HCFA Rulings

Department of Health and Human Services

Health Care Financing Administration

Ruling No. 98-1 Date: December 1998

Health Care Financing Administration (HCFA) Rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous provisions of the law or regulations relating to Medicare, Medicaid, Utilization and Quality Control Peer Review, private health insurance, and related matters.

HCFA Rulings are binding on all HCFA components, Medicare contractors, the Provider Reimbursement Review Board, the Medicare Geographic Classification Review Board, the Departmental Appeals Board, and Administrative Law Judges (ALJs) who hear Medicare

appeals. These Rulings promote consistency in interpretation of policy and adjudication of disputes.

This Ruling states the policy of the Health Care Financing Administration regarding the appropriate administrative appeals process the Medicare carrier must provide to physicians, non-physician practitioners, and to certain entities that receive reassigned benefits from physicians and non-physician practitioners. This appeals process will be available to a physician or entity that (i) has received reassigned benefits; (ii) has been denied enrollment in the Medicare program or had Medicare billing privileges revoked; and (iii) is not eligible to use the appeals procedures in 42 CFR part 498.

MEDICARE PROGRAM

Medicare Supplementary Medical Insurance (Part B)

THE ADMINISTRATIVE APPEALS PROCESS FOR PHYSICIANS, NON-PHYSICIAN PRACTITIONERS, AND ENTITIES THAT RECEIVE REASSIGNED BENEFITS AND THAT ARE NOT PROVIDED APPEAL RIGHTS UNDER 42 CFR PART 498

HELD: A physician, non-physician practitioner or entity that receives reassigned benefits from physicians and non-physician practitioners, and that is not already included within the definition of a provider or supplier (or a prospective provider or a prospective supplier) under 42 CFR 498.2, will be accorded administrative appeal rights as set forth in this Ruling. Physicians, non-physician practitioners, and entities aggrieved by a decision denying enrollment in Medicare or revoking Medicare billing privileges may pursue the administrative appeals process described herein. This Ruling establishes the exclusive administrative procedures for those physicians, non-physician practitioners, and entities.

CITATIONS: Sections 1833(e), 1842(b)(6), 1842(r), 1861(r), and 1862(e)(1) of the Social Security Act (42 U.S.C. sections 1395l(e), 1395u(b)(6), 1395u(r), 1395x(r), 1395y(e)(1)), 42 CFR sections 420.204, 424.73, 424.80, and 1001.1901.

BACKGROUND

A. Unique Physician Identifier Number (UPIN) and Billing Number Systems

In 1986, the Congress directed the Secretary of Health and Human Services to develop a system to identify "each physician

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who furnishes services" for which payment may be made under the Social Security Act (the Act). (See Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99-272, section 9202(g) (1986); now codified at section 1842(r) of the Act (42 U.S.C. 1395u(r)). The Secretary has established the Unique Physician Identifier Number (UPIN) system. Under this system, the Secretary collects certain identifying and background information through the Medicare General Enrollment Health Care Provider/Supplier Application (HCFA Form 855, OMB Approval No. 0938-0685).

To enroll a new physician, non-physician practitioner or entity in the Medicare Part B program, the Medicare carrier must receive completed HCFA Forms 855 and 855-R from the physician, non-physician practitioner or entity that seeks reassigned benefits. The Medicare carrier is responsible for reviewing the application to verify that the physician, non-physician practitioner or entity meets certain requirements prior to receiving a UPIN or Medicare billing number. The requirements will be referred to as "requirements" throughout this Ruling and are as follows:

- To receive a UPIN or Medicare billing number that will enable HCFA to make payment for Medicare services, the physician, non-physician practitioner or entity and/or any

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owner(s), managing employee(s), contractor(s), cannot be currently excluded from the Medicare program by the Department of Health and Human Services Office of Inspector General, or from participation in the program of any other Federal agency.

- A physician must be licensed to practice medicine, and an entity must comply with the applicable State and Federal licensure and Medicare regulatory requirements. Non-physician practitioners must be legally authorized to practice in the State where he or she practices and meet all of the qualification requirements for his or her speciality as set forth in 42 CFR 410 and section 2100 of the Medicare Carriers Manual, Part 3 Claims Process (HCFA-Pub. 14-3).
- An entity must qualify as a provider or supplier of medical and health services. An entity seeking Medicare payment must be eligible to receive reassigned benefits from a physician in accordance with the Medicare reassignment statute in section 1842(b)(6) of the Act (42 U.S.C. 1395u(b)(6)).

Upon approval, HCFA assigns a UPIN that uniquely identifies the physician, non-physician practitioner or entity. The UPIN is used by the physician, non-physician practitioner or entity for each claim for services furnished to a Medicare beneficiary and is used to expedite processing

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and payment for Medicare claims, including electronic transactions.

If the Medicare carrier reviews the application and determines that the requirements for obtaining a UPIN are not met, the physician, non-physician practitioner or entity will be denied enrollment in the Medicare program. For those physicians, non-physician practitioners, and entities that are enrolled already in the Medicare program but are found not to continue to meet these requirements, their billing privileges are revoked. The Medicare carrier notifies the physician, non-physician practitioner or entity by certified mail that it is not permitted to bill Medicare.

B. Unlicensed Individuals or Excluded Physicians and Non-Physician Practitioners

Physicians' and non-physician practitioners' services are a covered benefit under the Supplementary Medical Insurance Program (Part B of title XVIII of the Act). A physician is defined in section 1861(r) of the Act (42 U.S.C. 1395x(r)) and includes "a doctor of medicine or osteopathy legally authorized to practice

medicine or surgery by the State in which he [sic] performs such function or action." A non-physician practitioner encompasses the following

practitioners included in section 1842(b)(18)(C) of the Act: physician assistant, nurse practitioner, clinical nurse specialist, certified nurse-midwife, clinical social worker, and clinical psychologist. Each of these practitioners is defined in section 1861 of the Act, which requires that they each be legally authorized to practice in the State where he or she furnishes services. Thus, the Act requires that physicians and non-physician practitioners meet State licensing requirements before payment can be made for reasonable and necessary physicians' and non-physician practitioners' services. Licensing information, concerning the State where a physician or non-physician practitioner is licensed and the physician's and non-physician practitioner's current eligibility to participate in the Medicare program, must be provided by the physician or non-physician practitioner or Medicare payment will not be made. (See sections 1833(e) and 1861(r) of the Act, 42 U.S.C. 1395l(e) and 1395x(r)).

Section 1862(e)(1) of the Act bars payment in almost all instances for the services performed by or "at the medical direction or on the prescription of" an excluded physician and non-physician practitioner during the period the physician and non-physician practitioner is excluded. (See 42 CFR

420.204(b) and 1001.1901(b).) Moreover, unless an exception is granted by the Act, HCFA is prohibited from making any payment to a physician, non-physician practitioner or entity that has been debarred, suspended, or otherwise excluded in accordance with section 2455 of the Federal Acquisition Streamlining Act of 1994, Pub. L. 103-355.

The Office of Inspector General (OIG), in its November 1996 Report No. A-14-96-00202, identified situations in which an individual who was not properly licensed or had been excluded from participation in the Medicare program continued to file claims and receive Medicare reimbursement. Moreover, several published Federal court decisions have involved the situation whereby an individual had falsely claimed to have met State licensing requirements to act as a health care professional. To protect Medicare beneficiaries, HCFA has established enrollment procedures to ensure that individuals who seek to furnish services to Medicare beneficiaries are properly licensed and are not currently excluded from participation in the Medicare program.

C. Reassignment of Medicare Benefits

HCFA has recognized that a physician and non-physician practitioner may reassign his or her Medicare benefits (the

right to bill and receive payment from Medicare) to certain entities in some circumstances. While the form of the business arrangement may vary, if payments are appropriately reassigned from the physician and non-physician practitioner to the entity in accordance with the Medicare reassignment statute in section 1842(b)(6) of the Act, Medicare payments can be made to the entity.

Section 1842(b)(6) of the Act establishes the general principle that Medicare program payments should be made to the beneficiary or, under an assignment, to the physician or non- physician practitioner who furnishes the service. This principle was developed to ensure accountability and to prevent factoring, a practice of selling accounts receivable to a third party for Medicare payment that the Congress specifically found to be abusive. By preventing a third party from obtaining a direct payment from the Medicare program, the Congress hoped to destroy a third party's incentives to engage in abusive billing practices, or to submit claims for services that were not furnished. (See H. Rep. No. 92-231, at 104 (1971) and S. Rep. No. 92-1230, at 204 (1972).) The Congress, however, created several narrow exceptions that permit a physician and non-physician practitioner to reassign Medicare benefits to his or her employer, a facility where the service

was furnished, or to certain other entities if specific conditions are satisfied.

If an entity seeks direct Medicare payment for the services furnished by a physician or non-physician practitioner, the Medicare carrier may ask the entity to explain how the current arrangement is consistent with the Medicare reassignment statute in section 1842(b)(6) of the Act and our regulations in 42 CFR 424.73 and 424.80, and identify the specific statutory or regulatory exception that authorizes payment.

ADMINISTRATIVE APPEALS PROCESS FOR PHYSICIANS, NON-PHYSICIAN PRACTITIONERS, AND ENTITIES WHOSE MEDICARE ENROLLMENT IS DENIED OR WHOSE BILLING NUMBER IS REVOKED

A. Overview

A physician, non-physician practitioner or other entity, whose Medicare enrollment is denied or whose Medicare billing privilege is revoked, can request an appeal of that decision. This appeal procedure ensures that a physician, non-physician practitioner or entity that is not entitled to appeal rights under 42 CFR part 498 receives a fair and full opportunity to be heard.

The appeals process outlined in this Ruling is for physicians, non-physician practitioners or entities that receive reassigned benefits, and in general, is based on the existing appeals process used for suppliers of durable medical equipment, prosthetics, orthotics, or supplies (DMEPOS) at 42 CFR 405.874. The administrative appeals process includes the right to a Medicare carrier hearing before a hearing officer who was not involved with the original carrier determination and the right to seek a review before an HCFA official designated by the HCFA Administrator.

If a Medicare carrier reviews the application and finds that a physician, non-physician practitioner or entity does not meet one or more of the requirements listed under section A in the Background part of this Ruling, the Medicare carrier denies the application and sends a denial letter explaining the reason for the denial to the physician, non-physician practitioner or entity. The letter explains the procedures for requesting a Medicare carrier hearing.

Similarly, when a Medicare carrier discovers that a physician, non-physician practitioner or entity no longer meets one of the requirements for a billing number, the physician's, non-physician practitioner's or entity's billing number is revoked. The carrier sends the physician,

non-physician practitioner or entity a letter that explains that the billing number is revoked 15 days from the date of the letter, states why the billing number is being revoked, and informs the physician, non-physician practitioner or entity of the procedures for requesting a carrier hearing.

If a physician, non-physician practitioner or entity seeks review of the carrier's determination by filing a request for a carrier hearing, and there is a less than fully favorable decision by the hearing officer, the physician, non-physician practitioner or entity or the carrier may seek further review before an HCFA official. The decision of the HCFA official is the final administrative decision.

An initial carrier determination, a decision of a carrier hearing officer, or a decision of an HCFA official may be reopened by the carrier or hearing officer in accordance with the procedures set forth at 42 CFR 405.84l and 405.842.

If, instead of filing or completing an appeal, a physician, non-physician practitioner or entity completes a corrective action plan and provides sufficient evidence to the carrier that it has complied fully with the

Medicare requirements, the carrier may reinstate the physician's, non-physician practitioner's or entity's billing number. The

carrier may pay for services furnished on or after the effective date of the reinstatement.

B. Carrier Hearing

A physician, non-physician practitioner or entity that wishes to request a carrier hearing, must file its request with the Medicare carrier within 60 days from the date of the receipt of the initial determination letter to be considered timely filed. The date the letter is received by the carrier is treated as the date of filing. Failure to timely request a carrier hearing is deemed a waiver of all rights to further administrative review. The request may be signed by the physician, non-physician practitioner or any responsible official within the entity.

If a timely request for a carrier hearing is made, a carrier hearing officer, not involved in the original determination to disallow a physician, non-physician practitioner or entity enrollment application, or to revoke a current billing number, must hold a hearing within 60 days of receipt of the appeal request, or later if requested by the physician, non-physician practitioner or entity.

The physician, non-physician practitioner, entity or the carrier may offer new evidence. The burden of persuasion is

on the physician, non-physician practitioner or entity to show that its enrollment application was incorrectly disallowed or that the revocation of its billing number was incorrect. The carrier hearing officer's determination is based upon the information presented. The hearing is a thorough, independent review of the carrier's initial determination and the entire body of evidence, including any new information submitted. The carrier hearing can be held in person or by telephone at the physician's, non-physician practitioner's or entity's request.

The hearing officer issues a written decision as soon as practicable after the hearing and forwards the decision by certified mail to HCFA, the carrier, and the physician, non- physician practitioner or entity. The decision includes (i) information about the carrier's, physician's, non-physician practitioner's or entity's further right to appeal; (ii) the address to which the written appeal must be mailed; and (iii) the date by which the appeal must be filed, that is, 60 days after the date of receipt of the decision.

A physician, non-physician practitioner, carrier or entity may appeal the carrier hearing officer's decision to HCFA for a final administrative review within 60 days after the date of receipt of the hearing officer's decision. Failure to timely

request the final administrative review by HCFA is deemed a waiver of all rights to further administrative review.

A carrier hearing officer's partial or complete reversal of a carrier's initial determination is not implemented pending the carrier's decision to appeal the reversal to HCFA, unless the carrier, in its sole discretion, and without prejudice to its right to appeal, decides to implement the reversal pending an appeal. The carrier implements a reversal if it decides not to appeal a reversal to HCFA, or the time to appeal expires. A carrier may implement a carrier hearing officer's partial reversal even if the physician, non-physician practitioner or entity has appealed the partial reversal to HCFA, or the time for the physician, non-physician practitioner or entity to file an appeal has not expired.

C. Claims Submitted Following Revocation

If a carrier finds that payment to an organization or other entity is precluded under the reassignment statute and regulations, and the billing number is revoked, subsequent claims submitted by the reassignee following revocation will be rejected. The physician or non-physician practitioner that furnished the health care service can bill the Medicare

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program for payment in accordance with the applicable rules for submitting claims.

NOTE: HCFA may take the appropriate steps to collect Medicare overpayments or pursue other appropriate legal remedies.

D. HCFA Review

If a timely request for a final HCFA administrative review of the carrier hearing officer's decision is made, an HCFA official, designated by the Administrator of HCFA, issues a decision based on the decision and the record established by the carrier hearing officer. The HCFA official may supplement the record by requesting and obtaining any additional information from the carrier, physician, non-physician practitioner or entity. The HCFA official's decision is (i) issued in writing as soon as practicable after the HCFA official determines that there is sufficient information to decide the appeal (or that no additional information is forthcoming), unless the party appealing the hearing officer's decision requests a delay; (ii) is forwarded by certified mail to the carrier and the physician, non-physician practitioner or entity; and (iii) contains information that no further administrative appeals are available.

EFFECTIVE DATE

This Ruling is effective , 1998.

Dated: *Dec. 11 1998*

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Nancy-Ann Min DeParle
Administrator, Health Care Financing Administration.

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