American Hospital Association

Regulatory Advisory

May 25, 2006

Medicare Enrollment Procedures and New Periodic Enrollment Revalidation Procedures

AT A GLANCE

The Issue:

The Centers for Medicare & Medicaid Services (CMS) published the final rule, *Medicare Program: Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment* in the April 21 *Federal Register*. The rule details the process and requirements for providers and suppliers to enroll in the Medicare program in order to obtain a billing number and Medicare billing privileges. The final rule contains important new requirements that will apply not only to providers enrolling in Medicare for the first time but also to those already enrolled. For example, all providers and suppliers must complete the applicable CMS 855 Medicare Health Care Provider/Supplier Enrollment Application at least once, and enrollment information must be updated and validated every five years.

The rule also describes penalties for providers who do not comply with the enrollment rules and reasons why CMS may reject or deny a provider's enrollment form or revoke a provider's enrollment and billing privileges in Medicare. The final rule, available at www.access.gpo.gov/su_docs/fedreg/a060421c.html, takes effect June 20.

Our Take:

We are pleased that CMS adopted several AHA recommendations in the final rule, especially allowing providers to revalidate their enrollment information less often than CMS had previously proposed. However, we remain concerned about the administrative burden caused by the requirement that all Medicare providers complete the provider enrollment form and the revalidation process. We also are concerned that the increased caseload imposed on already overextended Medicare fiscal intermediaries and carriers could further impede their ability to approve enrollment and issue billing numbers for new Medicare providers in a timely manner.

What You Can Do:

Share this advisory with your senior management team, chief financial officer, billing and coding staff, and key physician leaders.

Further Questions:

Contact Roslyne Schulman, AHA senior associate director for policy, at (202) 626-2273 or rschulman@aha.org.

AHA Regulatory Advisories are produced whenever there are significant regulatory developments that affect the job you do in your community. A five-page, in-depth examination of this issue follows.

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BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) published the final rule, *Medicare Program: Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment* in the April 21 *Federal Register.* The rule, available at www.access.gpo.gov/su_docs/fedreg/a060421c.html, takes effect June 20. In the rule, CMS for the first time sets into regulation the process and requirements for providers and suppliers to enroll in the Medicare program in order to obtain a provider number and Medicare billing privileges. CMS believes this rule will allow it to bar fraudulent or excluded providers from the Medicare program and ensure that Medicare providers are qualified. The provisions in the final rule do not replace other regulations concerning the establishment of provider or supplier agreements, the issuance of provider billing numbers and payment for Medicare-covered services to eligible providers.

AT ISSUE

Enrollment

Requirement to Complete 855 Forms: All providers and suppliers (hereafter referred to as "providers") currently in or newly enrolling in the Medicare program will be required to complete the applicable *CMS 855 Medicare Health Care Provider/Supplier Enrollment Application* at least once. This means that all current Medicare providers who have never completed a CMS 855 form now will be required to do so.[1]

Although this is a primary requirement, existing providers do not need to take any action at this time. CMS, through its carriers and fiscal intermediaries (FIs), will notify providers when it is time to re-certify their Medicare enrollment information.

[1] The **new** Medicare Enrollment Applications (Form 855) are now available on the CMS Web site. Go to www.cms.hhs.gov/MedicareProviderSupEnroll and click on "Enrollment Applications" on the left side of the page. CMS encourages all providers and suppliers to use the new forms immediately.

Providers will enter the five-year revalidation cycle once the completed CMS 855 has been submitted and validated.

In addition, as part of CMS' revised enrollment process, all health care providers who bill Medicare must obtain their National Provider Identifier (NPI) prior to enrolling in or changing their Medicare enrollment data. In fact, providers are required to include their number NPI and a copy of the National Plan and Provider Enumeration System NPI notification with the CMS 855. No initial applications will be approved and no updates to existing enrollment information will be accepted without this NPI information.

Revalidation Requirement: To maintain Medicare billing privileges, CMS will require each provider to update, resubmit and revalidate its enrollment information at least once every five years. CMS will contact all providers and suppliers directly, in writing, as to when their five-year revalidation cycle starts.

Due to concerns from commenters about contractors' abilities to handle the increased workload that revalidation will involve and its implications for timeliness for processing enrollment applications for new Medicare providers, CMS will phase-in the requirements. The agency will instruct their contractors to process new enrollment applications first; request and process enrollment applications for providers who are currently billing the program but have not completed the CMS 855 second; and initiate revalidation activities for most other providers third. CMS also will monitor the processing of enrollment applications to ensure that all applications are processed within established timeframes.

Once notified by the Medicare carrier or FI, the validated CMS 855 must be submitted within 60 days of CMS request. CMS does *not* require that providers complete a new survey and certification or a new provider agreement as part of the recertification process. For those providers who initially enrolled in the Medicare program via the CMS 855, the agency will furnish a copy of the information currently on file for their review and revision and to certify as to the accuracy and completeness of the information. CMS is considering several options to minimize the burden of this requirement, such as using the Internet. The agency expects this process to be operational in 2007.

CMS reserves the right to require revalidation more frequently than every five years if there are complaints or evidence of non-compliance with Medicare rules or for national initiatives. Further, CMS also reserves the right to perform "non-routine" revalidation under certain other circumstances, such as random checks or national initiatives.

On-site Inspections: CMS reserves the right to conduct on-site inspections of a provider to verify that the information provided on the CMS 855 and supporting documents is accurate and to determine compliance with Medicare enrollment requirements. This is unrelated to the site visits performed for establishing conditions

of participation. While this is not a new requirement for hospitals, it is the first time on-site inspections have been used for physicians and other non-institutional providers.

Penalties

Deactivation of Billing Privileges: Providers who do not comply with required timeframes for reporting changes to enrollment information will be subject to deactivation of their Medicare billing privileges. CMS maintained its requirements that providers must report changes in enrollment information within 90 days of the change and changes to ownership and control within 30 days. Billing privileges may be reactivated if the provider completes and submits a new enrollment application or when current enrollment information is recertified.

CMS also maintained its current policy that deactivation of billing privileges will occur for the failure to submit claims for 12 consecutive months. Providers whose billing privileges are deactivated for non-submission of a claim must recertify that current enrollment information on file with Medicare is correct, furnish any missing information as appropriate and be prepared to submit a valid claim.

Reactivation of Medicare billing privileges does not require a new certification of the provider or supplier by the state survey agency or the establishment of a new provider agreement.

Rejection of Provider's CMS 855 for Medicare Enrollment: CMS will reject the CMS 855 application if the provider fails to furnish complete information or supporting documentation within 60 days of CMS' request. This timeframe can be extended if the provider is actively communicating with CMS to resolve any issues. After rejection, in order for a provider to enroll in Medicare, a new completed CMS 855, along with supporting documentation, must be submitted to CMS.

Denial of Enrollment: The regulations describe reasons for enrollment denial, the process for resubmitting an enrollment application and how a denial may be reversed. Reasons for denial include:

- The provider is out of compliance with the Medicare enrollment requirements and has not submitted a plan of corrective action.
- The provider or supplier, owner, managing employee, or an authorized or delegated official, medical director, supervising physician or other health care personnel furnishing Medicare reimbursable services who is required to be reported on the CMS 855 is: (1) excluded from the Medicare, Medicaid and any other federal health care programs; or (2) debarred, suspended or otherwise excluded from participating in any other federal procurement or non-procurement activity.
- The provider or any owner of the provider has been convicted within the last 10 years of a federal or state felony offense that CMS considers to be detrimental to the best interests of the program and its beneficiaries. This

includes felony crimes against persons, financial crimes and other offenses outlined in the proposed rule.
- Providing false or misleading information on the CMS 855 in order to gain enrollment. Offenders also may be referred to the Office of the Inspector General for investigation and possible criminal, civil or administrative sanctions.
- Problems identified upon on-site review. For example, CMS finds that the provider is not operational to furnish Medicare services, or the provider fails to satisfy any of the Medicare enrollment requirements.

Revocation of Enrollment and Billing Privileges: Reasons for revocation of billing privileges for a currently enrolled provider include the reasons noted above plus:
- The provider fails to furnish complete and accurate information and any applicable documentation within 60 days of CMS notification.
- The provider knowingly sells or allows another individual or entity to use its billing number (other than a valid reassignment of benefits).

Revocation of billing privileges also results in the provider's Medicare provider agreement being terminated. To re-establish enrollment in the Medicare program after revocation, the provider must complete and submit the CMS 855 enrollment form and applicable documentation for validation by CMS, and the provider must be resurveyed and recertified by the state survey agency as a new provider and must establish a new provider agreement with CMS. A revocation may be reversed if it was due to an adverse activity against an owner, managing employee or other individual and the provider terminates its business relationship with that individual within 30 days of revocation notification.

Appeal Rights: A provider who has been denied enrollment in the Medicare program, or whose Medicare enrollment has been revoked, has the right to administrative appeals and judicial review of any final agency decision. No payment will be made during the appeals process, but if the denial or revocation is overturned, unpaid claims for services provided during the overturned period may be resubmitted. A provider whose billing privileges have been deactivated may file a rebuttal.

AS IT STANDS

We are pleased that CMS adopted several AHA recommendations in the final rule, especially the decision to allow providers to revalidate their enrollment information less often than CMS had previously proposed. However, we remain concerned about the administrative burden on hospitals imposed by the requirements that all Medicare providers complete the provider enrollment form and the revalidation requirements. We also are concerned that increasing the caseload of already overextended Medicare FIs and carriers could further impede their ability to approve enrollment and issue billing numbers for new Medicare providers in a timely manner.

NEXT STEPS

The final rule takes effect June 20. The AHA will continue to urge CMS to carefully monitor the implementation of the new requirements to ensure that they do not result in further delays in processing new provider enrollments or place unreasonable administrative burdens on currently enrolled providers.