PUBLICATION

CMS Revamps Medicare Provider Enrollment Policy Guidance

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On May 22, 2020, CMS rolled out Transmittal 10146, which completely reorganizes existing Chapter 15 of the Medicare Program Integrity Manual (MPIM), CMS 100-08. These changes, effective July 24, 2020, implement the recent program integrity enhancements to the Medicare provider enrollment process, as well as other changes, and begin a transfer of some of the provider enrollment instructions from Chapter 15 to Chapter 10 of the MPIM.

In September 2019, CMS implemented the most significant changes to provider enrollment since the 2006 enrollment rules were initially adopted. Among these changes were new requirements for disclosures of affiliations that pose an undue risk of fraud, waste and abuse. The rule contained other restrictions on Medicare enrollment, such as the ability of CMS to prevent revoked providers and suppliers from enrolling or reenrolling in the Medicare program under a different name or business identity. 42 C.F.R. §§ 424.530(a)(12), 424.535(a)(18). The rule also extended CMS's revocation authority to cover, among other bases, when a provider or supplier bills from a non-compliant location and when a physician or other eligible professional has been subject to prior licensing actions that CMS believes led to patient harm. 42 C.F.R. §§ 424.535(a)(20), 424.535(a)(22). CMS policy guidance has now been released to effectuate these changes.

Some of the new instructions issued in Transmittal 10146 certainly address denial and revocation reasons implementing the requirements for disclosures of affiliations and the other recent changes; however, this policy guidance mainly tracks the regulatory language for the new enrollment changes and does not appear to contain any significant operational guidance beyond what the regulations set forth. Transmittal 10146 at 52-53, 89-93 (May 22, 2020). And, it is not surprising that the majority of these new denial and revocation reasons require approval from the CMS Provider Enrollment & Oversight Group (PEOG) prior to a contractor denying or revoking enrollment under this new authority, as is the case for most revocations. CMS did exempt PEOG approval for Revocation Reason 22 – Patient Harm (42 C.F.R. § 424.535(a)(22)), which authorizes CMS to revoke a physician or other eligible professional's enrollment for licensing disputes, as addressed in a prior article: The Nightmare Came True: Minor Licensing Actions Could Lead to Disastrous Collateral Damages.

At approximately 400 pages long, Transmittal 10146 is largely a reorganization of certain sections of Chapter 15 and contains roughly 100 new sections, all of which will now be part of Chapter 10. These are primarily organized into the following three categories: Medicare Contractor Processing Duties; Other Medicare Contractor Duties; and Development Letters. Transmittal 10146 at 396-398. These three categories represent a stark change from the current organization of Chapter 15, which has 29 different sections and contains guidance relating to different provider and supplier types/services and guidance for different individual practitioners, not just processing information for CMS contractors. It remains to be seen whether the change in organization and structure makes certain information more straightforward to locate. For example, a listing of revocations that carry a retroactive effective date is now its own sub-section in new section 10.4M(2)(a)(i). Transmittal 10146 at 81-82. Prior to the change, this information could be found in section 15.27.2C, but was not its own sub-section. Likewise, the location of the required elements of a revocation letter, which is important to determine whether CMS has properly notified a provider or supplier of the reason for a revocation, is now located in new section 10.4M(1)(d)(i) versus old section 15.25B.

CMS uses transmittals to communicate new or changed policies or procedures that are then incorporated into the CMS Online Manual System. CMS Manual provisions contain important policy guidance that provide a basis for understanding how CMS intends to interpret and effectuate regulatory requirements such as Medicare enrollment rules. Perhaps what is most significant about this Transmittal is a signal that the structure of Chapter 15 (and what will become Chapter 10) of the MPIM will be a different organization and format than its current form. As CMS has been vocal about its efforts to enhance restrictions to provider enrollment, these changes are not unexpected, yet it is unclear how much more reorganization will provide clarity to the existing policy guidance, especially when the guidance related to disclosure of affiliations (one of the most significant changes to enrollment rules) is largely a reiteration of the regulatory language. Transmittal 10146 at 52-53, 89-93. Further, it appears this is "Phase 1" of sections of Chapter 15 moving back to Chapter 10. Transmittal 10146 at 398. There is no indication of the timeframe for future phases. Since the changes made to CMS policy and guidance regarding Medicare enrollment can have a significant impact on how enrollment rules and requirements are implemented and effectuated, we will watch for further changes to Chapter 15 and Chapter 10 as provider enrollment continues to evolve.

For additional information or any questions regarding these issues, please contact any member of Baker Donelson's Reimbursement team.