Codify
BY AAPC

Eli's Hospice Insider

Compliance: Proposed Enrollment Rule Riddled With Flaws, Commenters Told CMS

Lack of targeting and unreasonable lookback period head the list.

A new proposed rule toughening up enrollment and reenrollment procedures could cut a swath through the ranks of law-abiding providers, unless CMS makes some big changes to the regulation. So said many of the 56 commenters on the rule published in the March 1 Federal Register. Here are the areas most in need of revision, according to commenters:

Lack of focus. The fraud-fighting provisions in Medicare's proposed rule for enrollment changes will actually mostly harm legitimate providers trying to comply, said many of the organizations that submitted 56 comment letters on the rule.

"As with most other compliance requirements, particularly those that require voluntary disclosure, the true criminals in our midst will simply lie and in a very convincing way," said the **Illinois HomeCare & Hospice Council** in its comment letter on the rule. "As a result, the primary burden of these new requirements will be borne by compliance-oriented agencies."

"Medicare providers can be forced to incur unnecessary costs to comply with a new rule and respond to a new integrity effort when a broadbased action is taken to address the abusive, but isolated conduct of a few providers," pointed out the **National Association for Home Care & Hospice** in its comments.

"The proposed rule would be overly burdensome on providers due to its numerous requirements," agreed the **American Physical Therapy Association** in its comment letter. "Innocent providers and suppliers will be unduly penalized because the costs associated with compliance are too high."

"The United States' health care system is already very complex and difficult to access," said the **Texas Association for Home Care & Hospice** in its comment letter. "We are concerned that the complexity of the proposed expanded reporting requirements on affiliations will make an already burdensome system even more difficult to navigate."

And providers aren't the only ones harmed by overly broad fraud-fighting programs. "Random, untargeted program integrity measures can bring harm to Medicare beneficiaries and all other stakeholders," NAHC told CMS. "For example, a measure could raise barriers to access to timely care for beneficiaries duly entitled to coverage."

Instead: "CMS could use its data mining capabilities more effectively to capture the necessary information instead of creating additional reporting requirements for providers," countered **Kindred Healthcare** in its comment letter.

"The Medicare program will be better served if CMS adopts a rule that is much more targeted in identifying and weeding out possible bad actors," APTA recommended.

CMS should focus on new entrants, NAHC urged. "Abusers of the Medicare program generally do not evolve into abusers over time," the trade group argued. "Instead, it can be expected that they come into Medicare with original intent to commit fraud. As such, program integrity measures that prevent such providers from entering into Medicare should be considered and implemented as a priority approach."

 Lookback period. CMS wants providers to report affiliated entities' disclosable events as part of the enrollment/reenrollment process, but the lookback period for them makes the requirement "nearly impossible," APTA told CMS in its letter.

The proposal sets a five-year lookback period for affiliations. But it sets no timeline for the disclosable events of those affiliates. "The disclosable event can occur before or after the actual affiliation," Kindred pointed out in its comments.

CPT® 2023 American Medical Association. All rights reserved.

Requiring disclosure of events that have occurred after a provider has terminated a relationship with an affiliate is "extremely burdensome" since providers "will have an affirmative duty to continue to perform due diligence on an organization with which they no longer do business," APTA maintained. "Once a financial relationship has been terminated, there would be no plausible reason for either party to maintain contact."

IHHC has "concerns about the costs that will be incurred by providers ... to conduct the type of due diligence that will be required by the requirement to disclose affiliations," the trade group told CMS in its comment letter. "The level of detail and even sleuthing that may be required to confidently attest to the veracity of the information submitted on the 855 at revalidation is significant and will include costs of staff time and potentially including legal or investigative contractors."

Instead: A number of providers suggested shortening the lookback period to two or three years for affiliations, and two or three years for disclosable events for those affiliations.

 Appealed events. Even if a provider is appealing a Medicare exclusion or debt, it would still report it in its enrollment/reenrollment application under this rule, CMS specifies. "We want to avoid situations where an initially enrolling provider or supplier would not have to disclose, for example, an affiliated provider that was revoked from Medicare 6 months ago (based on a felony conviction) because the revocation is under appeal," the agency explains in the rule. "Without this information, the provider or supplier in question might become enrolled in Medicare without CMS knowing of its relationship with a recently convicted affiliated provider or supplier."

Once an exclusion or other event is overturned on appeal, however, a provider would no longer have to report it, according to the rule.

Many commenters objected to reporting events that are still under appeal. "Providers who are in the appeal process should be exempt from disclosure," TAHC told CMS in its letter.

"Even though it is possible that a provider, supplier, or affiliate could continue to perform fraudulent acts before their appeals process was complete, we believe that not having innocent parties burdened by the high costs of compliance would far outweigh this remote possibility," APTA said. "We urge CMS to adopt a provision in the final rule that allows for all appeals to be exhausted before a provider or supplier is required to report."

For debts, "given the inability of CMS to process appeals in a timely fashion and the preponderance of claims that are overturned on appeal, it is inappropriate for CMS to include 'debt that is currently being appealed' in the definition of 'uncollected debt,'" Kindred said in its letter. "This definition should focus solely on final debt."

Plus: Including appealed debt "is administratively burdensome and pressures providers to affirmatively pay Zone Program Integrity Contractors (ZPIC) and Additional Documentation Request (ADR) amounts, versus allowing the Medicare Administrative Contractor (MAC) to recoup the amount," Kindred criticized. "By doing so providers waive statutory interest they are entitled to in the event of a win on appeal."

 Practice location. The rule proposes to allow revocation if a provider doesn't report a practice location change or change of ownership within 30 days. "While practice location changes are important matter for CMS to know, the imposition of an enrollment revocation is an overly severe penalty for what might be no more than an administrative oversight," NAHC said in its comment letter.

 Reenrollment bar. Increasing the max reenrollment bar from three to 10 years is too much for such a vaguely described action, "APTA insisted. "CMS has given no guidance as to which penalties will be given out for which offenses, and we are concerned that punishments for offenses could be determined arbitrarily and without a system of checks and balances."

The sharp increase in the reenrollment bar and other ban time periods is "overly punitive," Kindred judged.

 Physicians. Requiring ordering/certifying physicians' Medicare enrollment or valid opt-out status is "exceedingly onerous and administratively burdensome" since providers whose billing relies on physician orders/certs would have to "confirm a physician's status with every order," Kindred protested in its comment letter. "Since SNFs, pharmacies, HHAs, and other providers receive orders and referrals from physicians and other eligible professionals who are not their employees or even independent contractors, there is no realistic way for providers receiving such referrals to ensure such physicians are 'enrolled in or validly opted-out of Medicare,'" the company told CMS.

CPT® 2023 American Medical Association. All rights reserved.

Codify BY AAPC

The proposed rule would widen the requirement in home health from certifying physicians to all ordering docs, NAHC pointed out. "The experience of home health agencies should demonstrate that the application of such a requirement is significantly problematic as physicians that have the enrollment obligation trigger penalties for providers that supply the ordered services while the providers do not control the physician actions," NAHC related in its letter. "Further, the availability of real-time physician enrollment status data is limited."

CPT® 2023 American Medical Association. All rights reserved.