# PUBLICATION

## Enrollment Rules Continue to Provide Expanded Bases for Enforcement [Ober|Kaler]

**June 12, 2013**

**CMS continues to expand its enforcement efforts in the enrollment area. Proposed regulations titled, "Medicare Program; Requirements for the Medicare Incentive Reward Program and Provider Enrollment" [PDF], were published on April 29, 2013. The deadline for submitting comments in response to these proposed regulations is June 28, 2013.**

With respect to its enrollment initiatives to combat fraud and abuse, CMS proposes to:

- Expand the reasons **for denying an enrollment application** to a currently enrolled or previously enrolled legal entity (i.e., the provider or supplier) or any of its direct or indirect owners to include situations in which: (a) the provider or supplier has an existing Medicare debt, or (b) had an unpaid Medicare debt that existed when the provider's or supplier's enrollment was voluntarily terminated, involuntarily terminated, or revoked. Even in advance of finalizing the proposed regulations, CMS published Transmittal 469 to the Medicare Program Integrity Manual entitled: "Enrollment Denials When an Existing or Delinquent Overpayment Exists" [PDF], with an October 1, 2013 effective date, which will implement these rules most likely before the final regulations are published.
  - In order to deny enrollment to a direct or indirect owner under the second prong of this proposed regulation, CMS proposes that the following additional requirements would need to be satisfied:
    - The direct or indirect ownership interest would have to have been present within the last year prior to the voluntary termination, involuntary termination, or revocation; *and*
    - CMS would need to determine the uncollected debt poses an undue risk of fraud, waste, or abuse.
  - The proposed regulations provide a mechanism to avoid the denial of enrollment by repaying the outstanding debt in full, agreeing to repay the debt according to a CMS-approved extended repayment schedule, or satisfying the debt in accordance with the existing claims collection regulations at 42 C.F.R. § 401.607.
- Expand the reasons for **either denying an enrollment or revoking billing privileges** to include situations in which the provider, supplier, a direct or indirect owner, or *any managing employee* is or was, within the preceding 10 years, convicted of a federal or state felony offense that CMS determined to be detrimental to the best interests of the Medicare program and its beneficiaries.
  - The reasons for the denial or revocation are unchanged, but the proposed regulations would add managing employees.
  - The proposed regulations further specify that the period for the revocation would be set by the Secretary but would be for the full 10-year period when the conviction is a second or subsequent conviction.
- Expand the reasons to allow a **billing privilege revocation** for an *abuse of billing privileges*, defined as:
  - The submission of a claim or claims for services that could not have been furnished to a specific individual on the date of service, such as when the beneficiary is deceased, when the directing

physician or beneficiary is not in the state when services were furnished, the necessary testing equipment was not present, *or*
  - When the provider or supplier has a pattern or practice of billing for services that do not meet Medicare requirements.
- Change the date for the **start of the reenrollment bar** to 30 days after CMS or its contractor mails the billing privilege revocation notice. In situations where CMS has the authority to retroactively revoke billing privileges, the reenrollment bar would be expanded. This particular initiative could result in a reenrollment bar extending well beyond the current three-year maximum. If there is a delay in learning of an adverse final action, for example when the provider or supplier failed to report the action, CMS has the authority to retroactively revoke billing privileges. Currently, the bar to reenrollment begins as of that retroactive revocation date. Under the proposed rule, the reenrollment bar would not begin until 30 days after the revocation notice is mailed.
- Sets the time period for a provider or supplier that has a billing privilege revocation to submit claims for dates of service prior to the revocation effective date as follows:

  - With the exception of home health agencies (HHAs), within 60 calendar days after the effective date of revocation.
  - For HHAs, within 60 days after the *later of*:
    - (A) The effective date of the revocation, or
    - (B) The date that the HHA's last payable episode ends.
- Revise the appeal process for a billing privilege revocation to add to the regulations the ability to submit a Corrective Action Plan (CAP), which is currently provided for under CMS's enrollment policies. However, in adopting CAP regulations, CMS proposes:

  - To allow the submission of a CAP only in situations when 42 C.F.R. § 424.535(a)(1) served as the basis for the revocation.
  - The provider or supplier would only be granted one opportunity to correct the deficiencies through the CAP process.
  - Consistent with current CMS policy, the decision regarding the CAP is not a final determination providing any further appeal rights.
- Revise the process for determining the effective date of an ambulance supplier's enrollment to be consistent with that for physician and nonphysician group practices, i.e., the later of the date of receipt of an application that is capable of being processed or when services were first provided.

## Ober|Kaler's Comments

The denial of enrollment for an outstanding overpayment has significant implications for current and future transactions and business development. In light of the publication of Transmittal 469, it is especially important to consider submitting comments to these and other proposed regulations prior to the June 28th deadline.