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When MDs Can't Bill, Medicare Won't Pay Hospitals, but Screening Isn't Available

Hospitals may be blindsided by revocations of physicians' Medicare billing privileges, which means the services that these physicians perform, order and refer are not billable to Medicare. Physicians who fail to report certain events — mundane or serious — to Medicare may have their billing privileges taken away, but there is no routine way for hospitals to find out when that happens.

It may come as a surprise to some hospitals that physicians sacrifice their billing privileges and enrollment for failing to notify Medicare within 30 days of "adverse" actions, including license suspensions, as well as changes in practice locations, says San Francisco attorney Judy Waltz, with Foley & Lardner LLP. Physicians themselves may not be forthcoming, because they didn't realize their reporting obligations or didn't honor them. Whatever the reason, hospitals are at risk of losing Medicare revenue if services were ordered, referred or performed by physicians in provider-based clinics or hospital services were ordered or performed by independent physicians — and any one of them had privileges yanked.

"There are serious economic and professional consequences for revocation of billing privileges and it's almost impossible to find out who lost privileges," says Jim Sheehan, former federal prosecutor and New York state Medicaid Inspector General. CMS has new methods to sniff out physicians who lose their Medicare billing privileges, but there's no database that hospitals can use to check for billing revocations like the HHS Office of Inspector General's List of Excluded Individuals and Entities. "This should be available to everyone," says Sheehan, now executive deputy commissioner of the New York City Human Resources Administration.

CMS's view is that physicians whose billing privileges have been revoked are not authorized to order or refer patients for Medicare items or services, such as diagnostic tests, Waltz says. "It's pretty scary what CMS can do under these authorities to oust providers and suppliers from Medicare participation," she says. "Probably the only place that hospitals can get this information is from physicians themselves. Hospitals may need to take actions that will put doctors on notice that they expect reports on events which may impact Medicare and Medicaid billing privileges, and require physicians to regularly confirm their 'good-standing' status in government programs — in the bylaws and in policies and procedures requiring such reports."

Even physicians who aren't Medicare participating providers are affected. The Affordable Care Act required them to enroll in Medicare "for the sole purpose of ordering/ referring items or services for Medicare beneficiaries" using the 855o form, according to CMS.

Recently, one hospital was surprised to find that a physician had lost his license months earlier but didn't tell Medicare, according to the compliance officer, who asked not to be identified. "The 855i enrollment form requires that a provider needs to notify Medicare within 30 days of any adverse legal action including licensure suspension," the compliance officer says. "If a hospital has an employed physician, it has liability."

Even though suspension of a medical license itself is grounds for termination of Medicare billing privileges, failure to report extends the time of disenrollment. If physicians lose their license for a few months and are forthcoming with Medicare, they can reapply and may resume billing quickly when their license is reinstated. But failing to report almost guarantees a one-to-three year revocation plus a re-enrollment waiting period. And if all physicians have to disclose is a change of address, there are no consequences when the required information is updated on time — except the dire ones associated with failing to report it, which can include a retrospective disenrollment and resulting overpayment, Waltz says.

Revocations Are a Sleeper Risk

All of this goes to show that revocations are a sleeper risk of provider enrollment, which is already a hotbed of Medicare program integrity activity. And they can be the domino that leads to a provider's downfall.

"For failure to report, the Medicare billing privileges can be lost. For revocation of the billing privileges, the chance to order or refer was lost, as well as participation in Medicaid in that state. For loss of Medicaid enrollment in one state, there is supposed to be reciprocal loss of Medicaid enrollment in all other states. And ultimately, a career can be lost," Waltz says.

CMS now requires most health care organizations to re-enroll in Medicare every five years. That means filling out the 855 form, and thanks to a 2011 regulation spelling out a provision from the health reform law, coughing up more information about owners, managers and board members *(RMC 11/7/11, p. 1)*.

When information changes, providers must promptly update their 855 forms. Mistakes or intentional omissions may be penalized with revocation of Medicare billing privileges and loss of enrollment status. For example, physicians, nonphysician practitioners and nonphysician practitioner organizations have 30 days to inform their Medicare administrative contractor of (1) a change of ownership; (2) an adverse legal action (e.g., licensure suspensions or revocations); or (3) a change in practice location.

There's a good chance that CMS will know quickly when providers should have reported something to their Medicare contractors. "The government has reported it is doing data mining on a weekly basis," Waltz says. As part of its national Fraud Prevention System (FPS), which uses predictive modeling to identify improper payments in fee-for-service Medicare, CMS has tasked zone program integrity contractors (ZPICs), its fraud and abuse hunters, with more administrative actions, such as revocations of Medicare billing privileges. "As directed by CMS, ZPICs previously focused their investigative efforts on gathering evidence to verify overpayments and developing criminal and civil cases for law enforcement agencies — a lengthy process that often involved many investigative steps," the Government Accountability Office said in an October 2012 report (GAO 12-351). "According to CMS program integrity officials, the information provided by FPS is well-matched with the evidence necessary for ZPICs to recommend revocations against providers without having to conduct extensive investigations. These [CMS] officials also told us that they have directed the ZPICs to focus on pursuing revocations because revocations prohibit providers suspected of fraud from billing Medicare.

CMS also has deployed an automated provider screening contractor to screen enrollees for licensure revocations, exclusions and other black marks, and report its findings to MACs and the National Supplier Clearinghouse, according to the GAO report.

That's good for CMS but it still doesn't help health care organizations and private payers, Sheehan says. "There are states and managed care plans looking for this information and hospitals and clinics make credentialing decisions every day. If CMS made the right decision, [revocation information] should be available to everyone."

Recent HHS Decisions Clarify the Rules

Recent HHS Department Appeals Board decisions have made it clear that billing revocations will probably stick when based on the failure to notify Medicare of adverse events. In a July 18, 2011, decision, the administrative law judge (ALJ) ruled against physician John Crews, who was licensed to practice medicine and surgery in Virginia and Pennsylvania. The Virginia Board of Medicine in 2009 suspended his medical license over "nine separate violations related to inadequate patient care," but he kept practicing in Pennsylvania. The following year, the MAC for Virginia revoked Crews' Medicare billing privileges, and shared that information with Highmark Medicare Services, the MAC for Pennsylvania. Because Crews had failed to report the billing revocation to Highmark, it revoked his billing privileges for a year, a move that he appealed.

In the decision (CR2399), the ALJ stated Crews signed an enrollment application agreeing to tell the Medicare contractor of any final adverse action within 30 days, including license suspension. Crews said he believed that his attorney had told Highmark about the Virginia license suspension, but the ALJ said he presented no evidence to support this.

Contact Waltz at jwaltz@foley.com. For a list of all physicians enrolled in Medicare through the Internet-based Provider Enrollment, Chain and Ownership System (which Waltz warns may not always be accurate), visit www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html. ✧