PUBLICATION

Adverse Action Reporting – Avoid Medicare Enrollment Denial or Revocation

March 18, 2019

CMS revised its policy guidance regarding adverse action reporting requirements once again in the Medicare Program Integrity Manual (MPIM) Transmittal 865. This guidance is arguably inconsistent with the regulations and with CMS's prior policy guidance regarding compliance with the enrollment rules. Even though the expanded list of reportable adverse actions does not include any "final adverse action" for which an enrollment could be denied or revoked, the mere failure to report the adverse action could be deemed sufficient noncompliance with the enrollment rules to support the denial of an application or a billing privilege revocation. Now is the time to revise company policies related to Medicare enrollment updates to ensure compliance with the new reporting requirements. The effective date was March 12, 2019.

Historically, there was confusion over what specific types of adverse actions needed to be reported to Medicare, especially when the application instructions made reference to final adverse "legal" actions, then delineated different administrative sanctions. Refer to the instructions for Section 3 of the CMS 855A, CMS 855B or CMS 855I form, instructions that existed in the 2006 versions when the forms were revised in conjunction with the adoption of the enrollment regulations at 42 C.F.R. Part 424, Subpart P.

In the final 2009 Physician Fee Schedule regulations, CMS included revisions to the enrollment regulations at 42 C.F.R. § 424.502 by defining "final adverse action." This revision was consistent with an earlier 2009 final rule adding a "final adverse action" definition to the DMEPOS supplier standards at 42 C.F.R. § 424.57. CMS stated the "final adverse action" definition was being added to the enrollment regulations applicable to all providers and suppliers to be consistent with the DMEPOS supplier standards but, more importantly, "to be consistent with the definition of 'final adverse action' found in Section 221(g)(1)(A) of the Health Insurance Portability and Accountability Act (HIPAA) of 1996."

Following the publication of the 2009 regulations, providers and suppliers were allowed to follow the regulations and report only adverse actions that were included among the "final adverse action" definition, despite CMS's failure to update the application instructions to be consistent with the regulatory definition. Nevertheless, despite clarity and consistency in the rules, CMS expanded the reporting requirements by adopting new policies via MPIM Transmittal 718 in 2017, adding Section 15.5.3.1 to advise the Medicare Administrative Contractors (MACs) on reviewing adverse legal actions – a term that has never been defined under the regulations. CMS described the reason for the policy guidance was "to assist the MACs in reviewing final adverse actions," yet the policy included the reporting of certain misdemeanor offenses and payment suspensions which are not included in the delineated "final adverse action" regulatory definition. It appeared that CMS was publishing policy guidance to align its policies with the CMS 855 application instructions rather than implementing guidance to further explain the regulatory reporting requirements.

With Transmittal 865, CMS is now focused on other provisions in the application instructions – the word "final" (which now appears in multiple places in the adverse legal action reporting policy) and the reporting of "any sanction imposed by, a Federal or State health care program" (expressly requiring the reporting of any current or past "federal" sanction including "Civil Monetary Penalties (CMP)" and "Corporate Integrity Agreement (CIA)" as examples). These revisions make the reporting murkier:

- For example, it is less clear if a current payment suspension under the regulations at 42 C.F.R. § 405.371 would be reportable, especially since no appeal rights are granted following the implementation of a payment suspension under these regulations because CMS determined the payment suspension is not a "final" action.
- With the inclusion of CMPs and CIAs as examples of federal sanctions that need to be reported, do providers and suppliers now have to report other current and past federal sanctions such as requiring a directed plan of correction or placement of temporary management?

The accuracy of reporting is critical since the regulations at 42 C.F.R. § 424.530 (providing the *bases for CMS to deny* an enrollment application) and 42 C.F.R. § 424.535 (providing the *bases for CMS to revoke* billing privileges) include the permissive authority to deny or revoke a Medicare enrollment for noncompliance with the enrollment requirements in the application, which would include noncompliance with the MPIM policy guidance discussed above.

Suggested Next Steps

Providers and suppliers need to identify adverse legal actions set forth in CMS's MPIM policy guidance and determine the need to submit a change of information filing to update an existing enrollment. Consideration should be given to reporting non-final payment suspensions with an appropriate caveat to reflect that neither the regulations nor the current policy guidance appears to require such reporting. Policies related to enrollment compliance should also be updated to ensure that any completed application (new enrollment, change of information filing, revalidation) has a complete listing of adverse legal actions as delineated under CMS's current policy.

For assistance with Medicare enrollment matters, contact any member of Baker Donelson's Reimbursement Team.