Monitoring Medicare Enrollment

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Program Objectives

- Reporting ownership
- Recognizing changes that need to be reported and when they need to be reported
- Recognition of the importance of MAC and CMS communications; preparing for communication-related issues
- Preparing for proposed enrollment changes
- Monitoring Enrollment
- This program will focus on CMS Form 855A – Institutional providers including hospices

Enrollment Requirements

- Enrollment requirements:
  - Submission of complete enrollment application
  - Content of the enrollment application:
    - Complete, accurate, truthful
    - Required documents, i.e. proof of legal business name, practice location, SS#, TIN#, NPI#, and owners of business (direct and indirect)
    - Required documents relating to provision of services, i.e. licenses, eligibility to provider services
    - Appropriate signature; Authorized Official (individual with legal authority to bind the provider), i.e. general partner, chairman of the board, CFO, CEO, President, etc. The signature attests the accuracy of the information submitted.

Enrollment Requirements – Delegation of Authority

- Delegation of Authority:
  - Original application and revalidations must be signed by an Authorized Official.
  - Updates or changes may be signed by a Delegated Official
    - Individual practitioners and sole proprietors cannot delegate signature authority for any reason.
  - Delegated officials must be assigned by an Authorized Official and:
    - Be submitted to CMS
    - Include the title and SS#
    - Be an individual who has an ownership or control interest or is a W-2 Managing Employee

Enrollment Requirements

- Information submitted must be verifiable
- Survey requirements must be completed and up-to-date
- Provider must be operational
- Must be in compliance with §424.520; date of certification of services
- Right to on-site review

When is 855A Required?

- Initial Enrollment (entire 855A to be completed)
- Revalidation (entire 855A to be completed)
- Changes in Information (Identification information and information that changed must be reported)
- CHOW – “Change in Ownership”; substantial information to be reported; but not everything dependent on the specific factors

Reporting Changes

- Revalidation – Revalidation is required once every five (5) years (except DME – every three years) or more frequently as determined applicable.
- Other Changes – Following enrollment, a provider must report to CMS any changes on the enrollment application and furnish supporting documentation within 90 calendar days of the change, or a change of ownership or control of the provider, as well as a practice location change, within 30 calendar days of the change.
- Failure to report changes may result in the deactivation or revocation of the provider's Medicare billing changes.

Recurring Reporting Problems

- The following are problems that we, and providers, continually deal with:
  - Legal name and d/b/a names –Consistency between IRS, state filings, and/or bank records
  - Address – inconsistencies
  - Failure to report all owners (especially indirect ownership)
  - Failure to report secured lenders when loan balance exceeds 5% of assets
  - Confusion regarding who are key management, i.e. owners, CEO, CFO, Nursing Directors.
  - Additional informational requests not received or lost by provider (use Contact Person, check data consistency)
  - Failure to transfer informational access and records upon acquisition or equity transfer (change of information filing)
  - Incorrect filings for acquisitions (CHOW versus change of information; seller and buyer submission for CHOW)
  - Generally reporting changes

Summary of Consequences (not all-inclusive)

- Rejection of enrollment application:
  - Failure to provide complete information
  - Failure to submit all required documentation
  - Failure to respond to additional data requests or questions
  - There are no appeal rights
  - Recourse – resubmission of application and all supporting documentation (process starts all over again)

Summary of Consequences (not all-inclusive)

- Denial of enrollment
  - Compliance with Medicare enrollment requirements (generally survey related)
  - Conduct – Individuals required to be reported in enrollment:
    - Excluded from federal programs
    - Felony convictions
    - Submission of false or misleading information
    - On site review (not operational)

Summary of Consequences (not all-inclusive)

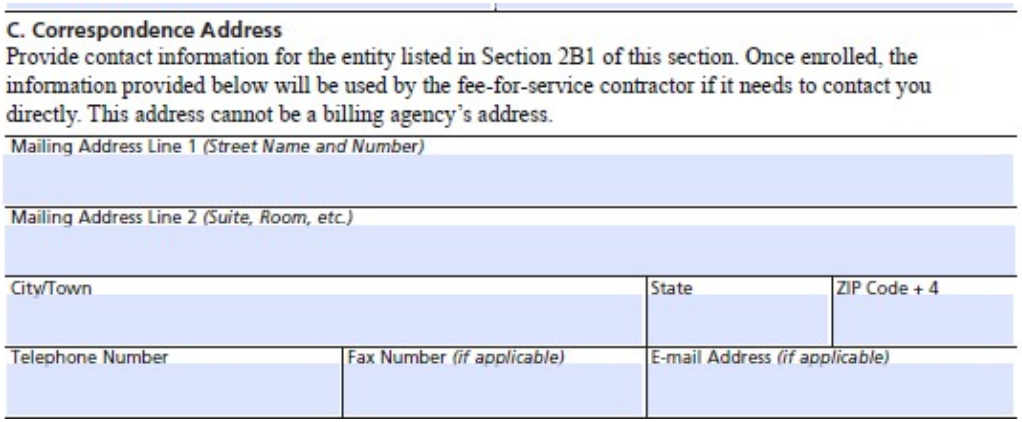
- Revocation of enrollment and billing privileges:
  - Noncompliance with requirements (generally survey related)
  - Conduct (previously discussed)
  - False or misleading information
  - On-site reviews
  - Failure to revalidate or submit requested information
  - Misuse of billing number
  - Recourse – generally re-enrollment or proof of termination with individuals (conduct related)

Summary of Consequences (not all-inclusive)

- Deactivation of Medicare billing privileges
  - Failure to submit any claims for 12 consecutive calendar months
  - Failure to report enrollment information change (not limited to):
    - Practice location
    - Change in managing employee
    - Change in billing services
    - Change in ownership or control
  - Recourse – new enrollment application or, when deemed appropriate, recertify that the enrollment information on file is correct.

Importance of Correspondence Address

- The correspondence address should be where the MAC sends important letters and documents to the provider.
- Make certain correspondence address is the same location identified in the NPI files.
- Some MACs use NPI information; however, additional communication may be required with the MAC for cost reporting related issues.



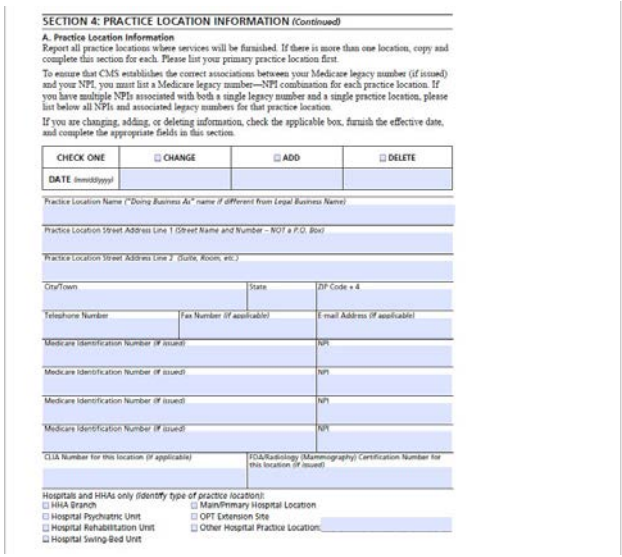
C. Correspondence Address

Provide contact information for the entity listed in Section 2B1 of this section. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 *(Street Name and Number)*			
Mailing Address Line 2 *(Suite, Room, etc.)*			
City/Town		State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*	

Practice Location Reporting

- The practice location(s) represent where services are rendered from – not the corporate office is separately located. Report multiple locations. Cover letter should clearly identify primary office from alternate sites. Special payments may go to another location.



SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

A. Practice Location Information

Report all practice locations where services will be furnished. If there is more than one location, copy and complete this section for each. Please list your primary practice location first.

To ensure that CMS establishes the correct associations between your Medicare legacy number (if issued) and your NPI, you must list a Medicare legacy number—NPI combination for each practice location. If you have multiple NPIs associated with both a single legacy number and a single practice location, please list below all NPIs and associated legacy numbers for that practice location.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Practice Location Name ("Doing Business As" name if different from Legal Business Name)

Practice Location Street Address Line 1 (Street Name and Number – NOT a P.O. Box)

Practice Location Street Address Line 2 (Suite, Room, etc.)

City/Town	State	ZIP Code + 4

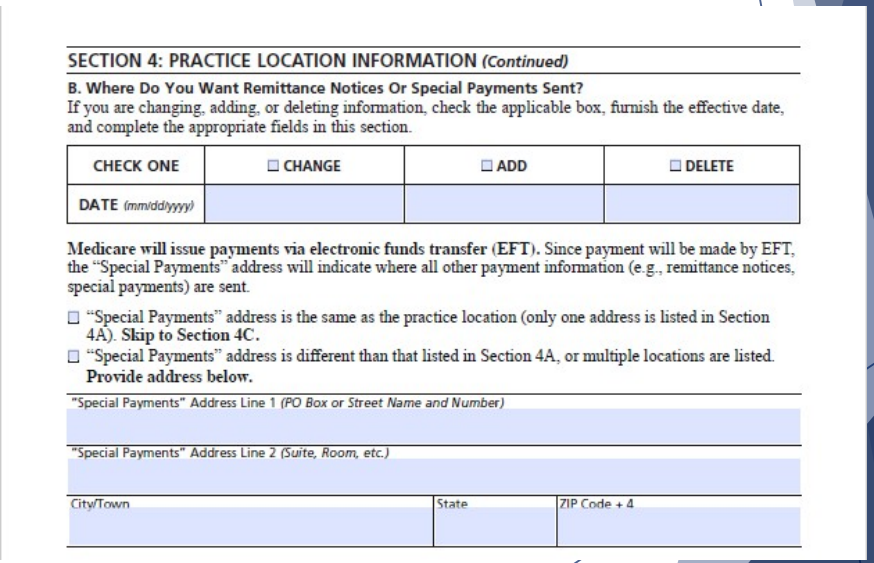
Telephone Number	Fax Number (if applicable)	E-mail Address (if applicable)

Medicare Identification Number (if issued)	NPI
Medicare Identification Number (if issued)	NPI
Medicare Identification Number (if issued)	NPI
Medicare Identification Number (if issued)	NPI

CLIA Number for this location (if applicable)	FDA/Radiology (Mammography) Certification Number for this location (if issued)

Hospitals and HHAs only (Identify type of practice location):

☐ HHA Branch
☐ Hospital Psychiatric Unit
☐ Hospital Rehabilitation Unit
☐ Hospital Swing-Bed Unit
☐ Main/Primary Hospital Location
☐ OPT Extension Site
☐ Other Hospital Practice Location:



SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

B. Where Do You Want Remittance Notices Or Special Payments Sent?

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Medicare will issue payments via electronic funds transfer (EFT). Since payment will be made by EFT, the "Special Payments" address will indicate where all other payment information (e.g., remittance notices, special payments) are sent.

☐ "Special Payments" address is the same as the practice location (only one address is listed in Section 4A). **Skip to Section 4C.**

☐ "Special Payments" address is different than that listed in Section 4A, or multiple locations are listed. **Provide address below.**

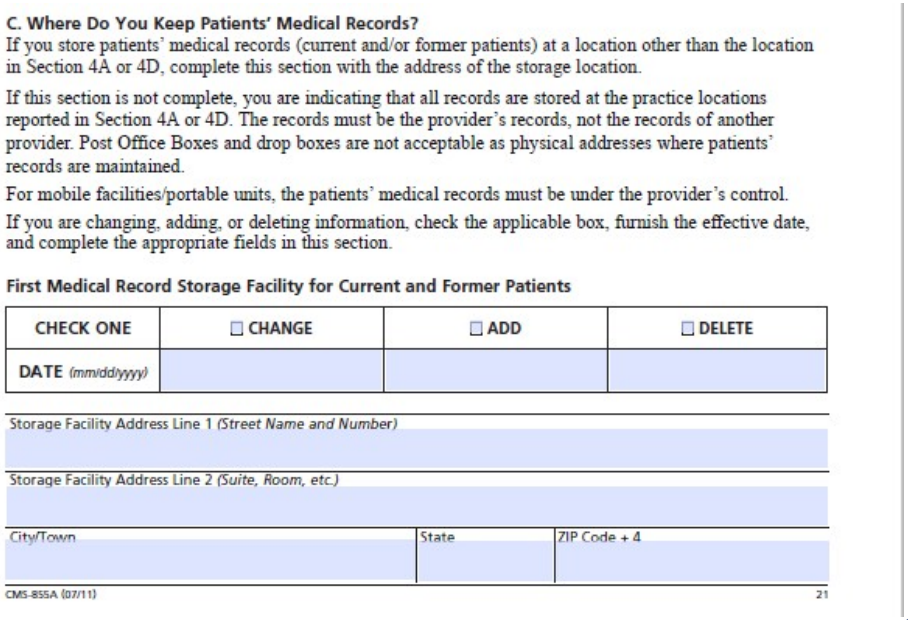
"Special Payments" Address Line 1 *(PO Box or Street Name and Number)*

"Special Payments" Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Medical Records (Section 4 – Practice Locations)

- You must report all locations. Each location must have a street address.



C. Where Do You Keep Patients' Medical Records?

If you store patients' medical records (current and/or former patients) at a location other than the location in Section 4A or 4D, complete this section with the address of the storage location.

If this section is not complete, you are indicating that all records are stored at the practice locations reported in Section 4A or 4D. The records must be the provider's records, not the records of another provider. Post Office Boxes and drop boxes are not acceptable as physical addresses where patients' records are maintained.

For mobile facilities/portable units, the patients' medical records must be under the provider's control.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

First Medical Record Storage Facility for Current and Former Patients

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

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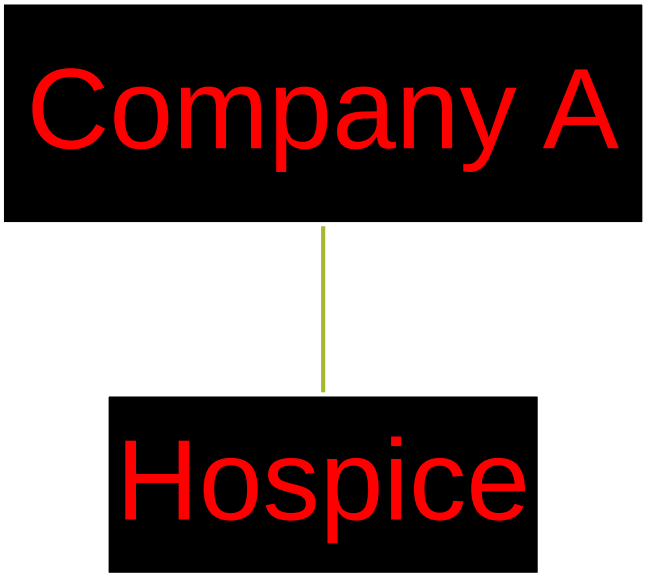
Reporting Ownership

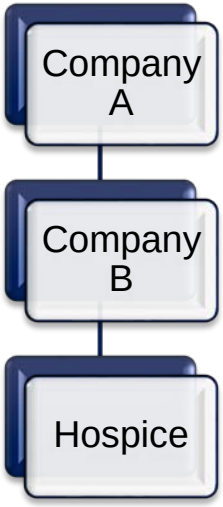
- Very important (consider the filing requirements themselves)
- Direct and indirect ownership must be reported.
- Organizations reported in Section 5
  - Must report mortgage and security interests in excess of 5% of assets
- Individuals reported in Section 6

Company A is Direct Owner of the Hospice



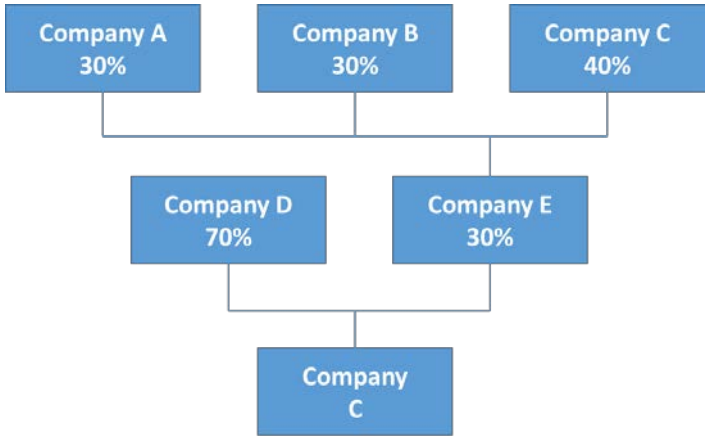
Ownership

- Company A is an Indirect Owner, Company B is the Direct Owner



Ownership

- Companies A, B, and C are indirect owners; Companies D and E are direct owners.



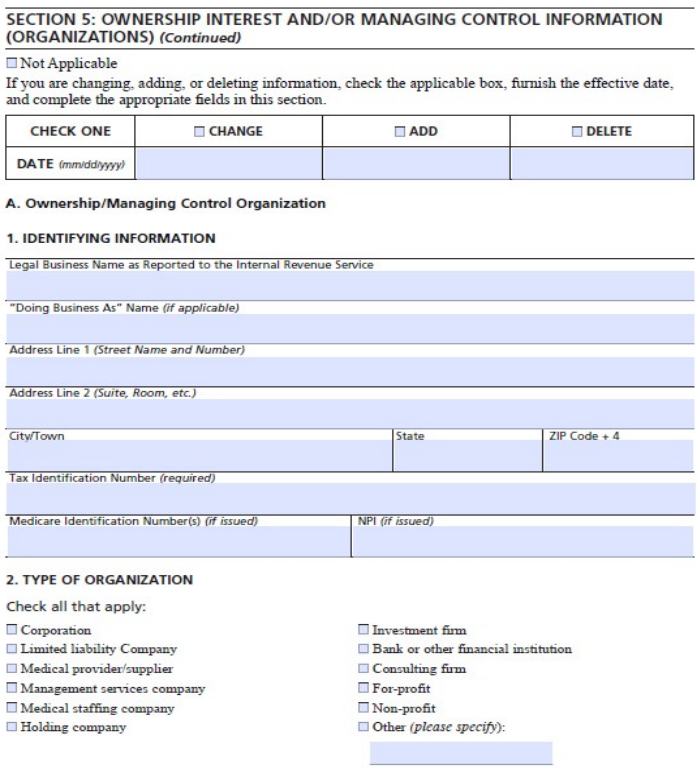
Assume Company A owns 30% of Company E and Company E owns 30% of the Hospice. Company A is a 9% indirect owner of the Hospice and must be reported in Section 5 of the 855A.

If Company A is owned 100% by Robert Morris, Robert Morris is a 9% indirect owner and must be reported in Section 6. If Robert owned 50% of Company A, Robert would be a 4.5% indirect owner of the Hospice. He would not need to be reported unless he had management control in another way.

Reporting Ownership and Key Persons

- Percentage Ownership (Direct and Indirect)
- Board Member, Officer
- Managing Employee
- Position
- Other Management Services Provided

Reporting Organizations and Individuals



SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) *(Continued)*

☐ Not Applicable

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

A. Ownership/Managing Control Organization

1. IDENTIFYING INFORMATION

Legal Business Name as Reported to the Internal Revenue Service

"Doing Business As" Name *(if applicable)*

Address Line 1 *(Street Name and Number)*

Address Line 2 *(Suite, Room, etc.)*

City/Town | State | ZIP Code + 4

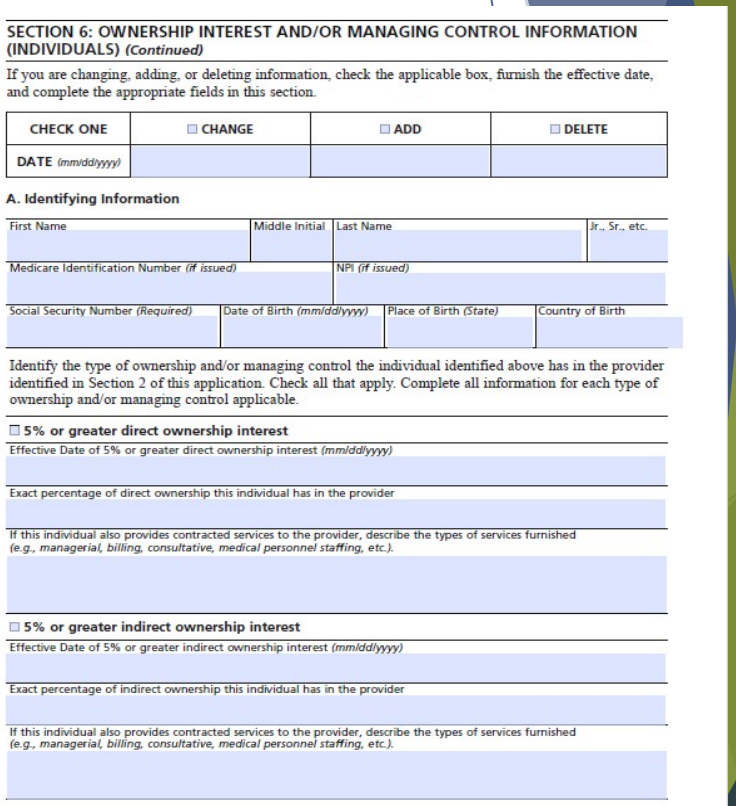
Tax Identification Number *(required)*

Medicare Identification Number(s) *(if issued)* | NPI *(if issued)*

2. TYPE OF ORGANIZATION

Check all that apply:

- ☐ Corporation
- ☐ Limited liability Company
- ☐ Medical provider/supplier
- ☐ Management services company
- ☐ Medical staffing company
- ☐ Holding company
- ☐ Investment firm
- ☐ Bank or other financial institution
- ☐ Consulting firm
- ☐ For-profit
- ☐ Non-profit
- ☐ Other *(please specify)*:



SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

A. Identifying Information

First Name | Middle Initial | Last Name | Jr., Sr., etc.

Medicare Identification Number *(if issued)* | NPI *(if issued)*

Social Security Number *(Required)* | Date of Birth *(mm/dd/yyyy)* | Place of Birth *(State)* | Country of Birth

Identify the type of ownership and/or managing control the individual identified above has in the provider identified in Section 2 of this application. Check all that apply. Complete all information for each type of ownership and/or managing control applicable.

☐ **5% or greater direct ownership interest**

Effective Date of 5% or greater direct ownership interest *(mm/dd/yyyy)*

Exact percentage of direct ownership this individual has in the provider

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

☐ **5% or greater indirect ownership interest**

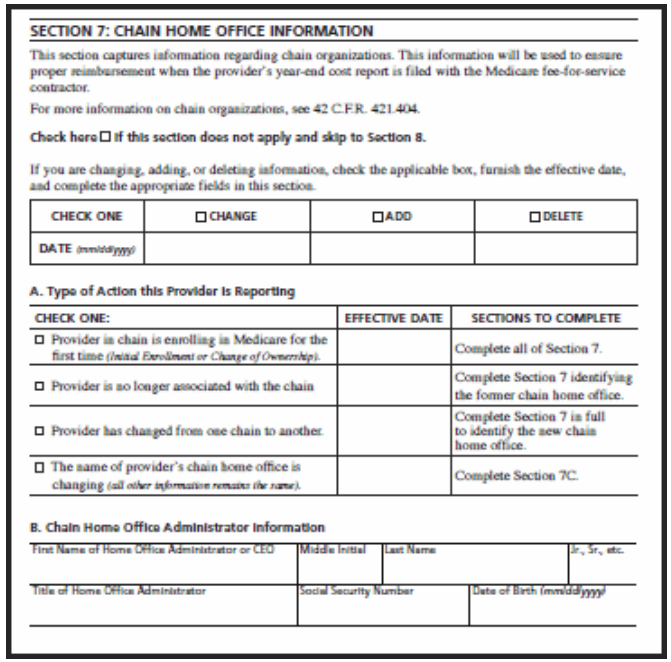
Effective Date of 5% or greater indirect ownership interest *(mm/dd/yyyy)*

Exact percentage of indirect ownership this individual has in the provider

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

Chain Home Office

- If a Home Office has been established with the Medicare program, the Home Office must be reported.



SECTION 7: CHAIN HOME OFFICE INFORMATION

This section captures information regarding chain organizations. This information will be used to ensure proper reimbursement when the provider's year-end cost report is filed with the Medicare fee-for-service contractor.

For more information on chain organizations, see 42 C.F.R. 421.404.

Check here ☐ if this section does not apply and skip to Section 8.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

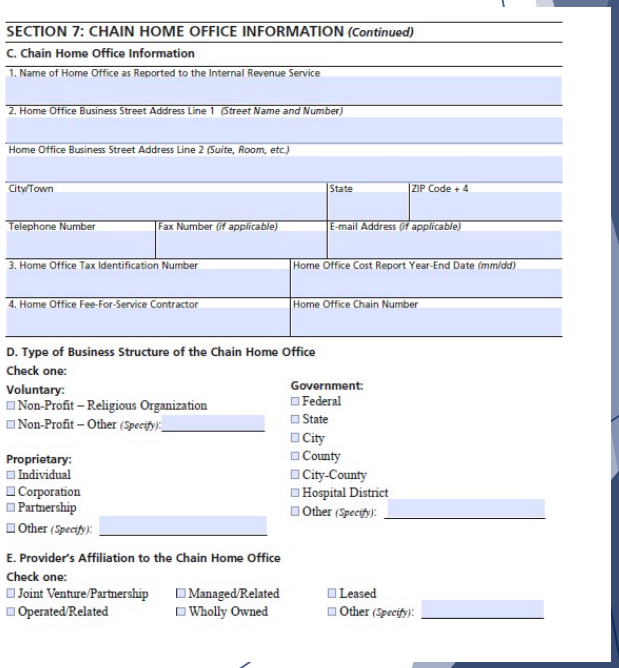
CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

A. Type of Action this Provider is Reporting

CHECK ONE:	EFFECTIVE DATE	SECTIONS TO COMPLETE
☐ Provider in chain is enrolling in Medicare for the first time *(Initial Enrollment or Change of Ownership)*.		Complete all of Section 7.
☐ Provider is no longer associated with the chain		Complete Section 7 identifying the former chain home office.
☐ Provider has changed from one chain to another.		Complete Section 7 in full to identify the new chain home office.
☐ The name of provider's chain home office is changing *(all other information remains the same)*.		Complete Section 7C.

B. Chain Home Office Administrator Information

First Name of Home Office Administrator or CEO	Middle Initial	Last Name	Jr., Sr., etc.
Title of Home Office Administrator	Social Security Number	Date of Birth (mm/dd/yyyy)	



SECTION 7: CHAIN HOME OFFICE INFORMATION *(Continued)*

C. Chain Home Office Information

1. Name of Home Office as Reported to the Internal Revenue Service

2. Home Office Business Street Address Line 1 *(Street Name and Number)*

Home Office Business Street Address Line 2 *(Suite, Room, etc.)*

City/Town | State | ZIP Code + 4

Telephone Number | Fax Number *(if applicable)* | E-mail Address *(if applicable)*

3. Home Office Tax Identification Number | Home Office Cost Report Year-End Date *(mm/dd)*

4. Home Office Fee-For-Service Contractor | Home Office Chain Number

D. Type of Business Structure of the Chain Home Office

Check one:

Voluntary:
- ☐ Non-Profit – Religious Organization
- ☐ Non-Profit – Other *(Specify)*:

Proprietary:
- ☐ Individual
- ☐ Corporation
- ☐ Partnership
- ☐ Other *(Specify)*:

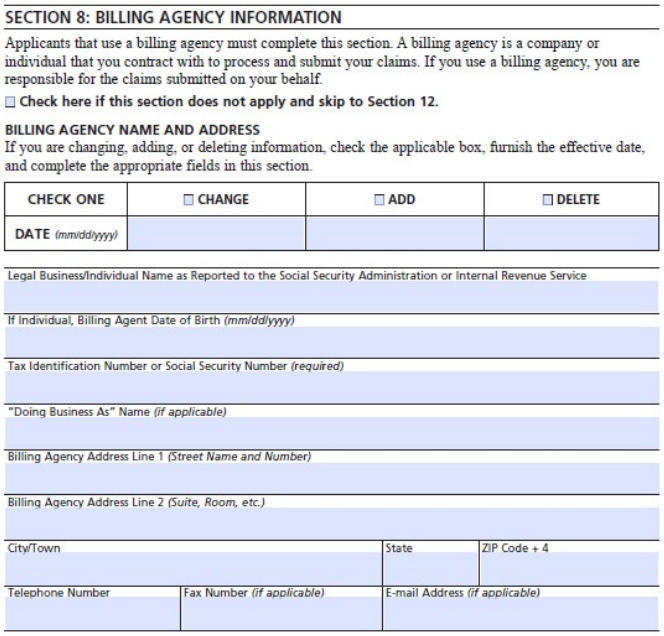
Government:
- ☐ Federal
- ☐ State
- ☐ City
- ☐ County
- ☐ City-County
- ☐ Hospital District
- ☐ Other *(Specify)*:

E. Provider's Affiliation to the Chain Home Office

Check one:
- ☐ Joint Venture/Partnership
- ☐ Managed/Related
- ☐ Leased
- ☐ Operated/Related
- ☐ Wholly Owned
- ☐ Other *(Specify)*:

Billing Agency

- This is not a software vendor (this is a billing service)



SECTION 8: BILLING AGENCY INFORMATION

Applicants that use a billing agency must complete this section. A billing agency is a company or individual that you contract with to process and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf.

☐ **Check here if this section does not apply and skip to Section 12.**

BILLING AGENCY NAME AND ADDRESS

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Legal Business/Individual Name as Reported to the Social Security Administration or Internal Revenue Service

If Individual, Billing Agent Date of Birth *(mm/dd/yyyy)*

Tax Identification Number or Social Security Number *(required)*

"Doing Business As" Name *(if applicable)*

Billing Agency Address Line 1 *(Street Name and Number)*

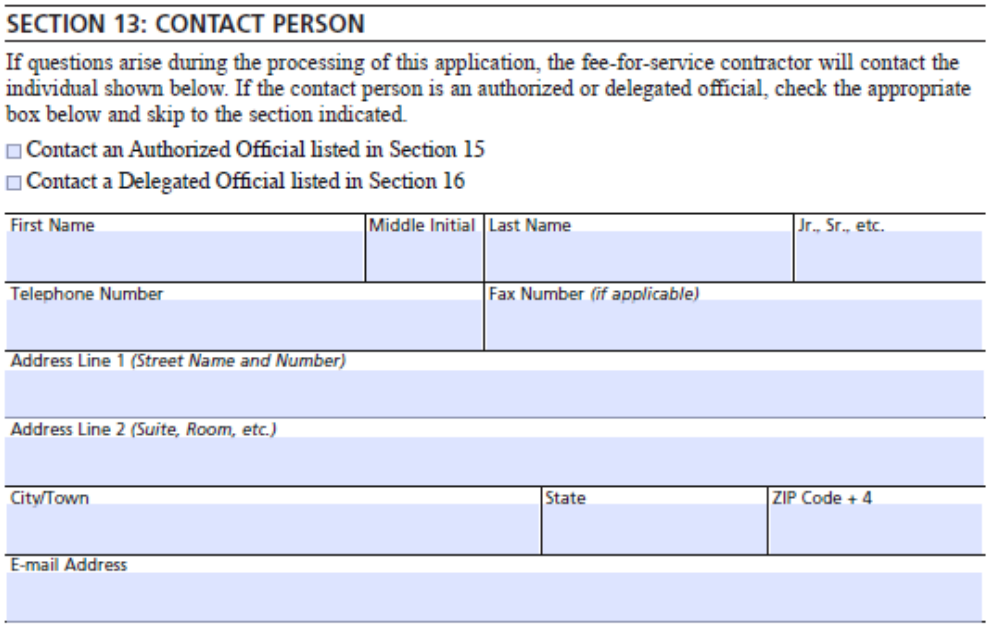
Billing Agency Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Contact Regarding Submission

- In most cases, a contact person should be identified.



SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the fee-for-service contractor will contact the individual shown below. If the contact person is an authorized or delegated official, check the appropriate box below and skip to the section indicated.

☐ Contact an Authorized Official listed in Section 15

☐ Contact a Delegated Official listed in Section 16

First Name	Middle Initial	Last Name	Jr., Sr., etc.

Telephone Number	Fax Number *(if applicable)*

Address Line 1 *(Street Name and Number)*

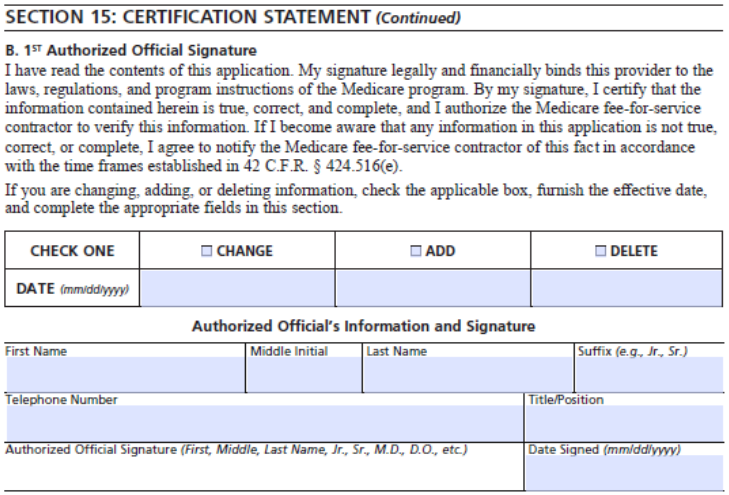
Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

E-mail Address

Certification (Authorized Official)

- A certified official (or delegate) need to sign all submissions.



SECTION 15: CERTIFICATION STATEMENT *(Continued)*

B. 1ST Authorized Official Signature

I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 C.F.R. § 424.516(e).

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

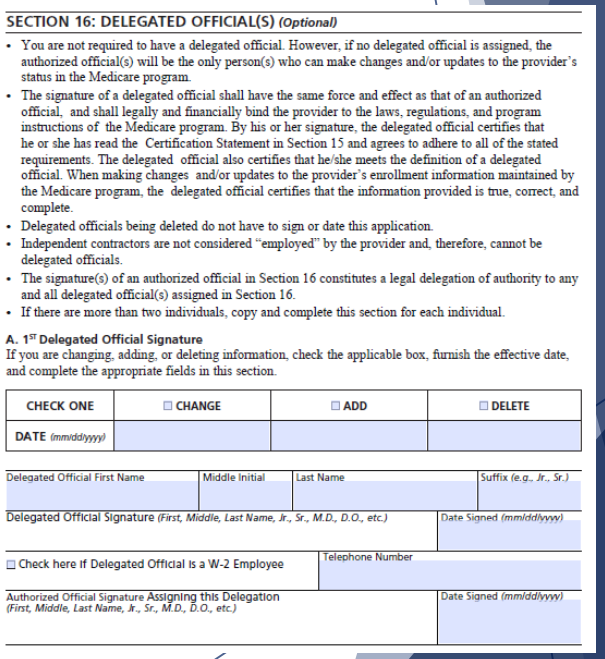
CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Telephone Number	Title/Position

Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*



SECTION 16: DELEGATED OFFICIAL(S) *(Optional)*

- You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the provider's status in the Medicare program.
- The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the provider to the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the provider's enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete.
- Delegated officials being deleted do not have to sign or date this application.
- Independent contractors are not considered "employed" by the provider and, therefore, cannot be delegated officials.
- The signature(s) of an authorized official in Section 16 constitutes a legal delegation of authority to any and all delegated official(s) assigned in Section 16.
- If there are more than two individuals, copy and complete this section for each individual.

A. 1ST Delegated Official Signature

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Delegated Official First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

☐ Check here if Delegated Official is a W-2 Employee	Telephone Number

Authorized Official Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

Freedom of Information

- The information provided on the CMS Form 855A and accompanying documents are not shared. They are protected under 5 U.S.C. Section 552(b)(4) and/or (b)(6), respectively.

Proposed Rules Not Finalized (March 1, 2016)

- "These enhancements, if finalized, would allow CMS to take action to remove or prevent the enrollment of health care providers and suppliers that attempt to circumvent Medicare's enrollment requirements through name and identity changes as well as through elaborate, inter-provider relationships. The proposed provisions will also address other program integrity issues and vulnerabilities – such as cases where providers and suppliers avoid paying their Medicare debts by re-enrolling as a different entity."

Definition of Affiliation

- A 5% or greater direct or indirect ownership interest that an individual of entity has in another organization,
- A general or limited partnership interest (regardless of percentage) that an individual or entity has in another organization,
- An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts the day-to-day operations of another entity regardless of the arrangement,
- An interest in which an individual acts as an officer or director of a corporation.

Disclosable (Proposed)

- Current or uncollected debt to Medicare – regardless of the amount even if being repaid or under appeal
  - Overpayments where notice is provided
  - Civil monetary penalties
- Has been subject to payment suspension
- Has been or is excluded from participation in the Medicare program
- Has had enrollment denied, revoked, terminated regardless of reason (even if under appeal); includes voluntary termination

Beginning of Integrating Affiliates

- In January 2016, CMS enhanced its financial accounting system to include a function that allows CMS to recover payments made to a provider of services or supplier that shares the same TIN# with a provider of services or supplier that has an outstanding Medicare overpayment within a MAC's jurisdiction.
- This is authorized by the Affordable Care Act.

Enrollment Information (High Priority)

- Recognize when changes need to be reported
- Periodically review info on file to make required changes. Check NPI records against Medicare enrollment records.
- Monitor revalidation dates https://data.cms.gov/revalidation.
- CMS has been recently releasing warnings for reporting changes. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Fast-Facts/2017-02-24-Reporting-Changes-in-Ownership.html.
- OIG has issued report, “Medicare: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure”

Questions