Maintaining Medicare Enrollment Data: Managing the Ongoing High-Hurdles Race

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The Medicare system faces a demographic crisis. As Baby Boomers continue to retire—no longer contributing to the tax base that supports Medicare—they also are drawing down on the Medicare system. In the annual 2018 report to Congress by the Board of Trustees for the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, it was expected that Medicare expenditures would increase from 3.7 percent of gross domestic product (GDP) in 2017 to 5.9 percent of GDP by 2042, "largely due to the rapid growth in the number of beneficiaries." In addition, the Medicare trust fund for Part A was projected to be depleted by 2026. Along with other efforts to control the outflow of funds from the system, Medicare has made it increasingly difficult for physicians and physician groups to obtain and maintain billing privileges (referred to as the "enrollment" process)—essentially making it harder to get and maintain access to the funds in the first place.

This article attempts to explain certain aspects of the enrollment process and to highlight particular pitfalls that often bedevil physicians. Within Medicare parlance, physicians and physician practices are referred to as "suppliers," whereas entities that bill Medicare Part A, such as hospitals and nursing facilities, are typically referred to as "providers." Because of how the regulations refer to them, this article will use the "supplier" terminology that Medicare uses when discussing physicians and physician practices.

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Enrollment Generally

Originally, Medicare enrollment could be accomplished by submitting a one-page form. Those days, however, are long gone. The current process involves either submitting paper CMS-855 application forms (the length of which varies, depending on the type of form submitted) or submitting information via the Provider Enrollment, Chain, and Ownership System (PECOS) Web site.

Medicare suppliers must submit a range of information, including the corporate name for the group, copies of licenses, certification statements signed by an "authorized official" such as a chief financial officer (CFO) or chief executive officer (CEO), business address, adverse legal history, etc.

In general, processing times for PECOS enrollment applications are required to be faster for the Medicare administrative contractors (MACs) than processing times for paper applications. As a result, we generally advise using the PECOS system where possible. The PECOS system also permits suppliers to upload a signature page for the application electronically, rather than rely on the mail, which can affect a supplier's effective date of billing privileges.

To bill Medicare at all, the supplier's MAC must grant billing privileges. The effective date of such privileges is the latter of (1) the date of filing an enrollment application that was subsequently approved by the MAC, or (2) the date the supplier began furnishing services to Medicare beneficiaries[1]; however, the Centers for Medicare & Medicaid Services (CMS) permits suppliers to bill for services rendered no more than 30 days *prior* to their effective date of billing privileges.[2]

In practice, what this means is that an application which is submitted by a supplier which is *not* successfully processed delays the effective date of billing privileges. All suppliers must be operational before being granted billing privileges. Thus, the effective date of such billing privileges is essential to ensuring that services provided prior to that date can actually be billed to Medicare. Each time a MAC makes a "development request" (*e.g.*, asking for additional documentation or corrections to the application), it delays the effective date and puts billings at risk. The PECOS system—as opposed to paper applications—is therefore preferable for two reason. First, application processing times are shorter for electronic submissions than for paper submissions, which means a shorter waiting time to actually be paid for past claims (even when there are no development requests). Second, there is no possibility of the application being lost in the mail or misplaced on a MAC enrollment specialist's desk.

This also applies to a revalidation, which is where the supplier is already enrolled in Medicare but recertifies the accuracy of their enrollment data by submitting a complete new application. Medicare suppliers must submit a revalidation every five years, although MACs may request revalidations outside of this five-year "cycle." These "off-cycle" revalidation requests may be triggered by "random checks, information indicating local health care fraud problems, national initiatives, complaints, or other reasons that cause CMS to question the compliance of the provider or supplier with Medicare enrollment requirements."[3] In addition to off-cycle revalidations, MACs are also permitted to perform "additional off-cycle revalidations," effectively allowing MACs to perform multiple off-cycle revalidations on a supplier. Failure to revalidate appropriately will result in the deactivation of a supplier's billing privileges.

In addition to revalidations, suppliers must report changes in their enrollment data. Most changes must be reported within 90 days; however, changes in ownership, adverse legal actions, and changes in practice locations must all be reported within *30* days. The term "adverse legal action" is not defined in the regulations (which instead describe "final adverse actions") but generally is meant to include revocations of Medicare billing privileges, suspension or revocation of state licensure, suspension or revocation of accreditation by the accrediting organization, conviction of a federal or state felony offense within the last 10 years, or exclusion or debarment from federal or state health care programs.[4]

Denial, Revocation, and Deactivation

Denial of an enrollment application occurs when the supplier is initially enrolling or revalidating their application, and the application is rejected by CMS or the MAC. Revocation occurs when the supplier has already applied for and received billing privileges, but those privileges are revoked.

Denial or revocation may occur for multiple reasons. These include where the supplier, an owner, a managing employee, or an authorized or delegated official, or other person providing Medicare reimbursable services who is reported on an enrollment application is excluded from the Medicare program. Denial or revocation can also occur if a supplier, an owner, or a managing employee was convicted within the past 10 years of a federal or state felony that CMS determines is detrimental to Medicare and its beneficiaries. "Conviction" can include pleas of *nolo contendere* and pretrial diversion programs such as deferred adjudication or first offender programs where conviction is withheld, as well as circumstances where a conviction is awaiting resolution of a post-trial motion or appeal.

The types of crimes CMS considers detrimental to the Medicare program include violent crimes such as murder or battery and financial crimes such as embezzlement, insurance fraud, and income tax evasion. Other felonies CMS considers detrimental include felonies that place the Medicare program and its beneficiaries at immediate risk, such as malpractice suits that result in conviction of criminal neglect or misconduct. Any denial or revocation on these grounds will last for at least 10 years from the date of the conviction if the individual has been convicted on a previous occasion for one or more offenses.

Both denial and revocation also can occur when the supplier submits false or misleading information on an enrollment application or fails an onsite review because it is not operational to provide Medicare services to the public. Failing to satisfy any other enrollment requirement can also trigger a denial or revocation, such as where the supplier has outstanding Medicare debt or previously owned a Medicare supplier that had Medicare debt when its enrollment was voluntarily or involuntarily terminated and the owner left within a year of termination or revocation, the debt has not yet been repaid, and CMS determines that the unpaid debt poses an undue risk of waste, fraud, or abuse. CMS can also impose temporary moratoria on enrollment, thereby guaranteeing a denial without regard to whether the supplier's application was appropriate.

Revocation can also occur if the supplier sells their billing number or allows someone else to use the number, or submits claims for deceased beneficiaries, claims when the rendering practitioner could not have provided the services (*e.g.*, the practitioner was not physically in the state), or claims where the required equipment was not present (*e.g.*, the practitioner claims to have performed a CT scan, but does not have access to a CT machine). Repeatedly submitting claims that fail to meet Medicare billing requirements can also result in revocation. As noted above, failure to report changes in enrollment data within the required timeframe can also result in revocation of billing privileges.

Typically, revocations occur due to combinations of the grounds listed here. For example, if a supplier fails to report the suspension of a managing employee's state license, such failure is grounds for revocation both because of the managing employee's loss of licensure and because of the failure to report the change. With respect to *denials* on grounds of adverse activity of an owner, managing employee, or authorized or delegated official, the denial may be reversed if the supplier terminates its relationship with the individual and provides proof of such termination within 30 days of receiving notice

of the denial. Denials and revocations provide suppliers with appeal rights, granting them the ability to appeal the determination to the MAC, then to an administrative law judge (ALJ), then to the Departmental Appeals Board (DAB), and finally to a federal court.

By contrast, *deactivation* does *not* confer appeal rights. It is instead treated by CMS as "an action to protect the provider or supplier from misuse of its billing number and to protect the Medicare Trust Funds from unnecessary overpayments."[5] The regulations explain that deactivation of billing privileges has no effect on a supplier's participation agreement or on any conditions of participation.

Deactivation can occur for multiple reasons, including failure to submit claims for 12 consecutive months, failure to report changes of information within required timeframes, and failure to provide complete and accurate information and supporting documentation for a revalidation (both on- and off-cycle).[6] Following deactivation, a supplier may apply for reactivation of billing privileges. In almost all cases, this requires submission of a new enrollment application (the one exception being where deactivation was for 12 months of billing inactivity), which subjects the supplier to the same processing and time considerations that an initial application does.

Likely Pitfalls

Medicare suppliers frequently face difficulties in maintaining Medicare billing privileges due to issues with their enrollment data. Certain common fact patterns, however, appear in ALJ and DAB opinions which indicate areas which prove especially difficult for suppliers.

One such common problem area is that of failed revalidations, due to the supplier's failure to effectively manage its enrollment data. Typically, this begins with the supplier being contacted by the MAC for a revalidation (either on- or off-cycle). The MAC, however, sends the notification letter to an out-of-date mailing address. The supplier never receives the notification and only later discovers its billing privileges have been deactivated due to a failure to revalidate. The supplier then submits an application to reactivate its billing privileges. Meanwhile, during the period in between the date of deactivation and the effective date of reactivation of billing privileges, the supplier cannot submit claims to Medicare patients. This is typically referred to as a "gap period." Depending on its length, if the supplier submits claims for services rendered during the "gap period," they may be denied.

Prior to March 2019, CMS would deny *all* claims rendered during the "gap period"; however, a change in Medicare policy was published that at least permits suppliers attempting to reactivate deactivated billing privileges the ability to retrospectively bill for services rendered up to 30 days prior to their effective date of reactivation. Still, a deactivation places pressure on the supplier to reactivate privileges as soon as possible, to avoid rendering noncompensable services. Suppliers also must understand that they do not have a right to appeal either the grounds for or the date of deactivation.

Neither an ALJ or the DAB has jurisdiction to address those matters. Even errors by the MAC in deactivating a supplier's billing privileges are not reviewable by the ALJ or DAB. In one case, a supplier claimed that the MAC had sent the notification to the wrong mailing address, that the supplier had correctly updated its address, and provided an email confirming that the supplier's billing agent had submitted an enrollment application to prove that the supplier updated the information.[7] In response, the DAB stated that these facts were irrelevant, since they went to the date of deactivation, over which the DAB had no jurisdiction.

Another area of concern is suppliers who face revocations for failure to

properly report information, or who submit improper claims. These suppliers have had similarly poor luck with ALJs and the DAB when attempting to claim that the revocation is itself improper due to a range of circumstances. Ultimately, if the revocation is facially appropriate, the ALJs and DAB are likely to uphold them. For example, in one case, a supplier attempting to enroll had been convicted of a felony within 10 years of submitting the application and had also been excluded from Medicare.[8] The supplier neglected to note the felony conviction on the application but did note the exclusion. When the supplier's billing privileges were revoked, the supplier claimed that CMS was aware of the conviction and thus revocation was inappropriate. The ALJ disagreed, noting that the supplier still had a duty to notify CMS and submit an accurate application.

In another case, a supplier relied upon a credentialing company to submit information on the supplier's behalf. The credentialing company neglected to report a previous revocation on the application. As a result, the supplier's privileges were revoked. The supplier argued to the ALJ that it had filed a lawsuit against the credentialing company, but that it was the credentialing company's negligence that was to blame, and that revocation should not stand. The ALJ, however, rejected this argument, stating that the supplier had a duty to review the submission by the credentialing company and that the supplier's CFO had signed the application indicating it had not been the subject of any adverse legal action (which was clearly incorrect). Thus, even if a third party included false information in the application, it is ultimately the supplier's responsibility to ensure the accuracy of the submission, and the certification of the supplier's authorized official binds the supplier to whatever is contained in the application.

A third case involved a supplier who had its billing privileges revoked for submitting 81 claims for services rendered to patients who were themselves deceased at the time the supplier claimed to provide the service.[9] When the supplier's billing privileges were revoked, the supplier claimed that the inappropriate bills had been sent in due to clerical error. Moreover, the supplier noted, it had never been paid for the claims. The ALJ, however, noted that the supplier's intent was irrelevant in determining whether abuse had occurred, and that a pattern of greater than three instances of billing for deceased payments was enough to support the revocation.

The main takeaway from the cases involving improper billing and failure to report certain information is that ALJs and DAB will not care about suppliers' arguments that they should be given special consideration when attempting to undo a revocation. The ALJs and DAB will instead stick to the regulatory language, and as long as the revocation fit the confines of the regulations, it will stand.

Practical Solutions

The simplest way for suppliers to avoid problems like these is to regularly update and maintain their enrollment information. This information should be maintained by someone familiar both with the requirements for reporting and with the relevant facts for the supplier. Consider the example of the failed revalidations that result from a notice being sent to an incorrect address. In addition to reporting current information, suppliers should be actively scrubbing their accounts to remove out-of-date information. This includes addresses, reassignments, etc.

Several years ago, we represented a client that had cut ties with a physician for over a decade; however, the physician was still listed as reassigning his right to payment to the client. When the physician lost his license to practice, the client did not report it…because the client had not worked with the physician in over 10 years. Still, the client's billing privileges were revoked. We managed to get the

privileges reinstated without any real loss of billings, but this was only by proving (1) that the physician hadn't worked with the client in ages, and (2) that the obligation to report his departure did not even exist at the time he left. Had that not been the case, the client might have lost billing privileges.

The same is true of practice location data. Old addresses should be removed as soon as the supplier no longer uses the location. This will avoid correspondence being sent to an incorrect address. Suppliers must understand that, even if they list a different address as their primary correspondence address, MACs legitimately can send information to any address listed in the account. Thus, an outdated address where a supplier has not worked in years and is no longer receiving mail forwarding can end up receiving notifications from the MAC—to the supplier's detriment—if the address is still listed.

On a related note, suppliers should ensure that they use genuinely knowledgeable individuals to maintain enrollment data. In some cases, office staff simply are not equipped or familiar enough to tackle this task. Maintaining enrollment data is highly detailed work, requiring careful attention to deadlines and an overall understanding of both what triggers a duty to report and the potential impact of failing to do so. Toward this end, suppliers may want to avail themselves of expert assistance, such as credentialing companies; however, even if the supplier uses such help, the supplier must still ensure that all of the information being submitted is accurate. As has been demonstrated in ALJ and DAB cases, the expert's failure will still be attributed to the supplier for billing privilege purposes.

Suppliers likewise should not count on the appeals process to save them if something goes wrong. Given the language of the regulations and the limited authority delegated to ALJs and the DAB, they often lack the ability to deviate from the precise wording of the regulations. Without clear evidence that a MAC has acted improperly, it is unlikely the ALJs or DAB will find against a MAC in most cases. Even improper conduct on the part of the MAC may be insufficient if the supplier is also shown to have technically violated the regulatory requirements, or if the issue is outside of the authority of the ALJ or DAB (*e.g.*, dates of deactivation).

Conclusion

All of these issues should be addressed in a supplier's compliance plan. The same way that the supplier would have a compliance officer or a Health Insurance Portability and Accountability Act (HIPAA) officer, they should consider having a Medicare enrollment officer responsible for maintaining Medicare enrollment data. Policies for responding to changes in information and the appropriate process for individual practitioners or staff to report such information to the Medicare enrollment officer also should be added to such a plan. Regular enrollment data checks should be made to ensure that information is current, and old information is removed as necessary. Suppliers should respond quickly to requests for revalidation, to avoid having their billing privileges deactivated and losing billings during a "gap period" before reactivation. Knowledgeable legal counsel can assist in all of these efforts, to help suppliers prevent deactivations, revocations, or denials of billing privileges.

Endnotes

1. 42 CFR § 424.520(d).
2. 42 CFR § 424.521.
3. 42 CFR § 424.515.
4. 42 CFR § 424.502.
5. 42 CFR § 424.540(c).
6. 42 CFR § 424.540(a).
7. *Hieu Ball, M.D., Inc. v. CMS*, ALJ CR5002, December 29, 2017.
8. *Breton L. Morgan, M.D., Inc. v. CMS*, CR5014, January 30, 2018.
9. *Scanameo v. CMS*, CR5001, February 6, 2018.

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