Home Health Revocation Actions by Medicare are Expanding Around the Country

(September 28, 2020): Last September, CMS published a Final Rule titled ***"Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process."***[1]Among its many changes, the Final Rule significantly expanded the reasons that may be asserted by the Centers for Medicare and Medicaid Services (CMS) when revoking a health care provider's enrollment and Medicare billing privileges. The Final Rule also extended the period that a health care provider can be barred from reenrolling in the Medicare program. Since the issuance of the Final Rule, the enrollment and Medicare billing privileges of an increasing number of home health agencies nationwide have been revoked. This article examines several of the primary regulatory bases that have been cited by CMS when pursuing a home health revocation action. It also examines a number of the issues that a home health agency should consider when faced with a potential revocation action.

I. Summary Listing of the Reasons a Home Health Agency's Medicare Enrollment May be Revoked:

With the implementation of the Final Rule, the number of reasons upon which CMS may seek to revoke the enrollment and Medicare billing privileges of a participating provider or supplier grew from 14 to 22.[2] A summary listing of the expanded list of reasons for revocation is set out below.

- **Revocation Reason #1. Noncompliance.** 42 C.F.R. §424.535(a)(1).
- **Revocation Reason #2. Provider or supplier conduct.** 42 C.F.R. §424.535(a)(2).
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Revocation Reason #3. Felonies. 42 C.F.R. §424.535(a)(3).

- **Revocation Reason #4. False or misleading information.** 42 C.F.R. §424.535(a)(4).

- **Revocation Reason #5. On-site review.** 42 C.F.R. §424.535(a)(5).

- **Revocation Reason #6. Grounds related to provider or supplier screening requirements.** 42 C.F.R. §424.535(a)(6).

- **Revocation Reason #7. Misuse of billing number.** 42 C.F.R. §424.535(a)(7).

- **Revocation Reason #8. Abuse of billing privileges.** 42 C.F.R. §424.535(a)(8).

- **Revocation Reason #9. Failure to report.** 42 C.F.R. §424.535(a)(9).

- **Revocation Reason #10. Failure to document or provide CMS access to documentation.** 42 C.F.R. §424.535(a)(10).

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Revocation Reason #11. Initial reserve operating funds. 42 C.F.R. §424.535(a)(11).

- **Revocation Reason #12. Other program termination.** 42 C.F.R. §424.535(a)(12).
- **Revocation Reason #13. Prescribing authority.** 42 C.F.R. §424.535(a)(13).
- **Revocation Reason #14. Improper prescribing practices.** 42 C.F.R. §424.535(a)(14).
- **Revocation Reason #15. Reserved.** 42 C.F.R. §424.535(a)(15).
- **Revocation Reason #16. Reserved.** 42 C.F.R. §424.535(a)(16).
- **Revocation Reason #17. NEW — Debt referred to the United States Department of Treasury.** 42 C.F.R. §424.535(a)(17).
- **Revocation Reason #18. NEW — Revoked under different name, numerical identifier or business identity.** Under 42 C.F.R. §424.535(a)(18).

- **Revocation Reason #19. NEW — Affiliation that poses an undue risk.** 42 C.F.R. §424.535(a)(19).

- **Revocation Reason #20. NEW — Billing from a non-compliant location.** 42 C.F.R. §424.535(a)(20),

- **Revocation Reason #21. NEW -- Abusive ordering, certifying, referring, or prescribing of Part A or B services, items or drugs.** 42 C.F.R. §424.535(a)(21).

- **Revocation Reason #22. NEW — Patient harm.** 42 C.F.R. §424.535(a)(22).

For a detailed discussion of the 22 revocation reasons summarized above, you may wish to review our **article** titled ***"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."***

II. Primary Reasons Cited in Home Health Revocation Actions:

In reviewing the 22 reasons that CMS may revoke a home health agency's enrollment and Medicare billing privileges, it is worth noting that only ***Revocation Reason #11. Initial reserve operating funds.*** 42 C.F.R. §424.535(a)(11), specifically targets home health agencies. Under this provision, CMS can revoke the Medicare billing privileges of a home health agency if the agency fails to provide documentation that CMS can use to verify that the home health agency meets the initial reserve operating funds requirement described in 42 C.F.R. §489.28(a). Although this particular basis for Medicare revocation is explicitly aimed at home health agencies, to date, it is rarely been cited by CMS as the primary reason for revoking an agency's enrollment and Medicare billing privileges.

Of the remaining revocation reasons cited above, the reasons CMS has repeatedly relied on a

home health revocation action are ***Revocation Reason #5. On-site review.*** 42 C.F.R. §424.535(a)(5) and ***Revocation Reason #8. Abuse of billing privileges.*** 42 C.F.R. §424.535(a)(8). Both of these reasons for revocation are discussed in more detail below, along with recent home health Medicare revocation case decisions examining these regulatory violations.

III. "On-Site Review" as a Basis for a Home Health Revocation Action:

In recent years, our attorneys have represented numerous home health agencies whose enrollment and Medicare billing privileges have been revoked due to the fact that an unannounced, on-site visit by a CMS-contracted inspector found that the provider was no longer operational to furnish Medicare covered home health services. As 42 C.F.R. §424.535(a)(5) provides:

> ***"(5) On-site review.*** *Upon on-site review or other reliable evidence, CMS determines that the provider or supplier is either of the following:*
>
> ***(i)*** *No longer* ***operational*** *to furnish Medicare-covered items or services.*
>
> ***(ii)*** *Otherwise fails to satisfy any Medicare enrollment requirement."* **(emphasis added).**

What does this mean? Simply put, if a CMS-contracted inspector conducts an unannounced site visit of a home health agency's existing certified location and finds that the agency is no longer "operational" at that location, the home health agency's enrollment and Medicare billing privileges are subject to revocation. A home health agency is considered to be operational[3] if it:

> **". . . *has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered), to furnish these items or services."***

Many of these revocation cases are the result of a home health agency's failure to properly notify the appropriate MAC that it intends to move from its surveyed and certified location to a new site

(within its current approved geographic area).[4] Home health agencies must also submit an amended Form CMS-855A, along with any other required documentation within 90 days.[5] A recent DAB decision affirmed the revocation of a home health agency by CMS on the basis that an on-site review of the provider's surveyed location found that the agency was not operational.

March 2020. Texas Home Health Agency. Reason for Revocation – *On-Site Review.* In a recent case decided by an Administrative Law Judge (ALJ) of the HHS, Departmental Appeals Board (DAB), the ALJ reviewed a revocation case involving a Texas home health agency that allegedly failed to meet its regulatory requirements under 42 C.F.R. §424.535(a)(5).

The facts in the case are fairly straightforward. In July 2017, a CMS-contractor inspector attempted to conduct an unannounced site visit of a home health agency in Tyler, Texas. When the inspector arrived at the agency address on file with CMS and the MAC, she found that the building at that location was ***"[v]acant and locked."*** The inspector also found that no employees were present and there were no signs of customer activity."

At appeal, the home health agency argued that the regulations require that a provider ***NOT*** the provider's physical practice location was required to be "open to the public" for the purpose of providing health care related services. The home health agency argued that since its staff delivered home health services in the homes of patients and not in a single practice location, it was, in fact, "open to the public." Based on the facts presented, the DAB ruled that since the home health agency was not operational at the address on file with CMS, it was in violation of the requirements under 42 C.F.R. §424.535(a)(5)(i). The DAB therefore affirmed the revocation action and the two-year enrollment bar that had been imposed.

III. "Abuse of Billing Privileges" as a Basis for a Home Health Revocation Action:

As a review of 2019 and 2020 DAB decisions will confirm, CMS is increasingly citing a home health provider's abuse of billing privileges when exercising its Medicare revocation authority. Most of the revocation actions taken during this period alleged that the home health agency ***"has a pattern or practice of submitting claims that fail to meet requirements."*** [6] As 42 C.F.R. §424.535(a)(8) provides:

> ***"(8) Abuse of billing privileges****. Abuse of billing privileges includes either of the following:*
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> *(i) The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to the following situations:*

(A) Where the beneficiary is deceased.

(B) The directing physician or beneficiary is not in the state or country when services were furnished.

(C) When the equipment necessary for testing is not present where the testing is said to have occurred.

(ii) ***CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements****. In making this determination, CMS considers, as appropriate or applicable, the following:*

(A) The percentage of submitted claims that were denied.

(B) The reason(s) for the claim denials.

(C) Whether the provider or supplier has any history of final adverse actions (as that term is defined under § 424.502*) and the nature of any such actions.*

(D) The length of time over which the pattern has continued.

(E) How long the provider or supplier has been enrolled in Medicare.

(F) Any other information regarding 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 described in this paragraph." **(emphasis added).**

What does this mean? When analyzing this revocation reason, it is worth noting that it is comprised of two parts, paragraphs (i) and (ii). Under 42 C.F.R. §424.535(a)(8)(i), several straightforward criteria are outlined in sections (i)(A)-(C) that can serve as the basis for revoking a provider's enrollment and Medicare billing privileges. In contrast, paragraph (ii) permits CMS to revoke a provider's enrollment if it determines that the provider ***"has a pattern or practice of submitting claims that fail to meet Medicare requirements."*** Although sections (ii)(A)-(F) are intended to provide a framework that can be used by CMS to determine if a ***"pattern or practice"*** of improper billing conduct is present, in our opinion this reason for revocation is still remarkably broad and subject to the vagaries of the discretion of CMS and its contractors. An overview of one of the more interesting Medicare revocation cases brought under 42 C.F.R. §424.535(a)(8) is set out below.

May 2020. Texas Home Health Agency. Reason for Revocation -- *Abuse of billing privileges:* In this case, an ALJ was faced with a case where a Texas home health agency was alleged to have submitted 38 claims (associated with 13 beneficiaries) to Medicare for services that were allegedly provided without a valid certification of eligibility.

In this case, the 13 home health Medicare beneficiaries at issue listed a Houston physician as the ordering / certifying physician. Qlarant, the Unified Program Integrity Contractor (UPIC) for Texas, conducted a review of these claims and discussed them with the physician who allegedly ordered the home health services. The physician attested that he did not order home health services for any of the 13 beneficiaries under review. Based on Qlarant's findings, Palmetto (the assigned Medicare Administrative Contractor) revoked the home health agency's enrollment and Medicare billing privileges, citing violations of 42 C.F.R. § 424.535(a)(8)(ii). In support of its decision, Palmetto noted that the physician denied ordering the home health services. Palmetto further stated that the physician did not have a prior Part B relationship with the 13 beneficiaries at issue.[7] Therefore, Palmetto took the position that the Physician was not involved in the care, treatment, or monitoring of the 13 beneficiaries whose medical records he reviewed.

On appeal, it was argued that a licensed nurse practitioner working under a valid collaboration agreement with a Houston-based physician properly certified the need for home health services in connection with these 13 beneficiaries. As the home health agency noted, the supervising physician had signed a letter which stated:

> **"*To whom it may concern: This is [to] certify that I [Physician] authorized [Nurse Practitioner] NP of [Pasadena Medical Clinic] to sign all Home Health orders on my behalf as her supervising physician."***

In its arguments, the home health agency conceded that ***"all related orders were signed and submitted by [Physician] and/or [Nurse Practitioner] of [Pasadena Medical Clinic]."*** *On appeal, the home health agency acknowledged that the claims were* **"noncompliant because there was an impermissible delegation of his authority to sign home health certification documents"** by the nurse practitioner. *Therefore, the DAB found that the claims did not qualify for coverage and payment. The DAB also ruled that it was appropriate to revoke the home health agency's enrollment and Medicare billing privileges for violating* 42 C.F.R. § 424.535(a)(8), ***"Abuse of Billing Privileges."*** The ALJ also upheld the three-year enrollment bar that had been imposed by CMS.

*As a final point, it is worth noting that d*uring the period at issue (August 2016 through November

2017), Medicare paid for home health services only if a physician certifies the beneficiary's eligibility for the home health benefit – not a nurse practitioner.[8]

IV. Length of a Medicare Enrollment or Re-enrollment Bar:

As the case examples above reflect, until recently a health care provider could only be barred from being enrolled in the Medicare program for a period of one to three years. Under the Final Rule effective November 4, 2019,[9] this period was extended to ten years[10] (under certain circumstances, a provider may be barred from enrolling or re-enrolling in the Medicare program for up to 20 years).[11]

V. Anticipated Impact of New Medicare Revocation Authorities:

Six of the reasons that may be relied on by CMS when revoking a home health agency's enrollment and Medicare billing privileges are new and became effective November 4, 2019. Of the six new reasons, we believe that ***Revocation Reason #17: Debt referred to the United States Department of Treasury.*** 42 C.F.R. §424.535(a)(17) may represent the most significant risk to your home health agency. As 42 C.F.R. §424.535(a)(17) provides:

> ***"(17) Debt referred to the United States Department of Treasury.*** *The provider or supplier has an existing debt that CMS appropriately refers to the United States Department of Treasury. In determining whether a revocation under this paragraph (a)(17) is appropriate, CMS considers the following factors:*
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> ***(i)*** *The reason(s) for the failure to fully repay the debt (to the extent this can be determined).*
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> ***(ii)*** *Whether the provider or supplier has attempted to repay the debt (to the extent this can be determined).*
>
> ***(iii)*** *Whether the provider or supplier has responded to CMS's requests for payment (to the extent this can be determined).*
>
> ***(iv)*** *Whether the provider or supplier has any history of final adverse actions or Medicare or Medicaid payment suspensions.*
>
> ***(v)*** *The amount of the debt.*
>
> ***(vi)*** *Any other evidence that CMS deems relevant to its determination."*

What does this mean? Many home health agencies around the country have been subjected to postpayment audits by UPICs (or their predecessor contractors, ZPICs). Alleged overpayments in these cases have been as high as $10 million. As you are likely aware, the Medicare administrative appeals process used to appeal these alleged debts has been hopelessly overwhelmed by the appeal of alleged debts identified in audits by UPICs, ZPICs and RACs. From a practical standpoint, if your home health agency files for a hearing before an ALJ, it will be an average of 3.9 years before your case gets adjudicated.

Assuming that you haven't paid-off the alleged debt, while your administrative appeal is pending, CMS and its contractors will be required under the Debt Collection Improvement Act of 1996 (DCIA) to refer eligible delinquent debt to the Department of Treasury (Treasury) for collection or offset through the Treasury Offset Program (TOP). Upon receipt of the referral, Treasury or one of its contracted collection agencies will initiate proceedings to satisfy the alleged debt.

We can typically get Treasury to place its collection efforts on hold while an alleged Medicare overpayment is actively being appealed, Unfortunately, with the implementation of 42 C.F.R. §424.535(a)(17), CMS is now also able to revoke a home health agency's enrollment and Medicare billing procedures after referring an alleged debt to Treasury for collection.

VI. Responding to a Proposed Home Health Revocation Action:

We cannot overstate the seriousness of a home health revocation action. For most home health agencies, traditional Medicare is the largest payor, with Medicaid typically constituting the second-largest payor. From a practical standpoint, if your home health agency's Medicare enrollment and billing privileges are revoked, it will be difficult, if not impossible, for your company to remain solvent.

It is therefore crucial that you contact experienced health law counsel to represent you when you first receive notice of a revocation action. The appeals procedures followed in a revocation case is quite different from that employed in the appeal of a claim denial or an alleged overpayment. Liles Parker attorneys have extensive experience representing health care providers and suppliers in challenging the imposition of a Medicare revocation action. Is your home health agency facing revocation? **Give us a call for a free consultation. 1 (800) 475-1906.**

Robert W. Liles and the health lawyers at Liles Parker, Attorneys &

Counselors at Law have extensive experience representing health care providers and suppliers nationwide in Medicare revocation actions. Has CMS proposed that your enrollment and Medicare billing privileges be revoked? Give us a call for a free consultation. We can be reached at: 1 (800) 475-1906.

[1] The Final Rule under 42 C.F.R. §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).

[2] Two of the new reasons for revocation have not yet been announced. Placeholder slots remain open at 42 C.F.R. §424.535(a)(15) and (16).

[3] The definition of "operational" is set out at **42 C.F.R. §424.502**.

[4] For additional information, please see CMS guidance titled *"**Home Health Agencies (HHAs): Change of Address Notification of the Medicare Administrative Contractor (MAC**)."*

[5] See **42 C.F.R. §424.516(e)(2)**.

[6] The revocation reason ***"Abuse of Billing Privileges"*** was added to the existing list of revocation reasons that may be asserted by CMS effective February 3, 2015. 79 Fed. Reg. at 72,513 (adding paragraph (ii) to 42 C.F.R. § 424.535(a)(8)).

[7] While not explicitly stated, we suspect that this means that the so-called ordering physician had not billed Medicare for an Evaluation and Management (E/M) service in the course of caring for these 13 patients.

[8] Prior to the emergence of COVID-19, CMS had identified limited exceptions to this rule. For example, under Maryland law, a nurse practitioner can provide primary care services. Effective January 1, 2020, CMS allowed Medicare-enrolled nurse practitioners to certify home health services for Medicare beneficiaries as part of the Maryland Total Cost of Care (TCOC) Model. See **MLM Matters Number MM 11330**. Additionally, as provided Section 3708 of the CARES Act, CMS is temporarily allowing a Medicare-eligible home health patient to be under the care of a nurse practitioner, clinical nurse specialist, or a physician assistant who is working in accordance with State law (for Medicare claims with a "claim through date" on or after March 1, 2020). For additional information on the temporary regulatory waivers that CMS has implemented in response to COVID-19, see the agency's guidance entitled ***"Home Health Agencies: CMS Flexibilities to Fight COVID-19,"*** issued September 8, 2020.

[9] "*Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process*"

[10] See 42 C.F.R. §424.535(c)(1)(i).

[11] See 42 C.F.R. §424.535(c)(1)(ii).