CMS Revises Enrollment-Related Provisions in the Medicare Program Integrity Manual

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The Centers for Medicare & Medicaid Services (CMS) made changes to important written guidance to Medicare providers by issuing a Change Request on June 24, 2016, to Chapter 15 of its Program Integrity Manual (titled "Medicare Enrollment").[1] The effective date of the revisions is July 26, 2016. The Manual not only provides guidance to providers, but also specifically provides instructions to Medicare Administrative Contractors (MACs) - the entities that process CMS-855 enrollment applications. Because the enrollment process is the critical first step to obtaining federal dollars, it is imperative that parties involved in Medicare understand the changes and respond to them accordingly.

In the Change Request, CMS provides that the changes to the Manual include, but are not limited to--

1. Clarifying the process for verifying correspondence addresses and telephone numbers;
2. Clarifying signature submission requirements;
3. Clarifying the supporting documentation requirements;
4. Incorporating new processing alternatives;
5. Correcting citations in a model revocation letter;
6. Clarifying the appeal process;
7. Clarifying Home Health Agency (HHA) 36-month rule policy; and
8. Clarifying revocation requirements.

Certain of these changes are self-explanatory and are relatively minor, but others may have a larger impact. In regard to the first change, relating to verification of correspondence addresses, the Manual currently provides that "[t]he correspondence address must be one where the contractor can directly contact the applicant to resolve any issues once the provider is enrolled in the Medicare program." The Change Request removes this language and substitutes the following: "The contractor may accept a particular correspondence address if it has no reason to suspect that it does not belong to or is not somehow associated with the provider. The contractor is not required to verify the correspondence address." The Change Request made a similar modification to the provision addressing telephone numbers, stating that "[t]he contractor is not required to verify the telephone number."

In regard to change seven, the Home Health Agency (HHA) 36-month policy currently states:

> If there is a change in majority ownership of an HHA by sale . . . within 36 months after the effective date of the HHA's initial enrollment . . . or within 36 months after the HHA's most recent change in majority ownership, the provider agreement and Medicare billing privileges do not convey to the new owner.

Provisions of the Manual already provide a definition of a "change in majority ownership." However, the Change Request clarifies that the rule pertains to both a single and multiple ownership transaction on form CMS 855A, "including changes of ownership or changes of information, [sic] that result in any one individual or organization acquiring greater than 50 percent ownership in the

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1 Change Request 9635 is accessible at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2016-Transmittals-Items/R659PI.html (last accessed July 18, 2016.).

HHA."[2]

Finally, the eighth change, regarding revocations of Medicare enrollment, includes a new specific reason for revocation: "[t]he provider or supplier has its provider or supplier agreement involuntarily terminated by the CMS regional office (RO) (as evidenced by a tie-in/tie-out notice, CMS-2007, or other notice from the RO/state)." In addition, the Change Request addresses overpayments based on revocations. If a revocation is made with a prospective effective date, the contractor is now required to assess an overpayment back to a date when Medicare claims are "determined to be ineligible for payment." CMS goes on to provide that this date will usually match the inactive date of the enrollment.

Providers should be mindful of the July 26, 2016, implementation date and the impact the updated Manual will have on Medicare enrollment. It is critical that any provider seeking to obtain or maintain access to Medicare funds be aware of the enrollment process and how MACs will review enrollment information submitted via 855 forms.

2 The Manual also now clarifies that if a 50 percent owner obtains even a .001 percent additional ownership stake, he or she becomes a majority owner and the transaction involves a change in majority ownership.

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