What is a Medicare Suspension of Payment Action?

Keeping "bad actors" out of the Medicare program in the first place is the most effective way for the Centers for Medicare and Medicaid Services (CMS) to protect the financial integrity of the Medicare Trust Fund. Once a health care provider or supplier has been enrolled in the Medicare program, there are a number of program integrity measures (such as the administrative suspension of a provider's payments) that can be used CMS and its contractors to address improper, fraudulent or abusive conduct. Over the last decade, since the passage of the Affordable Care Act (ACA), **[1]** we have seen a significant increase in the number of suspension actions taken by CMS and Unified Program Integrity Contractors (UPICs) around the country.

I. Medicare Suspension of Payment Authorities:

Pursuant to 42 C.F.R. §405.371(a)-(c), Medicare payments to participating providers may be suspended, offset or recouped by CMS or one of its authorized contractors as follows:

- ***Payments may be suspended, in whole or in part, if:*** *(1)* CMS or the Contractor has reliable information an overpayment exists, or (2) Payments to be made may not be correct, although additional information may be needed for a determination; **[2]**
- ***Payments may be suspended, in whole or in part, in cases of suspected fraud if:*** *(1)* CMS or the UPIC has consulted with the Office of Inspector General (OIG) and, as appropriate, the Department of Justice (DOJ); and (2) it is determined that a *credible allegation of fraud exists* against a provider or supplier; unless (3) there is good cause not to suspend payments; **[3]**
- ***Payments may be offset or recouped, in whole or in part if:***CMS or the Medicare contractor has determined that the provider or supplier to whom payments are to be made has been overpaid. **[4]**

II. Medicare Suspensions of Payment Based on Credible Allegations of Fraud:

The ACA expanded the ability of the government to detect health care fraud and protect the Medicare Trust Fund. One such provision was the expansion of CMS's suspension authority to permit suspensions based on a ***"credible allegation of fraud."***

Not surprisingly, the vagueness and potentially broad scope of a standard based on a "credible allegation of fraud" has been an ongoing concern of many providers. Unfortunately, the definitions of this term with respect to the Medicare program is extraordinarily broad. **[5]** With respect to the Medicare program, a credible allegation is broadly defined to include an allegation from ***any source***, such as (1) Fraud hotline complaints; (2) Claims data mining; and (3) Patterns identified through provider audits, civil false claims cases and Law enforcement All allegations are considered to be credible when they have indicia of reliability.

III. CMS Takes a Broad View of What Constitutes a Credible Allegation of Fraud:

As set out under MPIM Section 8.3.1.1, the suspension of a Medicare provider's payments based on a credible allegation of fraud are not limited to merely traditional fact patterns associated with fraud. CMS also considers the following situations to constitute a credible allegation of fraud:

- ***The Quality Improvement Organization (QIO) has reviewed inpatient claims and determined that the diagnosis related groups (DRGs) have been***
- ***The UPIC or MAC may suspect a violation of the physician self-referral ban.***
- ***Even though services are rendered and may be determined as medically necessary and reasonable by the Medicare contractor, law enforcement has credible allegations of kickback***
- ***Forged signatures on medical record documentation and/or other misrepresentations on Medicare claims or associated forms to obtain payment that would result in an overpayment.*** **[6]**

IV. Prior Analysis by the OIG of Medicare Payment Suspension Actions Taken:

On November 1, 2010, the OIG released a report for CMS entitled "The Use of Payment Suspensions to Prevent Inappropriate Medicare Payments." **[7]** The goal of this report was to evaluate CMS's use of suspension actions taken in 2007 and 2008 and assess the agency's procedures for implementing payment suspension actions. The OIG analyzed 253 payment suspensions made over the course of two years. The OIG reported that the great majority of suspensions that took place between 2007 and 2008 "*exhibited characteristics that suggest fraud.*" In fact, payment suspensions taken during this period were almost all used "*as a tool to fight fraud.* " The OIG based this conclusion on the following information:

99% of suspension notices were sent to the provider on or after the effective suspension date, indicating that fraud was a consideration in the suspension action.

74% of suspended providers had questionable billing patterns, such as spikes in multiple claims submitted for the same beneficiary or extensive services provided within a very short time

63% of suspensions involved complaints or information from beneficiaries raising concerns about services they never received or that were medically unnecessary.

V. Medicare Suspensions of Payment Based on Overpayments Rather Than a Credible Allegation of Fraud:

Initially, quite a few suspensions were imposed on a credible allegation of fraud. However, over the past year, payment suspensions have primarily been based on overpayments rather than a credible allegation of fraud. Suspensions based on ***"reliable information"*** that an overpayment exists or that payments may not be correct are the most common situations where a suspension action is taken. The Medicare Program Integrity Manual (PIM) states that suspensions of this sort may be implemented include, but are not limited to, the following examples:

- **Where several claimed services in a prepayment or postpayment review were determined to be non-covered or miscoded;**
- **It has been determined that there is a pattern of noncompliant billings and it is suspected that there may have been a substantial number of additional non- covered or miscoded claims paid in the past;**
- **There was a pattern of noncompliant billings identified in a prior review and the provider failed to change its billing behavior [8]**

Payment suspensions based on this section are referred to the CMS Center for Program Integrity (CPI) for approval and can be made by CMS without consultation with law enforcement or any other agency. They can also be imposed without prior notice in order to prevent placing additional Medicare funds at risk and hindering the government's ability to recover any determined overpayment. **[9]**

VI. Good Cause Exceptions Applicable to Medicare Suspensions of Payment:

Suspension regulations are somewhat limited by what is referred to as the ***"good cause"*** exception. Even in cases involving credible allegations of fraud, CMS may continue payments if there exists some good cause for doing so. Examples of what constitutes "good cause" include:

- The possibility that payment suspension will alert a violator to an investigation or inquiry;
- The possibility that payment suspension will expose whistleblowers or confidential sources;
- Where payment suspension may jeopardize beneficiary access to necessary items or services;
- Where remedies other than payment suspension available to CMS are more expeditious or effective in protecting Medicare funds; or
- Where payment suspension would "not be in the best interests of the Medicare " **[10]**

VII. Initiation and Investigation of Medicare Suspension Actions:

Medicare payment suspension actions may be initiated in several different ways. However, most

suspension or recoupment actions are generated through one of the following sources:

- ***Referrals:*** A number of entities will refer matters for investigation that may lead to a suspension such as CMS, law enforcement and the Medicare Administrative Contractors (MACs). Leads based on beneficiary and provider complaints and hotline tips allegations can also lead to a suspension;
- ***Contractor data analysis*****:** Medicare Program Integrity Contractors conduct their own data analyses to identify providers with suspect billing patterns;
- ***Fraud Preventive System (FPS) Analysis:*** **[11]** The FPS is used to identify providers with suspect billing patterns and prioritizes leads based on provider risk-scores.

VIII. Medicare Suspension Process and Procedures:

Before sending a suspension notice to a provider, a UPIC must first provide CPI with a draft of the notice to be sent. In addition to their recommendation regarding the suspension action, a UPIC must also provide any other supportive materials for the consideration of the CPI. A draft suspension notice to a Medicare provider must include the following:

- ***The date the payment suspension action will be or has been imposed;***
- ***How long the suspension is expected to be in effect (NOTE: All payment suspensions shall be established in 180 calendar day increments);***
- ***The reason for suspending payment. (For fraud suspensions, the UPIC shall include the rationale to justify the action being taken);***
- ***In most notices, the UPIC shall identify and describe at least five example claims that are associated with the reason for the payment suspension, if available. The claim examples are to be the most current claims available unless otherwise directed by CMS. The notice shall only reference the example claim control number, the amount of payment, and the date of service;***
- ***The extent of the payment suspension (i.e., 100 percent payment suspension or partial payment suspension, where less than 100 percent of payments are withheld);***
- ***The payment suspension action is not appealable;***
- ***CMS/CPI has approved implementation of the payment suspension;***
- ***Documentation that the provider has been given the opportunity to submit a rebuttal statement within 15 calendar days of notification; and***
- ***An address for the provider to mail the rebuttal.*** **[12]**

IX. CMS's Role in Approving a Medicare Suspension Action:

Once the proposed suspension letter has been drafted, CMS will review it and determine whether or not to approve the proposed action. If approved, CMS must then decide whether the provider should be notified ***before*** or ***after*** the effective date of the suspension. If a provider is targeted for suspension because of fraud, deliberate misrepresentation, or harm to Medicare trust funds, then

the provider is almost always notified of the suspension on or ***after*** the effective date. Health care providers who are suspended for all other reasons are typically notified at least 15 days prior to the suspension taking effect. From a practical standpoint, almost all providers are notified of a suspension action after the effective date, not before.

The initial period of suspension can last for up to 180 days from the effective date and it can be extended for an additional 180 days if CMS requires additional time to calculate the overpayment amount. Prior notice of the suspension does not have to be given in order to prevent placing additional Medicare funds at risk and hindering the government's ability to recover any determined overpayment. *See* 42 C.F.R. § 405.372(a)(3).

X. Can You Appeal a Medicare Suspension Action?

Unfortunately, there is not an administrative appeals mechanism available for providers to challenge a Medicare payments suspension action. At most, a provider can submit a "rebuttal" letter to CMS detailing why the proposed suspension action should not take effect or should be lifted. A rebuttal letter must be submitted within 15 days of the suspension notice. CMS contractors will then review the provider's rebuttal, draft a response and submit the proposed response (along with the provider's rebuttal) to CMS for approval. It has been our experience that CMS rarely changes its position and cancels the planned suspension action.

XI. Length of a Medicare Payment Suspension Action:

The length of a payment suspension period is usually 180 days, but this can be extended under certain circumstances. For example, if a contractor is unable to complete an examination of the information submitted by a provider, or if DOJ is investigating criminal charges or civil actions, the suspension may be extended for 180 days. In addition, if OIG is considering administrative action, such as exclusion from participation in Medicare or the assessment of civil monetary penalties, then the s

XII. Lifting a Medicare Payment Suspension Action:

During the suspension period, CMS contractors will usually initiate a post-payment audit of the provider's claims and request that the provider submit any medical records and other information in support of the claims identified. A Medicare contractor (most often a UPIC) will then analyze these medical records in order to determine the amount of any improper payments made to the provider, including overpayments. Once the claims have been evaluated, the results of the post-payment audit will be sent to the provider. A provider's Medicare Administrative Contractor (MAC) will then issue a demand letter to the provider requesting a refund of any overpayment identified. Once the nature and extent of an overpayment has been identified, the suspension action is usually lifted (although it is not unusual for the provider to remain on prepayment review.

Health care providers may continue to submit claims during a suspension period, but payments for these claims will not be made until a UPIC can determine the nature and amount of any overpayment that may be owed by a provider. Any claims found to qualify for coverage and payment are usually used to offset the amount of any overpayment that is later determined by the auditing contractor. Excess funds are then distributed to the provider.

XIII. Recommendations for Providers:

Medicare payment suspensions can dramatically impact and disrupt a provider's health care practice in light of their potential length and the lack of meaningful appeal rights. As such, below are some recommendations for responding to suspension actions and/or for avoiding them if the first place:

A. Engage Experienced Legal Counsel. In light of both the seriousness and complexity presented, it is strongly recommended that providers facing a payment suspension action immediately engage experienced counsel. Regardless of the stated reason for a suspension action, Medicare contractors, OIG and DOJ are looking for fraud or deliberate misrepresentation whenever a suspension is imposed. Therefore, care should be taken to ensure that the rights of the health care provider and its staff are properly protected.

B. Submit a Rebuttal. The OIG report noted that only 16% of providers suspended between 2007 and 2008 submitted a rebuttal to the suspension notification. While a rebuttal does not guarantee that CMS will not proceed with the suspension, it does give the provider an opportunity to explain any of the potential mistakes or errors that drew the attention of CMS. Additionally, it is critical to keep in mind that suspension actions are ***not appealable***. Once a suspension is imposed, there is no recourse for the provider. A rebuttal is a provider's only opportunity to be heard prior to imposition of the suspension.

C. Timely Provide Medical Records When Requested by CMS. Once a suspension has been imposed, the contractor will request medical records from the provider in order to evaluate the related claims and the OIG report noted that suspensions were often extended beyond the initial 180-day time period for the provider's failure to timely submit medical records. It is possible that providers who comply with CMS medical records requests as soon as possible will see their cases resolved more quickly and their suspensions lifted without any extension. Additionally, providers should thoroughly organize medical records for complex cases so that CMS contractors can review the records most efficiently and therefore resolve the suspension action.

D. Credible Allegations of Fraud Can Originate from Practically Anywhere. It is important to keep in mind that the information upon which a "credible allegation" is based

can come from ***any source.*** This includes patients, employees, or other providers. Therefore, it is extremely important for providers to be conscientious so that their conduct does not give rise to any inferences of fraud.

NATIONWIDE REPRESENTATION Call: 1 (800) 475-1906.

Liles Parker attorneys and staff have extensive experience conducting these assessments. Our attorneys are both seasoned health care lawyers AND have undergone special training and education so that they could become Certified Professional Coders (CPCs), Certified Medical Reimbursement Specialists (CMRSs) and / or Certified Medical Compliance Officers (CMCOs). Questions? For a free consultation, give us a call. We can be reached at: 1 (800) 475-1906.

[1] Pub. L. No. 111-148, 124 Stat. 119 (2010).

[2] 42 C.F.R. §405.371(a).

[3] 42 C.F.R. §405.371(b).

[4] 42 C.F.R. §405.371(c).

[5] 42 CFR § 405.370(a) is the Medicare definition.

[6] See, Medicare Program Integrity Manual sections 8.3.1.1.

[7] *Dep't of Health & Human Servs., Office of Inspector Gen., Memorandum Report: The Use of Payment Suspensions to Prevent Inappropriate Medicare Payments,* Rep. No. OEI-01-09-00180 (Nov. 1, 2010). The OIG hasn't followed up this report with a more recent assessment of the suspension actions taken.

[8] See, Medicare Program Integrity Manual sections 8.3.1.2 and 8.3.1.3**.**

[9] 42 C.F.R. § 405.372(a)(3).

[10] 42 CFR § 405.371(b).

[11] FPS is a data analytic system implemented in 2011 by CMS. FPS compares provider billing patterns and other data against models of potentially fraudulent behavior to identify providers with

suspect billing for potential investigation. In developing these leads, FPS is intended to help CMS prevent potentially fraudulent payments by furthering the agency's ability to more quickly identify and investigate suspect providers and take corrective action.

[12] MPIM Section 8.3.2.2.2.