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Compliance: Learn These Factors That Could Put You On The Recalcitrant Provider List

Your appeals success rate may save your bacon.

If your MAC and CMS agree that you fit the recalcitrant provider definition, the results will be dire.

The **Centers for Medicare & Medicaid Services'** newly articulated recalcitrant provider policy sets out civil money penalties and exclusion as punishments for providers that fit the definition. Exclusion is a harsh measure that equals a shut-down, points out attorney **Robert Markette Jr**. with **Hall Render** in Indianapolis. CMPs could have the same effect, depending on their magnitude.

CMS has shown a greater willingness than before to use exclusion, Markette says. So don't be surprised to see the penalty used liberally for recalcitrant providers.

Medicare Administrative Contractors should use these factors to identify recalcitrant providers for referral to the CMS Regional Office, CMS says in Change Request 8394:

- The provider being considered for referral by the Medical Review Unit should not be under any fraud investigation by the Program Safeguard Contractor (PSC)/Zone Program Integrity Contractor (ZPIC) or active with the **HHS Office of Inspector General**; and
- The provider is currently on prepayment medical review, has been educated and continues to show a pattern of inappropriate behavior (do not include providers who are demonstrating improvement, however slight, as a result of education); and

The contractor demonstrates the administrative burden (i.e., volume and dollars of claims being manually reviewed, volume and dollars of claims/services being denied, and associated resource costs); and

- The appeal history of denied claims indicate a low reversal rate (exclude potential case if claims have a high reversal rate); and
- The Medical Director concurs with the medical review determinations and is aware that he/she may be a potential witness.

In deciding whether to approve a MAC's request to classify a provider as recalcitrant, CMS will consider these questions and topics:

- What are the specific medically unnecessary services/items or non-covered services being provided and billed;
- What are the grounds for these services/items being medically unnecessary or covered;
- What education was provided to the provider to inform and correct the provider's pattern of inappropriate behavior;
- A description of the pattern of inappropriate behavior, including how the provider continued to provide medically unnecessary services/items or non-covered services after explicit education from the contractor;
- Appeal history (through ALJ level); and
- Availability of "Expert" witnesses being prepared to testify if necessary (Medical Director).

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