Latest Developments in Medicare Provider Enrollment

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Topics for Discussion

• Changes to the receipt date and signature requirements impacting Medicare enrollment applications
• Upcoming revisions to completion of paper applications
• Re-implementation of CMS deactivation policy
• Changes to CMS policy regarding reactivations of Medicare enrollments due to missed revalidations
• Compliance considerations for free-standing clinics who accept outside referrals for diagnostic imaging
• Status of the PECOS redesign (PECOS 2.0)
• CMS upcoming written guidance on comingling/sharing of space
Changes to Signature & Receipt Dates

• CMS made the following changes to the MPIM, Chapter 15, effective October 1, 2018 regarding the filing date of Medicare enrollment applications and certification statements via Transmittal 824, Change Request 10845, dated September 5, 2018.
  – The contractor shall begin processing both paper and Internet-Based PECOS applications upon receipt and shall develop for missing certification statements and all other missing information including application fee, upon review.
  – A signed certification statement is no longer required for applications to be considered received.
  – Signatures on paper certification statements are no longer required to be original.
  – Handwritten signatures for Forms CMS-855, CMS-20134, CMS-460 and CMS-588 shall be accepted for paper applications and web-based application submission upload.
  – Contractors can no longer accept paper certification statements for web-based application submissions via mail, fax or email. Instead this must be submitted through PECOS upload functionality.
Revisions to Completion of Paper Applications

• Effective Fall/Winter 2019
  – CMS will no longer accept handwritten CMS enrollment applications
    • All paper applications must be typed using the fill feature option on the CMS enrollment forms.
    • If any section of a submitted paper enrollment application is handwritten, the MAC will return the entire application and there will be no appeal rights.
    • For some providers and suppliers, effective dates are based on the receipt date of the application; therefore, the effective date can be impacted by this change if application is returned.
New Form CMS-855I Version

• Form CMS-855I, version (12/18), required for use as of 5/1/2019
  – Added new Medical Record Correspondence Address
  – Added employer Medicare ID to Physician Assistant Employment Arrangement
  – Added electronic record storage field to patient record storage address
  – Removed intern and fellowship data collection

• Note changes made to PECOS as well and additional items to address.
Medicare Deactivation Policy Reinstated

• CMS reinstated the below deactivation policy on a system wide basis April 8, 2019.
• Medicare claims not submitted for four (4) consecutive calendar quarters (12 months), unless current policy or regulations specify otherwise for the provider or supplier type.
  – The 12-month time period runs the 1\text{st} day of the 1\text{st} month without the submission of a claim through the last day of the 12\text{th} consecutive month without submitting a claim.
  – These types of deactivations are defined in the MPIM as CMS or contractor issued deactivations and may mean you also have a Medicare repayment situation.
Medicare Deactivation Policy Reinstated

- Per discussion with WPS provider enrollment supervisors, CMS provided a listing to the MACs of provider/suppliers to deactivate.
- The first WPS list was between 100-200 provider/suppliers.
- Notification letters were sent (see sample letter on next slide).
Medicare Deactivation Policy Reinstated

• Sample WPS deactivation letter

Month dd, yyyy

Provider or Supplier's Name
Provider/Organization’s Cont. Address
City, State, ZIP

Dear Provider/Supplier:

We have stopped your Medicare billing privileges on month dd, yyyy due to inactivity. We will not pay any claims after this date.

What record has been deactivated:

Provider Name:
Provider NPI:
Provider PTAN:

Reassignments:
Legal Business Name:
Tax ID (last 4 digits):
State:

How to recover your billing privileges:

Reactivate your Medicare enrollment record through PECOS.cms.hhs.gov, or form CMS-855.

• Online: PECOS is the fastest option. If you don’t know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.

• Paper: Download the right version of form CMS-855 for your situation at cms.gov. We recommend getting proof of receipt for your mailing.
Medicare Deactivation Policy Reinstated

- CMS excludes the following practitioners from this deactivation process if they are employees of Department of Veterans Affairs, Department of Defense, or Public Health Service and employees of Medicare enrolled Federally Qualified Health Center, Critical Access Hospital, and Rural Health Clinic.
  - Doctors of medicine or osteopathy, dental medicine, dental surgery, podiatric medicine, optometry, and chiropractic medicine
  - PAs, NPs, CNSs, CNMs, CPs and CSWs
- Regardless of their employment “pediatric medicine” physicians (specialty 37); and “oral surgery” (dentist only, specialty 19) are excluded from the deactivation process.
- Consider submission of the Form CMS-855O if practitioners will not be billing the Medicare program.
Status of Medicare Cycle 2 Revalidations

• Reminders:
  • All Medicare enrolled providers/suppliers must revalidate every 5 years (DMEPOS suppliers every 3 years)
  • Currently in Cycle 2 mandatory revalidations which started March 2016

• As of May 1, 2019

Medicare Revalidations Requested Through 11/30/2019

- Revalidations Requested: 814,274
- Medicare Enrolled Providers/Suppliers: 2,165,679
Update to the Reactivation Policy for Revalidations

• If a provider/supplier misses a revalidation due date, the MAC can apply a pay hold/send a letter of reminder within 25 days after the due date. Sixty to seventy-five days after non-response to a revalidation, the MAC can deactivate the enrollment.

• After deactivation, if the provider/supplier submits an application to reactivate/revalidate its billing privileges:
  – The PTAN will not change
  – There will be a gap in billing between the deactivation date and the date of receipt of the new application. Except for:
    • Certified providers and suppliers, including ASCs and portable x-ray suppliers.
    • A 30 day retrospective billing date is now allowed (see MPIM, Chapter 15, §15.29.4.3). This was a CMS policy change effective as of March 12, 2019.
PECOS 2.0 Redesign

• PECOS 2.0 Redesign contract awarded in 2017 to Solutions by Design II, LLC
• Rollout expected in late 2020
• Simplified interface
• Reduce redundant data collection
  – Board member information at a tax-id level rather than by enrollment
  – National profile for practitioner enrollments instead of by state
• Faster application submission
• Enhanced search capability
PECOS 2.0 Redesign

• Track the status of an application from submission through approval and greater access to information
  – Approval letters, requests for information, etc.
• Increased alignment between Medicare and Medicaid and enhanced Part C and D oversight
• Should not impact billing or claims information
• No action needed for providers/suppliers for information to transfer
• Provides CMS greater ability to leverage enrollment data and for verification controls
• Will allow other systems to read, create and update records systematically in PECOS
Upcoming Changes to IDTF Policies (Not Effective Yet)

- Independent Diagnostic Testing Facilities (IDTF)
  - No longer required to report equipment leased for less than 90 days
  - Will now be afforded the ability to change the ownership of an existing IDTF enrollment from one tax-id to another. The effective date of the change of ownership will be the effective date of the IDTF enrollment under the new tax-id (assuming the supporting transactional documents clearly denote the effective date).
  - If MACs are notified that an interpreting or supervising physician no longer provides services at an IDTF, they will request a change of information application be submitted
    - Failure to appropriately update the IDTF enrollment can result in revocation
Diagnostic Imaging Enrollment Updates

• CMS is contemplating requiring free-standing clinic group practices providing diagnostic services to **any** non-patient of the clinic group practice to enroll as an IDTF.
  – CMS may be going almost full circle to past sub-regulatory guidance with the addition of the following more restrictive requirements.
    • Instead of a substantial number of diagnostic tests performed for non-patients, it seems CMS’s new threshold would require IDTF enrollment if as few as one (1) diagnostic test was performed for a non-patient.
    • Would require diagnostic equipment to be located within a separate suite thus requiring all diagnostic tests for patients and non-patients to be performed by the IDTF.
  – Hopeful that CMS will consider our opposition before releasing any new regulatory or sub-regulatory guidance.
Hospital Comingling/Sharing of Space

- CMS Regional Office in Chicago Letter dated July 22, 2011

Shared Space Prohibition: 413.65(a)(2) Definitions & 413.65(g)(3) Compliance with Hospital’s Provider Agreement

413.65(a)(2) Definitions

Department of a provider means a facility or organization that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the same name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A department of a provider comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. A department of a provider may not by itself be qualified to participate in Medicare as a provider under §429.2 of this chapter, and the Medicare conditions of participation do not apply to a department as an independent entity. For purposes of this part, the term “department of a provider” does not include an RHC or, except as specified in paragraph (n) of this section, an FQHC.

To the extent that a facility does not meet the definition of a department of a provider, the facility cannot have provider-based status as a department of a provider. A department of a provider requires sufficient separation from any other facility. Sufficiently separated space is indicated by such features as exclusive entrance, waiting, and registration areas, permanent walls, and a distinct suite designation recognized by the United States Postal Service if the hospital department does not occupy an entire building.
Hospital Comingling/Sharing of Space

• CMS Regional Office in Chicago Letter dated July 22, 2011, continued

413.65(g)(3) Compliance with Hospital’s Provider Agreement

Hospital outpatient departments must comply with all the terms of the hospital’s provider agreement.

To the extent that the facility operates as a freestanding facility it does not operate under the terms of the hospital’s provider agreement with Medicare.

Hospitals are recognized as “providers of service” in SSA 1861(u). Hospitals themselves are defined at SSA 1861(a). Under SSA 1866(a), any provider of services may be qualified to participate in Medicare if it enters into an agreement with Medicare. Such agreements with Medicare must apply to the provider in its entirety. Hospitals are not permitted to “carve out” areas as non-hospital spaces. The SSA does permit certain provider types to exist as distinct parts of other institutions where defined in the statute. For example, Section 1861(f) of the SSA, which defines a “psychiatric hospital,” specifically allows an institution that contains a distinct part that satisfies the statutory definition to have that distinct part considered a “psychiatric hospital.” Similarly, Section 1819(a), which defines a “skilled nursing facility,” specifically allows an institution that contains a distinct part that satisfies the statutory definition to have that distinct part considered a “skilled nursing facility.” On the other hand, the Section 1861(a) definition of a hospital has no such provision allowing only a part of a hospital to be considered a hospital. Absent a statutory exception similar to that found for psychiatric hospitals, and SNFs, CMS interprets the statutory definition of a hospital to apply to the hospital in its entirety.
Hospital Comingling/Sharing of Space

• May 5, 2015 presentation by CMS, “Hospital Co-Location”
  – All certified hospital space
    • Must be under hospital’s control 24/7
    • Cannot be “part time” part of hospital and “part time” another hospital, ASC, physician office or any other activity
    • Required to be ‘the hospital’ 24/7, however, outpatient department are not required to be open for business 24/7
  – No comingling of physical space (cannot travel through hospital space to get to another entity (no shared space))
  – Cannot travel through another entity to get to the hospital
  – Cannot “time share” a space (hospital space is hospital space 24/7)
Hospital Comingling/Sharing of Space

St. Peter's Hospital Ends Leases With Out-of-Town Specialists

HELENA - Earlier this month, some out-of-town doctors were forced to leave the offices they had been renting from St. Peter's Hospital.

Those 13 specialists were not directly affiliated with the hospital or St. Peter’s Medical Group, but rented exam rooms -- perhaps just a few days a month -- to serve local patients.

But on Oct. 7, they were notified they had to leave by Oct. 23.

The problem involves the way St. Peter's was seeking reimbursement from Medicaid and Medicare for its own services.

"St. Peter's bills Medicare and Medicaid as a provider-based clinic," hospital spokeswoman Katy Peterson said in an email. "This results in higher payments than independent practices, recognizing the fact that hospital-based physician practices who accept Medicare/Medicaid patients have higher costs due to increased CMS (Center for Medicaid and Medicare Services) regulations that come with serving those patients."

In June 2013, the hospital requested that its two St. Peter's Medical Group facilities (on Broadway across the street from the hospital, and at its "north" location on Ptarmigan Lane) be certified as "provider-based clinics,” billing at the higher rate.
Hospital Comingling/Sharing of Space

• St. Peter’s Hospital Article continued

But CMS disagreed with that classification.

Peterson says patient confusion about the doctors was the issue.

"CMS stated that there was not clear separation between the hospital-employed physicians and the specialists from out of town based on the configuration of the exam room spaces, and as a result, CMS did not believe the public could differentiate between the two," Peterson wrote. "At that time, CMS also requested that provider-based payments from June 2013 to the present be returned, which could amount to $1,000,000-$2,000,000."
Draft – CMS Guidance for Hospital Co-location with other Hospitals or Healthcare Facilities

• Fall 2018 - CMS notified the provider community written guidance would be forthcoming related to policies on sharing of space, services and staff with other co-located hospitals and healthcare facilities.

• May 3, 2019 – QSO-19-13-Hospital was released in draft form.
  – Once finalized, the guidance will be manualized as sub-regulatory guidance in the Medicare State Operations Manual to guide survey and certification reviews.
  – A draft of the guidance was shared with the CMS Regional Offices, Accrediting Organizations and State Agencies in advance of release to the public on May 3, 2019.
  – Guidance focuses on the hospital provider type but references impact on other Medicare providers/suppliers. Past CMS sub-regulatory interpretations were very restrictive towards co-location arrangements, but CMS’s intent through this guidance is to allow more flexibility for shared space arrangements with a focus on patient health and safety.

• July 2, 2019 – Due date for comments to CMS.
Draft – CMS Guidance for Hospital Co-location with other Hospitals or Healthcare Facilities

• The guidance is for hospitals related to sharing of space, services and staff with other co-located hospitals and healthcare facilities.
  – CMS sought to provide clarity about how CMS and State Agency surveyors will evaluate a hospital’s space sharing or contracted staff arrangements with another hospital or healthcare entity when assessing the hospital’s compliance with its CoPs.
  – Co-location exists when two hospitals or a hospital and another healthcare entity are located in the same building or on the same campus and share space, staff or services.
  – Contractual arrangements of staff may be acceptable.
  – Sharing of public areas (not shared clinical areas) could be considered permissible.
  – Time block leases for specific periods of use by a hospital and other healthcare entity not included in this draft guidance.
Co-location surveying specifics

- Hospital may be co-located in its entirety or only certain parts of the hospital may be co-located with other healthcare entities. Examples –
  - One hospital entirely located on another hospital’s campus or in the same building as another hospital.
  - Part of one hospital’s inpatient services (e.g., at a remote location or satellite) is in another hospital’s building or on another hospital’s campus.
  - Outpatient department of one hospital is located on the same campus of or in the same building as another hospital or a separately Medicare-certified provider/supplier such as an ambulatory surgical center (ASC), rural health clinic (RHC), federally-qualified health center (FQHC), an IDTF, etc.
Co-location surveying specifics

- CMS states the guidance is specific to the requirements under the hospital CoPs and does not address the specific location and separateness requirements of any other Medicare-participating entity such as psychiatric hospitals, ASCs, RHCs, IDTFs, etc.
- Regardless of the situation, when a hospital is in the same location (building or campus) as another hospital or healthcare entity, each entity is responsible for demonstrating separate and independent compliance with the hospital CoPs.
• Distinct Space and Shared Space
  – A Medicare-participating hospital is evaluated as a whole for compliance with the CoPs and is required to meet the definition of a hospital at all times.
  – It is expected that the hospital have defined and distinct spaces of operation for which it maintains control at all times (floor plans).
  – Distinct spaces would include clinical spaces designated for patient care and is necessary for the protection of patients including, but not limited to, their right to personal privacy and to receive care in a safe environment, and right to confidentiality of patient records.
  – Co-mingling of patients in a clinical area such as a nursing unit from two co-located entities could pose a risk to the safety of a patient as the entities would have two different infection control plans.
Draft – CMS Guidance for Hospital Co-location with other Hospitals or Healthcare Facilities

• Distinct Space and Shared Space
  – Shared spaces are considered those public spaces and public paths of travel that are utilized by both the hospital and the co-located healthcare entity. Both entities would be individually responsible for compliance with the CoPs in those spaces. Examples include –
    • public lobbies,
    • waiting rooms,
    • reception areas (with separate “check-in” areas and clear signage),
    • public restrooms,
    • staff lounges,
    • elevators,
    • main corridors through non-clinical areas, and
    • main entrances to a building.
Draft – CMS Guidance for Hospital Co-location with other Hospitals or Healthcare Facilities

• Distinct Space and Shared Space

  – A public path of travel is, for example, a main hospital corridor with distinct entrances to departments such as outpatient medical clinics, laboratory, pharmacy, radiology. It is necessary to identify, for the public, which healthcare entity is performing the services in which department.
Distinct Space and Shared Space

Clinical space is any non-public space in which patient care occurs.

- Travel between separate entities utilizing a path through clinical spaces of a hospital by another entity co-located in the same building would not be considered acceptable as it could create patient privacy, security and infection control concerns.

- Examples of non-public paths of travel –
  - a hallway, corridor or path of travel through an inpatient nursing unit; or
  - a hallway, corridor or path of travel through a clinical hospital department (e.g., outpatient medical clinic, laboratory, pharmacy, imaging services, operating room, post anesthesia care unit, emergency department, etc.).
• Contracted Services
  – A hospital is responsible for providing all of its services in compliance with the hospital CoPs.
  – Services may be provided under contract or arrangement with another co-located hospital or healthcare entity such as laboratory, dietary, pharmacy, maintenance, housekeeping and security services.
  – It is also common for a hospital to obtain food preparation and delivery services under arrangement from the entity in which it is co-located, in addition to utilities such as fire detection and suppression, medical gases, suction, compressed air, and alarm systems such as oxygen alarms.
Staffing Contracts

- Each Medicare-participating hospital is responsible for independently meeting staffing requirements of the CoPs whether provided directly, under arrangement or contract.
- When staff are obtained under arrangement from another entity, they must be assigned to work solely for one hospital during a specific shift and cannot “float” between the two hospitals during the same shift, work at one hospital while concurrently being “on-call” at another, and may not be providing services simultaneously.
- All individuals providing services under contract should receive appropriate education and training in all relevant hospital policies and procedures as do those who are direct employees of the hospital.
• Emergency Services
  – Guidance is directed to hospitals without emergency departments and state policies and procedures must be in place for addressing individuals’ emergency care needs 24 hours per day and seven (7) days per week.
  – Policies and procedures should include –
    • identifying when a patient is in distress,
    • how to initiate an emergency response,
    • how to initiate treatment, and
    • recognizing when the patient must be transferred to another facility to receive appropriate treatment.
  – Other guidance set forth within the draft.
  – Hospitals without emergency departments that contract for emergency services with another hospital’s emergency department are then considered to provide emergency services and must meet the requirements of EMTALA.
• What is next?
  – CMS has confirmed in an email to Seim Johnson that they plan to include in their final guidance that time block leasing between a hospital and another healthcare entity will be permissible if certain requirements are satisfied.
  – Co-location questions –
    • Should first be directed to the applicable CMS Regional Office (RO) as each CMS RO has historically responded to questions regarding comingling/sharing of space although differently based on their own interpretations. The written guidance from the CMS Central Office (CO) should create consistency across all CMS regions.
    • If additional clarification is needed, the CMS CO could respond.
  – Remember comments are due July 2, 2019. We will be commenting and so should you.
Q&A

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