What's Going on Today with Medicare Payment and Enrollment Audits, Investigations and Appeals?

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Who is Polsinelli?

POLSINELLI

#1 **Ranked as Health Care "Law Firm of the Year"** by *U.S. News & World Report,* November 2014

#1 **Largest Healthcare Law Firm** according to *Modern Healthcare*, June 2015

#2 **Second largest Health Care practice** according to American Health Lawyers Association, *AHLA Connections*, June 2016

National **Nationally Ranked in Health Care** by *Chambers USA: America's Leading Lawyers for Business*, May 2016

Medicare Enrollment 101

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.

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.

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

Effective Date of Medicare Billing Privileges

- **Effective date of Medicare billing privileges** (physicians, nonphysician practitioners, group practices, and ambulance suppliers)
  - 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
- 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.
- Note: 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)

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

Obligation to Track and Update Information on File with CMS

- 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.

Tracking Changes

Provider Type	30-Day Reporting	90-Day Reporting
Certified Providers and Suppliers (e.g., hospice, HHA, hospital, etc.)	Change of ownership or control; changes in AOs or DOs; revocation/suspension of state/federal license	All other
Physicians, NPPs, Phys. Organizations	CHOW, adverse legal actions; change in address	All other
IDTF	CHOW, change in location; adverse legal actions; changes in supervision	All other
DMEPOS	All changes	N/A

When Enrollment Goes Wrong

What Happens When Enrollment Goes Wrong?

- 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)

What Happens When Enrollment Goes Wrong?

- Deactivations
  - Failure to report the following changes within 90 days of when the change occurred:
    - Change in practice location
    - Change of any managing employee
    - Change in billing services
  - Failure to report a change of ownership or control within 30 days
  - Failure to respond to a revalidation request between 60-75 days after the revalidation due date
- Deactivation of Medicare billing privileges does not have any effect on a provider or supplier's participation agreement

What Happens When Enrollment Goes Wrong?

- Provider's reactivation (if deactivation for failure to report a change of information (e.g., practice location, ownership, etc.)) 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
  - Providers required to submit a new full application to reactive their enrollment record after they have been deactivated
  - Providers will maintain their original PTAN
  - Reactivation date will be date of receipt of new complete application
  - No payments will be made for the period of deactivation

What Happens When Enrollment Goes Wrong?

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
  - Temporary moratorium

What Happens When Enrollment Goes Wrong?

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

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)
- *Denial* – Corrective Action Plan, Request for Reconsideration, Appeal
- *Deactivation* – File to reactivate, no appeal rights.
- *Revocation* – Appeal, appeal, appeal…

Strategies for Appeal

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)
  - Contact the MAC
  - Contact Congressional Representative

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

Corrective Action Plan (CAP)

- 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

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.

Reconsideration Appeals

- 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

Reconsideration Appeals

- 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

Reconsideration Appeals

- Early presentation of evidence
  - "After a hearing is requested but before it is held, the ALJ will examine any new documentary evidence submitted to the ALJ by a provider or supplier to determine whether the provider or supplier has good cause for submitting the evidence for the first time at the ALJ level." 42 CFR § 498.58(e)
- Supplement the reconsideration request, if necessary
  - "Consistent with 42 CFR §498.24(a), the provider, the supplier, or the Medicare contractor may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request at any time prior to the [Hearing Officer's] decision." MPIM 15.25.1.2.D

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)

Adverse Action Reporting

- Adverse Actions must be reported within 30 days
- Certain state and federal crimes must be reported—(expanded in 12/2014)
- Include State licensure revocation/ suspensions
  - Watch out for suspensions that are lifted in less than 30 days. (They still must be reported)
- Include Medicare enrollment revocations
- Failure to report can lead to **revocation** or **retroactive denial** of enrollment.

Revocation Actions and Recent Trends in the Medicare Program

- Revocation trends witnessed by providers in the field
  - Increased frequency of revocation actions
  - Revocations instituted for technical “failures”
  - Zero tolerance policy?
    - CMS not exercising discretion before revoking providers
    - CMS not getting involved outside appeals process
- What can I do to protect against a revocation action?
- Crystal ball forecasts

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)

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.

Collateral Consequences

- Medicaid termination
- Managed care contracts
- Commercial payor contracts
- Staff privileges for physicians
- Licensing issues

Best Practices and Case Studies

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

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)
- 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

Recent Enrollment Trends

Recent Enrollment Trends

- What is a “revocation action”?
- Who do revocation actions apply to?
- Why do they occur?
- I’m not in hospital operations—why should I care?

Recent Enrollment Trends

- So, I just received a notice of revocation from CMS—what do I do?
  - File an appeal
    - CAP (MAC Review); Request for Reconsideration (CMS/MAC Hearing Officer Review); Appeal to ALJ/DAB
  - Recent experience with appeals
    - No authority to force CMS to exercise discretion
    - No authority to hear equitable arguments
    - Motions for Summary Judgment
  - Alternatives to filing an appeal….

Recent Enrollment Trends

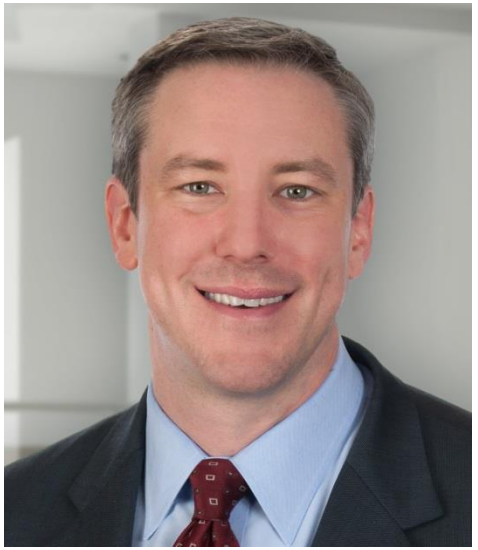
- 2016 proposed Medicare enrollment rule
  - Reporting of affiliates and disclosable events
  - Operational implications, *if finalized*
  - Potential implications – both today and *if finalized*
  - Anything similar being used by CMS today?
- Selected issues impacting specific provider types and impacting your deal…
  - Hospice; HHAs; DME and ASCs; Hospitals

Recent Enrollment Trends

- Payment changes under Sect. 603 of the Bipartisan Budget Act
  - Mechanics and operations covered this morning
  - Implications to hospital expansion efforts
  - Strategic alternatives to consider
- Hospital co-location arrangements
  - Mechanics and operations covered this morning
  - If you find a co-location in diligence, how do you make it work?
  - Anticipated developments from Medicare

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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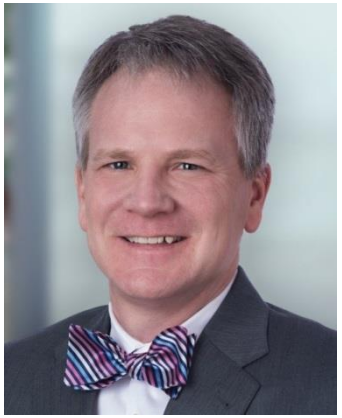
About the Presenters

Ross Sallade is a Shareholder with Polsinelli, PC and co-leader of the Reimbursement Institute (http://www.polsinelliri.com/). Ross focuses his practice on complex legal regulatory, operational, reimbursement and enrollment matters, including structuring business transactions in compliance with regulations, including change of ownership requirements, as well as federal anti-kickback statute and federal physician self-referral laws.



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