FINAL MEDICARE SCREENING REQUIREMENTS PUBLISHED, BUT MANDATORY COMPLIANCE PROGRAM REQUIREMENTS STILL PENDING

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On February 2, 2011, the Centers for Medicare and Medicaid Services ("CMS") published its final rule for establishing new screening requirements for enrollees in Medicare, Medicaid, and the Children's Health Insurance Programs ("CHIP") pursuant to Section 6401(a) of the Patient Protection and Affordable Care Act ("PPACA") (the "Final Rule").[1] Prior to PPACA's enactment, provider and supplier screening was not part of the Medicare enrollment process. The Final Rule will be effective on March 25, 2011 for newly enrolling providers and suppliers as well as for currently enrolled providers and suppliers whose revalidation cycle ends between March 25, 2011 and March 25, 2012. For all other currently enrolled providers and suppliers, the effective date for this Final Rule will be March 25, 2012.

The Final Rule solidified a three-tiered screening system for providers and suppliers, categorizing them as either "limited," "moderate" or "high" risk. In establishing these risk levels and the providers and suppliers assigned to them, CMS drew from its experience, as well as the experience of Medicare contractors, in identifying and investigating fraudulent billing practices. Depending on the level of risk assigned to a provider or supplier type, the Medicare contractor will impose different screening measures to account for those categorical risks. While providers and suppliers may initially pose either a "limited" or "moderate" risk, no provider or supplier is immune from having its risk level increased.

The providers and suppliers in the "limited" risk category include, for example, physicians and non-physician practitioners and medical groups or clinics, hospitals, and mammography screening centers. For providers or suppliers posing "limited" risk, Medicare contractors will (i) verify that the provider or supplier meets all of the applicable federal and state regulations; (ii) conduct license verifications (including licensure verifications across state lines); and (iii) conduct database checks on a pre- and post-enrollment basis to ensure providers and suppliers continue to meet the enrollment criteria.

Providers and suppliers posing "moderate" risk include, for example, ambulance service suppliers, community mental health centers ("CMHCs"), comprehensive outpatient rehabilitation facilities ("CORFs"), hospice organizations, independent diagnostic testing facilities ("IDTFs"), independent clinical laboratories, physical therapists enrolling as individuals or as group practices, portable x-ray suppliers, and revalidating home health agencies ("HHAs") and durable medical equipment, prosthetic, orthotics and supplies ("DMEPOS") suppliers. "Moderate" risk providers and suppliers will be subject to all of the "limited" screening requirements as well as an on-site visit.

[1] Please note: This article only addresses the Medicare enrollment screening process. In the Final Rule, CMS addressed the Medicaid and CHIP programs separately.

In the "high" risk category, CMS has included prospective (newly enrolling) HHAs and DMEPOS suppliers. In screening "high" risk providers and suppliers, Medicare contractors will perform all of the "moderate" screening measures, and require the submission of a set of fingerprints for a national background check and an FBI criminal history record check from all individuals who maintain a five percent or greater direct or indirect ownership interest in the provider or supplier.

Although some providers and suppliers are not specifically named in the "high" risk category, the Final Rule allows CMS to adjust a screening level from "limited" or "moderate" to "high" upon the occurrence of specific events. CMS has the authority to adjust a provider or supplier's screening level if the provider or supplier (i) has had a payment suspension at anytime in the last ten years; (ii) has been excluded from Medicare by the Office of Inspector General ("OIG"); (iii) has had its billing privileges revoked by a Medicare contractor within the last ten years and is attempting to establish additional Medicare billing privileges; (iv) has been terminated or otherwise precluded from billing Medicaid; (v) has been excluded from any federal healthcare program; or (vi) has been subject to any final adverse action (as defined in 42 CFR 424.502) within the last ten years. Finally, those providers and suppliers that were prevented from enrolling based on a temporary moratorium imposed on a particular provider or supplier type, and apply for enrollment as a Medicare provider within six months of CMS lifting the moratorium, will experience a higher level of screening for the six-months following the lifting of the temporary moratorium.

The Final Rule also addressed the compliance program requirement as set forth in Section 6401 of PPACA, which prescribes that, as a condition of enrolling in Medicare, Medicaid or CHIP, providers and suppliers must establish compliance programs that meet certain "core elements." Notably, at this time, CMS did not finalize any rules related to mandatory compliance. Instead, CMS continues to do further rulemaking and will "advance specific proposals at some time in the future." The September 23, 2010 Proposed Rule solicited comments on these "core elements." While the Final Rule did not finalize the compliance plan requirements, all providers and suppliers should remain attentive to the developments of the core elements to ensure full compliance with the future rule.

This Final Rule is, yet another, indication that, in its attempt to minimize fraud, waste and abuse, CMS will continue to scrutinize all providers and suppliers, including physicians. Physicians should remain alert for developments relating to the mandatory compliance program requirements.