

# Audit Today, Revocation Tomorrow?

Take steps now to avoid getting caught in CMS' web.

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Pursuant to 42 CFR 424.535, the Centers for Medicare & Medicaid Services (CMS) has the authority to revoke a healthcare provider's Medicare billing privileges for various reasons based on the provider's conduct, ranging from felony convictions to the provider's failure to notify CMS of a change in practice location. Although many of the violations in which revocation is applicable appear relatively straightforward and easily avoidable, we have seen a growing number of providers who find themselves facing revocation for actions classified by CMS as "abuse of billing privileges" under 42 CFR 424.535(a)(8). On December 5, 2014, a Final Rule was published in the Federal Register extending the circumstances under which CMS could revoke a provider for abuse of billing privileges.<sup>1</sup>

Prior to the Final Rule, CMS's authority to revoke a provider for abuse of billing privileges was limited to situations in which a provider submitted claims for services that could not have been furnished to a specific individual on the date of service indicated on the claim form. As stated specifically in the regulation, violations occur in instances where: 1) the beneficiary's date of death precedes

the date of service; 2) the physician or beneficiary is not in the state or country when services were claimed to have been rendered; and 3) when the equipment necessary for testing is not present where the testing is said to have occurred.

Under the Final Rule, which became effective on February 3, 2015, CMS may still revoke a provider's Medicare billing privileges for submitting claims for services that could not have been rendered. However,

plained that "abusive," as the term is used in the Final Rule, is meant to address a range of situations in which a provider "regularly and repeatedly" submits non-compliant claims over a period of time. However, CMS did not specifically define what constitutes a "pattern or practice" of submitting claims that fail to meet Medicare requirements. According to CMS, this definition was omitted to allow for CMS to maintain flexibility to address a variety of factual

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the Final Rule added a new subsection to 424.535(a)(8) in which CMS is now authorized to revoke a provider's Medicare billing privileges when CMS determines that the provider has a "pattern or practice" of submitting claims that fail to meet Medicare requirements. As a result, CMS's revocation authority now captures those providers who submit claims for medically unnecessary services or fail to maintain sufficient documentation to support their claims, along with other reasons causing submission of non-compliant claims.

In its Final Rule, CMS explains that "sporadic billing errors" would not result in revocation for abuse of billing privileges. Rather, CMS ex-

scenarios. Rather, the Final Rule sets forth six specific factors to be used by CMS when making determinations under its new revocation authority:

- 1) The percentage of submitted claims that were denied;
- 2) The reason(s) for the claim denials;
- 3) Whether the provider or supplier has any history of final adverse actions and the nature of any such actions;
- 4) The length of time over which the pattern has continued;
- 5) How long the provider or supplier has been enrolled in Medicare; and
- 6) Any other information regard-

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ing the provider or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice of submitting noncompliant claims.

A key component addressed by CMS in the Final Rule relates to those claims which have been denied by CMS or its contractors as part of a Medicare audit. By now, most providers are familiar with CMS's ability to audit providers. During an audit, CMS's contractors request from providers various medical documentation to substantiate Medicare claims paid by CMS. Upon review of the documentation, contractors will demand that providers return any overpayment found during the review process. In situations where an overpayment refund is requested, providers may exercise their right to appeal the audit findings via the Medicare appeals process.

Prior to the Final Rule becoming final, several comments were submitted by the public to CMS regarding whether CMS will consider in its revocation determination those claims that were or continue to be the subject of a CMS audit. In response, CMS provided

the increase in appeals submitted by providers has led to a significant backlog of appealed cases pending at the Administrative Law Judge (ALJ) level of the Medicare appeals process. Currently, providers find themselves waiting two to three years between the date the ALJ appeal was requested and the date the hearing is actually held.<sup>2</sup>

Thus, for revocations under the Final Rule, CMS is permitted to include in its revocation determination

dress Medicare claims denials. This should include timely appealing any questionable claim denials, because favorable results received through the Medicare appeals process will be excluded from CMS's revocations considerations. Furthermore, providers should closely evaluate CMS's rationale for the claim denials and determine any corrective actions to incorporate into their billing and documentation practices to ensure future

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audited claim denials despite the significant waiting period providers face before they even receive a final determination as to whether the claims were appropriately billed (i.e., the ALJ determines that the billed claims met Medicare requirements). This raises another question: what happens in cases where CMS revokes a provider's billing privileges based on claims that receive favorable ALJ decisions one or two years after the revocation became effective?

claims meet Medicare requirements.

In doing so, providers should proactively seek any available education from their Medicare Administrative Contractor and utilize any program guidance currently available, including CMS Program Manuals, Local and National Coverage Determinations, Medicare Learning Network articles, and information contained on CMS's or the contractor's website. Providers should have protocols in place to identify and correct any accidental billing mistakes.

In addition to the provisions contained in the Final Rule, providers should keep in mind that the language contained in the previous "abuse of billing privileges" section of the revocation regulation remains in effect. Accordingly, CMS may still revoke the billing privileges of providers who submit claims for services that could not have been rendered on the date of service included on the claim form. Specifically, there have been numerous instances where CMS has revoked providers for submitting claims for beneficiaries who were deceased on the date of service in question.

While billing for deceased beneficiaries appears "abusive" on its face, the truth of the matter is that billing mistakes can happen, often without the provider realizing such a mistake was made because CMS has system edits in place to reject such claims (i.e., no payment was ever received

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in the Final Rule that it will exclude from its revocation determination those claim denials having been: 1) fully (rather than partially) overturned on appeal; and 2) finally and fully adjudicated. However, CMS acknowledged that it is permitted to take into account any claim denials that are still pending at any stage in the Medicare appeals process when determining whether to revoke a provider's Medicare billing privileges. Although not addressed by CMS in the Final Rule, this factor is problematic given the current landscape of the Medicare appeals process.

Over recent years, the increase in audit activity by CMS combined with

In light of CMS's new revocation authority under the Final Rule, additional emphasis should be put on compliance with Medicare requirements. Historically, a provider's non-compliance with Medicare reimbursement requirements left the provider vulnerable to overpayment refund demands resulting from CMS audit activity. Today, while a single audit may not result in revocation, "regular" and "repeated" non-compliance exposes providers to CMS's revocation authority for abuse of billing privileges.

The Final Rule stresses the importance for providers to have effective compliance protocols in place to ad-

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for the claim). In fact, the Office of Inspector General (OIG) conducted a study in which the OIG identified over 46,000 providers who submitted unpaid Part B claims in 2011 where the beneficiary's date of death preceded the purported date of service.<sup>3</sup>

According to CMS, its authority to revoke under such instances is not intended to be used for "isolated occurrences" or "accidental billing errors."<sup>4</sup> While it is not the intent of CMS to use its revocation authority in instances where violations were isolated occurrences or the result of accidental billing mistakes, providers who fall within these circumstances often do not become aware of these issues until they receive a notice from CMS that their Medicare billing privileges are being revoked for billing deceased beneficiaries.

This is because the decision to revoke on the part of CMS is often based on claim edits identifying that the date of service on the claim is after the date of death in CMS's system. Consequently, the initial determination to revoke may be based solely on the claim being submitted, and the notice of revocation is sent to the provider without any further investigation on the part of CMS.

Consequently, providers may not have the opportunity to identify and explain these mistakes until CMS has

already made its initial determination to revoke.

Providers should have protocols in place to identify and correct any accidental billing mistakes. Failure to do so could lead to future mistakes going unnoticed, thus making these claims have the appearance of patterns of improper billing as opposed to isolated instances. It is important that providers and their staff review the Explanation of Benefits thoroughly to identify any rejected

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claim and corresponding Claim Adjustment Reason Codes for the rejection (e.g., CO-13: the date of death precedes the date of service). Once identified, further analysis should be conducted to determine the cause for the billing mistake (e.g., the deceased beneficiary has the same or similar name as the beneficiary who actually received the service).

Finally, discussions must take place between providers and their billing professionals to determine the most appropriate method for correcting the mistakenly billed claims, as well as what steps can be taken to ensure similar mistakes do not occur in the future.

With CMS's authority to revoke providers for abuse of billing privileges, whether under the previous regulation or the provisions in the Final Rule, providers are encouraged to treat these developments as a call for action. Dedicating time and resources to compliance activities will help ensure that providers do not find themselves repeating the same mistakes. As stated by CMS in the Final Rule, "[A] provider or supplier should be responsible for submitting valid claims at all times and that the provider or supplier's repeated failure to do so poses a risk to the Medicare Trust Fund. We note that the responsibility for submitting valid claims exists irrespective of whether the provider or supplier itself submits the claims or hires a billing agency to perform this function; in either case, the claims are submitted on behalf of the provider or supplier."<sup>5</sup> **PM**

### References

- <sup>1</sup> 79 Fed. Reg. 72500. December 5, 2014.
- <sup>2</sup> Medicare Appellant Forum, Office of Medicare Hearings and Appeal. February 12, 2014; [www.hhs.gov/omha/OMHA%20Medicare%20Appellant%20Forum/omha\\_medicare\\_appellant\\_forum\\_presentations.pdf](http://www.hhs.gov/omha/OMHA%20Medicare%20Appellant%20Forum/omha_medicare_appellant_forum_presentations.pdf).
- <sup>3</sup> Providers and Suppliers by Number of Unpaid Part B Claims With Service Dates After Beneficiaries' Death, 2011. Office of Inspector General, Report (OEI-04-12-00130). October 2013.
- <sup>4</sup> 73 Fed. Reg. 36488 at 36455. June 27, 2008.
- <sup>5</sup> 79 Fed. Reg. 72500 at 72513.

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