

# Health Care Compliance Association Presentation: "Medicare Enrollment Changes 2011"

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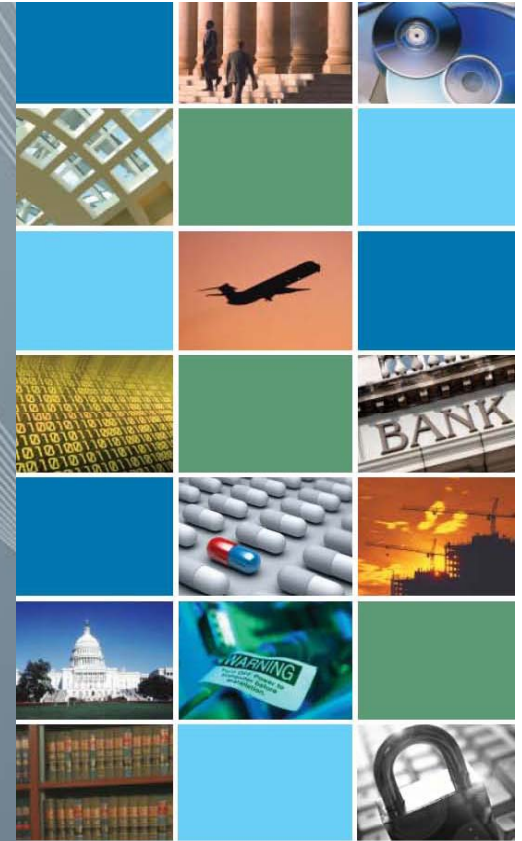
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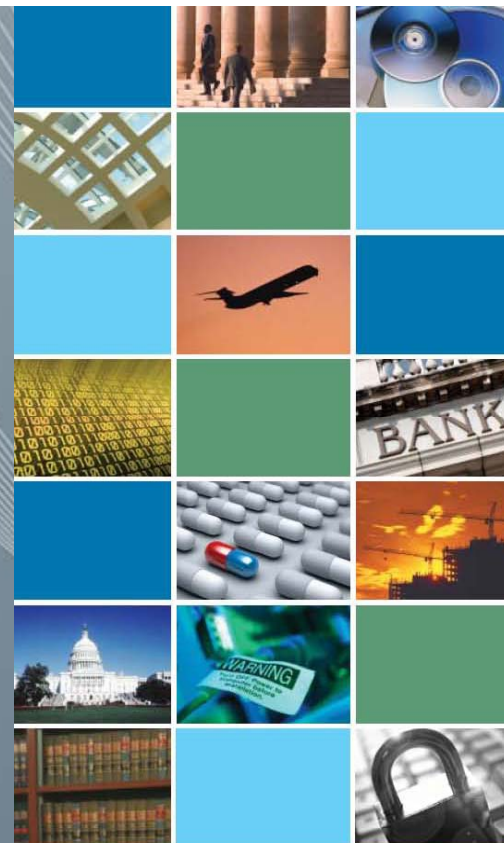
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# 2011 MEDICARE ENROLLMENT CHANGES



## Summary of 2011 Enrollment/Payment Changes

- More rigorous screening procedures
- Application fee
- Temporary moratoria on enrollment
- Suspending payments pending credible allegations of fraud
- Terminating provider participation if terminated under another health care program - Medicaid, Medicare, or CHIP

# Assignment of Provider/Supplier Types to Risk Categories

Limited	Moderate	High
<ul style="list-style-type: none"> <li>Physicians, PAs, NPs, CRNAs, OTs, speech language pathologists, audiologists, medical groups and clinics</li> <li>Pharmacies</li> <li>Hospitals, including CAHs</li> <li>Skilled nursing facilities</li> <li>Ambulatory surgical centers</li> <li>Radiation therapy centers</li> <li>ESRD facilities</li> <li>FQHCs</li> <li>Histocompatibility labs</li> <li>IHS facilities</li> <li>Mammography screening centers</li> <li>Organ procurement orgs</li> <li>Mass immunization roster billers</li> <li>Religious nonmedical health care institutions</li> <li>Rural health clinics</li> <li>Competitive acquisition program/Part B vendors</li> <li>Dentists</li> </ul>	<ul style="list-style-type: none"> <li>Comprehensive outpatient rehabilitation facilities (CORFs)</li> <li>Independent diagnostic testing facilities (IDTFs)</li> <li>Independent clinical laboratories</li> <li>Currently enrolled (re-validating) home health agencies</li> <li>Currently enrolled (re-validating) suppliers of DMEPOS*</li> <li>Hospice organizations</li> <li>Physical therapists and PT groups</li> <li>Portable x-ray suppliers</li> <li>Community mental health centers</li> <li>Ambulance services suppliers</li> </ul>	<ul style="list-style-type: none"> <li>Newly-enrolling home health agencies</li> <li>Newly-enrolling suppliers of DMEPOS*</li> </ul>

\*Applies even if the DMEPOS supplier is a physician, which is enrolled at a limited risk category, a community pharmacy or a PT/OT. NO exemptions for orthotists or prothetists.



# Medicare - Moving Risk Categories

CMS will move providers and suppliers from a "limited" or "moderate" risk level to the "high" risk level if the following occurs:

- CMS imposed a payment suspension on a provider or supplier at any time in the last 10 years
- CMS lifts a temporary moratorium applicable to such providers or suppliers at which point the move to the "high" risk level will last for six months after the lifting of the moratorium.
- The provider or supplier –
  - A. Has been excluded from Medicare by the OIG;
  - B. Had billing privileges revoked by a Medicare contractor within the previous 10 years and is attempting to establish additional Medicare billing privileges by –
    1. Enrolling as a new provider or supplier; or
    2. Billing privileges for a new practice location;
  - C. Has been terminated or is otherwise precluded from billing Medicaid;
  - D. Has been excluded from any Federal health care program; or
  - E. Has been subject to any final adverse action as defined at §424.502, within the previous 10 years.

## Screening Procedures

- The level of screening depends on the risk category a provider or supplier is assigned. (See next slide.)
- States can rely on the results of the Medicare contractor's screening to meet the provider screening requirements under Medicaid and CHIP.
- State Medicaid agencies can also rely on the results of another State's Medicaid program or CHIP's screening.

MEDICARE: Type of Screening Required	Prior Rule	"Limited"	"Moderate"	"High"
Verification of any provider/supplier-specific requirements established by Medicare	X	X	X	X
Verification of license (may include licensure checks across States)	X	X	X	X
Database checks: <ul style="list-style-type: none"> <li>Social Security Number</li> <li>National Provider Identifier</li> <li>National Practitioner Data Bank licensure</li> <li>Office of Inspector General (OIG) exclusion</li> <li>Verify taxpayer identification number</li> <li>Death of individual practitioner, owner, authorized official, delegated official, or supervising physician</li> </ul>	X	X	X	X
Unscheduled or unannounced pre-enrollment and/or post-enrollment site visits	Only DMEPOS and IDTFs had pre-enrollment site visits; ad hoc for others	N/A	X	X
Fingerprint-based Criminal History Record Check of law enforcement repositories – individual owners with 5% or more direct/indirect ownership (TO BE REQUIRED 60 DAYS FOLLOWING <b>SUBREGULATORY GUIDANCE</b> )	N/A	N/A	N/A	X

NOTE: Medicare can do unannounced site visits at any time for any provider or supplier enrolled in the Medicare program. 42 CFR § 424.517.

## Medicare - "High" Category Risk

- Criminal background checks and fingerprinting will be done on all owners
  - The submission of fingerprints is the only way to obtain a criminal history record check from the FBI.
- Final Rule confirmed that criminal history record (including fingerprinting) will include individuals with 5% or greater direct/indirect ownership interest .

# Timing of New Screening Procedures

- For newly enrolling providers/suppliers – effective March 25, 2011
- For currently enrolled Medicare, Medicaid and CHIP providers/suppliers whose revalidation is scheduled between March 25, 2011 and March 23, 2012 – effective March 25, 2011 or the date scheduled for the revalidation
- For all other currently enrolled providers and suppliers, the statute established an effective date of March 23, 2012.
- **NOTE:** There is an exception - The fingerprinting requirement for the high risk category will be effective 60 days after publications subregulatory guidance.



## Timing of New Screening Procedures

- **NOTE: On or after March 23, 2012, CMS can require that a provider or supplier revalidate its enrollment outside the routine revalidation cycle. 42 CFR § 424.515. This was designed to help ensure that the statutorily set date of March 23, 2013 is met.**
- **After the revalidation under the new rules, the current revalidation cycle (3 years for DMEPOS and 5 years for all others) will apply, unless an off-cycle revalidation is triggered by, for example, random checks, national initiatives, complaints, etc.**

# Application Fee – Statutory Mandate

- **ACA § 6401(a) requires the Secretary to impose a fee on each “institutional provider of medical or other items or services or supplier” to cover costs of screening and to carry out screening and other program integrity efforts.**

## Application Fee – "Institutional Providers"

- **"Institutional providers" is broadly defined to mean "any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (not including physician and nonphysician practitioner organizations), CMS-855S or associated Internet-based PECOS enrollment application."**
- **Medicaid-only and CHIP-only institutional providers include nursing facilities, intermediate care facilities for persons with mental retardation (ICF/MR), psychiatric residential treatment facilities, and may include other institutional provider types designated by a State in accordance with their approved State plan.**

# Application Fee - Amount

- The statutorily-mandated application fee is required in the following instances –
  - (1) with the submission of an initial enrollment application,
  - (2) with an application to establish a new practice location, or
  - (3) as part of revalidation.
- The application fee was statutorily set at \$500 for 2010 and is adjusted yearly based on the CPI for all urban consumers. For 2011, the fee is \$505.
- The application fee is not linked to the risk level associated with the provider or supplier, i.e., you do not pay more because you are at a "high" level versus a "limited" risk level.



# Application Fee – Nonrefundable except...

- The application fee is nonrefundable except if submitted with one of the following:
  1. A request for hardship exception that is subsequently approved;
  2. An application that is rejected prior to initiation of screening processes;
  3. An application that is subsequently denied as a result of the imposition of a temporary moratorium.

## Application Fee – How it works

- A provider or supplier enrolled in more than one program (i.e., Medicare and Medicaid or CHIP, or all three programs, or Medicaid and CHIP in multiple States) would only be subject to the application fee once and that fee would cover screening activities for enrollment in all programs.
  - States must collect the applicable fee from MCD-only and CHIP-only providers and suppliers.
- States have the flexibility to waive the application fee for particular providers or a class of providers if it determines that this would help assure access to services for beneficiaries.

# Application Fee – How it works

- If applying for two different kinds of institutional providers, e.g., DMEPOS and HHA, you will be required to submit the fee for each enrollment.
- Requirement – a provider/supplier will pay the application fee whenever a Form CMS-855 is submitted.
- The fee is paid at [https.pay.gov](https://pay.gov). You may not pay by sending payment with your application. You must pay in advance or the contractor will send out a request for additional information and give you 30 days to furnish the payment.
- An application will be rejected and, in the case of revalidations, billing privileges may be revoked, if the institutional provider does not submit the application fee or hardship exception.



# Application Fee - Hardship Exemption

- There is no blanket exception based on financial status, e.g., nonprofit or public provider/supplier.
- Providers or suppliers can apply for a hardship exemption to the enrollment fee by including a letter with the application.
- Hardship requests will be considered on a case-by-case basis
  - The proposed rule provided an example that might support a request for hardship exemption - a national public health emergency where a provider or supplier is enrolling for purposes of furnishing services required as a result of the emergency situation.

# Application Fee – Effective Dates

Essentially the same timing as the screening requirements:

- For newly enrolling providers/suppliers – effective March 25, 2011
- For currently enrolled Medicare, Medicaid and CHIP providers/suppliers whose revalidation is scheduled between March 25, 2011 and March 23, 2012 – effective March 25, 2011 or the date scheduled for the revalidation
- For all other currently enrolled providers and suppliers, the statute established an effective date of March 23, 2012.

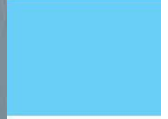
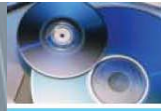
# Temporary Moratoria on Enrollment

- **ACA § 6401(a) – Allows the Secretary to impose a temporary moratoria on the enrollment of new Medicare, Medicaid or CHIP providers and suppliers, if the Secretary determines such moratoria are necessary to prevent or combat fraud, waste, or abuse.**
- **To date, no moratoria have been issued, but a likely candidate could be IDTFs**



## Medicare Payment Suspension

- **ACA § 6402(h) Allows the Secretary to institute payment suspensions against a provider or supplier *pending an investigation of a credible allegation of fraud, unless* the Secretary determines that there is *good cause* not to suspend payments.**
  - **Section 6402(h) requires that the Secretary consult with the OIG in determining whether there is a credible allegation of fraud.**
  - **Applies to Part A and Part B programs, not C and D.**

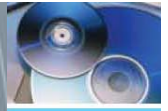


## Medicaid Payment Suspension

- **ACA §6402(h) Provides that *FFP in the Medicaid program shall not be made* with respect to any amount expended for items/services (other than an emergency item or service, not including items or services furnished in an ED) furnished by an individual or entity to whom a State has failed to suspend payments under the plan during any period *when there is pending an investigation of a credible allegation of fraud against the individual or entity as determined by the State* in accordance with these regulations.**
  - **Except when the State determines in accordance with these regulations that *good cause* exists not to suspend such payments.**

# Compliance Programs

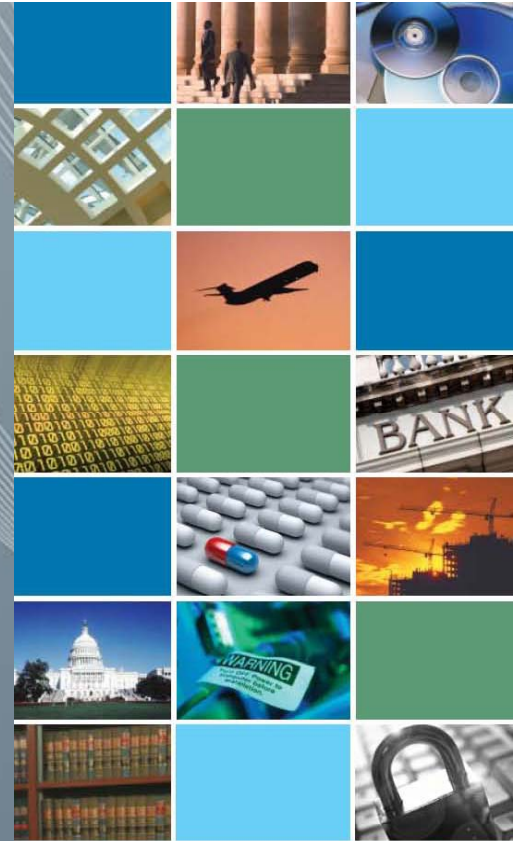
- **ACA § 6102 requires nursing facilities to have a compliance and ethics program that is effective in preventing and detecting criminal, civil and administrative violations and in promoting quality of care.**
- **ACA § 6401(a) requires providers and suppliers to establish a compliance program that contains certain “core elements.”**
  - **The statute requires that in the case of an organization that has 5 or more facilities, the formality or specific elements of the program vary with the size of the organization.**
- **The regulations related to the compliance program requirement have not been finalized.**



# Terminations

- **ACA § 6501 requires a State's Medicaid program to terminate an individual's or entity's participation if the individual or entity has been terminated under Medicare or another State's Medicaid program on or after January 1, 2011.**
  - **State Medicaid programs would terminate a provider only after the provider exhausted all available appeal rights in the State that originally terminated the provider or the timeline for appeal has expired. (*This is unlike Payment Suspensions which can occur before appeal rights are exhausted.*)**
  - **States would be required to terminate participation only in cases where providers, suppliers or eligible professionals were terminated or had their billing privileges revoked for cause (i.e. fraud, integrity or quality issues).**

# RECENT CHANGES TO THE MEDICARE ENROLLMENT APPLICATIONS



## 855 Changes – General

- **First set of amendments since 2008; some substantive and some not.**
- **All of the existing 855 Forms were amended, including the CMS Forms 855A, 855B, 855I, 855S and 855R.**
- **First new CMS 855 Form (the 855O Form) since origination of the 855 forms.**
- **Assumptions made by CMS were that the 855I and 855R would be completed by administrative staff, BUT the 855A, 855B, 855S would likely be completed by professional staff (attorney or accountant).**

## 855 Changes- Why Make These Amendments Now?

- **Clarification:** of the language in existing 855 Forms
- **ACA Provisions 6001 and 6401:** require additional data collection
- **New Regulations:** Advanced Diagnostic Imaging accreditation requirements.
- **Reimbursement Requirements:** CMS recognized the need to enroll suppliers who only order and refer
- **As with the ACA provisions,** desire to keep ineligible actors out of the Medicare program, rather than deal with them/chase them later on.

## 855 Changes – When must the new forms be utilized?

- The new forms were released this Summer.
- Most providers and suppliers are currently using them.
- NO transition schedules have been provided.
- Multiple MAC websites indicate that per CMS, the new forms must be used on or before November 1, 2011.

# 855 Changes – What is the purpose of the 855 Form?

- **Bottom Line:**
  - To obtain a Medicare billing number; and
  - Provide evidence to CMS that certain credentialing requirements are met
- **MACs use the data to:**
  - Identify the applicant and its owners, officers, directors and managers;
  - Ensure the applicant meets certain qualifications;
  - Ensure the applicant has not been excluded, suspended, sanctioned or barred from participating in Medicare, Medicaid or another federal agency program;
  - To gather information necessary to establish correct claims payments; and
  - To correctly price, process and pay claims.



## 855A – Background

- Used to enroll "providers"
- "Providers" primarily include institutional facilities, such as: hospitals, SNFs, HHAs, and hospice agencies.
- 855A forms are NOT utilized to enroll "suppliers"
- "Suppliers" primarily include physicians and non-physician practitioners, DMEPOS suppliers and facilities such as ASCs and IDTFs
- Suppliers enroll via use of CMS Form 855B, or CMS Form 855I or 855S

## 855A Amendments - Section 2

### ➤ Section 2A –

- Added a checkbox that will identify whether a hospital is physician owned.

### ➤ Section 2B –

- 2B1 was amended to require providers to identify how its business is registered with the IRS.
- 2B1 was amended to reinsert a data element that requests the provider's year-end cost report date.
- 2D added a request for the "Expiration date of accreditation" of the applicant provider.

## 855A Amendments - Section 5

- **Totally revised based on ACA requirements**
- **Requires reporting of certain entities that previously were unclear.**
  - **For example: investment firms, banks and financial institutions with mortgage or other security interests, holding companies, and trusts and trustees.**
- **Requires submission of an "organizational diagram"**

## 855A Amendments - Section 5B

- Submission of exact percentage of the following (as applicable):
  - direct or indirect ownership interest
  - mortgage or security interest
  - general or limited partnership interest
  - operational/managerial control
  - other ownership or control interest
- CMS inserted two new questions:
  - whether the entity disclosed was created for the purpose of acquiring the provider.
  - whether the entity provides any other services to the applicant and to describe such services.
- Requests effective date of the interest in the provider.

## 855A – Section 6

- Revisions largely mimic those for Section 5, i.e.,
  - disclosure of direct/indirect owners, mortgage/security interests, general/limited partnership interests and managing control.
  - effective date of ownership, exact percentage of ownership and whether the individual provides any other services to the provider and to describe those services.
- In addition, Section 6 now asks for the effective date of control for a listed individual, and the exact percentage of control
- Adds new blocks for individuals with "Operational/ Managerial Control" and "Other ownership or control/ interest"

## 855A – Sections 8 and 17

- **Section 8 –**
  - **Request for the billing agent's date of birth**
- **Section 17 – Added the following:**
  - **ability to request additional documents not listed or requested.**
  - **ability to request written confirmation from the IRS confirming classification as a Disregarded Entity**
  - **requests for copy of a providers "IRS Determination Letter"**

## 855A – Attachment 1

- Brand new and required under Section 6001 of ACA
- Requires hospitals to report whether they have any physician owners or managers
- Ownership disclosures are NOT restricted or limited to 5%.
- Extended to include owners and managers, and immediate family members

## 855A – Attachment 1

- **"Ownership interest" includes**
  - **direct and indirect owners; and**
  - **investment interests, whether through equity, debt, or other means.**
- **Owners must specify:**
  - **exact date of ownership;**
  - **exact percentage of direct or indirect ownership; and**
  - **any Adverse Legal History of the owner**
- **For indirect owners, must also provide the name/address of the organization through which the individual holds his or her interest.**



## 855A – Things to Consider

- The most relevant additions appear in Sections 5 and 6 and in Attachment 1
- Most pertain to the requirements to more specifically identify ownership interests, both direct and indirect, and to managerial, equity and other reportable interests.
- The inclusion of the effective date could be an issue for those who have missed previous filing deadlines.
- Requirement to include organizational charts.

## 855B – Significant Changes

- **CMS-855B is submitted for enrollment of suppliers including ambulance companies, ASCs, clinics/group practices, clinical laboratories, IDTFs, intensive cardiac rehabilitation suppliers (new), mammography centers, mass immunization (roster biller only), Part B drug vendors, portable x-ray suppliers and radiation therapy centers.**
- **Under Section 2A, the classification of Clinic/Group Practice no longer requires specifics on whether it is a single specialty, multi-specialty, or public health/welfare agency.**
  - **Hospital Department and PT/OT Group in Private Practice are their own "types of suppliers" – moved from under the clinic/group practice classification.**

## 855B – Significant Changes

- You must note in Section 2B whether your business is classified as proprietary or non-profit with the IRS.
- Section 2F – ASCs must now note the effective date AND expiration of current accreditation.
- Section 2H – Advanced Diagnostic Imaging (ADI) Suppliers accreditation information
  - Under MIPAA (2008), MRI, CT, and nuclear medicine imaging (e.g., PET) suppliers are required to be accredited by January 1, 2012 in order to furnish the technical component of their services to Medicare beneficiaries.
  - There are 3 Medicare-approved accreditation organizations – ACR, IAC and TJC

## 855B – Significant Changes

- **Section 2H – Advanced Diagnostic Imaging (ADI) Suppliers accreditation information – CONTINUED**
  - **Quality standards address – (1) qualifications of medical personnel who are not physicians, (2) quality and responsibilities of medical director and supervising physician, (3) procedures to ensure that the equipment meets performance standards**
  - **This requirement affects physicians, NPPs, and IDTFs who submit claims for the TC to Medicare.**
    - **Not hospitals because they are not paid under the Medicare Physician Fee Schedule**
    - **Not if the individual/entity is billing only the professional component (PC)/interpretation of the test**
  - **Section 2H requires information on the name of the accrediting organization for each modality, the effective date of the current accreditation and the expiration date of the current accreditation.**

## 855B – Significant Changes

- Section 3 – Final Adverse Legal Actions/Convictions – removed the discussion on querying the Healthcare Integrity & Protection Data Bank (HIPDB) if uncertain whether an action is a final adverse legal action.
- "Final adverse legal action" is (and has been) defined by the Medicare regulations as one or more of the following actions:
  - 1) A Medicare-imposed revocation of any Medicare billing privileges;
  - 2) Suspension or revocation of a license to provide health care by any State licensing authority;
  - 3) Revocation or suspension by an accreditation organization;
  - 4) A conviction of a Federal or State felony offense (as defined in § 424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or
  - 5) An exclusion or debarment from participation in a Federal or State health care program.

## 855B – Significant Changes

- **Section 5 – Ownership Interest and/or Managing Control Information (Organizations) – Now must provide telephone number, fax number (if applicable) and email address (if applicable) of owners, partners or entities with managing control**
- **Section 5 and 6 – Ownership Interest and/or Managing Control Information (organizations & individuals, respectively)**
  - **Must provide the effective date that the owner acquired ownership of the provider/supplier**
  - **Must provide the effective date the organization acquired managing control of the provider/supplier**

## 855B – Significant Changes

- Section 6 now requests the title of individuals, place of birth (state) and country of birth.
- Section 6 now specifically asks for you to check off if the individual's relationship with the supplier is "authorized official" or "delegated official".
- Section 8 (Billing Agency) added a field for the date of birth of the billing agent.
- CMS has noted on the signature pages "blue ink preferred".

## 855B – Significant Changes

- **Section 17 – Supporting documents –**
  - Now states that the Medicare contractor may also request documents other than the ones listed in Section 17.
  - Requires an IDTF to provide “all documentation verifying the IDTF supervisory physician(s) proficiency and/or State licenses or certification for IDTF non-physician personnel.”
  - Requires copies of all documents verifying state licenses or certifications of the lab director or NPP personnel of an independent clinical laboratory.
  - IRS documentation - Requires a copy of the IRS Determination Letter if the supplier is registered with the IRS as non-profit and written confirmation from the IRS confirming the LLC is automatically classified as a disregarded entity

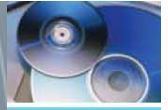
## 855B- Significant Changes

### ➤ Attachment 2 – IDTFs

- Updated the instructions to match current regulations - (1) clarify the requirement of comprehensive insurance coverage, e.g., failure to maintain at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed, \$300,000 coverage per incident, etc.; (2) shared-space prohibition; (3) requirement to enroll for any diagnostic testing services that it furnishes to a Medicare beneficiary; (4) that the IDTF bills for all mobile diagnostic services that are furnished to a Medicare beneficiary, unless the service is provided "under arrangements".

# 855S – DMEPOS Suppliers - Significant Changes

- Section 2A1C – requests information on whether the supplier is registered with the IRS as proprietary or non-profit.
- Section 2B – added a new type of supplier – ocularists
- Section 2D – products to be supplied - split up “enteral nutrients” and “enteral equipment and/or supplies” and “parenteral nutrients” and “parenteral equipment and/or supplies”
- Like the 855B, Section 3 – final adverse legal actions– left out the information about making a query to HIPDB to determine if there was a “final adverse action.”
- Section 4 – current business location – now lists states below Jurisdiction (A-D) in which they below, so it is clear in what jurisdictions the supplier is operating.
- Like the 855B, Section 5 and 6 – ownership interest and/or managing control interest (organizations and individuals, respectively) – now requires the effective date of ownership or managing control.
- Like the 855B, Section 8 requires the DOB of the billing agent.
- Like the 855B, Section 17 requires copy of IRS Determination Letter if registered as non-profit and written confirmation confirming an LLC is automatically classified as a disregarded entity.
- Section 17 also requires a copy of the surety bond.
- The DMEPOS Supplier Standards were removed and replaced with a cite to the electronic version. (NOTE: in the last version of the 855S, the form only reflected 26 standards, i.e., the form did not keep up with the changes in the requirements.)



## 855I - Background

- Revisions not as extensive as those to the 855A or 855B.
- 855I is for enrollment of physicians and non-physician practitioners.
- New requirement for physicians to complete a new 855I with next change of information.
- Entire application must be completed, if currently enrolled and no submissions since 2003.

## 855I – Sections 2 and 4

- **Section 2, added:**
  - **new question: "Do you accept new patients?"**
  - **new section requesting information from ADI suppliers**
- **Section 4, added a requirement to identify the legal entity type and whether the entity is a non-profit or for profit entity.**

## 855I – Sections 6 and 8

### Section 6

- CMS inserted a data element into Section 6 that asks for the effective date of an individual's managing control of the business to help verify the individual's relationship with the practice.
- CMS is requesting the birthplace of each individual listed in Section 6 in order to verify each individual's identity.

### Section 8

- CMS is now requesting the billing agent's date of birth (when an individual).

## 855I – Section 17 (Documents)

- Similar to the changes in the other 855 Forms.
- Added a statement that the Medicare contractor may request from the provider additional documents not listed or requested in Section 17.
- Added a requirement for suppliers (where relevant) to confirm their IRS status as a “disregarded entity” for tax purposes.
- Added request for the following documents be attached:
  - For suppliers who are non-profit entities, a copy of their IRS 501(c)
  - For all suppliers, a copy of their CP-575 Form to verify the business's EIN.

## 855R – Small Changes

- **General Information now notes: (1) Physicians and NPPs who are enrolled in Medicare, but have not submitted an 855I since 2003, are required to submit an 855I as an initial application prior to completing an 855R; (2) with regard to physician assistants, the 855R should not be used to report employment arrangements. (Employment arrangements must be reported in Sections 2E through 2G of the 855I application.)**
- **Telephone (required) and Fax Number (optional) added to Contact Person information.**

## 8550 - Background

- Brand new form.
- CMS determined it was necessary for suppliers who only order and refer services.
- Will result in the issuance of a Medicare identification number, but NOT billing privileges.
- Without a Medicare identification number, the claims for these services will be rejected.
- The Medicare identification number will be submitted in Box 17 of the 1500 Claim Form.

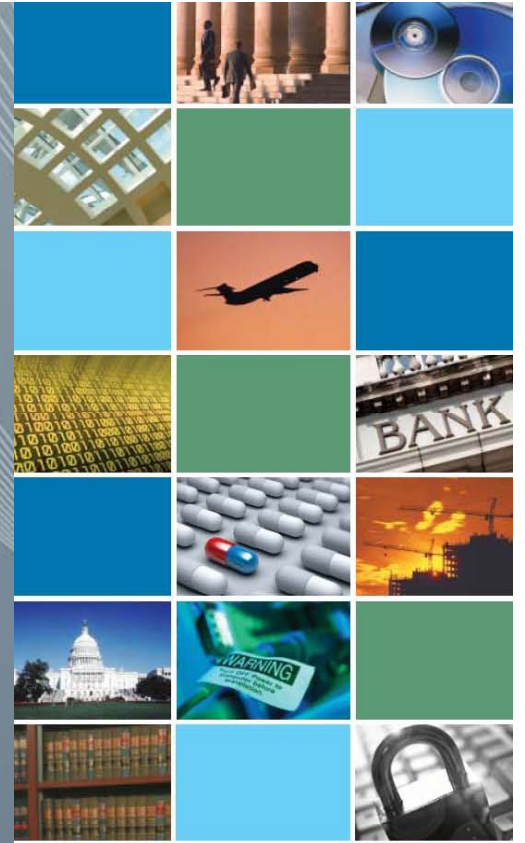
## 8550 – Background

- Before institution of this form:
  - providers and suppliers completed CMS Form 855I to obtain an identification number;
  - claims were paid if the ordering provider or supplier was listed, even without an identification number; and
  - the remittance advice included a message indicating the claim failed certain edits.
- Examples include orders for, lab tests, imaging procedures, DMEPOS orders and specialty services.

## 8550 – Specific Sections

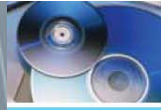
- Information submitted will be used:
  - to ensure the applicant has the appropriate credentials; and
  - is not prohibited from participating in the Medicare Program.
- CMS believes the form will be utilized by:
  - physicians in the VA, PHS, DOD, IHS; physicians of FQHCs, RHCs, and CAHs; residents and fellows Dentists/oral surgeons and pediatricians
- The information requested is fairly benign, and in general asks for:
  - Personal identifying and licensure information
  - Identification of your status and specialty and
  - Final adverse legal actions
- There is no requirement to execute and submit a supplier agreement or EFT form

# CHANGES OF OWNERSHIP/ CHANGES OF INFORMATION



## Changes of Ownership (CHOWs) – Part A Primer

- Change of ownership filings must be performed for Medicare/Medicaid purposes, licensure purposes, CON, accreditation, etc.
- CHOWs in the Medicare context are NOT the simple sale of a provider agreement and a provider number.
- A provider agreement cannot be sold and transferred without CMS approval and provider numbers cannot be sold or transferred.
- For Medicare purposes, a CHOW primarily occurs with the sale of an entity, and is dictated by both the type of entity sold and the style of transaction under consideration.
  - For example, stock vs. asset sale, corporation vs. partnership, sale vs. lease.



# What constitutes a CHOW under Part A?

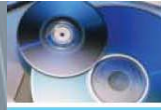
CMS determined by regulation (489.18) that four specific types of transactions resulted in a CHOW. Those include the following:

- **Partnership/LLC**: With partnerships, CMS indicates there is a CHOW if there is a removal, addition, or substitution of a partner "unless the partners expressly agree otherwise as permitted by state law."
- **Sole proprietorship**: CMS indicates that for sole proprietorships a CHOW occurs with the passage of title from one person to another or property of the enterprise.
- **Corporations**:
  - **Mergers** – when the provider entity merges with another entity and is the survivor, there is no CHOW. However, when the provider entity does not survive or there is the creation of a new provider entity there is a CHOW.
  - **Consolidation** – when two provider entities merge and consolidate to one of the two provider entities, there is no CHOW, but if the consolidation results in a new provider entity there is a CHOW.



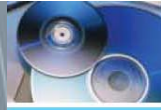
## What constitutes a CHOW under Part A?

- **Asset sale** – Quintessential CHOW and results in automatic assignment of the provider agreement and provider number, unless the buyer specifically does not accept.
- **Leases**: CMS indicates that the lease of all or part of a provider is a CHOW of the leased portion. This assumes that this is not just a real estate transaction, but a transaction where the lessor previously operated the provider and post lease the lessee operates the provider and the lessor has no more involvement in the operations of the provider entity.
- **Management agreement**: CMS indicates there can be a CHOW if the new manager retains all operational control and the owner relinquishes it ("when the owner has relinquished all authority and responsibility for the provider organization"), otherwise there generally is no CHOW.



## Changes of Ownership (CHOWs) – Part A entities

- If there is a CHOW, the seller's existing provider agreement and provider number are automatically assigned to the buyer.
- This assignment eliminates cash flow delays that naturally result from an initial enrollment in the Medicare program, but it carries with it the risk of assuming liability for the prior owner's past transgressions.
- Specifically, the buyer takes the provider agreement subject to all terms and conditions under which the original provider agreement was issued.
- Courts have affirmed in the past that this can include Medicare overpayments, civil monetary penalties, and false claims act liability.
- To stop the automatic assignment, a buyer has to take affirmative steps in advance, but requires initial enrollment and resulting cash flow lags.



# CHOW Process

## Process perspective:

- CHOW applications can be submitted up to 90 days pre-closing, but must be submitted within 30 days of closing .
- When there is a CHOW, the CHOW is recognized at 12:01AM on the date of closing.
- Both the buyer and seller must file a CMS Form 855A indicating there is a CHOW and whether the buyer will accept assignment of the provider agreement. The MACs have indicated they prefer these two forms to be submitted together to facilitate processing, but there is no express requirement to do so.
- For payment purposes, payments are issued to the seller until CMS issues the tie-in notice – which could be 6 months later – and in the interim CMS indicates it is up to the parties to determine how to work out funds flows.
- CMS must be notified of a prospective CHOW at least 35 days in advance. This notice can be provided to the MAC, or even to the State survey agency.



## Changes of Ownership (CHOWs) – Part B

- For the most part, CHOWs only apply in the Medicare Part A context for providers. There are some limited exceptions for a few Medicare Suppliers in the Part B context, notably, ASCs, RHCs, FQHCs, Portable X-Ray Suppliers, and certain hospital provider-based outpatient departments
- The general rule in the Part B context that if the tax identification number changes, then there is a change of ownership and control that requires the submission of a new application by the buyer and a termination by the seller.
- In the Part A or B context, if there is a stock/membership interest transfer and the tax identification number does not change (which is typical), then it is not a change of ownership or control that would require a new application. In such case, a change of information filing must be submitted within 30 days of the change.



## Change of Control – Part A/B

- If there is a stock deal, there is a wholesale sale of the entity, and the provider number stays with the entity.
- As with the CHOW in the Part A description above, where the buyer accepts the number/agreement of the seller, in the stock purchase, it is also important that you understand that you are purchasing the entity “as is” with any overpayments, CMPs, etc. that may exist. That is because in acquiring the stock you are not changing the entity enrolled in the eyes of the Medicare program.
- **DUE DILIGENCE IN SUCH CIRCUMSTANCES IS VERY IMPORTANT**

# Questions?

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