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Lost Revenue, Overpayments and Harsh Sanctions — Updated CMS Enrollment Rules

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Two changes to the Medicare enrollment rules are not well understood and, unfortunately, the financial implications are significant when the rules are not followed. More recently, CMS is announcing enrollment rule changes in conjunction with the publication of the physician fee schedule rules, rather than publishing regulations specific to the Medicare enrollment process, making it more difficult to monitor enrollment rule changes.

Failure to Report Certain Changes in Enrollment Data

Prior to the 2006 changes in the Medicare enrollment rules, there were no sanctions that could be assessed when a provider or supplier failed to timely update its enrollment data as required under federal rules. With the 2006 rule changes came the authority for CMS to deactivate or revoke billing privileges for certain provider and supplier actions or inactions, including the failure to update enrollment data or respond to a revalidation request. An overview of the 2006 enrollment rule changes appears in an Ober|Kaler Health Law Alert article, "**New Enrollment Regulations: Protect Your Current Medicare Participation**."

CMS continued to express concern that enrollment data was not always accurate and published additional enrollment regulations on June 27, 2008. CMS not only highlighted situations in which billing privileges could be denied or revoked, but also granted Medicare contractors the discretion to establish a one- to three-year period of time in which the provider or supplier who is subject to a revocation action is barred from seeking re-enrollment in the Medicare program. CMS did indicate that the length of the re-enrollment bar should reflect the severity of the basis for the revocation. A more detailed overview of these 2008 enrollment rule changes was provided in an Ober|Kaler Payment Matters article, "**Are You At Risk For Losing Your Medicare Billing Privileges?**"

Concerned that providers and suppliers have no incentive to report certain changes, especially a sanction that could affect the provider's or supplier's enrollment status, CMS increased the penalties for non-reporting effective January 1, 2009. Prior to this latest change, CMS did not believe it had the

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authority to initiate an overpayment action following a revocation of billing privileges. When CMS proposed the 2009 Physician Fee Schedule rules, it announced its intention to adopt regulations giving CMS the authority to assess an overpayment in situations when a provider or supplier failed to report certain adverse actions or a change in practice locations. These rules were finalized and became effective January 1, 2009. **Transmittal 295 [PDF]**, which made the corresponding changes to the provider enrollment rules in Chapter 10 of the Program Integrity Manual, confirms that an overpayment action can only be taken for services provided after January 1, 2009, even if the revocation is effective as of an earlier date. Therefore, in addition to the financial implications of a one-three year bar for re-enrollment, a revocation action may now be followed by an overpayment action for services that had been provided during the period in which the enrollee had billing privileges revoked. Since the failure to report a change in enrollment data is likely to have a prior effective date (i.e., effective as of the date of the change that was not reported), the overpayment amount may be significant.

Supplier Enrollment Effective Date

Effective January 1, 2009, CMS changed the enrollment rules with regard to the effective date of a supplier's enrollment. This particular change not only affects a new enrollment for a physician or non-physician practitioner, but it also applies to the effective date of a re-assignment. When the proposed 2009 Physician Fee Schedule rules were published, CMS announced its intention to change the rules regarding the effective date of a suppliers Medicare enrollment and solicited comments for one of two options. A prior Payment Matters article, **"Act Now or Risk Losing Ability to Bill for Services Prior to Obtaining Medicare Enrollment,"** was written in response to the proposed rule and highlights the two options that CMS proposed and the particular suppliers that would be affected by this enrollment rule change.

Despite numerous comments to maintain the status quo, CMS implemented the change to the supplier's enrollment effective date, making it the *later of* (1) the date services were first provided *or* (2) the date that an enrollment application (which is ultimately processed) is received. For the second prong the key is that the enrollment application must be processed and, when it is, the date it was initially received (and date stamped) by the enrollment contractor is the effective date of the enrollment or reassignment. Therefore, it is important to be sure that the application that is filed is both complete and accurate with all required supporting documents enclosed.

CMS did allow a 30-day look-back period, such that an enrollee could bill for services provided within the 30-day period prior to the effective date of enrollment. There was also a 90-day prior billing period exception included in the final rule for certain declared national disasters. Under the prior rules, a supplier could bill for services that had already been provided so long as the time period for filing a claim has not expired, which in some cases was as much as 27 months prior to the completing the Medicare enrollment or reassignment process. Since this ability to bill for prior services existed, obtaining Medicare credentialing was not often the first priority when hiring or contracting with a new physician or non-physician practitioner.

In making such a drastic change to the enrollment effective date, CMS included a revision in the final rule that was designed to provide relief for an applicant that submitted an incomplete application that could not be processed. CMS indicated it would require enrollment contractors to deny billing privileges rather than reject the application. There is no appeal right to a rejected application, but a denial of billing privileges entitles the applicant to pursue both a Corrective Action Plan and an appeal. The entitlement to the appeal process preserves the earlier filing date as the effective date of enrollment, if the appeal is successful.

Ober|Kaler's Comments: Providers and suppliers need to implement systems

to ensure that enrollment data is accurate and that any reportable enrollment data change is timely made. When hiring or contracting with physicians and non-physician practitioners, consider starting the Medicare enrollment or reassignment process in advance of when the individual starts to provide services. And, if an application is rejected rather than being denied, try to obtain a denial so that the earlier effective filing date can be preserved.