It's a government program. Did you expect it to be easy?

Medicare Enrollment: Staying in the Game Even When the Rules Change

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Even before the economic meltdown of September 2008, the Centers for Medicare & Medicaid Services (CMS) jealously guarded the Medicare fund, using a range of mechanisms to control access to Medicare dollars. From MACs and RACs (Medicare administrative contractors and recovery audit contractors) to pre- and post-payment audits to fraud and abuse legislation, CMS has been dedicated to controlling and limiting the amount of money Medicare pays to physician practices and other providers. Last year, with the publication of the 2009 Medicare Physician Fee Schedule, CMS further increased its control over who gets access to Medicare funds in the first place by making major changes in the enrollment process and CMS-855 enrollment forms. These changes not only affect new Medicare providers but also have practical implications for those physicians who have long been enrolled in Medicare. And the process is anything but simple.

Physician practices once were able to stay enrolled indefinitely (barring revocation of billing privileges). Today, they must "revalidate" every five years, at which time they must submit a complete new enrollment application. In addition, practices must update their information within specific time frames whenever certain changes occur. Failure to keep your enrollment information up-to-date may result in a revocation of billing privileges, imposition of overpayment penalties or exposure to false claims liability. This article answers common questions and focuses on how to avoid problems you may face in the enrollment process. You can find additional information on the CMS web site at http://www.cms.hhs.gov/MedicareProviderSupEnroll/.

Which form do we use?

There are three enrollment forms for physicians: 855B for physician practices (and other entities such as diagnostic testing facilities), 855I for individual physicians and nonphysician providers, and 855R for those who are reassigning benefits to another entity. These forms can be found online at http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp. If you use an out-of-date version of the form, it will be returned to you unread and you will have to start the submission process all over again. If in addition to using an older form you make errors in the substance of the application or omit required information, the problems will not be pointed out until the correct forms are submitted and reviewed.

At the time of this writing, most of the current forms carry a revision date of February 2008, although the 855B and 855I forms were revised in July 2009. (The date is indicated in the lower left-hand corner of most pages of the enrollment form.) What makes this portion of the process confusing and frustrating, as some physicians have reported, is that CMS regional contractors may not have updated their web sites to include the most recent forms. This, however, has not stopped them from rejecting applications submitted on out-of-date forms, even when the forms came from their web sites. To avoid such problems,

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Today, practices must "revalidate" every five years, at which time they must submit a complete new enrollment application.

Maintaining your status as a Medicare provider has recently become much more complex.

You must complete the most recent version of the correct application form every five years to stay enrolled as a provider.

The forms are complicated and confusing, and varying deadlines apply to different parts of the application process.

you can complete the application using CMS' online enrollment system, known as the Provider Enrollment, Chain and Ownership System (PECOS; see https://pecos.cms.hhs.gov). This will help eliminate the danger of using an outdated form, although some physicians and other providers have reported difficulties accessing the system.

When do we have to … ?

The new enrollment and revalidation rules impose different deadlines on different parts of the enrollment process. For example, if your business changes its legal business name, you must report the change within 90 days. In contrast, changes of location and "final adverse actions" (including suspensions of state licenses, revocations of billing privileges, felony convictions, etc.) must be reported within 30 days. Physician practice applications (855B forms) must be accompanied by a plethora of additional documentation (including a completed CMS-588 electronic funds transfer form, necessary reassignment forms, etc.) within 30 days of submission.

Moreover, other changes require that you complete different sections of the 855B form. For example, if your practice hires a new billing company, you must update the section relating to billing agents. If the billing company also provides management services, you must also complete the section on entities with management duties. The management section requires that you report adverse legal actions for any managing entity, including a management company. Much of this is information you might not otherwise think to ask for. All of this information must be collected and submitted within 90 days of the change to the new company.

Authorized officials vs. delegated officials vs. managing employees

The 855B form requires that your practice designate an "authorized official" who can sign the form. The "authorized official" is described as an "appointed official" (like a CEO or CFO) with legal authority to enroll the practice in Medicare. You may also choose to designate a "delegated official" – any individual delegated by the authorized official solely to report changes and updates to enrollment information. A delegated official may not, however, be an independent contractor. He or she must be a W-2 managing employee of the practice but need not be a corporate officer or an owner.

To further confuse matters, the 855B form requires you to list "managing employees," who may be general managers, business managers, administrators, directors or any other individual exercising operational or managerial control over the day-to-day operations of the practice. The relationship may be established by contract or through other arrangements, regardless of whether the individual is actually a W-2 employee.

In other words, in one section of the form, you *may* choose to report a delegated official who *must* be a managing employee *and* a W-2 employee, and in another section of the form you *must* list individuals who are "managing employees" but may in fact only be 1099 independent contractors. So you can't list a management company or any of its employees as the delegated official even if it actually performs the duty of preparing your 855 forms. An authorized official or delegated official still needs to sign them.

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Denial vs. rejection

Denial and rejection of an enrollment application have two very different results. A practice that is determined ineligible for enrollment (for example, due to adverse legal history, or because a CMS on-site review determines that the practice is not qualified to provide Medicare services) will have its 855B form denied by the local CMS contractor. The practice may appeal a denial within 60 days but may not hedge its bets by submitting a new application in that time. Resubmissions during this period will be returned. If you choose to appeal a denied application, you cannot resubmit unless there is a final determination upholding the denial.

Rejection, on the other hand, means that there was some deficiency in the application itself that was not corrected within the required time. Grounds for rejection include failure to submit all required information within 30 days of the application or failure to respond to CMS requests for additional information within 30 days. Rejections cannot be appealed. Instead, you must submit the entire application again.

Back-billing restricted

Finally, in perhaps the biggest change with direct financial impact, you may no longer "back-bill" for services rendered before your practice was approved for enrollment. Whereas physicians used to be able to bill for services provided up to 27 months before the date of enrollment, the absolute earliest billing date is now 30 days before the date on which you submit a complete application that is successfully processed. However, even this 30-day window is restricted to cases where circumstances prevented earlier enrollment. CMS has yet to define these circumstances. In most cases, the earliest billing date is the date on which you submitted a successfully processed application. Unfortunately, this may not be as simple as it sounds. Suppose you send in a completed 855B form on Jan. 1, and are notified by the contractor of a deficiency in the application on Jan. 15. You correct the problem and supply the information on Jan. 30. The application is complete, and you are awarded billing privileges 60 days later. Under this scenario, you may only bill for services rendered on or after Jan. 30 – the date your application was complete. If your application is rejected, however, you won't be able to bill for services rendered before the day when your *reapplication* is complete.

Getting it wrong

Failure to properly maintain your enrollment can have dire consequences, not the least of which is the loss of billing privileges. Even though you can appeal the loss of billing privileges, your Medicare cash flow will be halted while the appeal is pending. Worse yet, if you fail to maintain enrollment, you may face federal False Claims Act (FCA) liability. Courts have held that submitting false reports or certifications that are required by the government to be paid (e.g., billing Medicare when you do not qualify for enrollment, when you have failed to properly update your enrollment forms or, in the case of a hospital, while failing to meet Medicare's conditions of participation) can be enough to create liability under the FCA. Negligence alone will not create liability, but deliberate ignorance or reckless disregard of the truth is enough to prove you knew the claims were false. In addition, if you fail to disclose an event that affects your right to payment with the fraudulent intent to be paid, you could be found guilty of a felony punishable by up to a $25,000 fine or imprisonment for up to five years (or both).

Conclusions

Both the initial enrollment process and the requirements to maintain enrollment as a Medicare participating physician are anything but simple. There are a host of detailed requirements not even mentioned here. The point is that under the new rules, physician practices must manage and report to their CMS contractor a range of different information and ensure that it remains current. The consequences for failure to maintain enrollment information can be severe. If you have not evaluated your enrollment status, you should. Look at the forms you submitted the last time. You may want to update before you are asked to revalidate. To stay in the game, it will be important to learn the rules and requirements or contact a knowledgeable attorney. FPM

Send comments to **fpmedit@aafp.org.**

If your application is denied for cause, you may appeal, but if it is rejected for some deficiency in the application, you must resubmit the entire application.

Practices are no longer allowed to bill Medicare for services rendered before submission of a successful application, except under special circumstances.

Failure to maintain enrollment can result in cessation of Medicare cash flow and even indictment for fraud.