Dynamic Chiropractic

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Health Act Includes Changes to Medicare Enrollment

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The passage of the Patient Protection and Affordable Care Act brought some benefits for chiropractors that have been widely publicized, but, as is oft quoted, "The large print giveth and the fine print taketh away." There are some surprises in the health care act, one of the most immediate of which concerns Medicare enrollment. Subtitle E - Medicare, Medicaid and CHIP Program Integrity Provisions, on page 629 of the act, lists these changes.

Before I discuss the changes, I need to point out that this discussion is based on the newly enacted law. Before these changes are implemented, regulations need to be written and in some cases, timelines need to be developed. This process could change some of the details, so you need to stay informed as to what is happening.

Screenings

First, there will be a screening process when you enroll in Medicare. Starting 180 days after the bill was signed into law (which was March 23, making the effective date Sept. 20), "the Secretary of Health and Human Services shall establish procedures under which screening is conducted." These screenings shall include a licensure check, including such checks across states, and may, as the HHS secretary determines appropriate based on the risk of fraud, waste, and abuse, include some or all of the following:

- Criminal background checks
- Fingerprinting
- Unscheduled and unannounced site visits, including pre-enrollment site visits
- Database checks (including across states)
- Other screenings as the HHS secretary deems appropriate

The last two, "database checks" and "such other screenings as the Secretary deems appropriate," are wide open and can mean just about anything.

Just in case you were thinking that Medicare was going to provide all of this for free, there is now a $200 fee charged for the screening when you enroll in Medicare. The fee will increase annually starting in 2011 according to a formula based on the consumer price index in urban areas.

The implementation of these screenings will take place incrementally over the next three years. Providers undergoing the revalidation process will be screened starting 180 days after the signing of the act (Sept. 20, 2010). Newly enrolling providers will be screened starting one year after the signing of the act (March 23, 2011). Providers currently enrolled in Medicare will be screened starting two years after the signing of the act (March 23, 2012). No provider who has not been screened will be allowed to be enrolled in Medicare after three years of the act's signing (March 23, 2013).

Provisional Period

Newly enrolled providers will have a provisional period of between 30 days and one year, during which they will be subject to enhanced oversight such as prepayment reviews and payment caps. An implementation timeline has not yet been established and may only apply to certain categories of providers, as the HHS secretary deems appropriate.

Increased Disclosure

After March 23, 2011, any provider who submits an enrollment or revalidation application shall disclose any current or previous affiliation (directly or indirectly) with a provider who has uncollected debt, is subject to payment suspension under a federal health care program, has been excluded from participation in Medicare, Medicaid or CHIP; or has had billing privileges denied or revoked.

If the HHS secretary determines such previous affiliation poses undue risk of fraud, waste or abuse, they may deny the application. Based on the dictionary definition of *affiliation*, this could include having or being an associate, membership in an association or a business partnership. We have yet to see how the regulations will define *affiliation*.

Adjusting Payments

The HHS secretary may adjust payments to a provider who owes money to Medicare, Medicaid or CHIP, in order to recover the money. This is a simple provision that allows CMS to recover money owed from future payments.

Temporary Moratorium on Enrollment

HHS may impose a temporary moratorium on enrollment of new providers, including categories of providers, if they determine that such a moratorium is necessary to prevent or combat fraud, waste or abuse. There shall be no judicial review of a temporary moratorium imposed.

This provision concerns me the most, as there is absolutely no recourse for a purely discretionary decision. The HHS secretary could decide that there should be a moratorium on enrollment of the provider types that have the 10 highest error rates (chiropractors have never been better than eighth worst since they have been keeping this statistic) until their error rates improve. There would be nothing that we could do about it. The potential for abuse of this provision is staggering.

Compliance Program

A provider within a particular industry sector or category shall, as a condition of enrollment in Medicare, Medicaid or CHIP, establish a compliance program that contains core elements established with respect to provider and industry or category. The core elements and timeline are yet to be established. I would expect the core elements to include the seven elements of the office compliance program that are now in effect. These elements include:

- Implementation of written policies and procedures
- Designation of a compliance officer
- Comprehensively training and educating all personnel
- Development of open and accessible lines of communication
- Internal monitoring and auditing

- Enforcement of standards through well-publicized disciplinary guidelines
- Promptly responding to detected offences and undertaking corrective action

The stated purpose of these changes is to combat fraud and abuse. Given that purpose, I expect all of these provisions to be implemented during the next three to five years. This article gives you some advance warning of what to expect.

Knowing that change is coming is the first step in preparing for it. As mentioned previously, there are some steps that you can take to prepare for these changes. For example, continue to improve your documentation to comply with Medicare standards of proof of medical necessity. The better you document medical necessity, the more likely that you will pass a review and keep your personal error rate low. Keep up-to-date on changes to Medicare laws, rules and regulations. If you haven't already, sign up to receive e-mail updates from your local carrier or MAC. Encourage your state association to bring in certified experts to conduct Medicare seminars on a regular basis to stay as current as possible. And implement an office compliance program now so it will be fully operational by the time it is required.

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