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CMS Implements Significant Changes to Medicare Enrollment and Change Notification Rules for Physicians and Non-Physician Practitioners

On April 1, 2009, the Centers for Medicare and Medicaid Services (CMS) implemented significant changes to the Medicare enrollment rules for physicians and non-physician practitioners (NPP).¹ The new rules dramatically changed the effective dates for initial physician and NPP Medicare enrollment. Specifically, physicians and NPPs used to be able to retroactively bill the Medicare program for services furnished to beneficiaries up to 27 months prior to enrollment. Under the new rules, physicians and NPPs may only bill Medicare for services provided a maximum of 30 days prior to the later of 1) the date the enrollment application is filed or 2) the date that services were furnished at the new practice location.²

The new rules also amended the

notification deadlines for certain reportable events, including changes in practice location and final adverse actions. These events must now be reported to Medicare within 30 days, or CMS may assess overpayments or revoke the practitioner's Medicare billing privileges.

CMS has stated that the new rules are designed to address the agency's concerns that some physicians, NPPs and group practices may be billing Medicare for services when they are not meeting the Medicare program requirements.

I. New Enrollment Rules

A. Effective Date

Effective April 1, 2009, CMS established a new Medicare billing effective date for physicians, NPPs and physician and NPP organizations

¹ Affected non-physician practitioners include nurse practitioners, physician assistants, anesthesiology assistants, certified registered nurse anesthetists; clinical social workers, clinical psychologists, speech language pathologists, registered dietitians and nutrition professionals.

² There is a limited exception to this rule which allows practitioners to bill for services rendered up to 90 days prior to the effective date of their enrollment if their enrollment was delayed due to a presidentially declared disaster.

CLIENT ADVISORY

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(e.g. group practices). Under the new rule, the effective date will be the later of:

1. The date the physician, NPP or group practice files a Medicare enrollment application that was subsequently approved by the Medicare contractor (e.g. carrier, fiscal intermediary or Medicare Administrative Contractor [MAC]); or
2. The date the physician, NPP or group practice started furnishing services to Medicare beneficiaries.

Additionally, with two limited exceptions, physicians, NPPs and group practices will no longer be permitted to bill Medicare for services rendered prior to the effective date of their enrollment in the Medicare program. This rule represents a significant change from past Medicare enrollment practices, under which a provider could bill Medicare for services rendered up to 27 months prior to enrollment.

Under the new rule, physician, NPP and group practice practitioners will still be able to bill for pre-effective date services in two limited circumstances. First, practitioners may be allowed to retrospectively bill for services rendered up to 30 days prior to the effective date of their enrollment, provided that:

1. The physician, NPP or group practice met all program requirements, including State licensure requirements, at the time services were rendered; and
2. Circumstances precluded the submission of an enrollment application prior to furnishing services.

CMS has yet to define what “circumstances” will be sufficient to warrant the 30 day retroactive billing privileges and it is unclear whether contractors will liberally allow such retroactive billing. Second, CMS will allow physicians, NPPs and group practices to retrospectively bill for

services rendered up to 90 days prior to the effective date in the event that their enrollment was delayed due to a presidentially declared disaster.

Because of the limited nature of these two exceptions, it is essential that physicians, NPPs and group practices begin submitting all Medicare enrollment applications no later than the first day that the practitioner begins seeing Medicare beneficiaries. Additionally, practitioners may want to submit their enrollment applications well in advance of seeing Medicare beneficiaries, as the effective date of their billing privileges will be set when the practitioner files a Medicare enrollment application that is subsequently approved by the Medicare contractor. If, for example, the practitioner’s enrollment application is submitted on the first day he or she sees Medicare patients, but is then ultimately rejected by Medicare, the practitioner will likely not be permitted to bill for services he or she rendered to Medicare beneficiaries while the enrollment application was pending.

B. Changes to the Submission and Review Process

CMS has acknowledged that under the new rule, practitioners do face some risk of providing unpaid services in the event that their enrollment applications are rejected after the practitioner has rendered services to Medicare beneficiaries. Accordingly, CMS has made some changes to the enrollment form submission and review process. First, CMS now allows physicians, NPPs and group practices to submit Medicare enrollment forms via the Internet-based PECOS system. CMS asserts that the online system should reduce the amount of time it takes practitioners to complete enrollment forms because the PECOS system is “scenario-driven;” that is, it only asks practitioners for information that is required for their applications and supplier-types.



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Practitioners should be aware that CMS will not consider a PECOS-submitted enrollment application to be complete until the physician, NPP or group practice administrator prints, signs and mails a copy of the certification statement contained within the application form to its CMS contractor. Accordingly, while the Internet-based PECOS system may reduce the time required to complete the Medicare enrollment forms, the effective date of the practitioner's enrollment application will be the date on which the contractor receives both the electronic version of the enrollment application and the signed certification form.

Second, CMS has instructed its contractors to fully process most complete Internet-based PECOS enrollment applications within 30 to 45 calendar days. Under the current paper-based enrollment process, contractors typically take 60 to 90 days to complete the enrollment process. CMS recommends that providers submit new enrollment applications at least 45 days prior to rendering services to Medicare beneficiaries to increase the likelihood a determination will be rendered before services are provided.

Finally, CMS has instructed its contractors to give applicants at least 30 days to cure any deficiencies in a submitted enrollment application. To accomplish this goal, CMS has instructed contractors to deny, rather than reject, incomplete enrollment applications. This new procedure is designed to provide physicians, NPPs and group practices with the opportunity to preserve their initial application filing date as the effective date for the application, provided that the contractor ultimately approves the enrollment application. If the Medicare contractor does not ultimately approve the enrollment application, a new effective date for Medicare billing would be established when the practitioner submits a new enrollment

application that its contractor is able to process to approval.

II. New Reporting Requirements

Prior to April 1, 2009, providers had limited obligations to report changes to the Medicare program within 30-days of the reportable change. Specifically, while providers were required to notify Medicare contractors of changes in ownership within 30 days, other types of changes, including adverse actions and changes in practice location, had to be reported within 90 days of the change. CMS has now amended the reporting obligations related to final adverse actions and changes in practice location to require that the provider report these changes within 30 days. Additionally, if the provider fails to comply with these new 30-day reporting requirements, CMS may impose hefty penalties, including assessment of overpayments or revocation of billing privileges.

A. Final Adverse Actions

Effective April 1, 2009, CMS requires that physicians, NPPs and group practices report "final adverse actions" to their Medicare contractors within 30 days. CMS defined "final adverse actions" to include:

1. Medicare-imposed revocation of billing privileges;
2. Suspension or revocation of a State license to provide health care;
3. Revocation or suspension by an accreditation organization
4. A conviction of a Federal or State felony offense within the last 10 years; and
5. An exclusion or debarment from participation in a Federal or State health care program.

CMS explained that the new reporting rule is warranted because a final adverse action may preclude Medicare payment for services, thus establishing an overpayment to the practitioner from the date of the adverse action. Accordingly, CMS is requiring that

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practitioners report final adverse actions within 30 days to limit the possibility that the practitioner will receive unwarranted reimbursement.

B. Changes in Practice Location

CMS will also require, effective April 1, 2009, that physicians, NPPs and group practices report all changes in practice location to their Medicare contractors within 30 days. CMS explained that changes in practice location may impact the amount of payment warranted for a given service because practitioners' payments are based, in part, on locality adjustments. Accordingly, changes in practice location could potentially result in an overpayment to the practitioner for the difference in payment rates between the old and new practice location.

If practitioners fail to report changes in practice location within 30 days, CMS has authorized its contractors to assess overpayments to the practitioner dating back to the change in location. Additionally, CMS contractors are permitted to revoke a physician, NPP or group practice's billing privileges for a period of at least one year for failure to report a change in practice location.

III. Summary

The Medicare regulatory landscape continues to change as CMS looks for

new ways to combat improper payments to Medicare providers and suppliers. Physicians, NPPs, and physician and NPP organizations must act quickly to comply with the new enrollment and change notification rules imposed by the Medicare program. Practitioners will no longer be able to obtain payment for most services rendered to Medicare beneficiaries in advance of the effective date of the practitioner's enrollment in the Medicare program. Accordingly, practitioners should ensure that, whenever possible, they submit their enrollment applications well in advance of the first day they begin seeing Medicare patients. Enrolled practitioners must also take care to inform Medicare contractors of reportable changes within the new reporting timelines. Specifically, practitioners must report final adverse events and changes in practice locations within 30 days, or face potentially harsh consequences for non-compliance.

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