Responding to Medicare Contractor Audits and Investigations

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Presented By:

Kimberly Brandt
Chief Oversight Counsel
United States Committee on Finance
Washington, D.C.

Lester J. Perling, Esq., CHC
Partner
Broad and Cassel, Fort Lauderdale, FL

This presentation will cover:

- Audits and Investigations (contractors who perform them and the scope of their authority);
- What providers should expect when going through audits and investigations;
- Overpayment appeals process;
- Strategies for providers.
Disclaimer & Fine Print

The comments expressed by Kimberly Brandt are her own opinions and ideas, and do not reflect the opinions of the Senate Finance Committee or Senator Orrin G. Hatch.

Audits and Investigations
Who Is Performing These Audits?

- Medicare Administrative Contractors (MACs)
- Recovery Audit Contractors (RACs)
  - Medicare RACs & Medicaid RACs
  - DME, Home Health and Hospice RAC
- Zone Program Integrity Contractors (ZPICs)
- Comprehensive Error Rate Testing (CERT)
- Supplemental Medical Review Contractor (SMRC)
- Unified Program Integrity Contractors (UPICs)
- Office of Inspector General (OIG) audits

MACs: Brief Overview

- MACs are private companies that serve as contractors performing claims administration for Medicare Part A and Part B.
  - 12 Contracts for Parts A and B.
- MACs analyze claims to determine provider compliance with Medicare coverage, coding, and billing rules and take appropriate corrective action when providers are found to be non-compliant.
MACs: Brief Overview (Cont.)

- MACs have the option of performing prepayment or postpayment review of claims submitted by new providers as needed.
  - MACs have the authority to review any claim at any time; however, they should focus their efforts on error prevention. (MPIM, Ch. 3.2.1).
- MACs enroll health care providers in the Medicare program and educate providers on Medicare billing requirements.

MACs: Brief Overview (Cont.)

- Historically, CMS used the "pay and chase" model – paying claims before investigating if those claims were proper.
- In 2011, CMS announced it would use predictive modeling in an attempt to move away from the "pay and chase" model, but still timely pay proper claims.
  - Using risk scoring technology to identify fraud using real-time data before the claim is paid.

MACs: Progressive Corrective Action The Process

- For each provider identified as "at risk", the potential error is validated with prepayment or postpayment probe review of generally 20-40 potentially erroneous claims.
- The error is categorized as either minor, moderate or major concerns. Examples:
  - Minor: provider with a low error rate and relatively low financial impact. Education and collection of overpayment would be sufficient.
  - Moderate: provider with a low error rate, but substantial financial impact. Prepayment review would be tracked and adjusted or eliminated according to provider's response.
  - Major: provider with a high error rate (generally 20% or greater) and no mitigating circumstances. This would call for stringent administrative action, including possible payment suspension or referral to the ZPICs.

RACs: Brief Overview

- RACs detect and correct past improper payments so that CMS and MACs can implement actions that will prevent future improper payments.
- Four Regions.
- Fifth region coming: will cover the entire country's home health and hospice providers.
What do RACs do?

- The Recovery Audit Review Process:
  - RACs review claims on a post-payment basis
  - RACs use the same Medicare policies as MACs: NCDs, LCDs and the CMS Manuals
  - Three types of review:
    - Automated (no medical record needed)
    - Semi-Automated (claims review using data and potential human review of a medical record or other documentation)
    - Complex (medical record required)
  - Recovery Audits look back three years from the date the claim was paid.

RACs: The Collection Process

- Same as for MAC identified overpayments (except demand letter comes from the RAC).
  - Carriers, FIs and MACs issue Remittance Advice
    - Remark Code N432: Adjustment Based on Recovery Audit
  - MAC recoups by offset unless provider has submitted a check or a valid appeal
RACs: Differences in Review

- RAC issues the Demand Letter
- Outside the normal appeals process, RACs offer a means to discuss the improper payment determination with the provider
- Each RAC posts "CMS approved issues" on its website, which puts the industry on notice before performing a widespread review

ZPICs: Brief Overview

- ZPICs investigate instances of suspected fraud, waste, and abuse, to ensure Medicare Trust Fund monies are not inappropriately paid.
- They also identify any improper payments that are to be recouped by the MAC.
- 7 ZPIC zones
ZPICs: Brief Overview (Cont.)

- Actions that ZPICs take to detect fraud include:
  - Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement;
  - Performing medical review, as appropriate.
  - Performing data analysis in coordination with CMS' Center for Program Integrity Fraud Prevention System.
  - Referring cases to law enforcement for consideration and initiation of prosecution.
  - Referring cases to the OIG, regardless of dollar thresholds or subject matter.

ZPICs: Brief Overview (Cont.)

- In performing these functions, ZPIC may:
  - Request medical records and documentation;
  - Conduct an interview;
  - Conduct an onsite visit;
  - Identify the need for prepayment or auto-denial edit and refer these edits to the MAC for installation;
  - Withhold payments; and
Referral Standard to other Agencies

- PIM, chapter 4, sections 4.18ff, 4.19ff, 4.20ff
- ZPICs shall identify cases of suspected fraud and make referrals to the OIG, regardless of dollar thresholds or subject matter.
- Documented allegations pertaining to:
  - Provider, beneficiary, supplier or other subject
  - Engaged in a pattern of improper billing
  - Submitted improper claims with suspected knowledge of their falsity
  - Submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity
- OIG has 90 days to accept the case; refer the case to DOJ or reject the case
- If OIG does not respond, ZPIC may refer the case to the FBI
- ZPICs shall alert and coordinate with OIG, FBI, and civil and criminal divisions in the US Attorneys Office of contemplated suspensions, denials, and overpayment recoveries where there is evidence of fraud and a referral is pending to one of those agencies.
  
  Program Integrity Manual, Chapter 4, Section 4.18

OIG Action

- OIG normally takes the one of the following actions to investigate a case:
  - Conduct a criminal and/or civil investigation
  - Refer the case back to the ZPIC for administrative action/recovery of overpayment either after an investigation or with no further investigation
  - Refer the case back to the ZPIC for administrative action/recovery after consulting with DOJ
  - Refer the case to another law enforcement agency for investigation
Immediate OIG referral

▪ ZPIC will immediately advice the OIG telephonically if it receives evidence of one of the following:
  □ Government contractor employee fraud
  □ Cases involving an informant that is an employee or former employee of the suspect physician or supplier
  □ Involvement of providers who have prior convictions for defrauding Medicare or who are currently under investigation by OIG
  □ Cases that are likely to get widespread publicity
  □ Allegations of kickbacks or bribes
  □ Allegations of a crime by a federal employee

CERT Contractor

▪ Measures "improper" payments in the Medicare fee-for-service program.
▪ Selects a stratified random sample of 40,000 Part A and Part B claims each reporting period.
▪ Two Contractors: Documentation and Review.
▪ Overpayments recouped/underpayments paid
Supplemental Medical Review Contractor

- Conducts nationwide review as directed by CMS.
- Parts A and B and DME providers selected by CMS.
- Compliance with coverage, coding payment and billing practices.
- Vulnerabilities identified by CMS internal data, analysis, CERT audits, professional organizations and federal oversight agencies, e.g. OIG.

UPICs: Brief Overview

- CMS has plans to establish UPICs to reorganize and consolidate the work of the Medicaid Integrity Contractors (MICs) and the Medicare Zone Program Integrity Contractors (ZPICs).
  - CMS expects contracts with the ZPICs and MICs to end once UPICs are implemented to specific geographic regions.
- This will bring further consolidation and increased claims data transparency and availability to integrity contractors.
  - More and improved surveillance.
  - Increased potential for government scrutiny of claims payments by federal healthcare programs.
What Will UPICs Do?

- UPICs will perform many of the functions currently contracted to ZPICs and MICs.
  - CMS will provide UPICs with a centralized case management capability, centralized data, and some centralized analytic capability.
- They will perform data analysis and data matching activities on, Medicare-only claims, Medicaid-only claims, and Medicare-Medicaid claims.
- Contracts are projected to be awarded in the third quarter of FY 2015
- UPICs will likely not be operational before 2016

CMS Contractor Access to Information

- The Medicare Program Integrity Manual, CMS 100-08, Ch. 3.1 authorizes MACs to analyze claims to determine provider compliance with Medicare coverage, coding, and billing rules, and take appropriate corrective action when providers are found to be non-compliant.
- Once a MAC has initiated pre-payment or post-payment review, the MAC may request additional documentation (authorized under 42 U.S.C. 1395l, 1395g generally).
- MACs may also request documents from third-parties, including the treating physician, even if the services are being billed by another provider/supplier (PIM Ch. 3.2.3).
CMS Contractor Access to Information

- ZPIC reviews are similar to MAC pre- and post-payment review.
- But, they also have a variety of unique and powerful tools at their disposal.
- For example, in addition to review of claims submitted, ZPICs may (PIM Ch. 4.7.1):
  - conduct telephone interviews of beneficiaries;
  - review fraud and abuse history;
  - perform data analysis of the provider’s claims data;
  - conduct and review telephone calls and written questionnaires of physicians;
  - perform random validation of physician licensure;
  - review certificates of medical necessity (CNMs);
  - perform analysis of procedures and items based on frequency and cost;
  - perform analysis of local patterns/trends of practice/billing against national and regional trends, beginning with the top 30 national procedures for focused medical review and other kinds of analysis that help to identify cases of fraudulent billings; and,
  - initiate “other analysis enhancements to authenticate proper payments.
- If there appears to be a pattern of fraudulent behavior, the ZPIC in coordination with other enforcement agencies will determine whether or not an investigation should be developed for possible referral to the OIG or DOJ.

Exclusion for Noncompliance

- Conviction relating to obstruction of an investigation or audit (42 U.S.C. § 1320a-7(b)(2); 42 C.F.R. § 1001.301) The OIG may exclude “any individual that interferes with or obstructs an investigation relating to (1) any offense [warranting a mandatory exclusion]; or (2) the use of funds received, directly or indirectly, from any Federal health care program.” 42 U.S.C. § 1320a-7(b)(2).
- Length of Exclusion. An exclusion imposed in accordance with this section will be for a period of three years, unless aggravating or mitigating factors form the basis for lengthening or shortening that period. 42 C.F.R. § 1001.301(b)(1).
Exclusion for Noncompliance

- **Failure to supply payment information (42 U.S.C. § 1320a-7(b)(11); 42 C.F.R. § 1001.1201)** Any individual . . . furnishing, ordering, referring for furnishing, or certifying the need for items or services for which payment may be made under subchapter XVIII of this chapter or a State health care program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary or that agency as may be necessary to verify such information." 42 U.S.C. § 1320a-7(b)(11).

- **Length of exclusion.** There is no minimum period of exclusion. The following factors will be considered in determining the length of an exclusion under this section: (i) the number of instances where information was not provided; (ii) the circumstances under which such information was not provided; (iii) the amount of the payments at issue; (iv) whether the individual or entity has a documented history of criminal, civil or administrative wrongdoing (the lack of any prior record is to be considered neutral); and (v) the availability of alternative sources of the type of health care items or services provided by the individual entity." 42 C.F.R. § 1001.1201(b).

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Exclusion for Noncompliance

- **Failure to grant immediate access (42 U.S.C. § 1320a-7(b)(12)).** The Secretary may exclude any physician that fails to grant immediate access, upon reasonable request to:
  - The Secretary, or to the agency used by the Secretary for the use of State agencies to determine compliance by providers of services with conditions of participation or payment;
  - The Secretary or the State agency, to perform the reviews and surveys required under State plans;
  - The Inspector General of the Department of Health and Human Services, for the purpose of reviewing records, documents, and other data necessary to the performance of the statutory functions of the Inspector General; or
  - A State Medicaid fraud control unit.

- **Length of Exclusion.** "An exclusion of an individual under this section may be for a period equal to the sum of: (i) The length of the period during which the immediate access was not granted, and (ii) An additional period of up to 90 days." 42 C.F.R. § 1001.1301(a). The exclusion of an entity may be for a longer period than the period in which immediate access was not granted based on consideration of the following factors-- (i) The impact of the failure to grant the requested immediate access on Medicare or any of the State health care programs, beneficiaries or the public; (ii) The circumstances under which such access was refused; (iii) The impact of the exclusion on Medicare, Medicaid or any of the other Federal health care programs, beneficiaries or the public; and (iv) Whether the entity has a documented history of criminal, civil or administrative wrongdoing (The lack of any prior record is to be considered neutral)." 42 C.F.R. § 1001.1301(b)(2).
Revocation for Noncompliance

- Revocation of Medicare Enrollment (42 C.F.R. § 424.535(a)(10)) *Failure to document or provide CMS access to documentation.*
  - (i) The provider or supplier did not comply with the documentation or CMS access requirements specified in § 424.516(f) of this subpart (which pertains to DMEPOS, clinical laboratory, imaging services, or covered ordered/certified home health services);

  *Revocation period.* Subject to revocation for a period of not more than 1 year for each act of noncompliance.

Use of Statistical Sampling

- Contractors use statistical sampling in retrospective audits to determine overpayments
- Prerequisite under the Medicare Act, Regulations and Guidance:
  - A Medicare contractor may not use extrapolation to determine an overpayment unless documented educational intervention has failed to correct the payment error, or there is a sustained or high level of payment error.
Use of Statistical Sampling, cont.

- A sustained or high level of payment error may be determined to exist through a variety of means, including, but not limited to:
  - Error rate determinations by Medical Review (“MR”) unit, Program-Safeguard Contractor (“PSC”), Zone Program Integrity Contractor (“ZPIC”) or other area;
  - Probe samples;
  - Data analysis;
  - Provider/Supplier history;
  - Information from law enforcement investigations;
  - Allegations of wrongdoing by current or former employees of a provider or supplier;
  - Audits or evaluations conducted by the OIG.

Overpayment Determination

- If a contractor determines an overpayment exists, the provider will receive a Demand Letter
- Provider may respond by:
  - Submitting a check
  - Submitting a rebuttal
  - Undergo the recoupment process
  - Appeal
- Medicare Financial Management Manual, Chapter 3 (Overpayments)
Recoupment

- If the provider does not pay the overpayment stated on the Demand Letter in full within 40 calendar days of the date of the Demand Letter, the overpayment will be "recouped" from current payments due or from future claims submitted.
- If the debt is not paid or recouped within 60 days and no appeal is pending, an "Intent to Refer" letter will be sent, meaning the contractor may refer the debt to the Department of Treasury for offset or collection.
- There are extended repayment plan options.
- Recoupment can be stopped by initiating a valid and timely appeal.

Overpayment Appeals
**Rebuttal**

- The provider may submit a rebuttal statement to the demand letter within 15 calendar days from the date of the demand letter.
- The rebuttal will lay out why Medicare should not initiate recoupment.
  - The reasons should be other than a disagreement over the overpayment assessment.
- A rebuttal statement is *not* an appeal.
- 42 CFR 405.373; 405.375.
- Medicare Financial Management Manual, Chapter 3, Section 200.1.2

**Appeal**

Administrative Appeals Process:

- Redetermination: 42 C.F.R. §§ 405.940, 948:
  - Contractor independent review of the initial determination.
- Reconsideration by a Qualified Independent Contractor (QIC): 42 C.F.R. § 405.904.
- ALJ Hearing. 42 C.F.R. § 405.1000.
- Medicare Appeals Council:
  - A *party* to the ALJ hearing may submit a request for review of the ALJ’s decision by the Medicare Appeals Council of the Departmental Appeals Board (MAC). 42 C.F.R. §§ 405.1100, 405.1102.
- Judicial Review (United States District Court).
Limitation on New Issues

- No new issues may be raised by contractors at redetermination or reconsideration when appealing post-payment audit. Can only address original denial reason.
- Applies to redetermination and reconsideration requests received after August 1, 2015.
- CMS recommends sending audit results with

Audit & Appeal Fairness, Integrity, and Reforms in Medicare Act of 2015 (AFIRM)

June 4, 2015 – Senate Finance Committee passed AFIRM.

Purpose:
- Seeks to increase coordination and oversight of government audit contractors while implementing new strategies to address growing number of audit determination appeals that delay taxpayer dollars from reaching the correct source.

December 8, 2015 – Chairman Hatch
AFIRM of 2015

Proposed Changes

1. Improve oversight capabilities for HHS/CMS that increase the integrity of the Medicare auditors and claims appeals process.

2. Coordinate efforts between auditors and CMS to ensure that all parties receive transparent data regarding audit practices, improved methodologies, and new incentives/disincentives to improve auditor accuracy.

3. Establish voluntary alternate dispute resolution.

4. Ensure timely and high quality reviews, raise amount in controversy for review by an ALJ to match amount for review by District Court.

5. Allow for use of sampling and extrapolation, with the appellants consent, to expedite the appeals process.
AFIRM Praised in D.C. Court of Appeals

• *American Hospital Association, et al., v. HHS*

• **Main dispute:** To “force” HHS to work more quickly through a buildup of findings by Medicare’s RACs.

• Lower court dismissed the case in December 2014 – Stating that the delay in the RAC process wasn’t “unreasonable enough”.

On February 9, 2016, a three-judge panel reversed. 41

AFIRM Praised in D.C. Court of Appeals

• “Moreover, the Senate is considering a bill known as the “AFIRM Act,” which would provide $125,000,000 in additional annual funding for OMHA, as well as other reforms to the appeal process designed to address the backlog...If enacted, this legislation might go some way toward resolving the problems.” 42
Strategies for Providers

Limits and Waiver of Recovery for Overpayments

- If the contractor concludes an overpayment has been made to a provider, the provider will be liable unless the carrier determines it is "without fault" with respect to the overpayment.
- If the contractor finds the provider is without fault, the provider is relieved of the liability for the overpayment.

- Appeals Council consistently find that a provider has actual or constructive knowledge of non-coverage through CMS notices, including:
  - Program manuals
  - Bulletins
  - Other written guides or directives from Medicare contractors

- See In the Case of Barnes Healthcare Services, 2013 WL 7094069 (H.H.S.) ("Council concurs with the ALJ's determination that the appellant knew or should have known that payment would not be made for the equipment provided to the beneficiary because the appellant did not demonstrate that it was medically reasonable and necessary.").
Statistical Sampling

• Burden of Proof
  □ Provider/supplier must set forth specific arguments that demonstrate that the flaws in the methodology were so significant as to render the overpayment arbitrary and capricious
    - MAC has repeatedly acknowledged CMS Ruling 86-1, which states that the use of statistical sampling 'creates a presumption of validity as to the amount of an overpayment which may be used as the basis for recoupment'
    - Burden shifts to provider to take next step
  □ No generally accepted principles of statistical sampling:
    □ Medicare Appeals Council of the Departmental Appeals Board ("MAC") and federal courts have held that there is no formal

Statistical Sampling Issues Subject to Challenge

• Sample size;
• Representativeness of sample;
• Randomness of sample;
• Documentation provided to support sampling;
• Precision of overpayment.
**Payment Suspension**

The withholding of approved Medicare payment amount while a CMS contractor reviews previously paid claims to determine the existence and amount of an overpayment or until resolution of credible allegation of fraud.

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**CMS Suspension Trends**

- In 2007 and 2008, CMS implemented 253 suspensions
  - 85% were Part B providers
  - 79% were providers located in FL, CA, MI, and PR
  - Overpayments totaled over $206 million
- 2013 – 297 suspensions implemented
- 2014 – 507 suspensions implemented
Grounds for Suspension

- “Reliable information” exists of a past or imminent overpayment
  - Examples of reliable evidence:
    - Unusual billing patterns identified through audits, FCA cases, data mining
    - Statements of patients, employees as to fraudulent activity
- See 42 C.F.R. § 405.371(a)(1)

Grounds for Suspension

- Suspension may be imposed if there is a “credible allegation of fraud”
- Exception: “good cause” exists NOT to suspend
  - Suspension would compromise investigation
  - Beneficiary access problems
  - Other remedies would be more effective
  - Not in best interests of the program
Suspension Procedures (§ 405.372)

- Notice requirements
  - Suspensions can be imposed with or without prior notice
- Opportunity to rebut
- Cannot appeal imposition of a payment suspension; may appeal only the resulting overpayment determination

Duration of Suspension

- If based on reliable evidence of overpayment
  - Initial period is 180 days
  - “One-time only” extension of 180 days if unable to complete investigation during initial 180-day period
  - OIG/DOJ must submit extension request to CMS
Duration of Suspension

- If based on credible allegation of fraud
  - Every 180 days, CMS must reevaluate whether good cause exists NOT to continue the suspension
  - No longer than 18 months, unless
    - Case referred to OIG for admin action
    - DOJ requests continuation based on anticipated filing of criminal or civil action

Appealing Medicare Revocations

- Step 1: Submission of Corrective Action Plan (CAP)
- Step 2: Reconsideration
- Step 3: ALJ review
- Step 4: Departmental Appeal Board
- Step 5: U.S District Court review
Appealing Medicare Revocations

Corrective Action Plan (PIM, Ch. 15.25(B))
- CAPs are available to providers in limited circumstances to correct the situation leading to the revocation of its billing privileges. “The CAP process gives a supplier an opportunity to correct the deficiencies (if possible) that resulted in . . . the revocation of its billing privileges.”
- The CAP must:
  - Contain at a minimum, verifiable evidence that the supplier is in compliance with Medicare requirements;
  - Be submitted within 30 days from the date of the revocation notice;
  - Be submitted in the form of a letter that is signed by the individual supplier, the authorized or delegated official, or a legal representative; and,
  - Be based only the following types of noncompliance:
    - Noncompliance with enrollment requirements;
    - Not submitted a plan of corrective action under Part 488 (survey/certification provisions); or
    - Failed to pay any user fees under Part 488;
- CAPs cannot be appealed.

Request for Reconsideration (42 C.F.R. § 498.22)
- If a provider is dissatisfied with the initial [revocation] determination may request reconsideration by filing the request:
  - With CMS or the State survey agency;
  - Directly through its legal representative or authorized official; and
  - Within 60 days from receipt of the notice of the initial determination
- Content of Reconsideration:
  - State the issues, or findings of fact and reasons for disagreement;
  - the request must be submitted in the form of a letter that is signed and dated by the supplier/provider or its legal representative.
- Effect of the reconsideration decision:
  - A reconsidered determination is binding unless CMS further revises the revised determination, or if the revised determination is reversed or modified by a hearing determination. See 42 C.F.R. § 498.25(b)(1)-(2).
Appealing Medicare Revocations

ALJ Hearing (42 C.F.R. § 498.40)

- “A [provider] may file a request for a hearing with the ALJ office identified in the determination letter.” 42 C.F.R. § 498.40(a)(1)
- “The affected party or its legal representative or other authorized official must file the request in writing within 60 days from receipt of the notice of initial, reconsidered, or revised determination unless that period is extended in accordance with paragraph (c) of this section.” 42 C.F.R. § 498.40(a)(2).
- “The request for hearing must – (1) identify the specific issues, and the findings of fact and conclusions of law with which the affected party disagrees; and (2) specify the basis for contending that the findings and conclusions are incorrect.” 42 C.F.R. § 498.40(b).

The ALJ will issue a decision “no later than the end of the 180-day period beginning from the date the appeal was filed with an ALJ.” 42 C.F.R. § 498.79

Appealing Medicare Revocations

DAB Appeal (42 C.F.R. § 498.80)

- Either of the parties has a right to request Departmental Appeals Board review of the ALJ's decision or dismissal order, and the parties are so informed in the notice of the ALJ's action."
  - Any party that is dissatisfied with an ALJ's decision or dismissal of a hearing request, may file a written request for review by the Departmental Appeals Board.” 42 C.F.R. § 498.82(a)(1).
  - “The requesting party or its representative or other authorized official must file the request with the OHA within 60 days from receipt of the notice of decision or dismissal, unless the Board, for good cause shown by the requesting party, extends the time for filing.
  - “A request for review of an ALJ decision or dismissal must specify the issues, the findings of fact or conclusions of law with which the party disagrees, and the basis for contending that the findings and conclusions are incorrect.” 42 C.F.R. § 498(b).
- Effect of DAB Decision - Binding unless the supplier timely files a civil action in the United States District Court; or the Board reopens and revises its decision in accordance with 42 C.F.R. § 498.102.
Appealing Medicare Revocations

Judicial Review in U.S. District Court (42 C.F.R. § 498.95)
- Any affected party that is dissatisfied with a Departmental Appeals Board decision and is entitled to judicial review must commence civil action within 60 days from receipt of the notice of the Board’s decision.
- This is the final step in the administrative appeal process.

Medicare Revocations Generally

- 42 C.F.R. § 424.535(a):
- CMS may revoke a currently enrolled provider or supplier’s Medicare billing privileges and any corresponding provider agreement or supplier agreement for noncompliance.
- Not in compliance with Medicare Requirements. 42 C.F.R. § 424.535(a)(1):
  “The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section or in the enrollment application applicable to its provider or supplier type, and has not submitted a plan of corrective action as outlined in 42 C.F.R. § 488”. 42 C.F.R. § 424.535(a)(1).
- Noncompliance includes failure to furnish complete and accurate information and all supporting documentation within 60 calendar days of provider’s notification from CMS or its contractor to submit an enrollment application and supporting documentation, or resubmit and certify the accuracy of its enrollment information or the provider does not otherwise meet general
Medicare Revocations Generally

A provider can also be revoked for:

- **Abuse of Billing Privileges** (42 C.F.R. § 424.535(a)(8)) - “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.”

- **Non-Compliance with Documentation Requirements** (42 C.F.R. § 424.535(a)(10)) – Provider failed to maintain and provide access to documentation (42 C.F.R. § 424.526(f)).

- **Improper Prescribing Practices** (42 C.F.R. § 424.535(a)(14)) - CMS may revoke a physician if it determines that the physician or eligible professional has a pattern or practice of prescribing Part D drugs that is abusive or represents a threat to the health and safety of beneficiaries, or where the prescribed drugs are not indicated for the diagnosis (among other reason).

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Know Your Resources

- **MAC General Information:**

- **RAC General Information:**

- **ZPIC General Information**

- **Medicare Internet-Only Manuals:**

- **Appeals Timeline:**
For more information, please contact:

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<tr>
<th>Name</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kimberly Brandt</td>
<td><a href="mailto:Kim_Brandt@finance.senate.gov">Kim_Brandt@finance.senate.gov</a></td>
<td>202.224.4515</td>
</tr>
<tr>
<td>Lester J. Perling, Esq., CHC</td>
<td><a href="mailto:lperling@broadandcassel.com">lperling@broadandcassel.com</a></td>
<td>954.764.7060</td>
</tr>
</tbody>
</table>

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ATTORNEYS AT LAW