Health Law Alert: CMS Announces New Medicare Enrollment Revalidation Initiative, Issues Revised Enrollment Applications

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CMS announced recently that it will require all providers and suppliers enrolled in Medicare before March 25, 2011, to reconfirm the accuracy of their enrollment, a process known as "revalidation." The only category of providers and suppliers that are exempt are those who enrolled in Medicare after March 25, 2011.

Many providers may remember the massive revalidation initiative that occurred in 2009, and in particular some of the challenges that were part of that process. For several reasons, CMS' earlier initiatives caught providers off-guard. Revalidation requests were not sent via certified mail, which in some cases led to requests being lost in the everyday shuffle of correspondence. Some requests were addressed to practice locations on file with CMS that did not receive mail (because the provider receives mail at a separate address). There was also confusion about how revalidation requirements interact with obligations to report changes of information—like changes in practice locations—to CMS within specified time periods. Some providers fell into the trap of thinking that revalidation allowed them to wait to inform CMS all at once of changes, when in fact they were obligated to inform the agency within 30 days of the change.

In its new initiative, CMS will contact providers and require complete enrollment applications and supporting documents to be provided to the agency within 60 days. Failure to respond within this timeframe can lead to loss of billing privileges for one year, effective just 30 days after CMS mails notice of its determination. Although an appeals process exists, there is no guarantee that a provider will succeed in reversing CMS' decision. Thus, quick action in response to a revalidation request is imperative. Some providers might prefer to proactively revalidate—with the goal of taking care of this obligation while it is fresh in mind, as opposed to waiting to receive CMS' request. Unfortunately, this will not be permitted. Instead, providers and suppliers must wait to receive a request from CMS.

CMS Announces New Medicare Enrollment Forms

CMS has also published revised Medicare enrollment forms for all provider and supplier types. The most substantial revisions were made to the Form 855A (for Institutional Providers) and on the new Form 855O, which will be used by physicians and nonphysician practitioners (NPPs) who enroll for the sole purpose of

ordering or referring items for Medicare beneficiaries.

Why Did CMS Revise the Enrollment Forms?

2010's Affordable Care Act is the latest step in CMS' effort to implement ever more rigorous program integrity standards. The theory is that by keeping bad actors out, much of the fraudulent activity that has bedeviled federal health care programs can be stopped before it starts. While no one disputes the value of fighting genuine fraud, many providers and suppliers have been inadvertently tripped up by the ever increasing complexity associated with the enrollment process. Providers and suppliers that have been participating in Medicare since the 1990s may long for the predecessor to the current enrollment forms—the HCFA-1513, a document that had one page of instructions and eight questions. By comparison, the current version of the CMS-855A form is 59 pages long and includes dozens of intricate questions.

Changes to the CMS 855 Forms

Form 855A

The revised 855A requires the submission of new information by all enrolling providers. Additional disclosures include the identification of the hospital's compliance plan and the reporting of the provider's cost-year-end date. Sections 5 and 6 have also been expanded to collect information on the type of organization (e.g., holding company, medical staffing company, investment firm, etc.), the percentage of direct or indirect ownership interest, and the effective date of the ownership or controlling interest. Given the precision with which ownership interests must be reported, it is unclear whether CMS will expect providers to update the Form each time an ownership percentage fluctuates. If so, this may be particularly burdensome for providers owned by publicly traded companies, where ownership levels change frequently.

The 855A was also revised to enact new restrictions made under the Act to the Stark Law's exception for physician ownership in hospitals. Section 2 of Form 855A now requires the applicant to indicate whether it is a physician-owned hospital. If so, the hospital is required to complete the new Attachment 1, which consists of two sections. Section 1 of the Attachment must be completed for every organization that has any percentage of ownership or investment interest in the physician-owned hospital. Similarly, Section 2 must be completed for every individual that has any percentage of ownership or investment interest in the physician-owned hospital.

Form 855O

Unlike the other CMS-855 enrollment forms, the 855O is an entirely new document. It is to be completed by physicians or NPPs who do not intend or desire to participate in Medicare, but do order tests or procedures for, or refer beneficiaries to, other Medicare enrolled providers or suppliers for Medicare covered services. This form asks for only basic information about the provider or NPP, such as contact information, professional licensure and credentialing information, and a description of any adverse legal history. Physicians and NPPs completing the 855O must certify that they will comply with the False Claims Act,

Stark Law, and other regulatory standards governing the Medicare and Medicaid programs.

855B, 855S, and 855I

The revised CMS 855B (supplier enrollment), 855S (DME suppliers), and 855I (individual physicians and NPPs) forms now require the identification of the supplier as proprietary or nonprofit, reporting of accreditation for independent diagnostic testing facility suppliers that will bill Medicare for advanced diagnostic imaging services, and the place and country of birth for individuals that have an ownership or managing control interest in the supplier. Other changes to these three forms include:

- 855B—CMS has removed the enrollment distinction between single specialty and multispecialty medical groups.
- 855S—In order to incorporate new regulatory provisions implementing new quality standards for DME suppliers, Section 2 is revised to clarify supplier types, products, and services, including individual states to be served.
- 855I—In a subsection of Section 2 titled "New Patient Status Information," physicians and NPPs are now required to indicate whether or not they accept new patients.

Transitioning to the Revised Forms

The 855O form is to be used immediately. CMS is "encouraging" providers and suppliers to use the other new forms now, although the agency has said that it will permit the previous versions of these forms (issued in 2008) to be used through October 2011.

If you have questions on CMS' new revalidation initiative or the new CMS-855 forms, please contact Jesse Berg at jesse.berg@lathropgpm.com or 612.632.3374.