PUBLICATION

Medicare Enrollment and Physician Fees Schedule 2009 Final Rules

January 21, 2009

The Physician Fees Schedule 2009 Final Rules, published in the *Federal Register* late in 2008, include updated Medicare enrollment and revocation provisions which impact claims payment timelines for suppliers and practitioners. The Centers for Medicare and Medicaid Services (CMS) provides special rules for Independent Diagnostic Testing Facilities (IDTFs) and DMEPOS suppliers and for physicians, non-physician practitioners (NPP), and physician and non-physician practitioner organizations. CMS also provides on-site review to verify accuracy of enrollment information and for revocation or denial of billing privileges if the enrollment information is invalid.

Each physician, NPP, physician organization or NPP organization must certify compliance with all applicable requirements including any Medicare regulatory and state licensure requirements, practice location and eligibility to participate in the Medicare program.

Medicare Enrollment

Enrollment is considered to be the later of: 1) the date of filing if the application is approved or, 2) the date an enrolled physician or NPP or their respective organizations first started furnishing services at a new practice location. The filing date is considered to be the date the Medicare contractor receives a signed application that can be processed to approval. An Internet-based enrollment option is being implemented to shorten the enrollment process. The date of filing for an Internet-based enrollment is the date of receipt of all of the following: 1) a signed certification statement; 2) an electronic version of the enrollment application; and 3) the signature page.

Errors in an enrollment application must be timely corrected or a timely correction action plan must be filed within 30 days to preserve the filing date. The Medicare contractor will deny rather than reject paper or web submissions when a physician, NPP, physician organization or NPP organization fails to timely file a corrective action plan to cure any deficiencies or technicalities with the supporting documentation. In those circumstances a new file date is established with a new corrected application, unless a timely appeal is taken. If the supplier is successful on appeal, billing privileges start from the original file date or date the enrolled physician or NPP or their organization first started furnishing services at the new practice location.

CMS reiterates the requirement that providers and suppliers revalidate their enrollment information with an enrollment application every five years or, if enrolled prior to 2003, voluntarily file an enrollment application to come into voluntary compliance. Providers and suppliers are also encouraged to update their enrollment records with any reportable changes and update their enrollment records if this has not been done within the last 5 years. If they do not, the information must be received within 60 days of the revalidation request. Providers and suppliers who fail to come into voluntary compliance or fail to timely and completely respond to the revalidation request will be out of compliance and may be subject to revocation of their billing privileges.

Enrollment can be denied if an owner (as defined in the regulations), authorized or delegated official, physician or practitioner or their organization has an existing overpayment or there is an existing payment suspension at the time of the enrollment application.

A physician, NPP, physician organization or NPP organization has billing privileges once enrolled in Medicare. Once enrolled, the rule only permits retrospective billing of claims if circumstances precluded enrollment in advance of providing services. Further, the retrospective billing is limited to 30 days prior to the later of the date of filing of the approved application or the date the enrolled practitioner's new practice location was established. The physician, NPP or their respective organizations must meet all program requirements, including state licensure requirements. The services must have been performed in the enrolled practice location. There is a 90 day retrospective reprieve when the circumstance involves a presidentially-declared disaster under the Stafford Act.

IDTFs have special enrollment requirements. IDTFs must separately enroll each practice location and mobile unit. IDTF billing privileges, like physicians, NPPs, physician organizations and NPP organizations, are tied to enrollment. Further, there is a new IDTF billing requirement that provides that an IDTF must bill for all mobile diagnostic services that are furnished to a Medicare beneficiary except a service that is part of a hospital service provided under arrangement with the hospital. The mobile IDTF must also comply with all performance standards.

Once an IDTF or a physician, NPP, physician organization or NPP organization's enrollment and billing privileges have been revoked, it must submit all outstanding claims within 60 days of the revocation effective date to be paid. Since these individuals or entities are provided 30 days advance notice of revocation, they are effectively given 90 days to submit outstanding claims.

IDTFs, physicians, NPPs and physician and NPP organizations also have new timely claims submission requirements which do not permit retrospective billing. Thus, the timely enrollment requirements are all the more important in preserving the right to reimbursement of claims.

Reporting Requirements

CMS also provides four sets of reporting requirements. The first set applies to physicians, non-physician practitioners, and physician and non-physician practitioner organizations and requires reporting of change of ownership, adverse legal actions, practice location, and all other changes of enrollment. The first three reportable events must be made within 30 days. All other changes in enrollment must be made within 90 days. There are also overpayment assessments back to the date of a final adverse action or change in practice location when the reporting requirements are not met. An "adverse legal action" is defined in the regulation as: 1) a Medicare imposed revocation of billing privileges; 2) suspension or revocation of a state license; 3) revocation or suspension of accreditation; 4) conviction of a felony (as defined in the regulations) within the last 10 years preceding the enrollment, revalidation or reenrollment; or 5) exclusion or debarment from participation in a federal or state health care program.

The second and third set of reporting requirements apply to IDTF and DMEPOS respectively and are contained in current regulations. These requirements are not new.

The fourth set of reporting requirements applies to all other providers and suppliers. CMS requires reporting of a change of ownership within 30 days and all other enrollment changes within 90 days.

Revocation of enrollment may occur if there is a failure to meet the reporting requirements, or a failure to meet the documentation requirements. Revocation of enrollment for providers and suppliers is effective 30 days after CMS or its contractor mails the notice of its determination, except in the case of revocation based on a federal exclusion or debarment, felony conviction, licensure suspension or revocation, or if the practice location is determined by CMS or its contractor not to be operational, in which events the revocation is effective as of the date of those events.