The ongoing ordeal of maintaining Medicare enrollment

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Every month, Dermatology World *covers legal issues in Legally Speaking. This month's author, Daniel F. Shay, Esq. is a health care attorney at Alice G. Gosfield and Associates, P.C.*

The Medicare system continues to struggle with the burden of demographics and an increasingly aging population. The Centers for Medicare and Medicaid Services (CMS) attempt to stanch the flow of money out of the system through a variety of methods, including the Medicare credentialing system (referred to as "enrollment"). A physician, non-physician practitioner (NPP), or other non-institutional entity (referred to collectively as "suppliers" by CMS) cannot bill Medicare without billing privileges. Moreover, enrollment requirements extend to suppliers who have already obtained billing privileges. Unfortunately, many suppliers, including dermatologists, do not appreciate what these obligations are and what failure to meet them means.

Reporting obligations, deactivation, and revocation

Most changes in enrollment information must be reported to Medicare within 90 days of their occurrence. Strict standards apply to changes to a supplier's location, ownership, and certain adverse legal actions, which must be reported within 30 days. The full range of information that must be reported can be seen either on the CMS-855 series of forms (available on CMS' website at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html**) or in the Provider Enrollment, Chain, and Ownership System (i.e., "PECOS," Medicare's online enrollment system).

The two major consequences of failing to properly maintain billing privileges are: (1) a deactivation of such privileges, or (2) their revocation. A deactivation means that the physician is not able to submit claims for services but may reactivate billing privileges by correcting an error in their enrollment data or submitting a new application. A revocation, however, includes a bar on reapplying for billing privileges for one to 10 years, depending on the reason for revocation. Different events will trigger one of the two penalties. Revocations can be appealed, but deactivations cannot. Avoiding both is critical. Keeping records up to date on an ongoing basis may prove difficult in practice. Several common problems can arise.

Common reporting failures

The range of data that must be reported to maintain enrollment status is broad and can prove complicated. Consider the requirement to report the termination or reassignment of a physician or NPP within 90 days of the termination/reassignment. Often, the departing practitioner will assume their former job will report the change and will not bother to report it themselves. However, a failure to report such change can be imputed to both the departing practitioner and their former practice, and either or both may have their billing privileges deactivated until the issue is resolved. Failure to remove a previous reassignment may also create billing problems, where services might be accidentally recorded as having been performed by the departed practitioner due to errors within a practice's electronic health records. This may require a voluntary repayment for the practitioner's improperly billed services to avoid false claims liability.

A practice must notify CMS of a change in ownership, such as when a physician becomes a partner in a group with an ownership interest of more than 5%, which must be reported within 30 days. While the obligation to report such change might seem straightforward, during the tumult

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of making the change in ownership, the practice may neglect to report the change. Similarly, adding or removing a managing employee will trigger the same 30-day reporting requirement. In both cases, the changes will also require reporting the adverse legal history of any new personnel added as owners or managing employees.

Separate from reporting changes to enrollment information as they occur, CMS may require Medicare suppliers to "revalidate" their enrollment data. A revalidation requires the supplier to submit a full enrollment application (as opposed to only submitting the information that is changing), regardless of whether any information has actually changed. This process occurs every five years for suppliers, although CMS may also engage in one or more "off-cycle" revalidations more frequently. A failure to revalidate in a timely fashion may result in deactivation.

Enforcement and appeals

Due to increased enforcement efforts by CMS and its Medicare Administrative Contractors (MACs), the process for resolving problems has become more difficult. For example, we represented a practice several years ago that had its billing privileges deactivated for failing to inform the MAC of the adverse legal history of a physician who had left the practice several years previously, had never been removed from the group's enrollment account, and who had lost his license to practice. We were able to resolve the matter by communicating directly with the MAC officer assigned to the case and got the group's billing privileges reinstated retroactively to the date they were deactivated. We were able to prove to the MAC that the obligation to remove the physician from their enrollment account had been added years after the physician had left. The MAC officer agreed to reinstate billing privileges, if the group removed the physician from their account.

In the current environment, this result would be unlikely. The group would instead have to use the appeals system, in which MAC hearing officers, administrative law judges (ALJs), and the Departmental Appeals Board (a panel made up of ALJs) review the facts of cases, considering established law and regulations. However, the ALJs and DAB do not function like federal judges and have no authority to interpret the meaning of regulations in any manner other than as CMS has interpreted them. The appeals process, therefore, often favors the MAC because of the lack of flexibility afforded to ALJs and the DAB. The ideal approach for a dermatology practice is to avoid the need to appeal anything in the first place, by properly maintaining enrollment data.

Conclusion

Maintaining Medicare enrollment credentials is a complicated task that should be entrusted only to someone who understands the enrollment system itself (including how to use PECOS), who understands the requirements regarding timely submission of data, and in a position to monitor and maintain this information on an ongoing basis. It is not simple clerical work. Failure to properly maintain such detailed information can result in a loss of billing privileges and a loss of Medicare revenue, potentially including the need to submit voluntary repayments to Medicare. Coordination with knowledgeable health care legal counsel can assist in these efforts. ***dw***