THE INCREASING IMPORTANCE

of Monitoring Your Medicare Enrollment Compliance

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As CMS enhances its IT capabilities, providers must be vigilant about keeping their Medicare enrollment records up-to-date or else risk suspension or loss of their billing privileges.

There are a variety of causes for which CMS may deactivate or revoke a provider's billing privileges. For example, privileges may be revoked for giving misleading information on one's enrollment application, misusing or abusing one's billing privileges, or being convicted of certain felonies. On the other end of the spectrum, privileges may be deactivated or revoked for simply failing to timely report certain changes to one's enrollment, which this article refers to as "administrative noncompliance."

Active enrollment is contingent upon providers continually meeting (and certifying that they meet) certain requirements–e.g., that they do not employ or contract with excluded entities or individuals. Accordingly, Medicare requires providers to report to the Medicare contractor: (1) within 30 days, any (i) change of ownership, (ii) adverse legal action, or (iii) change in practice location, and (2) within 90 days, all other enrollment changes. Failure to notify CMS within the prescribed time period constitutes administrative noncompliance and may result in the revocation or deactivation of billing privileges.

The effects of losing Medicare privileges can be stark. Revocation comes with a mandatory re-enrollment bar of one year (up to three years) and, in any event, the loss or suspension of privileges requires CMS to deny claims for services rendered by the provider. Imagine having to sit out from Medicare for a year simply because your practice administrator forgot to update an address in your enrollment materials. Such administrative noncompliance may seem benign, but when the federal government has a mandate to increase enforcement activities it is not uncommon for low-hanging fruit to get a disproportionate share of the attention.

CMS's scrutiny of Medicare providers' enrollment records and its enforcement of the notice rules is becoming increasingly rigorous and uncompromising. To see for yourself, peruse some DHHS Departmental Appeals Board's decisions affirming revocations of billing privileges for providers who failed to update basic information. For example, see *Chaturbhai B. Patel, M.D.*, DAB No. 2809 (2017) and *Jason R. Bailey, M.D., P.A.*, DAB No. CR4793 (2017), both of which involved revocation based on failure to report a change of practice location. How many similar outcomes will result when CMS can continuously monitor and cross-reference exclusion, debarment, criminal conviction, and other databases against PECOS?

The advent of "big data," analytics, and data mining tools could enable CMS to audit more enrollment records in a few minutes than it previously could in an entire week. Last year, CMS confirmed that it is enhancing its IT capabilities and implementing "continuous data monitoring" as part of its broader "strategies designed to reinforce provider screening activities." Using PECOS to cross-check address verification databases is just one step in CMS's path to greater reliance on technology as a means of combating fraud and abuse.

CMS has procured a total redesign of PECOS that will add programming features to allow other systems to read, create, and update PECOS records, increase agency interoperability, and provide greater ability to leverage enrollment data and verification records. CMS has also awarded more than $64 million to 26 states "to design comprehensive national background check programs for direct patient access providers." The new PECOS 2.0 will almost certainly interface with those programs. When such capabilities are part of CMS' audit protocols, daily monitoring and cross-referencing of providers' enrollment records against data compilations, such as address lists, background check programs, and public records databases, will likely be standard fare.

Medicare providers are well advised to review and update their reporting procedures to ensure that information provided to CMS is accurate and up-to-date. Given the 30-to-90-day timeframe for notifying CMS, it is critical that institutional providers have effective processes that promote vigilance, facilitate information sharing, and enable prompt reporting to CMS to avoid needless deactivation or revocation of billing privileges for administrative noncompliance.

Such processes may require that certain information be assessed at least every 30 days, but, regardless of the frequency, institutional providers should conduct periodic monitoring and audits of their enrollment data. Persons in charge of keeping PECOS updated need to be promptly informed of reportable changes, such as the addition or termination of a managing employee, final adverse legal action, changes in practice locations, license suspensions, and even changes of medical records storage locations. The bottom line is that providers should have a proactive approach to Medicare enrollment compliance, because the alternative can be costly indeed.