# Changes in Medicare Provider Enrollment

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# Provider Enrollment

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Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements.

https://www.govinfo.gov/content/pkg/FR-2023-11-13/pdf/2023-24455.pdf

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Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program.

https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-f

Effective Date: January 1, 2024

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# Provider Enrollment

§ 424.502 Definitions:

§ 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program

§ 424.518 Screening levels for Medicare providers and suppliers.

§ 424.527 Provisional period of enhanced oversight. : Denial of enrollment in the Medicare program.

§ 424.530 Denial of enrollment in the Medicare program.

§ 424.535 Revocation of enrollment in the Medicare program

§ 424.540 Deactivation of Medicare

§424.541 Stay of enrollment.

§ 424.542 Prohibition on ordering, certifying, referring, or prescribing based on felony conviction.

§ 424.550 Prohibitions on the sale or transfer of billing privileges.

§ 424.555 Payment liability.

§ 489.52 Termination by the provider.

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# Provider Enrollment

## § 424.502 Definitions

**Several new and clarifying definitions related to enrollment concepts**

***Authorized official***: means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program**. For purposes of this definition only, the term "organization" means the enrolling entity as identified by its legal business name and tax identification number.**

***Indirect ownership interest*** (1) (i) Any ownership interest in an entity that has an ownership interest in the enrolling or enrolled provider or supplier.

- (ii) Any ownership interest in an indirect owner of the enrolling or enrolled provider or supplier.
- (2) The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the provider or supplier, A's interest equates to an 8 percent indirect ownership interest in the provider or supplier and must be reported on the enrollment application. Conversely, if B owns 80 percent of the stock of a corporation that owns 5 percent of the stock of the provider or supplier, B's interest equates to a 4 percent indirect ownership interest in the provider or supplier and need not be reported.

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# Provider Enrollment

## § 424.502 Definitions - continued

***Managing employee*** means a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W–2 employee of the provider or supplier. ***For purposes of this definition, this includes, but is not limited to, a hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director***

***Supplier*** means, for purposes of this subpart, all of the following:

- (1) The individuals and entities that qualify as suppliers under § 400.202.
- (2) Physical therapists in private practice.
- (3) Occupational therapists in private practice.
- (4) Speech-language pathologists.

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# Provider Enrollment

**§ 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program**

(e)(1) Within 30 days for a change of ownership or control , (including changes in authorized official(s) or delegated official(s)) *or a change, addition, or deletion of a practice location.*

- ***Includes addition and deletion of practice location***
- ***Changes reporting requirements for all providers to 30 days rather than 90 days***

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# Provider enrollment

**§ 424.535 Revocation of enrollment in the Medicare program**

***(a) Reasons for revocations.***

**(1) )** ***Noncompliance.*** …….The provider or supplier is determined to not be in compliance with the enrollment requirements described in this subpart P is changed to **title 42**……

***(15) False Claims Act (FCA).***

(ii)The provider or supplier, or any owner, managing employee or organization, officer, or director of the provider or supplier, has had a civil judgment under the FCA (31 U.S.C. 3729 through 3733) imposed against them within the previous 10 years.

(iii) In determining whether a revocation under this paragraph is appropriate, CMS

A) The number of provider or supplier actions that the judgment incorporates (for example, the number of false claims submitted).

(B) The types of provider or supplier actions involved.

(C) The monetary amount of the judgment.

(D) When the judgment occurred.

(E) Whether the provider or supplier has any history of final adverse actions (as that term is defined in § 424.502).

(F) Any other information that CMS deems relevant to its determination.

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# Provider Enrollment

**§ 424.535 Revocation of enrollment in the Medicare program**

***(a) Reasons for revocations (continued)***

*……*

(17) ***Debt referred to the United States Department of Treasury.***

(i) The provider or supplier *failed to repay a debt ….**changed from has an existing debt***

(ii) Paragraph (17)(i) of this paragraph does not apply to the following situations:

(A) The provider's or supplier's Medicare debt has been discharged by a bankruptcy court; or

(B) The administrative appeals process concerning the debt has not been exhausted or the timeframe for filing such an appeal (at the appropriate level of appeal) has not expired

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# Provider Enrollment

**§ 424.535 Revocation of enrollment in the Medicare program**

***(a) Reasons for revocations (continued)***

**……**

**(23) *Supplier standard or condition violation.***

(i) The independent diagnostic testing facility is non-compliant with any provision in 42 CFR 410.33(g).

(ii) The DMEPOS supplier is non-compliant with any provision in § 424.57(c).

(iii) The opioid treatment program is non-compliant with any provision § 424.67(b) or (e).

(iv) The home infusion therapy supplier is non-compliant with any provision in § 424.68(c) or (e).

(v) The Medicare diabetes prevention program is non-compliant with any provision in § 424.205(b) or (d).

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# Provider Enrollment

## § 424.535 Revocation of enrollment in the Medicare program

(e) ***Reversal of revocation.*** If the revocation was due to adverse activity (sanction, exclusion, or felony) against the provider's or supplier's owner, managing employee, managing organization, officer, director, authorized or delegated official, medical director, supervising physician, or other health care or administrative or management services personnel furnishing services payable by a Federal health care program, the revocation may be reversed if the provider or supplier terminates and submits proof that it has terminated its business relationship with that individual party within 15 days of the revocation notification. ***Changed from 30 days***

(g) ***Effective date of revocation.*** (1) Except as described in paragraphs (g)(2) and (g)(3) of this section, a revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier.

(2) Except as described in paragraph (g)(3) of this section, the revocation effective dates in the situations identified in this paragraph (g)(2) are as follows:

Several organizational changes to and expansions of § 424.535(g).**Effective dates vary by revocation reason**

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# Provider Enrollment

## § 424.540 Deactivation of Medicare

(a) ***Reasons for deactivation.*** CMS may deactivate the Medicare billing privileges of a provider or supplier for any of the following reasons:

(1) The provider or supplier does not submit any Medicare claims for 6 consecutive calendar months. The 6month period will begin the 1st day of the 1st month without a claim submission through the last day of the 6th month without a submitted claim.

- ***Changed to 6 months from 12 months***

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# Provider Enrollment

## §424.541 Stay of enrollment.

- New enrollment status
- Intended to avoid deactivations or revocations if the supplier /providers can remedy the non-compliance via the submission of, as applicable, a Form CMS–855, Form CMS–20134, or Form CMS–588 change of information or revalidation .
- The stay of enrollment is effective for no more than 60 days.
- Suppliers /providers notified in writing that a stay is in effect
- The stay of enrollment ends on the date on which CMS or its contractor determines that the provider or supplier has resumed compliance with all Medicare enrollment requirements or the day after the 60-day stay period expires, whichever occurs first.
- Claims submitted by the provider or supplier with dates of service within the stay period will be rejected.
- Claims may be resubmitted if the supplier/provider comes into compliance within the 60 day stay period.

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# Provider Enrollment

## §424.541 Stay of enrollment (continued)

- The provider or supplier has 15 calendar days from the date of the written notice to submit a rebuttal to the stay
- CMS may extend the 15-day time-period
- The rebuttal determination is not appealable
- CMS is not required to delay the stay while the rebuttal is reviewed.

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## Provider Enrollment

**§ 424.542 Prohibition on ordering, certifying, referring, or prescribing based on felony conviction**

(a) ***General prohibition.*** A physician or other eligible professional (regardless of whether he or she is or was enrolled in Medicare) who has had a felony conviction within the previous 10 years that CMS determines is detrimental to the best interests of the Medicare program and its beneficiaries may not order, refer, certify, or prescribe Medicare-covered services, items, or drugs.

(b) ***Payment.*** Medicare does not pay for any otherwise covered service, item, or drug that is ordered, referred, certified, or prescribed by a physician or other eligible professional (as that term is defined in section 1848(k)(3)(B) of the Act) who has had a felony conviction within the previous 10 years that CMS determines is detrimental to the best interests of the Medicare program and its beneficiaries.

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## Provider Enrollment

**§ 424.555 Payment liability.**

(b) No payment may be made for otherwise Medicare covered items or services furnished to a Medicare beneficiary by a provider or supplier if the billing privileges of the provider or supplier are deactivated, denied, or revoked, or if the provider or supplier is currently ***under a stay of enrollment*** (except as stated in § 424.541(a)(2)(ii)(B)). The Medicare beneficiary has no financial responsibility for expenses, and the provider or supplier must refund on a timely basis to the Medicare beneficiary any amounts collected from the Medicare beneficiary for these otherwise Medicare covered items or services.

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## Provider Enrollment

**§ 489.52 Termination by the provider.**

(b) ***Termination date.***

(4) A provider may request a retroactive termination date if no Medicare beneficiary received services from the facility on or after the requested termination date.

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## Provider Enrollment

**§ 424.518 Categorical Risk Screening**

- New hospices and those submitting applications to report any new owner will be moved into the “high” level of categorical screening
- Revalidating hospices continue to be subject to “moderate” screening requirements
- Screening occurs:
  - Initial applications
  - Revalidation application
  - Adding a practice location
  - Reporting any new owner

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# Provider Enrollment

## § 424.518 Categorical Risk Screening continued

- Limited: MAC does the following:
  - Verifies that entity meets all federal and state requirements
  - Conducts license verifications
  - Conducts database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type
- Moderate: MAC does the following:
  - Performs the “limited” screening
  - Conducts an on-site visit

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# Provider Enrollment

## § 424.518 Categorical Risk Screening continued

- High:  MAC does the following:
  - Performs the “limited” and “moderate” risk screening activities
  - *Requires the submission of a set of fingerprints for a national background check from all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the provider/supplier
  - *Conducts a fingerprint-based criminal history record check of the FBI’s Integrated Automated Fingerprint Identification System on all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the provider/supplier

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# Provider Enrollment

## § 424.518 Previously Waived Fingerprinting of High-Risk Providers/Suppliers

- During COVID-19 PHE, CMS waived requirement for fingerprint-based background checks (FBCBCs) for high-risk providers/suppliers
- CMS plans to conduct the checks as part of the revalidation process for affected providers/suppliers
- CMS currently lacks authority to conduct the checks at revalidation because all revalidation applications are screened at the moderate risk level
- CMS classifies providers/suppliers who missed background check at initial enrollment as High-Risk providers/suppliers

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# Provider Enrollment

## § 424.518 Previously Waived Fingerprinting of High-Risk Providers/Suppliers

- Established a revised regulation reclassifying High Risk providers/suppliers as Moderate Risk if they underwent background checks at initial enrollment or upon revalidation after CMS waived the background check requirement

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# Provider Enrollment

**§ 424.527 Provisional Period of Enhanced Oversight**

- Added § 424.527(a) New provider defined for provisional period of enhanced oversight (PPEO)
  - A newly enrolling Medicare provider or supplier
  - A certified provider or certified supplier undergoing a change of ownership
  - A provider or supplier (including an HHA or hospice) undergoing a 100 percent change of ownership via a change of information.
- Added § 424.527(b) The effective date of the PPEO's commencement is the date on which the new provider or supplier submits its first claim rather than the date the first service was performed or the effective date of the ownership change

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# Provider Enrollment

**§ 424.527 Provisional Period of Enhanced Oversight cont.**

- Period range:
  - 30 days to
  - 1 year
- Oversight can include but is not limited to:
  - Prepayment review
  - Payment caps

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# Provider Enrollment

**§ 424.530 Reapplication Bar**

- Prohibit a prospective provider or supplier from enrolling in Medicare for up to 10 years if its enrollment application is denied because the provider or supplier submitted false or misleading information on or with (or omitted information from) its application in order to enroll
- CMS determines the bar's length by considering the following factors:
  - The materiality of the information in question.
  - Whether there is evidence to suggest that the provider or supplier purposely furnished false or misleading information or deliberately withheld information.
  - Whether the provider or supplier has any history of final adverse actions or Medicare or Medicaid payment suspensions.
  - Any other information that CMS deems relevant to its determination.

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# Provider Enrollment

**§ 424.530(f) Ordering, Referring, Certifying, and Prescribing Restrictions**

- Any provider/supplier subject to a reapplication bar may not order, refer, certify, or prescribe Medicare-covered services, items, or drugs
- Medicare will not pay for any otherwise covered service, item, or drug that is ordered, referred, certified, or prescribed by a provider/supplier under a reapplication bar

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## Provider Enrollment

**§ 424.550 36-Month Rule**

- Hospice change in majority ownership (CIMO) defined as more than 50 percent by sale within 36 months after the effective date of initial enrollment or within 36 months following the hospice's most recent CIMO, the provider agreement and Medicare billing privileges will not convey
- Prospective provider/owner of the hospice will be required to:
  - Enroll in Medicare as a new (initial) hospice
  - Obtain a state survey or an accreditation from an approved accreditation organization

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## Provider Enrollment

**§ 424.550 36-Month Rule continued**

- Exceptions: 36-month rule does not apply when:
  - The organization submitted two consecutive years of full cost reports since initial enrollment or the last CIMO, whichever is later
  - The organization's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation
  - The owners of an existing agency are changing the business structure (for example, from a corporation to a partnership – general or limited – and the owners remain the same)
  - An individual owner of the agency dies

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# Provider Enrollment

**§ 424.550 36-Month Rule continued**

- Hospice ownership transactions whose effective date is on or after January 1, 2024.
- Provisions can apply irrespective of when the hospice first enrolled in Medicare
  - Initially enrolled effective February 1, 2022. Change in majority ownership effective February 1, 2024.
  - Initially enrolled February 1, 2016. First change in majority ownership effective February 1, 2024. *NOT APPLICABLE*
    - Another change in majority ownership effective February 1, 2025. *APPLICABLE*

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# Provider Enrollment

**§ 424.550 36-Month Rule continued**

Assumption of greater than 50 percent direct ownership interest

- Outside party currently not an owner purchases more than 50 percent of the business in a single transaction
- Existing owner purchases additional interest that brings total ownership to greater than 50 percent
- A 50 percent owner obtains any additional amount of ownership, regardless of percentage, and becomes a majority owner

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## Provider Enrollment Resource

- CMS Transmittal 12393/Change Request 1333

| | |
|---|---|
| CMS Manual System | **Department of Health & Human Services (DHHS)** |
| Pub 100-08 Medicare Program Integrity | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 12393** | **Date: December 7, 2023** |
| | **Change Request 13333** |

**SUBJECT: Incorporation of Recent Provider Enrollment Regulatory Changes into Chapter 10 of CMS Publication (Pub.) 100-08 - Home Health Prospective Payment System (HH PPS) Final Rule**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to update Chapter 10 of CMS Pub. 100-08 with instructions regarding the implementation of certain provider enrollment regulatory provisions in the Calendar Year (CY) 2024 HH PPS final rule.

**EFFECTIVE DATE: January 1, 2024**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: January 2, 2024**

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