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Revocation of Enrollment in the Medicare Program- A Powerful Weapon in Medicare's Arsenal

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In 2014, CMS issued a final rule related to 42 CFR 424.535, which gave CMS expanded authority to impose penalties on providers. Although the rule is several years old, the first version published in 2006, the rule has been expanded over the years, and CMS's use and enforcement appears to be increasing. Therefore, it is important to understand the basis of revocation and the implications for providers who receive notification from CMS or its MAC contractor regarding revocation.

The regulation allows CMS to revoke a provider's billing privileges under the following circumstances:

1. Noncompliance with enrollment requirements;
2. Provider or supplier conduct - being barred or excluded from Medicare;
3. Felony convictions in the past 10 years which would be detrimental to Medicare or its beneficiaries;
4. False or misleading information - the provider certified as true false or misleading information when enrolling in the Medicare program or to maintain enrollment in the program;
5. On-site review - if during onsite review, CMS determines the provider is no longer operational or does not meet provider enrollment requirements;
6. Grounds related to provider screening requirements - failure to submit an application fee or CMS is unable to deposit funds submitted for the application fee;
7. Misuse of billing number - knowingly sells or allows another to use its billing number (does not include assignment of billing number);
8. Abuse of billing privileges - submitting claim for services that could not have been furnished (i.e., beneficiary is deceased) or pattern and practice of submitting claims that do not meet Medicare requirements;
9. Failure to report changes in location, ownership or adverse legal action;
10. Failure to document or provide CMS access to documentation;
11. For a home health provider, failure to meet initial reserves operating fund requirement;
12. Medicaid termination;

13. Prescribing authority - suspension or revocation of DEA number or state revocation or prescribing authority;
14. Improper prescribing authority - a provider has a pattern or practice of prescribing Part D drugs that fails to meet Medicare requirements or is abusive or is a threat to the health and safety of Medicare beneficiaries.

When a provider's or supplier's billing privileges are revoked, the Medicare provider agreement is also terminated. The revocation results in a bar from participating in the Medicare program from the date of the revocation until the end of the re-enrollment bar. This is not the same as being excluded or "debarred" from Medicare. The re-enrollment bar begins 30 days after CMS mails notice of the revocation and can last from 1 to 3 years. The period of the bar is supposedly based on the severity of the basis of revocation. If after the bar on enrollment ends, a provider or supplier seeks to re-establish enrollment in the Medicare program, it must re-enroll in the Medicare program as a new provider or supplier through the completion and submission of a new enrollment application and applicable documentation. Certain providers and suppliers will be resurveyed and recertified.

If the revocation was due to adverse activity (sanction, exclusion, or felony) against an owner, managing employee, or an authorized or delegated official, or a medical director, supervising physician, or other personnel of the provider or supplier furnishing Medicare services, the revocation may be reversed if the provider or supplier submits proof that it has terminated its business relationship with that individual within 30 days of the revocation notification. When a provider or supplier is revoked from the Medicare program, CMS automatically reviews all other related Medicare enrollment files that the revoked provider or supplier has an association with (for example, as an owner or managing employee) to determine if the revocation warrants an adverse action of the associated Medicare provider or supplier.

Except for home health agencies, a revoked provider or supplier must submit all claims for items and services furnished before the date of the revocation letter within 60 calendar days after the effective date of revocation. A revoked home health agency must submit all claims for items and services within 60 days after the later of the effective date of the revocation or the date that the home health agency's last payable episode ends.

If you receive a revocation notice, you have 60 days from the postmark on the letter to file a redetermination request. This is a review by an "independent" reviewer who was not involved in the initial determination. The reviewer has 90 days to make a redetermination, and the revocation date is not tolled pending the appeal. If the redetermination request is not successful, the provider may appeal the decision to an administrative law judge and, ultimately, to the federal courts. Pursuant to this review schedule, your appeal at the administrative level can take several months; whereas, the revocation takes place 30 days after you receive notification of the revocation.

In a recent case, Medicare revoked the billing privileges of a large supplier of diabetic supplies, Arriva Medical, LLC. The basis of revocation was abuse of billing privileges (42 CFR 424.535(a)(8)(i)). According to CMS, Arriva had billed Medicare for testing supplies for Medicare beneficiaries who were deceased. Out of 5.8 million claims over a 5 year period, CMS focused on 211 claims submitted by Arriva, 0.003% of all claims submitted. Because of the length of time it takes for the

administrative appeals process to play out, Arriva filed a lawsuit in federal court seeking to enjoin CMS from revoking its billing privileges, which was denied. Arriva received notice of revocation in October 2016 with an effective date of November 4, 2016. On March 17, 2017, the federal district court issued an order denying Arriva's request for a preliminary injunction of the revocation, which would have stopped the revocation until Arriva had exhausted its administrative remedies. The administrative appeal is still pending at the Departmental Appeals Board.

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