

Medicare Provider Enrollment: Strategies for Denials, Revocations and Appeals

Challenging Adverse Enrollment Determinations and Ensuring Billing Privileges Amid Expanded CMS Authority

THURSDAY, JANUARY 7, 2016

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

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ENROLLMENT REGULATIONS

- Section 1866(j) of the Social Security Act, enacted as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) directed HHS to adopt a regulatory process for Medicare enrollment
 - 4/21/2006, CMS published a final rule setting forth requirements for providers and suppliers to obtain and maintain billing privileges
 - Enrollment regulations codified in 42 C.F.R. Part 424, Subpart P
 - Regulations most recently updated on 12/5/2014, when CMS published a final rule expanding its ability to deny and revoke Medicare providers' and suppliers' Medicare privileges (the "2014 Final Rule")
 - The 2014 Final Rule became effective February 3, 2015.

2014 FINAL RULE

- 8 key provisions of the 2014 Final Rule:
 - Definition of enrollment
 - Debts to Medicare
 - Felony convictions
 - Abuse of billing privileges
 - Post-revocation submission of claims
 - Effective date of billing privileges
 - Effective date of re-enrollment bars
 - Corrective Action Plans (“CAPs”)

DEFINITION OF ENROLLMENT

- The 2014 Final Rule amended the CMS definition of enrollment codified at 42 C.F.R. §§ 424.502 and 424.510 to include actions of physicians and non-physician practitioners completing CMS Form 8550 solely to become eligible to order or certify items or services for Medicare beneficiaries
 - The prior version of the regulation encompassed only actions related to becoming eligible to obtain Medicare billing privileges

DEBTS TO MEDICARE

- Prior to the 2014 Final Rule, CMS had the authority to deny an enrollment application if the owner of an applying provider or supplier or physician or non-physician practitioner applicant had an existing “overpayment” of \$1,500 or more, which had not been repaid in full at the time of filing of an enrollment application.
 - Purpose was to address those situations where a provider or supplier incurred a debt to Medicare, exited the Medicare program, and then attempted to re-enroll via another business entity.

DEBTS TO MEDICARE

- CMS expressed concerns that the regulations:
 - Did not extend to situations in which an enrolling provider or supplier had a Medicare debt other than an “overpayment.”
 - Did not address situations in which an entity with which the enrolling provider, supplier or owner was affiliated incurred a Medicare debt and existed the Medicare program.

DEBTS TO MEDICARE

- In the 2014 Final Rule:
 - CMS replaced the term “overpayment” with the term “**debt**” in 42 CFR 424.530 (a) (6)
 - Regulations broadly define “**debt**” to include any financial obligation to the Medicare program, regardless of how it was incurred or discovered
 - CMS expanded its authority to deny an applicant’s enrollment application to include the situation where either the applicant or any entity (including a non-health care entity) related to the applicant has an outstanding debt.
 - The 2014 Final Rule did not grant CMS authority to revoke an existing Medicare provider’s or supplier’s privileges for incurring a debt to Medicare.

DEBTS TO MEDICARE

- Pursuant to 42 CFR 424.530 (a) (6), CMS may deny an enrollment application where:
 - An enrolling provider, supplier or owner was previously the owner of a provider or supplier with a Medicare debt in existence at the time its Medicare enrollment was voluntarily terminated, involuntarily terminated or revoked;
 - The owner became unassociated with the debtor entity within one year of the debtor's termination or revocation;
 - The debt was not repaid in full; and
 - CMS determines that the debt poses an undue risk of fraud, waste or abuse

DEBTS TO MEDICARE

- In determining whether an unpaid debt poses an undue risk of fraud, waste or abuse, CMS will consider:
 - The amount of the Medicare debt;
 - The length and timeframe that the enrolling provider, supplier or owner was an owner of the prior entity;
 - The percentage of the enrolling provider's, supplier's or owner's ownership of the prior entity;
 - Whether the debt is currently being appealed; and
 - Whether the enrolling provider, supplier or owner was an owner of the prior entity at the time the debt was incurred

In the commentary to the 2014 Final Rule, CMS assured providers and suppliers that it would "only exercise [its] discretion under § 424.530 (a) (6) in a careful and consistent manner." 79 Fed. Reg. at 72509.

DEBTS TO MEDICARE

- A Medicare applicant with an existing Medicare debt can avoid denial by repaying the debt in full or agreeing to a CMS-approved extended repayment schedule.

FELONY CONVICTIONS

- Prior to the 2014 Final Rule, 42 C.F.R. §§ 424.530 (a) (3) and 424.535 (a) (3) permitted CMS to deny or revoke a Medicare provider's or supplier's enrollment if, within the 10 years preceding enrollment or revalidation, the provider, supplier or any of its owners was convicted of certain enumerated federal or state felony offenses that CMS had determined to be detrimental to the best interests of the Medicare program and/or its beneficiaries
 - Examples included:
 - Financial crimes (extortion, embezzlement, income tax evasion)
 - Making false statements
 - Insurance fraud

FELONY CONVICTIONS

- Pursuant to the 2014 Final Rule, CMS's denial and revocation authority was expanded:
 - (1) CMS's denial and revocation authority expanded to situations in which a provider or supplier or any of its owners **or managing employees** were convicted of **any** felony.
 - In the commentary to the 2014 Final Rule, CMS attempted to assure that not every felony conviction would result in denial or revocation, but CMS also declined to exclude certain felonies from denial or revocation consideration and further declined to adopt regulatory language limiting its authority to felonies meeting a certain severity threshold.
 - (2) CMS clarified that it was permitted to deny or revoke Medicare privileges if the provider, supplier, owner or managing employee had been convicted of a felony within the preceding 10 years
 - (3) CMS clarified the definition of the term "**convicted**" has the same definition as set forth in 42 C.F.R. § 1001.2
 - Prior to the 2014 Final Rule, the term convicted was undefined.

ABUSE OF BILLING PRIVILEGES

- Prior to the 2014 Final Rule, 42 C.F.R. § 424.535 (a) (8) permitted CMS to revoke a Medicare provider's or supplier's billing privileges based on a finding that the provider or supplier had abused its billing privileges as follows:
 - 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:
 - Where the beneficiary is deceased.
 - The directing physician or beneficiary is not in the state or country when services were furnished.
 - When the equipment necessary for testing is not present where the testing is said to have occurred.

ABUSE OF BILLING PRIVILEGES

- The 2014 Final Rule added the following situation to 42 C.F.R. § 424.535 (a) (8):
 - Where the provider or supplier demonstrates a pattern or practice of billing for services that do not meet Medicare requirements such as, but not limited to, the requirement that the service be reasonable and necessary.

ABUSE OF BILLING PRIVILEGES

- CMS did not define the term “**pattern or practice**” in its regulations. Pursuant to CMS, “[W]e did not define ‘pattern or practice’ to maintain flexibility to address a variety of factual scenarios.” 79 Fed. Reg. at 72514.
- In an effort to avoid inconsistent application by CMS contractors, CMS (rather than its contractors) will make all determinations under § 424.535 (a) (8) (ii).

ABUSE OF BILLING PRIVILEGES

- CMS will consider the following 6 factors in determining whether a provider or supplier has abused its billing privileges:
 - (1) The percentage of claims denied.
 - *The proposed rule solicited comments regarding whether a minimum numerical or percentage threshold should be established and incorporated into the regulations; however, CMS declined to adopt such a threshold in the 2014 Final Rule*
 - (2) The reasons for the claim denials
 - (3) Whether the provider or supplier had a history of “final adverse actions” as defined by 42 C.F.R. § 424.502
 - (4) The length of time over which the pattern continued
 - (5) The duration of time the provider or supplier had been enrolled in Medicare
 - (6) Any other information CMS deems relevant

POST-REVOCACTION SUBMISSION OF CLAIMS

- Prior to the 2014 Final Rule, 42 C.F.R. 424.535 (h) limited revoked physician organizations', physicians', non-physician practitioners and IDTF's ability to submit claims for pre-revocation services rendered to 60 calendar days from the effective date of the revocation.
- In the 2014 Final Rule, CMS expanded 424.535 (h) to require **all** revoked providers and suppliers to submit claims for items and services rendered pre-revocation within 60 days of the effective date of the revocation
 - Revoked HHAs are required to submit all claims within 60 days of the later of (1) the effective date of the revocation; or (2) the final date of the HHA's last payable episode of care

EFFECTIVE DATE OF BILLING PRIVILEGES

- Prior to the 2014 Final Rule, 42 C.F.R. § 424.520 (d) established that, for *newly-enrolling physicians, non-physician practitioners, physician organizations and non-physician organizations*, the effective date of their billing privileges would be the later of
 - (1) the date a Medicare enrollment application was filed, if that application was subsequently approved or
 - (2) the date an enrolled physician or non-physician practitioner first began furnishing services at a new practice location.
- The 2014 Final Rule revised 42 C.F.R. § 424.520 (d) to include ambulance suppliers.

EFFECTIVE DATE OF RE-ENROLLMENT BARS

- When a Medicare provider's, supplier's, owner's or managing employee's privileges are revoked (for any reason other than failure to respond timely to a revalidation request or other request for information), a re-enrollment bar is instituted for a period of 1 to 3 years, based on the severity of the basis for revocation.
- Prior to the 2014 Final Rule, the effective date of any re-enrollment bar was either
 - (1) 30 days after CMS or the CMS contractor mailed its revocation determination; or
 - (2) the date that CMS or its contractor determined that a provider or supplier had been excluded for a federal exclusion or disbarment, felony conviction, license suspension or revocation, or if the practice location is found not to be operational.

EFFECTIVE DATE OF RE-ENROLLMENT BARS

- Due to concerns for situations in which delays in updating databases with criminal convictions and licensure actions led to abbreviated periods of revocation, the 2014 Final Rule revised 42 C.F.R. 424.535 (c) to specify that **all** re-enrollment bars would begin 30 days after CMS or its contractor mails a revocation determination to the provider or supplier.

CORRECTIVE ACTION PLANS

- Prior to the 2014 Final Rule, providers and supplier that received a Medicare revocation determination were permitted to submit a corrective action plan (“CAP”), unless the revocation was based on 42 C.F.R. §§ 424.535 (a) (2), (3) or (5).
- In its 2014 Final Rule, CMS revised 42 C.F.R. 405.980 to add a new paragraph (a) (1):
 - *“(a) a provider or supplier – (1) may only submit a corrective action plan for a revocation for noncompliance under § 424.535 (a) (1) of this chapter...”*



Application of the December 2014 Final Rule to Providers and Suppliers

1. Revocations for a pattern of abuse of billing privileges

- The final rule (both preamble and text) is explicit that CMS and not the contractors will make the revocation determination, but they continue to be issued by the contractors
- The rule is also explicit that whether privileges will be revoked will depend on an application of specified factors (see 424.535(a)(8)(ii) (A) – (F)) but notices are not indicating whether and how these factors were applied





Application of the December 2014 Final Rule to Providers and Suppliers

1. Revocations for a pattern of abuse of billing privileges
 - Contractors continue to issue revocations based on 424.535(a)(1) (“not . . . in compliance with the enrollment requirements described in this subpart P or in the enrollment application applicable for its provider or supplier type) for billing errors
 - Such revocations are erroneous. CMS itself recognized in the December 2014 rulemaking that it currently did not have the authority to revoke for billing errors except in narrow circumstances under 424.535(a)(8)(i) (“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’)





Application of the December 2014 Final Rule to Providers and Suppliers

1. Revocations for a pattern of abuse of billing privileges
 - DAB decision in *Proteam Healthcare, Inc.* (Sept. 28, 2015) holds that 424.535(a)(1) does not allow revocation based on incorrect claims
 - Since *Proteam*, contractors are reopening 424.535(a)(1) denials and converting them into 424.535(a)(8) (ii) denials
 - *But...* the (a)(8)(ii) denial is supposed to be made by CMS, and supposed to include a discussion of the factors.
 - *And* the revised revocation notice may include the revocation effective date from the previous determination based on (a)(1), which is improper.
 - Revised determination stands on its own, so revocation must be prospective under regulation





Application of the December 2014 Final Rule to Providers and Suppliers

2. Revocations based on felony conviction

- Prior to December 2014 final rule, only four specified types of felonies resulted in revocation
- Now, any felony conviction that CMS determines is “detrimental to the best interests of the Medicare program and its beneficiaries” is grounds for revocation
 - Does this standard provide fair notice to a provider or supplier that it/his/her conduct may result in revocation?
 - Language “CMS determines” implies that CMS and not the contractor must make determination, yet contractors are issuing determinations
 - Some contractors revoking based simply on a crime that is one of the four specified, with no weighing of facts and circumstances



Application of the December 2014 Final Rule to Providers and Suppliers



2. Revocations based on felony conviction

- Effective date of revocation is retroactive to date of conviction
 - This means that all claims billed and previously paid with DOS back to date of conviction will be reopened and payments recouped
 - Does this serve a valid purpose or is it just punitive?
 - OIG does not have authority to make retroactive exclusions
 - Given that PPACA requires Medicaid to revoke billing privileges when Medicare has, is there any functional difference between a Medicare revocation of billing privileges and an exclusion from Federal health care programs (chiefly Medicare and Medicaid, plus TRICARE)?
 - Because revocation is not automatic, and because there is no time limit for CMS to make revocation determination, provider or supplier is left hanging as to whether to continue to see Medicare and Medicaid patients





Application of the December 2014 Final Rule to Providers and Suppliers

3. Retroactive Revocations and the Prohibition on Retroactive Rulemaking

- December 2014 final rule states “These regulations are effective on February 3, 2015,” but what does that mean?
- *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204 (1984) provides that absent specific Congressional authorization, agencies may not issue rules with retroactive effectiveness
- Suppose some or all of the billings at issue in a revocation based on a pattern of abuse occurred prior to February 3, 2015





Application of the December 2014 Final Rule to Providers and Suppliers

3. Retroactive Revocations and the Prohibition on Retroactive Rulemaking

- Suppose revocation is based on a felony conviction but conviction predates February 3, 2015
 - ALJ decision in *Derm One, PLLC*, CR 2355 (Apr. 12, 2011) held that because at the time of conviction (2008) regulations allowed revocation based only on felony conviction for financial crime, petitioner's revocation, based on regulation change effective January 1, 2009, was impermissibly retroactive
- Suppose revocation is based on a felony conviction and conviction postdates February 3, 2015, but conduct predates February 3, 2015



Application of the December 2014 Final Rule to Providers and Suppliers

4. Effect on Revoked Provider or Supplier

- If individual whose billing privileges are revoked due to adverse activity (sanction, exclusion, or felony) is an owner of an enrolled provider or supplier, that provider or supplier will also have its billing privileges revoked
 - If individual is divested of ownership interest w/in 30 days of revocation notice, entity can have its billing privileges reinstated and retroactively so
 - Workaround – individuals enrolled in Medicare under the 855I can bill on their own and then turn proceeds over to revoked entity
 - Example: Dermatology Group is revoked based on felony conviction of owner Dr. A. Drs. B, C and D may continue to bill Medicare in their own names and receive payment and turn over receipts to Dermatology Group





Application of the December 2014 Final Rule to Providers and Suppliers

4. Effect on Revoked Provider or Supplier

- Revocation is based on the NPI, so if entity is revoked it may apply for and be enrolled under a new NPI/new entity
 - Example: ABC LLC, a DMEPOS supplier, is revoked for being non-operational. The owners of ABC form a new entity, that would supply DMEPOS, XYZ LLC. If XYZ meets all the requirements for a DMEPOS supplier, it will be enrolled notwithstanding the common ownership of ABC and XYZ
- Revocation is based on the NPI, so a revoked physician may provide services to Medicare beneficiaries as a locum tenens physician, because services will be billed under the billing number/NPI of the “permanent” physician
 - There are specific rules for duration and circumstances of locum tenens arrangements





Application of the December 2014 Final Rule to Providers and Suppliers

4. Effect on Revoked Provider or Supplier

- Physician or qualifying NPP may opt out of Medicare
 - Program instructions provide that even excluded physicians/NPPs can opt out of Medicare
 - No limit as to how much an opt-out physician or NPP can charge beneficiary
 - Opt-out is for a 2-year period
 - Specific rules on opting out at 42 CFR 405.400 et seq, and Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, section 40 et seq.
 - Opt out rules do not allow a physician or NPP to sign a private contract for emergency or urgent care services, but instead must bill Medicare (405.440), so does this mean a revoked physician who has opted out may bill Medicare for urgent care/emergency services?



Application of the December 2014 Final Rule to Providers and Suppliers

4. Effect on Revoked Provider or Supplier

- Providers and suppliers may continue to treat Medicare patients (despite recent statement to the contrary by CMS, which has been retracted)
- Providers and suppliers may also bill Medicare, but claims will bump up against an edit and be rejected
 - If provider or supplier later wins appeal, does timely filing limit in 424.44 apply, and if so, how does provider or supplier prove that claims were timely filed if they were initially rejected and contractor has no record of them having been filed?
 - Does exception in 424.44(b) for governmental error apply, and if so, is the 4-year limitation in 424.44(b)(5) valid?



Application of the December 2014 Final Rule to Providers and Suppliers



4. Effect on Revoked Provider or Supplier

- Physician and NPPs will lose ability to order and refer for items and services to a Medicare beneficiary
 - This because physician or NPP must be enrolled via the 8550 in order to order and refer
 - Workaround: Have another physician or NPP who is enrolled via the 8550 order and refer. That physician or NPP takes responsibility for medical necessity of such items or services



Reconsideration Appeals

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- 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

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Key Considerations

- 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
- Timing issues
 - ▣ Revocation becomes effective 30 days after the date of revocation notice
 - ▣ Provider likely to be revoked while reconsideration appeal is pending review

Reconsideration Appeals

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- Revocations based on billing for deceased beneficiaries (424.535(a)(8)(i))
 - *This revocation authority is not intended to be used for **isolated occurrences or accidental billing errors**. Rather, this basis for revocation is directed at providers and suppliers who are **engaging in a pattern of improper billing**. 73 Fed. Reg. 36488 at 36455*
 - *...[CMS] will not revoke billing privileges under § 424.535(a)(8) unless there are multiple instances, at least three, where abusive billing practices have taken place. Id.*
 - *In considering whether to revoke enrollment and billing privileges in the Medicare program, we would consider the severity of the offenses, mitigating circumstances, program and beneficiary risk if enrollment was to continue, possibility of corrective action plans, beneficiary access to care, and any other pertinent factors. 71 Fed. Reg. 20754 at 20761*
- Applicability of above language to revocations under §424.585(a)(8)(ii)?

Reconsideration Appeals

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- Submit a detailed position paper
 - ▣ If revocation is claim based (e.g., claims submitted for deceased beneficiaries), provide a clear and detailed explanation for each claim at issue
 - Show why claim was billed appropriate
 - Demonstrate a mere accidental billing mistake
 - Example: service rendered to alive beneficiary but inadvertently billed to deceased beneficiary with the same name
 - GOAL: minimize the number of “abusive” claims cited in the revocation notice

Reconsideration Appeals

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- Submit a detailed position paper (continued)
 - Severity of offense
 - Accidental/isolated occurrences (e.g., 10 claims identified over 3-year period)
 - Mitigating circumstances
 - Was payment ever received?
 - Claim corrections?
 - Beneficiary access to care
 - Provider/supplier specialty?
 - Number of similar provider types within geographic area?
 - Quality of care
 - Supporting affidavits from peers and/or institutions
 - Excessive re-enrollment bar
 - The regulations provide for re-enrollment bars between one (1) and three (3) years, ***“depending on the severity of the basis for revocation.”*** 42 CFR 424.535(c)

Reconsideration Appeals

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- 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
- Effects of Medicare revocation beyond the Medicare program
 - Commercial payor contracts
 - Managed care contracts
 - Medicaid enrollment
 - Staff privileges for physicians

Corrective Action Plans

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- 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
- 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

ALJ Appeals

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- 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 pertaining to abuse of billing privileges, 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)

ALJ Appeals

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ALJ case excerpts

- The statements in the preamble, however, are an articulation of enforcement policy rather than a rule establishing essential elements that must be proven to uphold a revocation under section 424. 535(a)(8). . . . CMS's decision to revoke billing privileges is, after all, discretionary. Louis J. Gaefke, D.P.M., DAB No. CR2785 (2013)
- Petitioner does not dispute that he submitted claims that identified individuals who were deceased at the alleged time of service, but he argues that the claims at issue were “submitted in good-faith as a result of an inadvertent clerical billing error,” and that Petitioner did not receive any Medicare payments for the improper claims. Petitioner also explains that he provided services to individuals with similar names to the deceased individuals identified in the claims he submitted. However, the general nature of the billing errors — that is, whether they were accidental or not — is not material to the outcome of the case. The plain language of the regulation applicable in this case does not necessarily require a “pattern of improper billing,” which derives solely from the preamble, nor does it expressly exclude clerical billing errors as a basis for revocation. Patrick Brueggeman, D.P.M., DAB No. CR4422 (2015)
- I must sustain CMS's determination and may not second guess CMS's judgment if a legitimate basis for the revocation exists and where the facts established noncompliance with one or more of the regulatory standards at the time of the revocation. ASAP Home Oxygen, Inc., DAB No. CR2364 (2011)
- ...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)

ALJ Appeals

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Key Considerations

- ▣ ALJs may give minimal consideration, if any, to the enforcement policy language contained in the preamble, including:
 - Whether the improper claims were the result of accidental billing mistakes
 - Mitigating circumstances
 - Excessiveness of the re-enrollment bar
- ▣ Aim to win appeal at the reconsideration level where a wider range of factors may be taken into account by the decision maker to overturn the revocation

Departmental Appeals Board Appeals

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- Any party (i.e., CMS, Medicare contractor, or provider) dissatisfied with an ALJ's decision may file a written request for review by the DAB within 60 days of the ALJ decision
- Standard of review
 - ▣ Disputed factual issue: whether the ALJ decision is supported by substantial evidence in the record as a whole
 - ▣ Disputed issue of law: whether the ALJ decision is erroneous.
 - ▣ The bases for modifying, reversing or remanding an ALJ decision include the following:
 - A finding of material fact necessary to the outcome of the decision is not supported by substantial evidence
 - A legal conclusion necessary to the outcome of the decision is erroneous
 - The decision is contrary to law or applicable regulations
 - A prejudicial error of procedure (including an abuse of discretion under the law or applicable regulations) was committed

Federal Court Appeals

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- A provider dissatisfied with a DAB decision may seek judicial review by timely filing a civil action in a United States District Court within 60 days from receipt of the DAB decision
- Standard of review
 - ▣ The Secretary's findings as to any fact, if supported by substantial evidence, shall be conclusive, and must be upheld if a reasonable mind, reviewing the evidence in the record as a whole, could accept it as adequate to support his conclusion
 - ▣ Questions of law are reviewed de novo
- 42 U.S.C. § 405(g) limits judicial review to a “final decision” of the agency
 - ▣ Requires exhaustion of administrative remedies

Federal Court Appeals

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- Causes of action
 - Violation of regulation
 - Violation of statute
 - Due process arguments
 - Temporary restraining orders

Thank You

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