



June 24, 2011

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CLIENT ADVISORY

The CMS-855 Medicare Enrollment Process: Requirements to Establish and Maintain Medicare Enrollment

Any health care provider or supplier who wishes to participate in Medicare must first enroll with the program. In 2006, the Centers for Medicare and Medicaid Services (CMS) amended the requirements for health care providers and suppliers to establish and maintain their Medicare enrollment. CMS also revised the CMS-855 forms required for enrollment.

In 2010, the Affordable Care Act (ACA) established a number of additional requirements for providers aimed at preventing and detecting fraud and abuse that have implications for the Medicare enrollment process. A new Final Rule is in place, effective March 25, 2011, implementing the new requirements. While all Medicare physicians, providers, and suppliers should continue using the most recent version of the CMS-855 Medicare enrollment application, there are a number of recent changes relevant to provider enrollment.

This guide will serve as a quick reference regarding the policy and process changes that providers and suppliers will face as they seek to initially enroll, update, and re-enroll as a Medicare participant using the applicable CMS-855 Medicare enrollment form. Links are provided throughout this document directing current and prospective participants to the required forms available at the Centers for Medicare & Medicaid Services (CMS) website. General information, including answers to frequently asked questions regarding the enrollment process, is also available at the CMS website:

➤ <http://www.cms.hhs.gov/MedicareProviderSupEnroll/>

Medicare Enrollment Policies

Purpose

The stated purpose of many of the steps in the Medicare enrollment process is to deter Medicare fraud and abuse. The applicable regulations are intended "to protect beneficiaries and the Medicare Trust Funds by preventing unqualified, fraudulent, or excluded providers and suppliers from providing items or services to Medicare beneficiaries or billing the Medicare program . . ."

Temporary Moratorium

Under Medicare, CMS may impose moratorium on the enrollment of new Medicare providers and suppliers in renewable six month increments. The

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moratoria do not apply to existing providers and suppliers “unless they were attempting to expand operations to new practice locations where a temporary moratorium was imposed.” The moratoria also do not apply when there are changes in ownership, mergers, or consolidations involving existing providers or suppliers. The temporary moratoria will not be reviewable immediately at the judicial level, but must be appealed administratively through the Departmental Appeals Board (DAB).

Temporary moratoria may be put in place for four main reasons. First, CMS may initiate moratoria if it finds “high risk of fraud, waste or abuse” for a specific provider or supplier type, geographic region, or both. Second, a temporary moratorium may be placed when a state places a moratorium on Medicaid providers and suppliers that also have enrollment in the Medicare program. Third, CMS may reciprocate if a state imposes moratoria on providers or suppliers in a specific geographic area or on a certain type of provider or supplier, or both. Finally, moratoria can be imposed if CMS identifies a certain supplier or provider type or a particular region as “having a significant potential for fraud, waste or abuse in the Medicare program.” This conclusion must be reached in consultation with the U.S. Department of Justice, the OIG, or both. There are also certain conditions that provide for lifting of a moratorium. Absent moratoria, enrollment of a new provider or supplier to Medicare generally should proceed as follows:

Timing

Initial and re-enrollment in Medicare is handled by the Medicare Administrative Contractor (MAC) in the jurisdiction where the provider is located. In Virginia, the MAC is Palmetto GBA. After initial enrollment, CMS requires participants to re-enroll with Medicare at a minimum of every five years to verify that their enrollment information is accurate. Participants also have a duty to update their enrollment application if any information changes. Additionally, the MAC may require a provider to verify enrollment information at any time, and may conduct unannounced site-visits to confirm the accuracy of information provided by participants.

Certifying

The sole proprietor, practitioner, or other official who has legal authority to enroll the organization in the Medicare program must sign the 855 application forms. This individual must have an ownership or control interest in the corporation. If the application is being changed or updated voluntarily by the provider, then signature authority may be delegated to another individual within the organization.

In addition, Section 6 of the application requires individuals with either ownership interest or management control to provide personal information, such as social security numbers, and a list of any adverse legal actions. This information is used to ensure that such individuals have not been excluded from participation in any federal healthcare program.

Change of Ownership (CHOW)

If a facility or provider is sold, both the current and prospective owner must submit a Medicare application, or otherwise face sanctions or penalties including deactivation of the Medicare billing number. The regulations prohibit billing numbers from being sold or transferred to another entity. Because of concern over home health agency (HHA) proliferation, on November 2, 2010 CMS adopted a Final Rule that prohibits transfer of a provider agreement and corresponding provider number to the new owner of an HHA if the change of ownership takes place within thirty-six months of the HHS’s enrollment in Medicare.

Rejection and Denial

Medicare contractors may reject and return an application for a number of reasons. Common reasons for rejection of an application include no signature on the application or a copied or stamped signature, an undated signature, a signature by someone other than the individual practitioner or not signed by an authorized official, failure to submit all the necessary forms, Part A change of ownership applications submitted more than three months before anticipated date of sale, Part B supplier applications received more than 30 days prior to effective date listed on application, and inclusion of a CMS-588 (Electronic Funds Transfer Agreement) form without an original signature or date. If an application is rejected, providers or suppliers must submit a new application.

For other types of problems in applications, the Medicare contractor may send a notice of lacking information. Failure to respond timely to such a notice (within 60 days) can result in a provider being denied enrollment in the program, which may be appealed.

Revocation and Appeal

If the MAC revokes a Medicare provider agreement, the provider must submit a new application. Major causes of revocations include failure to respond to revalidation requests issued to Part B individual practitioners or groups, contractor site visits that identify closed practice locations, failure to provide updated bank account information, failure to report licensure suspension or revocation, failure of DMOPOS providers to comply with DME standards, and failure to report adverse legal actions or convictions. As a specific example, the MAC may revoke billing privileges if a provider neglects to report a change in ownership, adverse legal action, or change in practice location within 30 days, or fails to report *any* other change to its enrollment information (even contact information or board members) within 90 days. Providers may appeal revocation determinations by MACs. Re-enrollment in Medicare requires a new survey, provider agreement, and billing number. If CMS revokes a provider's application for one facility, then CMS will subject all other applications by that provider to review for accuracy.

Deactivation and Reactivation

The Medicare contractor may also deactivate a provider's billing number for a period of time, during which no claims will be paid. A provider number may be deactivated if a provider or supplier fails to submit claims for a period of 12 months or longer, fails to report information changes within 90 calendar days, fails to report a change in ownership or control within 30 days, or fails to submit lacking information requested by the contractor within 30 days. A provider must submit a new application in order to reactivate an application, but this does not require a new survey, provider agreement, or billing number. Providers may also generally receive payment for services rendered between deactivation and re-enrollment.

Suspension of Payments

While not directly related to enrollment, providers should be aware of policies allowing for suspension of payments. The Secretary may suspend payments to a provider pending an investigation of a "credible allegation of fraud" unless the Secretary determines that there is good cause not to suspend payments. New 2011 rules extended the definition of "credible allegation of fraud" to make suspension actions more frequent, as the new definition includes "an allegation, which has been verified by the State, from any source,

including, but not limited to" fraud hotline complaints, claims data mining, patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Medicare Enrollment Process

1. *CMS-855 Medicare Enrollment Application*

To enroll in Medicare, the provider or supplier must first complete the appropriate version of the CMS-855 Medicare Enrollment Application:

- CMS 855A—Medicare Enrollment Application for Institutional Providers.
- CMS-855B—Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers.
- CMS-855I—Medicare Enrollment Application for Physicians and Non-Physician Practitioners.
- CMS-855R—Medicare Enrollment Application for Reassignment of Medicare Benefits.

The forms (and accompanying instructions) can be downloaded in PDF format from the links at the CMS website:

- <https://www.cms.gov/CMSForms/CMSForms/list.asp>.

Section 17 of the applicable CMS-855 form lists the supporting documentation that is required to be submitted with the enrollment application. In addition to the items previously required, all applicants must include the additional materials described in the following paragraphs:

2. *National Provider Identifier (NPI)*

The provider or supplier must submit its National Provider Identifier (NPI) and a copy of the NPI notification provided by the National Plan and Provider Enumeration System with each enrollment application. An NPI can be obtained by submitting the National Provider Identified (NPI) Application/Update Form:

- <http://www.cms.hhs.gov/cmsforms/downloads/cms10114.pdf>

3. *Authorization Agreement for Electronic Funds Transfer*

For initial enrollments, or if the provider or supplier is not currently receiving payments via EFT, the applicant must file the CMS-588 Authorization Agreement for Electronic Funds Transfer:

- <http://www.cms.hhs.gov/cmsforms/downloads/CMS588.pdf>

4. *Supporting Documentation Required by Your Fee-for-Service Contractor*

The Medicare fee-for-service contractor will process enrollment applications. In Virginia, the contractor is Palmetto GBA. The provider or supplier should be prepared to respond to any requests by the contractor for additional information or materials. The following chart provides contact information for contractors in each state:

- http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/contact_list.pdf

5. Application Fee

Finally, all prospective institutional providers submitting an initial application or currently enrolled institutional providers that are submitting an application to establish a new practice location must pay an application fee. The application fee was established at \$500 for 2010, and is adjusted each year based on the consumer price index. Providers may request a hardship exception to the application fee at the time of filing a Medicare enrollment application.

Further Information

As the MAC for Virginia, Palmetto GBA provides educational materials for providers who need assistance with the Medicare enrollment or claims processing after enrollment. A service that may be particularly helpful to newly enrolled providers, upon request, Palmetto GBA provides in-service education targeted to the particular needs of each health care provider.

In addition, for answers to questions that are not answered on Palmetto GBA's website, Palmetto GBA allows providers to submit specific questions to be answered at quarterly "Ask-the-Contractor" teleconferences held by the Provider Outreach and Education Advisory Group. While questions submitted prior to the teleconferences are answered during the calls, Palmetto GBA posts written minutes containing answers within 30 days of the call on their website. The forms section of the Palmetto GBA website contains forms to request either in-service education or to submit a question for the quarterly teleconferences:

- <http://www.palmettogba.com/palmetto/providers.nsf/docsCat/Providers~Jurisdiction%2011%20Part%20A~Resources~Forms?open&expand=1&navmenu=Resources>

Conclusion

The Medicare enrollment, update, and re-enrollment process requires providers to carefully and accurately submit information to CMS. Mellette PC has experience in guiding health care providers through the intricate and often burdensome Medicare enrollment process and advising providers on Medicare obligations and enforcement issues. If your organization needs assistance in navigating the Medicare enrollment process, interpreting information updating requirements, or understanding enforcement rules, please contact Peter Mellette (peter@mellettepc.com), Harrison Gibbs (harrison@mellettepc.com), or Nathan Mortier (nathan@mellettepc.com). Mellette PC can be reached by phone at (757) 259-9200.