PUBLICATION

Medicare Enrollment Rules - Expanded Enforcement Finalized in Regulations [Ober|Kaler]

January 08, 2015

On December 5, 2014, CMS published final regulations that expand the bases for CMS to deny enrollment or revoke billing privileges of an enrolled provider or supplier. These final regulations also change the method to determine the effective enrollment date for ambulance suppliers, limiting the ability to bill for services provided prior to the effective date. And CMS provided some clarity to the enrollment rules to distinguish between an enrollee granted billing privileges and the completion of an application (the CMS 855O form) for the sole purpose of providing orders and referrals for Medicare beneficiaries.

We first reported on this CMS initiative to enhance its enforcement authority under the enrollment rules in a June 12, 2013 *Payment Matters* article, when the proposed rules were published. CMS did not, however, wait for the publication of final regulations before adopting some of the proposed rules via manual guidance. A September 5, 2013 *Payment Matters* article provided an overview of this manual guidance which was released as Transmittal 479 to the Medicare Program Integrity Manual and became effective on October 1, 2013.

The following provides a brief overview of some of the key provisions of the final regulations that will become effective February 3, 2015:

- Expansion of the reasons for **denying an enrollment application** to include when the enrolling provider or supplier, or any of its direct or indirect owners, has an existing Medicare debt *or* had an unpaid Medicare debt that existed when the provider's or supplier's enrollment was voluntarily terminated, involuntarily terminated, or revoked. CMS explained that its reasoning for adopting this regulation is to prevent an owner of a Medicare-enrolled business from incurring a substantial debt, ceasing to operate, and attempting to reenroll in the Medicare program through another business entity. Transmittal 479 had implemented the proposed regulations but with CMS instructing its contractors to only review enrollment files within its jurisdiction to identify unpaid debts. The final regulations do not include this limited jurisdictional reach, but instead include factors for determining if the uncollected debt poses an "undue risk" justifying the enrollment denial.
- Expansion of the reasons for **denying an enrollment or revoking billing privileges** related to federal and state felony convictions. The final regulations were essentially adopted as proposed and: (a) qualify that the rules cover federal and state offenses CMS determines to be *detrimental to the best interests of the Medicare program and its beneficiaries*; and, (b) expand the list to include denials and revocations based on adverse actions involving managing employees, in addition to the provider, supplier, or a direct or indirect owner.
- Expansion of the reasons to allow a **billing privilege revocation** for an *abuse of billing privileges* to include situations in which a provider or supplier has a "pattern or practice" of billing for services that do not meet Medicare requirements. In the final regulations, CMS delineated factors to be considered in making a determination regarding a "pattern or practice" of noncompliant billing.
- Change in the date used for the **start of the reenrollment bar** to 30 days after CMS or its contractor mails the billing privilege revocation notice. This change was finalized as proposed and has its greatest impact in situations where CMS has authority to retroactively revoke billing privileges and

there has been a delay in CMS's issuing a revocation notice due to a delay in CMS's becoming aware of a prior adverse action.

- Establishing the time period in which claims can be submitted by a provider or supplier that has a billing privilege revocation. The proposed regulations were adopted without change, requiring providers and suppliers to submit claims for dates of service prior to the revocation effective date within 60 calendar days after the effective date of revocation. There is a special requirement for home health agencies which must submit claims within 60 days after the *later of* the effective date of the revocations or the date that the HHA's last payable episode ends.
- Incorporation of the existing CMS policy allowing the submission of a Corrective Action Plan (CAP) for certain billing privilege revocations. The CAP regulations were adopted as proposed.
- Determining the effective date of an ambulance supplier's enrollment applying the rules for physician and non-physician 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

CMS stated it would be implementing manual guidance consistent with these final regulations. It will be important to monitor any new policy developments to see if further clarification on implementation is provided by CMS to its contractors. It will also be important to monitor how CMS and its contractors implement these regulations.