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Suspended Without a Net: Provider's Guide to Medicare Payment Suspensions

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A suspension of a provider's Medicare payments is one of the most powerful tools the Medicare program has to combat suspected program fraud and abuse. Medicare providers and suppliers need to understand the payment suspension regulations and process, particularly because the Centers for Medicare & Medicaid Services can sometimes implement this sanction without prior notice.

CMS and its Medicare contractors have the authority to suspend all payments to a provider or supplier if CMS or one of its contractors has ''reliable information'' that an overpayment exists or fraud is suspected based on a ''credible allegation of fraud.''[1]

Under payment suspension standards, CMS may implement and keep a suspension in effect for an indeterminable length of time. And CMS may suspend payments to a provider or supplier *before* an overpayment determination has actually been made, and *before* any potentially fraudulent conduct has been confirmed.

Worse yet, under current law, there is no effective remedy to block a payment suspension. Simply put, a payment suspension can become an all-consuming—and a potentially fatal—financial, administrative and organizational burden for the provider or supplier.

[1] 42 C.F.R. § 405.370 *et seq*.

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Medicare Payment Suspensions: The Process and the Key Players

Medicare regulations define the ''suspension of payment'' as ''[t]he withholding of payment by a Medicare contractor from a provider or supplier of an approved Medicare payment amount before a determination of the amount of the overpayment exists, or until the resolution of a credible allegation of fraud.''[2] A payment suspension may be imposed against part or all of a provider's Medicare payments under a given Medicare Provider Transaction Access Number (PTAN),[3] a Medicare-only number issued to providers and suppliers by Medicare contractors upon enrollment to Medicare.[4]

Upon receiving notice of a payment suspension, a provider may continue to process, submit, and credit claims for Medicare services provided, notwithstanding the suspension, resulting in the accumulation of reimbursement due to the provider for approved claims in an escrow or ''suspense'' account.[5]

Possible companion sanctions to a payment suspension include the imposition of prepayment review be-

[2] 42 C.F.R. § 405.370.

[3] 42 C.F.R. § 405.371(a)(1). Medicare could decide to suspend payments against more than one of the provider's Medicare PTANs at the same time.

[4] Centers for Medicare & Medicaid Services, MLN Matters, *Examining the Difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN)* (SE1216), revised May 30, 2012.

[5] CMS, Medicare Program Integrity Manual, Chapter 8, Section 8.3.2.3.1.

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fore claims will be credited to the payment suspension account or post-payment review before the Medicare contractor would issue an overpayment determination. In some instances, providers are subjected to both.

Payment suspensions are imposed by CMS or one of its contractors, such as the Zone Program Integrity Contractors (ZPICs).[6] A decision by CMS or its contractor to impose a payment suspension can be based upon ''reliable information that an overpayment exists or that the payments to be made may not be correct, although additional information may be needed for a determination.''[7]

Alternately, the decision to impose a payment suspension can be based upon a ''credible allegation of fraud'' that, as determined, may exist against the provider.[8] A ''credible allegation of fraud'' can be an allegation from any source, including, but not limited to, fraud hotline complaints, claims data mining and/or patterns identified through provider audits, civil false claims cases, and law enforcement investigations.[9]

In cases of suspected fraud, CMS or its contractor must consult with the Department of Health and Human Services Office of Inspector General and, as appropriate, with the Department of Justice as to whether to impose the suspension and if prior notice regarding such a determination is appropriate.[10]

However, despite the interests of any law enforcement agency (e.g., OIG, DOJ, Federal Bureau of Investigation and assistant U.S. attorneys) that may be involved in such consultations, CMS is the official party in interest and ultimately responsible for the decision to suspend a Medicare provider's payments.[11]

Although a provider faced with a payment suspension has the opportunity to submit a rebuttal statement (as discussed later), the decision by CMS or its contractor to impose a payment suspension is expressly not an appealable determination.[12] Currently, there is no effective administrative process in place to protest a payment suspension, which means that a provider generally has no choice but to let a payment suspension run its course, at least until the related investigation is complete.

Despite assurances from CMS that the agency ''must review all allegations, facts, and information carefully and act judiciously on a case-by-case basis when contemplating a payment suspension, mindful of the impact that payment suspension may have upon a provider,'' in reality a provider navigates the payment suspension process with limited information about how and when the suspension will be lifted.

One resource that may be helpful in understanding the payment suspension process, the Medicare Program Integrity Manual (PIM), contains a basic overview of when and how payment suspensions are imposed.[13] According to the PIM, payment suspensions may be imposed against providers in four circumstances: (1) when fraud or willful misrepresentation exists (known as ''fraud suspensions''), (2) when an overpayment exists but the amount of the overpayment is not yet known, (3) when payments to be made may not be correct, or (4) when a provider fails to furnish records and other requested information needed to determine amounts due to the provider.[14] These four circumstances are discussed in the PIM, without much detail.[15]

Often, the process begins with a recommendation for a payment suspension by one of CMS's contractors. In recent years, CMS has relied on the recommendations of the ZPICs as the preliminary basis for contemplating payment suspension sanctions against a Medicare provider. Whether a CMS contractor recommends a payment suspension action to CMS is a case-by-case decision and, according to the PIM, ''[t]here is considerable latitude with regard to complaints alleging fraud and abuse.''[16]

However, if there is a ''credible allegation'' (as previously defined) that a provider is submitting or has submitted false claims, a CMS contractor may recommend suspension of that provider's Medicare payments to CMS's Central Office (CO), Division of Benefit Integrity Management Operations Fraud and Abuse Suspensions and Sanctions (DBIMO FASS) team. Initiating any payment suspension action requires the explicit prior approval of the CO DBIMO FASS team. To obtain this approval, the CMS contractor will forward to the CO DBIMO FASS team a draft of the proposed notice of suspension and a brief summary of the evidence upon which the contractor's payment suspension recommendation is based.[17]

Once the CO DBIMO FASS team approves a payment suspension action, the CMS contractor will then inform the provider, when prior notice is appropriate, of the ac-

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[6] *See* 42 C.F.R. § 405.370(a), defining ''Medicare contractor'' as including the ZPICs.

[7] 42 C.F.R. § 405.371(a)(1). Generally, the notice period to a Medicare provider regarding an impending payment suspension is 15 days. However, CMS, the contractor, or the carrier may shorten or eliminate that notice period, as appropriate. *See* 42 C.F.R. § 405.372; CMS, Medicare Program Integrity Manual, Chapter 8, Section 8.3.2.2.

[8] 42 C.F.R. § 405.371(a)(2).

[9] 42 C.F.R. § 405.370(a).

[10] 42 C.F.R. § 405.372(a)(4).

[11] *Id*.

[12] 42 C.F.R. § 405.375(c). *See, e.g., MJG Mgmt. Assocs. v. NHIC Corp. and Safeguard Servs. LLC*, Civ. Action No. 12-11414-FDS (D. Mass. 2013); *Midwest Family Clinic, Inc. v. Shalala*, 998 F. Supp. 763, 767 (E.D. Mich.1998); *Neurological Assocs.—H. Hooshmand v. Bowen*, 658 F. Supp. 468, 471 (S.D. Fla. 1987). These cases reference 42 U.S.C. § 405(h), which has been adopted and incorporated into the Medicare Act (42 U.S.C. § 1395ii). *See alsoJohn Balko & Assocs. v. Secretary of U.S. Dep't of Health & Human Servs.*, No. 13-1568 (3d Cir. 2014).

[13] Another resource, the *Joint Guidance on CMS Administrative Actions and the Impact on Health Care Fraud Cases* (''**Joint Guidance**''), provides information to law enforcement agencies regarding payment suspensions and associated law enforcement investigations. The Joint Guidance is not a publicly available resource. *See* U.S. Department of Health & Human Services, Office of Inspector General, *Memorandum Report: The Use of Payment Suspensions to Prevent Inappropriate Medicare Payments* (OEI-01-09-00180) (Nov. 1, 2010), at 3 and 12-13.

[14] CMS, Medicare Program Integrity Manual, Chapter 8, Section 8.3.1. This section of the PIM was updated after the implementation of the post-ACA regulations to include the ''credible allegation of fraud'' standard, but the introduction was not updated with this new standard.

[15] *See* CMS, Medicare Program Integrity Manual, Chapter 8, Sections 8.3.1.1 to 8.3.1.4.

[16] CMS, Medicare Program Integrity Manual, Chapter 8, Section 8.3.1.1(A).

[17] CMS, Medicare Program Integrity Manual, Chapter 8, Section 8.3.2.1.

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tion being taken.[18] When prior notice is appropriate, the CMS contractor is advised in the PIM to give the provider at least 15 calendar days' prior notice (day one begins the day after the notice is mailed to the provider). By contrast, the PIM also provides that, when there is a credible allegation of fraud, a CMS contractor may recommend to the CO DBIMO FASS team that prior notice not be given.

If the CO DBIMO FASS team agrees with this recommendation and waives the notice requirement, the CMS contractor will then send the provider notice of the payment suspension concurrent with its implementation, but no later than 15 days after the date on which the suspension is imposed,[19] and provide a copy of this notice to OIG, or possibly to the FBI or AUSA's office if either agency has been previously involved.[20]

Timing for payment suspensions is discussed only in the payment suspension regulations, 42 C.F.R. §§ 405.370 - 405.377. Payment suspensions are initially approved by the CO DBIMO FASS team for a period up to 180 days.[21] The team may extend the initial suspension period for up to an additional 180 days upon a written request from the CMS contractor or other law enforcement agency.[22] Some exceptions exist to these general rules regarding timing. Significantly, the CO DBIMO FASS team may grant a second 180-day extension beyond the first extension if an overpayment has not yet been determined and the DOJ (including an AUSA) submits a written request for such an extension.[23]

However, these time limits now do not apply if a suspension of payments is based upon the newer, lower threshold of ''credible allegations of fraud.''[24] Rather, every 180 days after CMS imposes a suspension of payments based upon ''credible allegations of fraud,'' CMS will evaluate whether there is good cause not to continue a payment suspension and will request a certification from OIG or other law enforcement agency involved in the matter that the matter continues to be under investigation and warrants continuation of the suspension.[25]

When a payment suspension is recommended and/or imposed, the CMS contractor will discuss the case with OIG to ascertain the agency's interest in pursuing the case. If OIG declines to intervene, OIG and the contractor will determine whether a referral by OIG to another law enforcement agency is appropriate.[26] If that law enforcement agency declines to intervene, the contractor may consider preparing the case for civil monetary penalty or permissive exclusion.

However, whether or not a case is accepted by law enforcement, the CMS contractor is expected to develop its case ''as expeditiously as administratively feasible'' and will keep law enforcement informed of dollars being withheld and any potential recoupment actions against the provider.[27]

CMS's Authority to Impose Medicare Payment Suspensions: An Evolving Standard

It is a common misconception that the authority to suspend a Medicare provider's or supplier's payments is new authority granted under the 2010 Patient Protection and Affordable Care Act (ACA) On the contrary, CMS, formerly the Health Care Financing Administration, has had the authority to suspend payments in cases of suspected fraudulent activity since the publication of a 1972 final rule.[28]

The payment suspension regulations were most recently addressed when Congress enacted the ACA. Notably, Section 6402(h) of the ACA amended Section 1862 of the Social Security Act (SSA)[29] by adding a new paragraph (o), under which the Secretary of HHS would have the authority to suspend payments to a Medicare provider or supplier pending an investigation of a ''credible allegation of fraud'' unless the Secretary determines that there is good cause not to suspend payments.[30]

This section of the statute now requires that the Secretary consult with OIG when there is a credible allegation of fraud against a Medicare provider or supplier.[31]

In a September 2010 proposed rule, CMS sought to implement changes to the payment suspension regulations based on Section 6402(h) of the ACA, which, in turn, lowered the standard that the government must meet to suspend payments based upon suspected fraud. Pre-ACA, regulations authorized CMS to suspend Medicare payments to providers for suspected fraud based upon ''information . . . [that] CMS determines . . . is reliable.''

The post-ACA regulations effectively lowered the standard from ''reliable evidence of fraud'' to merely a ''credible allegation of fraud'' and gave wide latitude to CMS, its contractors and law enforcement to decide

[18] Section 8.3.2.2.2 in Chapter 8 of the PIM describes the required content to be included in a notice of payment suspension.

[19] CMS, Medicare Program Integrity Manual, Chapter 8, Section 8.3.2.2.1.

[20] CMS, Medicare Program Integrity Manual, Chapter 8, Section 8.3.2.2.4.

[21] 42 C.F.R. § 405.372(d)(1).

[22] 42 C.F.R. § 405.372(d)(2).

[23] CMS, Medicare Program Integrity Manual, Chapter 8, Section 8.3.2.4.

[24] 42 C.F.R. § 405.372(d)(3). This change is based upon the revised CMS regulations that implemented Section 6402(h) of the ACA.

[25] 42 C.F.R. § 405.371(b)(2).

[26] Chapter 4 of the PIM discusses the referral of cases by a ZPIC to other government agencies for action. CMS, Medicare Program Integrity Manual, Chapter 4, Section 4.18.1.

[27] CMS, Medicare Program Integrity Manual, Chapter 8, Section 8.3.2.3.2.

[28] 37 Fed. Reg. 10722 (May 27, 1972). Although not discussed in detail in this article, the payment suspension regulations were subsequently addressed in 1988 and 1996, prior to the most recent changes in 2010 resulting from the Affordable Care Act. *See* 53 Fed. Reg. 31888 (Aug. 22, 1988) and 61 Fed. Reg. 63740 (Dec. 2, 1996).

[29] Section 1862(a)(1)(A) of the SSA prohibits payment under Parts A and B of the Medicare program for items or services that ''are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.'' 42 U.S.C. § 1395y(a)(1)(A).

[30] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 760 (2010). This new subsection (o) became effective on March 23, 2010. *See also* 42 U.S.C. § 1395y(o); 42 C.F.R. § 405.372. The proposed rule was finalized in February 2011. 76 Fed. Reg. 5862, 5929 (Feb. 2, 2011).

[31] *Id*. In previous versions of the payment suspension rules the standard was ''fraud or willful misrepresentation.''

what constitutes a ''credible allegation of fraud'' that can become the basis for a payment suspension.

The post-ACA regulations, which became effective in February 2011, considerably broadened CMS's authority to suspend a Medicare provider's payments. For one, CMS added a definition of the phrase ''credible allegation of fraud,'' which contains allegations from any source including, but not limited to, fraud hotline complaints, claims data mining, patterns identified through provider audits, civil false claims cases, and law enforcement investigations.[32] In other words, literally anything can now be the basis for a potential ''credible allegation of fraud'' against a provider or supplier, and the basis for CMS deciding to suspend Medicare payments.

Moreover, the definition of ''credible'' is not very enlightening—according to the regulations, allegations are ''credible'' when they have ''indicia of reliability.'' Using this new and arguably lower standard, CMS may determine whether there has been a ''credible allegation of fraud'' after consulting with OIG. According to CMS, ''consultation between CMS and OIG prior to implementing a payment suspension will provide ample opportunity for the credibility of an allegation to be assessed.''[33]

After this definition of ''credible allegation of fraud'' was proposed, CMS received numerous comments challenging this proposal. In response, CMS stated, ''We did not intend to detail a precise evidentiary standard . . . rather we intended to give examples of the typical sources of allegations of fraud and explain that assessing the reliability of an allegation is a process that will occur on a case-by-case basis.''[34]

CMS also received comments suggesting that the required consultation between CMS and OIG/DOJ lacks specificity. CMS responded that it retains the ''ultimate authority'' to decide whether or not a payment suspension will be imposed in a given case. Despite this statement, it is highly unlikely that CMS would exercise its discretion to lift a payment suspension where a law enforcement agency, such as OIG or DOJ, recommends otherwise.

Notably, CMS declined to discuss the ''mechanics'' of such consultations between it and the law enforcement agency involved to determine the credibility of allegations against a Medicare provider, and instead stated that these details would be outlined in a Memorandum of Understanding (MOU) between CMS and OIG.[35] To date, CMS has not provided any further detail regarding this process involved with these intra-agency consultations, nor is the relevant MOU publicly available.[36]

[32] 75 Fed. Reg. 58204, 58222 (Sept. 23, 2010).
[33] 76 Fed. Reg. 5862, 5929 (Feb. 2, 2011).
[34] 76 Fed. Reg. 5862, 5929 (Feb. 2, 2011).
[35] This MOU allegedly allows OIG to request a payment suspension based on a declaration signed by an OIG Special Agent. U.S. Department of Health & Human Services, Office of Inspector General, *Memorandum Report: The Use of Payment Suspensions to Prevent Inappropriate Medicare Payments* (OEI-01-09-00180) (Nov. 1, 2010), at 3.
[36] The author submitted a Freedom of Information Act request to CMS in May 2013 to secure a copy of the MOU but has not received a response yet.

Fighting a Medicare Payment Suspension: Any True Recourse for Providers?

New standards for imposing payment suspensions post-ACA have potentially subjected more providers to these sanctions and to significant financial and organizations risks related to dealing with a payment suspension, even if a provider ultimately prevails. Remarkably, under the regulations, there is no basis to appeal a payment suspension. While the payment suspension regulations suggest that providers have several potential paths of recourse during the pendency of a payment suspension, none are certain paths to success.

Despite a low likelihood of success, providers should not overlook these opportunities to communicate with CMS and/or its contractor regarding the payment suspension. Even if the resulting determination upholds the payment suspension sanctions, consistent and continued dialogue with CMS and/or its contractor may facilitate speeding up the timeline of the ''investigation'' and lifting the sanctions.

Rebut the Allegations. The payment suspension regulations allow providers the opportunity to submit a rebuttal against the allegations that are the basis for the payment suspension.[37] If it receives prior notice of a payment suspension, the provider may submit this rebuttal statement before the suspension goes into effect. If a payment suspension takes effect without prior notice (the common course of action for fraud suspensions), the provider may still submit a rebuttal statement but should focus the statement on why the suspension should be removed. In either instance, if CMS or the contractor rejects the arguments set forth in the provider's rebuttal statement, the payment suspension goes into effect.

Numerous commenters raised concerns over a perceived lack of due process under the September 2010 proposed rule. CMS responded that a provider has ''ample opportunity to submit information to us in the established rebuttal statement process to demonstrate their case for why a suspension is unjustified.''[38] Yet, the post-ACA payment suspension regulations do not require CMS or its contractors, or any other agency for that matter, to inform the provider of the reasons for, or in some cases the existence of, the suspension.

It is therefore unclear what information a provider can submit in a rebuttal statement that would enable the provider to avoid or compel the lifting of payment suspension sanctions. In fact, the PIM describes the required content to be included in a notice of payment suspension and, for fraud suspensions, states that, although notice must describe why a suspension action is being taken, ''[f]or fraud suspensions, the contractor . . . shall do so in a way that does not disclose information that would undermine a potential fraud case. . . .''[39]

Because the basis for many payment suspensions is an investigation of ''credible allegations of fraud,'' providers may have a chance to be successful at this early stage of the payment suspension process based on the submission of a rebuttal statement. However, if the government has not had sufficient time to complete its in-

[37] 42 C.F.R. § 405.372(b).
[38] 76 Fed. Reg. 5862, 5930 (Feb. 2, 2011).
[39] CMS, Medicare Program Integrity Manual, Chapter 8, Section 8.3.2.2.2.

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vestigation at that stage, it may demand additional time, as a basis for upholding the suspension.

Make a Case for ''Good Cause'' to Lift the Suspension. Even when there are ''credible allegations of fraud,'' payment suspensions will be temporary and not continue after the resolution of an investigation, unless a suspension is warranted because of reliable evidence of an overpayment or that payments to be made may not be correct.[40]

The regulations further provide that ''good cause'' not to continue to suspend payments against which there have been ''credible allegations of fraud'' must be deemed to exist if a payment suspension has been in effect for 18 months and there has not been a resolution of the investigation, unless one of two actions has occurred: (1) the case has been referred to, and is being considered by, OIG for administrative action (or such administrative action is pending), or (2) the DOJ submits a written request to CMS that the suspension continue beyond the 18 months based on the ongoing investigation and the anticipated filing of criminal/civil action (or based on a pending criminal/civil action).[41]

CMS defines ''good cause'' for not continuing a payment suspension as: (1) specific requests by law enforcement because of the risk of alerting the target, jeopardizing an undercover investigation, or exposing confidential sources such as whistleblowers; (2) jeopardizing beneficiaries' access to medical care; (3) a determination by CMS that there are other, more effective, remedies; and/or (4) a determination by CMS that a payment suspension is not in the best interests of the Medicare program.[42]

However, the strategy for making an effective ''good cause'' argument to CMS is unclear. The potential parameters for establishing ''good cause'' either are wholly outside a provider's control (e.g., a request that only can come from law enforcement, a determination that only can be made by CMS) or are highly subjective (e.g., deciding when beneficiaries' access to care is in jeopardy, determining when a payment suspension is not in the best interests of the Medicare program).

There is no defined process through which a provider may make a case for ''good cause'' to lift a payment suspension, no specific timeframe for making a case for ''good cause,'' and no specific format in which to present these arguments.

Await the Conclusion of the Investigation. Unfortunately, a provider generally is forced to wait—a long time—for CMS or its contractor to complete its investigation and make a determination as to whether an overpayment was made or that fraud exists.

Post-ACA, CMS is authorized to continue a payment suspension until an investigation of the ''credible allegation of fraud'' has been resolved. The payment suspension regulations define the ''resolution of an investigation'' as the termination of legal action by settlement, judgment, dismissal, or when the case is dropped for lack of sufficient evidence.[43]

As the investigation proceeds, the provider will continue to operate and serve its Medicare population, but without the benefit of receiving payment for providing services to these beneficiaries. While the payment suspension regulations establish an initial 180-day period for a payment suspension, requests by CMS or its contactor for extensions of time are not often denied.

It is easy to see how a payment suspension can be in place for a minimum of a year or longer. Realistically, most providers cannot easily operate—and, in some cases, have ceased to operate—when their Medicare payments have been suspended for a full year or longer. Sadly, providers often are forced to wait until the investigation concludes and even then may not receive answers to some of their pressing questions regarding the nature of the suspension and the grounds for keeping it in place.

* * *

In a post-ACA world, CMS—and, in particular, its ZPICs—will likely continue to turn up the heat on noncompliant providers by imposing payment suspensions while potential instances of fraud and abuse are investigated. In light of the significant financial, administrative, and operational risks associated with a payment suspension, providers should redouble efforts to ensure that their organizations have effective compliance programs in place. In particular, providers should:

- Assume that scrutiny by CMS and its contractors is a given in the current environment, and should pay particular attention to compliance efforts that focus on regular and aggressive activity around claims auditing and monitoring, as well as on collecting supporting documentation;
- Scrutinize their compliance programs to proactively assess their current billing and documentation practices, and confirm that they are following all applicable Medicare policies and procedures when billing Medicare claims;
- Take immediate action when faced with potential instances of noncompliance by investigating and implementing corrective actions, as necessary; and
- If they believe that an overpayment issue has arisen, repay the funds at issue promptly and correct any aspects of its billing and documentation practices that may have led to such overpayments.

[40] 42 C.F.R. § 405.372(d)(3).
[41] 42 C.F.R. § 405.371(b)(3).
[42] 76 Fed. Reg. 5862, 5929 (Feb. 2, 2011).
[43] 76 Fed. Reg. 5862, 5929 (Feb. 2, 2011).