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Potential problems exist in the Medicare enrollment process

When the Medicare program first began, providers enrolled using a single two-page form. There are now six enrollment forms, the shortest of which is nine pages long. Why has the enrollment process become so much more complicated?

In September 2010, U.S. Department of Health and Human Services Inspector General Daniel Levinson explained in congressional testimony that the Medicare enrollment process needed to be used as a means of "locking the front door" to the Medicare trust fund. New regulations have been published subjecting applicants to scrutiny ranging from database searches to verify information contained in the enrollment applications, to site visits, to checking fingerprints against criminal records. These new screening processes will be applied to all new enrollees now and to current providers soon.

These efforts represent an ongoing, increasingly intrusive attempt to prevent bad doctors from gaining access to the Medicare trust fund in the first place, rather than chasing down monies paid to them in an effort to recoup losses.

POTENTIAL PROBLEMS

Meanwhile, providers who already have Medicare billing privileges must periodically update their information through the revalidation process and must report changes to their information on an ongoing basis. This article explores some of the complexities of the enrollment process, focusing specifically on four potential problem-areas for physician practices. Difficulties may arise when noting changes in location and staff, reporting owners and managers, practicing in multiple jurisdictions, and timing enrollment submissions.

POWER POINTS

New Medicare enrollment screening processes will be applied to all new enrollees now and current providers soon.

Providers with Medicare billing privileges must periodically update their information and report changes on an ongoing basis.

Issues related to outdated information, management, jurisdiction, and timing may cause problems for physician practices.

For help, consult an attorney familiar with the Medicare enrollment process.

OUT-OF-DATE INFORMATION

Physician practices must notify the Centers for Medicare and Medicaid Services (CMS) of changes to their office location within 30 days. Failure to do so may result in revocation of billing privileges.

For physician practices that maintain multiple satellite offices, this issue can be of critical importance.

Moreover, for certain types of providers (including independent diagnostic testing facilities, portable x-ray suppliers, and physical therapy practices), CMS may now conduct unannounced site visits both before granting billing privileges and after. If the location is not operating when CMS visits, it may revoke the practice's billing privileges.

In fact, in a recent report from the Miami area Office of Inspector General (OIG), the OIG determined that of the 27 (out of a total of 92) independent diagnostic testing facilities that failed their site visits, 23 were not at the locations on file with CMS.

In practical terms, the most likely scenario that would trigger this predicament is where the practice maintains satellite offices and fails to notify CMS upon closing an office. It is essential to remember that CMS must be notified both when a new location is opened and when an old location is closed.

Similarly, when a physician ceases working for a practice, either the physician or the practice must submit another CMS-855R form to terminate the reassignment. If this is not done, it can lay the groundwork for future problems. Without terminating the reassignment, CMS will continue to believe the physician works for the practice. If the physician runs afoul of an "adverse

"MEDICARE ENROLLMENT IS A TIME-CONSUMING, NUANCED PROCESS FOR PHYSICIAN PRACTICES."

legal event" (like loss or suspension of a license), the information must be reported to CMS within 30 days.

Of course, if the physician no longer works for the practice, the practice may be completely unaware of this development. But if it never terminated the reassignment and removed the physician from its enrollment record, and CMS still believes the physician works for the practice and the practice has a duty to report the event, then CMS may revoke the practice's billing privileges. It therefore is critical for practices to remove physicians from their enrollment records (including terminating reassignments) promptly, just as they must do with old office locations.

MANAGEMENT CONCERNS

One particularly nuanced aspect of the enrollment process is navigating the reporting requirements for those entities and individuals who have some level of management duties and/or ownership of the practice. In general, practices must report on the CMS-855B form:

- business entities with ownership or managing control of the practice;
- individuals with ownership or managing control of the practice; and
- "authorized officials" and "delegated officials."

Owners are generally considered to be anyone (or any corporate entity) with a 5% or greater interest in the practice, or any individual who is a partner in the practice. Management companies and individual managers also must be reported, however. "Authorized officials" generally are corporate officers and also must be W-2 employees with the authority to legally bind the practice to its obligations under the enrollment application. A "delegated official" on the other hand, is a W-2 managing employee of the practice who has been delegated the authority (by an authorized official) to keep the practice's Medicare enrollment information up to date.

The difficulty in managing the reporting requirements lies in the ways in which these entities can overlap, the information that must be reported, and the timeframes for reporting updates to such information.

For example, if a practice hires a management company, that company must be reported in the section of the application relating to entities with managing control. The individuals who operate the management company, however, cannot be listed as delegated officials, because they are not W-2 employees of the practice. On the other hand, the practice's authorized official(s) and delegated official(s) must be listed in the section relating to individuals with managing control.

Moreover, when changes in ownership (such as adding a new partner or removing an old one) occur, or where the individuals or entities listed as owners or having managing control experience adverse legal events, this information must be reported within 30 days. By contrast, when adding a new delegated official or authorized official, the practice need notify only CMS within 90 days.

Naturally, the removal of any of these individuals or entities also should be followed up with their removal on the enrollment forms to avoid potential problems.

Medical Economics online

Medicare will ask thousands of physicians and millions of healthcare professionals to revalidate their enrollment records by 2013. To learn more, see MedicalEconomics.com/Medicareenrollment

Well-meaning physicians who do not follow Medicare's enrollment guidelines may choose to appeal the final determinations of their Medicare contractor status. To find out how to proceed through the appeals process, see MedicalEconomics.com/Medicareenrollmentappeal

JURISDICTIONAL ISSUES

In 2006, CMS changed how Medicare is administered from the previous state-by-state carrier/fiscal intermediary system, to a system whereby multi-state jurisdictions were assigned to Medicare administrative contractors (MACs). This reorganization has implications on the enrollment process for practices operating in multiple states.

On the one hand, if a practice has locations within the same jurisdiction, the enrollment process

will remain relatively straightforward. The practice will not necessarily have to complete an entire application form, nor will it have to re-enroll all of its physicians and non-physician practitioners who participate in Medicare (such as nurse practitioners and physician assistants).

If a practice moves to another jurisdiction or opens another office in another jurisdiction, however, the move will be treated as a "new" enrollment. In practical terms, this means that a physician practice in New York City that wants to open a satellite office just over the bridge in northern New Jersey must enroll as if the MAC in Jurisdiction 12 (the jurisdiction for New Jersey, Pennsylvania, Delaware, and Maryland) has no knowledge of it, regardless of having already enrolled in Jurisdiction 13 (the jurisdiction for New York and Connecticut). It will have to complete new enrollment applications for the practice itself, as well as for its physicians and nonphysician practitioners. Those who can reassign their rights to payment to the practice must submit a new CMS-855R reassignment form. In addition to these administrative hassles, each "new" enrollment will subject the practice to the new screening processes previously discussed.

TIMING ISSUES

Physician practices must understand the financial implications for the timing of their Medicare enrollment submissions. As previously discussed, failure to properly maintain enrollment information after being granted billing privileges may result in revocation of privileges, or the imposition of False Claims Act liability. But even the initial enrollment process must be timed carefully.

If a practice submits an incomplete enrollment form or one containing errors, it will face delays in obtaining billing privileges, which in turn will implicate its potential Medicare claims. In the past, practices could "back-bill" for up to 27 months before their effective date of billing privileges. This changed in 2008, when CMS shortened the "back-billing" window to 30 days before the effective date of billing privileges. Moreover, the effective date itself is the date on which the practice submitted a complete application that could be successfully processed.

In other words, if a practice submits a faulty application, the effective date will be pushed further into the future, and the practice will be unable to bill for any services rendered 30 days before that date.

Practices therefore must ensure that they get it right the first time. They should obtain all necessary permits and licenses before submitting the application. If a site visit will be required, the practice locations should be open during whatever hours are listed on the application.

In addition, the application must be submitted with all required documentation. For practices hiring professionals who can bill Medicare, this may mean the professionals must submit their own enrollment documentation (including the reassignment form). Fortunately, these documents can be submitted as a single "enrollment packet" to be processed together—a better approach than submitting the documentation on a piecemeal basis, where the applications may end up being processed at different speeds by different MACs.

"THE CONSEQUENCES OF FAILING TO OBTAIN AND/OR MAINTAIN BILLING PRIVILEGES CAN LEAD TO SEVERE FINANCIAL AND LEGAL REPERCUSSIONS."

THE BOTTOM LINE

Medicare enrollment is a time-consuming, nuanced process for physician practices. The consequences of failing to obtain and/or maintain billing privileges can lead to severe financial and legal repercussions. Having knowledgeable delegated officials who can manage this process can help, as can consulting an attorney familiar with the potential pitfalls associated with enrollment.

The author is a health law attorney with Alice G. Gosfield and Associates PC, Philadelphia, Pennsylvania. Law Consult deals with questions on common professional liability issues. Unfortunately, we cannot offer specific legal advice. If you have a general question or a topic you would like to see covered here, please send it to medec@advanstar.com.