

# HEALTH REFORM IMPACT

## What you need to know NOW

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

### **“Pay and Chase” No More: CMS Begins Implementing Health Reform's Provider Enrollment Provisions**

November 12, 2010

On September 23, 2010, the Centers for Medicare & Medicaid Services (“CMS”) published a proposed rule intended to implement various fraud and abuse provisions of the health reform legislation, including new enrollment screening measures and enrollment application fees.<sup>1</sup> In addition, CMS has recently provided guidance addressing the requirement that certain physicians and other practitioners enroll in the Provider Enrollment, Chain and Ownership System (PECOS) in order to be eligible to certify or order services for Medicare beneficiaries. This issue of *Health Reform IMPACT* summarizes these recent developments.

#### **Proposed Screening Requirements for Medicare, Medicaid, and CHIP**

In its September 23, 2010 proposed rule, pursuant to broad discretion granted under section 6401 of the Patient Protection and Affordable Care Act (“PPACA”), CMS creates three categories of risk—limited, moderate, and high—for purposes of provider enrollment in Medicare. Each type of provider and supplier would be assigned to one of these three risk categories, and Medicare contractors would apply different screening tools to each of the three categories during the provider enrollment process.

Specifically, for those providers and suppliers categorized as limited risk, Medicare contractors would be required to: (i) verify compliance with any applicable provider- or supplier-specific requirements; (ii) conduct license verifications; and (iii) perform pre- and post-enrollment database checks to verify social security number, national provider identifier (“NPI”), Office of Inspector General (“OIG”) exclusion status, and tax delinquency, among other items, with respect to each individual practitioner, owner, authorized official, delegated official, and/or supervising physician. For those providers and suppliers categorized as moderate risk, Medicare contractors would, in addition to performing the screening requirements applicable to limited risk providers and suppliers, perform unannounced pre- and/or post-enrollment site visits. Finally, for high risk providers and suppliers enrolling in Medicare, CMS would require its contractors to perform, in addition to the screening measures applicable to the limited risk and moderate risk categories, criminal background checks and collection of fingerprints.

<sup>1</sup> See 75 Fed. Reg. 58204 (Sept. 23, 2010).

The health reform legislation requires that states also comply with these new enrollment and screening provisions. For providers and suppliers that are enrolled in Medicare, states may rely on the screenings conducted by Medicare contractors and are not required to independently conduct the same screenings. For those providers and suppliers that are not enrolled in Medicare (*i.e.*, Medicaid-only or Children's Health Insurance Program ("CHIP")-only providers), CMS would require the states to follow the minimum Medicare screening provisions (although CMS would allow a state to conduct additional screenings). States are also permitted to rely on the screenings performed by Medicaid agencies in other states.

### *Provider Types Assigned to Risk Categories*

CMS proposes to assign providers and suppliers to one of the three risk categories based on CMS' assessment of fraud, waste, and abuse risk.<sup>2</sup> CMS considers physicians, nonphysician practitioners, and medical clinics and group practices to pose limited risk because they are licensed by the state (or are composed of practitioners licensed by the state) and CMS is not aware of evidence that they pose an elevated risk to the Medicare program.<sup>3</sup> CMS also includes various other providers and suppliers, including but not limited to hospitals, ambulatory surgical centers, government-affiliated ambulance services, and skilled nursing facilities, as limited risk providers. In addition, *providers or suppliers of any type* that are publicly traded on the NYSE or NASDAQ exchange would be assigned to the limited risk category because of the financial oversight provided by investors, boards of directors, and the Securities and Exchange Commission (SEC).

Those provider and supplier types that CMS considers "generally highly dependent on Medicare, Medicaid, or CHIP to pay their salaries and other operating expenses" and generally subject to less government or professional oversight than limited risk providers are grouped into the moderate risk category (provided they are not publicly traded, in which case they would be limited risk).<sup>4</sup> CMS proposes that this moderate risk category include community mental health centers, comprehensive outpatient rehabilitation facilities, hospice organizations, independent diagnostic testing facilities, independent clinical laboratories, and nongovernment-affiliated ambulance services. In addition, currently enrolled home health agencies and currently enrolled Durable Medical Equipment and Prosthetic and Orthotic Supplies ("DMEPOS") suppliers would be considered moderate risk for revalidation applications. The high risk category would consist of newly enrolling home health agencies and DMEPOS suppliers that are not publicly traded. CMS also proposes that limited risk or moderate risk providers and suppliers that have been the victim of identify theft or that are subject to certain program sanctions could be required to undergo the screening requirements applied to high risk providers.

### *Enrollment Fees and Implementation Timeline*

Subject to limited hardship exceptions and waivers, CMS proposes to establish an application fee of \$500 (adjusted annually) for all initial enrollments and revalidations submitted by "institutional providers," as required by the health reform legislation. *Institutional provider* would include any provider that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (excluding physicians, nonphysician practitioners, or physician/nonphysician practitioner organizations), or CMS-855S (or, in each case, the analogous

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<sup>2</sup> 75 Fed. Reg. 58208.

<sup>3</sup> 75 Fed. Reg. 58209.

<sup>4</sup> 75 Fed. Reg. 58210.

Internet-based PECOS enrollment application). States would be permitted to collect the application fee for an institutional provider not enrolled in Medicare that is enrolling in fee-for-service Medicaid or CHIP.

All applications for initial enrollment would be subject to the new enrollment requirements, including the application fee, beginning March 23, 2011. In addition, those providers and suppliers required to revalidate their enrollments between March 23, 2011 and March 23, 2012 would be subject to the new enrollment requirements as of March 23, 2011. For all other currently enrolled providers and suppliers, the new enrollment requirements would be effective March 23, 2012. CMS acknowledges that, due to this implementation timeline, some providers and suppliers may be required to revalidate their enrollment outside of their regular revalidation cycles.

### **Ordering Physicians and Practitioners - Enrollment in PECOS**

Pursuant to section 6405 of PPACA, CMS issued an interim final rule on May 5, 2010 requiring that certain physicians and other practitioners (collectively referred to as "ordering physicians") be enrolled in the Medicare program's PECOS system for the sole purpose of certifying or ordering services for Medicare beneficiaries. Enrollment in PECOS will be necessary even if these ordering physicians themselves do not submit claims to Medicare for services they furnish.

In the interim final rule, CMS specifies that a Medicare-certified ordering physician must be identified (by name and NPI) on certain types of claims that require the identification of the ordering physician. Medicare contractors will be instructed to reject any such claims that do not properly identify a Medicare-certified ordering physician. Claims for which identification of a Medicare-certified ordering physician will be required include claims for DMEPOS, home health items or services, laboratory services, imaging, and certain specialists' services. In order to verify the credentials of the ordering physicians, CMS is requiring that all such ordering physicians have enrollment records in PECOS. CMS provides a limited exception for those physicians and other practitioners who have properly opted out of the Medicare program.

CMS expects that any ordering physicians who, within the past six years, have either (a) enrolled in Medicare or (b) submitted updates to their Medicare enrollment will have a PECOS enrollment record. Those ordering physicians that do not already have a PECOS enrollment record will be required to enroll in PECOS. In the interim final rule, CMS stated that July 6, 2010 would be the deadline for enrollment in PECOS, but CMS subsequently indicated that rejections of claims for failure to identify a Medicare-certified ordering physician would not begin until January 3, 2011. In September of 2010, CMS published a document, "The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement," in which CMS again revised the deadline by indicating that claims for ordered or certified items and services will not be rejected due to the lack of the ordering physician having an approved enrollment record in PECOS until CMS advises otherwise.<sup>5</sup>

In the meantime, CMS has issued guidance, including Transmittal 355, dated September 17, 2010, acknowledging that it has become aware of several unique enrollment issues for certain types of ordering physicians or practitioners and, consequently, has modified the enrollment

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<sup>5</sup> Available [online here](#).

process for these physicians and practitioners. Specifically, CMS has created an abbreviated paper-based PECOS enrollment process for physicians employed by the Department of Veterans Affairs, Public Health Service, Department of Defense/TRICARE program, Federally Qualified Health Centers, Rural Health Clinics, or Critical Access Hospitals. The abbreviated PECOS enrollment is also available for physicians in a fellowship and for dentists, including oral surgeons. CMS emphasizes, however, that anyone who enrolls via the abbreviated enrollment process will not be enrolled in Medicare for the purpose of providing (or billing for) Medicare services to Medicare beneficiaries, but rather only for the purpose of ordering or certifying Medicare services.

## **Conclusion**

Through the above-described reforms and other changes to the provider enrollment process for Medicare and other governmental healthcare programs, CMS is working to “transition...from ‘pay and chase’ to fraud prevention.”<sup>6</sup> Of course, as with many other reforms, the process for screening out those involved in fraud, waste, and abuse also imposes administrative burdens and additional cost on legitimate providers of healthcare services. If you have any questions regarding this issue of *Health Reform IMPACT*, please contact any of the attorneys in our Healthcare Practice Group listed below.

Also, please [click here](#) to visit our special Web site for Health Reform IMPACT.

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<sup>6</sup> 75 Fed. Reg. 58238.

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