CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 495	**Date: December 13, 2013**
	Change Request 8394

SUBJECT: Recalcitrant Provider Procedures

I. SUMMARY OF CHANGES: The purpose of this CR is to manualize the formal process for addressing recalcitrant providers and suppliers. CMS has learned from contractors that providers are abusing the program and not changing inappropriate behavior even after extensive education to address these behaviors. These noncompliant providers who refuse to comply with CMS rules, result in contractors' placing these providers on prepay medical review for years and utilize resources that would be better utilized for other types of oversight activity.

EFFECTIVE DATE: January 15, 2014 - This process is currently in effect and this is a clarification through a manual update.
IMPLEMENTATION DATE: January 15, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/Table of Contents
R	4/4.27/ Recalcitrant Providers
N	4/4.27.1/ Issues to Consider Before Referring a Recalcitrant Provider Case to CMS
N	4/4.27.2/ CMS Approval/Disapproval for Notification for a Recalcitrant Provider/Supplier Case Submission
N	4/4.27.3/ Case Format for Referring Recalcitrant Providers/Suppliers

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-08	Transmittal: 495	Date: December 13, 2013	Change Request: 8394

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I. GENERAL INFORMATION

A. Background: Over the years, CMS has heard from contractors that providers are abusing the program and not changing inappropriate behavior. These noncompliant providers, who refuse to comply, result in contractors' placing these providers on prepay medical review for years. Though such an activity is protecting the Trust Fund dollars on the front end, it is exhausting contractor resources which could be utilized in more productive activities.

Accordingly, CMS is taking advantage of current sanctions that we believe may address this problem. The two authorities that may be appropriate to impose a sanction are Section 1128A(a)(1)(E) or 1128 (b)(6) of the Act. Both of these sanctions are delegated to the OIG. CMS has been in contact with the OIG and they are willing to work with us in pursuing these cases.

Contractors who believe they have a case that meets the criteria we have established should make contact with their respective regional office and with the Center for Program Integrity's Fraud and Abuse Suspensions and Sanctions Team. **NOTE**: It is important that for any case submitted, different mitigating or aggravating circumstances may need to be applied.

B. Policy: A recalcitrant provider is defined as a provider that is abusing the program and not changing inappropriate behavior even after extensive education by Medicare contractors to address these behaviors. These noncompliant providers who refuse to comply with CMS rules, result in contractors' placing these providers on prepay medical review for years. Though such an activity is protecting the Medicare Trust Fund dollars on the front end, it is exhausting contractor resources which could be utilized in more productive activities.

Medicare contractors shall take advantage of the current sanctions that may address this problem. The two authorities that may be appropriate to impose a sanction are Section 1128 A(a)(1)(E) for civil monetary penalties or 1128(b)(6) of the Act for exclusion from Medicare and State Health Care Programs. Both of these sanctions are delegated to the Office of Inspector General (OIG) and are types of civil monetary penalties. CMS has been in contact with the OIG and they are willing to work with CMS to pursue such cases.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8394.1	CMS oversight contractors shall, through the process determined in Chapter 4, Section 27 of the manual, review recalcitrant provider cases and submit such cases to the CPI FASS team for review.	X	X	X	X								ZPICs

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8394.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): August Nemec, 410-786-0612 or august.nemec@cms.hhs.gov (Joel Cohen X3349)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out within their operating budgets.

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Program Integrity Manual

Chapter 4 - Benefit Integrity

Table of Contents
(Rev. 495, 12-13-13)

Section 4.2 - *Recalcitrant Providers*

(Rev. 495, Issued: 12-13-13, Effective: 01-15-14, Implementation: 01-15-14)

Recalcitrant provider is defined as a provider that is abusing the program and not changing inappropriate behavior even after extensive education by Medicare contractors to address these behaviors.

These noncompliant providers who refuse to comply with CMS rules, may result in contractors' placing these providers on prepay medical review for years. Though such an activity is protecting the Medicare Trust Fund dollars at the front end, it is exhausting contractor resources which could be utilized in more productive activities.

Medicare contractors are encouraged to take advantage of the current sanctions that may address this problem. The two authorities that may be appropriate to impose a sanction are Section 1128 A (a)(1)(E) for civil monetary penalties or 1128(b)(6) of the Act for civil monetary penalty (CMP) and/or exclusion from the Medicare and State Health Care Programs. Both of these sanctions are delegated to the Office of Inspector General (OIG) and are types of civil monetary penalties. The Fraud and Abuse Sanctions and Suspensions (FASS) team shall review the recalcitrant provider/supplier case before CMPs are requested.

Section 4.27.1 - Issues to Consider Before Referring a Recalcitrant Provider Case to CMS

(Rev. 495, Issued: 12-13-13, Effective: 01-15-14, Implementation: 01-15-14)

Contractors who believe they have a case(s) that meet the criteria CMS have established should make contact by email with their respective COR and with the Fraud and Abuse Sanctions and Suspensions (FASS) team within CMS' Center for Program Integrity (CPI).

The following criteria shall be considered before exploring a referral to the FASS team:

- *The provider being considered for referral by the Medical Review Unit should not be under any fraud investigation by the Program Safeguard Contractor (PSC)/Zone Program Integrity Contractor (ZPIC) or active with the OIG (the MAC and the ZPIC shall include this coordination in the joint operating agreement (JOA); and*
- *The provider is currently on prepayment medical review, has been educated and continues to show a pattern of inappropriate behavior (do not include providers who are demonstrating improvement, however slight, as a result of education); and*
- *The contractor demonstrates the administrative burden (i.e., volume and dollars of claims being manually reviewed, volume and dollars of claims/services being denied, and associated resource costs); and*
- *The appeal history of denied claims indicate a low reversal rate (exclude potential case if claims have a high reversal rate); and*
- *The Medical Director concurs with the medical review determinations and is aware that he/she may be a potential witness; and*

Section 4.27.2 - CMS Approval/Disapproval for Notification for a Recalcitrant Provider/Supplier Case Submission

(Rev. 495, Issued: 12-13-13, Effective: 01-15-14, Implementation: 01-15-14)

- *What are the specific medically unnecessary services/items or non-covered services being provided and billed;*
- *What are the grounds for these services/items being medically unnecessary or covered;*
- *What education was provided to the provider to inform and correct the provider's pattern of inappropriate behavior;*
- *A description of the pattern of inappropriate behavior, including how the provider continued to provide medically unnecessary services/items or non-covered services after explicit education from the contractor;*

- *Appeal history (through ALJ level); and*
- *Availability of "Expert" witnesses being prepared to testify if necessary (Medical Director).*
- *CMS will notify the MAC and PSC/ZPIC of approval and then coordinate with the PSC/ZPIC before they will refer the provider/supplier to the MAC for revocation.*

Section 4.27.3 - Case Format for Referring Recalcitrant Providers/Suppliers

(Rev. 495, Issued: 12-13-13, Effective: 01-15-14, Implementation: 01-15-14)

The following case format is to be used by all contractors for submitting Recalcitrant Provider/Supplier cases to CPI's FASS team. All contractors shall follow this standard to ensure consistency and uniformity in the product being presented as a referral. ***NOTE****: Where information is not available or applicable, the contractor should indicate this behind the respective tab.*

Tab A – Referral Summary

The summary shall denote background information on the subject, a brief overview of the non-compliance. The following shall be detailed in this summary and everything submitted shall be in encrypted or secure email:

- *Subject Identification****:***

    1. *Name of the subject*
    2. *Name of individual or organization (if incorporated, etc.)*
    3. *Address(es) (include physical address, postal address)*
    4. *Telephone number(s)*
    5. *Date(s) of Birth*
    6. *Social Security Number(s)*
    7. *Specialty (include known sub-specialty)*
    8. *Participating Provider/Supplier (yes/no)*
    9. *NPI number (National Provider Identifier)*
    10. *PTAN number (Provider Transaction Access Number)*
    11. *UPIN number (Unique Physician Identification Number)*
    12. *TIN number (Tax Identification Number) (include all known TINs)*

- *Contractor Contact:*

    1) *Name/s*
    2) *Telephone number*
    3) *Email address*

- ***Non-compliance Issue:***

    Briefly describe the non-compliance issue. Is the issue involving one specific procedure code? Is it multiple codes? Briefly explain why these services are not medically necessary or non-covered. The applicable codes shall be listed if applicable.

- ***Billing History:***

    1) *Time period of non-compliance being referred. (Start Date is when contractor first establishes contact with provider and initiates education to correct non-compliance. End Date is date of last claim reviewed and denied because of the continued non-compliance.)*
    2) *For the time period being referred, please indicate the following:*
        a. *Total number of all claims submitted for payment and respective billed charges.*
        b. *Total number of services/items for above.*
        c. *Total number of claims (also indicate number of services/items) reviewed for non-compliance and respective billed charges.*

d. *Total number of claims paid from c) and allowed amount.*
e. *Total number of claims denied from c) and respective billed charges.*
f. *Total number of e) claims appealed for reconsideration.*
g. *Total number of f) claims and respective charges upheld at by Qualified Independent Contractor (QIC).*
h. *Total number of g) claims appealed to ALJ.*
i. *Total number of h) claims and respective charges upheld at ALJ level.*

- ***Educational Contacts Regarding Non-compliance with Provider:***

1) *Number of educational letters to provider during time period.*
2) *Number of telephone contacts with provider during time period.*
3) *Number of onsite contacts with provider during time period.*

- ***Administrative Resource Costs:***

1) *Estimate the administrative cost for manually reviewing the non-compliant claims. (Number of claims reviewed times the average time it takes to review the claim and make a determination times the average hourly rate of medical reviewers.)*
2) *Estimate the administrative cost (if any) for preparation of the appealed claims at the QIC level as identified in the billing history (2F).*
3) *Estimate the administrative cost (if any) for preparation of the appealed claims at the ALJ level as identified in billing history (2H).*

Tab B – Provider Background

The first page behind this tab should be a cover sheet listing the information below:

- *When licenses were active.*
- *When billings to the Medicare program began.*
- *Any adverse actions that have been imposed (e.g., fraud or civil case, settlements, license revocations, license suspensions, etc.).*
- *Copy (if applicable) of participation agreement or enrollment application.*
- *Any other applicable information.*

Tab C – Non-compliance Issue

Prepare a narrative fully describing the non-compliance issue. The first part of the narrative should describe what service(s) are being denied for medical necessity (including HCPCS) and the specific reason(s) why the service is not medically necessary and/or non-covered. Include the code/s a description of the services. This information should be described in a manner where a non-medical person will understand what is being written.

The last part of the narrative should describe the documented education attempted between the contractor and the subject provider. Include in this description the provider's responses to the contractor's educational attempts.

Tab D – Educational Contacts

The first page behind this tab should be a cover sheet chronologically listing the information that follows.

- *Copies of all written correspondence from the contractor to the provider regarding the non-compliance issue and any responses from the provider.*
- *Copies of all contact reports as a result of telephone calls between the contractor and the provider regarding the non-compliance issue.*
- *Copies of all contractor contact reports as a result of onsite contacts with the provider regarding non-compliance issue.*

- *Listing of all General Outreach sessions held (seminars, etc.) where non-compliance issue was discussed and indication if the provider or provider's employee(s) attended the session. The listing should include the date, location and identification of the provider's employee who attended where applicable.*

Tab E – Complaints

The first page behind this tab should be a cover sheet listing (in chronological date order) the information that follows.

- *The complainant name, HIC number and brief description of the complaint as it relates to the non-compliance issue, and the date of the complaint.*

Tab F – Data Analysis

The first page behind this tab should be a cover sheet listing the information that follows.

- *Copies of any data analysis reports conducted on the provider regarding the non-compliance issue.*

Tab G – Claims History

Provide a listing, in chronological date order, of all claims denied (and upheld through all appeal levels if denial was appealed) during time period. At a minimum, the listing should contain the following information:

- *Beneficiary Name*
- *Beneficiary HIC number*
- *Claim Control Number*
- *Description of service involved and related code/s (CPT-4/HCPCS)*
- *Charges Denied*
- *Was an Advanced Beneficiary Notice (ABN) associated with the claim (Yes-No)*

Provide a copy of 100 randomly selected claims during the last twelve (12) months of the time period (and any supportive documentation if received) from claims noted above.

Tab H – Policies

The first page behind this tab should be a cover sheet listing the information that follows.

- *Copy of any appropriate citations in the Code of Federal Regulations regarding the noncompliance issue.*
- *Copy of any policy related to or discussing the non-compliance issue in the Medicare Manuals.*
- *Copy of any Local Medical Review Policy related to or regarding the non-compliance issue.*
- *Listing of articles, if any, related to or regarding the non-compliance issue published in the contractor's bulletins/newsletters or on their Web site.*

Tab I – Other Materials

The first page behind this tab should be a cover sheet listing the information that follows.

- *Any additional material that the contractor believes is relevant to the case.*