Morgan Lewis

FAST BREAK: MEDICARE SUSPENSIONS

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Agenda

1. Medicare Suspension Basics

2. Preparing for a Suspension

3. The Rebuttal Process

4. After the Suspension

SUSPENSION BASICS

What is a Medicare Suspension?

- A Medicare payment suspension is a program integrity enforcement action that CMS or a Medicare contractor (MAC/UPIC) may use when either determines that a Medicare provider may be committing fraud or has received an overpayment
- Regulatory provisions exist at 42 C.F.R. § 405.370-375
- Suspends all Medicare payment to the provider/supplier
- Typically runs for 180 day period and often extended for at least one additional 180 day period

Medicare Suspension Effect

- When a provider or supplier receives a Medicare payment suspension, payments to the provider/supplier are stopped on the effective date of the suspension

- However, the provider/supplier is still able to submit claims to the Medicare program; these claims are adjudicated in the normal course

- Paid claims are placed into a suspension account controlled by the Medicare contractor; when the suspension is lifted, any funds left in these accounts (**minus any overpayments**) are released to the provider/supplier

Medicare Suspension Bases

- Two basic reasons that suspensions occur:
  - CMS or MAC/UPIC "possesses reliable information" that an overpayment exists or that Medicare payments "to be made may not be correct"
  - CMS or MAC/UPIC has determined that "credible allegations of fraud" exist
- Extremely broad authorities
- Suspensions may also be initiated if cost reports or hospice cap reports are not timely filed, but not routinely used

What Constitutes a "Credible Allegation of Fraud"?

- The "Credible Allegation of Fraud" standard was added by the Affordable Care Act in 2010

  – In rulemaking, CMS indicated that allegations are considered to be "credible" when they have "indicia of reliability" and that each allegation needs to be reviewed on a case-by-case basis

> *"We continue to believe that CMS or its contractors must review all allegations, facts, and information carefully and act judiciously on a case-by-case basis when contemplating a payment suspension, mindful of the impact that payment suspension may have upon a provider."*

What Constitutes a "Credible Allegation of Fraud"?

- The definition of "credible allegation of fraud" includes allegations of any source, including:

1. Fraud hotline complaints.

2. Claims data mining.

3. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

PREPARING FOR A SUSPENSION

Preparing for a Suspension

- Unfortunately, there is little that can be done to prepare for a suspension, other than having an extensive cash reserve set aside

- Suspensions can be implemented either with or without prior notice, but in nearly every instance, MACs/UPICs implement the suspension without prior notice

- However, if a provider/supplier has recently received a probe audit (5-10 claims), this is the type of audit from which a suspension generally arises

Preparing for a Suspension

- Proactive compliance efforts are the best – perhaps only – remedy to reduce suspension risk
  - Active auditing efforts
  - Monitoring of government-identified risk areas
  - Attention to employee compliance concerns

REBUTTAL

Rebuttals

- Medicare rules permit a suspended provider/supplier to submit a rebuttal as to why the suspension should not go into effect or be withdrawn
  - If prior notice is given, rebuttal must be submitted within 15 days of notice
  - If no prior notice, no timeframe for submission of rebuttal

- Rebuttal allows provider/supplier to provide pertinent information about why the suspension should be removed
  - Beneficiary access
  - Harm to the program
  - Inaccuracy of initial MAC/UPIC review

Rebuttals

- Pertinent contractor must respond to a rebuttal within 15 days of the submission of the rebuttal
- The response must contain "specific findings" of the suspension and an "explanatory statement of the determination"
- Ultimately, the MAC/UPIC's determination is **not appealable**
- In practice, most responses to rebuttals uphold the suspension
  - Can be circular in analysis of the basis of suspension

AFTER THE SUSPENSION

During the Suspension

- The purpose of the suspension is to protect Medicare funds while an investigation is ongoing or the MAC/UPIC is working to determine what funds are due the provider/supplier
- After the suspension is implemented, typically the MAC/UPIC will request an additional set of records to validate their initial findings
  - Typically an SVRS sample that will be extrapolated
- Approximately 5 months after the suspension, the MAC/UPIC must petition CMS for an extension of time; routinely granted

During the Suspension

- While the suspension is in place, Medicare funds continue to accrue to the provider/supplier's suspension account
  - Depending on size and type of provider, this account can exceed millions of dollars
- Holding claims?

After the Suspension

- Typically, after MAC/UPIC has completed additional investigation/review, it will release the suspension simultaneous with its investigation findings

- Under suspension rules, when the suspension is lifted, the suspended payments are first applied to reduce or eliminate any Medicare overpayments identified in the investigation, and then applied to any other obligations the provider/supplier may owe to CMS or HHS

- If any additional amounts are left over, that excess is released to provider/supplier

- The provider/supplier can pursue any identified overpayments through the Medicare administrative appeals process

After the Suspension

- As an example:

A provider receives a suspension on January 1, 2020. On January 15, 2020, the UPIC submits a request for an additional 30 patient records. The UPIC reviews these additional records while the provider continues to submit bills and have claims "paid." The UPIC then extends the suspension on July 1, 2020. On July 30, 2020, the value of the provider's suspension account is $3 million. On that day, the UPIC asserts an overpayment of $5 million. All $3 million in the suspension account and the suspension is lifted. The provider then has an outstanding liability to CMS of $2 million.

Thanks!

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Jacob Harper advises stakeholders across the healthcare industry, including hospitals, health systems, large physician group practices, practice management companies, hospices, chain pharmacies, manufacturers, and private equity clients, on an array of healthcare regulatory, transactional, and litigation matters. His practice focuses on compliance, fraud and abuse, and reimbursement matters, self-disclosures to and negotiations with OIG and CMS, internal investigations, provider mergers and acquisitions, and appeals before the PRRB, OMHA, and the Medicare Appeals Council.

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"*Fast Break*: COVID-19"

Featuring Jake Harper

- Thursday April 2, 3:00 PM (EST)