Keeping current with Medicare enrollment

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In the early days of the Medicare system, it was relatively simple for physicians to become credentialed — a process that Medicare refers to as "enrollment" (not to be confused with Medicare beneficiary enrollment). The forms to enroll were short, in some cases not more than two pages, and required little information. Over time, however, Medicare has become more cautious about gatekeeping access to the Medicare trust fund, the pool from which Medicare pays for services. The Medicare enrollment process, therefore, acts as the first line of defense for the system: If you can't get access to the money in the first place, there is less risk of fraud. As the enrollment process has grown in complexity, Medicare has also imposed requirements on physicians and physician practices which allows Medicare to restrict or revoke billing privileges for failure to meet certain reporting requirements.

Medicare enrollment itself is done using one of two mechanisms: Medicare's online enrollment system (known as the Provider Enrollment, Chain, and Ownership System, or "PECOS"), and paper applications referred to as the "CMS-855" series of applications. Information that must be reported includes demographic information. For example, the name of the entity enrolling (including doing-business-as name), the address of the enrolling entity, license and certification numbers, and more. Depending on the type of application, such as for an individual or a physician practice, additional information may be required. For example, physician assistants must identify their employer. Physician practices must identify their managing employees and owners. Individual physicians must report where their paper records and electronic records are stored.

Most information must be reported within 90 days of any change. However, three significant changes must be reported within 30 days of occurrence across most provider types:

1. Changes in ownership
2. Changes in practice locations
3. Reporting of any final adverse legal actions.

Final adverse legal actions include Medicare-imposed losses of billing privileges, exclusion from a federal or state health care program, suspension/revocation of state licensure, or convictions of felony offenses within the last 10 years.

It is critical for physicians to stay on top of these deadlines and report changes to this information in a timely manner. Failure to meet the reporting requirements can result in the loss of billing privileges. The interaction of this information with other aspects of Medicare enrollment can further complicate matters.

- **Example:** Our practice represented a physician group that had its billing privileges deactivated for failure to report an adverse legal

action for a physician allegedly in the group. The physician had left the practice 10 years prior. However, the practice had never terminated his Medicare reassignment to them — the process by which a physician directs Medicare to pay for the physician's services directly to their employer. From Medicare's perspective, the physician still worked for the practice. When the physician lost his license and the practice failed to report this, Medicare deactivated the practice's billing privileges. We managed to get the deactivation reversed after explaining the misunderstanding (along with the fact that the physician had left before the obligation to report this information even existed), but the incident illustrates how essential it is to update Medicare enrollment information consistently.

Changing documentation

The specific range of information that must be reported, and how the reporting requirements are interpreted by Medicare, has also changed over time, requiring physicians and physician practices to remain up to date on the current requirements. For example, at a basic level, the paper versions of Medicare's enrollment forms have changed several times. At one point, CMS used two forms for enrollment of individual practitioners: the CMS-855I enrollment form and the CMS-855R reassignment form. Practitioners would fill out the 855I to enroll and submit that along with an 855R for any practice they were joining. These two documents submitted together were often referred to as an "enrollment packet."

However, in 2023 CMS eliminated the 855R form and incorporated the information that used to be requested in it into an updated version of the 855I. Interestingly, and somewhat confusingly, the CMS-855B form, by which physician groups (among others) enroll, has not been updated and thus contains references to using the now-discontinued CMS-855R!

Provider transaction access numbers

Another aspect of reporting requirements that has changed is the requirement to associate individual practitioners with the "provider transaction access numbers" (PTANs) of their employers to which the practitioner reassigns payment. The PTAN is an internal Medicare identification number (sometimes referred to as a "Medicare billing number" or "Medicare identification number") assigned to individual practitioners, but it is also assigned to certain physical locations for physician practices, among other entities. If a physician practice maintains multiple offices within a single Medicare fee locality (a geographic subdivision within Medicare where payment rates differ from one locality to another), all the practice's offices will be listed under a single PTAN. However, if the practice has one or more offices in a separate fee locality, those offices will have a different PTAN.

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When a physician practice adds a new location in a different fee locality, all practitioners who will practice at that location must be issued a new PTAN to be used at the new location, which itself will be issued a PTAN different from those issued to other locations in a different fee locality. In effect, this means that the practice must also update its own enrollment data to ensure that CMS knows which practitioners are working at this new location. The manuals also make clear that the reassigning practitioner does not need to update their reassignment data every time they add a practice location, but rather that group practice must have a PTAN issued to each practitioner who wants to bill from the new location.

This requirement was added to Medicare's manuals only in 2021 and was updated as recently as 2023 but existed in informal CMS guidance (CMS presentations) as far back as 2019. Note, however, that this requirement is not the same as the requirement to report a "change of practice location," since a PTAN can be associated with multiple practice locations.

Additional guidance

The matter of formal versus informal guidance raises the issue of sources of information on Medicare enrollment. The core requirements are found in Medicare's regulations (42 CFR part 424, subpart P). CMS has provided additional guidance primarily for Medicare administrative contractors in its Medicare manuals, specifically in Chapter 10 of the *Program Integrity Manual*. Also, as mentioned, there are the CMS-855 forms themselves. There are also informal sources of guidance, such as presentations, webinars, FAQs, and *Medlearn Network* articles. These latter sources are informative, but as noted earlier, it is the regulations and, to some extent, the manuals that are ultimately legally binding. Physicians can consult each of these sources for guidance but should be careful to obtain them from the CMS website itself (rather than from web search engines or worse — AI chatbots). The requirements and available information can change over time, and it is important to rely only on the most up-to-date information.

Staying current on both practice and individual physician reporting requirements is critical to retaining the ability to submit claims to Medicare. A failure to report can result in a loss of billing privileges and can expose a physician or physician practice to false claims liability. While the precise requirements can seem daunting, experienced and knowledgeable health care counsel can help. **DW**

Maintaining compliance

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