Enrollment Basics: A Refresher

Provider and Supplier Enrollment Forms – the 855

- CMS 855A – For institutional providers
- CMS 855B – For clinics/group practices, IDTFs, ASCs, and other entities (non-individuals billing under Part B), not including DMEPOS suppliers
- CMS 855I – For individuals (physicians, NPPs) billing under Part B
- CMS 855O – For registration of ordering/referring physicians and NPPs
- CMS 855R – For reassigning benefits under Part B
- CMS 855S – For DMEPOS suppliers

Other Forms

- 588 Electronic Funds Transfer Agreement
- 460 Participating provider agreement
Enrollment Basics: Authorities

Provider and Supplier Enrollment Regulations
- 42 CFR Part 424, Subpart P (the 424.500’s) -- establishing and maintaining Medicare billing privileges (including rules for denying, revoking and deactivating billing privileges, and special rules on HHA changes in majority ownership)
- 424.57 -- DMEPOS supplier standards
- 424.58 DMEPOS accreditation procedures
- 410.33 IDTF Standards
- 42 CFR, Part 498 – appeals procedures (also 42 CFR 405.874)


PECOS Guide
- “Getting Started With Internet-based Provider Enrollment, Chain and Ownership System (PECOS)” -- available at http://www.cms.gov/MedicareProviderSupEnroll/downloads/Internet-basedPECOS%E2%80%93GettingStartedGuideforDMEPOSSuppliers.pdf

Enrollment: Recent Final Rules

- April 27, 2012 – final rule in furtherance of May 5, 2010 interim final rule with comment period (see below), on enrollment requirements for ordering/referring physicians and NPI requirements (77 FR 25284)
- March 14, 2012 – further changes to DMEPOS supplier standards, including changes to patient anti-solicitation provision (77 FR 14989)
- February 2, 2011 – implementing provisions of PPACA on screening requirements, application fees, temporary enrollment moratoria, payment suspensions, and Medicaid terminations of providers and suppliers that have been terminated or that had their billing privileges revoked (76 FR 5682)
- August 27, 2010 – additional DMEPOS supplier standards (75 FR 166)
Enrollment: Recent Final Rules

- May 5, 2010 -- implementing provisions of PPACA to require all providers and suppliers that qualify for an NPI to include their NPI on all applications to enroll in the Medicare and Medicaid programs and on all claims for payment submitted under the Medicare and Medicaid programs (75 FR 24437)
- January 2, 2009 -- surety bond requirement for DMEPOS suppliers (74 FR 166)
- November 19, 2008 – established the re-enrollment bar of 1 to 3 years on providers and suppliers that have had their billing privileges revoked, and placed limitations on retroactive billing by providers and suppliers (73 FR 69726)
- June 27, 2008 -- “Appeals of CMS or CMS Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges” (73 FR 36448)

- November 27, 2007 – changes to IDTF provisions in 410.33 (72 FR 66222)
- December 1, 2006 – established performance standards for IDTFs (71 FR 69624)
- April 21, 2006 – “Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment,” implementing section 1866(j)(1)(A) of the Act (71 FR 20754)
- October 11, 2000 -- additional standards for DMEPOS suppliers (65 FR 60366)
Enrollment: The CMS 855 Form

Essential things to know about the 855 forms

- They can be downloaded from CMS’s website
  - On the CMS website Medicare page, select Forms on the left side of the page http://www.cms.gov/CMSForms/CMSForms/list.asp#TopOfPage, then check the box for “Show only items containing the following word” and type "855" in the space provided
  - CMS changes the forms from time to time:
    - You must use the right version or enrollment will be delayed! So what? you ask. Enrollment is effective beginning on the date that the contractor receives an 855 that can be processed to conclusion, and generally suppliers (and to a lesser extent providers) are not allowed to bill for services furnished before the enrollment date

- The submitted form must be complete and accurate (this is particularly important as it relates to retroactivity)
- The enrollment application must be kept current
- The 855R must be signed by the individual reassigning the benefits, and completed by the entity (or person) to which (or to whom) the benefits are being reassigned
- The forms are forms and not regulations. They are not perfect and they do not fit all situations (particularly complex CHOWS) well
Enrollment: The CMS 855 Form

Essential things to know about the 855 forms

- The 855S requires a copy of a surety bond in the correct amount to be submitted with it (unless the supplier is exempt from the surety bond requirement)
- The 855S requires proof of accreditation to be submitted with it (for those items for which accreditation is required)
- Adverse legal action documentation must be attached
- There is a backlog in processing the 855 forms
  - Backlog varies by contractor and type of provider/supplier
  - Backlog varies by type of transaction

PECOS

What is PECOS?

- It is a secure Web site that providers and suppliers can access to submit an application to enroll
  - In order to use Internet-based PECOS, a provider or supplier must log in by entering his or her User ID and password or register to obtain log in information in the PECOS Identity and Access (I&A) System.
  - After access to PECOS is granted, the user must complete and then submit the enrollment application electronically; print the Certification Statement, have it signed and dated by the appropriate individual, gather any required supporting paper documentation, and send this material to the appropriate Medicare contractor
PECOS

- After the designated contractor receives the signed and dated Certification Statement and any additional paper documentation, it begins to process the enrollment application to an approved or disapproved status. Once the application is approved, the provider or supplier will have an approved enrollment record in PECOS.
- PECOS can be accessed at: https://pecos.cms.hhs.gov/pecos/login.do.
- PECOS instructional guides for physicians, NPPs and DMEPOS suppliers are available at: http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp

Enrollment: The Players

- MAC Enrollment Staff/Enrollment Director
- The National Supplier Clearinghouse (NSC)*
- The Surety Bond Companies*
- The DMEPOS Accrediting Organizations*
- The State Survey Agencies**
- TJC and other accrediting organizations**
- CMS Regional Office
- CMS Baltimore
  - Provider Enrollment Operations Group
    - Division of Enrollment Systems
    - Division of Enrollment Policy

* For DMEPOS suppliers only
** For providers and those suppliers needing to be surveyed
Enrollment: The Appeals Process

- Four steps are:
  - Reconsideration before the MAC
  - ALJ Hearing
  - DAB Review
  - District Court
- Unwritten step: Informal “reconsideration” before CMS—either RO or CMS Central Office

Appeals Process -- Reconsideration

- Must be requested within 60-days of receipt of initial determination
  - Presumption that notice of initial determination was received 5 days after date of notice
    - Presumption is rebuttable upon a showing the notice was received later, or earlier(!)
    - Time for requesting recon may be extended for good cause
- Request for recon must identify error made by contractor
- Must be signed by authorized representative or legal representative
- Note: Documentation cannot be submitted past the recon stage unless good cause for not submitting it earlier
- Submitting a CAP does not substitute for submitting a request for recon and does not toll the time for submitting a request for recon
Corrective Action Plan (CAP)

- Use in addition to request for reconsideration
- Must be submitted within 30 days (not a month)
- For some contractors (e.g., Trailblazers), party must use the form on the contractor website
- Identify what was wrong and how it was corrected
- Submit a new 855 or related form to address problem
- Effective date might leave a gap unless the CAP can make clear that it was a simple error and/or problem relates to something at the contractor

These are discretionary in terms of review and processing
- CAPs do not work in all situations. The CAP, also, may cure a prospective issue but the provider/supplier may still face retroactive claims issues. Carefully consider how you "agree to improve" something without agreeing that you are at fault
- There is no appeal of a CAP rejection. If you choose to go the CAP route and miss the appeal timeline, you are out
- Get to know the people processing your CAP
Appeals Process – ALJ Hearing

- Request for hearing must be made within 60 days of notice of reconsidered determination
  - Same 5-day (rebuttable) presumption of receipt, same opportunity for good cause extension for filing
- ALJs are bound by statute, regulations and CMS Rulings (but not manual instructions) – “ALJs do not do equity!” DAB sends out prehearing order within about 10 days after the request is filed
- OGC Regional Counsel has 30 days put case together
  - OGC attorneys generally have been reasonable to deal with and settle many of the cases
- Some ALJ decisions are favorable to the provider or supplier – most are not

The parties to an ALJ hearing include the affected provider or supplier and CMS
- At any time prior to conducting an ALJ hearing, ALJ may call a prehearing conference
- The ALJ hearing is an adversarial process. Parties may present oral arguments, question and cross-examine witnesses, and file briefs or other written statements. The ALJ, upon his or her own motion or at the request of a party, may issue subpoenas
- The ALJ is required to issue a written decision or dismissal order, or remand to CMS, no later than 180 days after the date the hearing request was filed
Appeals Process – DAB Review

- Either party may request DAB review of the ALJ’s decision or dismissal. The same 60-day deadline, 5-day presumption of receipt and good cause for late filing rules apply.
- Request for review must specify the issues, findings of fact or conclusions of law with which the appellant disagrees, and the basis for contending that the findings and conclusions are incorrect. The DAB may grant, deny or dismiss a request for review.
- Upon request by the DAB, the parties will be permitted to file briefs or other written statements and (rarely) an opportunity to present to the DAB oral arguments and evidence.
- Upon taking review, the DAB may issue a decision, or it may remand the case back to the ALJ either for a hearing and decision or for a recommended decision (in which case, the final decision will be issued by the DAB).

Appeals Process – District Court

- Following a final decision by the Secretary “made after a hearing” a party can seek review in the district court.
- This generally means that one must receive a DAB “decision,” or an ALJ “decision” (if the DAB declines review):
  - A “dismissal” does not count — one must have a “decision” in order to get into court.
  - Exhaustion of remedies generally required, but if no right to administrative appeal (e.g., deactivation), there may be federal question jurisdiction. See Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 (1986).
Enrollment Issues for Particular Types of Providers and Suppliers

DMEPOS Suppliers

- DMEPOS Suppliers are heavily regulated with 30 supplier standards at 424.57(c)
- Surety bond requirement -- $50,000 for most, $100,000 for problem suppliers
- Accreditation requirement
- Limits on solicitation of beneficiaries
  - March 14, 2012 final rule made changes
- Has its own enrollment form (855s)
- May bill only for those items that were furnished on or after the date that they are issued a billing number
DMEPOS

- Generally, must have a location that is at least 200 sq feet and is in a location that is accessible to the public, is accessible and staffed during posted hours of operation, and maintains a permanent visible sign that is in plain view and posts hours of operation
- Generally, is prohibited from sharing a practice location with any other Medicare supplier or provider
  - Can be located with a physician or NPP who supplies DMEPOS as part of his or her professional service, or with a provider of services that owns the DMEPOS supplier
  - DMEPOS supplier of CPAP device will not receive Medicare payment if it, or its affiliate, is directly or indirectly the supplier of the sleep test used to diagnose the beneficiary with obstructive sleep apnea
    - does not apply if the sleep test is facility-based

IDTFs– Independent Diagnostic Testing Facilities

- Medicare pays for diagnostic testing under the PFS only when performed by a physician (or physician group), portable x-ray supplier, NP, clinical nurse specialist or an IDTF.
- IDTFs have been around since 1997
- IDTFs enroll using the CMS 855B Enrollment Form and completing the (very detailed) Attachment 2 of the Form
- Must meet the IDTF standards in 410.33
- Must have a supervisory physician with oversight of testing, quality, equipment, and NPPs
  - a physician may supervise no more than 3 IDTFs
IDTFs

- Supervising physician must have a demonstrated proficiency in the performance and interpretation of diagnostic procedures performed
  - IDTF is required to list on the CMS 855B all of the tests (by CPT-4 or HCPCS code) it will perform, and each supervising physician for the IDTF is required to sign an attestation, stating that he or she is proficient in the performance and interpretation of all of the tests so listed, except for ones that are specifically listed on his or her attestation.

IDTFs

- Tests performed must be ordered in writing by patient's treating practitioner
- IDTFs may bill for the technical and professional components of diagnostic tests
  - IDTF is required to list NPPs who perform the tests, as well as interpreting physicians, on the CMS 855B.
IDTFs

- An IDTF can be a fixed location or a mobile testing unit
- A fixed IDTF is not allowed to share space (treatment or waiting room) with another provider or supplier (except an IDTF can share space with a hospital). Also cannot share equipment (even through subleasing agreements)
  - Must have separate walls and entrance and signage if an IDTF will be located in the same office suite with another provider or supplier (e.g., physician practice, interventional radiologists)

IDTFs

- IDTFs have to comply with all of the standards in 410.33, but physician practices do not
  - CMS proposed applying most of the IDTF standards to physician practices, but decided not to do so (see FY 2009 PFS rule)
  - Regardless of whether enrolled as a physician practice or IDTF, entity must be accredited to perform advanced imaging
- So why not enroll as a physician practice instead of an IDTF?
  - Unclear as to what is a physician practice, and when an entity with physician(s) (particularly radiologists) must enroll as an IDTF
IDTF or Physician Practice?

- In CY Proposed 2009 PFS rule CMS proposed that physician practices would have to meet most of the IDTF standards in 410.33
- In CY Final 2009 PFS rule, CMS did not finalize proposal, but said physician practices would have to meet MIPPA advanced imaging accreditation requirements
- But 855B says “A radiologist or group practice of radiologists is not necessarily required to enroll as an IDTF. If enrolling as a diagnostic radiology group practice or clinic and billing for the technical component of diagnostic radiological tests without enrolling as an IDTF (if the entity is a free standing diagnostic facility), it should contact the carrier to determine that it does not need to enroll as an IDTF”

IDTF or Physician Practice?

- There is no definition per se of an IDTF in the regulations or program instructions.
- Former PI Manual section stated: “if a substantial portion of the entity’s business involves the performance of diagnostic tests, the diagnostic testing services may be a sufficiently separate business to warrant enrollment as an IDTF. In that case, the physician or group can continue to be enrolled as a physician or a group practice of physicians, but must also enroll as an IDTF”
  - Section disappeared mysteriously prior to 2007
IDTF or Physician Practice

- So how does an entity know whether to enroll as an IDTF or physician practice?
- The 855B does not distinguish between a “clinic/group practice” and an IDTF
- Note that in *Hobbs v. Medquest*, FCA claim was based in part that defendant entity was improperly classed as a physician practice rather than an IDTF.

HHA 36-Month Rule

- Where there is a CHOW of a provider of services, the new owner assumes the provider agreement of the old owner (unless the new owner expressly declines to do so)
- However, there is a special rule for certain changes of ownership in HHAs that take place within 36 months after the effective date of the HHA’s enrollment in Medicare
  - Where the rule applies, the HHA must enroll as a new provider and must be re-surveyed or re-accredited prior to enrollment in Medicare
  - Rule has its genesis in CMS’s concerns with owners who are only interested in “flipping” the HHA, instead of operating the HHA.
HHA 36-Month Rule

- CY 2011 HH PPS rule provides that the 36-Month Rule is triggered where there is a “change in majority ownership”
  - “change in majority ownership” does not include an indirect change in ownership (supposed to be in text, but in preamble only)
- CY 2010 rule provided that 36-Month Rule was applicable where there was a “change in ownership”
  - “change in majority ownership” or “change in ownership” is not synonymous with a CHOW (as defined in 489.18)
    - includes the acquisition of a majority ownership (more than 50%) in an HHA through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA’s most recent change in majority ownership

4 Exceptions to Rule (424.550(b)(2))

1. HHA submitted two consecutive years of full cost reports
   - low utilization or no utilization cost reports do not qualify as “full cost reports”
2. HHA’s parent company is undergoing an internal corporate restructuring, such as a merger or consolidation
3. Owners of an existing HHA are changing the HHA’s existing business structure and the owners stay the same
   - e.g. from corp to partnership; from LLC to corp; from partnership to LLC
4. An individual owner of an HHA dies
ASCs

- Ambulatory surgical centers furnish outpatient surgical procedures in a non-provider based (or free-standing) setting
- ASCs need not be located in a separate building and may operate under common ownership and control of a hospital, physician's office, or clinic
- ASC must be physically separated from other services by at least semi-permanent walls and doors, and generally may not commingle functions in common space
- ASCs enroll using the CMS 855B. ASCs are one of the few supplier types that must be surveyed or accredited prior to enrollment (others are portable X ray suppliers, rural health clinics, ESRD facilities. Clinical laboratories are subject to survey and certification process under CLIA, rather than the Medicare statute)

Hospitals

- Like all providers, Hospitals must have a provider agreement
- Where buyer of hospital assumes provider agreement, no interruption of Medicare payments, but buyer is responsible for any claims overpayments, and any False Claims Act liability, civil monetary penalties attributable to seller
- Where provider agreement is not assumed, billing is retroactive to date that hospital first met all conditions of participation – 489.13(c)
  - 489.13(d), which provided that, under certain circumstances, for a retroactive billing date for up to one year, was removed from the regulation. 75 FR 50042 (Aug. 16, 2010).
CHOW Part A Providers

- Generally occurs when a Medicare provider has been purchased (or leased) by another organization
- Results in the transfer of old owner’s Medicare CCN and provider agreement
- Ownership changes such as a stock transfer or a change of member for a nonprofit are not a CHOW and are reported as CHOI
- CMS-855A separates transactions into CHOWS, acquisitions/mergers and consolidations

CHOW Part B Suppliers

- ASCs and portable x-ray suppliers
  - Treated like Part A providers despite enrolling in Medicare using CMS-855B
  - CMS generally applies CHOW provisions and handles in accordance with 42 CFR 489.18
  - Considered a voluntary termination if the new owner rejects assignment of old owner’s Medicare assets and liabilities.
- Other Part B supplies and DMEPOS suppliers
  - Old owner cannot assign Medicare assets and liabilities to a new owner
  - New enrollment generally triggered by change in tax identification number
Acquisitions and Combinations of Hospitals

- Acquisition is when a person or entity purchases or leases a provider or supplier
- Combination is when:
  - Owner of a provider combines two or more providers under one Medicare number
  - Owner acquires one or more new providers and combines all providers under one Medicare provider agreement or combines an acquiring provider with one the owner currently owns

Acquisitions of Hospitals

- When a new owner acquires a Medicare participating hospital, the owner must decide whether:
  - Will the hospital operate as a freestanding hospital; or
  - Will the owner combine the hospital with a hospital the owner currently operates (typically a multi-campus situation)
Acquisitions

- CMS automatically assigns the provider agreement to the new owner

- If the new owner accept the assignment of the existing provider agreement, then the provider agreement remains intact and all benefits and liabilities of that agreement continue.

- If the new owner rejects assignment, the owner has voluntarily terminated the provider agreement and the owner loses all know Medicare liabilities and eligibility for payment

Combinations

- Combination of two or more hospitals under one agreement or one CCN

- If multi-location, one location become the main provider and all other locations become provider-based

- The resulting combined hospital participates in Medicare as “one hospital”. Truly integrated at all levels
Combination without Acquisition

- A corporation that currently owns 2 or more separately certified hospitals may be able to combine those hospitals into one certified hospital if the combined hospital meets:
  - The hospital CoP as a single entity
  - The provider based regulation
  - Any other applicable Medicare regulation
- Keep in mind that combining some hospitals may have a negative impact on participation or payment (i.e., IPPS hospital with an LTAH)

Combination without Acquisition

- Typically the larger hospital is designated as the main provider and its CCN is retained
- CCN of the smaller hospital is retired, not terminated
- The existing Medicare provider agreement of the smaller hospital is subsumed into the provider agreement of the larger hospital
- If the main provider has deemed status, the accrediting organization can extend accreditation with deemed status to the other hospital locations
Effects of Accepting Assignment

- No break in Medicare participation
- New owner is responsible for all known and unknown Medicare liabilities of the previous owner
- No break in Medicare payments
- No survey required (accrediting organization may conduct an extension survey)
- Retains all applicable payment statuses such as: GME, PPS exclusion, Transplant Center certifications, provider based grandfathering, grandfathering of CAH necessary provider designations, and grandfathering of CAH co-locations

Rejecting Automatic Assignment

- Voluntary termination of Medicare provider agreement
- Previous Medicare provider ceases to exist
- Any data, any status, any payment or payment status tied to the provider agreement ceases with the termination
- Not eligible for Medicare payments during the period of time it takes the entity to re-enroll
- Known and unknown liabilities do not transfer
Hospitals

- Problem: XYZ Acquisitions is merging with ABC Hospital Corp. XYZ does not want to assume the provider agreement of one of the hospitals, St. Elsewhere, which either has a qui tam action filed against it (no one knows), or is at great risk for one due to events that happened pre-merger. On the other hand, XYZ does not want to go through the delay of a survey (and the risk that it may not pass).
- Solution?? Make St. Elsewhere a “remote location” of one of its other, nearby hospitals
  - See “provider based” rules at 413.65
  - Nothing is free – many requirements to be met, and cost and inconvenience to becoming a remote location

Ordering and Referring Physicians/Practitioners

- Section 6405 of PPACA requires that, with respect to DMEPOS and home health services, physicians and "other eligible professionals" be enrolled in Medicare to order or refer items or services for Medicare beneficiaries. "Other eligible professionals" are:
  - Physician Assistants
  - Clinical Nurse Specialists
  - Nurse Practitioners
  - Clinical Psychologists
  - Interns, Residents, and Fellows
  - Certified Nurse Midwives
  - Clinical Social Workers
- Section 6405 authorized CMS to expand requirements to other services
Ordering and Referring Physicians/Practitioners

- May 2010 interim final rule implementing section 6405 of PPACA provisions by requiring that, with respect to DMEPOS claims, Part B laboratory, imaging and specialist claims, and Part A and Part B home health claims
  - a provider or supplier may receive Medicare payment only if such services are ordered or referred by a physician or eligible professional who has an enrollment record in PECOS (unless the referring physician or eligible professional has opted out of Medicare)
  - all claims for the above-referred services must contain the legal name and the NPI of any ordering or referring physician or practitioner

- Claims that do not meet these requirements will be rejected

Ordering and Referring Physicians/Practitioners

- April 27, 2012 final rule
  - Removed services ordered or referred by specialist from the scope of the rule
  - Clarified that it is not necessary for providers and suppliers to complete a new 855 simply to provide an NPI, but rather are required only to update their enrollment application, through either a revised 855 paper form or through PECOS
  - Clarified that only the TC and not the PC of imaging services are within the scope of rule

- Delayed the implementation of automated edits that would cause a claim rejection due to the lack of an approved enrollment record in Medicare for the ordering or certifying physician or eligible professional
Ordering and Referring Physicians/Practitioners

- CMS clarification: If a physician’s billing number is revoked, he or she is not in an approved status and would not be authorized to order and refer.
- In October 2009, CMS alerted providers and suppliers that it would develop claim edits to deny a claim if the identification of the ordering/referring provider is missing, incomplete, or invalid, or if the ordering/referring provider is not eligible to order or refer.
- Effective May 1, 2013, CMS will turn on the edits to deny Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits. MLN Article SE 1305

Ordering and Referring Physicians/Practitioners

- Edits will determine if the ordering/referring physician or practitioner required to be identified in Part B, DME, and Part A HHA claims has a current Medicare enrollment record and contains a valid NPI (the name and NPI must match), and, if a practitioner, is of a type who is eligible to order or refer for Medicare beneficiaries.
- For Medicaid claims, effective July 6, 2010 NPIs of billing physician or practitioner must be included on all claims.
  - In April 2012 interim final rule, CMS clarified that NPI must be included on pharmacy claim – it is not sufficient to include DEA number.
How to Check Enrollment Record

- Providers and suppliers may check the Ordering Referring Report to verify their enrollment records.
  - The Ordering Referring Report is published by CMS and reflects the approval status of all physician and eligible professionals who have applied to order and refer.
  - Report shows all physicians and EPs who have an approved record in PECOS to order and refer and those who have an application that has been received and is pending approval.

- Some physicians and EPs have been mistakenly omitted from the Report

- Providers and suppliers may also use Internet-based PECOS to view their enrollment records, including whether their NPI is included in their enrollment record

Recent ALJ and DAB Opinions

DAB Decisions

- Enrollment revoked for 3 years due to physician’s practice location not being operational – Eugene Alexander Istomin, No. 2484 (Nov. 12, 2012)

- Revocation of billing privileges sustained where supplier did not seek reconsideration timely; further ALJ should not have reviewed whether contractor was correct to find good cause did not exist to extend the time for seeking reconsideration – Better Health Ambulance, No. 2475 (Sept. 14, 2012); See also Denise A. Hardy, No. 2464 (Jun. 11, 2012); Hiva Vakil, No, 2460 (May 30, 2012)
Recent ALJ and DAB Opinions

DAB Decisions

■ Where hospital did not assume provider agreement, its effective date of billing privileges was not the date the hospital took over operation of the facility but rather was the date 8 ½ months later when accrediting organization deemed hospital to meet the health and safety code requirements -- Mission Hospital Regional Medical Center, No. 2459, (May 21, 2012)

■ Denials of re-enrollment applications following revocation were not reviewable by ALJ, as they were requests for reinstatement – Experts Are Us, Inc., No. 2452 (April 3, 2012)

DAB Decisions

■ ALJ correctly found that effective date of billing privileges was the date the supplier filed an application could be processed, and not the earlier date the supplier began rendering services, and “special circumstances” alleged by supplier were irrelevant -- Shalbhadra Bafna, No. 2449 (Mar. 30, 2012)

■ ALJ properly found that pharmacy’s billing privileges were revoked for failing to notify contractor within 30 days of changing its location – El Jardin Pharmacy, Inc., No. 2438 (Feb. 1, 2012)
Recent ALJ and DAB Opinions

ALJ Decisions

- Physician was given proper effective billing date -- Bryan James Kracijek, No. CR 2672 (Nov. 27, 2012) (no equitable estoppel against Gov’t); Robert M. Barbati, No. CR 2670 (Nov. 21, 2012) (no ability for ALJ to waive requirements or give equitable relief); Laurie S. Coyner, No. CR 2666 (Nov. 19, 2012) (physician failed to prove contractor received enrollment application on date alleged); Bellmore Medical PLLC, No. CR 2648 (Oct. 17, 2012) (no ability to waive requirements or give equitable relief); Steve McFarland, No. CR 2631 (Sept. 28, 2012) (effective date based on PECOS filing and no proof of earlier paper application)

- No right to ALJ decision in challenge of revocation if no reconsideration -- Haissam Elzaim, No. CR 2650 (Oct. 16, 2012) (failure to request reconsideration); Mary Manesis, No. CR 2646 (Oct. 15, 2012) (case remanded where NSC incorrectly informed that physician had not requested reconsideration and failed to act on request for reconsideration); Bono Home Health Care, LLC, No. CR 2588 (Aug. 27, 2012) (failure to request reconsideration timely)
Recent ALJ and DAB Opinions

ALJ Decisions

- Contractor properly denied application where it did not have signature of authorizing official – *Arizona Medical Boutique*, No. CR 2674 (Nov. 12, 2012)

- Psychologist properly denied enrollment as clinical psychologist, because license did not allow him to practice independently – *Paul L. Daniels*, No. 2640 (Oct. 5, 2012)

- Independent clinical lab properly denied enrollment because site visit determined it was not operational, *Community Medical Lab, LLC*, No. CR 2635 (Oct. 2, 2012)

- Entity properly denied enrollment as an IDTF because it was not capable of performing services (facility-based sleep studies) listed on its enrollment application – *Better Sunrise Corporation*, No. CR 2628 (Sept. 28, 2012) (alternatively, case dismissed for failure to follow ALJ order)

- IDTF’s billing privileges were properly revoked because it did not complete revalidation – *Ultrasound & Radiology Specialist, Inc.* – No. CR 2558 (June 25, 2012)

- Entity properly had its billing privileges revoked because it was billing improperly (billing DME as orthotics) – *The Orthotics Center, Inc.*, No. CR 2627 (Sept. 28, 2012)
Recent ALJ and DAB Opinions

ALJ Decisions

- DMEPOS supplier's billing privileges were properly revoked because it was not accredited -- *Nostrand RX Corp.*, No. CR 2620 (Sept. 21, 2012)
- Physician's billing privileges were properly revoked because she certified as true false or misleading information on enrollment application -- *Conchita Jackson*, No. CR 2615 (Sept. 19, 2012)
- Laboratories' CLIA certificates were properly revoked because owner was owner of another laboratory that had its CLIA certificate revoked -- *Mercedes Children's Clinic/Mercedes Kids Med*, No. CR 2614 (Sept 18, 2012)

- DMEPOS supplier's billing privileges were properly revoked because it was not operational -- *Eagle Eye DME, LLC*, No. CR 2564 (July 12, 2012)
- HHA's billing privileges were properly revoked because it was not operational-- *Suitable Homehealth Care*, No. CR 2488 (Jan. 12, 2012)
- Entity formed solely to act as a billing agent was properly denied enrollment as a medical group because it did not meet the definition of a "supplier" -- *Mound City Inpatient Services*, No. CR 2569 (July 18, 2012)