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CMS Caps Payment Suspensions at 18 Months, Leaves Door Open for Extensions

CMS can suspend payments to providers for 18 months if there is a "credible allegation of fraud," according to a new regulation finalizing screening and enrollment measures from the health reform law. The 18-month cap is one of the changes CMS made to the payment suspension and other key program-integrity provisions first spelled out in September *(RMC 9/27/10, p. 1)*. Under limited circumstances, CMS could extend the suspension beyond 18 months.

While a cap is better than an indefinite payment suspension, 18 months is still a long time to withhold Medicare reimbursement to providers when it may turn out they are not guilty of anything, says San Francisco attorney Judy Waltz, with Foley & Lardner LLP. "Suspending payments is such a business breaker."

Sec. 6402(h) of the health reform law allows CMS to suspend Medicare payments to a provider when there is a credible allegation of fraud unless there is "good cause not to suspend payments." Suspension of payments means shutting down some or all of a provider's Medicare cash flow.

According to the regulation, a "credible allegation of fraud" means "an allegation from any source," including hotline complaints, claims data mining, provider audits, civil False Claims Act accusations and investigations. "Allegations are considered to be credible when they have indicia of reliability," the rule states, which will be determined on a case-by-case basis. When decoding a credible allegation of fraud, CMS must consult with OIG and, if appropriate, DOJ. Notwithstanding credible fraud allegations, CMS can skip payment suspensions if there's good cause (e.g., if the suspension would endanger beneficiary access or it would alert the target of an investigation).

The proposed rule did not cap the length of payment suspensions. CMS just stated that it would end payment suspensions when a fraud investigation is resolved by settlement, judgment or dismissal, or when the case is closed because of lack of evidence. In the proposal, every 180 days CMS planned to assess whether there was justification to continue suspensions.

The final rule, however, established boundaries. Payment suspensions must end after 18 months, unless either of two extenuating circumstances apply: (1) the case is being considered by OIG for administrative action, or (2) DOJ requests an extension of the payment suspension based on an ongoing investigation "and anticipated filing of criminal and/or civil actions or based on a pending criminal and/or civil action," the regulation states.

Waltz notes that while OIG and DOJ will give their input, CMS makes the ultimate decision about whether there is good cause to impose a payment suspension. "I think that's important because CMS is in a better position to assess whether payment should be suspended," she says. But she's concerned that providers could actually face endless payment suspensions while a fraud investigation is pending because the latter trumps the former.

Her impression comes from language in the final regulation, where CMS seems to talk from both sides of its mouth. "If the payment suspension is based on credible allegations of fraud, CMS and its contractors will take subsequent action to determine if an overpayment exists or if the payments may be made, however the termination of the suspension and the issuance of a final determination notice to the provider or supplier may be delayed until resolution of the investigation. At the end of the fraud investigation, it is possible that the Medicare contractor will not have completed its overpayment determination, but will have reliable evidence of an overpayment or will have evidence that the payments to be made may not be correct. This typically occurs when a law enforcement investigation results in civil or criminal resolution prior to the Medicare contractor having had sufficient time to complete its overpayment determination. In such a situation, we would allow the suspension to continue as an overpayment suspension," according to CMS.

Waltz says CMS seems to be saying that providers could finish their credible-allegation-of-fraud suspension and then face a new suspension.

The regulation also finalizes CMS's new enrollment-risk hierarchy. The health reform law enhances CMS's procedures for keeping bad apples out of Medicare and Medicaid. Sec. 1866(j)(2)(B) requires CMS and OIG to screen provider categories according to the level of fraud-and-abuse risk they pose. The proposed regulation set forth three risk levels — limited, moderate and high — and assigned provider/supplier types to

each. Screening gets progressively more intense as the risk grows. For example, hospitals are in the limited category and therefore subject to certification of Medicare-specific screening requirements license verification and assorted other checks (e.g., Medicare exclusion).

The final rule pretty much sticks to this, but there is a bit of retooling. For example, under the proposed rule, only newly enrolling home health agencies and durable medical equipment, prosthetics and orthotics suppliers (DMEPOS) were in the high-risk category — but CMS exempted them if they were publicly traded on the New York Stock Exchange or NASDAQ. CMS eliminates that distinction in the final rule, including all HHAs and DMEPOS.

Also, providers and suppliers can be shifted to the high-risk category if, during the previous decade, they have been thrown out of Medicare or had their billing privileges revoked. The final rule adds another reason to raise the alert level: if providers or suppliers have been subject to any final adverse action as defined at Sec. 424.502 (e.g., revocation or suspension by an accreditation organization; state license revocation or suspension), they can be moved from the low or medium-risk categories to high-risk.

The final rule also adds portable X-ray suppliers to the moderate screening level.

The regulation — called the Medicare, Medicaid and CHIP Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers — takes effect March 23. Its publication date is not clear, but it will be available at www.archives.gov/federal-register/news.html.

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