THE USE OF PAYMENT SUSPENSIONS IN THE AUDIT LANDSCAPE

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The suspension of Medicare payments in conjunction with a CMS contractor audit creates a one-two punch that can easily result in a provider being forced out of business before having the opportunity to defend against a contractor's allegations. CMS may suspend payments to Medicare providers and suppliers in situations involving suspected fraud or where an overpayment exists but additional information is required to make a determination. In accordance with the Affordable Care Act, CMS recently issued proposed regulations on September 23, 2010, providing that in cases of suspected fraud, Medicare payments may be suspended pending an investigation if "a credible allegation of fraud exists against a provider or supplier, unless there is good cause not to suspend payments." The proposed regulations define a "credible allegation of fraud" as an allegation from any source, including but not limited to fraud hotline complaints, claims data mining and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered "credible" when they have "indicia of reliability."

The Office of Inspector General ("OIG") for the Department of Health and Human Services recently released a Memorandum Report addressing the use of payment suspensions to prevent inappropriate Medicare payments. This memorandum provides some insight on the frequency with which suspensions are imposed, the likelihood of successfully rebutting a suspension, and the rate at which overpayments of suspended providers are ultimately reversed.

The OIG memorandum notes that payment suspensions are typically requested from Program Safeguard Contractors (PSCs) and Zone Program Integrity Contractors (ZPICs), both of which conduct benefit integrity activities to identify potential Medicare fraud. Law enforcement entities also request payment suspensions from CMS through PSCs and ZPICs. A Medicare contractor may initiate a request for payment suspension based on its own analysis, CMS's request or at the request of a law enforcement entity such as the OIG or Department of Justice (DOJ).

Because the extent and amount of an overpayment need not be determined prior to imposing a suspension, a suspension may occur prior to the initiation of a formal audit of the provider's services. To initiate a payment suspension, the contractor provides CMS with a draft notification letter and a summary of the reliable information the suspension is based upon. CMS then determines if suspension should be implemented and whether the provider should receive notice of the suspension before or after it is initiated. Generally if the provider's payments are suspended due to suspected fraud or willful misrepresentation, the provider is notified *after* the suspension is implemented.

Providers are not permitted to appeal a payment suspension. The only recourse offered is the opportunity to file a rebuttal statement to explain why CMS should remove the suspension. A provider experiencing a payment suspension must file its rebuttal statement within 15 days of the date of the suspension notification letter. CMS contractors are instructed to respond to the provider's rebuttal within 15 days of receipt. According to the OIG's memorandum, only 16

percent of providers submitted rebuttals to CMS and, of those 16, only 3 rebuttals resulted in CMS lifting the suspension.

Payments are typically suspended for a period of 180 days, though CMS may extend the suspension if warranted under the circumstances. During the course of payment suspension, providers may continue to submit claims to their Medicare contractor, but payment amounts from valid claims will be held in suspense, thus eliminating cash flow to the provider's business.

Once the payment suspension is implemented, the contractor procures any additional information needed to calculate the overpayment. This calculation can involve the use of a statistically valid random sample and the request and review of medical records from the provider. Once the overpayment amount is calculated, a demand letter is issued by the provider's Medicare claims processing contractor. Payments that have been held in suspense over the course of the suspension are applied to the overpayment and the suspension is then removed. Once the suspended payments have been applied to the overpayment amount, any remaining monies are returned to the provider.

The OIG's memorandum involved the analysis of 253 payment suspensions implemented by CMS over 2007 and 2008. The vast majority of suspensions involved Part B providers and were concentrated in four states/territories: Florida, Puerto Rico, California and Michigan. More than half of the payment suspensions were in areas with Medicare Fraud Strike Force operations. As of August 2009, CMS had removed suspensions in 182 cases it approved over the course of 2007 and 2008. In reviewing these 182 suspensions, the majority of the providers demonstrated questionable billing patterns and many of the suspensions were supported with information from beneficiaries or other providers that raise question about their practices. When the contractors requested medical records in order to make overpayment determinations, 55 percent of providers failed to provide records for review.

While the OIG memorandum states that the great majority of suspended providers exhibited characteristics that suggested fraud, it is also important to note that, in 23 cases the CMS contractors ultimately found no overpayment. In 16 cases, the CMS contractor did not provide the OIG with information regarding the size of the overpayment and in 71 cases the final overpayment amount had not been determined. These statistics highlight the very real and harsh possibility that in some situations suspensions have been imposed against providers whose billings were ultimately approved or possibly had only minor overpayments. Further, it is likely that many suspended providers did not have the necessary resources to defend the overpayment allegations because of cash flow issues created by the suspension.

Although the OIG's memorandum highlights the low success rate of the rebuttal process, providers should consider making arguments based upon any circumstances that are unique to their billing practices. Providers should also vigorously appeal any overpayment findings, or denials based upon audit findings, including additional development requests, arising in connection with a payment suspension. Although the appeals process can be difficult in light of cash flow issues and the time allocated to each stage of the appeals process, it remains the best hope for fighting a payment suspension.