Medicare Enrollment: Appeals, Compliance, and Collateral Consequences Under CMS's Expanded Revocation Authority

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Introduction

- Medicare Enrollment 101
- When Enrollment Goes Wrong
- Appeal Strategies
- Best Practices and Case Studies
- Expansions to CMS's Enrollment Authority

Medicare Enrollment 101

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Medicare Provider Enrollment

- Enrollment is the process followed by *providers* and *suppliers* to obtain privileges allowing them to bill Medicare for services furnished to beneficiaries.
- Enrollment is also a means to enable CMS to screen prospective providers and suppliers.
- Enrollment screening is CMS's first line tool to ensure the integrity of the Medicare program.

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Medicare Provider Enrollment

1) Provider
   - Defined as institutional health care facilities, including hospitals, skilled nursing facilities, home health agencies, hospices and others (42 U.S.C. 1395x(u))
2) Supplier
   - Defined as "a physician or other practitioner, or an entity (other than a provider)" (42 U.S.C. 1395x(d))
     - DMEPOS suppliers, IDTFs, physician clinics, independent labs, radiation therapy centers, etc.

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Medicare Provider Enrollment

- Survey & Certification
  - ALL providers undergo certification surveys by the CMS SA to test for compliance with Medicare "conditions of participation"
  - SOME suppliers undergo surveys by MAC contractors to test for compliance with Medicare "conditions for coverage"
    - DME suppliers, for example, comply with the requirements at 42 CFR 424.57
- Provider Agreements
  - *Providers* enter into provider agreements with Medicare, agreeing to abide by the applicable COPs and laws
  - *Suppliers* do not enter into "provider agreements" and abide by the Medicare CFCs

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Effective Date of Medicare Billing Privileges

- Physicians, nonphysician practitioners, group practices, ambulance suppliers, and IDTFs
  - The effective date for Medicare billing privileges is the later of –
    - The date of filing of a Medicare enrollment application **that was subsequently approved by CMS**; or
    - The date the supplier first began furnishing services at a new practice location
  - Retrospective billing date
    - Providers may retrospectively bill for services provided at the enrolled practice location up to 30 days prior to the effective date (assuming all other program requirements were met)
      - Note: retrospective billing does not apply to IDTFs
  - Also applies to reassignment relationships (via 855R form)

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Enrollment Revalidations

- Section 6401(a) requires all existing providers and suppliers to revalidate their enrollment information under new enrollment screening criteria.
  - Normally required to revalidate Medicare enrollment every 5 years (every 3 years for DMEPOS)
    - CMS reserves the right to perform off-cycle revalidations as deemed necessary
  - CMS posts a list of all currently enrolled providers and their revalidation due date (Data.CMS.gov/revalidation)
    - Revalidations are due on the last day of the month
    - Due dates are updated every 60 days at the beginning of the month
    - Due dates are listed up to 6 months in advance
    - Due dates not yet assigned will be listed as "TBD" (more than 6 months away)
  - MACs will send a revalidation notice within 2-3 months prior to revalidation due date
    - Notices sent via either email or postal mail

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Reporting Changes

- Required as condition of participating in Medicare to provide timely updates to any changes in information encompassed in your 855.
- Need to design a tracking mechanism of what was reported, and what/when that information changes.
- Need to understand timelines.

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Reporting Changes

Provider Type	30-Day Reporting	90-Day Reporting
Certified Providers and Suppliers (e.g., hospice, HHA, hospital, etc.)	1) Change of ownership or control (including changes in AOs or DOs) 2) Air ambulance – revocation or suspension of state/federal license	All other
Physicians, NPPs, Phys. Organizations	1) Change of ownership 2) Adverse legal actions 3) Change in practice location	All other
IDTF	1) Change of ownership 2) Change in location 3) Adverse legal actions 4) Changes in general supervision	All other
DMEPOS	All changes	N/A

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When Enrollment Goes Wrong

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Adverse Enrollment Actions

- Return
- Rejection
- Denial
- Deactivation
- Revocation
- Impact on Payment

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Adverse Enrollment Actions

Rejections

- CMS may reject a provider's application if the provider fails to furnish complete information on the enrollment application within 30 calendar days from the date the contractor's request for missing information
- Common mistakes
  - Certification statement unsigned/undated
  - Certification statement signed 120 days prior to the date on which the contractor received the application
  - Failure to complete all required section of the application
  - Failure to submit all supporting documentation
  - Wrong application was submitted (e.g., Form CMS-855B was submitted for Part A enrollment)
- Enrollment applications rejected by CMS will require the provider to resubmit the application as a new application.
  - Result: The effective date will be the date in which the resubmitted application was filed because it was the resubmitted application "that was subsequently approved by CMS" instead of the initial application.

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Adverse Enrollment Actions

Deactivations (42 CFR 424.540(a))

- Reasons for deactivation
  1. Provider does not submit any Medicare claims for 12 consecutive calendar month
     - Effective date of deactivation = last day of 12-month period
  2. Failure to report a change of ownership or control within 30 days
     - Effective date of deactivation = expiration of 30-day period
  3. Failure to report a change of information within 90 days of when the change occurred (e.g., change in practice location, managing employee, billing services, etc.)
     - Effective date of deactivation = expiration of the 90-day period
  4. Failure to respond to a revalidation request between 60-75 days after the revalidation due date
     - Effective date of deactivation = date CMS's deactivation action is taken (but after 60-75 day period)
- Deactivation of Medicare billing privileges does not have any effect on a provider or supplier's participation agreement

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Adverse Enrollment Actions

Reactivations (42 CFR 424.540(b))

- Deactivations for failure to report a change of information (e.g., practice location, ownership, etc.)
  - Provider's reactivation application is treated as an initial enrollment application
    - New PTAN with new effective date
    - Effective date = date provider submitted reactivation application (that was subsequently approved)
    - Result: Provider is not entitled to retrospective billing for services rendered between the deactivation date and new effective date
- Deactivations for failure to respond to a revalidation request
  - Required to submit a new full application
    - Application submitted within 120 days of revalidation request
      - Maintain original PTAN with a gap in coverage (between the deactivation and reactivation)
    - Application submitted after 120-day period
      - New PTAN with new effective date
      - Reactivation date will be date of receipt of new complete application
  - No payments will be made for the period of deactivation

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Adverse Enrollment Actions

Denials (42 CFR 424.530)

- Common denial reasons
  - Not in compliance with enrollment requirements
  - Excluded from any federal health care program
  - Felony convictions
  - False or misleading enrollment information
  - On-site review
  - Medicare debt
  - Payment suspension
- May not submit a new enrollment application until either of the following has occurred:
  - If the denial was not appealed, the date the provider's appeal rights have lapsed (i.e., 60 days following date of denial notice)
  - If appealed, provider has received notification that the determination was upheld

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Adverse Enrollment Actions

Revocations (42 CFR 424.535)

- Common revocation reasons
  - Noncompliance with enrollment requirements
  - Excluded from any federal health care program
  - **Felony convictions**
  - On-site review
  - **Failure to report**
  - **Abuse of billing privileges**
  - Medicaid termination
  - Failure to document or provide CMS access to documentation
  - Suspension/revocation of DEA Certification or Registration
  - Improper prescribing practices

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Revocations: Abuse of Billing Privileges

- **Abuse of billing privileges – 42 CFR 424.535(a)(8)**
  - Type 1: Provider submits a claim or claims for services that could not have been furnished to a specific individual on the date of service
  - Type 2: CMS determines that the provider has a pattern or practice of submitting claims that fail to meet Medicare requirements
    - Factors taken into consideration by CMS:
    - Percentage of submitted claims that were denied
    - The reason(s) for the claim denials
    - Whether the provider has any history of final adverse actions
    - The length of time over which the pattern has continued
    - How long the provider has been enrolled in Medicare
    - Any other information CMS deems relevant

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Revocations: Abuse of Billing Privileges

Interplay Between Revocations, Audits, and FCA Liability

- Abuse of Billing Privileges (42 C.F.R. § 424.535(a)(8)(ii))
  - CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement if CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements.
- 60-Day Overpayment Final Rule
  - "A provider or supplier's claim denial that has been both—(1) fully (rather than partially) overturned on appeal; and (2) finally and fully adjudicated will be excluded from our consideration in determining whether the provider or supplier's Medicare billing privileges should be revoked under § 424.535(a)(8)(ii)."
  - ''Finally and fully adjudicated'' means that—(1) the appeals process has been exhausted; or (2) the deadline for filing an appeal has passed.
  - Impact of ALJ audit appeals backlog?
  - "[W]e do not believe a claim denial that fails to meet both of these requirements should be excluded from our review for two reasons. First, excluding claims that are currently being appealed could encourage providers and suppliers to file meritless appeals simply to circumvent the application of § 424.535(a)(8)(ii). Second, merely because a claim is under appeal does not necessarily mean it will be overturned."

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Revocations: Felony Convictions

- **Felony convictions – 42 CFR 424.535(a)(3)**
  - The **provider**, **supplier**, or any **owner** or **managing employee** of the provider or supplier was convicted of a Federal or State felony offense that CMS determines is *detrimental to the best interests of the Medicare program and its beneficiaries*. Offenses include, *but are not limited in scope or severity to*:
    - Felony crimes against persons (such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions)
    - Financial crimes (such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions)
    - Any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct)
    - Any felonies that would result in mandatory exclusion under section 1128(a) of the Act
  - Applies to felonies within preceding 10 years
  - **Effective date of revocation** = date of felony conviction
  - **Reversal of revocation**: The revocation may be reversed if the provider or supplier terminates and submits proof that it has terminated its business relationship with the convicted individual within 30 days of the revocation notification
    - Note: Appeal deadline is 60 days

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Revocations: Failure to Report

- **Failure to report – 42 CFR 424.535(a)(9)**
  - Provider failed to report (within 30 days):
    - Any adverse legal action
    - A change in practice location
  - Failure to report is typically used in combination with revocations based on either: (1) adverse actions (e.g., felonies/exclusions); or (2) upon on-site review or other reliable evidence, CMS determines that the provider is no longer operational to furnish Medicare-covered items or services
    - ALJ decisions often only address the underlying offense giving rise to the revocation (i.e., adverse action or non-operational) without ruling on the secondary revocation reason (failure to report)
      - Implications?
  - CMS will assess an overpayment back to the effective date of revocation (i.e., change in practice location)
  - Differences between regulations and 855 instructions?

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What Can you do When Enrollment Goes Wrong?

- *Return* – Nothing, start over. Considered a "non-application"
- *Rejection* – Fix the deficient sections within 30 days from the date the "Development Letter" is mailed by MAC (but be mindful of CHOW/CHOI timelines)
- *Deactivation* – File to reactivate, no appeal rights.
- *Denial* – Corrective Action Plan, Request for Reconsideration, Appeal
- *Revocation* – Appeal, appeal, appeal…

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Appeal Strategies

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Appeal Options

- *Standard Process*:
  - Corrective Action Plan ("CAP")
  - Request Reconsideration
  - Appeal to Administrative Law Judge
  - DAB Review
  - District Court Review
- *Outside the Box*:
  - Contact CMS (RO or Central Office)
    - Settlement discussions
  - Contact the MAC (Hearing Officer)
  - Contact Congressional Representative

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Corrective Action Plan (CAP)

- The CAP process provides an opportunity to correct the deficiencies that resulted in the revocation
- Under 2014 Final Rule, providers may only submit a CAP for a revocation for noncompliance under §424.535(a)(1) – provider determined not to be in compliance with enrollment requirements
- The CAP must contain, at a minimum, verifiable evidence that the provider is in compliance with Medicare requirements
- If the CAP is approved, billing privileges will be reinstated
- If the CAP is not approved, provider may still submit a reconsideration appeal
  - CMS's refusal to reinstate a provider's billing privileges based on the CAP is NOT considered an *initial determination* under 42 CFR Part 498
    - Thus, providers have no right to appeal CAP decisions
- The CAP must be submitted within 30 days from the date of the revocation notice
  - A determination on the CAP will be made within 60 days
- Submission of a CAP will NOT toll the 60-day reconsideration appeal deadline

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Reconsideration Appeals

- 42 CFR § 498.5(l)(1)
  - Any prospective provider, an existing provider, prospective supplier or existing supplier dissatisfied with an initial determination or revised initial determination related to the denial or revocation of Medicare billing privileges may request reconsideration in accordance with §498.22(a).
- Appeal deadline = 60 days from receipt of the notice of revocation
- Content of the request
  - Reconsideration request must state the issues, or the findings of fact with which the affected party disagrees, and the reasons for disagreement.
- Reconsideration decision must be issued within 90 days of the date of the appeal request. Medicare Program Integrity Manual, chapter 15, section 15.25.1.2.D.

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Reconsideration Appeals

Key Considerations

- Open communications with CMS and/or its contractors
  - Request opportunity to discuss findings via telephone conference
- CMS (rather than its contractors) will make all determinations pertaining to revocations for abuse of billing privileges
- Timing issues
  - Revocation becomes effective 30 days after the date of revocation notice
    - Exception: Revocations based on adverse actions (e.g., felony conviction, license suspension, federal exclusion) will be effective the date of the adverse action
    - Exception: Revocation based on practice location determined not to be operational by CMS will be effective the date on which CMS made such a determination (e.g., date of on-site visit)
  - Provider likely to be revoked while reconsideration appeal is pending review

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Reconsideration Appeals

Rules for Submission of Evidence on Appeal

- Early presentation of evidence requirement – 42 CFR 498.56(e)
  - All supporting documentary evidence must be submitted during the reconsideration appeal stage
  - New documentary evidence may be considered by the ALJ if the ALJ finds that there is good cause for the new evidence for the first time at the ALJ level
- Supplement the reconsideration appeal request, if necessary
  - Provider may submit new information to the reconsideration Hearing Officer that was not previously included with its initial reconsideration appeal request (MPIM 15.25.1.2.D)
  - Any additional evidence must be submitted prior to the Hearing Officer's decision

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ALJ Appeals

Recent Departmental Appeals Board (DAB) decisions

- *Arriva Medical, LLC*, CR4834 (April 25, 2017)
  - CMS revoked the "largest supplier of home-delivered diabetic testing supplies in the nation."
  - CMS identified 47 claims billed by Arriva for deceased beneficiaries over a 5-year period (Arriva submitted 5.8 million claims during that 5-year period)
- *Adora Healthcare Services, Inc.*, RUL2017-4 (May 18, 2017)
  - DAB (Appellate Division) upheld ALJ's decision that CMS has no authority to revoke a provider as "no longer operational" based only on a site visit to the practice location of record when the provider's operations have been relocated to a new practice location and the time for reporting the change of location has not expired.
- *Kermit E. White, M.D*, DAB2765 (January 23, 2017)
  - DAB (Appellate Division) upheld ALJ's decision that revocation is authorized whenever a supplier permits another to use its billing number for any purpose, unless an exception applies (e.g., valid reassignment). Because no valid reassignment existed, the DAB did not need to address whether the ALJ correctly determined that Petitioner *knew* that another physician would misuse Petitioner's billing number to bill for the other physician's own services.

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ALJ Appeals

- ALJ request must be submitted within 60 days from receipt of the reconsideration decision
- ALJ must issue a decision, dismissal order, or remand no later than the 180-day period from the date the ALJ appeal request was filed
- For revocation appeals, ALJs have consistently recognized that CMS's decision to revoke providers is an *act of discretion* on the part of CMS
  - **Revocation of enrollment is a discretionary act of CMS**…[ALJs] do not have the authority, however, to review CMS's discretionary act to revoke a provider or supplier…Rather, the right to review of CMS's determination by an [ALJ] serves to determine whether CMS has the authority to revoke [the provider's or supplier's] Medicare billing privileges, not to substitute the [ALJ's] discretion about whether to revoke. *William R. Vivas, D.P.M., P.A.*, DAB No. CR2874 (2013)
- Because the ALJ is reviewing a discretionary act, the likelihood of overturning the discretionary act depends on appellant's ability to show:
  1) CMS did not have the authority to revoke (i.e., the enumerated conditions precedent were not present); or
  2) CMS abused its discretion when using its revocation authority

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ALJ Appeals

Additional ALJ/DAB case excerpts

- I must sustain CMS's determination and may not second guess CMS's judgment if a legitimate basis for the revocation exists and where the facts established noncompliance with one or more of the regulatory standards at the time of the revocation. *ASAP Home Oxygen, Inc.*, DAB No. CR2364 (2011).
- The statements in the preamble, however, are an articulation of enforcement policy rather than a rule establishing essential elements that must be proven to uphold a revocation under section 424. 535(a)(8).... CMS's decision to revoke billing privileges is, after all, discretionary. *Louis J. Gaefke*, D.P.M., DAB No. CR2785 (2013).
- I am required to follow the Act and regulations, and I have no authority to declare statutes or regulations invalid.... Thus, even though I accept for purposes of summary judgment that Petitioner's owner and employee did not understand either the regulations or the CMS-855I, that fact is not a basis on which I may conclude that the regulations are invalid and that Petitioner's failure to comply with the regulations is not a basis for revocation. Lf Med. Servs. of Ny, P.C., DAB No. CR4350 (2015).

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ALJ Appeals

Additional ALJ/DAB case excerpts

- Petitioner argues that 42 C.F.R. § 424.535(a)(9) is unconstitutionally vague and that the CMS-855I provides inadequate instructions about how to report a change in practice location.... My authority is limited to determining whether there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges.... I am required to follow the Act and regulations, and I have no authority to declare statutes or regulations invalid.... Thus, even though I accept for purposes of summary judgment that Petitioner's owner and employee did not understand either the regulations or the CMS-855I, that fact is not a basis on which I may conclude that the regulations are invalid and that Petitioner's failure to comply with the regulations is not a basis for revocation. Lf Med. Servs. of Ny, P.C., DAB No. CR4350 (2015)
- …the duration of a re-enrollment bar is not an appealable initial determination, and thus an administrative law judge does not have the authority to consider it. *Patrick Brueggeman, D.P.M.*, DAB No. CR4422 (2015)

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Collateral Consequences

- **Re-enrollment bar**
  - If a provider has its billing privileges revoked, the provider is barred from participating in the Medicare program from the date of the revocation until the end of the re-enrollment bar. 42 CFR 424.535(d)
    - Re-enrollment bar period established by CMS will depend on the severity of the basis for revocation
      - **Minimum** re-enrollment bar = 1 year
      - **Maximum** re-enrollment bar = 3 years
  - Length of re-enrollment bar issued by CMS cannot be challenged at ALJ hearing
    - "…the duration of a re-enrollment bar is not an appealable initial determination, and thus an administrative law judge does not have the authority to consider it." *Patrick Brueggeman, D.P.M.*, DAB No. CR4422 (2015)

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Collateral Consequences

- **Overpayments**
  - A physician, nonphysician practitioner, or physician/nonphysician practitioner organization that fails to report a final adverse action or change in practice location will be assessed an overpayment back to the date of the final adverse action or change in practice location. 42 CFR 424.565.
  - No payment may be made for otherwise Medicare covered items or services furnished to a Medicare beneficiary by a revoked provider. 42 CFR 424.555.
    - The beneficiary has no financial responsibility for any expenses, and the provider must timely refund to the beneficiary any amounts collected for those items/services.
    - If any otherwise covered Medicare item/service is furnished by a revoked provider, any expense incurred for such item/service shall be the responsibility of the provider.
      - Provider may be criminally liable for pursuing payments from the beneficiary.

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Collateral Consequences

- Revocation of related Medicare enrollments
- Medicaid termination
- Managed care contracts
- Commercial payor contracts
- Staff privileges for physicians
- Licensing issues

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Best Practices and Case Studies

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Practical Tips To Avoid Enrollment Errors

- Ownership of the Process – Whose job is this?
- Develop checklists to review prior to any filing going out the door (e.g., right form/version, correct address, paid application fee, NPI, dated application, signed application, postage, fed ex tracking)
- Form Completion Tips
  - Tricky sections (Sec. 4, 5, 6)
  - Must get SSNs, not optional
  - Must know date ownership/control began and report accurately
  - Exact percentages of ownership needed
  - Watch for MAC transitions

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Practical Tips To Avoid Enrollment Errors

- Avoid unnecessary rejections
  - Prompt and continuous follow up on the status of submitted enrollment applications
  - Keep an eye out for any development requests sent by CMS
- Ensure all enrollment changes are timely updated within the required timeframes (30 or 90 days)
- Timely submit initial enrollment applications and reassignment applications within 30 days to ensure complete reimbursement
  - Hold all claims for the enrolling/reassigning individual until application is approved by CMS
- Revalidations
  - Periodically check CMS's revalidation list
  - If you are within 3 months of the listed due date but have not received notice from the MAC, contact the MAC to verify if/when notice has/will be sent
  - If you are **within 2 months** of the listed due date but have not received notice from the MAC, **submit your revalidation application**
- Enrollment addresses
  - Ensure all reported addresses in your enrollment record are correct (correspondence address, special payments address, practice location address)
  - May not be a P.O. Box

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Case Study – Effective Date

- *Facts*:
  - Provider begins providing services on **March 1** and submits application on March 1.
  - Provider is surveyed on June 1, and receives a number of technical deficiencies, the most substantive, failure to include background insurance information, and the information is updated within two weeks.
  - Provider's effective date of enrollment issued by the MAC is **June 15**.
- *Options?*

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Case Study – Adverse Action Reporting

- *Facts*:
  - Physician practice gets terminated from state Medicaid program.
  - Physician fails to timely report change within 30 days to Medicare via 855 update to Section 3 (Adverse Legal Actions). Instead, reports it 90 days late.
- *Action*: MAC revokes billing privileges
- *Result*: Revocation upheld.
- *Lesson Learned*?

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Case Study – Untimely Updates

- Facts: Supplier fails to implement system to monitor and track changes of information reported in its 855B. Supplier recognizes failure to timely update information. Supplier comes to you, the compliance officer asking for advice. What do you tell him?
- Obligation: File updated 855B notifying MAC/CMS of changes, even if not timely, and accurately. Consider implications of revalidation timing.
- Risk: MAC can revoke billing privileges.
- Ever seen it happen? Yes, but only recently, and still on appeal. Prior history demonstrated revocation limited to failure to report more sensitive changes.
- Lesson Learned? Track, monitor, timely report, audit, catch the changes before they are caught by CMS or the MAC

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Case Study – Revocation for Pattern/Practice of Billing Abuse

- *Facts*:
  - Group practice enrolls with three physicians (A, B, and C) in year one.
  - Year two group adds a new physician (D) in January. Physician D begins providing services January 1, but is not approved by the MAC as a member of the group until April 1.
  - Physician D's services are billed under Physician A with Q6 modifier (locum tenens) through June 1.
  - Physician A is available and providing/billing for services throughout the period Physician A's enrollment in Medicare is revoked.
- *Result*?
  - Revocation reversed

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Case Study - Abuse of Billing Privileges

- Provider revoked under 42 CFR 424.535(a)(8)(i) for allegedly billing for deceased beneficiaries for 11 claims over a 4 year time period
- Revocations based on billing for deceased beneficiaries (424.535(a)(8)(i))
  - This revocation authority is not intended to be used for **isolated occurrences or accidental billing errors**. Rather, this basis for revocation is directed at providers and suppliers who are **engaging in a pattern of improper billing**. 73 Fed. Reg. 36488 at 36455.
  - …[CMS] will not revoke billing privileges under § 424.535(a)(8) unless there are multiple instances, at least three, where abusive billing practices have taken place. Id.
  - In considering whether to revoke enrollment and billing privileges in the Medicare program, we would consider the severity of the offenses, mitigating circumstances, program and beneficiary risk if enrollment was to continue, possibility of corrective action plans, beneficiary access to care, and any other pertinent factors. 71 Fed. Reg. 20754 at 20761.

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Case Study - Abuse of Billing Privileges

- Demonstrate a mere accidental billing mistake
  - Example: service rendered to alive beneficiary but inadvertently billed to deceased beneficiary with the same name
  - GOAL: minimize the number of "abusive" claims cited in the revocation notice
- Additional considerations
  - Severity of offense
    - Accidental/isolated occurrences (e.g., 11 claims identified over 4-year period)
  - Mitigating circumstances
    - Was payment ever received?
    - Claim corrections?
  - Beneficiary access to care
    - Provider/supplier specialty?
    - Number of similar provider types within geographic area?
  - Quality of care
    - Supporting affidavits from peers and/or institutions

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Case Study – Non-Operational

- *Facts*:
  - DMEPOS supplier operates at 123 Main St. for 10 years.
  - DMEPOS supplier relocates next door to 456 Main St.
  - DMEPOS supplier is concurrently revalidating its enrollment information with CMS/NSC
  - NSC Site Visit Contractor shows up at 123 Main St. and nobody is there.
  - NSC Site Visit Contractor calls 123 Main Street and even comes out again.
  - DMEPOS supplier files its CHOI to notify NSC of its new address location.
- Result?
  - Supplier gets revoked for being "non-operational" and failing to report CHOI timely.

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Case Study - Crimes Must be Revealed

Rey. R. Palop (CR3273)

- ALJ upheld revocation for failing to report felony conviction
- Petitioner physician was convicted of felony drug fraud in 2008 but did not report it until 2013; his 2009 855R (which did not report felony) was approved
- In 2013, WPS retroactively denied Petitioner's 2009 enrollment application. ALJ said this was a problem of the petitioner's own making.
- Petitioner argued that 2009 version of 855 did not require him to list adverse action, but ALJ found that he had promised to abide by the Medicare rules and regulations and that he knew or should have known that he was required to report the conviction.

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Case Study - Felony Offense

- Provider pled guilty to DWI felony offense on July 25, 2013
- CMS contractor sent notice of revocation on December 14, 2015.
  - 42 CFR 424.535(a)(3) – felony conviction
  - 42 CFR 424.535(a)(9) – failure to report
- Applied retroactive effective revocation date of July 25, 2013 (date of conviction)

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Case Study - Felony Offense

- Which rules should apply (date of revocation vs. date of conviction)?
  - (a)(3) language on date of revocation (December 2015) or
    - (i) The provider, supplier, or any owner or managing employee of the provider or supplier was, within the preceding 10 years, convicted (as that term is defined in 42 CFR 1001.2) of a Federal or State felony offense that CMS **determines** is detrimental to the best interests of the Medicare program and its beneficiaries.
    - (ii) Offenses **include, but are not limited in scope or severity to** –
  - (a)(3) language on date of conviction (July 2013)
    - (3) Felonies. The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS **has determined** to be detrimental to the best interests of the program and its beneficiaries.
      (i) Offenses **include**—
- Does a DWI fall within the scope of 42 CFR 424.535(a)(3)?
  - Felony crime against persons? Financial crime? Felony placing Medicare program or beneficiaries at immediate risk? Mandatory exclusion felony?
- If DWI is not listed or similar to a listed crime, did provider have a duty to report for purposes of revocation under 42 CFR 424.535(a)(9)?
- **Outside the box resolution**: settlement with CMS to reduce re-enrollment bar

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Expansions to CMS's Enrollment Authority

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Expansions to CMS's Enrollment Authority

- Proposed Rule – 81 FR 10719 (March 1, 2016)
- Proposed new and revised enrollment and program integrity requirements
- Comments were due April 25, 2016
- Less than 75 comments received
- Still awaiting Final Rule…

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Expansions to CMS's Enrollment Authority

- **Disclosure of Affiliations**
  - Require health care providers and suppliers to report affiliations with entities and individuals that:
    - Currently have uncollected debt to Medicare, Medicaid, or CHIP
    - Have been or are subject to a payment suspension under a federal health care program or subject to an OIG exclusion
    - Have had their Medicare, Medicaid, or CHIP enrollment denied or revoked.
  - "Affiliations" includes:
    - 5% or greater direct or indirect ownership interest
    - General or limited partnership interest
    - Operational or managerial control or directly/indirectly conducts the day-to-day operations (regardless of whether or not a W-2 employee)
    - Officer or director
    - Reassignment relationship
  - Lookback period = 5 years
  - Disclosure requirements apply to initial enrollment, revalidation, and subsequent changes of information applications
  - CMS could deny or revoke the provider's Medicare, Medicaid, or CHIP enrollment if CMS determines that the affiliation poses an undue risk of fraud, waste, or abuse

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Expansions to CMS's Enrollment Authority

- **Failure to report**
  - Currently authority: Can only revoke for failing to report adverse actions or change in practice location within 30 days
  - Proposed expansion: Can also revoke provider for failing to report a change of ownership within 30 days or any other change within 90 days
- **Referral of debt to U.S. Treasury**
  - Revoke provider who has an existing debt that CMS refers to the Department of Treasury
  - Medicare audit appeals?

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Expansions to CMS's Enrollment Authority

- Deny or revoke a provider's Medicare enrollment if CMS determines that the provider is currently revoked under a different name, numerical identifier, or business identity.
- Increased re-enrollment bars
  - Raise maximum re-enrollment bar from 3 years to 10 years
    - Maximum of 20-year re-enrollment bar for second revocation
  - Allow CMS to add an additional 3 more years to re-enrollment bar if the provider attempts to re-enroll under a different name, numerical identifier, or business entity
- Reapplication bar
  - Prohibit a provider from enrolling in Medicare for 3 years if an enrollment application is denied because the provider submitted false or misleading information with its application

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Expansions to CMS's Enrollment Authority

- Adoption of a "Reasonableness" Standard
  - CMS proposed to build in "reasonableness" standards
  - Most proposed rules contain a balancing factor test.
  - CMS proposed fact specific inquiries to weigh any "undue risk" to the program
- Exception to "Reasonableness" Standard
  - Circumvention of revocation actions

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QUESTIONS?

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About the Presenters

Ross Burris is a Shareholder in the Atlanta office of Polsinelli P.C. where he focuses his practice on healthcare regulatory issues and represents a wide variety of healthcare organizations, including hospitals and health systems, long term care providers, ambulatory surgery centers and DME suppliers, in regulatory audits, investigations and appeals.

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About the Presenters

Andrew B. Wachler has been counseling healthcare providers and organizations nationwide in a variety of health care legal matters for over 30 years on RAC and Medicare appeals, the Stark law, fraud and abuse, enrollment and revocation and other topics.

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