THE NEW ENVIRONMENT FOR FRAUD & ABUSE ENFORCEMENT FOR ANESTHESIA & PAIN MANAGEMENT

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Overview

- Fraud Enforcement Recovery Act of 2009 ("FERA")
- Health Care Fraud Prevention and Enforcement Action Team ("HEAT")
- Recovery Audit Contractors ("RACs")
- Red Flags Rule Compliance

Environment

- Over 1.2 billion claims are submitted to Medicare per year (= 4.5 million claims per work day; 574,000 claims per hour; 9,579 claims per minute)
  - *Due to this volume, Medicare contractors pay most claims without reviewing medical records associated with the services*
- To protect the Medicare Trust Funds, in 2003 the Recovery Audit Contractor ("RAC") demonstration program began in the states with the highest Medicare expenditures; in 2006 the RAC program was made permanent and was expanded nationwide.
- In 2006, Program Safeguard Contractors were established – special fraud fighter units that perform data analysis to identify problem areas, identify fraud, develop fraud cases and coordinate Medicare fraud and abuse efforts

Environment - continued

- President Obama's budget for FY 2010 increases funding for fraud prevention by 50%, to $311 million
  - Potential savings calculated to be $2.7 billion over 5 years
- America's Affordable Health Choices Act of 2009 (H.R. 3200) provides for an additional $100 million each FY beginning with 2011

Fraud Enforcement Recovery Act of 2009 ("FERA")

- Applies to conduct after May 20, 2009
- FERA amends the civil False Claims Act ("FCA")
  - *The FCA establishes criminal and civil monetary penalties for the presentation of a "false … or fraudulent claim" for payment to the Federal Government*
  - *FCA enacted in 1863; only amended once in 1986*
  - *FERA made possible by the federal bailout initiative*

False Claims Act

- Treble (3x) damages plus $5,500 to $11,000 forfeiture for each false "claim" presented for a payment.
- False Claims Act permits the United States to intervene and take over "qui tam" lawsuits by private whistleblowers
- No proof of specific intent to defraud is required.
  - 31 USC § 3729(b)
- Knowing or knowingly means that a person with respect to information:
  - Has actual knowledge
  - Acts in reckless disregard of the truth or falsity of the information; or
  - Acts in deliberate ignorance of its truth or falsity

FERA - continued

Retroactively overturned the Supreme Court decision *Allison Engine Co. v. United States ex rel. Saunders,* 128 S.Ct. 2123

1. Now, FCA applies even if a false claim was not submitted directly to the government but instead to, e.g., a government contractor, and
2. Even without specific intent to defraud the Gov't

FERA - continued

- *Liability for overpayments* – health care providers (and others) may face severe penalties for the knowing retention of government overpayments, even though the provider or contractor made no false or improper claim for such payments.
  - How do you know when you are holding an overpayment?

FERA - continued

- How much time from discovery of possible overpayment to sending the check?
  - Is an allegation enough to trigger liability?
  - Duty to investigate any allegation of overpayment?
- How does this affect credit balance policies?
- If you appeal an adverse post-payment audit but don't know whether you will win, is that "improperly avoiding an obligation to pay?"

FERA - continued

- Allows the Attorney General or his designee to disclose information gathered through the Civil Investigative Demand process with any whistleblower (qui tam relator) at the discretion of the Attorney General or designee.
  - Whistleblower investigations against health care entities may proceed more quickly and with better access to government obtained evidence

FERA - continued

- Extends broad protection to whistleblowers, defining “retaliation” as conduct directed not only against employees, but also against contractors and agents
  - Eliminated the previous requirement that an employment relationship exist to safeguard a whistleblower.

FERA - final

"It is unlikely that any health care provider did not receive at least one overpayment over the past year from a federal health care program."

Health Care Fraud Prevention & Enforcement Action Team ("HEAT")

- Announced May 20, 2009
- HEAT is an intra-agency effort between the Department of Justice ("DOJ") and the Department of Health and Human Services ("HHS")
- HEAT will:
  - build upon and strengthen existing programs to combat Medicare and Medicaid fraud, and
  - invest resources and technology to prevent fraud, waste and abuse.

HEAT – continued

Expand Medicare Fraud Strike Force teams

- South Florida 2007-present (Phase 1):
  - $186 million ; 146 defendants convicted
- Los Angeles 2008-present:
  - $55 million sought; 37 defendants indicted
- Detroit 2009:
  - $50 million sought; 53 defendants indicted
- Houston 2009:
  - $16 million sought; 32 defendants indicted

HEAT – continued

- Medicare Fraud Strike Forces use data analysis and "community policing*" to uncover fraudulent schemes:
  - Billing "arthritis kits," power wheelchairs etc. not medically necessary or never received – even to deceased beneficiaries
  - Billing for infusion therapy, OT not necessary or not provided – paid some beneficiaries cash kickbacks for allowing providers to bill Medicare

* www.hhs.gov/stopmedicarefraud; 1-800-HHS-TIPS

HEAT – continued

- Fraud, waste & abuse prevention strategy advocated in OIG testimony before House Energy and Commerce Health Subcommittee:
  - *Enrollment:* screening of providers by requiring accreditation / surety bond or other business integrity proof / full disclosure of ownership and control
    - *Provisional enrollment with enhanced oversight*
    - *On-site verification of compliance with Conditions of Participation*

HEAT – continued

- *Compliance:* IG advocated for requiring compliance plans as a COP and requiring by law restitution of any overpayments discovered through providers' own compliance efforts
- *Oversight:* better data; consolidate various provider databases; provide real-time access
- *Response:* punishment should include civil monetary penalties
- *Payment:* find and eliminate fraud risks and incentives

What does this all mean?

Recovery Audit Contractor ("RAC") Program

- RAC Overview
  - RAC Demonstration Program
  - Key Concerns
- RAC Audits
- RAC Appeals
- RAC Appeals Strategies

www.cms.hhs.gov/RAC

RAC Overview

- ***Purpose*** – To identify and correct Medicare overpayments and underpayments
- ***Caveat*** – RACs are compensated on a contingency fee basis based on the principal amount collected from and/or returned to the provider or supplier

RAC Overview
The RAC Demonstration Program

- Section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA)
  - Department of Health and Human Services ("HHS") to conduct a three-year demonstration program using RACs, beginning in 2005
- ***Objective*** – Determining whether the use of RACs is a cost effective way to identify and correct improper Medicare payments

RAC Overview
The RAC Demonstration Program

- ***Results*** – The Demonstration Program proved highly cost effective
  - RACs identified and collected more than $1.03 billion in improper payments
  - CMS estimates that the RAC demonstration program cost approximately 20 cents for each dollar returned to the Medicare Trust Funds

Overview of RAC
Making RAC Permanent

- Section 302 of the Tax Relief and Health Care Act of 2006
  - Made the RAC Program permanent and required nationwide expansion by 2010
  - CMS plans to expand to all 50 states by August 1, 2009 or later

RAC Overview
RAC Vendors

- Region A – ME, NH, VT, MA, RI, NY
  - Diversified Collection Services, Inc., of Livermore, CA
  - www.dcsrac.com
- Region B – MI, IN, MN
  - CGI Technologies and Solutions, Inc. of Fairfax, VA
  - http://racb.cgi.com
- Region C – SC, FL, CO, NM
  - Connolly Consulting Associates, Inc. of Wilton, CT
  - www.connollyhealthcare.com/RAC
- Region D – MT, WY, ND, SD, UT, AZ
  - HealthDataInsights, Inc. of Las Vegas, NV
  - http://racinfo.healthdatainsights.com

RAC Overview
The RAC Reality

- Although the RACs are responsible for correcting both overpayments and underpayments, Medicare is most concerned with overpayments
- During the Demonstration Program, the RACs identified and collected $992.7 million in overpayments and ordered repayment of only $37.8 million in underpayments
  - *96% of the alleged improper payments were overpayments, not underpayments*

RAC Overview
Identifying Improper Payments

- RACs are permitted to attempt to identify improper payments resulting from
  - Incorrect payments;
  - Non-covered services (including services that are not reasonable and necessary);
  - Incorrectly Coded Services (including DRG miscoding; and
  - Duplicate services

RAC Overview
Concerns Addressed by Medicare

- Because Medicare providers and suppliers raised concerns with certain aspects of the RAC program, CMS tried to address the concerns by adopting certain changes
  - RAC reviewers have a 3-year maximum look-back period
  - Registered nurses or therapists are required to make determinations regarding medical necessity and certified coders are required to make coding determinations
  - RACs are entitled to keep their contingency fees if a denial was upheld at the first stage of the appeal, regardless of later stage appeals results

RAC Audits
What to Expect – RAC Reviews

- 2 Types of Reviews for Improper Payment
  - Automated Review – A review of claims data without a review of records
  - Complex Review – A review of medical or other records
- Both types of reviews are for detecting overpayment
- Targeted Review – Using proprietary data techniques to determine claims likely to have overpayments
  - Therefore, audits are *not* random

RAC Audits
Preparing for a RAC Audit

- Anesthesiologists and Pain Management physicians cannot prevent RAC audits from happening, but they can prepare for increased claims scrutiny in the following ways
  - Internally monitoring protocols to better identify and monitor areas that may be subject to review
  - Responding to record requests within the required timeframes
  - Implementing an effective compliance program in accordance with OIG guidelines and/or strengthening procedures currently in place

RAC Audits

Compliance Risk Areas Facing Anesthesia and Pain Management Physicians

- Information from the RAC demonstration program does not provide specific guidance to the anesthesia and pain management industries in terms of strategic planning for the permanent RAC program.
- Taking into account other available guidance (OIG Work Plans, OIG reports, etc.), anesthesia and pain groups are well advised to strengthen their compliance programs to ensure that certain focus areas are enhanced. For example:

RAC Audits

Compliance Risk Areas Facing Anesthesia and Pain Management Physicians

- Groups should ensure that:
  - Each provider only captures allowable anesthesia time, and appropriate documentation exists to support the recorded start and end times;
  - Compliance with the medical direction requirements is satisfied, including enhancing documentation practices to demonstrate such compliance;
  - Documentation practices are improved with regard to separately payable services, such as invasive monitoring lines and post-operative pain services;
  - Documentation practices are improved with regard to medical necessity documentation in connection with the provision of chronic pain management procedures; and
  - Documentation practices are improved with regard to medical necessity documentation relative to the provision of evaluation and management services.

RAC Appeals

- Discussion of Appeals Process
  - Stage 1 – Redetermination
  - Stage 2 – Reconsideration
  - Stage 3 – Administrative Law Judge (“ALJ”) Hearing
  - Stage 4 – Medicare Appeals Council (“MAC”) Review
  - Stage 5 – Federal District Court

RAC Appeals Strategies

- Be aggressive
- Advocating the merits
- Audit defenses
  - Treating Physician Rule
  - Waiver of Liability
  - Provider without Fault
  - Reopening Regulations
  - Challenges to Statistics

MLN Matters MM6131
(Jan. 1, 2009)
Denial for Stark violations

- Institutes a new denial code to be used when claims are denied because of non-compliance with the physician self-referral prohibitions
- Denial code will be used when a claim is denied because a physician (or one or more of their immediate family members) has a financial interest in a DHS provider and fails to meet one of the statutory exceptions
- Violations of physician self-referral laws are punishable by:
  - Denial of payment for all DHS claims
  - Refunds of amounts collected for DHS claims
  - Civil money penalties for knowing violations.

Recommendations for Going Forward

- Monitor websites of RAC vendors for approved issues
- Monitor OIG reports
- Appoint a RAC point-person
- Increase compliance efforts
- Track appeal deadlines

Red Flags Rule

- Requires that every "creditor" that offers or maintains a "covered account" must develop and implement a written Identity Theft Protection Program designed to detect, prevent, and mitigate identity theft in connection with the opening of a covered account or in connection with any existing covered account.
  - Enforcement Date: **August 1, 2009**
  - *See* 16 C.F.R. § 681.2 and 72 Fed. Reg. 63772-63774 (November 9, 2007)
  - *See* "The 'Red Flags' Rule: What Health Care Providers Need to Know About Complying with New Requirements for Fighting Identity Theft," http://www.ftc.gov/bcp/edu/pubs/articles/art11.shtm

Overview

Does the Red Flags Rule Apply to Your Practice?

- (1) Are you a creditor?
- (2) Does your practice offer or maintain covered accounts?
  - If YES to both (1) and (2), the Red Flags Rule applies to your practice.

ARE ANESTHEISA AND PAIN PRACTICES CREDITORS?

- A health care provider is a “creditor” if it does not regularly demand payment in full at the time services are rendered.
- The government has taken the position that providers are creditors – this would include anesthesia and pain practices.

Overview
Definition of Covered Account

- Includes accounts offered or maintained by a creditor that involves or is designed to permit multiple payments or transactions
  - 16 C.F.R. § 681.2 (b) (3) (i)
- In summary, an anesthesia or pain management practice is subject to the Red Flags Rule if it extends credit by failing to collect co-pays, deductibles up front or by entering into payment plans for the services provided.

How Does The Red Flags Rule Apply to Your Anesthesia/Pain Management Practice?

- If the Red Flags Rule applies to your practice, then a written Identity Theft Protection Program (the “Program”) must be adopted.
- The Program must be “appropriate to the size and complexity” of the practice and the “nature and scope” of its activities.

Elements of an Identity Theft Prevention Program

- (1) Identify relevant "Red Flags"
  - A Red Flag is a pattern, practice or specific activity that indicates the possible existence of identity theft.
- (2) Detect Red Flags
- (3) Respond Appropriately to any Red Flags that are detected to prevent and mitigate identity theft; and
- (4) Update the policies and procedures.

Identity Theft Prevention Program Administrative Requirements

- A practice must obtain approval of the initial policies and procedures from its board of directors (or other appropriate committee of the board);
- A practice must involve the board of directors (or other appropriate committee of the board) or another senior management in the oversight of the Program and train appropriate staff.

Identity Theft Prevention Program Categories of Red Flags to Consider

- Each covered practice is required to consider applicable guidelines set forth in Appendix A of the FTC portion of the regulations.

Identity Theft Prevention Program Categories of Red Flags to Consider

- Key factors to consider:
  - Presentation of suspicious documents;
    - Documents provided for ID in connection with obtaining anesthesia services that appear to have been altered or forged;
    - The picture ID is not consistent with the appearance of the patient;
  - Suspicious identifying information;
    - Using a SSN that has not been issued or is listed on the SSA's Death Master File;
    - Inconsistent information;
  - Presentation of incomplete information;
  - Notice from a victim of identity theft or others that another person has engaged in identity theft or opened a fraudulent account.

When Does The Red Flags Rule Apply to Your Anesthesia Practice?

- At the time a patient presents identifying information in connection with obtaining anesthesia services for which payment may be made over time
  - Because anesthesia practices typically rely on the hospital or other facility personnel to gather relevant payment and identifying information, practices will need to coordinate with their hospitals/facilities to ensure that appropriate procedures and protocols will be followed, with an eye toward identifying, detecting and responding to problematic identity theft behaviors.
    - Your practice could meet with the hospital or facility administration to ensure that appropriate procedures are in place.

When Does The Red Flags Rule Apply to Your Practice?

- If your practice has a chronic pain component with your own patient admission process, your practice must establish written protocols for the patient admission process. For example:
  - Stopping the patient admission process if a patient presents with ID that appear to have been altered or forged or that contains inconsistent information.

Questions?