



PAHCOM OCTOBER 18, 2011-
COMPLIANCE ISSUES FOR
PHYSICIAN PRACTICES 2012

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WHAT YOU NEED TO KNOW FROM THIS PRESENTATION

- Significant changes in government approaches to compliance and enforcement
- Requires changes in your business practices and compliance program
- Requires you to assure you know about government-identified issues in your billing and ordering activities

CONTROLLING HEALTH CARE FRAUD AND ABUSE: A PREVENTION STRATEGY AS WELL AS A PROSECUTION STRATEGY

- Who gets into the program?
- How does government oversee providers once in the program?
- What controls do providers themselves have to assure compliance and prevent fraud and abuse?
- How do agencies respond to information suggesting potential fraud or abuse?

Howard Goldstein, Missouri psychiatrist

- Medicare fraud conviction
- Five months in jail, 5 year exclusion
- \$830,000 repayment to federal and state programs
- Employed physician
- Employed by SSM St. Charles Medical Group

Dr. Howard Goldstein- Compliance history

- Dr. Goldstein's criminal false statement-
"minimized and mischaracterized concerns
and problems raised by SSM" (St. Louis
Business Journal 10/12/2010)

SSM St. Charles Medical Group

- 2007-Audited Dr. Goldstein -records "scant and illegible"
- Considered firing, but sent him to coding education classes
- 2009-routine peer review identifies continued record issues-reported to compliance officer, who reported to DOJ
- SSM to pay \$865,812

Lessons from Dr. Goldstein case

- What routine monitoring do you undertake?
- What actions do you take when physicians records do not support billing?
- What records do you make of findings?
- What records do you make of corrective actions?
- What do you do to monitor current actions of non-compliant physicians?
- You are responsible for employee bills

HEALTH FRAUD AND ABUSE ENFORCEMENT-A GROWTH BUSINESS

- AFFORDABLE CARE ACT(PPACA)-2200 pages to change health care-AND FRAUD AND COMPLIANCE (SECTIONS 6400-6500)
- MANDATORY DISCLOSURE OF OVERPAYMENTS TO MEDICARE AND MEDICAID-ACA Section 6402(a)
- MANDATORY COMPLIANCE PROGRAMS
- DATA ANALYSIS AND TARGETING
- BOUNTY HUNTERS-Medicare RACs, Medicaid RACS, Whistleblowers
- IMPROPER PAYMENTS MEASUREMENT AND RECOVERY

HEALTH FRAUD AND ABUSE ENFORCEMENT-A GROWTH BUSINESS

- GAO and CONGRESS to CMS:
 - You must measure and report improper payments
 - you must use contractors to recover improper payments
 - you must measure and report on ROI (return on investment) from your contractors' recovery efforts

NEW CMS REVIEWS

- “Predictive modeling technology (is being applied) to Medicare fee-for-service claims nationwide on July 1, 2011. All claims across the country are now being screened before they are paid. The ones with the highest risk scores will receive immediate attention and additional review by our analysts through our new rapid response strategy.” Dr. Peter Budetti, Director, CMS Center for Program Integrity

PREDICTIVE MODELING

- The Small Business Jobs Act of 2010, signed Sept. 27,2010 requires the Center for Medicare & Medicaid Services (CMS) to “adopt predictive modeling and other analytics technologies to identify improper claims for reimbursement and to prevent the payment of such claims under the Medicare fee-for-service program.”
- two year predictive modeling contest for hospital admissions. WSJ 3/16/11
- GAO Report GAO-11-409T 3/9/2011-5 steps to reduce M/M fraud, waste, abuse, including data mining, better predictive modeling, followup to RAC findings on providers

OLD-FASHIONED DATA MINING

- FOCUS ON CLAIMS
 - Edits
 - Pay and report
 - Don't pay
 - Prior authorization
 - Diagnosis and service
 - Bundling/unbundling
 - Inpatient/outpatients same day

OLD-FASHIONED DATA MINING: COMPLIANCE RESPONSE

- Why are your claims being denied?
- Revenue and compliance issues
- Edit codes
 - Patient was in hospital at time outpatient service allegedly rendered
 - Patient was dead at time service rendered
 - Roster billing
 - Other insurance

CURRENT DATA MINING-

- FOCUS ON PROVIDERS, PROVIDER BEHAVIOR, RECIPIENT BEHAVIOR, NETWORKS
- THE PHARMACY EXAMPLE
 - Excluded physicians or pharmacists
 - Time of day
 - DUR/refill too soon overrides
 - forged prescriptions
 - Credited scripts
 - Where do abusers go to fill scripts
 - Networks with physicians
 - Where do patients go after provider taken out?

COMPLIANCE RESPONSE TO CURRENT PHARMACY DATA MINING

- What record do your physicians make of change authorizations in prescriptions?
- What records do you require on prescription of controlled substances?
- What controls do you have on controlled substances prescription forms?
- How does your practice address patients with need for pain meds?

FUTURE DATA ANALYSIS

- Admissions volume/percentage
- Internal referrals in multispecialty practices
- Ordered services volume
- Ordered services relationships
- Ordered services representations
 - Face-to-face encounters prior to or concurrent with ordered services
 - -patient condition and need for seervices

THE 6402 (a) Compliance Challenge

- "AVOIDS "
- "OBLIGATION"
- "IDENTIFY"
- "TEMPORARY"
- "OVERPAYMENT"

THE LEGAL FRAMEWORK FOR DATA MINING AND REPORTING

- DEFICIT REDUCTION ACT OF 2005 (DRA)
- FRAUD ENFORCEMENT AND RECOVERY ACT OF 2009(FERA)
- THE AFFORDABLE CARE ACT OF 2010 (ACA)
- IMPROPER PAYMENTS ACT OF 2002/IMPROPER PAYMENTS ELIMINATION AND RECOVERY ACT OF 2010(IPERA) (P.L. 111-204)

DEFICIT REDUCTION ACT OF 2005?

- ENHANCED DATA ON THIRD PARTY LIABILITY
- PERMANENT DATA-SUPPORTED RACS (first recapture audits)
- MEDICAID MICS w/specific dm contractors
- MEDICAID INTEGRITY GROUP AT CMS
- CREATION OF MEDICAID INTEGRITY INSTITUTE TO TRAIN STATE MI STAFF
- REGULAR REVIEWS OF STATE MEDICAID PROGRAM INTEGRITY UNITS
- CREATION OF NY OMIG

FRAUD ENFORCEMENT AND RECOVERY ACT OF 2009

- 1) enhances whistleblower protection and right to recovery, defeats procedural motions
- 2) creates liability for person who “knowingly conceals or knowingly and improperly **avoids** or decreases an **obligation** to pay or transmit money or property to the Government” **new** 31 U.S.C. 3729(a)(1) (G)

THE AFFORDABLE CARE ACT OF 2010 (ACA)

- MANDATORY REPORTING, REPAYMENT, AND EXPLANATION OF **OVERPAYMENTS** BY "PERSONS"
- MANDATORY COMPLIANCE PLANS
- THE "**TEMPORARY**" SUSPENSION REQUIREMENT AND REGULATIONS

PPACA SECTION 6402 MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

- *"(d) REPORTING AND RETURNING OF OVERPAYMENTS.—*
- *"(1) IN GENERAL.—If a person has received an overpayment, the person shall—*
- *"(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and*
- *"(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.*

SEC. 6402 (d) MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

- *"(2) DEADLINE FOR REPORTING AND RETURNING OVERPAYMENTS.—An overpayment must be reported and returned under paragraph (1) by the later of—*
- *"(A) the date which is 60 days after the date on which the overpayment was **identified**; or*
- *"(B) the date any corresponding cost report is due, if applicable.*

PPACA SECTION 6402 (d) MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

- *"(3) ENFORCEMENT.—Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an **obligation** (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title. (False Claims Act)*

SEC. 6402 (d) MEDICARE AND MEDICAID PROGRAM INTEG- RITY PROVISIONS.

- *"(4) DEFINITIONS.—In this subsection:*
- *'(A) KNOWING AND KNOWINGLY.—The terms 'knowing' and 'knowingly' have the meaning given those terms in section 3729(b) of title 31, United States Code.*
- *"(B) OVERPAYMENT.—The term "overpayment" means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.*

EXAMPLES OF OVERPAYMENTS

- Services provided by excluded persons
- Services ordered by excluded persons
- Services “provided” to deceased persons
- Mispriced drugs
- Credit balances
- Claims billed and paid twice
- No record of treatment of patient
- Copied progress note
- Default entry of diagnosis
- NOTE: No need for bad intent
- NOTE: Stark violations governed by different disclosure policy

EXAMPLES OF OVERPAYMENTS

- Claims billed and paid twice
- No record of treatment of patient
- Copied progress note
- Forged prescription/physician denies ordering service
- Patient denies receiving service
- Default entry of diagnosis
- Identified audit finding outside audit year

PROVIDER MUST REPORT AND RETURN THE OVERPAYMENT AND STATE THE REASON, IN WRITING FOR THE PAYMENT

- NO CMS REGULATION OR GUIDANCE; NO PLANS FOR REGULATION OR GUIDANCE
- PA 2010 self-audit protocol: Medical Assistance Bulletin 99-02-13, <http://www.dpw.state.pa.us>
- NJ Self-Disclosure Process www.nj.state.us/njomig
- **NY OMIG's Disclosure Protocol, available on the OMIG website, www.OMIG@ny.gov**
- Mass., Ct. Do not yet have disclosure protocols
- COMPARE WITH federal OIG self-disclosure protocol <http://oig.hhs.gov/authorities/docs/selfdisclosure.pdf>.
- COMPARE WITH "unsolicited/voluntary refunds" to Medicare contractors (last checked July 2, 2010)
- See, e.g., <http://www.wpsmedicare.com>

PROVIDER MUST REPORT AND RETURN THE OVERPAYMENT AND STATE THE REASON, IN WRITING FOR THE PAYMENT-WHAT ABOUT MANAGED CARE?

- “This protocol is equally applicable to managed care providers. Inappropriate payments made by managed care organizations (MCOs) to providers within their networks inflate the costs of providing care to MA recipients, and DPW retains its right and responsibility to identify and recover payments or take any other action available under law. While DPW will return to the applicable MCO any payments identified through this protocol, providers must make the self disclosure directly to DPW.” (Pa.)

PA. Medical Assistance Provider Self-Audit Protocol

- Option 1 - 100 Percent Claim Review - A provider may identify actual inappropriate payments by performing a 100 percent review of claims
- Option 2 - Provider-Developed Audit Work Plan for BPI Approval
- Option 3 - DPW Pre-Approved Audit Work Plan with Statistically Valid Random Sample (SVRS)

THE ACA OBLIGATION TO RETURN AN IDENTIFIED OVERPAYMENT IS CONTINUING

- EFFECTIVE DATE OF 6402-3/24/10
- CRITICAL DATE: WHEN WAS THE OVERPAYMENT IDENTIFIED
- NOT: WHEN WAS THE OVERPAYMENT RECEIVED
- CONTINUING DUTY TO REPAY IDENTIFIED OVERPAYMENTS FROM PRIOR TIME PERIODS
- HOW FAR BACK?

“IDENTIFY”

- Need not know the amount of overpayment; need to have credible evidence that an overpayment has occurred
- CMS 2002 proposed regulation impact statement for mandatory disclosure:
 - Expect over 900,000 disclosures per year
 - Average time to report: 5 minutes
 - Draft reg. disclosure section withdrawn by CMS

CONSEQUENCES OF FAILURE TO REPORT

- False Claims Act imposes liability for a person who “knowingly” conceals or knowingly and improperly **avoids** or decreases an **obligation** to pay or transmit money or property to the Government” **new** 31 U.S.C. 3729(a)(1) (G) added by FERA
- “knowingly” includes reckless disregard, deliberate ignorance
- An overpayment which is timely reported and explained will not give rise to FCA liability even if the provider is unable to repay it within 60 days, unless there is evidence of improper “avoidance.”

WHO IS MOST LIKELY TO USE THE FERA FCA PROVISIONS TO ENFORCE THE 6402 ACA DUTY?

- WHISTLEBLOWERS AND THEIR COUNSEL
 - Data analysis for whistleblower case evaluation, supporting whistleblower allegation
 - Using your data and benchmarks
 - Matching exclusion lists against employee/contractor lists
 - Publicly available data on outliers
 - Discovery and access to govt. data and documents
 - Publicly available data on provider behavior
 - Best practices research

MANDATORY COMPLIANCE PLANS

- ACA requires CMS to issue regulations governing mandatory compliance plans for nursing facilities by March 24, 2012; required facility compliance by 3/24/2013
- Look for draft regs in fall of 2011
- “obligation”
- “identify”
- Auditing and risk assessment

ACA SECTION 6402 :EFFECT OF 2011 CMS REGS

- NEW MEDICAID PAYMENT SUSPENSION
REQUIRED UNLESS EXCEPTION
SATISFIED
- "CREDIBLE ALLEGATION OF FRAUD"
- **"TEMPORARY"**

“Suspension of payment”

- **42 CFR §405.370 Definitions** The 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 an investigation of a credible allegation of fraud.
- January 24, 2011 Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers Final Regulation- Preamble

“Credible allegation of fraud”-the CMS authority to cut off funding to providers

- **42 CFR §405.370 Definitions**
- A credible allegation of fraud is an allegation from any source, including but not limited to the following:
 - (1) Fraud hotline complaints.
 - (2) **Claims data mining.**
 - (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability.
- January 24, 2011 Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers Final Regulation- Preamble

NO FEDERAL FUNDS TO STATE IF STATE FAILS TO CUT OFF PAYMENT

- §447.90 FFP: Conditions related to pending investigations of credible allegations of fraud against the Medicaid program.
- (a) Basis and purpose. This section implements section 1903(i)(2)(C) of the Act which prohibits payment of FFP with respect to items or services furnished by an individual or entity with respect to which there is pending an investigation of a credible allegation of fraud except under specified circumstances.
- (b) Denial of FFP. No FFP is available with respect to any amount expended for an item or service furnished by any individual or entity to whom a State has failed to suspend payments in whole or part as required by §455.23 of this chapter unless
- January 24, 2011 Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers Final Regulation – Preamble.

MEDICAID: Credible allegation of fraud

- **§ 455.2 Definitions.** Credible allegation of fraud. A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following:
 - (1) Fraud hotline complaints.
 - (2) **Claims data mining.**
 - (3) Patterns identified through **provider audits**, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
- January 24, 2011 Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for

§455.23 Suspension of payments in cases of fraud (Medicaid)

- (a) Basis for suspension.
- (1) The State Medicaid agency **must suspend all Medicaid payments** to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.
- (2) The State Medicaid agency may suspend payments without first notifying the provider of its intention to suspend such payments.
- (3) A provider may request, and must be granted, administrative review where State law so requires.
- January 24, 2011 Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers Final Regulation, Preamble

§ 455.23(c) Duration of suspension

- (1) All suspension of payment actions under this section will be **temporary** and will not continue after either of the following:
 - (i) The agency or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider.
 - (ii) Legal proceedings related to the provider's alleged fraud are completed.
- January 24, 2011 Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers Final Regulation- Preamble

THE CHANGING LANDSCAPE OF “IMPROPER PAYMENTS”: FEDERAL AGENCY, CONTRACTOR AND GRANTEE ACCOUNTABILITY

- **Improper Payments Elimination and Recovery Act of 2010 (IPERA) (P.L. 111-204)**

WHAT IS AN IMPROPER PAYMENT?

- “An improper payment is any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. An improper payment includes any payment that was made to an ineligible recipient or for an ineligible service, duplicate payments, payments for services not received, and payments that are for the incorrect amount. “

“RECAPTURE AUDITS”

- “One approach that has worked effectively is using professional and specialized auditors on a contingency basis, with their compensation tied to the identification of misspent funds. ”
- “I hereby direct executive departments and agencies to expand their use of Payment Recapture Audits, to the extent permitted by law and where **cost-effective.**”
- Presidential Memorandum Regarding Finding and Recapturing Improper Payments March 10,2010

SO HOW ARE THEY DOING?

- HHS currently has nine programs that have been deemed risk susceptible: Medicare Fee-for-Service, Medicare Advantage, Medicare Prescription Drug Benefit, Medicaid, Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), Head Start, Child Care, and Foster Care.
- *FY 2010 HHS Agency Financial Report*

PROGRESS?

- **In FY 2010, the Medicare fee-for-service error rate dropped to 10.5 percent, or \$34.3 billion in estimated improper claims payments. The 2009 error rate was 12.4 percent, or \$35.4 billion.**
- CMS News release November 16, 2010.

SO HOW ARE THEY DOING

- HHS GOALS FOR MEDICAID
- ERROR RATE 2010:9.4%
- ERROR RATE 2013: 6.4%
- *FY 2010 HHS Agency Financial Report*

FREE STUFF!

www.omig.ny.gov

- Model compliance programs-hospitals, managed care (coming soon) and Compliance Alerts
- Over 2000 provider audit reports, detailing findings in specific industry
- Annual work plans
- New York excluded provider list
- Self-Disclosure protocol
- Corporate Integrity Agreements
- Listserv
- Link to sites for all 18 states which currently publish their state exclusion lists