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Case Shows Strong Link Between Enrollment Errors and Recoupment

A federal appeals court has upheld Medicare's recoupment of two years of payments to a Florida medical group based on its sin of omission on an enrollment application.

On Aug. 19, the U.S. Court of Appeals for the 11th Circuit ruled in favor of HHS, which had recouped $311,263 from Florida Medical Center of Clearwater (FMC). The court ruled that HHS appropriately took back payments it made to a provider based on misleading information on the medical group's Medicare enrollment form. But it wasn't all smooth sailing for HHS, as the three-judge appeals panel agreed with the provider on one key point.

The case illustrates the link between the enrollment process and overpayment determinations. When providers and suppliers make mistakes or omissions in the enrollment process, they may face a big payback to Medicare.

At the heart of the case is physician Surindar Bedi. After Bedi's conviction and incarceration for a program-related crime, the HHS Office of Inspector General threw him out of Medicare under its mandatory exclusion authority. Bedi apparently has not yet been reinstated, according to the OIG exclusion website.

Majority Owner Was Excluded From Medicare

While still excluded from Medicare, Bedi became president and 51% owner of FMC, a position he held between 1996 and 1998. But when Aaron Stuart, the officer manager and 24% owner of FMC, submitted a Medicare enrollment application, he listed himself as the sole owner "and failed to disclose both Bedi's controlling ownership interest and his position as president of FMC."

When he was president and majority owner, Bedi was not involved in FMC's daily operations and didn't treat any of its patients or order or prescribe services. In 1998, he sold his shares. Three years later, the Florida Medicare carrier asserted that FMC was overpaid $311,263, saying it was ineligible for payment between 1996 and 1998, when Bedi, an excluded provider, was majority owner.

FMC appealed to an administrative law judge (ALJ), who upheld the recoupment because OIG intended to impose a mandatory exclusion on FMC (in addition to Bedi) and because FMC's "misrepresentations and omissions on its enrollment application rendered it ineligible for Medicare payments." FMC appealed to the Medicare Appeals Council, which denied review, and then to the U.S. district court, which affirmed HHS's recoupment. So FMC appealed to the second-highest court in the land.

The appeals court agreed with FMC that the ALJ was wrong to uphold the recoupment based on the supposed mandatory exclusion facing FMC. Only Bedi — not FMC — was subject to mandatory exclusion. FMC faced Medicare exclusion only through OIG's permissive exclusion authority. OIG has the discretion to throw entities out of Medicare if, for example, they are controlled by "a sanctioned individual" (e.g., someone with a direct or indirect ownership or control interest of 5% or more in the entity). FMC does not appear on OIG's exclusion website.

Enrollment Information Was Erroneous

However, the appeals court upheld the Medicare recoupment for a different reason cited by the ALJ and district court: FMC misled CMS on its enrollment application.

"CMS is taking provider enrollment very seriously," says San Francisco attorney Judy Waltz, with Foley & Lardner. There has been a lot of recent activity in this area. CMS on Aug. 20 issued Transmittal 350, which requires Medicare contractors to notify CMS when they revoke providers' and suppliers' billing numbers. CMS will then notify state Medicaid agencies and Children's Health Insurance Plans so they can dump them as well.

In June CMS set in motion the process to communicate terminations (including those resulting from billing privileges revocations) between the federal and state governments *(RMC 6/28/10, p. 1)*, but the transmittal makes it part of the Medicare manual (i.e., CMS policy).

There are 10 grounds for revocation of billing privileges, according to a 2006 regulation. For example, the provider or supplier no longer meets CMS regulatory re-

quirements for the specialty for which it has been enrolled; put misleading information on the enrollment application; was convicted of a crime; "fails to furnish complete and accurate information and all supporting documentation within 30 calendar days of the provider or supplier's notification from CMS to submit an enrollment application and supporting documentation"; or lost its license.

"They sort of snuck up on us," Waltz says. Some lawyers say some of their clients have lost billing privileges for relatively trivial reasons.

At the same time, CMS is "revalidating" — which means re-enrolling — hundreds of Part A providers who enrolled before 2003, Jim Bossenmeyer, director of the CMS division of provider and supplier enrollment, tells *RMC*. Medicare contractors are verifying and updating enrollment information, but hospitals (and other Part A providers) can take the initiative and re-enroll themselves.

Providers can re-enroll using Form CMS 855 or enter data on the Internet-based Provider Enrollment Chain and Ownership System (PECOS), CMS's national repository of enrollment information. Even when providers send in a paper form, their data get entered into PECOS by Medicare contractors, Bossenmeyer says. "The hospital doesn't do the work, but it still winds up in PECOS and gets transferred to claims processing systems to make sure we are making correct payments," he notes.

The reason for revalidation, he says, is to ensure CMS has complete, accurate information on all providers and suppliers, such as hospital ownership information. Correct enrollment information improves accuracy.

"Compliance is an important issue to us," Bossenmeyer says, noting that providers should study the PECOS "Getting Started" guide on the Internet if they go the electronic route. Hospitals also should "be cognizant of their reporting responsibilities to Medicare and report changes in ownership in the proscribed time frames," he says. Changes in ownership or control of providers and suppliers should be reported to CMS within 30 days. Hospitals and other providers that use the 855A form must provide certain information from both the seller and buyer.

Contact Waltz at jwaltz@foley.com. To learn about PECOS, visit www.cms.gov/medicareprovidersupenroll and look for the tab on the left side that says "Internet-based PECOS," and select "Getting Started Guide for Organizations." ✧