and impact on billing privileges.
  - “Effective date of billing privileges” is granted by CMS on the latter of: (1) date when an enrollment packet that was successfully processed is submitted or (2) date on which enrolled supplier began rendering services. Can reach back 30 days prior to this date to submit claims.

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The Enrollment Process (Part 4)

- Processing times vary, depending on submission method (paper vs. electronic), and whether there are “development requests.”
  - Electronic submission is usually faster. 45 days to process, as opposed to 60 days for paper submission.
  - “Development requests” are where CMS asks for corrections/additional information. Extends processing times.
  - One wrinkle: DMEPOS suppliers get effective dates of billing privileges when they meet supplier standards, and submit complete application.
- The key to enrollment is getting it right the first time. Cut down on development requests.

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Enrollment: Reporting Changes

- Changes to enrollment data have to be reported promptly.
  - Most changes must be reported w/in 90 days.
  - HOWEVER, Changes in ownership or management control, changes in practice location, or adverse legal actions must all be reported in 30 days.
  - "Adverse legal action" = "final adverse action."
    - Medicare-imposed revocation of Medicare billing privileges.
    - Suspension/revocation of license to practice or accreditation
    - Conviction of felony offense w/in previous 10 years.
    - Exclusion/debarment from participation in Federal/State health care program.

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Enrollment: Revalidation

- Revalidation: process by which CMS requests supplier to recertify enrollment data. Must submit new application.
  - Can happen every 5 years. CMS can also request “off-cycle” revalidation.
  - “Off-cycle” revalidation can happen as part of random checks, or receipt of information suggesting local health care fraud problems, or as part of national initiatives.
  - More than one “off-cycle” revalidation can occur before an “on-cycle” revalidation.
  - May include site visit.
  - Failure to revalidate will lead to deactivation of billing privileges.

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Enrollment: Deactivation

- Described by CMS as,

  "*An action to protect the provider or supplier from misuse of its billing number and to protect the Medicare Trust Funds from unnecessary overpayments. The deactivation of Medicare billing privileges does not have any effect on a provider or supplier's participation agreement or any condition of participation.*" (42 CFR § 424.540(c)).

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Enrollment: Deactivation (Part 2)

- Deactivation can happen for multiple reasons.
  - Failure to submit a claim for 12 consecutive months.
  - Failure to report changes of information within required timeframes
  - Failure to provide complete and accurate information and supporting documentation for a revalidation.
  - Can apply for reactivation after a deactivation to restore billing privileges. If deactivation occurred for reasons other than non-submission of claims, must resubmit a complete enrollment application.

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Enrollment: Deactivation (Part 3)

- Deactivation creates a “gap period” in billing where supplier cannot submit claims for services, and for which the supplier cannot retroactively bill after receiving a new effective date of billing privileges.
- In other words: you cannot reach back to the date of deactivation, only to the new effective date.
- Deactivation does not grant appeal rights.

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Enrollment: Revocation & Denial

- Revocation involves the supplier having current billing privileges revoked.
- Denial involves the supplier being denied billing privileges initially.
- Examples of grounds for revocation/denial:
  - Conviction within the past 10 years of a felony.
  - Out of compliance with enrollment requirements, and fails to submit a plan of corrective action.
  - Conduct grounds (e.g., owner is excluded from Medicare).

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Enrollment: Revocation & Denial (Part 2)

- Revocation can also occur for misuse of billing number (e.g. selling it or allowing another to use it), or claims for services rendered to deceased beneficiaries or when the supplier was not in the same state or could not have provided the services.
- Denial can also occur when supplier has outstanding Medicare debt or was owner of supplier with Medicare debt that existed when enrollment was terminated/revoked.

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Problem Scenarios: Failed Revalidations

- The common fact pattern:
  - Supplier is contacted by Medicare Administrative Contractor (MAC) to revalidate.
  - Contact is sent to wrong address (an old one on the supplier's record that was never removed).
  - Supplier fails to file timely revalidation.
  - MAC deactivates supplier's billing privileges.
  - Supplier learns of deactivation and files application for billing privileges.
- Creates "gap period" for billing. Supplier appeals, and loses on appeal.
  - Departmental Appeals Board (DAB) and Administrative Law Judges (ALJs) rely upon Willie Goffney Jr., M.D. v. CMS opinion.

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Problem Scenarios: Failed Revalidations (Part 2)

- Goffney opinion involved deactivation for failure to submit claims. Goffney appealed, said he shouldn't have been deactivated. DAB ultimately held that deactivation is not appealable, although revocation is.
- Decision serves as basis for repeated rejections of appeals by DAB and ALJ when suppliers claim to have been improperly deactivated. Because Medicare regulations do not explicitly treat deactivation as "an initial determination," there are no appeal rights and DAB and ALJ lack authority to grant an appeal.

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Problem Scenarios: "Extenuating Circumstances"

- Suppliers try to claim facts create extenuating circumstances that should protect them from revocation. This usually fails as long as the revocation was proper on its face.
- Example 1: Sunsites Pearce Fire District v. CMS
  - Fire dept. filed CMS-855B to enroll for its ambulance service. Managing employee had been put into an "adult diversion program" after discharging a firearm at former girlfriend. Court had ordered charges suspended for 2 years, and then dismissed upon completion. Fire dept. neglected to report this as "adverse legal action."
  - Prior version of regulations did not explicitly include deferred adjudication as "adverse legal action," but ALJ argued that regulations merely clarified what a "conviction" included, instead of expanding the scope of the term.

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Problem Scenarios: "Extenuating Circumstances" (Part 2)

- Example 2: Breton L. Morgan M.D., Inc. v. CMS
  - Dr. was convicted on felony in 2007. Failed to list conviction on a 2013 application. Privileges were granted, but later revoked. Dr. had also been excluded from Medicare for five years as a result of the conviction. Reported the exclusion in the 2013 application, but not the conviction. Dr. tried to argue that CMS was aware of the conviction and therefore revocation was inappropriate.
  - ALJ stated "Whether or not CMS had records and was aware of Dr. Morgan's felony conviction in 2007 is not the issue. Petitioners had an affirmative duty under the regulations, of which they were advised by the CMS-855I, to submit a true, complete, and accurate application. Petitioners violated that affirmative duty. Petitioners offer no explanation for their failure."
  - ALJ explained that, as long as there was a basis for the revocation, the ALJ had no authority to review CMS' exercise of its discretion in choosing to revoke billing privileges.

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Problem Scenarios: "Extenuating Circumstances" (Part 3)

- Example 3: Premier Integrity Solutions, Inc. v. CMS
  - Supplier relied upon credentialing company to submit and maintain enrollment data on supplier's behalf, as well as to report previous revocation of billing privileges when submitting a new application. Company failed to report the previous revocation. Privileges were granted, and then revoked. Supplier argued that it had begun pursuing damages against the credentialing company for negligence, and that it should not be penalized for the credentialing company's failure.
  - ALJ pointed out that supplier's CFO (the "Authorized Official") had signed the applications and therefore was bound by any false or misleading statements no the application.

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Problem Scenarios: Deceased Suppliers

- This issue arises when a supplier dies, which can implicate billing privileges and lead to deactivation.
- We represented a solo physician practice where the owner had died. Physician's estate had take control. But, occurred in a "corporate practice" state; estate could not own the corporation. Estate sought to transfer interest to physician's son (himself a doctor as well), but this raised tax issues that delayed transfer.
- Deactivation was made retroactive to the physician's date of death, based on failure to report upon date of death by the practice.
- Is this a constitutional violation? Deactivation should be prospective, not retrospective.

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Problem Scenarios: Deceased Suppliers (Part 2)

- Example: Urology Group of NJ, LLC v. CMS
  - CMS contractor learned in December, 2015 from monthly file at Social Security Administration that a group's physician had died in October of 2015. Local MAC requested an updated CMS-855B. Group didn't respond. MAC sent a follow-up letter informing of deactivation of billing privileges. Supplier submitted corrected CMS-855B and requested redetermination of date of deactivation to avoid a "gap period." Also argued that effective date of billing privileges was based on manual instructions that contradicted the regulations because deactivation should have no effect on supplier's participation agreement.
  - DAB relied upon the Goffney decision. Would only review reactivation effective date because there is no right to appeal deactivation. Noted that deactivation does not authorize "gap period" but that this was the wrong forum for that debate.

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Practical Solutions: The Best Defense…

- The best way to avoid problems with revocations/deactivations is to manage enrollment data on an ongoing basis.
- Revalidation and deactivation cases demonstrate that saying “I didn’t get the letter” is insufficient. Happens frequently because account information is out of date.
- Even if constitutional issues apply to “gap period” issue, the problem would be avoided by cleaning supplier account of all outdated information.
- It is the supplier’s responsibility to do this, and to report changes in a timely fashion (including the shuttering of old locations).
- Same guidance applies to reassignments. Terminate and remove old reassignments once they no longer apply.

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Practical Solutions: The Buck Stops Here

- Support staff and credentialing companies can be essential to managing the enrollment process, but the supplier is ultimately responsible for their work.
- Managing enrollment information requires high familiarity with the CMS-855 forms, as well as the regulatory requirements and the regulatory impact of failing to properly maintain information.
- Must understand more than just the requirements on their face. For example, it's not enough to know that "adverse legal actions" must be reported. Must understand what types of events have to be reported and have the information available to report.

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Practical Solutions: Forget the Appeals Process

- Based on a review of ALJ and DAB opinions, the Medicare appeals process is rigid, inflexible, and bound by regulatory language.
- ALJs and DAB lack authority to ignore/challenge the regulations.
- Unless a MAC has acted in a clearly improper manner – defying the letter of the regulations – the ALJs/DAB will probably find in favor of the MAC.
  - ALJs/DAB also presume that MAC will have acted properly, without proof to the contrary.
- Backlog of appeals exists, as well, so the process is not timely.

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Conclusion

- Medicare enrollment process is detail-oriented, time-consuming, and requires ongoing maintenance.
- Information to be submitted is extensive.
- Suppliers should regularly check their enrollment data and correct whatever information is no longer accurate.
- Suppliers must also bear in mind the requirements to respond to requests for revalidation, and to update enrollment data, in a timely manner or risk loss of billing privileges.
- Competent, knowledgeable legal counsel can also assist in the enrollment process.

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Additional Resources

- Shay, "The Medicare Part-B Enrollment Obstacle Course: It Hasn't Gotten Any Easier," HEALTH LAW HANDBOOK, (2019 Edition) WestGroup, a Thomson Company, available at www.gosfield.com.