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CMS Announces New Rules That Make Owner Doctors Liable for All Practice Medicare Debts

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CMS announced its final rules on “Medicare Provider Oversight” on December 3, 2014, (http://federalregister.gov/a/2014-28505). According to CMS’ press release,

These new rules strengthen oversight of Medicare providers and protect taxpayer dollars from bad actors. These new safeguards are designed to prevent physicians and other providers with unpaid debt from re-entering Medicare, remove providers with patterns or practices of abusive billing, and implement other provisions to help save more than $327 million annually.

What do these rules really mean for physicians and other providers?

Ownership has its downside!CMS will deny enrollment to any person who was an owner of a provider or supplier that has an outstanding Medicare debt. This provision applies even if the person was a minority owner who did not participate in the management of the entity. CMS intends to use this provision to collect Medicare Debts from physicians who do not otherwise have any responsibility for repayment of the debt.

The prior rules limited the persons responsible for Medicare overpayments to the entity or the billing physician. Now, CMS can use its power to deny Medicare enrollment to any physician, physician extender or other person who was an “owner” of the practice during the one year prior to termination of the entity’s Medicare enrollment. Of course, the physician has an option – the physician can pay the full amount of the practice’s Medicare Debt or enter into a payment arrangement with Medicare to pay the amount in full.

The term “Medicare Debt” is a new term .That term means any amount owed to Medicare regardless of the basis for the liability. It includes overpayments, but it is not limited to overpayments. Finally, a liability is a “Medicare Debt” even if the practice is appealing the determination and the appeal has not been fully resolved.

Similarly, enrollment may be denied to an entity if it owned, or if its current owner owned, an entity that has an unpaid Medicare Debt. The entity can avoid denial by paying the Medicare Debt in full.

Felons are not allowed.A felony conviction is now grounds for denial or revocation of Medicare enrollment. In its final rule, CMS announced that it intends to deny and revoke Medicare privileges of any provider or supplier “convicted” of a federal or state felony within the preceding 10 years. More importantly, Medicare extends this taint to any person who was an owner or “managing employee” of a provider or supplier.

The “Offenses” include traditional crimes: murder, rape, assault; financial crimes: extortion, embezzlement, income tax evasion and crimes that result in mandatory exclusion from Medicare. In addition, CMS adds “any felony that placed the Medicare program or its beneficiaries at immediate risk. CMS, however, states that the term “Offenses” is not “limited in scope or severity” to these crimes. Further, CMS includes “pretrial diversion” in its definition of “conviction.”

According to CMS, it is up to the enrollee to determine whether a person has a felony conviction within the past ten (10) years. Further, CMS will not provide any guidance on whether a particular felony will result in revocation.

Abusive Billing Practices.Finally, Medicare announced that it would revoke the privileges of any provider or supplier that it determines engages in “abuse of billing privileges.”

The term “abuse of billing privileges” includes submission of a claim for services that could not be furnished to a patient on the date of service. CMS notes that these include claims for services when the beneficiary is dead, the directing physician or beneficiary is out of the country, or the equipment necessary is not present at the location where the testing occurred.

In addition, “abuse of billing practices” occurs when CMS determines that a provider “has a pattern or practice of submitting claims that fail to meet Medicare requirements.” In making this determination CMS considers:

- 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 (as that term is defined under § 424.502) 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's 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.

Once revoked, the provider, supplier, owner or managing employee is barred from participation in Medicare for a period ranging from one (1) year to three (3) years.

Significantly, CMS can take this action without any finding of "fraud" or other intentional action. Thus, revocation can occur simply because the physician's staff makes mistakes.

One area that is likely to create issues for physicians is CMS' position on "medical necessity." CMS will not inform the medical community of its position on "medical necessity." It has stated on numerous occasions that decision is one left to medical practitioners. But, CMS in its commentary to its rule, refused to include an exception to revocation for "good faith" disagreement among medical practitioners about medical necessity. Instead, CMS stated that it will make the decision of medical necessity when it revokes the practitioner's Medicare billing privileges. At that point, the practitioner may appeal the decision through CMS' administrative appeal process.

Finally, CMS announced that the time period for submission of claims once billing privileges are revoked has been reduced to 60 days from 180 days.

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