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Eli's Hospice Insider

Fraud & Abuse: Watch For New Ways To Yank Your Medicare Billing Privileges

Providers may live in fear of arbitrary decision-making by CMS.

Take extra care with your billing accuracy, or the feds could use a new rule to shut down your Medicare reimbursement.

New fraud rules "strengthen oversight of Medicare providers and protect taxpayer dollars from bad actors," says **Centers for Medicare & Medicaid Services** Administrator **Marilyn Tavenner** in a release. "These new safeguards are designed to ... remove providers with patterns or practices of abusive billing."

The changes will "revoke enrollments of providers and suppliers engaging in abuse of billing privileges by demonstrating a pattern or practice of billing for services that do not meet Medicare requirements," CMS says in the release about the rule released Dec. 3. "CMS has demonstrated that removing providers from Medicare has a real impact on savings."

Big problem: The major risk to you in this proposal is that it fails to spell out in sufficient detail what kinds of billing will result in revocation, notes Washington, D.C.-based health care attorney **Elizabeth Hogue**. "This is not only worrisome, it is downright scary," Hogue warns.

Under this rule, CMS could use any billing pattern it doesn't like to shut you down, fears attorney **Robert Markette Jr**. with **Hall Render** in Indianapolis. "The government is saying, 'trust us, it's going to be OK,'" Markette tells **Eli**. "But it's never OK."

Home care has been repeatedly identified as a fraud risk area by CMS, the **HHS Office of Inspector General**, and other authorities, Markette notes. HHAs may have a target on their backs when it comes to using this new authority from the Afford-able Care Act.

Learn These 6 Factors Before It's Too Late

CMS does spell out six factors it will use when considering whether it should revoke a provider's billing privileges (see story, p. 6). It uses five of the six factors it previously proposed, plus a new one suggested by commenters.

Booted: CMS decided not to finalize the factor "total number of claims denied," as it proposed, because the measure "could present a distorted view of the provider or supplier's billing practice," CMS concedes in the final rule published in the Dec. 5 Federal Register.

Adopted: CMS agrees with commenters' suggestion to include "any other information regarding the provider or supplier's specific circumstances" (see story, this page, for full language of the new factor).

"We recognize that there may be special circumstances surrounding the provider or supplier's non-compliant billing that are beyond the scope of the five factors we are finalizing," CMS acknowledges in the rule. To effectively address situations that vary widely, "we believe that a sixth criterion should be established that enables CMS to consider any other applicable and available information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination of a pattern or practice of non-compliant billing. ... (S)uch information ... should be considered ... to help ensure that the Medicare Trust Funds are protected and, by the same token, that providers and suppliers are treated fairly."

HHAs Face Heightened Risks Under Rule

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While it's helpful for CMS to spell out what factors it uses in the revocation decision, the lack of specifics for the factors make them unhelpful, Markette says.

For example: CMS says it will consider the percentage of claims denied, but it doesn't spell out what benchmark would throw up a red flag or cause revocation, Markette points out.

Without those specifics, CMS is free to make arbitrary decisions based on these factors, Markette worries.

The same goes for the other measures based on numbers length of time the problem has gone on and the provider's length of enrollment.

CMS responds to this concern in the rule. "Numerical thresholds should not be established because we need the flexibility to address a myriad of scenarios," the agency contends. "Each case must be judged on its own specific facts, and establishing numerical thresholds would, we believe, hinder our ability to do so."

But this leaves HHAs having no idea what will put them in the danger zone, Markette criticizes.

CMS also takes on the criticism that the new rule is arbitrary. "We do not believe that our proposal is arbitrary or grants CMS unlimited discretion," the agency responds in the rule. "To the contrary, ... we were very clear in the preamble of the proposed rule that sporadic billing errors would not result in revocation" under the new rule. "Although we did not define 'pattern or practice' to maintain flexibility to address a variety of factual scenarios, we listed several factors that would be considered in our ... determinations," CMS continues. "Additionally, not only will CMS (rather than its contractors) make all such determinations, but also [revocation] will be applied only: (1) in situations where the behavior could not be considered sporadic; and (2) after the most careful and thorough consideration of the relevant factors."

The problem is that claims denials frequently are incorrect, Hogue and Markette worry. Both attorneys cite instances of perfectly legit claims that were denied due to medical reviewer error. Denials like those may add up to an agency finding itself under scrutiny for revocation, based on a shadowy benchmark figure.

"Once you are tagged for scrutiny, it's an uphill battle" to get out from under the microscope, Hogue observes.

Note: The rule is at https://federalregister.gov/a/2014-28505.

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