CONQUERING COMPLIANCE ...
WHERE TO BEGIN?

NM Association for Home and Hospice Care
Presented by David Johnson & Rebecca Avitia
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COMPLIANCE PLANS

- Are they required?

- What must be in a compliance plan?
THE 7 BASIC ELEMENTS

2. Compliance Professionals
3. Training
   - Relevant, Mandated, Documented and Periodic. Targeted to Audiences.
4. Effective Communication
5. Internal Monitoring
   - Periodic, Documented, with Corrective Actions Noted.
6. Enforce Standards
7. Promptly Respond to Issues

BENEFITS OF A COMPLIANCE PLAN

- Improve business functioning and care provided
- Formalize otherwise informal procedures
- Assist in responding to and defending against payor audits
- Safety-net in the new world of fraud and abuse investigations and enforcement

PAYOR AUDITS

- Governed by contract and related materials
- Conducted by payor and may occur with or without your knowledge or involvement
- Items deemed “improper” billings likely aren’t “improper” in your mind
- Audits may or may not involve internal or independent reviews
- Outcomes may include recoupments, withholdings, admission holds, extrapolation and questionable methodologies
PAYOR DISPUTES

- Know and negotiate contract language
- Know and use language in provider manuals and payor’s policies and procedures
- Document how and why billing is done a specific way
- Document any established course of dealing with payor
- Comply with all appeal requirements
- Do not rely on payor’s data; keep your own reliable payment data

HEALTH CARE FRAUD

- Defining Fraud, Waste & Abuse
- Fraud recovery is big business-4.5 billion
- Fraud recovery is here to stay
- Enforcement is expanding at both state & federal levels
- Home Health and Hospice in the cross-hairs?
- Next up—Medicare and Medicaid withholds of future payments

PLAYERS IN GOVERNMENT ENFORCEMENT

- CMS:
  - Civil Monetary Penalties
  - Enrollments, suspensions and terminations
- Office of Inspector General, HHS:
  - Audits, fraud alerts, Anti-Kickback advisory opinions
  - CMPs
  - False Claims Act investigations
  - Criminal investigations
  - Exclusions (mandatory and permissive)
- Department of Justice ("Main Justice"/US Attys)
  - False Claims Act resolutions
  - Criminal cases
- Medicaid Fraud Control Units/State Attorney General’s Office
EXPANSION OF FRAUD THEORIES

- Services not provided or authorized
- Certification of compliance part of payment
- Medical necessity
  - In past phys authorization sufficient
  - Diagnostic Imaging as a warning
  - Pharma/Med Device Rx-Sunshine Act
- Worthless services

EXPANSION OF THEORIES, CONT.

- Failure to meet all regulatory requirements
  - Conditions of participation v. payment
- Failure to identify & return overpayments

THE FRAUD ENVIRONMENT

- Billing and Payment Rules: Can anyone understand them?
  - Examples: Anti-Markup Rule, In-Office Ancillary Services Exception
- FCA litigation often directed to deep pockets rather than culpability or damages
- Proof that govt paid for something it didn’t get not necessary for Stark violation
Historical double standard re physician enforcement (although changing)
Physicians in denial
“I know Pete Stark and he can’t possibly intended what you are saying about the law.”
Private payors use threat of fraud enforcement in payment disputes

Explosion of new Medicare & Medicaid Auditors
MAC: Medicare Admin Contractors
RAC: Recovery Audit Contractors
Medicaid RACs
MIC: Medicaid Integrity Contractors
ZPIC: Zone Program Integrity Contractors
Last two focus on fraud
Relationship of audits to 60 day repayment rule?

Federal civil statute providing for damages and penalties for the knowing submission of false or fraudulent claims to the government for payment.
Many states have their own false claims acts with similar provisions.
NM Medicaid False Claims Act
NM Fraud Against Taxpayers Act
NM Medicaid Fraud Act
ELEMENTS

- A person that: (1) knowingly (2) presents or causes to be presented (3) a false (4) claim is liable to the United States Government for civil penalties of $5,500 to $11,000 per claim and three times the amount of damages the Government sustains.


THE FCA'S QUI TAM PROVISION

42 U.S.C. § 3730(B)

Allows private individuals – known as relators – to bring civil actions in the name of the government. If the prosecution is successful, the relator is entitled to receive some of the proceeds.

FCA DAMAGES & PENALTIES

- Persons convicted of violating the FCA are liable to the U.S. Government for:
- Penalties of $5,500 to $11,000, and
- Three times the amount of damages which the Government sustains (i.e. “treble damages”).

ANTI-KICKBACK STATUTE BASICS

- Makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal health care program
- ACA amends AKS to state that a violation may be shown without showing actual knowledge of this section or specific intent to violate the statute (§ 6402(f)(2))

AKS SAFE HARBORS

- If an arrangement meets all elements, it is exempt from prosecution
- Failure to fully satisfy safe harbor
  - Not per se illegal
  - Violations will turn on subjective intent

PHYSICIAN SELF-REFERRAL LAW, AKA “STARK”

- If a physician (or an immediate family member) has a financial relationship with an entity, the physician may not make a referral to the entity for the furnishing of designated health services (DHS) for which payment may be made under Medicare, and the entity may not bill Medicare, an individual, or another payor for the DHS, unless an exception applies
THREE KEY QUESTIONS UNDER STARK

- Is there a referral by a physician for a designated health service payable by Medicare?
- Does the physician have a financial relationship with the entity furnishing the DHS?
- Does the financial relationship fit into an exception?

THE FRAUD ENVIRONMENT FOR HOME CARE AND HOSPICE PROVIDERS

- CMS and OIG and DOJ believe that home care and hospice are particularly susceptible to fraud
- Perception is everything

OCTOBER HEADLINES

- DOJ Strike Force charges 91 indiv with fraud-multiple cities
- 230 mil in home health fraud
- Detroit Physician, HHA owner convicted of kickbacks-17 mil
- Texas HHA owner pled guilty in 374 mil scheme re unnecessary services or services not performed
- Miami HHA owner sentenced 10 y for 42 mil pt recruitment scheme
QUESTIONABLE BILLING PRACTICES

- High number of visits per beneficiary (>91 per ben)
- High number of therapy visits (24 or more per ben)
- High payments per beneficiary (> $11,653)
- High average number of therapy visits (>60% of ben also served by other HHAs)
- Source: Elizabeth Hogue & 2012 OIG report

CHANGES IN MEDICARE CONDITIONS OF PARTICIPATION RULES

- 2013 PPS proposed rules
- Noncompliance actionable under CMP law
- Applies to many types of violation not just immediate jeopardy
- Penalties of $500-$10,000 per day plus CAP
- Possible termination from Medicare
- Concern re interaction with FCA and MFCU enforcement

2013 OIG WORK PLAN

- Face to face encounter w/ physician or midlevel w/in 90 days prior or 30 days before
  - 30% compliance rate
- Billing codes c/w OASIS reporting
- Review efforts to prevent fraud
  - Home health susceptible to fraud
- Hospice marketing practices
60 DAY OVERPAYMENT RULE:
PROVIDER CONCERNS

- No clear definition of “identify”
- Repay w/in 60 days
- 10 year look back period
- Cost of compliance
- Interplay w/ RACs, etc.
- Relationship w/ existing protocols