


POST & SCHELL
ATTORNEYS AT LAW

PACAH Spring Conference
April 24, 2012

**Stop the World ...
I Wanna Get Off!**

Paula G. Sanders, Esquire



YOU ARE HERE.

http://www.hms.com/our_services/services_program_integrity.asp

What's In Store?

- Elder Justice Act
- New program integrity issues
- Exclusion checks
- 60 day repayment of overpayments
- Medicaid and Medicare audits

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Hot Off the Presses

- NLRB rules requiring posters enjoined indefinitely—stay tuned
- OSHA targets facilities with a days-away-from-work rate of 10 or higher per 100 full-time workers
 - Focus areas include exposure to blood, other potentially infectious materials, other communicable diseases; ergonomic stressors related to lifting patients; workplace violence; slips, trips and falls; and exposure to hazardous chemicals and drugs



Hot Off the Presses

- Dept. of Health (“DOH”) issues guidance on informal dispute resolution (“IDR”) options
- CMS working on regulations and survey guidance for hospice care in nursing facilities (“SNFs”)
- CMS working on new guidance for abuse prevention – strict liability for intentional acts of employees and contractors?
- OIG issues report critical of emergency preparedness



Elder Justice Act (“EJA”) Reporting Requirements

- Individuals to whom EJA applies
 - Owner, operator, employee, manager, agent, or contractor of long term care (LTC) facility
 - Contractor is “one who, for a fixed price, undertakes to procure the performance of works on a large scale, or the furnishing of goods in large quantities, whether for the public or a company or individual”
- Covered LTC facilities receive >\$10,000 in federal funds
 - SNFs; ICF/MRs; hospices that provide services in SNF

CMS FAQ’s <https://www.cms.gov/Medicare/Provider-EnrollmentandCertification/SurveyCertificationGenInfo/downloads/5-12-10-FAQs.pdf>



EJA Reporting Requirements

- Individual obligation to report *reasonable suspicion* that a crime has occurred to a person receiving care in an LTC facility
- Report to local law enforcement and DOH
 - Within 2 hours if serious bodily injury
 - Within 24 hours if no serious bodily injury
- Sanction for failure to report include civil monetary penalties of up to \$300,000 and possible exclusion

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Facility's EJA Reporting Duties

- No duty to report under the EJA
- Must provide annual notice of EJA reporting responsibilities to covered individuals
- Must post notice about EJA
- Must have EJA policies and procedures
- Facility must report all allegations of abuse, neglect and misappropriation of property to DOH and Aging and law enforcement under other laws

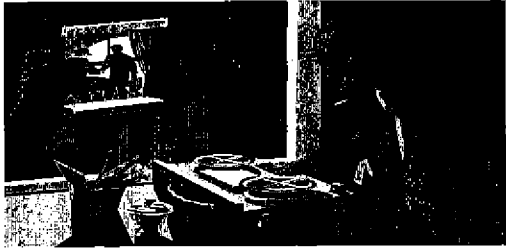
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EJA Facility Considerations

- EJA prohibits retaliation
- Do not confuse EJA and other reporting obligations
- Use the EJA to strengthen your internal reporting systems
- DOH will have list of EJA reports from your facility
- How can you ensure that you know if there are EJA reports?
 - Abuse/neglect policies

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New Program Integrity Rules



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Provider Screening And Enrollment

- Final rules issued Feb. 2, 2011 (76 Fed. Reg. 5862)
 - Apply to Medicare, Medicaid & CHIP
- Major components:
 - Screening and enrollment requirements
 - Enrollment re-validation
 - Ordering or referring providers
 - Payment suspensions
 - Terminations

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Provider Screening


- Based upon perceived level of risk of fraud, waste & abuse for category of provider or supplier
- Three screening levels:
 - Limited
 - Moderate
 - High
- Each provider type subject to its own screening level, even if part of related entity

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Provider Screening – Risk Levels			
Screening Required:	Limited	Moderate	High
Verification of Provider/Supplier Specific Requirements	X	X	X
License Verification	X	X	X
Database Checks Pre and Post-enrollment	X	X	X
Site Visits		X	X
Criminal Background Check			X
Fingerprinting			X


Medicaid Provider Screening

- Medicaid Database checks apply to:
 - Providers
 - Persons with 5% or greater ownership or control interest
 - Agents and managing employees
- Criminal background checks and fingerprinting apply to:
 - Providers
 - Persons with 5% or greater direct or indirect ownership interest

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Medicaid Enrollment Revalidation

- Revalidation period is every five (5) years
- No application fee
- Screening levels consistent with enrollment

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CMS 855 Reporting

Routine Revalidation (3-5 year cycle)	Within 60 days	
Change in Owners, Ownership or Control	Within 30 days	Onsite review and possible deactivation/revocation of billing privileges and collection of overpayments
Change in Officials, Directors, Authorized Official, Delegated Official or Managing Employee	Within 30 days	Onsite review and possible deactivation/revocation of billing privileges and collection of overpayments

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CMS 855 Reporting

Change in Billing Services	Within 60 days	Onsite review and possible deactivation/revocation of billing privileges and collection of overpayments
Adverse Activity and Subsequent CMS Action Against an Individual or Organization	Within 30 days from official notice or CMS Initial revocation	Onsite review and possible deactivation/revocation of billing privileges and collection of overpayments
Change in any Other 855 fields	Within 60 days (DMEPOS <u>must</u> report within 30 days)	Onsite review and possible deactivation/revocation of billing privileges and collection of overpayments

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Medicaid Database Checks

- Monthly:
 - List of Excluded Individuals/Entities (LEIE)
 - Excluded Parties List System (EPLS)
- Enrollment, reactivation and re-validation:
 - Master Death File
 - Social Security Administration
 - State Sanctions Database
 - State Licensing Agency files
 - CMS Certification file
 - National Provider Databank (NPDB)
 - Termination file from other states/Medicare

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Provider Terminations

- State Medicaid Agency must terminate participation of individual or entity if that individual or entity has been terminated from Medicare or any other State Medicaid Program
- Termination
 - Must be "for cause"
 - Provider has exhausted appeal rights or appeal period has expired
- CMS developed web-based portal for States to share information



New Disclosure Requirements

- Person with 5% ownership or control interest in a "disclosing entities," fiscal agents and managed care entities must disclose:
 - Name and address
 - For Corporation, primary business address, every business location and P.O. Box
 - DOB & SSN for individual
 - Familial relationships
- Managing employees must disclose:
 - Name, address, DOB and SSN



Ordering And Referring Providers

- Ordering and referring physicians and other professionals must be enrolled as participating Medicaid providers
- Claims must include NPI of ordering or referring physician or other professional



Ordering And Referring Providers

- Applies
 - When Medicaid is secondary payor
 - When ordering or referring practitioner is out-of-state
 - To charity providers
 - To VA or IHS providers

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Ordering And Referring Providers

- Does not apply
 - If the category of practitioner or professional is not enrolled as provider in the State Medicaid Program (e.g., residents, hospitalists, physician assistants)
 - State may permit claims to be made under the NPI of the employing or supervising provider that is enrolled in the Medicaid Program
 - To prescription refills if prescription was processed prior to March 25, 2011
 - Refills may be paid until the refill period has lapsed

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Payment Suspensions

- State Medicaid Agency must suspend payments to a provider if:
 - There is a pending investigation of **credible allegations of fraud** against the individual or entity and
 - No **good cause exception** applies
- No FFP is available for Medicaid payments made by a State that fails to suspend payments

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Payment Suspensions

- A credible allegation:
 - An allegation from any source
 - That has been verified by the State based upon a preliminary investigation
 - Has an "indicia of reliability"
- State must:
 - Refer to MFCU
 - Suspend payments unless good cause exists not to suspend or to suspend only in part
 - Request MFCU to certify each quarter that investigation is ongoing

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Payment Suspensions

- Good Cause Exceptions:
 - Law Enforcement Request
 - More efficient and prompter alternative remedies
 - Written evidence from the provider
 - Jeopardy to recipient access
 - Law enforcement failure to certify ongoing investigation
 - Contrary to best interests of the Medicaid Program
 - Suspension in part would be effective
- State must document Good Cause

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Payment Suspensions

- May be imposed without advance notice to the provider
- Notice of the suspension must
 - Be provided within 5 days (or 30 days if delay is requested by law enforcement)
 - Include general allegations but **not** any specific information as to the ongoing investigation
 - Specify that the suspension is temporary
 - Give provider the opportunity to submit written information
 - Inform provider of applicable State appeal procedures

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Payment Suspensions

- Payment suspensions are temporary
- Must end when –
 - State Medicaid Agency or law enforcement determine there is insufficient evidence of fraud
 - Legal proceedings relating to the allegations are completed

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Monthly Exclusion Checks



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Mandatory Grounds For Exclusion

Conviction of program-related crimes

Conviction of two mandatory exclusion offenses

Conviction on 3 or more occasions of mandatory exclusion offenses

Felony conviction: health care fraud
Conviction relating to patient abuse or neglect

Felony conviction: controlled substance

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OIG Permissive Grounds For Exclusion

Misdemeanor conviction relating to health care fraud	Claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of health care, or failure of an HMO to furnish medically necessary services
Conviction relating to fraud in non-health care programs	Failure to meet statutory obligations to provide medically necessary services meeting professionally recognized standards of health care (Peer Review Organization (PRO) findings)
Conviction for obstruction of an investigation - Misdemeanor conviction: controlled substances	

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OIG Permissive Grounds For Exclusion

License revocation or suspension	Fraud, kickbacks, and other prohibited activities
Exclusion or suspension under federal or state health care program	Failure to take corrective action
Entities controlled by a sanctioned individual	Failure to grant immediate access
Entities controlled by a family or household member of an excluded individual and where there has been a transfer of ownership/control	Failure to disclose required information, supply requested information on subcontractors and suppliers, or supply payment information

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OIG Permissive Grounds For Exclusion

Making false statement or misrepresentations of material fact	Default on health education loan or scholarship obligations; Exclusion: until default has been cured or obligations have been resolved to Public Health Service's (PHS) satisfaction
	Individuals controlling a sanctioned entity; Exclusion: same period as entity

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**PA Dept. Of Public Welfare's (DPW)
MA Bulletin 99-11-05 (Aug.15, 2011)**

- Requires Medicaid providers to do monthly screenings for excluded individuals and entities
 - OIG List of Excluded Individuals and Entities ("LEIE") <http://oig.hhs.gov/exclusions/index.asp>
 - GSA's Excluded Parties List System (EPLS) <https://www.epls.gov/>
 - DPW's Medlicheck List http://www.opw.state.pa.us/learnaboutdpw/traudandabuse/medlicheckprecludedproviderslist/S_001152

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Exclusion Consequences

- Excluded individuals may not provide or to direct the ordering or delivery of services or supplies, or undertake certain administrative duties whether or not direct care activities are involved if any part of the task is reimbursed by federal program dollars
- This includes salary and benefits of non-direct caregivers and staff

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Exclusion Consequences

- Limited employment options
 - Pay excluded individual exclusively with private funds or from non-federal funding sources AND
 - Services furnished relate SOLELY to non-federal program patients

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Exclusion Consequences

- For the excluded individual/entity submitting claims:
 - \$10,000 fine for each item/service claimed or "caused to be" claimed (i.e., by another entity)
 - Plus treble damages = amount claimed for each item/service
 - Extension of existing exclusion period
- Reinstatement is not automatic after exclusion
- False claim under Federal False Claims Act
- Separate basis for administrative sanctions or exclusion

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Exclusion Screening

- Who should you screen?
 - Anyone you pay with federal healthcare dollars or whose expenses you claim on a cost report
 - Employees, agents, contractors
 - Clinicians who prescribe/order for your clients if you act on the prescriptions or orders
- How often should you screen?
 - Upon hire or at time of contract
 - Monthly

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Exclusion Precautions

- Perform regular checks of all lists
- Job applications
 - Exclusion inquiries: Have you ever been or are you currently excluded?
 - List all names you have used
 - Falsification is grounds for immediate termination
 - Advise that you are running exclusion checks
- Include appropriate language in all contracts to cover possible indemnification
- Carefully word termination/separation agreements for unemployment challenges

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Exclusion: Employment Issues

- Non-exclusion should be a condition of employment
- Job descriptions -- Qualification/essential function
- Advertisement for position
- On-going obligation to notify of exclusion
- Collective Bargaining Agreements (CBAs)
 - Side agreement or memorandum of understanding

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Exclusion: Employment Issues

- Employee at will: willful misconduct?
- Employment contracts: do you have the right to terminate for exclusion?
- Union employee: review CBA management rights provisions and discipline/terminations
- Civil service: review civil service ordinances

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Federal Guidance on Exclusions

- OIG recovered >\$10 million in settlements for over 60 cases in past 3 years
- OIG Special Advisory Bulletin on Effect of Exclusion (Sept. 1999)
- CMS State Medicaid Directors' Letters:
 - SMDL #09-001 January 16, 2009
 - SMDL #08-003 June 12, 2008
 - > <http://www.cms.hhs.gov/SMDL/SMDL/list.asp#TopOfPage>
- OIG Frequently Asked Questions <http://oig.hhs.gov/fraud/exclusions.asp>

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60 Day Repayment



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PPACA Required Reporting And Refunding Overpayments As Of 3/2010

- Providers, suppliers, Medicaid MCOs, Medicare Advantage plans, and PDP sponsors must report and return overpayments to HHS, the State, or a Medicare intermediary or carrier by the later of:
 - 60 days of identification of overpayment, or
 - Due date of cost report
- Treble damages and CMPs up to \$50K for knowing failure to return overpayments on time
- Knowing failure also a false claim under the Federal False Claims Act

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CMS Proposed Rule On 60 Day Repayment Obligation

- Proposed regulations issued 2/16/2012
- When does the 60 day repayment obligation start?
- What triggers the repayment?
- How far back in time does the obligation extends?
- How is the repayment made?
- The proposed rules can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2012-02-16/pdf/2012-3642.pdf>

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	CMS Proposed Rules: Examples of Overpayments
	<ul style="list-style-type: none">• Medicare payments for noncovered services• Medicare payments in excess of allowable amount for an identified covered service• Errors and nonreimbursable expenditures in cost reports• Duplicate payments• Receipt of Medicare payment when another payor had the primary responsibility for payment <p style="text-align: right;"><small>46</small> POST SCHELL</p>

	CMS Proposed Rules: Knowledge Of The Overpayment
	<ul style="list-style-type: none">• Overpayment is "identified" if the provider has "actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment"• Rule creates an incentive to exercise reasonable diligence to determine whether an overpayment exists• Provider may receive information about a potential overpayment; the provider must make "reasonable inquiry" <p style="text-align: right;"><small>47</small> POST SCHELL</p>

	CMS Proposed Rules: Examples Of When An Overpayment Has Been "Identified"
	<ul style="list-style-type: none">• A provider that has reviewed its billing records and learns that it incorrectly coded certain services resulting in increased reimbursement• A provider learns that a patient death occurred prior to the service date• A provider learns that services were provided by an unlicensed or excluded individual <p style="text-align: right;"><small>48</small> POST SCHELL</p>

CMS Proposed Rules: Examples Of When An Overpayment Has Been “Identified”

- A provider performs an internal audit and discovers that an overpayment exists
- A provider is informed by a government agent of an audit that discovered a potential overpayment, and the provider fails to make a reasonable inquiry
- A provider experiences a significant increase in Medicare revenue and there is no apparent reason for the increase

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CMS Proposed Rules: The Look-Back

- How far back -- 10 years of the date the overpayment was received
 - Selected a 10 year period to coincide with the 10 year statute of limitations in the False Claims Act

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CMS Proposed Rules: The Repayment Process

- Absent evidence of fraud, overpayment should be voluntarily reported and returned to either CMS, a fiscal intermediary, a Part B carrier, or a Medicare contractor

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**CMS Proposed Rules:
The Repayment Process**

- Explain why the refund is being made
- How the error was discovered
- Describe the corrective action plan implemented to ensure the error does not occur again
- Detail the reason for the refund
- State if you have a corporate integrity agreement with the OIG or are under the OIG Self-Disclosure Protocol

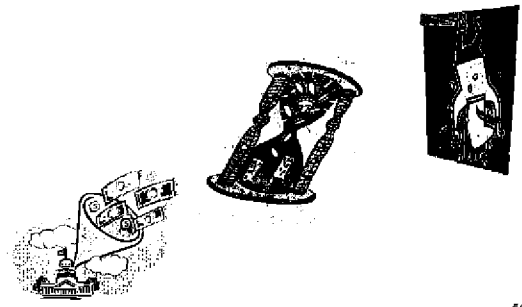
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**CMS Proposed Rules:
The Repayment Process**

- State the timeframe and the total amount of the refund
- Include Medicare claim control number and Medicare National Provider Identification number
- Provide a refund of the overpayment
- If a statistical sample was used to determine the overpayment amount, describe the statistically valid methodology

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Preparing for the Audits



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**The Audit Landscape:
Who Are They?**

- Medicare Administrative Contractor: Novitas Solutions, Inc.
- Medicare Recovery Auditor (f/k/a RAC): DCS
- Zone Program Integrity Contractor ("ZPIC"): SafeGuard Services, LLC
- Other investigators:
 - Federal Office of Inspector General ("OIG")
 - Federal Bureau of Investigation ("FBI")
 - US Department of Justice ("DOJ")

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**The Audit Landscape:
Who Are They?**

- Medicaid Recovery Audit Contractor: HMS Holding Corp.
- Medicaid Integrity Contractor (MIC): Health Integrity
- Payment Error Rate Measurement (PERM) Program: A+ Government Services
- PA Medicaid Fraud Control Unit (MFCU)
- PA Bureau of Program Integrity (BPI)

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OIG Reviews MICs

- Review MICs had problems with data and analyses
- 81% of audits did not identify overpayments
- 11% audits completed: \$6.9 M in overpayments
 - \$6.2M resulted from 7 completed collaborative audits involving Audit MICs, Review MICs, States and CMS
- States invalidated more than one-third of sampled potential overpayments
- Medicaid Statistical Information System needs additional data elements important to detecting Medicaid fraud, waste and abuse
- <http://oig.hhs.gov/oei/reports/oei-05-16-06290.pdf> (2/22/2012)
- <http://oig.hhs.gov/oei/reports/oei-05-16-06290.pdf> (2/22/2012)

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PERM Audits FY 2012

- CMS contractor A+ Government Services
- Expect medical record requests starting April & May 2012
- Claims reviewed FFY 2012
 - Oct. 1, 2011 thru Sept. 30, 2012
- CMS webinars May 23, 2012 & Aug. 23, 2012
- Update all your information with DPW
- http://www.dpw.state.pa.us/ucm/prd/groups/webcontent/documents/communication/p_012278.pdf

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PA Medicaid RAC: HMS Holdings Corp

- Awarded 2 MA RAC contracts 9/15/2011 running 4 years w/2 renewable 2 year periods
 - State Plan Amendment approved 3/11/2011
- Tasks: third party liability data exchange and recovery services, data match, cost avoidance, and recovery billings
 - Financial overpayment reviews and recovery services under subcontract

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How Are Providers Selected For Audit?

- Depends on who is doing the auditing
- Recovery auditors look for overpayments
- Integrity contractors look for fraud, waste and abuse—aberrant patterns
- Everyone is looking at your data
- *No MIC/RAC audit is "random"*

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Preparation Even Before An "Audit" Is Key

- Develop effective policies and procedures by:
 - Establishing company policy
 - Training your employees
 - Identifying your team
 - Knowing the issues and your exposure
 - Preparing for extensive document production

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Review Your Contracts

- What are your obligations regarding notice of claims?
- An audit may not be the same as a claim denial
- Define cooperation obligations
- When is your claim final?
- Do you have to complete the entire appeals process?
- What are you entitled to recover?
- Who is ultimately responsible?

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Internal Audits and Monitoring

- Gather disclosure information
- Review denied claims for legitimacy, rebuttal or appeal—root cause analyses
- Identify and fix any internal control or procedural deficiencies
- Refile corrected claims where appropriate
- Consult with counsel as necessary
- **Remember the 60 Day Repayment Rule**

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The Importance of the Mail Room

DCS
 RA Operations Center
 2818 Southwest Boulevard
 San Angelo, TX 76904

Important: Dated Information Enclosed

Immediate Response Required

RA Correspondence Enclosed

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Best Practices

- Select an Audit Coordinator to manage all inquiries and coordinate evaluation of all records sent out for audit/review
- Tell the RA the name and address of your coordinator
 - <http://dcsrc.com/ProviderContactInformation.aspx>
- Make sure your MAC has the right address

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Timeliness Is Important

- Implement systems for timely responses to audit
- Develop a log
 - Date stamp all correspondence *and monitor electronic remittance advices*
 - Track requests for information, deadlines, extensions and dates sent
 - Log *all* contacts with the RA (names, dates, times and summary of conversation)
 - Log notices of overpayments, dates for repayment, dates for appeals

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Timeliness Is Important

- Do you know where your records are?
 - Storage, soft files, filing back log
- Request extension if needed
- Copy entire medical record and all relevant documents, *and* keep a copy
- Follow instructions from the auditor (e.g. DCS--<http://dcsrac.com/Documentation.aspx>)
- Proof of mailing/proof of receipt

07 DCS SCHELL

The CYA Committee

- Know your internal operations
 - Trends, spikes, claims denials, complaints
- Monitor external sources for issues and "hot" areas
 - AHCA RA website: http://www.ahcancal.org/facility_operations/medicarerac/Pages/default.aspx
 - OIG Work Plan, advisory opinions, fraud alerts
 - RAC, MIC, ZPIC, PERM and CERT reports and settlements

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Name	Type	Provider	Type	Status	Impact	Date	Port
000142000	Optimal Care, PA B	Admitted	Professional Services	07 10 02 PA, MD, DC, CT	2012010		Calix
4000142000	Optimal Care, PA B	Admitted	Professional Services	07 10 02 PA, MD, DC, CT	2012010		Calix
4000142000	Optimal Care, PA B	Admitted	Professional Services	07 10 02 PA, MD, DC, CT	2012010		Calix
4000142000	Optimal Care, PA B	Admitted	Professional Services	07 10 02 PA, MD, DC, CT	2012010		Calix
4000142000	Optimal Care, PA B	Admitted	Professional Services	07 10 02 PA, MD, DC, CT	2012010		Calix
4000142000	Optimal Care, PA B	Admitted	Professional Services	07 10 02 PA, MD, DC, CT	2012010		Calix
4000142000	Optimal Care, PA B	Admitted	Professional Services	07 10 02 PA, MD, DC, CT	2012010		Calix
4000142000	Optimal Care, PA B	Admitted	Professional Services	07 10 02 PA, MD, DC, CT	2012010		Calix
4000142000	Optimal Care, PA B	Admitted	Professional Services	07 10 02 PA, MD, DC, CT	2012010		Calix
4000142000	Optimal Care, PA B	Admitted	Professional Services	07 10 02 PA, MD, DC, CT	2012010		Calix

Therapy Caps - KX Modifier

- Middle Class Tax Relief & Job Creation Act, Sec. 3005, extends therapy caps to hospitals outpatient providers
- Mandates *manual* medical review for all therapy claims that exceed cap
- Manual reviews start Oct.1, 2012 based on claims for services on or after 1/1/2012
- Medical review limited to last quarter 2012

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Therapy Caps - KX Modifier

- OIG targets KX modifier in 2012 Work Plan
- Comparative billing reports in 2010 and 2012 profiled 10,000 PTs for use of KX modifiers
- MACs (Cahaba and National Government Services) reviewing therapists with high KX usage

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Web Sites for PA Auditors

- DPW MIC information
http://www.dpw.state.pa.us/ucmprc/groups/webcontent/documents/communication/s_002861.pdf
- ZPIC: SafeGuard Services, LLC
<http://www.safeguard-services/llc.com/zpic.asp>
- Medicare RA: DCS
<http://www.dcsrec.com/PROVIDERPORTAL.aspx>
- Medicaid RAC : HMS <http://www.hms.com/>
- MIC: Health Integrity
<http://www.healthintegrity.org/html/contracts/mic/index.html>

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Web Sites for PA Auditors

- **PERM: A+ Government Services**
<http://www.aplusgov.com/services/>
- **DPW BPI:**
http://www.dpw.state.pa.us/dpworganization/officeofadministratio n/bpi/S_001936
- **PA MFCU:**
<http://www.attorneygeneral.gov/crime.aspx?id=177>
- **MAC: Novitas Solutions, Inc.** <https://www.novitas.solutions.com/>

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Other Key Web Sites

- **OIG:** <http://oig.hhs.gov/>
 - Quality of care corporate integrity agreements
<http://oig.hhs.gov/compliance/corporate-integrity-agreements/quality-of-care.asp>
- **FBI:** <http://www.fbi.gov/about-us/investigate/white-collar/health-care-fraud>
- **DOJ:** <http://www.justice.gov/>
- **US Attorney's Office for the Eastern District of Pennsylvania -- quality of care cases:**
<http://www.justice.gov/usao/pae/Documents/elderabuse.htm>

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QUESTIONS????

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