New Rule Permits CMS to Revoke Medicare Billing Privileges for Providers/Suppliers with "Pattern or Practice" of Denied Claims

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On December 5, 2014, the Centers for Medicare & Medicaid Services (CMS) issued a final rule titled "Requirements for Medicare Incentive Reward Program and Provider Enrollment" ("the Rule").1 The Rule implemented several provider enrollment requirements, including a significant, new regulatory provision that will permit CMS to revoke Medicare billing privileges for a provider or supplier that has a pattern or practice of submitting claims that fail to meet Medicare requirements. The new provision should be of particular concern to laboratories that bill Medicare for their clinical testing, because clinical testing is undergoing rapid innovation in both clinical utility and payment arrangements among laboratories, and that often results in large numbers of denied claims.

The provisions of the new rule will become effective on **February 3, 2015**. The previous regulation, 42 C.F.R. § 424.535(a)(8), stated that CMS could revoke Medicare billing privileges if the provider/supplier submitted a claim for services that could not have been furnished to a specific individual on the date of service. Examples of such "impossible" services included services to a deceased beneficiary and services for which the necessary equipment was not present.

In the Rule, CMS expanded its revocation powers to include a pattern or practice of billing for services that do not meet Medicare requirements. In making these determinations, CMS will consider the following criteria:

- The percentage of submitted claims that were denied.
- The reason(s) for the claim denials.
- Whether the provider or supplier has any history of final adverse actions and the nature of any such actions.
- The length of time over which the pattern has continued.
- How long the provider or supplier has been enrolled in Medicare.
- Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice described in this paragraph.

The immediate implication of this expanded provision is that CMS's finding that a laboratory billing practice is incorrect may affect—or in fact, preclude—future claims in addition to existing claims.

In the preamble discussion to the Rule, CMS provided additional details regarding the implementation and enforcement of the provision. CMS noted the following:

- Claim denials that have been both fully overturned on appeal and fully adjudicated will be excluded from the consideration in determining whether the Medicare billing privileges should be revoked.
- While the term "pattern or practice" is not defined, sporadic billing errors would not result in revocation. Additionally, there is no denied-claims percentage threshold for revocation.
- Denied claims would serve as a notice to a provider/supplier. There would not be an opportunity for the provider/supplier to remedy its errors under the Rule.
- Revocation does not require a finding of fraud or even knowledge (i.e., provider/ supplier "should have known"), because it is an

administrative remedy separate and distinct from the government's other remedies for fraudulent behavior.

- The weight and importance of each criterion would vary based on the particular situation.
- CMS, and not its contractors, will make all determinations to revoke Medicare billing privileges.
- The revocations provision is not limited to claim denials based on medical necessity.

The new regulatory provision is a powerful enforcement tool for CMS and a major consideration for providers and suppliers billing Medicare. It remains to be seen how CMS will use the provision against providers and suppliers, and whether revocations of privileges would be made public to serve as examples of CMS's enforcement powers.

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1. 79 Fed. Reg. 72500 (December 5, 2014).↩

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