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# Medicare enrollment: A never-ending high hurdles race

**EACH MONTH DERMATOLOGY WORLD** will tackle issues "in Practice" for dermatologists trying to balance practicing medicine with running a business and living life. This month, attorneys Daniel F. Shay, Esq., and Alice G. Gosfield, Esq., discuss legal issues.

Controlling access to Medicare dollars has become a major focus of both Congress and the Centers for Medicare and Medicaid Services (CMS). In new regulations, published Feb. 2, CMS is implementing even tighter restrictions in the Medicare enrollment process. As a result, dermatology practices face new challenges not only in enrolling new physicians, but perhaps more dauntingly, in maintaining enrollment effectively.

Physicians and practices that fail to properly maintain their Medicare enrollment risk delays in claims payment, revocation of billing privileges, or even potential false claims liability. The process itself is complicated and nuanced, with a host of reporting requirements for issues that might otherwise seem trivial. As if that were not bad enough, there are deadlines that must be met. This article provides a very brief overview of the tedious types of information that must be included on the Medicare enrollment forms, touches on the practical issues providers must confront when completing the forms, and provides some general advice for maintaining enrollment.

## INITIAL ENROLLMENT/REVALIDATION

Physicians and practices that have not previously enrolled in Medicare must complete the entire enrollment form (the CMS-855I for individual physicians or sole proprietorships, and the CMS-855B for physician groups). Forms can be found at www.cms.gov/cmsforms/cmsforms. As part of this process, all new Medicare providers, including physicians and physician practices, face screening procedures imposed March 25. Currently enrolled providers will be screened beginning in 2012. The screening procedures differ, depending on the provider type. For physicians, local Medicare Administrative Contractors (MACs) will check that the prospective provider meets Medicare requirements, will confirm licensure status, and will search databases applicable to the physician or practice members listed on the enrollment form, such as the Social Security database, National Practitioner Data Bank, etc.

Once enrolled, Medicare also requires physicians and physician practices to "revalidate" their enrollment every five years. Revalidation requires the physician or practice to submit a complete, new enrollment application as if they were enrolling for the first time, subjecting the revalidating physician or practice to the same background checks as a newly enrolling physician or practice. MACs are also permitted to request a revalidation "off-cycle," to conduct random checks, and to conduct checks in cases where fraud or non-compliance is suspected. If the application contains errors and the MAC requires corrections or additional information, billing privileges will reach back to only 30 days before the corrected application was submitted. If a physician is terminated or leaves, the practice will have to file another CMS-855R to end the reassignment.

## ON-GOING REPORTING

Even after CMS awards a physician or practice Medicare billing privileges, they will face ongoing requirements to report any changes to their information, with different reporting deadlines depending on the nature of the change. For example, changes in ownership,

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office or billing agent locations, or "adverse legal history" (such as convictions, loss or suspension of licensure, etc.) must be reported within 30 days. Most other changes must be reported within 90 days. If the practice opens a new location (even merely to change where medical records are stored), adds or removes a billing agent, or changes its personnel or corporate officers (as discussed more fully below), it must report each such change within the appropriate timeframe. The following are principal examples of the reporting requirements.

## ADDING AND REMOVING PHYSICIANS, NPS, PAS

Even the seemingly simple task of adding a new physician or terminating the employment of a physician assistant will generate enrollment reporting requirements. Any new physician will need to reassign his or her right to payment to the practice using the CMS-855R enrollment form. If the physician has never enrolled or is new to the MAC's geographic jurisdiction, he or she must complete the CMS-855I as well, and will face all of the hurdles associated with a new enrollment as described above. Timing issues matter here, too. While both the CMS-855I individual enrollment form and the CMS-855R reassignment form can be sent at the same time, the physician will not be able to bill for any services rendered more than 30 days prior to the date that the application was sent, and then only if the application can be processed successfully by the MAC.

Physician assistants present additional wrinkles. While nurse practitioners and other non-physician practitioners follow the same enrollment process as physicians, physician assistants are treated differently. Physician assistants must still complete a CMS-855I individual enrollment form when first enrolling. However, because they are not reimbursed directly for their services and Medicare payment is only made to their employers, physician assistants do not reassign their right to payment using the CMS-855R. Similarly, while a practice employing a physician assistant is not required to list the physician assistant on its initial CMS-855B, the practice must report when that physician assistant's employment terminates.

## AUTHORIZED OFFICIALS VS. DELEGATED OFFICIALS VS. MANAGERS

One confusing aspect of the enrollment process pertains to reporting of personnel in certain positions of control or management. The CMS-855B enrollment form for medical groups requires that practices report information about the practice's "authorized officials" and "delegated officials." An authorized official is an employee of the practice, usually a corporate officer, such as a CEO or COO, with the authority to complete the Medicare enrollment forms, and to legally bind the practice to them using his or her signature. This person need not be a physician. A delegated official must be an employee of the practice who is granted authority by an authorized official to make changes to and complete the Medicare enrollment forms. However, delegated officials cannot be independent contractors to the practice. Wholly separate from these two positions, practices must also report all 5 percent-or-more owners, all partners (regardless of any percentage ownership), and any employees or independent contractors with managerial authority. To make matters more confusing, both authorized and delegated officials must be reported in this section of the forms, even if they are not owners or partners.

In practical terms, this means that the practice CEO must be listed as a managing employee, and may also be listed as an authorized official. Each practice must have at least one authorized official, but the practice may designate any person meeting the criteria. The authorized official may choose to designate a delegated official to handle the completion and management of the Medicare enrollment forms, but is not required to do so. Be aware — if your practice uses a management company to handle most administrative duties, an employee of the management company cannot act as your delegated official. Yet all three — an authorized official, delegated official, and independent contractor with management authority — must be listed in the section of the form relating to individuals with ownership or control of the practice.

## PRACTICAL TIPS

Because of the effect on cash flow of even minor errors in managing Medicare enrollment, this process should be handled by a detail-oriented manager willing to learn the nuances of the rules, keep information current, and get help when necessary. Always retain a copy of any application form you submit and make sure all forms are sent by a method that produces a dated receipt of delivery. Doing so will help you to keep track of what was said in the past, so that you know what to update when changes occur. The receipt will be important as evidence of the submission date if something goes awry. Every practice should conduct periodic reviews of its enrollment documents to make certain all information is current. Finally, you can ask a health lawyer who is familiar with the enrollment process to help. ***dw***

**SHAY AND GOSFIELD** have written extensively about Medicare enrollment issues; learn more at www.gosfield.com/publications.htm.