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TABLE OF CONTENTS

- A Healthcare Case for the Ages1
Mark A. Hall

NOTES AND COMMENTS

- The New Relators: In-House Counsel and
Compliance Officers 16
Kathleen M. Boozang

- Achieving Coordination of Care in Behavioral Health:
A Call for Revisiting Confidentiality Laws56
Tom O'Donnell, Daniel H. Willick, and Suzette E. Gordon

- The Legal Challenge of Incorporating Artificial
Intelligence into Medical Practice 90
Amanda Swanson and Fazal Khan

PRACTICE RESOURCES

- CMS Regulation Expands Authority to Suspend Payments:
What Providers Need to Know147
Alan G. Gilchrist and Timothy Burkhard

- Establishing and Communicating Critical Laboratory
Values: The Mayo Clinic Approach.....173
Sharon Zehe

PRACTICE RESOURCE

CMS Regulation Expands Authority to Suspend Payments: What Providers Need to Know

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Gilchrist and Burkhard: CMS Authority to Suspend Payments

CONTENTS

Introduction	149
What Was the Government's Prior Ability to Suspend Provider Payments?	151
The old regulation and payment suspensions for fraud.....	154
Payment suspensions: How they are used and what they mean to providers.....	155
Providers and attorneys beware: Examples of legal challenges.....	156
Exhaustion of administrative remedies.....	160
The New Rules, Payment Suspensions, and Credible Allegations of Fraud.....	163
What do the new rules mean? Why should providers be concerned?	163
Changes to Medicaid payment suspensions: What do providers need to know?.....	167
What can providers do? What challenges do they face?	169
Conclusion: Concerns for the Future.....	172

Introduction

Combating Medicare fraud is one of the federal government's top priorities. In May 2009, the Department of Justice (DOJ) and the Department of Health and Human Services (HHS) announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT). The joint DOJ-HHS Medicare Fraud Strike Force, a multi-agency team of federal, state, and local investigators, combats Medicare fraud through the use of Medicare data analysis techniques and an increased focus on community policing. One of HEAT's missions is to reduce fraud and recover taxpayer dollars. President Obama's 2010 budget for HHS contained funding for anti-fraud efforts and stopping fraud and abuse within the Medicare Advantage and Medicare prescription drug programs. It also invested \$311 million to strengthen Medicare and Medicaid program integrity.

Almost daily, there are reports of settlements or convictions for providers for falsely submitting claims to Medicare. Recently, a large pharmaceutical company agreed to a \$3 billion settlement and pled guilty to criminal charges to resolve fraud allegations, which is the largest healthcare fraud settlement in the history of the United States and the largest payment ever by a drug company.¹

In a Final Rule published February 2, 2011, the Centers for Medicare & Medicaid Services (CMS) significantly expanded its ability to suspend payments to Medicare providers pursuant to an amendment to the Social Security Act (42 U.S.C. § 1395y), consistent with the increased focus on healthcare fraud.² The Secretary of HHS, in consultation with the HHS Office of Inspector General (OIG), now has the ability to suspend Medicare payments to a provider "pending an investigation of a credible

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- 1 See Press Release, U.S. Dep't of Justice, GlaxoSmithKline to Plead Guilty and Pay \$3 Billion to Resolve Fraud Allegations and Failure to Report Safety Data (July 2, 2012), available at www.justice.gov/opa/pr/2012/July/12-civ-842.html.
 - 2 76 Fed. Reg. 5852, 5928 (Feb. 2, 2011), available at www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf.

allegation of fraud . . .” unless the Secretary finds good cause not to suspend the payments.³ Section 6402(h) also contains a parallel provision requiring state Medicaid programs to suspend payments to providers when an investigation of a credible allegation of fraud is pending against a provider or risk forfeiting federal financial participation (FFP).

To be clear, the federal government already has a variety of methods to recover from those providers who receive payments to which they are not entitled; for example, the civil forfeiture statute to recover property that constitutes or is derived from proceeds traceable to a violation of healthcare fraud statutes.⁴ The government also is able to recover a surcharge of ten percent of the amount of a debt to cover the cost of processing and handling litigation and enforcement of its claim.⁵ However, these recovery mechanisms are of the *pay and chase* variety, where the government must try to hunt down the proceeds already paid or the property derived from the proceeds paid. This collection method presents a variety of challenges—many things can happen with proceeds after they are paid and, as such, proceeds can be difficult to track down and can take significant time to recover.

Because of the uncertainties of the pay and chase approach to fraud prevention, CMS’s ability to suspend payments on the front end maximizes efforts, as the government will be able to realize recovery before a provider obtains the money and has the ability to spend or otherwise dispose of Medicare proceeds. Of course, a provider who has to deal with a Medicare payment suspension is much more significantly inconvenienced and faces a daunting task in getting CMS to lift a payment suspension.

Although the new rule expands CMS’s suspension authority, it is not a completely new enforcement tool. This Practice Resource first

3 See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119–1025, § 6402(h).

4 See 18 U.S.C. § 981; *see also* United States v. Guerra, 307 F. App’x 283 (11th Cir. 2009), *cert. denied*, 130 S. Ct. 58 (2009).

5 See 28 U.S.C. § 3011(a); *see also* United States v. Accela Medical LLC et al., No. 2:2010cv14627 (E.D. Mich. Nov. 22, 2010).

will discuss the government's ability to [suspend payments prior to the recent expansion](#) of its authority and the government's use of such pre-expansion authority. It will then analyze the various methods providers have used to [combat a suspension](#) in the court system under the previous authority and the results of those challenges. We will provide an in-depth review of the newly [expanded governmental authority](#) to suspend payments to providers. This resource concludes with [advice to providers](#) in light of the government's expanded authority.

What Was the Government's Prior Ability to Suspend Provider Payments?

A suspension of payments to providers or suppliers is one of the most powerful tools the Medicare program has to address suspected program fraud and abuse. Before the new regulation, CMS, an intermediary, or carrier had (and still has) the ability to suspend payments to Medicare providers or suppliers. This authority, which has been in place for years, provides that a suspension can occur when “[R]eliable information that . . . an overpayment [or fraud or willful misrepresentation] exists or that the payment[] to be made may not be correct.”⁶

A *suspension* is a “withholding of payment by an intermediary or carrier . . . of an approved Medicare payment amount. . . .”⁷ The regulation's preamble states:

The purpose of suspending payment is to verify whether, and how much, payment was actually due the provider for past claims and to ensure that, if a provider or supplier was overpaid, sufficient funds are available to recover the overpayment. These actions are clearly necessary to protect the Trust Funds from loss.⁸

6 42 C.F.R. § 405.371(a)(1).

7 United States v. Lahey Clinic Hosp., Inc., 399 F.3d 1, 17 (1st Cir. 2005). See 42 C.F.R. § 405.370.

8 61 Fed. Reg. 63740, 63742–43 (Dec. 2, 1996).

A suspension is limited to 180 days.⁹ If the carrier, the OIG, or a law enforcement agency is unable to complete its examination of the information or investigation, CMS may extend the payment suspension for up to an additional 180 days.¹⁰ In certain circumstances and based on the ongoing investigation and anticipated filing of criminal and/or civil actions, CMS may grant an additional extension if the DOJ submits a written request to continue the payment suspension.¹¹

In the case of suspected fraud, CMS or the Medicare contractor must consult with the OIG, and, as appropriate, with the DOJ, as to whether to impose the suspension and if prior notice is appropriate.¹² Although CMS ultimately is the real party in interest and is responsible for the decision to impose a suspension, it directs the Medicare contractor as to the timing and content of the notification (if any) given to the provider or supplier about a payment suspension.¹³ CMS generally recommends that no prior notice be given to a provider or supplier if:

- (a) [a] [d]elay in [imposing the] suspension will cause the overpayment to rise at an accelerated rate (i.e., dumping of claims);
- (b) [t]here is reason to believe that the provider may flee the contractor's [] jurisdiction before the overpayment can be recovered; or
- (c) [t]he contractor [] has first hand knowledge of a risk that the provider will cease or severely curtail operations or otherwise seriously jeopardize [the] ability to repay¹⁴

9 See 42 C.F.R. § 405.372(d)(1).

10 See *id.* § 405.372(d)(2).

11 See 61 Fed. Reg. 63740, 63743.

12 See 42 C.F.R. § 405.372(a)(4).

13 *Id.*

14 CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE PROGRAM INTEGRITY MANUAL § 8.3.2.2.1 (Rev. 377, May 27, 2011), available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c08.pdf [hereinafter MEDICARE PROGRAM INTEGRITY MANUAL].

However, if “[A] suspension of payment is put into effect without prior notice . . . the [carrier] must, once the suspension is in effect, give the provider or supplier an opportunity to submit a rebuttal statement as to why the suspension should be removed.”¹⁵ If the provider has a rebuttal statement, CMS or the carrier must, within fifteen days from the date of the rebuttal statement, consider its contents together with any other material bearing on the case and determine whether the facts justify the suspension.¹⁶ The carrier then must send the provider written notice of its determination.¹⁷ A very important aspect of this regulatory framework is that a determination that a suspension of Medicare payments is justified is not an “initial determination.”¹⁸ This is important because only an initial determination is appealable pursuant to 42 C.F.R. § 498.3. Except for rebuttal statements and other evidence, there are no other administrative processes that providers or suppliers can use to protest a suspension.¹⁹

After a suspension has taken effect, the carrier or CMS must act in a timely manner to obtain the additional evidence to determine whether an overpayment exists.²⁰ Only payments are suspended; the Medicare contractor will continue to process and credit claims notwithstanding the suspension, resulting in the accumulation of a *suspense account* much like an escrow.²¹ As soon as the carrier or CMS makes a determination, the carrier must inform the provider or supplier of the decision, rescind the suspension if appropriate, and dispose of the suspended funds in accordance with the determination.²² Suspended payments “are first applied to reduce or eliminate any overpayments determined by the [intermediary, carrier], or CMS . . . and then applied to reduce

15 42 C.F.R. § 405.372(b)(2).

16 See *id.* § 405.375(a).

17 See *id.* § 405.375(b).

18 *Id.* § 405.375(c).

19 See *id.* § 405.374.

20 See *id.* § 405.372(c).

21 See MEDICARE PROGRAM INTEGRITY MANUAL § 8.3.2.3.1.

22 See 42 C.F.R. § 405.372(c).

any other obligation to CMS or to HHS.²³ . . . In the absence of a legal requirement that the excess be paid to another entity, the excess is released to the provider or supplier.”²⁴

The old regulation and payment suspensions for fraud

The initiation (including whether or not to give advance notice), modification, or removal of any type of suspension requires the explicit prior approval of the CMS Central Office, Division of Benefit Integrity Management Operations, Fraud and Abuse Suspensions and Sanctions (DBIMO FASS).²⁵ Suspension actions are coordinated with law enforcement partners.²⁶

Suspensions may be premised on reliable information of fraud or willful misrepresentation. According to the *Medicare Program Integrity Manual*, fraud is a concept that is broadly intended and fraud suspensions may “be imposed for reasons not typically viewed within the context of false claims,”²⁷ which are claims submitted to the government for services not provided or when a provider upcodes or otherwise submits a claim for reimbursement for which they are not entitled. (Actions to recover for false claims typically are pursued pursuant to the False Claims Act, 31 U.S.C. § 3729.) Some specific examples of reasons not typically viewed within the context of false claims include a Quality Improvement Organization review of inpatient claims, which reveals that diagnosis-related groups (DRGs) have been upcoded; suspected violations of the physician self-referral ban; forged signatures on Certificates of Medical Necessity (CMN) and treatment plans; and other misrepresentations on Medicare claims and claim forms to obtain payment.²⁸ Per the Medicare Program Integrity Manual “[c]redible

²³ *Id.* § 405.372(e).

²⁴ *Id.*

²⁵ See MEDICARE PROGRAM INTEGRITY MANUAL § 8.3.2.3.1.

²⁶ *Id.*

²⁷ *Id.* § 8.3.1.1.

²⁸ *Id.*

allegations of such practices are cause for suspension pending further development.”²⁹ Fraud suspensions also may be premised on credible complaints and when a provider or supplier is identified as engaging in practices described in a CMS Fraud Alert, or when CMS receives a request from outside agencies (e.g., DOJ or OIG) or Medicare contractors to impose fraud suspensions.³⁰

Payment suspensions: How they are used and what they mean to providers

In November 2010, the OIG prepared a report concerning the use of payment suspensions to prevent inappropriate Medicare payments.³¹ For this report, the OIG examined 253 suspensions imposed by CMS in 2007 and 2008.³² According to the OIG, the great majority of providers suspended in 2007 and 2008 exhibited characteristics that suggested fraud and the payment suspensions were used almost exclusively to fight fraud.³³ It is also noteworthy that in 2007 and 2008, Part B providers comprised 85 percent of the suspensions and 79 percent of the providers were located in four jurisdictions (Florida, California, Michigan and Puerto Rico).³⁴ This report provides some insight into CMS's use of payment suspensions; CMS has been judicious with its use of this very strong tool, given the large number of Medicare providers and suppliers.

29 *Id.*

30 *Id.*

31 See OFFICE OF INSPECTOR GEN., DEP'T OF HEALTH & HUMAN SERVS., MEMORANDUM REPORT: THE USE OF PAYMENT SUSPENSIONS TO PREVENT INAPPROPRIATE MEDICARE PAYMENTS, OEI-01-09-00180 (Nov. 1, 2010), available at <http://oig.hhs.gov/oei/reports/oei-01-09-00180.pdf> [hereinafter OIG MEMORANDUM REPORT].

32 *Id.*

33 *Id.*

34 *Id.*

Providers and attorneys beware: Examples of legal challenges

Periodically and not surprisingly, providers or suppliers negatively impacted by a payment suspension have challenged the government's ability to impose a payment suspension under this regulation. As discussed below, these types of legal challenges have been virtually universally unsuccessful. Although the following cases stem from decisions under the previous regulation, they are important in the context of the newly expanded power, as a provider or supplier would likely be making some of the same or substantially similar arguments if a legal challenge is initiated.

The essential lesson for healthcare providers and attorneys is the importance of exhausting administrative remedies prior to initiating suit, as shown in *Homewood Professional Care Center v. Heckler*.³⁵ In this case, the court would not even hear the claims. The Medicare fiscal intermediary, after receiving information from a disgruntled part-owner of Homewood Professional Care Center, Ltd., a nursing home, suspended payments to Homewood. Before the administrative review of the issue was resolved, Homewood initiated a lawsuit against, among others, the Secretary of HHS, wherein Homewood claimed that it was deprived of its property without due process of the law.³⁶ The District Court found that it lacked subject matter jurisdiction to hear the claim because HHS had not issued a final decision.³⁷ On appeal, the Seventh Circuit Court of Appeals upheld that decision.³⁸

35 *Homewood Prof'l Care Ctr., Ltd. v. Heckler*, 764 F.2d 1242 (7th Cir. 1985) [hereinafter *Homewood Prof'l Care Ctr., Ltd.*].

36 According to the Fifth Amendment to the United States Constitution: "[N]or shall any person . . . be deprived of life, liberty, or property, without due process of law . . ."

37 *Homewood Professional Care Center, Ltd.*, at 1246.

38 *Id.* at 1253.

The right to due process was a battle fought and lost in a Nebraska federal trial court.³⁹ In *Krebsbach v. Heckler*, the Medicare intermediary suspended payments to the physician without giving notice of the suspension, having what it deemed to be reliable evidence of fraud or willful misrepresentation.⁴⁰ The physician claimed that a lack of hearing prior to the suspension deprived him of his right to due process.⁴¹ The court found that the suspension of payments without a hearing did not deprive the plaintiff physician of his due process right, ruling in favor of the government.⁴²

A second challenge based on right to due process failed a couple of years later when a Florida physician tried a similar claim. In *Neurological Associates—H. Hooshmand, M.D. v. Bowen*,⁴³ the court found that there was “no basis” for the physician’s assertion that due process required him to receive a hearing prior to the payment suspension.⁴⁴ The court noted that it had been “conclusively established that Medicare providers have no constitutional right to a hearing prior to being suspended from the program.”⁴⁵ The 1996 decision in *Clarinda Home Health v. Shalala*⁴⁶ is much the same as the challenges from the 1980s. Clarinda Home Health had its payments suspended after the DOJ and Federal Bureau of Investigation’s investigation produced reliable evidence that Clarinda had committed acts of fraud and/or willful misrepresentation.⁴⁷ Clarinda sought an injunction to stop the govern-

39 See *Krebsbach v. Heckler*, 617 F. Supp. 548 (D. Neb. 1985), *superseded by statute as stated in* Diagnostic Cardioline Monitoring of N.Y. v. Shalala, No. 99-CV-5686, n.1 (E.D.N.Y. Jun. 26, 2000) [hereinafter *Krebsbach*].

40 *Id.* at 551.

41 *Id.*

42 *Id.*

43 *Neurological Assocs.—H. Hooshmand, M.D. v. Bowen*, 658 F.Supp. 468 (S.D. Fla. 1987).

44 *Id.* at 473.

45 *Id.* at 472, citing *Northlake Cmty. Hosp. v. United States*, 654 F.2d 1234, 1241–45 (7th Cir. 1981) and *Town Court Nursing Ctr., Inc. v. Beal*, 586 F.2d 266, 277–78 (3rd Cir. 1978).

46 *Clarinda Home Health v. Shalala*, 100 F.3d 526 (8th Cir. 1996) [hereinafter *Clarinda Home Health*].

47 *Id.*

ment from suspending payments without a hearing, claiming violation of due process rights.⁴⁸ The court found that the suspension was not a final decision that could be subject to judicial review; the court, therefore, lacked subject matter jurisdiction over the plaintiff's claim.⁴⁹ Only after the government makes a final decision does the provider have the right to a hearing and judicial review.⁵⁰ The court held that it is not a violation of due process to temporarily withhold Medicare payments during an ongoing fraud investigation.⁵¹ Thus, courts are in agreement that a temporary suspension of Medicare payments is not a final decision subject to a hearing or judicial review and that suspension without a hearing in cases of fraud or misrepresentation does not violate providers' due process rights.

Undeterred by the negative case law interpreting the regulations, providers continued to bring challenges. In *Midwest Family Clinic v. Shalala*,⁵² the plaintiff, Midwest Family Clinic, Inc., brought a motion for a preliminary injunction after the Medicare intermediary notified Midwest that Medicare payments would be suspended. The suspension letter advised Midwest of their right to challenge the suspension by submitting a rebuttal statement.⁵³ The plaintiff Midwest submitted a rebuttal claiming that the suspension of Medicare payments violated both their Fifth Amendment right to due process and their Fourth Amendment right to be free from unreasonable seizures,⁵⁴ but the intermediary upheld the suspension.⁵⁵

Regarding plaintiff's due process claims, the court noted that it likely did not have jurisdiction to hear the claim because the decision to suspend Medicare payments was not a final decision under the

48 *Id.* at 528.

49 *Id.* at 530.

50 *Id.*

51 *Id.* at 531.

52 *Midwest Family Clinic v. Shalala*, 998 F.Supp. 763 (E.D. Mich. 1998).

53 *Id.*

54 *Id.* at 766.

55 *Id.* at 765–66.

administrative review process for Medicare.⁵⁶ The court assumed for the sake of argument that it could exercise jurisdiction, yet found that the plaintiff likely could not succeed on its due process claim that the failure to provide a pre-suspension or post-suspension hearing violated the constitutional rights of plaintiff, citing multiple cases that rejected similar arguments.⁵⁷ The court also rejected plaintiff's claim that an indefinite suspension of Medicare payments without a hearing was a due process violation, finding that the regulations do not provide for an indefinite suspension of payments.⁵⁸ The court further noted that the regulations in effect prior to 1996 contained no time limits and provided for no pre-suspension or post-suspension hearing and that those regulations were found to be constitutional.⁵⁹ In regard to the Fourth Amendment claim, the court likewise rejected this argument, indicating that it "doubts that a 'seizure' has even occurred here."⁶⁰ Even assuming that the suspension constituted a seizure under the Fourth Amendment, the court found that any such seizure was reasonable.⁶¹

More recently, in *Long Island Ambulance v. Thompson*,⁶² *Guzman, M.D. v. Shewry*,⁶³ and *Personal Care Products v. Hawkins*,⁶⁴ challengers brought similar claims that a suspension of Medicaid payments violated their rights. In each case, the respective courts rejected those claims.

An important take-home lesson—exhaust all avenues before filing suit: The take-away lesson from this discussion is that providers and suppliers challenging the government's ability to suspend payments have failed universally. It seems exceedingly clear that a payment suspension imposed pursuant to the regulation in effect prior to the new expan-

56 *Id.* at 769, citing *Homewood Professional Care Center, Ltd. and Clarinda Home Health*.

57 *Id.* at 769–70.

58 *Id.* at 770.

59 *Id.* at 770–71, citing *Krebsbach*.

60 *Id.* at 771.

61 *Id.*

62 *Long Island Ambulance, Inc. v. Thompson*, 220 F. Supp. 2d 150 (E.D.N.Y. 2002).

63 *Guzman v. Shewry*, 552 F.3d 941 (9th Cir. 2009).

64 *Pers. Care Prods., Inc. v. Hawkins*, 635 F.3d 155 (5th Cir. 2011).

sion of power will be upheld and is not likely to result in a finding that the constitutional rights of the affected provider or supplier were violated. Healthcare providers faced with a payment suspension under the old authority, which is still a viable avenue for the government to suspend payments, are almost certain to find that their legal challenge will not be well received in the judicial system, especially if they fail to exhaust their administrative remedies.

Exhaustion of administrative remedies

As the above discussion illustrates, a major impediment an aggrieved provider or supplier faces is the administrative review process under which the Medicare program operates. A judicial review of claims arising under the Medicare Act is available only after a final decision has been rendered on a claim.⁶⁵ A final decision is rendered only after the individual claimant has pressed the claim through all designated levels of administrative review, including redetermination, reconsideration, a hearing before an administrative law judge, and review in the Appeals Council.⁶⁶ Only if the Appeals Council denies the claim can a party obtain judicial review in a federal district court of the “Secretary’s final decision.”⁶⁷

The courts consistently have upheld the administrative review process found in the Medicare regulations. In *Heckler v. Ringer*,⁶⁸ the Supreme Court, after reviewing the administrative review process for Medicare claims, held that administrative remedies had to be exhausted before judicial review of the denial of a claim. In *Heckler*, multiple beneficiaries sought review of the denial of their claim for Medicare benefits for a certain procedure they had performed, but pursued the administrative review process only part way. Similarly, the court in *Russi*

65 42 U.S.C. § 1395ff(b)(1)(A); see also *id.* § 405(g).

66 *Id.* § 1395ff.

67 *Id.*

68 *Heckler v. Ringer*, 466 U.S. 602 (1984).

*v. Weinberger*⁶⁹ found that medical practitioners and their professional corporations seeking declaratory and injunctive relief after the government suspended payments were not entitled to judicial review due to their failure to exhaust administrative remedies.

In a case briefed and argued by co-author Alan Gilchrist on behalf of the prevailing party, the Supreme Court did recognize a distinction between seeking judicial review of the amount of benefits payable under the Medicare program and the method by which such amounts are to be determined.⁷⁰ In *Bowen*, an association of family physicians and several individual physicians challenged the validity of a regulation that authorized the payment of benefits in different amounts for similar physician services. The Supreme Court upheld the decision of the Sixth Circuit Court of Appeals, which had upheld the District Court decision that the regulation in question contravened several provisions of the Medicare program's governing statute.

There are some instances where the exhaustion of administrative remedies requirement can be relaxed, however. Generally, to be excused from the administrative exhaustion requirement, a plaintiff must show that:

- the suit involves a collateral attack rather than one on the merits; and
- its interest in prompt judicial review is so compelling that deference to the agency's determination is inappropriate.⁷¹

In *Ridgeview Manor of Midlands v. Leavitt*, the court issued an injunction prohibiting the government from revoking the nursing home

69 *Russi v. Weinberger*, 373 F. Supp. 1349 (E.D. Va. 1974).

70 *Bowen v. Mich. Acad. of Family Physicians*, 476 U.S. 667 (1986). Note that *Bowen* was decided prior to the Omnibus Budget Reconciliation Act of 1986, which amended §1395ff(b)(1)(C) to extend Part A's administrative review and exhaustion provisions to Part B disputes.

71 See *Ridgeview Manor of Midlands, L.P. v. Leavitt*, No. 3:07-cv-861-JFA (D. S.C. 2007), citing *Johnson v. Sullivan*, 922 F.2d 346, 352–53 (7th Cir. 1990) and *Bowen v. New York*, 476 U.S. 467, 483 (1986).

plaintiffs' billing privileges or terminating the plaintiffs' provider agreement until after a hearing on the issues. The court found a significant chance of irreparable injury, not only to the nursing home, but to the nursing home patients who would have to be transferred elsewhere should the revocation of billing privileges be allowed prior to a hearing.

Similarly, the court in *Oak Park Health Care Center v. Johnson*⁷² issued a temporary restraining order to stop the government from terminating the plaintiff's provider agreements, relying on the irreparable harm likely to be suffered by the residents of the nursing home if the plaintiff's agreements were terminated without a hearing.

Other providers have not had the same success as the plaintiffs in *Ridgeview Manor* and *Oak Park*. A home health agency brought a similar action for injunctive relief in the case of *Indeplus Group of Companies v. Sebelius*.⁷³ The court noted that it was sympathetic to the plaintiff's claims that the suspension of payments would be extremely damaging and force it out of business; however, the court declined to issue an injunction and dismissed the action because the plaintiff had failed to exhaust administrative remedies.⁷⁴

The lesson is that a provider or supplier must exhaust administrative remedies prior to obtaining judicial review of a decision by the government, *absent exceptional circumstances*. Note, however, that this review appears to show that the courts are more sympathetic to providers like nursing homes than to other providers, such as home health agencies.

72 *Oak Park Health Care Ctr., LLC v. Johnson*, No. 09 CV 217 (W.D. La. 2009).

73 *Indeplus Group of Cos. v. Sebelius*, No. 3:10-CV-0557-O (N.D. Tex. 2010).

74 *Id.*

The New Rules, Payment Suspensions, and Credible Allegations of Fraud

We now turn our attention to the newly enacted suspension authority, which appears to significantly broaden the government's ability to suspend Medicare payments. The most significant of the fraud-fighting tools in the Patient Protection and Affordable Care Act (PPACA) is the enhanced authority for CMS to suspend Medicare and Medicaid payments on the basis of a pending investigation of a credible allegation of fraud. In the recent OIG report discussing CMS's 253 Medicare suspension actions for 2007 to 2008, the OIG noted that the majority of such actions were taken because of factors suggesting fraud, and that for those actions, approximately \$206 million in overpayments were identified.

What do the new rules mean? Why should providers be concerned?

The new rules implement § 6402(h) of PPACA, which authorizes CMS to suspend payments to Medicare providers and suppliers "pending an investigation of a credible allegation of fraud . . . unless the Secretary determines there is good cause not to suspend such payments." Section 6402(h) contains a parallel provision requiring state Medicaid programs to suspend payments to providers when an investigation of a credible allegation of fraud is pending against the provider.

Although CMS regulations authorized the suspension of Medicare and Medicaid payments prior to the enactment of PPACA, § 6402(h) lowers the standard the government must meet to suspend payments based on suspected fraud. As noted above, the pre-PPACA regulations authorized CMS to suspend Medicare payments to providers for suspected fraud based on reliable information of fraud. States had been authorized to withhold Medicaid payments to a provider based on the

receipt of “reliable evidence of fraud.”⁷⁵ Under § 6402(h) of PPACA, the new standard for both Medicare and Medicaid is *credible allegation of fraud*, and the new regulations define this term broadly.

Credible allegations of fraud

The term *credible allegation of fraud* is not defined in PPACA. Medicare regulations define the term to mean

an allegation from any source, including but not limited to the following:

- (i) Fraud hotline complaints.
- (ii) Claims data mining.
- (iii) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.⁷⁶

The definition of *credible* is likewise not very enlightening: allegations are credible when they have an “indicia of reliability.”⁷⁷ Using this standard, the Secretary of HHS will determine whether there has been a credible allegation of fraud after consultation with the OIG.⁷⁸ Many commentators suggested that the proposed definition was ambiguous and failed to detail a precise evidentiary standard that will determine if a payment suspension is warranted.⁷⁹ CMS responded to these comments and decided not to change the definition, stating “[C]onsultation between CMS and the OIG prior to implementing a payment suspension will provide ample opportunity for the credibility of an allegation to be assessed and for a preliminary investigation into the allegation of fraud to occur sufficient to meet a reasonable evidentiary standard.”⁸⁰

⁷⁵ See *explanation* at 76 Fed. Reg. 5862, 5931 (Feb. 2, 2011).

⁷⁶ 42 C.F.R. § 405.370(a).

⁷⁷ *Id.*

⁷⁸ See PPACA § 6402.

⁷⁹ See 76 Fed. Reg. 5862, 5929.

⁸⁰ *Id.*

Another concern for providers is that these statements do not provide much guidance into what exactly the government looks for or when an allegation rises to the level of credible. This lack of guidance is especially troubling for healthcare providers because the basis for suspensions can be as little as a fraud hotline complaint or the filing of an action under the False Claims Act, which in many instances is subsequently proven untrue.

The new regulation also provides that CMS can choose not to suspend payments if there is “good cause” for not suspending payments. *Good cause for not suspending payments* has been defined by CMS 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
- (4) a determination by CMS that a suspension is not in the best interests of the Medicare program.⁸¹

Conclusion of an investigation

Because PPACA authorizes a payment suspension until an investigation of a credible allegation of fraud has concluded, the new rule includes a definition for the *conclusion of the investigation*. It is defined as the termination of legal action by settlement, judgment, dismissal, or when the case is dropped for lack of sufficient evidence.⁸² Although this appears to allow for an indefinite suspension, the regulations fur-

⁸¹ See 42 C.F.R. § 405.371(b).

⁸² See 76 Fed. Reg., at 5929.

ther provide that suspensions are limited to a period of 180 days.⁸³ The no-more-than 180-day suspension can be extended, however, if (i) administrative action is pending or being considered by OIG; or (ii) the DOJ requests a continuation of the suspension based on an ongoing investigation and anticipated or pending criminal or civil action.⁸⁴ In response to many commentators supporting an additional good cause exception not to continue a suspension when an investigation continued beyond a certain length of time, CMS, however, indicated that there is an 18-month maximum duration for a credible fraud allegation investigation.⁸⁵ A suspension can last longer than 18 months only if special circumstances exist, such as if the case has been referred to and is being considered by OIG, or the DOJ submits written request to CMS to continue suspension.⁸⁶ CMS indicated that it does not intend to suspend payments indefinitely, but believes it should have flexibility to complete the investigation and that it actively will evaluate the progress of any investigation, including requesting certification from the OIG or other law enforcement agency that the matter continues to be under investigation.⁸⁷

There is little surprise that many are expressing concern. Commenters especially focus on the perceived lack of due process afforded to providers in the new rule. This is especially true given the new rule's broad impact for suspension of Medicare payments and the lack of success providers have had challenging the previous regulations in court.⁸⁸ The new rule has no additional appeal rights or hearing rights. CMS indicated that the rule "affords providers who have had their payments suspended based on credible allegations of fraud ample opportunity to submit information to us in the established rebuttal statement process

83 See 42 C.F.R. § 405.372(d).

84 *Id.*

85 See 76 Fed. Reg., at 5930.

86 *Id.*

87 *Id.*

88 *Id.*

to demonstrate their case for why a suspension is unjustified.”⁸⁹ CMS also indicates that “[O]nly in the most egregious cases will payment suspensions last longer than the previously established timeframes [i.e., the timeframes established under the prior regulations] for payment suspensions.”⁹⁰

Overpayments

Another concern for providers is CMS’s treatment of payment suspensions in the cases of overpayments without credible allegations of fraud, such as inadvertent billing errors or Medicare contractor claims processing errors that are no fault of the provider.⁹¹ CMS indicated that although it has had the ability to suspend payments even in cases that do not involve fraud, historically it has not suspended payments often in such circumstances.⁹² Such a statement seems to be substantiated by the OIG report for 2007 and 2008, which, as you will recall, found that payment suspensions were used almost exclusively to combat fraud.⁹³ CMS further indicated that it would approach the question of whether a payment suspension is appropriate on a case-by-case basis and take into consideration factors such as inadvertent billing errors or Medicare contractor claims processing errors.⁹⁴ In spite of stakeholder objections, CMS adopted the proposed rule virtually verbatim, with the sole exception being the outside cap of 18 months for a payment suspension to continue, absent special circumstances.

Changes to Medicaid payment suspensions: What do providers need to know?

States have long been authorized to withhold Medicaid payments to a provider in cases of fraud and willful misrepresentation. PPACA now

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ See 76 Fed. Reg., at 5931.

⁹² *Id.*

⁹³ See OIG MEMORANDUM REPORT.

⁹⁴ See 76 Fed. Reg., at 5931.

provides that states may not receive FFP in cases in which the state has failed to suspend Medicaid payments to a provider when an investigation of a credible fraud allegation is pending, unless the state finds good cause not to suspend payments.⁹⁵

The new regulations implement this statutory provision. Although CMS's definition of credible allegation for Medicaid is virtually identical to that for Medicare, states have the flexibility to determine what constitutes a credible allegation of fraud under state law.⁹⁶ Moreover, "[s]tate agency investigations, though they may be preliminary . . . are adequate vehicles by which it may be determined that a credible allegation of fraud exists sufficient to trigger a payment suspension to protect Medicaid funds."⁹⁷ A state is not required to suspend all payments to a provider; CMS will continue its policy of allowing states to suspend payments, in part, to a provider.⁹⁸ The temporary suspension will continue until (i) law enforcement authorities determine that there is insufficient evidence of fraud on which to base a legal action; or (ii) legal proceedings are completed.⁹⁹ A state is required to request, on a quarterly basis, a certification from the applicable law enforcement agency that the matter continues to be under investigation or that enforcement proceedings have been initiated and have not been completed.¹⁰⁰ CMS expressly declined, however, to impose a 180-day initial limit on the duration of a suspension of Medicaid payments similar to the time limit imposed on suspensions under Medicare, finding that, in contrast to the national Medicare program, which needs some uniformity, each state needed flexibility to decide the duration of payment suspensions to accommodate state laws and legal processes.¹⁰¹

95 See PPACA § 6402.

96 See 76 Fed. Reg., at 5932.

97 *Id.*

98 See *id.*, at 5934.

99 See *id.*, at 5933.

100 *Id.*

101 See *id.* at 5940.

Providers should note that state Medicaid agencies are required to notify them of a payment suspension within five days of taking action to suspend payments.¹⁰² This five-day period can be extended, however, for up to three thirty-day periods (i.e., a total of ninety days) at the request of a law enforcement agency.¹⁰³ The notice of suspension sent by a state should reference the general allegations on which the suspension has been based and also should reference any existing state appeals procedures.¹⁰⁴ States, however, are not required to notify a provider prior to suspending payments.¹⁰⁵

What can providers do? What challenges do they face?

Given the broadened power government payors now possess, the logical inquiry is what can an affected provider do if faced with a payment suspension under the new rules? Experience tells us, almost conclusively, that due process and other constitutional claims are likely to fail. However, to the extent that the new rules have expanded the government's powers to suspend payment, these provisions have not yet been tested in the court system. Because the new rules allow a suspension to last up to 18 months (and possibly beyond that 18-month period under certain circumstances), a suspension can effectively amount to a provider's termination or, in some cases, may force a provider reliant on Medicare reimbursement out of business. Given that a hearing is not required prior to a final determination in the administrative process, this new provision could open the doors to new constitutional challenges.

102 See *id.* at 5932.

103 *Id.*

104 See *id.* at 5937.

105 *Id.*

However, a suspension under the prior regulations started with a 180-day suspension (i.e., six months), which could be extended for an additional 180 days in cases of fraud and misrepresentation where the carrier, OIG, or law enforcement agency is unable to complete its examination or investigation, and which, in certain circumstances, may be further extended. Challenges to these time frames have been universally rejected. Given that the previous suspension periods have been upheld with no indication that a court was willing even to contemplate striking down the applicable regulations, one would imagine that an outside bar of eighteen months almost certainly would withstand due process and other constitutional challenges. The guidance from the cases discussed above seems very clear: a “temporary” suspension will not result in a colorable legal claim.

Given the relatively recent finalization and implementation of the new rules, they have not yet come under the judiciary’s constitutional scrutiny. No doubt an aggrieved provider will attempt to assert similar arguments to those previously advanced and hope that the expansion of the rules will lead to a different result. Given the lack of any additional administrative review procedures, there really does not appear to be an attractive alternative for a provider faced with such a suspension other than to attempt such a lawsuit.

As the regulations are drafted, a provider or supplier could be under suspension for up to eighteen months (or possibly longer) and ultimately be found to have done nothing improper. It remains to be seen if any provider/supplier could withstand eighteen months without receiving Medicare reimbursement.

Providers take note: The only instance where providers have had some success in challenging decisions in court prior to the exhaustion of administrative remedies is to bring an action for an injunction. The examples of the plaintiffs in the nursing home cases discussed above showed that the best course of action may be to argue that if a suspension is allowed to continue without any assurances of a hearing, the provider and its patients or beneficiaries will be irreparably harmed.

In the authors' view, an important factor in the courts' decisions was the hardship that the nursing home patients would have suffered by having to be moved to new facilities if the adverse action were allowed to proceed without a hearing. Contrast that decision to the home health agency decision, which arguably had similar facts, except that its patients did not live at the agency. It may be that a provider such as a nursing home, where vulnerable and physically unable individuals reside, will have a better chance of prevailing in challenge to a suspension under these new regulations than a provider like a home health agency. To the authors' knowledge, no such argument has made its way into the judiciary; however, one would expect to see cases challenging the constitutionality of the newly expanded authority in the near future.

Personal Experience: The authors' first (and, to date, only) experience with a suspension under the new rules involved a home health agency suspended without notice. The authors were repeatedly told that a letter was coming setting forth the basis for the suspension. The best that could be determined at this time is that the Medicare contractor transposed two numbers on the national provider identifier, suspending the wrong provider. Although we were able to clear up the mistake, it took approximately forty-five days from the date the suspension began before it was lifted. As a result, the provider lost a month and a half of income, had to lay off all of its employees, and was forced to take drastic measures to keep the business afloat. The provider is attempting to rebuild, but it is a difficult task with limited available remedies for the inconvenience and lost business incurred. This provider was heavily dependent on Medicare reimbursement and could not absorb the loss of income while the suspension was in effect.

Conclusion: Concerns for the Future

The uncertainty of the application of the payment suspension rules certainly raises concerns for providers. Because CMS left itself the flexibility to decide whether a payment suspension is appropriate on a case-by-case basis, providers must carefully monitor any developments, including any additional CMS guidance. In light of the significant potential negative impact of a payment suspension, providers should:

- ensure that they have an effective compliance program in place;
- consult legal counsel as soon as they become aware of the potential suspension to ensure they avail themselves of every available avenue to challenge an impending or already in process payment suspension; and
- file an action to contest the suspension even if the provider may not prevail. Such an action will be assigned to a local Assistant U.S. Attorney who may very well, at least, inquire as to the basis of the suspension.

These actions may provide additional safeguards to ensure the providers have the artillery needed to do battle, if, in fact, the payment is suspended.