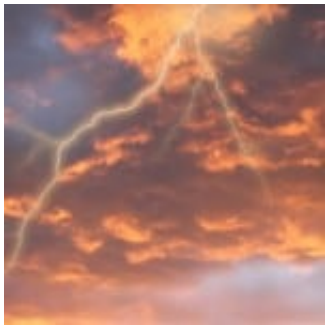
42 CFR Sec. 424.535(a) Medicare Revocation Actions -- Your Medicare Billing Privileges Can be Revoked For a Host of New Reasons. Are You Facing a Medicare Revocation Action? If so, You Must Act Fast to Preserve Your Appeal Rights.



(March 9, 2020): Last September, the Centers for Medicare and Medicaid Services (CMS) published a Final Rule titled ***"Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process."*** The Final Rule under 42 CFR Sec. 424.535(a), was published in order to implement sections 1866(j)(5) and 1902(kk)(3) of the Social Security Act (as amended by the Affordable Care Act).

As we discussed in earlier articles[1], the Final Rule is quite expansive. It implements a wide range of new enrollment, affiliation, revocation and denial authorities. As a reminder, here's an overview of the timeline we are concerned with:

- **November 4, 2019: Purported effective date of the expanded revocation bases outlined in the Final Rule.**

- **September 10, 2019: CMS published the Final Rule titled *"Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process."* in the Federal Register. [2] The Final Rule sets out the expanded reasons for revocation or denial of a provider's or supplier's billing authority.**

- **March 1, 2016: CMS published a Proposed Rule titled *"Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process."*[3] This Proposed Rule set out the enrollment revocation and denial changes CMS planned to implement in an effort to address long-standing program integrity risks that have previously been exploited in the past.**

Within hours of the purported[4] effective date of the Final Rule, CMS Medicare Administrative Contractors (MACs) began issuing revocation letters to participating Medicare providers and suppliers who had been identified as slated to have their Medicare billing privileges revoked (based on one or more of the expanded revocation letters set out in the Final Rule). This updated article focuses on one aspect of the Final Rule – the expanded Medicare billing privilege revocation authorities now exercised by CMS.

I. Implementation of Medicare's Expanded Billing Privilege Revocation Authorities Under 42 CFR Sec. 424.535(a):

Prior to the issuance of the Final Rule, under 42 CFR Sec. 424.535(a), CMS exercised the authority to revoke the Medicare billing privileges of a currently-enrolled provider or supplier (along with any related provider or supplier agreement) based on fourteen reasons. Under the Final Rule, the number of reasons upon which revocation could be based grew to 22.[5] Moreover, the scope of several of the original fourteen reasons for revocation was expanded under the Final Rule, primarily due to implementation of new requirements with respect to ***"Affiliations," "Disclosable Events,"*** and ***"Uncollected Debts."*** Over the last few months, since the expanded bases for revocation have been implemented, we have seen a significant increase in the number of revocation actions being pursued by Medicare MACs around the country. Moreover, as discussed in Section III below, CMS is now typically imposing a 10-year reenrollment bar (rather than the previous 3-year reenrollment bar) when pursuing a revocation action. An overview of the expanded list of reasons upon which a provider's Medicare billing privileges can be revoked is provided below:

1. Noncompliance. **Under 42 CFR Sec. 424.535(a) (1), CMS can revoke Medicare billing privileges if it has determined that a provider or supplier is*not in compliance with its enrollment requirements*(as set out in the appropriate enrollment application) *AND* has not submitted an appropriate plan of correction, CMS may revoke the Medicare billing privileges.**

2. Provider or supplier conduct. **Under 42 CFR Sec. 424.535(a) (2), CMS can revoke Medicare billing privileges if a provider, supplier or any owner, managing employee, delegated official, medical director, supervising physician or other health care personnel of the provider or supplier *has been excluded* from participation in a Federal health care program OR *has been disbarred, suspended, otherwise excluded from participating in any other Federal procurement program*.**

3. Felonies. **Under 42 CFR Sec. 424.535(a) (3), CMS can revoke Medicare billing privileges if a provider, supplier or any owner or managing employee was *convicted of a Federal or State felony (within the preceding 10 years) that CMS determines is detrimental to the best interests of the Medicare program* and its beneficiaries.**

4. False or misleading information. **Under 42 CFR Sec. 424.535(a) (4), CMS can revoke Medicare billing privileges if a provider or supplier *certified as "true" information on the enrollment application that is misleading or false*. As the regulation is quick to point out, the false certification action can also lead to fines and imprisonment.**

5. On-site review. **Under 42 CFR Sec. 424.535(a) (5), CMS can revoke Medicare billing privileges if when conducting an "on-site review" at the purported address of the provider or supplier, it *finds that the site is no longer operational* *OR* the *on-site review shows that the provider has moved and did not update their address appropriately.* In recent years, this revocation reason is typically cited when a Unified Program Integrity Contractor (UPIC) conducts an unannounced, on-site visit of a practice, home health agency, hospice or other provider, based on the location listed in PECOS. If a provider has moved offices and has failed to update CMS Form 855B and the Provider Enrollment, Chain, and Ownership System (PECOS), the CMS contractor will recommend that a provider's billing privileges be revoked.**

6. Grounds related to provider or supplier screening requirements. **Under 42 CFR Sec. 424.535(a) (6), CMS can revoke the Medicare billing privileges of an institutional provider[6] that *fails to submit an application fee or hardship exception request* with their Medicare revalidation application.**

7. Misuse of billing number. **Under 42 CFR Sec. 424.535(a) (7), CMS can revoke Medicare billing privileges if a provider or supplier *knowingly sells to or allows another individual or entity to use its billing number* (other than in the case of a valid reassignment of benefits).**

8. Abuse of billing privileges. **Under 42 CFR Sec. 424.535(a) (8), CMS can revoke the Medicare billing privileges of a provider or supplier:**

> **Submits a claim for services that have not been furnished to a specific individual on the date of service. Examples provided under 42 CFR scc. 424.535(a) (8) include *situations where beneficiary is deceased*, *situations where the directly physician or beneficiary is not in the state or country when the serves were allegedly furnished*, *OR* *when the equipment necessary for testing is not present when the testing is said to have taken place*.**
> ***Has a pattern or practice of submitting claims that fail to meet Medicare requirements*.[7]**

***9. Failure to report*[8]. Under 42 CFR Sec. 424.535(a) (9), can revoke the Medicare billing privileges if a provider or supplier:**

> **Failed to comply with its reporting requirements under 42 CFR Se. 516(d), *such as changes in ownership or control, any other changes in enrollment within 90 days, any revocation or suspension of a Federal or State license within 30 days*; *OR***
> **Failed to comply with its reporting requirements under 42 CFR Sec. 33(g)(2), *such as changes in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported to the Medicare fee-for-service contractor on the Medicare enrollment application within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 days*. As a recent letter to a provider from CMS contractor Novitas Solutions stated:**

"An undeliverable records request sent to the provider's Medicare 855 correspondence address constitutes a failure to provide CMS access to documentation in violation of 42 U.S. Code Sec. 424.516(1)."

OR

> **Failed to comply with its reporting requirements under 42 CFR Sec. 424.57(c)(2), *such as changes in information on a provider's application for billing privileges within 30 days of the change*.**

***10. Failure to document or provide CMS access to documentation.* Under 42 CFR Sec. 424.535(a) (10), CMS can revoke the Medicare billing privileges *if a provider or supplier has failed to comply with the documentation or CMS access requirements*. Under 42 CFR Sec. 516(f), *a provider or supplier is required to maintain documentation for 7 years from the date of services, AND upon the request of CMS or Medicare contractors, provide access to that documentation*.**

11. Initial reserve operating funds. **Under 42 CFR Sec. 424.535(a) (11), CMS can revoke the Medicare billing privileges of a home health agency *if within 30 days of CMS or a Medicare contractor request, the home health agency cannot furnish supporting documentation verifying that the home health agency meets the initial reserve operating funds requirement* found in 42 CFR Sec. 489.28(a).**

12. Other program termination. **Under 42 CFR Sec. 424.535(a) (12), CMS can revoke Medicare billing privileges *if a provider or supplier is terminated, revoked or otherwise barred from participation in a State Medicaid program or any other Federal health care program*. This represents a significant change.**

13. Prescribing authority. **Under 42 CFR Sec. 424.535(a) (13), CMS can revoke Medicare billing privileges if a physician or other eligible professional's Drug Enforcement Administration *(DEA) Certificate of Registration is revoked or suspended*; *OR* a *State licensing body suspends or revokes the ability of a physician or other eligible professional to prescribe drugs*.**

14. Improper prescribing practices. **Under 42 CFR Sec. 424.535(a) (14), CMS can revoke Medicare billing privileges of a physician or other eligible professional *if it determines that there has been a pattern or practice of prescribing Part B or Part D drugs* that is:**

> **Abusive or represents a threat to the health and safety of Medicare beneficiaries or both; *OR***
> **Fails to meet Medicare requirements.**

15. Reserved.

16. Reserved.

17. NEW *-- Debt referred to the United States Department of Treasury.* Under 42 CFR Sec. 424.535(a) (17), CMS can revoke Medicare billing privileges *if a provider or supplier has an existing debt that CMS appropriately refers to the United States Department of Treasury*.[9]

18. NEW *-- Revoked under different name, numerical identifier or business identity.* Under 42 CFR Sec. 424.535(a) (18) CMS can revoke the Medicare billing privileges if a provider or supplier is *currently revoked under a different name, numerical identifier, or business identity, and the applicable reenrollment bar period has not expired*. [10]

19. NEW *-- Affiliation that poses an undue risk.* Under 42 CFR Sec. 424.535(a) (19), CMS may revoke the Medicare billing privileges if it determines that the provider or

supplier *has or has had an affiliation under 42 CFR Sec. 424.519 that poses an undue risk of fraud, waste, or abuse to the Medicare program*.

20. NEW *-- Billing from a non-compliant location.* Under 42 CFR Sec. 424.535(a) (20), CMS may revoke the Medicare billing privileges of a provider or supplier, even if all of the practice locations associated with a particular enrollment comply with Medicare enrollment requirements, *if the provider or supplier billed for services performed at or items furnished from a location that it knew or should have known did not comply with Medicare enrollment requirements*.[11]

21. NEW *Abusive ordering, certifying, referring, or prescribing of Part A or B services, items or drugs.* Under 42 CFR Sec. 424.535(a) (21), CMS may revoke the Medicare billing privileges if it determines that a physician or eligible professional *has a pattern or practice of ordering, certifying, referring, or prescribing Medicare Part A or B services, items, or drugs that are abusive, represents a threat to the health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements*.[12]

22. NEW *-- Patient Harm.* Under 42 CFR Sec. 424.535(a) (22), CMS may revoke the Medicare billing privileges if it determines that a physician or eligible professional *has been subject to prior action from a State oversight board, Federal or State health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm*.[13]

As the above expanded list of revocation authorities reflects, CMS now has the express ability to revoke the Medicare billing privileges of a health care provider or supplier for serious violations of law (such as conviction of a felony or patient abuse). However, it also has the authority to revoke Medicare billing privileges for conduct that may only amounts to an administrative error or mistake by a provider or supplier. Perhaps even more troubling is the fact that the past or current "affiliations" of a provider or supplier may lead to a revocation action if CMS determines that the affiliation represents an undue risk to the Medicare program or its beneficiaries.

A hundred years ago, the U.S. Supreme Court stated in the case Rock Island Arkansas & Louisiana R. Co v. United States**[14]**:

*"**Men must turn square corners when they deal with the government**"*

That statement still rings true in today's world. Health care providers and suppliers are permitted to apply to participate in the Medicare and Medicaid programs. Participation isn't a "right." It is a privilege. When you complete your enrollment paperwork, you expressly agree to comply with the terms of the Form 855 Enrollment Application. Should you fail to comply with each of the obligations set out in that agreement, CMS reserves the right to revoke your Medicare billing privileges. Now, more than ever, it is essential that you have an effective Compliance Program in place and that you periodically review your practices to ensure that you and your staff are fully complying with applicable Medicare regulatory, statutory and legal requirements.

II. Length of Time a Provider's Medicare Billing Privileges May be Revoked Under 42 CFR Sec. 424.535(c):

The Final Rule significantly modified 42 CFR Sec. 424.535(c). This regulatory provision sets out the potential reenrollment bar time limits that may imposed by CMS when initiating a Medicare revocation action. If this is the first time that a provider's Medicare billing privileges are being revoked, the minimum reenrollment bar is 1 year, and the maximum reenrollment bar is 10 years.[15] If CMS determines that a provider attempted to ***"circumvent its existing reenrollment bar by enrolling in Medicare under a different name, numerical identifier or business identity,"*** the agency can further tack on up to 3 additional years onto the reenrollment bar it has imposed.[16] As a final point in this regard, Moreover, under if a provider or supplier is being revoked from Medicare a second time, CMS may choose to impose a reenrollment bar of up to 20 years.[17]

III. Responding to a Medicare Revocation Action:

If you receive notice that CMS is intending to revoke your Medicare billing privileges, it is essential that you engage experienced health law counsel to represent you in the appeal process. This is especially critical given the fact that recent revocation actions initiated by CMS have all sought to impose of reenrollment bar of 10 years, rather than the 3-year bar that was typically imposed prior to November 4, 2019. Unfortunately, a Medicare revocation action can trigger a number of other secondary adverse actions by law enforcement, private payors and a provider's State Medical Board. If your Medicare billing privileges are being revoked, please feel free to give us a call for a free consultation. Liles Parker attorneys have extensive experience representing health care providers around the country in Medicare revocation actions. **We can be reached at: 1 (800) 475-1906.**

Robert W. Liles is a former Federal prosecutor and has more than 25 years of health law experience. Mr. Liles and the other attorneys at Liles Parker have extensive experience representing providers and suppliers in the appeal of proposed Medicare revocation actions. Questions? Give Robert Liles a call. For a free consultation, he can be reached at: 1 (800) 475-1906.

[1] September 2019 article titled ***"Medicare, Medicaid and CHIP Enrollment Revocation and Denial Authorities Have Expanded. What Steps are You Taking to Reduce Your Level of Risk?"***

and our December 2017 article titled ***"Revocation of Your Medicare Billing Privileges."***

[2] 84 FT 47794 (September 10, 2019). **https://www.govinfo.gov/content/pkg/FR-2019-09-10/pdf/2019-19208.pdf**

[3] 81 FR 10720.

[4] We are in currently in the process of challenging the purported effective date of November 4, 2019. CMS failed to provide the proper notice requirements mandated under the Congressional Review Act. This failure thereby delays the effective date of the expanded revocation authorities.

[5] Slots have been placed in reserve for revocation reasons number 15 and 16 which would likely be assigned by CMS in the future and would presumably go through the rulemaking process.

[6] Under 42 CFR Sec. 424.502, the term ***"Institutional Provider"*** means any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (not including physician and nonphysician practitioner organizations), CMS-855S, CMS-20134, or an associated Internet-based PECOS enrollment application.

[7] Under 42 CFR Sec. 424.535(a) (8), when making this determination, CMS considers:

- The percentage of submitted claims that were denied;
- The reasons for the denials; whether the provider has a history of final adverse actions (and the nature of these actions;
- The length of time over which the pattern has continued; how long the provider has been

enrolled in Medicare; and
- Any other information that CMS deems relevant to its determination of whether the provider or supplier has or has not engaged in the pattern or practice identified.

[8] Under 42 CFR Sec. 424.535(a)) (9), when determining whether a revocation under this paragraph is appropriate, CMS considers the following factors:

(i) Whether the data in question was reported.

(ii) If the data was reported, how belatedly.

(iii) The materiality of the data in question.

(iv) Any other information that CMS deems relevant to its determination.

[9] Under 42 CFR Sec. 424.535(a) (17), when determining whether a revocation under this paragraph is appropriate, CMS is supposed to consider:

- The reason(s) for the failure to fully repay the debt (to the extent this can be determined).
- Whether the provider or supplier has attempted to repay the debt (to the extent this can be determined).
- Whether the provider or supplier has responded to CMS' requests for payment (to the extent this can be determined).
- Whether the provider or supplier has any history of final adverse actions or Medicare or Medicaid payment suspensions.
- The amount of the debt. (vi) Any other evidence that CMS deems relevant to its determination.

[10] Under 42 CFR Sec. 424.535(a) (18), when determining whether a provider or supplier is a currently revoked provider or supplier under a different name, numerical identifier, or business identity, CMS investigates the degree of commonality by considering the following factors:

- Owning and managing employees and organizations (regardless of whether they have been disclosed on the Form CMS–855 application).
- Geographic location.
- Provider or supplier type.
- Business structure.
- Any evidence indicating that the two parties are similar or that the provider or supplier was created to circumvent the revocation or reenrollment bar.

[11] Under 42 CFR Sec. 424.535(a) (20), when determining whether and how many of the provider's or supplier's enrollments, involving the non-compliant location or other locations, should

be revoked, CMS considers the following factors:

- The reason(s) for and the specific facts behind the location's noncompliance.
- The number of additional locations involved.
- Whether the provider or supplier has any history of final adverse actions or Medicare or Medicaid payment suspensions.
- The degree of risk that the location's continuance poses to the Medicare Trust Funds.
- The length of time that the noncompliant location was non-compliant.
- The amount that was billed for services performed at or items furnished from the non-compliant location.
- Any other evidence that CMS deems relevant to its determination.

[12] Under 42 CFR Sec. 424.535(a) (21), when making its determination as to whether such a pattern or practice exists, CMS considers the following factors:

(i) Whether the physician's or eligible professional's diagnoses support the orders, certifications, referrals or prescriptions in question.

(ii) Whether there are instances where the necessary evaluation of the patient for whom the service, item or drug was ordered, certified, referred, or prescribed could not have occurred (for example, the patient was deceased or out of state at the time of the alleged office visit).

(iii) The number and type(s) of disciplinary actions taken against the physician or eligible professional by the licensing body or medical board for the state or states in which he or she practices, and the reason(s) for the action(s).

(iv) Whether the physician or eligible professional has any history of final adverse action (as that term is defined in Sec. 424.502).

(v) The length of time over which the pattern or practice has continued.

(vi) How long the physician or eligible professional has been enrolled in Medicare.

(vii) The number and type(s) of malpractice suits that have been filed against the physician or eligible professional related to ordering, certifying, referring or prescribing that have resulted in a final judgment against the physician or eligible professional or in which the physician or eligible professional has paid a settlement to the plaintiff(s) (to the extent this can be determined).

(viii) Whether any State Medicaid program or any other public or private health insurance program has restricted, suspended, revoked, or terminated the physician's or eligible professional's ability to practice medicine, and the reason(s) for any such restriction, suspension, revocation, or termination.

[13] Under 42 CFR Sec. 424.535(a) (21), when determining whether a revocation is appropriate, CMS considers the following factors:

(A) The nature of the patient harm.

(B) The nature of the physician's or other eligible professional's conduct.

(C) The number and type(s) of sanctions or disciplinary actions that have been imposed against the physician or other eligible professional by the State oversight board, IRO, Federal or State health care program, or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care. Such actions include, but are not limited to in scope or degree:

(1) License restriction(s) pertaining to certain procedures or practices.

(2) Required compliance appearances before State medical board members.

(3) License restriction(s) regarding the ability to treat certain types of patients (for example, cannot be alone with members of a different gender after a sexual offense charge).

(4) Administrative or monetary penalties.

(5) Formal reprimand(s).

(D) If applicable, the nature of the IRO determination(s).

(E) The number of patients impacted by the physician's or other eligible professional's conduct and the degree of harm thereto or impact upon.

[14] 254 U.S. 141, 143 (1920).

[15] 42 CFR Sec. 424.535(c)(1)(i).

[16] 42 CFR Sec. 424.535(c)(2)(i).

[17] 42 CFR Sec. 424.535(c)(3),