

Provider Enrollment Traps for the Unwary

The Basics of Provider Enrollment

- CMS is ultimately responsible for the enrollment of providers in the Medicare system
- CMS contracts with various regional contractors to process provider enrollment applications
- These contractors also handle revalidations and revocations
- In order to submit claims to Medicare, the rendering/billing provider must be enrolled
- In order to order or refer services, the ordering or referring provider must be enrolled

Provider Agreement

- The provider enters into an agreement with CMS and agrees to abide by the Medicare laws and regulations in exchange for payment from Medicare
- The agreement continues in effect until terminated by the provider or CMS



Certifying Compliance

- Provider or supplier must certify that it meets and continues to meet all of the following:
 - Compliance with Title XVIII of the Social Security Act (Medicare Act)
 - Compliance with federal and state licensure, certification, and regulatory requirements
 - Not employing or contracting with individuals or entities that have been excluded or debarred

PECOS or Paper

- PECOS is encouraged – CMS says it is faster and easier
- Cannot use PECOS to:
 - Change a SSN
 - Change a provider's or supplier's TIN
 - Change an existing business structure, for example:
 - Solely owned professional association (PA), professional corporation (PC), or limited liability company (LLC) can't be changed to a sole proprietorship
- PECOS times out after 15 minutes
 - if you haven't saved your work and the system times out, you will have to start over

Provider Enrollment Obligations

- Submission of Enrollment Applications
 - complete, accurate, and with all supporting documentation
- Compliance with Enrollment Requirements
 - meet and continue to meet enrollment requirements
- Report Changes
 - change in practice location or final adverse action – 30 days
 - all other changes – 90 days



Maintaining Enrollment

What could go wrong?



- Rejection of Application
- Denial of Application
- Deactivation
- Revocation
- Preclusion

Rejection

- Failure to furnish complete information within 30 days
 - Timely respond to development requests – if MAC follows up, it does not restart the 30-day clock
 - CMS may exercise its discretion to extend the 30-day period if it decides the provider/supplier is actively working with CMS to resolve any issues
- Signatures
 - unsigned, undated, copied or stamped signatures, signed by an unauthorized person, signed more than 120 days before the MAC received the application
 - wet signature **BLUE** ink
 - PECOS will allow a digital signature
- No appeal rights for rejected applications
- Can impact billing effective date

Enforcement by Enrollment

CMS moving away from “pay and chase”

Trying to keep “bad actors” out of the program from the start



17 Reasons for Enrollment Denial

42 C.F.R. §424.530(a)

<p>1</p> <p>Noncompliance</p> 	<p>2</p> <p>Provider or Supplier Conduct</p> 	<p>3</p> <p>Felonies</p> 	<p>4</p> <p>False or Misleading Information</p> 	<p>5</p> <p>On-Site Review</p> 	<p>6</p> <p>Medicare Debt</p> 
<p>7</p> <p>Payment Suspension</p> 	<p>8</p> <p>Initial Reserve Operating Funds</p> 	<p>9</p> <p>Application Fee / Hardship Exception</p> 	<p>10</p> <p>Temporary Moratorium</p> 	<p>11</p> <p>Prescribing Authority</p> 	<p>12</p> <p>Revoked Under Different Identity</p> 
<p>13</p> <p>Affiliation Poses Undue Risk</p> 	<p>14</p> <p>Other Program Termination or Suspension</p> 	<p>15</p> <p>Patient Harm</p> 	<p>16</p> <p>Reserved</p>	<p>17</p> <p>False Claims Act (FCA)</p> 	<p>18</p> <p>Supplier Standard or Condition Violation</p> 

Reasons to Deny

Most Common Denial Reasons

- Felony conviction within last ten years
- On-site review, showing noncompliance
- Noncompliance with program requirements

Newest Denial Reasons (eff. 1/1/24)

- False Claims Act Judgment
- Supplier Standard Violation



Provider Enrollment Oversight Group (PEOG)



When PEOG Approval is Necessary

- Felony conviction
- False or misleading information or application
- Existing overpayment at time of application
- Revoked under different name, numerical identifier, or business identity affiliation that poses an undue risk
- Other program termination or suspension

PEOG will also instruct the contractor whether a re-enrollment bar is to be imposed

Anecdote

- Physician convicted of felony DUI in 2013 – disclosed on application
- CMS denied enrollment in 2022
- CMS says that felony conviction is detrimental to the best interest of the Medicare program and its beneficiaries
- Appeal unsuccessful because CMS had a “lawful basis” to deny



Practice tip

- If the denial was due to adverse activity (e.g., exclusion, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care or administrative or management personnel of the provider or supplier furnishing services payable by a federal health care program, the denial **may be reversed** (with PEOG approval) **if the provider or supplier submits proof that it has terminated its business relationship with that individual or organization within 30 days** of the denial notification



Deactivation

- Program integrity safeguard where billing privileges are paused
- Reasons for deactivation:
 - Failure to submit a claim for 6 consecutive calendar months (previously 12)
 - Failure to report a change within the applicable time period
 - Failure to furnish complete information to CMS upon request
 - Provider or supplier is not in compliance with all enrollment requirements
 - Practice location is non-operational or otherwise invalid






Deactivation does not affect the Participation Agreement, but a provider or supplier may not receive payment for services or items furnished while deactivated

Reactivation

- In order for a deactivated provider or supplier to reactivate its Medicare billing privileges, the provider or supplier must recertify that its enrollment information currently on file with Medicare is correct, furnish any missing information as appropriate, and be in compliance with all applicable enrollment requirements.
- CMS **may** require a deactivated provider or supplier to, as a prerequisite for reactivating its billing privileges, submit a complete Form CMS-855 application.

22 Reasons for Enrollment Revocation

42 C.F.R. §424.535(a)

			1 Noncompliance 	2 Provider or Supplier Conduct 	3 Felonies 
4 False or Misleading Information 	5 On-Site Review 	6 Grounds Related to Provider & Supplier Screening Requirements 	7 Misuse of Billing Number 	8 Abuse of Billing Privileges 	
9 Failure to Report 	10 Failure to Document or Provide CMS Access to Documentation 	11 Initial Operating Funds for HHAs 	12 Other Program Termination 	13 Prescribing Authority 	
14 Improper Prescribing Practices 	15 False Claims Act 	16 Reserved	17 Debt Referred to Department of Treasury 	18 Revoked Under Different Identity 	
19 Affiliation Poses Undue Risk 	20 Billing From Non-Compliant Location 	21 Abusive Ordering, Certifying, Referring or Prescribing of Medicare Part A/B Services / Items / Drugs 	22 Patient Harm 	23 Supplier Standard Violations 	

Reasons to Revoke

Most Common Reasons

- Noncompliance
- Failure To Report
- Felonies

Newest Revocation Reasons (eff. 1/1/24)

- False Claims Act Judgment
- Supplier Standard Violation



Effective Date of Revocation

- 30 days after CMS or contractor mails the Notice letter
- However, can be **retroactive**
 - Date of exclusion
 - Date of conviction
 - Date of license suspension
 - Date practice location no longer operational

Retroactive revocation can trigger an overpayment demand



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Re-Enrollment Bar

- Revoked providers or suppliers are barred from participating in the Medicare program from the date of the revocation until the end of the re-enrollment bar.
- Re-enrollment bar lasts **1 – 10 years***
 - However, CMS may add up to 3 more years to the provider or supplier's reenrollment bar if the provider or supplier is attempting to circumvent its existing reenrollment bar by enrolling in Medicare under a different name, numerical identifier or business identity.

*CMS may impose a reenrollment bar of up to 20 years if the provider or supplier is being revoked from Medicare for the second time.

Anecdote

- Physician pleaded guilty to identity theft (to obtain prescriptions) and court granted pre-trial diversion
- After successfully completing pre-trial diversion, the charges were dismissed and the records were expunged
- Indicated “no” on the 855-I application related to felony convictions when joining another practice (office personnel completed in PECOS)
- Enrollment revoked, 10-year re-enrollment bar imposed, placed on preclusion list



Part C and Part D Preclusion List

- Replaces the Medicare Advantage (Part C) and Prescriber (Part D) enrollment requirements and creates a Preclusion List
- Reasons
 - Currently revoked and under an active re-enrollment bar,
 - Engaged in behavior for which CMS could have revoked the individual or entity had they been enrolled in Medicare
 - Convicted of a felony within last ten years under federal/state law that CMS deems detrimental to the best interest of the Medicare program

Preclusion List

- Effect
 - MA plans will deny payment for a health care item or service if the individual/entity is on the Preclusion List
 - Part D plans will reject pharmacy claims or deny a beneficiary's request for reimbursement for a Part D drug that is prescribed by an individual on the Preclusion List
- Length
 - Length of the re-enrollment bar
 - If based on a felony conviction, for 10 years from the date of the conviction, unless CMS determines that a shorter length of time is warranted
- Appeal
 - May appeal inclusion on the list but not the underlying reason for the revocation, exclusion, or other adverse action that led to inclusion on the list

Appeals

Corrective Action Plans

- Must submit evidence to prove that you are in compliance
- CAPs are only available for
 - Denials under 42 CFR 530(a)(1) - Noncompliance
 - Revocations under 42 CFR 535(a)(1) – Noncompliance
- Only one opportunity to correct all deficiencies that served a basis for the initial determination
- Must be signed by the provider or supplier, an authorized or delegated official (as reported in enrollment record), or attorney
- Must be received in writing within 35 calendar days of the date of the denial or revocation letter
- Deadline to Request Reconsideration not tolled

Levels of Appeal

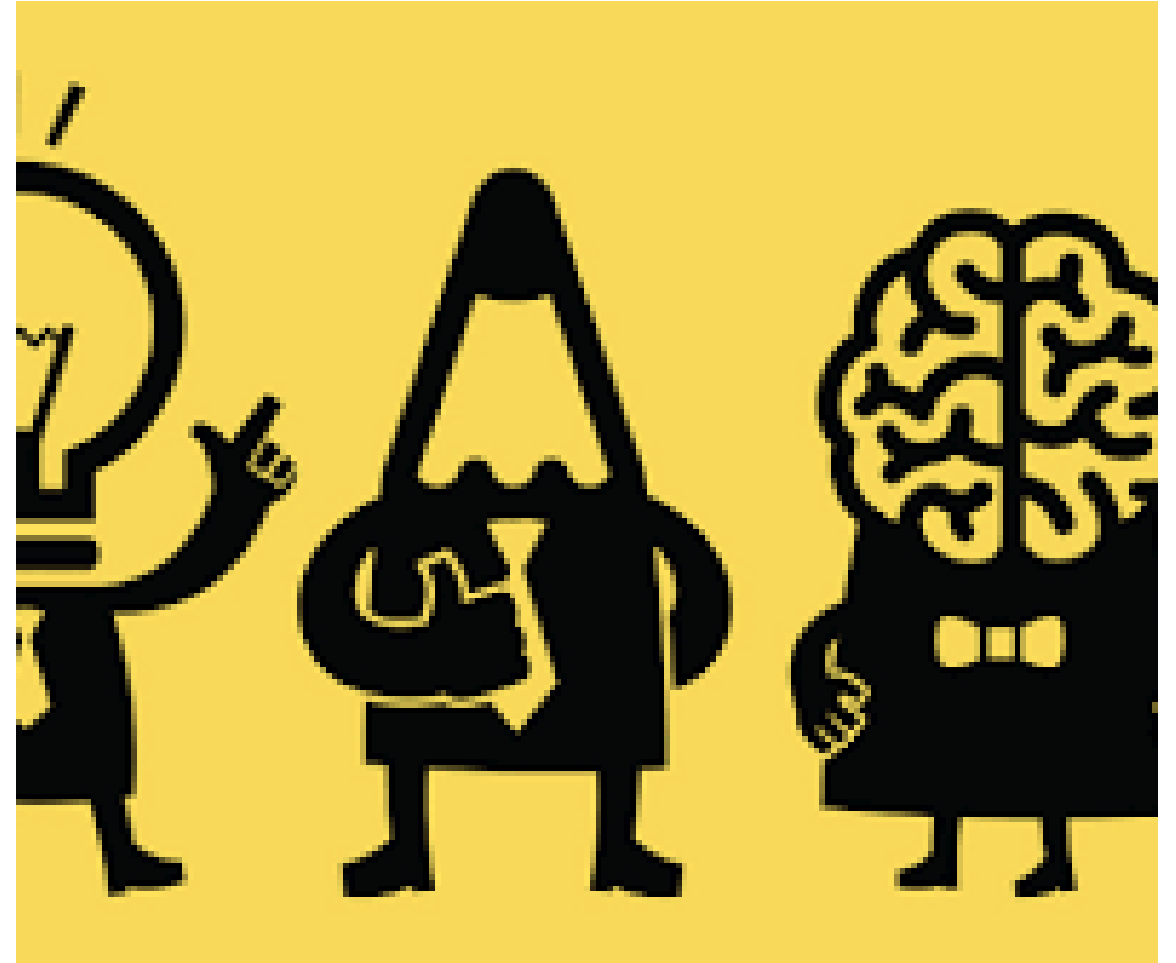
- Request for Reconsideration
- Request for ALJ Hearing
 - Identify specific issues as well as the findings of fact and conclusions of law with which the provider or supplier disagrees
 - Specify the basis for contending the findings and conclusions are incorrect
- Request for Department Appeals Board (DAB) review
 - Specify the issues, the findings of fact and conclusions of law with which the party disagrees
 - Specify the basis for contending the findings and conclusions are incorrect
- Judicial Review of DAB Decision
 - Only available to provider or supplier

Requests for Reconsideration

- Available for all denials and revocations
- Must be received within 65 days calendar days of the date of the denial or revocation letter
- Must be signed by the provider or supplier, an authorized or delegated official (as reported in enrollment record), or attorney
- Must state the issues of fact with which provider or supplier disagrees and the reasons for disagreement
- Only opportunity to submit evidence that may have a bearing on the decision
 - ALJs very rarely allow additional information to be submitted

Behind the Scenes

Sometimes it is possible to resolve matters outside of the appeal process **BUT** must submit an appeal to get a CMS attorney involved



Anecdote

- DME supplier requested to revalidate
- Following a site visit, the supplier received a notice of revocation and imposition of a one-year re-enrollment bar for not being in compliance with various supplier standards
- CAP submitted but did not include photo of posted hours
- Reconsideration decision upheld revocation and re-enrollment bar
- At ALJ level able to settle -- CMS rescinded revocation and retroactively restored billing privileges



Anecdote

- DME supplier revoked for failing to maintain surety bond
- Reconsideration decision was unfavorable and revocation was upheld
- DME supplier requested an ALJ hearing
- Settlement reached to increase the surety bond from \$50K to \$150K and rescind revocation



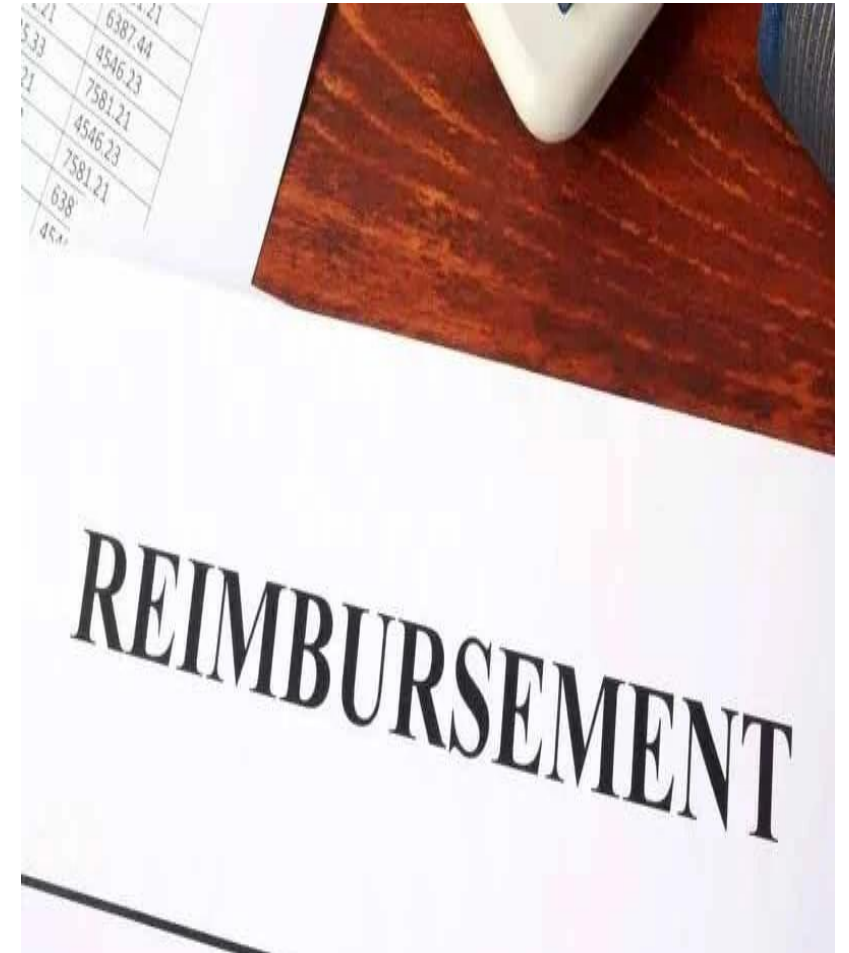
Anecdote

- PA's enrollment revoked following submission of revalidation application
- The state of licensure had two physician licensing boards – MD and DO
- Previously the PA was supervised by a MD and had a license issued by the Board of Medicine
- At the time of revalidation, the PA was being supervised by a DO and had a license issued by the Board of Osteopathic Medicine – she allowed the other license to expire
- The expired license number was mistakenly reported on the revalidation application – MAC checked license and discovered it was expired
- Able to convince CMS that PA's participation was vital for RHC – revocation rescinded

**#WRONG
#NUMBER**

Provider-Based Attestation Requirements

- The Consolidated Appropriations Act (signed into law on Feb. 3, 2026): Included a requirement that CMS stop paying for Medicare services **at existing off-campus hospital outpatient departments** beginning January 1, 2028, unless the hospital has satisfied the following requirements:
 - Obtained location-specific NPI for the off-campus outpatient department(s)
 - Submitted a PBA between January 1, 2026, and December 31, 2027
 - Failure to submit by this date will result in the loss of provider-based status and Medicare payments for items and services furnished by the off-campus department



PBA Requirements - Background

- All hospital locations and services paid by Medicare as hospital services have always had to meet the provider-based requirements at 42 CFR 413.65
 - May be on-campus or off-campus but must demonstrate clinical and financial integration with the main provider
 - Includes things like shared governance, unified financial operations, integrated clinical services, and being held out to the public as part of the hospital
 - Off-campus departments must comply with additional ownership and control standards
- From 2000-2002, providers were required to submit PBAs to obtain CMS confirmation of compliance; then it became voluntary - UNTIL NOW

PBA Requirements – cont’d

- The Consolidated Appropriations Act requires CMS to promulgate notice-and-comment rules to establish a process for the ongoing submission of PBAs and regulatory reviews to confirm compliance
 - May include site visits, remote audits, and “other means” tbd by CMS
- New requirements are **NOT** one-time obligations
 - Hospitals must submit subsequent PBAs for each existing off-campus hospital outpatient location on a periodic basis tbd by CMS (**possibly every two years**)
- For now, providers should look at the current regulations in 42 CFR §413.65 that describe the criteria and procedures for determining whether a facility or organization is provider-based

PBA Requirements – Key Takeaways

- Start compiling PBAs for all off-campus outpatient departments ASAP and be prepared to timely submit (no later than December 31, 2027)
 - May discover gaps in compliance
 - Any evaluations of off-campus provider-based locations that reveal noncompliance (whether recent or long-standing) require analysis of potential overpayments and risk of false claims
- Some locations currently operating as off-campus hospital outpatient locations may be unable to comply with the requirements of 42 CFR 413.65 and will need to convert to another type of healthcare provider to continue to receive Medicare payments
 - These changes may require updates to CMS enrollments, licensing, and other aspects of the location's operations
- Use existing attestation forms as a starting point
- Consider allocating additional staff/resources to undertake the regular preparation and submission of PBAs for off-campus provider-based locations



Questions?



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Thank You



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