Part I

REIMBURSEMENT

Chapter 1

Enrolling in Medicare: Fraternity Hazing or Keeping out Bad Actors?

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Five cardiologist partners have, for 10 years, in one practice, provided diagnostic and therapeutic services at two offices, through one Medicare billing number. Two of the partners are leaving. The group is hiring a new physician employee. The new constellation of four physicians will open a new office to pick up new patients, to make up for those who might follow the two departing doctors. In preparing for the changes, they discover that they accidentally put down their d/b/a name on their enrollment form.

A solo physician providing pain care services with the help of two physician assistants has had enough of handling his own business affairs. He hires a management company to run the day-to-day arrangements in his office. At the same time, one of his PAs is leaving his practice.

What Medicare obligations do these practices have? What penalties will they face if they fail to understand or comply with those requirements? Why do the rules exist in the first place?

§ 1:1 Introduction
§ 1:2 Where are we and how did we get here?
§ 1:3 —The halcyon days of yore
§ 1:4 —2001: An enrollment odyssey
§ 1:5 —2006 and 2008: CMS strikes back
§ 1:6 —The 855 Form
§ 1:7 —Denials, revocations, and appeals
§ 1:8 —Penalties
§ 1:9 Common scenarios and problems

§ 1:10 —Structural changes
§ 1:11 —Scenario 1: Adding locations
§ 1:12 —Scenario 2: Adding a management/billing company
§ 1:13 —Scenario 3: "Long-time supplier, first-time reviser"
§ 1:14 —Scenario 4: "It's just over the bridge" and other difficulties
§ 1:15 —Personnel changes
§ 1:16 —Scenario 4: Ownership personnel changes
§ 1:17 —Scenario 5: More than just a fresh face—Risks in adding a new physician
§ 1:18 —Scenario 6: "What do we do now that Phil's leaving?"—Departure of an owner/manager physician
§ 1:19 —Scenario 7: The d/b/a mix-up
§ 1:20 —Scenario 8: Avoiding a pyrrhic victory
§ 1:21 Conclusion

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§ 1:1 Introduction

A day of reckoning approaches in the Medicare program. Utilization of services is on the rise and shows no signs of slowing. In July 2006, the GAO reported that "From April 2000 to April 2005 . . . the average number of services provided per 1,000 beneficiaries who were treated rose by 14 percent."[1] Demographics are working against the Medicare system, so a still more dramatic increase in utilization looms beginning in 2011 when the baby boomer generation will begin to reach Medicare eligibility.[2] By 2030, the first of the baby boomers will reach 85 years old.

Medicare has attempted to contain the growing drain on its coffers through a variety of measures, including caps on or reductions to physician payment rates. However, these efforts have not always been successful, and even the Medicare

[Section 1:1]

[1] GAO-06-704, July 2006, p. 29.

[2] GAO-01-563T, March 27, 2001, p. 4.

Payment Advisory Commission (MedPAC) has recommended repealing or revising mechanisms like the "sustainable growth rate." In its March 2002 Report to Congress, MedPAC stated "We conclude that although Medicare's payments for physician services were not too low in 1999, payment updates since then have been less than the increase in input prices."[3]

Other methods of controlling expenditures include revamping the various Medicare oversight entities, including increased payment review, programs aimed at denying claims and recouping overpayments (such as Program Safeguard Contractors (PSCs)), and prepayment reviews which do not permit appeals. In addition to scrutiny by Medicare contractors, Medicare has gone live with the Recovery Audit Contractors (RAC) program—private contractors with Medicare authority to pursue overpayments from which they are compensated on a contingent-fee basis.[4] At the same time, the government continues to revise the fraud and abuse laws in an effort to minimize expenditures related to what it considers problematic financial arrangements. While each of these initiatives individually may be taken at face value, together they form a tapestry of sweeping efforts to slow down the outflow of money from the Medicare fund.

One of the more underappreciated weapons in the government's arsenal against the Medicare bleed rate is the method by which providers and suppliers first gain access to Medicare funds: the enrollment process. Gradual revisions to this first step in obtaining and maintaining access to Medicare dollars have increased the difficulty of becoming a Medicare provider or supplier.[5] The primary justification for these changes is to prevent "bad actors" from securing

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[3]MedPAC Report to Congress, March 2002, Ch. 2C, p. 73.

[4]*See* the CMS RAC Status Document for Fiscal Year 2007, published February 2008. Other attempts to curtail fraud and abuse have included increased surveillance of Florida physicians. *See* GAO-04-709, relating to disproportionately high per-patient payments in Florida for CORF therapy services. *See also* http://www.cms.hhs.gov/RAC/01_Overview.asp.

[5]Under 42 C.F.R. § 498.2 and 42 C.F.R. § 405.802, the term "supplier" is defined to include (among other entities) any physician "or other practitioner such as [sic] physician assistant," physical therapist in independent practice, independent laboratory, and ambulatory surgical center. "Prospective suppliers" are defined as any of the above-listed entities seeking to be approved for coverage of their services by Medicare. The changes specifically did not include occupational therapists.

Medicare dollars, including providers or suppliers with a "propensity" to bill in ways that the Medicare program considers problematic.

> As Medicare program expenditures have grown, increased attention was focused on strategies to curb improper Medicare payments by implementing business processes and standards that safeguard the Medicare program and its beneficiaries, while ensuring that well qualified individuals and health care organizations serve beneficiaries as promptly as possible.[6]

However, in addition to removing "bad actors" from the system, enrollment changes have increased the burden on providers and suppliers to the point where even "good actors" face delays in obtaining billing privileges. As the enrollment process has become more burdensome, the rules also have (1) shortened response times where Medicare requests additional information, (2) expanded grounds for revocation of billing privileges, and (3) increased the amount of information requested on the application form and supporting documentation.

This chapter examines recent changes in Medicare enrollment requirements and their rationales, and explains the practical and legal effects of these changes on physician practices. It provides a brief overview of how the enrollment process has changed, highlights specific physician practice pitfalls in the enrollment form, and presents some common scenarios, and how they trigger the need for a new (or updated) Medicare enrollment application. Finally, this chapter discusses the legal implications for practices who fail to properly enroll or maintain enrollment, including penalties as well as the appeals process.

§ 1:2 Where are we and how did we get here?

What was once open-ended, relatively simple Medicare enrollment has become more burdensome and complicated with each new iteration. These heightened levels of inquiry have the dual effect not only of helping to ensure that only qualified providers or suppliers are approved, but also slowing down the process by which they gain access to the system. As complex and time-consuming as the process is now, however, it was simple once upon a time.

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[6] 71 Fed. Reg. 2074 (April 21, 2006).

§ 1:3 Where are we and how did we get here?—The halcyon days of yore

In the very beginning, there was chaos. From the inception of Medicare, carriers had their own idiosyncratic enrollment forms, some of which were little more than a one page declaration of demographics. Out of this primordial muck came the HCFA-1513, a two-page, 18-question form requiring information on who owned and/or controlled the practice. This represented the first real attempt at national uniformity in enrollment requirements. The HCFA-1513 was filed with state-level entities.[1] However, in May 1996 for implementation in 1997, the Health Care Finance Administration (HCFA) created a new enrollment form: the HCFA-855—16 pages of questions, not including the instructions, to be filed only with HCFA itself (or a carrier/fiscal intermediary).[2]

The changeover from the HCFA-1513 to the HCFA-855 came partially in response to President Clinton's Medicare and Medicaid Fraud, Abuse, and Waste Prevention Amendments of 1997,[3] as well as Congress' own initiatives. In 1997, Bruce C. Vladek, the then-current HCFA Administrator, testified before the Senate Committee on Government Affairs, Permanent Subcommittee on Investigations:

> We propose to clarify the provider enrollment process, and strengthen HCFA's ability to combat fraud and abuse by not allowing 'bad actors' to become Medicare providers or suppliers. These provisions would provide the Secretary the authority to deny Medicare entry for those provider applicants who have been convicted of a felony . . . by developing a National provider enrollment application (HCFA 855) that captures that specific data for all Medicare providers, and the application will be available and effective on July 1, 1997.[4]

The form was revised again in 1998, mostly by adding a single page of additional inquiry. However, in 2001, the HCFA-855 underwent a radical change.

[Section 1:3]

[1] This could be either the HCFA Regional Office or the applicable state Medicaid agency.

[2] Interestingly, the HCFA-1513 was only officially discontinued in 2003. *See* S&C-03-29, August 14, 2003.

[3] 1997 Cong. U.S. H.R. 1770.

[4] http://www.hhs.gov/asl/testify/t970626c.html.

§ 1:4 Where are we and how did we get here?—2001: An enrollment odyssey

Originally, the HCFA-855 was only the primary enrollment form by which all entities enrolled with a mere few additional forms: the 855R for an individual reassigning benefits and the 855C for making changes rather than filling out a full 855. The 2001 revisions made substantial changes. Five new forms were introduced: the 855A (for hospital enrollment), the 855B (for physician group enrollment, IDTFs, and ASCs), the 855I (for individual physician enrollment), keeping the 855R and 855S (for reassignment of benefits and DMEPOS enrollment, respectively). The HCFA-855C—the form by which providers and suppliers submitted changes to their enrollment—was declared obsolete. Changes would now be made directly on the same forms used for initial enrollment. The newer forms also requested more information than before. As a practical matter, this meant that any practice that had enrolled using the older 855 had to make updates and changes using the new 855B form.

Providers and suppliers were required to report changes of ownership; and the new forms distinguished between "change of ownership" and an acquisition, merger, or consolidation. The new forms also simplified the reporting of owners and individuals who were managers or directors by combining the two individual reports into a single page. Internal deadlines for processing applications were also tightened—Centers for Medicare and Medicaid Services (CMS) was required to process 99% of all applications within 120 days of receipt, and 90% within 60 days of receipt. Finally, practices could now name a "delegated official" with authority to change or update the practice's enrollment information, although the official had to be a W-2 managing employee or an owner with at least a 5% interest in the practice.

In addition to changing the initial enrollment forms, in the same year, CMS introduced the concept of the "revalidation." Under the proposed system, every three years, providers and suppliers would be required to complete an enrollment form (thereby "revalidating" their enrollment information). This process applied even if there had been no change in any of the information. In the proposed rules for revalidation, CMS justified the imposition of the revalidation

system by claiming it would give CMS current and complete information on Medicare providers and suppliers, ensure compliance with Medicare requirements, further ensuring that Medicare beneficiaries received services only from legitimate providers and suppliers, thereby protecting the Medicare trust fund.[1] The revalidation process was put on hold in 2006 until the Office of Management and Budget (OMB) could approve it. As CMS explained in the 2006 Final Rule for Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment, "We will phase in the revalidation process for providers and suppliers currently participating in the Medicare program."[2] These revisions to the enrollment process also changed the frequency of revalidations from every three years to every five years, and mandated that enrollees as well as carriers and fiscal intermediaries respond within 60 days to any notification.[3]

§ 1:5 Where are we and how did we get here?—2006 and 2008: CMS strikes back

Some of the most extensive changes came in 2006. In addition to the revalidation changes, the new National Provider Identifier (NPI) was required for all Medicare applications.[1] There had also been a lingering question regarding "back-billing" under Medicare which CMS confronted directly.

In general, practices obtaining billing privileges have always been permitted to bill for services rendered after the date of *approval*, rather than the date of *enrollment*. As CMS later illustrated, "For example, if a supplier is enrolled in the Medicare program in December 2008, with an approval date back to October 2006, that supplier could retrospectively

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[Section 1:4]

[1] 68 Fed. Reg. 22068.

[2] 71 Fed. Reg. 20764. However, as of the 2009 Medicare Physician Fee Schedule, CMS has encouraged physicians and physician practices to voluntarily submit updated enrollment forms, rather than wait for a Medicare contractor to contact them. The revalidation process has begun again.

[3] 71 Fed. Reg. 20765.

[Section 1:5]

[1] 71 Fed. Reg. 20765. Although the NPI had not been implemented in 2006, it has now taken effect.

bill for services furnished to Medicare beneficiaries as early as October 1, 2006."[2] In response to commenters' concerns regarding effective billing dates, CMS clarified in 2006 that "it was never our intent to change our policy on effective billing dates . . . We will continue to pay claims under all current reimbursement policies."[3] Therefore, practices enrolling in Medicare could "back-bill" for these periods.

The 2006 revisions also addressed the Provider Enrollment Chain and Ownership System (PECOS). First announced in 2001, the PECOS system has long been in development. The system is intended to permit practices to enroll electronically, rather than only by paper applications. However, it still remains only partially functional, and there continue to be problems.[4]

Two sets of additional changes to the enrollment process itself came in the 2009 Medicare Physician Fee Schedule (MPFS), in addition to changes to the appeals process associated with CMS enrollment decisions. The 2009 MPFS overturned the clear 2006 CMS guidance on retroactive billing privileges. Though CMS had explicitly expressed intent not to change the longstanding ability of physicians to bill retroactively, the 2009 MPFS limited the effective date of billing privileges to the later of either: (1) the date of filing of a subsequently approved Medicare enrollment application, or (2) the date an enrolled supplier first started rendering services at a new practice location. Practices may now bill no earlier than their effective date of their billing privileges, or for no more than 30 days prior to the effective date if the practice met all enrollment requirements, but circumstances prohibited enrolling in advance.[5] The "date of filing" for paper applications is considered the date the Medicare contractor

[2]73 Fed. Reg. 37535. This explanation was provided in the proposed Physician Fee Schedule for 2009.

[3]71 Fed. Reg. 20763.

[4]In 2007, the OIG conducted an audit of the PECOS system and found significant delays. While many of the Part B applications were delayed as a result of applicant failures to respond, as well as a single Medicare contractor being responsible for 52% of the backlog, many of the problems with PECOS related to the inability of contractors to access the system itself. *See* "Provider Enrollment, Chain and Ownership System: Early Implementation Challenges," OEI-07-05-00100.

[5]73 Fed. Reg. 69768 (Nov. 19, 2008). The specific language reads: "We are finalizing a provision that allows physicians, NPPs (including

receives a signed enrollment application which is ultimately processed to approval.[6] For electronically submitted applications, the date of filing is the date that a Medicare contractor has received a signed certification statement, a complete electronic application, and a signed signature page for the enrollment application.[7]

CMS justified this 180-degree reversal of its 2006 statements on two grounds. First, "We maintain that it is not possible to verify that a supplier has met all of Medicare's enrollment requirements prior to submitting an enrollment application."[8] Second, the PECOS system would "significantly decrease the number of incomplete applications and the need for [Medicare] contractors to request additional information."[9]

CRNAs), and physician or NPP organizations to retrospectively bill for services up to 30 days prior to their effective date of billing when the physician or nonphysician organization has met all program requirements, including State licensure requirements, where services were provided at the enrolled practice location prior to the date of filing and circumstances, such as, when a physician is called to work in a hospital emergency department which precluded enrollment in advance of providing services to Medicare beneficiaries . . ." Aside from this discussion, CMS has not clarified what "circumstances" would have to be shown to retroactively bill.

[6] 73 Fed. Reg. 69773.

[7] 73 Fed. Reg. 69767.

[8] 73 Fed. Reg. 69767.

[9] 73 Fed. Reg. 69769. In addition to these limitations, CMS is currently considering limiting a provider's ability to bill if the provider is determined to be delinquent in its payment of taxes. Citing a GAO report (GAO-07-587T) which determined that high numbers of physicians were delinquent on taxes, CMS has indicated that it is considering revoking a provider's billing privileges if CMS determines the provider is delinquent in payment of taxes, and CMS is unable to impose a levy through the Federal Payment Levy Program. Moreover, CMS now denies billing privileges to physician or nonphysician practitioner current owners or authorized or delegated officials who are under a payment suspension or who have an outstanding overpayment that has not been repaid in full. These providers can no longer enroll and reassign payments to a third party. The goal here is to prevent providers from shuffling NPIs (for example, moving from one location to another and obtaining a new NPI along the way, while discontinuing using the old NPI which had an administrative action against it). 73 Fed. Reg. 69774 to 69777.

In addition, enrollees must now report "final adverse actions"[10] to the appropriate Medicare contractor within 30 days. Failure to comply with this requirement will result in revocation of billing privileges and a declaration of overpayments from the date of the adverse action. In other words, if a practice fails to report a suspension of a state license—even pending the outcome of the disciplinary hearing—within 30 days, then *all* Medicare payments from the date of the suspension are considered to be overpayments, regardless of their appropriateness otherwise. Practices must also update their enrollment applications within 30 days of any change of location. While CMS will not revoke billing privileges for failure to update the information, it will declare an overpayment. This change limits practices' ability to establish new locations. What had previously been simply a matter of completing a new lease agreement now requires changes to the practice's enrollment application.

Additional burdens imposed by the new MPFS include a requirement that physicians and practices maintain orders and referrals for seven years from the date of the *service*, including the NPI of the ordering/referring entity. Failure to comply is grounds for revocation of billing privileges, not merely an overpayment. Prior to this change, practices were required to maintain such documentation for only seven years from the date of *payment*. This change may impose a significant administrative and/or financial burden on physicians (possibly even requiring the lease of additional storage space for old records), although CMS has explained that the change does not preclude the use of off-site electronic storage of records.[11]

Finally, as a further measure to curb payments to "bad ac-

[10]Defined to include a Medicare-imposed revocation of billing privileges, suspension or revocation of a health care license by a State licensing authority, revocation or suspension by an accreditation organization, a conviction of a federal or state felony offense within the last 10 years prior to enrollment, revalidation, or reenrollment, or an exclusion or disbarment from participation in a federal or state health care program. 73 Fed. Reg. 69778, 42 C.F.R. § 424.502(a).

[11]73 Fed. Reg. 69781. One issue which CMS has not yet addressed is whether a practice must update its enrollment information if it changes how it handles electronic off-site storage or indeed whether it must report this in the first place. Practices are currently required to list their off-site storage *facilities* in section 4 of the CMS-855B, but there is no discussion of whether an electronic storage provider constitutes a "facility."

tors," CMS now limits a practice's ability to submit claims predating a revocation once notified of the revocation. Previously, physicians whose billing privileges had been revoked were able to continue submitting claims for services performed before the revocation for 27 months after the revocation date. Under the regulations, physicians must now submit all such claims within 30 days.[12] CMS justified this change by citing the use of false documents as a means around the prohibition. The change imposes a significant burden on any physician whose billing privileges have been revoked. Even if the basis for revocation was unrelated to the claims in question, and even if all of the physician's claims are medically necessary, properly documented, and legitimate, the physician must scramble to file them all within one month of the revocation date.

Perhaps acting as a balance on these new pressures placed on physicians, CMS contractors are now required to process applications within 180 days for enrollment actions, although the regulations do not specify what consequences will apply for failure to meet this requirement. Additionally, changes of information and reassignment must be processed within 90 days of receipt.[13] However, these timeframes are merely the maximum time within which CMS requires a response by the Medicare contractor. In practice, 80% of paper applications must be processed within 60 days of receipt, 90% must be processed within 120 days, and 99% must be processed within 180 days.[14] Web site applications are given even shorter turnaround times, with 90% being processed within 45 days, 95% processed within 60 days, and 99% being processed within 90 days of receipt.[15]

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[12] 73 Fed. Reg. 69782.

[13] 42 C.F.R. § 405.874(h).

[14] Medicare Program Integrity Manual, Chapter 10 § 2.1.1. Changes of information are given tighter timeframes, with 80% processed within 45 days, 90% processed within 60 days, and 99% processed within 90 days of receipt. Medicare Program Integrity Manual, Chapter 10, at 2.2.1.

[15] Medicare Program Integrity Manual, Chapter 10 § 2.1.3. As with paper-based changes of information, web-based changes of information must be processed on tighter timeframes: 90% must be processed within 45 days, 95% within 60 days, and 99% within 90 days of receipt. Medicare Program Integrity Manual, Chapter 10, at 2.2.3.

§ 1:6 Where are we and how did we get here?—The 855 Form

What information is required of physicians upon initial enrollment, and with what portions of the enrollment forms are they most likely to have problems? In addition, what issues will longtime Medicare enrollees face when revalidating their enrollment? In short, where do the pitfalls for enrollment lie in the form itself?[1] On its face, most of the information seems relatively straightforward. However, physicians may make mistakes in the enrollment process, which may delay their billing privileges.

The first potential problem appears in section 2.B.1, where practices are required to enter their *legal* business name. Currently, the 855B form indicates that this is *not* a practice's "doing business as" name and must be the name reported to the IRS. Practices *may* list an "other name" in this section as well, but must indicate whether it is a former legal business name, a d/b/a name, or some other name. Failure to properly enter this information may result in the Medicare contractor requesting corrected information from the practice, which will delay the practice's ability to bill. Practices that have already enrolled may face problems if they previously submitted their "d/b/a" name on their initial enrollment form. In addition, practices that change their legal business name over time will have to update this information within 90 days.

Section 2.G also presents a potential stumbling block for already-enrolled practices that use physician assistants (PAs). Although section 2.G does not require physicians or practices to list their PA employees when initially enrolling, practices that employ PAs must notify Medicare when they terminate the PA's employment. In addition to the date of termination, the physicians or practice must include the PA's name and NPI. Here, the danger lies not in the complexity of the issue, but in simply remembering to fulfill the obligation—perhaps made more problematic by the fact that the physician or practice need not inform CMS of the fact that it has begun employing a PA in the first place.

[Section 1:6]

[1] Because of this chapter's focus on physicians and physician groups, the following discussion focuses on the CMS-855B.

Another area where physicians and practices must maintain constant vigilance appears in section 3, regarding adverse legal actions that require reporting. Physicians and practices must report this both upon initial enrollment, and throughout their enrollment upon 30 days of any action. The current form instructs physicians and practices to notify their regional Medicare contractor if the practice itself or any owner of the practice has been convicted of (among other offenses): (1) a felony offense deemed by CMS to be detrimental to the interests of the program[2] within the last 10 years; (2) misdemeanor federal or state convictions relating to the delivery of an item or service under Medicare or a state health plan, or abuse or neglect of a patient in connection with delivery of health care items or services; (3) federal or state misdemeanor convictions for theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct related to the delivery of health care items or services. In addition, practices must report:

- revocations or suspensions of licenses to provide health care by any state licensing authority;[3]
- revocations or suspensions of accreditation;
- suspensions, exclusions, or sanctions imposed by federal or state health care programs;
- current Medicare payment suspensions under *any* Medicare billing number; and[4]
- revocation of *any* Medicare billing number.

Practices must also submit information regarding entities

[2]These include crimes (as well as guilty pleas or "adjudicated pretrial diversions") against people; financial crimes such as extortion, embezzlement, income tax evasion, or insurance fraud; felonies that placed the Medicare program or beneficiaries at immediate risk (such as malpractice suits that lead to convictions of criminal negligence or misconduct); and felonies resulting in mandatory exclusion under the Social Security Act.

[3]CMS explicitly *includes* suspensions while a formal disciplinary hearing is pending before the licensing authority.

[4]It is unclear whether this would include prepayment review or offsets applied to a physician's or practice's billing number when an overpayment is determined. Arguably, these would not be payment freezes, since the physician or practice could still technically be paid. In the case of a prepayment review, the physician or practice might still be paid if its claims were determined to be appropriate after much scrutiny. With offsets, the physician or practice is still being "paid" by Medicare, but the payment is being applied to the amount of overpayment the physician or

and individuals who own or control the practice in sections 5 and 6. For example, a practice with a physician owner holding 5.5% of the practice and another corporate entity holding 94.5% would have to complete both sections 5 and 6. Practices that contract with physician management companies must also submit information about the management company. While the type of information required for both sections is primarily demographic information (legal business name, d/b/a name, addresses, tax ID number, NPI, etc.), the form requires same kind of adverse legal history as in section 3. Additionally, practices must list at least one individual owner or managing employee.[5]

CMS can reject a practice if it determines that the practice is controlled by entities with adverse legal histories. While on its face this information may not seem difficult to report, the practice may find it difficult to obtain sufficient information about its owners and/or managers. Practices likely do not consider asking a management company whether its CEO has been convicted of a felony in the past. As with the rest of the application, practices must continually update this information. Whenever the practice changes management companies, loses or adds a shareholder, or is bought out by or merges with another practice, these sections must be revisited. Likewise, if any owner or manager later is convicted or sanctioned, the information may have to be reported to CMS.[6]

Related to the ownership and management information are the roles of "Authorized Official" and "Delegated Official." As described by the 855B, an "Authorized Official" is an ap-

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practice previously received. Still, the enrollment application itself is silent as to these finer distinctions.

[5]A "managing employee," as explained by the form, can be a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over the day-to-day operations of the practice. This relationship may be established either via contract, or through other arrangements, regardless of whether the individual is actually a W-2 employee.

[6]Practices must also list billing agents in section 8 which, similar to sections 5 and 6, require disclosure of demographic information, but not adverse legal history. While this section is relatively brief, it must be kept up to date, and practices must remember that a management company that also submits bills on behalf of the practice must be listed under section 5 and section 8.

pointed official[7] with the legal authority to enroll the practice in Medicare; make changes/updates to the enrollment status; and commit the practice to abide by the statutes, rules, and regulations of the Medicare program. A "Delegated Official," on the other hand, is any individual delegated by an Authorized Official to report changes/updates to the enrollment information. "Delegated Officials" must either have an ownership or control interest in the practice or be a W-2 managing employee of the practice. They may not be independent contractors. Authorized and Delegated Officials are reported in sections 15 and 16, respectively, and must also be listed in section 6. Practices must report at least one Authorized Official, although they may report more than one if they choose. Only the Authorized Official can sign the initial enrollment, and only an Authorized or Delegated Official can make changes to the practice's enrollment information. When either an Authorized or Delegated Official leaves the practice, it must update both section 6 and either section 15 or 16, as applicable.

Physician practices must keep up-to-date records on their authorized and delegated officials. For practices intending to use a management company, it is important to realize that the owner of the management company, while required to be listed as a "managing employee" under section 6, may not be listed as either an Authorized or Delegated Official under section 15 or 16 specifically because the owner of the management company is not a W-2 employee of the practice.

Finally, the 855B requires a plethora of additional documentation to be submitted upon initial enrollment. These documents include licenses, certifications, and registrations required by Medicare or state law; federal, state, and/or local business licenses, certifications, and/or registrations required to operate a health care facility; written confirmation from the IRS confirming the applicant's tax identification number (TIN) with the entity's legal business name as provided on the CMS-855B; a completed CMS-588 form (which authorizes electronic funds transfer, or EFT); completed CMS-855R reassignment forms (if the practice is contracting with individuals already enrolled in Medicare);

[7] Such as a CEO, CFO, general partner, chairman of the board, or owner.

and copies of adverse legal action documentation.[8] Without this information, the application will be considered incomplete, and the practice will be notified by the Medicare contractor to submit the information. The time for an applicant to respond to requests for information from a Medicare contractor has also been halved from 60 days to 30 days.[9] Additionally, applicants must submit all required supporting documentation within 30 days of submitting the application for enrollment.[10] While this may seem minor, the amount and scope of supporting documentation required of physicians and practices is considerable.

The practical effect of this reduced submission timeframe is that applicants are better off gathering all of the relevant supporting documentation to submit with the CMS-855B itself. Unfortunately, this may delay the date of submission by however long it takes the applicant to assemble the necessary information. These changes, coupled with the prohibitions on retroactive billing, place pressure squarely on the applicant to "get it right" the first time. Failure to do so may result in the application being rejected. Unlike a denial or revocation of enrollment and billing privileges, a rejection under 42 C.F.R. § 424.525 simply means that the practice must resubmit an application. By contrast, if a practice is denied enrollment or its billing privileges are revoked, it may take more than simply submitting a new application to obtain billing privileges.

§ 1:7 Where are we and how did we get here?—Denials, revocations, and appeals

When a practice is determined to be ineligible for enrollment, the practice's application will be denied. In general, practices will be denied enrollment for several reasons: (1) noncompliance with the requirements for Medicare enrollment; (2) the practice is excluded from Medicare, Medicaid,

[8] CMS-855B form, section 17. In addition, if applicable, applicants must submit (among other things) copies of all adverse legal action documentation and a completed CMS-460 Medicare Participating Physician or Supplier Agreement.

[9] 42 C.F.R. § 424.525(a)(1).

[10] 42 C.F.R. § 424.525(a)(2).

or any other federal health care program;[1] (3) the practice or any owner was, within the 10 years prior to enrollment or revalidation, convicted of a federal or state offense deemed detrimental to the interests of the Medicare program; (4) the practice submitted false or misleading information on the enrollment application; (5) CMS or a Medicare contractor determine upon on-site review that the practice is not operational to provide Medicare services;[2] or as discussed above, the practice has an overpayment or a payment suspension against it.[3]

Practices whose 855Bs have been denied must wait 60 days from the date of the initial denial before they may resubmit an application. Any resubmissions within the 60-day period will simply be returned by the Medicare contractor.[4] CMS has explained that the 60-day period is the time within which an applicant may request an appeal, and the appeals request period must end before a resubmission may be made.[5] In other words, an applicant cannot "hedge its bets" by resubmitting an application while simultaneously awaiting the results of an appeal of the first application's denial; the choice is an either/or option—appeal, or wait the 60 days and resubmit. An applicant, therefore, must decide which path is best: is it faster to wait the 60 days and resubmit, or should the applicant address the grounds for denial via the appeals process? For example, if the applicant was denied because a necessary license was not submitted with the enrollment packet and was not received by the contractor within the required timeframe, resubmitting

[Section 1:7]

[1]This extends to any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel who must be reported on the 855B.

[2]As examples, CMS describes lack of a license or authorization by federal, state, or local government to perform services; lack of a physical business address or mobile unit where services can be rendered and/or lack of a location for patient record storage; failure to meet CMS regulatory requirements for the applicant's specialty; and failure to qualify as a supplier of medical and health services—specifically the inability to receive reassigned benefits. *See* Medicare Program Integrity Manual, Ch. 10 § 6.2.

[3]42 C.F.R. § 424.530(a).

[4]73 Fed. Reg. 36451.

[5]73 Fed. Reg. 36451.

likely is faster. If the grounds for denial are more serious and cannot be resolved by simply resubmitting, for example if the applicant was denied because of adverse legal history which it believes should not be grounds for the denial, an appeal may be necessary.

Practices that have obtained billing privileges may have them revoked under similar circumstances. In addition to several of the grounds for denial listed above,[6] practices may have their billing privileges revoked if they provide "undeliverable" services, such as with a date of service after a beneficiary has died, when the physician was out of the country or jurisdiction and could not have rendered the service, or when necessary equipment was not available on the date of service.[7] CMS explained that,

> This basis for revocation is essential to the efficient operation of the Medicare program, because it will enable us to take an important step in protecting the expenditure of public monies for service providers whose motive and billing practices are questionable, at best, and at worst, of a sort that might prompt an aggressive response from the law enforcement community.[8]

However, CMS explained that there might be situations where seemingly "undeliverable" services would be legitimate and noted that "We will not revoke billing privileges . . . unless there are multiple instances, at least three, where abusive billing practices have taken place."[9] CMS has further pointed out that physicians and practices have access to the appeals process to challenge a revocation.

Practices that have been denied enrollment or have had their enrollment revoked may appeal the denial or revocation. This process was slightly revised in 2008, to ap-

[6] Specifically, (1) noncompliance with the requirements for Medicare enrollment; (2) the practice is excluded from Medicare, Medicaid, or any other federal health care program; (3) the practice or any owner was, within the 10 years prior to enrollment or revalidation, convicted of a federal or state offense deemed detrimental to the interests of the Medicare program; (4) the practice submitted false or misleading information on the enrollment application; and (5) CMS or a Medicare contractor determines upon on-site review that the practice is not operational to provide Medicare services.

[7] 73 Fed. Reg. 36457.

[8] 73 Fed. Reg. 36457.

[9] 73 Fed. Reg. 36457.

ply to "suppliers" and "prospective suppliers" alike. The inclusion of "prospective suppliers" was intended to grant access to the appeals process for first-time applicants. However, while these revisions expanded the appeals process in some respects, they also created multiple administrative hurdles for physicians and physician practices.[10] Once the physician's or practice's enrollment has been denied or revoked, the physician or practice will be notified by the Medicare contractor, at which point the physician or practice may submit an appeal.[11] On appeal, the practice must submit all evidence it wants considered on appeal.[12]

In general, practices may appeal denials or revocations first by requesting a reconsideration of the initial determination to deny or revoke privileges.[13] The practice must submit its request for reconsideration within 60 days of receipt of notice of the initial determination.[14] If the practice is dissatisfied with the results of the reconsideration, it may request a review by an administrative law judge (ALJ), which must be filed within 60 days of the result of the reconsideration.[15] The ALJ's decision or dismissal may be appealed to the departmental appeals board (DAB), again within 60 days of the ALJ's decision.[16] Finally, a practice may appeal the decision of a DAB to a federal district court within 60 days of the DAB's decision.[17]

Physicians or practices that succeed in overturning a revocation can submit claims for services rendered during the re-

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[10]Applicants must now also sign up for electronic funds transfer (EFT) upon enrollment. While this requirement may not be overly burdensome, it does mean that a practice must fill out yet another CMS form—in this case, the CMS-588. This is required for practices enrolling for the first time, as well as those submitting changes of information. 42 C.F.R. § 424.510(d)(2)(iv).

[11]For denials of enrollment applications and revocations, the contractor will inform the physician or practice via certified mail of the denial or revocation, and the notice will include (1) the reason for the denial or revocation, (2) that the physician or practice has the right to appeal, and (3) the address to mail the appeal. 42 C.F.R. §§ 424.405, 424.874.

[12]42 C.F.R. § 405.874(c).

[13]42 C.F.R. § 498.22(a).

[14]42 C.F.R. § 498.22(a).

[15]42 C.F.R. §§ 498.5(f)(1), 498.40(a)(2).

[16]42 C.F.R. §§ 498.5(f)(1), 498.82(a).

[17]42 C.F.R. §§ 498.5(f)(2), 498.95(a).

vocation period, back to the date of revocation.[18] CMS further clarified that, if a physician or practice's billing privileges are revoked, the revocation applies to the date on which the service was rendered.[19] Additionally, claims filed during a period where a physician or practice lacks billing privileges are rejected, rather than denied,[20] and physicians or practices that succeed in reinstating their billing privileges or overturning a revocation may submit claims for services provided while the physicians or practice qualified with Medicare's requirements.[21] Claims filed during this period and which are rejected are considered to have been timely filed, and previously denied claims provided during this period are considered timely if filed up to one year following the date of reinstatement or reversal.[22]

It is therefore in the physician's or practice's best interest to continue submitting claims during any period in which its billing privileges have been revoked, if it is currently appealing the decision. Even if the claims are rejected, the physicians or practice may resubmit them and the resubmission will be considered timely, assuming the revocation is ultimately overturned. While this may pose an administrative burden to the revoked entity, especially if they must continue to pay billing staff to prepare and submit claims while Medicare has effectively stopped what is likely a crucial revenue stream, it can file the claims at a later date.

§ 1:8 Where are we and how did we get here?—Penalties

Physicians or practices who fail to comply with the requirements for enrollment, either initially or on an ongoing basis,

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[18]42 C.F.R. § 405.874(d). However, if a practice's privileges are revoked and the revocation is not overturned, the practice cannot reenroll for at least one year, and no more than three years.

[19]As an example, CMS described a scenario in which if a physician submits a claim for services provided on June 22, 2007, and the beneficiary dies on June 23, 2007. If the claim is not received by a Medicare contractor until August 1, 2007, any action taken regarding the claim will be in regard to the June 22, 2007 date. This is significant for issues surrounding "undeliverable" services. *See* 73 Fed. Reg. 36455.

[20]42 C.F.R. § 405.874(d)(1).

[21]42 C.F.R. § 405.874(g).

[22]42 C.F.R. § 405.874(g).

expose themselves to a range of penalties. Bearing in mind the scope of information they must regularly report and the timeframes within which they must update this information, the potential effect from even benignly delinquent lapses poses a significant risk. First, practices that fail to accurately maintain their enrollment information may find their billing privileges revoked and/or may face an overpayment. Physicians or practices that fail to report final adverse actions, for example, are subject to revocation and the application of an overpayment from the date of the incident that should have been reported.

However, the most serious penalties for a physician or practice that is tardy in updating its enrollment information include jail time and financial penalties. Those who know of any event affecting their right to receive payments from a federal health care program and who conceal or fail to disclose such event with the intent to fraudulently secure benefits or payments either in a greater amount than that to which they would normally be entitled, or when no such benefit or payment is authorized, may be found guilty of a felony punishable by up to a $25,000 fine or imprisonment for up to five years (or both).[1] Similarly (and potentially in addition to these penalties), an individual who knowingly submits claims for medical items or services which the person knows or should know are false or fraudulent, or who submits claims for medical items or services during a period of exclusion, is subject to civil monetary penalties up to $10,000 for each item or service.[2]

In addition, section 14 of the CMS-855B form itself includes a lengthy list of penalties for practices that deliberately falsify information in the application to gain or maintain enrollment in Medicare. These include hefty fines of up to $250,000 and imprisonment up to five years for individuals, or fines of up to $500,000 for organizations, as well as fines of up to two times the gross gain derived by an offender if the amount is greater than the penalties listed

[Section 1:8]

[1] 42 U.S.C.A. § 1320a-7b(a)(3).

[2] 42 U.S.C.A. § 1320a-7a(a)(B) and (D), respectively.

under the law.[3] In addition, civil liability under the False Claims Act (FCA) includes penalties of up to $10,000 *per violation* plus three times the amount of damages sustained by the government.[4] The penalties imposed by the FCA require that the claim in question be false, and that the entity submitting the claim did so with specific intent, or did so knowingly. However, deliberate ignorance or reckless disregard of the truth is enough to establish that the defendant knew the claims to be false.[5] In several cases, courts have noted that submission of false reports or certifications which are prerequisites for government reimbursement is sufficient to establish liability under the FCA.

For example, in *U.S. ex rel. Mathews v. Healthsouth Corp.,*[6] the Fifth Circuit Court of Appeals addressed a lower court's ruling to dismiss in a case where the defendant was alleged to have falsely stated to the government on a self-attestation form that it complied with the requirements to obtain reimbursement as a prospective payment system (PPS) exempt rehabilitation hospital between 1994 and 1999.[7] The defendant was alleged to have been aware of the falsity of the certification from 1996 at the latest and continued to submit the false forms. The defendant argued that the plaintiff's claims amounted to mere negligence. The court found that the plaintiff had appropriately stated more than mere negligence, sufficient to make a claim under the FCA and dismissal was premature. Although only addressing a motion to dismiss, the case illustrates that false claims liability may attach when the defendant submits a false certification to the government which is a prerequisite for reimbursement.

In *U.S. ex. rel. Sanders v. East Alabama Healthcare*

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[3]Under 18 U.S.C.A. § 1001.

[4]31 U.S.C.A. § 3729.

[5]31 U.S.C.A. § 3729(b).

[6]U.S. ex. rel. Mathews v. Healthsouth Corp., 54 Fed. Appx. 404 (5th Cir. 2002).

[7]Specifically, the forms indicated that the hospital in question certified that it complied with a rule requiring it to maintain a 75% patient population with specific diagnoses to operate as a PPS-exempt rehabilitation hospital. The plaintiff alleged that this rule was never satisfied, despite the fact that the hospital regularly operated at nearly 100% capacity. U.S. ex. rel. Mathews v. Healthsouth Corp., 54 Fed. Appx. 404 (5th Cir. 2002).

Authority,[8] the District Court for the Middle District of Alabama addressed a case in which a relator brought suit under the FCA, claiming that reimbursement claims based on a false Certificate of Need (CON) which allowed a hospital to be reimbursed by the Medicare and Medicaid programs. The court stated "This court finds that the knowing submission of a claim that falsely represented attainment of state licensing requirements is enough to constitute a false claim."[9] Although the court ultimately noted that the link between the hospital's submission of claims for reimbursement and the falsely obtained CON was, according to the plaintiff's complaint, only tenuous and barely sufficient to survive a motion to dismiss, the implication of this case is that claims where reimbursement is conditional upon compliance with the law are sufficient to attach liability.

Similarly, in *U.S. ex. rel. Thompson v. Columbia/HCA Healthcare Corp.,*[10] the Fifth Circuit Court of Appeals addressed a case in which Columbia/HCA was alleged to have filed false claims. The relator claimed that Columbia/HCA had violated both the federal anti-kickback statute and Stark, and had submitted annual cost reports certifying that the health care services identified in the reports had been provided in compliance with laws and regulations regarding the provision of health care services. In addressing Columbia/HCA's motion to dismiss for failure to state a claim, the court noted,

> Where the government has conditioned payment of a claim upon a claimant's certification of compliance with, for example, a statute or regulation, a claimant submits a false or fraudulent claim when he or she falsely certifies compliance with that statute or regulation.[11]

Again, this case reinforces the proposition that the act of submitting a claim for reimbursement where such reimbursement is contingent upon some certification or statement of

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[8] U.S. ex rel. Sanders v. East Alabama Healthcare Authority, 953 F. Supp. 1404 (M.D. Ala. 1996).

[9] U.S. ex rel. Sanders v. East Alabama Healthcare Authority, 953 F. Supp. 1404, 1411 (M.D. Ala. 1996).

[10] U.S. ex. rel. Thompson v. Columbia/HCA Healthcare Corp., 125 F.3d 899 (5th Dist. 1997).

[11] U.S. ex. rel. Thompson v. Columbia/HCA Healthcare Corp., 125 F.3d 899, 902 (5th Dist. 1997).

compliance with the law or a regulation will be sufficient to apply false claims liability.

The implication in all of these cases is that the "intent" portion of the statute may be met when the entity knowingly submits a false claim. So, if a practice knows one of its physician employees has had his license temporarily suspended (thereby constituting a "final adverse action" requiring an update of enrollment information), no update is made, and the practice continues to submit claims for the physician's services, it is possible that the practice could be held liable under the FCA. Because Medicare reimbursement is predicated on enrollment eligibility, and the physician in question is not eligible to be paid (by virtue of failing to report the final adverse action as required by 42 C.F.R. § 424.516(d)), the practice may be found liable for submitting false claims. Practices should be able to avoid many of these issues, but doing so will require constant vigilance, an understanding of the Medicare enrollment requirements, and how these requirements apply to the practical realities of day-to-day operation.

§ 1:9 Common scenarios and problems

Failure to comply with the requirements for obtaining and maintaining enrollment may lead to a slowdown or freeze in Medicare revenues and may expose a practice to administrative sanctions and additional penalties. The following common scenarios elucidate how failure to comply with these requirements may impact physician practices. The scenarios focus on how practices must contend with structural changes to their business, personnel changes, miscellaneous scenarios, and addressing the appeals process.

§ 1:10 Common scenarios and problems—Structural changes

Several types of changes may be considered "structural" changes for physician practices. These include changes of ownership, changes in billing and/or management companies, and adding or changing practice locations (including storage facilities).

§ 1:11 Common scenarios and problems—Scenario 1: Adding locations

Cardiovascular Associates of Springfield (CAS) is a profes-

sional corporation with six shareholder physicians. The practice primarily provides cardiovascular services and wants to expand into a new facility to perform all of its diagnostic testing services. It intends to maintain a separate office location to provide other consultation and treatment services to patients. CAS has been enrolled in Medicare since 2006 and completed a CMS-855B when it initially enrolled.

CAS must file because of the change of location due to the addition of the diagnostic site. The practice must also submit "change of ownership interest and/or managing control information" on the CMS-855B because it is hiring a management company.

Finally, as an additional hurdle, CAS cannot bill for services rendered at the diagnostic location until the application is processed by CMS. Recall that CMS must process this change of information within no more than 90 days, but this means that the practice cannot submit claims while awaiting the new location's approval. While the practice may bill for services rendered, at least as of the date of submission of the CMS-855B, it cannot count on immediate revenue from the diagnostic location until approval has been granted. Additionally, CAS must submit all applicable supporting documentation with its application, including licenses and/or certifications for the diagnostic site. If the practice has not obtained these prior to submitting the application, it may face additional delays while it responds to CMS's request for such documentation. If it is unable to respond in time, it must wait an additional 60 days from the date CMS rejects the application for the new facility before submitting a subsequent application with the required documentation.

As a variation on this scenario, suppose CAS is eager to obtain billing privileges at its new location, knowing that it will be a key income center, and submits its application while the lease agreement is being negotiated (and therefore before it has obtained all of the necessary permits). CAS recognizes that this is a gamble, but hopes that the negotiations will proceed swiftly, allowing it to quickly obtain what will be the necessary supporting documentation. Unfortunately, the negotiations drag as the lawyers for both sides parse the finer points of Stark and anti-kickback compliance in the lease.

While CAS is waiting for the contract to be finalized, the

Medicare contractor demands copies of the necessary supporting documentation, including facility licenses. CAS now has 30 days to respond to the request. If the negotiations do not finish within that time, and if CAS cannot obtain the necessary licenses in that window, its application will be denied under the new appeals rules. There will be no point in appealing the denial, so CAS will have to wait 60 days from the date of denial before it can resubmit an application for the new site, which will remain unable to submit claims during the time period. In addition, CAS will only be able to begin submitting claims, at the earliest, on the date it submits the second application.[1] Even if CAS is successful in its second attempt, the time between its second application submission and subsequent approval may last as long as 180 days in addition to the time it waited during its first submission and the 60 day "appeals period" during which it could not submit a subsequent application. Taken together, it is therefore the wiser course of action to wait until all documentation can be simultaneously submitted to avoid delays in obtaining billing privileges.

§ 1:12 Common scenarios and problems—Scenario 2: Adding a management/billing company

Sawbones, Inc., is an orthopedic surgery group. Rather than juggle surgery schedules and administrative duties, three years ago the group hired MDMGT Systems, Inc., a management company to run the group's day-to-day affairs. However, the group is frustrated with MDMGT's handling of its accounts and has received complaints of how MDMGT personnel interact with the group's nonphysician employees and patients. As a result, the group has decided to terminate its agreement with MDMGT.

If MDMGT is providing billing services, the practice must complete the section of the 855B regarding changes in billing agencies (which may also require a change of payment address) when it terminates the contract. When Sawbones hires a new billing and/or management company, it must

[Section 1:11]

[1] CAS will still be unable to submit claims until after the second application is approved but will be able to submit claims for the period between the submission date and the date of approval.

complete both the sections regarding management and control interests, and the billing agency section. It need not submit the billing/management contract to CMS.

§ 1:13 Common scenarios and problems—Scenario 3: "Long-time supplier, first-time reviser"

Main Street Family Physicians (MSFP) is a four-physician family medicine practice. MSFP owns its office building, and leases two exam rooms and the use of the common areas and front desk staff to RadioCare, P.C., a small radiology group, three days a week for one four-hour session per day. MSFP uses the exam rooms when they are not in use by RadioCare. RadioCare performs only diagnostic work at the MSFP office location. In addition to leasing its front desk staff, RadioCare now wishes to lease the use of MSFP's billing personnel to file claims on behalf of RadioCare.[1] The original lease arrangement has existed unchanged since 1997, when RadioCare first enrolled. MSFP has been enrolled with Medicare since 1996. The lease has only been renewed annually and to update the rental rates to what is fair market value. RadioCare has never updated its enrollment information.

RadioCare will want to fill out a complete CMS-855B. While at first blush it might only seem necessary to complete the sections relating to a "change of billing agent" because it has not updated its information since 1997, there will be additional information that Medicare does not have on file about RadioCare, unrelated to the lease arrangement. Depending on what information was not captured on the original enrollment application, the required changes and updates may be substantial enough to warrant submitting a complete, new application.

As long as none of the facts applicable to RadioCare's original arrangement have changed, there will be no problem with it having not previously updated its information. Without some change to warrant a resubmission of the information, and without having received a request to revalidate its information from a Medicare contractor, RadioCare was under no obligation to update its information, even though

[Section 1:13]

[1]Assume that the lease between MSFP and RadioCare complies with Stark and the federal anti-kickback statute.

the Medicare enrollment forms changed considerably from the time it originally enrolled. However, in light of the requirement to update its information regarding its billing agent, RadioCare should consider submitting a complete CMS-855B. This may also act to forestall a future request by CMS that RadioCare revalidate within the next three years.

§ 1:14 Common scenarios and problems—Scenario 4: "It's just over the bridge" and other difficulties

TheraMed, LLC, is a rehabilitation medicine practice located in St. Louis, MO, and is adding a new office location just across the border in East St. Louis, IL. TheraMed intends to hire as independent contractors three new physician assistants (PAs) who have never enrolled in Medicare. TheraMed has been enrolled since 2002 and has had no reason to update its information prior to these changes.

Adding a new physical location raises several issues. First, TheraMed must enroll the new location and cannot bill for services rendered at the new office until its enrollment application is processed. Second, TheraMed must fill out a complete, separate enrollment application with a different Medicare contractor.[1] However, until the PECOS system is sufficiently updated to permit national enrollment, practices must enroll with each Medicare contractor that governs the states in which the practice submits claims. Once TheraMed has completed its lease negotiations to use the new location, and once it has obtained all necessary supporting documentation, it should enroll as soon as possible with the applicable Medicare contractor(s).

In addition, TheraMed must meet applicable state law requirements to provide services in that state. Therefore, as part of its enrollment in Illinois, TheraMed must ensure that all of its personnel, including the PAs, are authorized

[Section 1:14]

[1] St. Louis, MO, falls into Medicare Administrative Contractor (MAC) Jurisdiction 5, which is under the aegis of Wisconsin Physicians Services, Inc. (WPS). However East St. Louis, IL, falls into MAC Jurisdiction 6, the contract for which had not been awarded as of this writing. While at the time of this writing, WPS still administers Illinois Part B Medicare, when the Jurisdiction 6 contract is awarded, this will change. *See* http://www.cms.hhs.gov/MedicareContractingReform/02_WhatsNew.asp for the most current list of MACs.

under Illinois law to provide services and have the appropriate licenses and/or certifications.[2] Moreover, even if the PAs are licensed to practice in Illinois, until each PA has individually enrolled in Medicare, TheraMed cannot bill for their services. The PAs will each need to fill out a CMS-855I. Finally, if any of the PAs leave TheraMed at a later date, the practice will need to update its CMS-855B to indicate the deletion of each PA who leaves.[3]

§ 1:15 Common scenarios and problems—Personnel changes

Some practice changes involve additions or deletions of personnel, rather than structural aspects of the business. For example, the addition or removal of clinical personnel, owners, or managers may each require different changes on the CMS-855B form and may present additional practical hurdles.

§ 1:16 Common scenarios and problems—Scenario 4: Ownership personnel changes

Ear, Nose, and Throat Associates of Mississippi, LLP (ENTAM) is a limited liability partnership. A promising young doctor has been working at ENTAM for several years and is being offered a partnership interest. At the same time, one of the older physician partners is retiring and divesting his partnership interest.

Both the addition of a new partner and the removal of an existing partner will require that ENTAM's enrollment information be updated, with respect to the section regarding "ownership interests" of individuals.[1] If either the retiring partner or the new partner hold or will hold a 5% interest, ENTAM must update its information. The addition of the new partner as a 5% (or more) owner means the new partner must disclose any adverse legal actions imposed against him.

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[2] All of which must be submitted as supporting documentation with CMS-855B.

[3] Physician assistants are not required to complete an 855R, however, because Medicare does not pay them directly for their services. There is therefore nothing for them to "reassign."

[Section 1:16]

[1] Section 6 of the CMS-855B.

As a practical matter, depending on the timing of each of these activities, ENTAM may need to file separate applications for each action. For example, if the older partner leaves ENTAM in September, but the negotiations regarding the partnership agreement for the new partner are not completed until January of the following year, ENTAM must submit a separate application for each individual—the departing partner and the newer partner. On the other hand, if the deals for both parties are concluded and occur within a few days of each other, a single enrollment form may be submitted with both changes listed.

§ 1:17 Common scenarios and problems—Scenario 5: More than just a fresh face—Risks in adding a new physician

KLA Associates, P.C., a family medicine group, is undergoing some internal shakeups. Until recently, the practice had two separate offices. It has decided to close one location and is dismissing two of its four PAs. Instead, KLA has decided to hire a young cardiologist coming out of fellowship to address the increasing number of Medicare patients with heart problems coming to them, following the dissolution of a competing cardiology group. Rather than refer business to other cardiology practices in the area, KLA would like to keep "in house" at least some of the cardiology services required by its patients. The new cardiologist will be an employee, but for the time being will not be a shareholder in the business.

The addition of the new physician will impact KLA in multiple ways. First, he must be enrolled in Medicare, which necessitates filing a CMS-855I. Second, he must reassign his right to payment to KLA using CMS-855R. The addition of a cardiologist to a primarily family-medicine-oriented practice will also cause the local carrier to classify the practice as a "multi-specialty" group, and will require the practice to submit a change of information indicating that it operates a multispecialty clinic.[1]

Aside from the administrative hassle of submitting a new

[Section 1:17]

[1] *See* CMS-855B, section 2.A. Physician practices are instructed to check the type of supplier they are enrolling as. If they are more than one

enrollment application due to the addition of a single physician, KLA may face other problems. For example, once it is considered a "multi-specialty" group by its local carrier, the practice may find itself "kicking out" on the carrier's computer system due to its billing patterns, in comparison to other multispecialty practices that report to the carrier. This may lead to further headaches as CMS (or the local PSC) places the practice on prepayment review and requests copies of medical records to substantiate what the carrier sees as an abnormally high volume of certain kinds of services. Even if KLA is ultimately able to demonstrate that its claims are all medically necessary and reasonable, the cost and potential impact to cash flow of being placed on prepayment review can be devastating to a small business, even if all of the claims are ultimately paid.[2]

§ 1:18 Common scenarios and problems—Scenario 6: "What do we do now that Phil's leaving?"—Departure of an owner/manager physician

Beartooth Valley Medical Partners, LLC, a Montana multispecialty group, enrolled with Medicare only three months ago. However, due to internal dissent, one of the five physician owners—the CEO who was listed on the 855B as an "Authorized Official"—is leaving the practice. Another physician owner (the COO) will list herself as the Authorized Official, but wants nothing to do with the day-to-day responsibility of keeping the Medicare enrollment information up to date. A junior shareholder in the business (who holds 5% interest) has been selected to assume these duties.

The practice will need to submit several reports. First, the removal of the CEO shareholder will need to be reported. Second, a new Authorized Official will need to be named, requiring the COO to be listed on the CMS-855B. The COO, however, need not maintain the enrollment information and can instead delegate this task to a W-2 employee practice

type of supplier, they must submit a separate application for each type. Likewise, if they change the type of service they provide—as in scenario 5 above—they must submit a new application.

[2]Separate from the issues surrounding the addition of the new physician, KLA must further update its enrollment forms to account for the closing of the second location as well as the removal of the PAs. However, these kinds of facts have already been discussed above.

manager as a Delegated Official. This requires another change to the enrollment information. The Authorized Official may still retain the authority to update the information, but need not do so as long as the Delegated Official is performing his duties.

§ 1:19 Common scenarios and problems—Scenario 7: The d/b/a mix-up

While not necessarily a structural or personnel change, this scenario provides an example of a practice seeking to correct a past error. McCoy & Associates, P.C. (doing business as "Space-Age Medicine") enrolled in Medicare in 2001. However, on its original CMS-855B, the practice listed their name as Space-Age Medicine, rather than the legal business name of McCoy & Associates, P.C., listed in its incorporation documents. The practice only discovered this error this year and has never been notified by Medicare about it. To correct this situation, McCoy & Associates should file an updated, correct CMS-855B as soon as possible. While doing so, the practice may want to update its enrollment information, rather than wait for CMS to contact it and request a revalidation.[1]

§ 1:20 Common scenarios and problems—Scenario 8: Avoiding a pyrrhic victory

Ardmore Family Medicine, Inc. (Ardmore Family) is a family medicine practice in Pennsylvania that has been in operation for 20 years, and has had billing privileges with Medicare throughout this period. Unfortunately, a patient has recently filed a complaint with the Pennsylvania Board of Medicine, alleging that one of Ardmore Family's physician owners (with more than 5% ownership) has made improper sexual advances. The Pennsylvania Board of Medicine has suspended the physician's license pending an investigation into the matter, which is standard procedure in Pennsylvania. Ardmore Family has engaged local counsel in Pennsylva-

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[Section 1:19]

[1]Ideally, the revalidation process will help to eliminate or at least reduce the impact of these types of scenarios. As practices are required to submit full, new applications on a reoccurring basis, they should be able to correct problems of this kind.

nia to represent the physician owner and is awaiting the outcome of the case. Knowing it has an obligation to update the information on its Medicare enrollment, Ardmore Family submits a CMS-855B listing the adverse legal action. It sends the enrollment application two days before the 30-day limit to notify CMS of changes in ownership and control. The following day, the Pennsylvania Board of Medicine dismisses the claim and reinstates the physician's license.

Eventually, the local Medicare contractor discovers the adverse legal action and revokes Ardmore Family's billing privileges. Ardmore Family continues to submit claims, although they are all rejected during the revocation period. Ardmore Family appeals the revocation, and is, after a 2 1/2 month ordeal, able to prove that, although the application was received five days after the 30-day limit, it sent the change of information within the required timeframe. Although Ardmore Family is ultimately able to resubmit the claims that were rejected during the appeals process, the practice's revenues have already suffered to the point where it must take out a line of credit, thereby taking on considerable debt purely to make ends meet pending the outcome of the appeal.

This scenario illustrates: (1) how the specific requirements of Medicare enrollment and the CMS-855B (in this case, reporting adverse legal actions which include suspensions of licenses pending the outcome of an investigation) must be constantly monitored, and (2) how a practice can minimize the impact of a revocation of billing privileges during the appeals process. By continuing to submit claims during the revocation period, Ardmore Family is at least able to protect its ability to resubmit claims at a later date. Even so, Ardmore Family likely could have avoided the revocation altogether if it had submitted an updated enrollment application as soon as its physician owner was suspended, regardless of the eventual outcome of the suspension.

§ 1:21 Conclusion

In the last analysis, are the changes to the enrollment process and those systems surrounding it (such as the appeals process) really necessary—even to the point where changes are issued less than six months apart in entirely different government publications? Is it really just hazing, or

do the administrative details support a loftier goal? Ultimately, the changes are designed to bar miscreants from gaining access to the Medicare trust fund. Unfortunately, they may snare otherwise well-intentioned physicians in the process. Moreover, it is clear that the burdens on the Medicare system will grow in the near future. This will likely prompt CMS to further control spending and create additional hurdles for physician practices designed to curtail Medicare expenditures. Enrollment is likely to remain a tool in CMS's arsenal toward this end.

Given the importance CMS places on maintaining proper enrollment, physician practices must remain vigilant in monitoring the status of their enrollment. Not only is it critical that the practice understand the myriad information that must be submitted, it must also keep track of how soon such information must be submitted. Failure to understand the requirements for maintaining enrollment may transform otherwise ordinary business transactions into nightmare scenarios that result in revocations of billing privileges, while continued submission of claims after deadlines have passed may transform law abiding practices into notches on the belt of a federal prosecutor. Practices that fail to understand the intersection of CMS regulations and policies and their own practical realities may face delays to their ability to submit claims.

Amazingly, because of the pitfalls in the process and the draconian effects of inadvertent slip-ups, it is now prudent to obtain legal review of applications and guidance on maintenance of information. It is crucial that practices understand both the legal implications of the enrollment process and the practical implications to their business plans. Ideally, practices that understand these issues may avoid the more severe pitfalls of the enrollment process. With a clearer understanding of these requirements, the process should at its worst be little more than "hazing" to join the Medicare "fraternity."