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Medicare Enrollment Revocations: The Government Enforcement Initiative You May Not Know About

March 8, 2018

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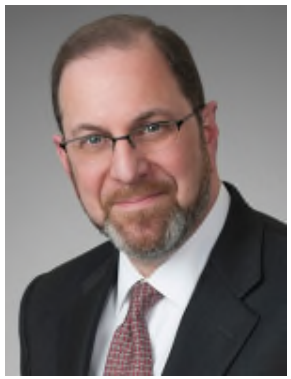

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Introduction

- CMS's revocation authority
- Why it is important to know about CMS's revocation authority?
- Why should that be a part of your compliance program?
- Why it is important to respond rapidly to any actions that may result in a revocation by CMS?

Medicare Revocations Based on Other Government Agency Actions

- OIG exclusions under Section 1128 (program-related crimes, etc.)
- OIG exclusion for a failure to refund a Medicare overpayment (Section 1128A)
- Exclusions for substandard care under Section 1156
- Exclusions based on a student loan default
- DEA revocations or suspensions
- Revocations imposed by a state Medicaid program, after all appeals have been exhausted
- Felony Conviction

Medicare Revocations Based on CMS Determinations

- Noncompliance with Medicare enrollment requirements
  - Licensure

- Failure to update information on Medicare enrollment forms
  - Change of location or "adverse legal action" within 30 days of the event
  - All other information within 90 days

Medicare Revocations Based on CMS Determinations

- False or misleading information on enrollment application
- On-site review – provider is not "operational" or otherwise fails to satisfy any Medicare enrollment requirement.
  - What is "Operational?"
- Hardship exception denial and enrollment fees not paid
- Misuse of billing number (allowing a different individual or entity to use a provider number)

Medicare Revocations Based on CMS Determinations

- Abuse of billing privileges
  - Impossible claims (e.g., claims for deceased beneficiaries)
  - Pattern of claims that fail to meet CMS requirements
- Home health capitalization – a home health agency's failure to provide CMS with supporting documentation detailing initial reserve operating funds
- Pattern of Part D drug prescribing that is abusive, a threat to health and safety, or fails to meet Medicare requirements

Effect of Revocation

- Revocation means that you won't be paid for services furnished to Medicare beneficiaries as of either:
  - 30 days after receiving the revocation notice, or
  - In the case of a felony conviction, exclusion or debarment, or license suspension or revocation, the Medicare revocation can be backdated to the underlying action
- Any Medicare Part A provider agreement is simultaneously revoked.
- CMS will pay claims for covered services furnished before the effective date of a revocation
- It is possible to re-enroll after the revocation period ends. It is not automatic, and you have to re-enroll as if you are a new provider or supplier. For providers such as hospitals and nursing facilities, that means a brand-new survey must be conducted.

Effect of Revocation

- Re-Enrollment Bar
  - Re-enrollment bar lasts from 1-3 years, depending on severity of offense.
    - Ex: Felony convictions = 3 years; Onsite Review = 2 years

- Potential Derivative Effects
  - Termination of contracts with third-party payors and Medicaid state plans.
  - Deactivation of enrollment privileges for individual providers.
  - Enrollment notice: requirement to notify other MACs and third-party payors.
  - Claims for services furnished before revocation:
    - 60 day post-revocation window
    - EXCEPT – home health agencies and retroactive revocations.
  - Overpayment liabilities

Medicare Administrative Contractors ("MACs")

- MACs
  - Primarily responsible for overseeing enrollment activities
- Zone Program Integrity Contractors ("ZPICs")
  - Non-governmental contractors who audit providers
  - May uncover revocation grounds in the course of an audit or investigation
  - Will refer to PEOG
- CMS Provider Enrollment & Oversight Group ("PEOG")
  - Revocation approval (when necessary)

Special Rules for Organizations

- The revocation authority applies to Medicare providers and suppliers if "any owner, managing employee, authorized or delegated official, medical director, or other health care personnel" have been the subject of a range of administrative and criminal offenses that include:
  - CMS and OIG exclusions and debarments
  - Felony convictions within the preceding 10 years that involve
    - any violent or financial crimes
    - crimes that threaten the health or safety of Medicare beneficiaries or the Medicare program
    - other felonies that may result in a mandatory exclusion by the OIG.
      - **However, the regulation does allow the provider or supplier to avoid a revocation if it demonstrates to CMS that it severed all business relationships with the affected employee, director, or medical director within 30 days of receiving the revocation notice.**

Special Rules for Organizations

- Onsite review of a provider/supplier and "operational" status
  - Onsite review conducted by MAC or ZPIC at the provider's "practice location" as listed on Medicare provider enrollment forms.
    - Common Issues
      - "practice location" looks empty (e.g., administrative office only)
      - "practice location" is P.O. Box
  - Was the provider "operational"? (*see* 42 C.F.R. § 405.502)
    - the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (***as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered***), to furnish these items or services (emphasis added).

Special Rules for Organizations

- Misuse of Billing Number
  - The provider or supplier knowingly sells to or allows another individual or entity to use its billing number
  - This does not include valid reassignment of benefits
- Examples
  - A provider allowing another practitioner to use his/her/its provider number (without a proper reassignment of benefits).
  - Improper use of *locum tenens* physicians
  - Using an old provider number from a different practice

Revocations and Deactivations

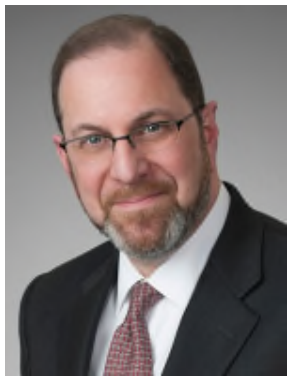
- Revocations are different from deactivations, which can occur if
  - you have not submitted a Medicare claim for a 12-month period, or
  - you do not report certain changes to your enrollment information on the CMS-855 within 90 days of the change or request for information from the MAC.

- In those cases, you can be reactivated by filing the appropriate updated information (as long as there are no other changes).

Appeals and Remedies

- Specific path for administrative appeals
- Special rule for revocations involving providers or suppliers:
  - If the revocation is based on a conviction, exclusion, or felony involving an owner, managing employee, authorized official, medical director, supervising physician, or other personnel, the provider or supplier may avoid the revocation by submitting proof that it has "terminated its business relationship with that individual within 30 days of the revocation notification"
- Corrective Action Plans ("CAPs")
  - Opportunity to correct deficiencies
  - Only available for a few grounds for revocation

Questions?



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Thank you.