# You Want Me to What?!?!: New Changes to Medicare Enrollment and Revalidation

This change presents new challenges to certain Medicare providers as they will be required to undergo additional screening measures and subject to greater scrutiny during enrollment and revalidation as part of CMS's latest effort to combat fraud and abuse. The consequences of not being ready can be substantial. Under the proposed regulations, CMS now has authority to deny or revoke Medicare billing privileges for providers and suppliers who do not maintain the established provider or supplier performance standards. Thus, it is more important than ever for both prospective and enrolled providers to be ready for these new screening measures before they are implemented.

CMS proposes that providers and suppliers be classified into 3 levels of risk: "limited," "moderate" and "high." Depending on the level of risk, certain providers will be subject to greater scrutiny before being given or having their Medicare billing privileges revalidated.

## Limited Risk

Under the proposed regulations, limited risk providers will be subject to the following screening measures: (1) verification that a provider or supplier is in compliance with all State and Federal regulations prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) database checks on a pre- and post-enrollment basis to ensure that providers remain in compliance with enrollment criteria.

Physicians, non-physician practitioners, and medical clinics and grounds are considered limited risk because they are State licensed and subject to administrative oversight. Similarly, providers and suppliers that are publicly traded companies are also considered limited risk because of oversight provided by investors, directors, and the Securities and Exchange Commission.

Finally, CMS also identified the following providers who pose little risk to the Medicare program: Ambulatory surgical centers, end-stage renal disease facilities, Federally qualified health centers, histocompatibility laboratories, hospitals, Indian Health Service facilities, mammography screening centers, organ procurement organizations, mass immunization roster billers, portable x-ray supplier, religious nonmedical health care institutions, rural health clinics, radiation therapy centers, public or government owned or affiliated ambulance services suppliers, and skilled nursing facilities.

## Moderate Risk

In addition to the limited risk screening measures, moderate risk providers and suppliers will be subject to an unannounced pre- and/or post-enrollment site inspection to ensure compliance with state and federal regulations. CMS believes that unannounced visits are crucial to ensuring compliance with applicable regulations and reporting requirements. Currently, only a few types of providers and suppliers are subject to an on-site visit prior to an enrollment determination, e.g. independent diagnostic testing facilities ("IDTFs")

Under the new regulations, the following prospective providers are considered moderate risk and will be subject to unscheduled on-site visits: nonpublic, non-government owned or affiliated ambulance service suppliers, community mental health centers (CMHCs), comprehensive outpatient rehabilitation facilities (CORFs), hospice organizations, IDTFs, and independent clinical laboratories.

Similarly, the following currently enrolled Medicare providers are also considered moderate risk: home health agencies and suppliers of durable medical equipment that are not publicly traded. (As indicated above, publicly traded companies are considered limited risk.)

These providers and prospective providers were determined to be moderate risk based on claim reviews and the Office of Inspector General research.

## High Risk

In addition to an unannounced on-site visit, high risk providers will also have to undergo a criminal background check and submit fingerprints. This new requirement applies to owners, authorized or delegated officials or managing employees of any “high” risk provider. CMS hopes that, by conducting more thorough background checks, they will eliminate providers who pose a threat to the Medicare program and cut down on fraud and abuse.

Providers who are considered high risk include new durable medical equipment providers andhome health agencies.

Limited and moderate risk providers may become considered high risk upon one of the following conditions: (1) CMS receives evidence that another individual is using a provider’s identity within the Medicare program; (2) the provider or supplier has been placed on a previous payment suspension; or (3) the provider or supplier has been excluded or had its Medicare billing privileges denied or revoked within the previous 10 years and is attempting to establish additional Medicare billing privileges for a new practice location or by enrolling as a new provider or supplier.

## Effective Dates

These proposed regulations are scheduled to take effect on March 23, 2011 for newly enrolling providers and suppliers, as well as providers and suppliers currently enrolled in Medicare who need to revalidate their enrollment information between March 23, 2011 and March 23, 2012. For all other currently enrolled Medicare providers, the proposed regulations will become effective on March 23, 2012. Some providers and suppliers may be required to revalidate their enrollment outside of their regular revalidation cycle