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# Insights

## If A CMS Surveyor Knocks, Will You Be There To Answer?

April 25, 2017

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In order to maintain enrollment in Medicare, suppliers and providers must comply with Medicare program mandates, including the "enrollment requirements" detailed in Medicare's conditions for payment regulations.[1] The enrollment requirements obligate a provider to submit – and keep current – a CMS-approved "enrollment application" that identifies, among other things, the provider's "practice location." What sounds straightforward proves challenging for providers, particularly those with multiple practice locations all utilizing the same Medicare billing number. A quick review of the CMS enrollment requirements indicates that providers must provide timely updates whenever their enrollment undergoes a substantive change. These changes can be as minimal as a new member on the board of directors or as significant as a true change of ownership. In either capacity, the CMS provider enrollment rules require these changes be communicated to CMS within the timeframes required by the regulations (generally within 30 to 90 days of the change).

Why should a currently-certified Medicare provider care about these requirements? Despite undergoing a significant number of unreported changes, does Medicare continue to pay your organization's claims? As a home health agency in Texas recently learned, CMS reserves substantial rights to unannounced inspections in order to confirm a provider's enrollment record accurately reflects its operations.[2]

In this instance, the home health agency had taken all steps necessary to communicate to CMS a recent relocation of their main practice location. A CMS inspector later conducted an unannounced survey of the home health agency, only to find the location locked and seemingly unoccupied. A follow-up inspection the next day yielded similar results for the inspector. Three months after the failed inspection attempts, the home health agency received word from its Medicare Administrative Contractor ("MAC") that its Medicare billing privileges were revoked, effective immediately.

A review of the home health agency's appeal informs that the practice location was staffed at the time of the inspection, but the staff was busy receiving training in the rear of the office and could not hear the inspector knocking at the locked front entrance. Regardless, a CMS Administrative Law Judge and the Departmental Appeals Board both agreed with the MAC's determination, narrowly holding that the home health agency was not "operational" as reflected in its enrollment record. In dramatic fashion, the home health agency's largest payor had cut off reimbursement.

The lesson for Medicare-certified providers is two-fold: 1) Constant, timely update of your Medicare provider enrollment record is crucial; and, 2) CMS will use your provider enrollment record to verify operations. A contradiction of either your enrollment record or actual operations puts continued Medicare reimbursement at risk.

Krieg DeVault LLP recommends its Medicare-certified clients take a close look at their Medicare provider enrollment records and internal processes for timely updating of this record. A comprehensive review works best, whereby clinical, operational, financial, and other organizational stakeholders scrutinize the enrollment to make sure the information contained therein accurately reflects the current state of the organization and its operations.

Our health care practice group members are happy to assist in this process, whereby our Medicare provider enrollment experience can identify issues or concerns we have resolved for other health care provider clients. Should you have any questions regarding your Medicare provider enrollment record, please contact Thomas N. Hutchinson.

[1] *See* 42 C.F.R. § 424.516(a).

[2] *See* DAB No. 2778 (March 30, 2017).