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Perspectives on health care legal issues

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RAC 'n' roll

CMS to roll out its Recovery Audit Contractor program nationwide

As part of the Tax Relief and Health Care Act of 2006, Congress mandated that CMS's Recovery Audit Contractor (RAC) demonstration project become a permanent program and that CMS gradually expand the program to all 50 states no later than 2010.

The RAC program was initiated in 2005, when CMS announced a three-year demonstration project in California, Florida and New York pursuant to the Medicare Modernization Act of 2003. Independent contractors were selected by CMS to review Medicare claims data to identify and recover Medicare overpayments and underpayments that hadn't been detected through CMS's existing program efforts. CMS reported that, for fiscal year 2006, the pilot contractors identified about $303.5 million in improper payments.

CMS plans to have the permanent contractors in place when the RAC demonstration project ends in March 2008. The contractors will receive financial incentives for accomplishing the program's goals.

RAC program operations

Each contractor uses its own proprietary software to identify overpayments and underpayments. Under CMS's *Draft Statement of Work* for the nationwide RAC program, CMS will provide the permanent contractors access to a "RAC Data Warehouse" containing all identifications and collections for the contractor's jurisdiction, as well as suppressions or exclusions, which are claims ineligible for RAC review.

When reviewing claims, the contractors must comply with applicable Medicare rules, regulations and policies, including national and local coverage decisions, coverage provisions in interpretive manuals, and national and local coverage and coding articles. The contractors may attempt to identify improper payments on claims paid by the carrier, the fiscal intermediary and Medicare administrative contractors, including those specializing in durable medical equipment. (See "Which claims may be reviewed under the Recovery Audit Contractor program?" on page 3.)

The review process

Overpayments and underpayments are identified through a variety of review processes. The automated — or computerized — review examines claims data without human review of medical or other records. This type of review identifies claims that contain an identifiable error, such as a duplicate payment or a noncovered or incorrectly coded claim. For example, automated review could be used to identify an overpayment for Service A, if such service is *never* considered medically necessary for a patient with Condition X.

Under a complex review, the contractor's data mining methods identify claims with a high probability of an improper payment, but these claims must be further reviewed to determine if payment was incorrect. In these cases, the contractor will request the medical records from the provider to verify that an improper payment was made. For example, a contractor may use a complex review to identify an overpayment if a national coverage decision states that Service B is *rarely* considered reasonable and necessary for a patient with Condition Y. If the provider doesn't respond to a medical record request within a specified period, the contractor may categorize the payment as an overpayment.

When an overpayment is identified, the contractor will inform the provider of its appeal rights. Regardless of whether the overpayment was identified as a result of an automated or complex review, once the contractor's determination is final, a provider may appeal the overpayment determination.

Get ready to RAC

As details of the permanent RAC program continue to be released, providers should monitor new developments and become familiar with the rules governing the contractors and the provider's rights. In particular, health care providers should develop protocols and procedures to verify that RAC medical record requests are responded to in a timely fashion, that claims targeted by the contractor are, in fact, eligible for review, and that all claims identified by the contractor for recoupment were actual overpayments. <

Which claims may be reviewed under the Recovery Audit Contractor program?

Subject to review:

- Incorrect payment amounts,
- Noncovered services (including services that aren't "reasonable and necessary"),
- Incorrectly coded services, and
- Duplicate services.

Excluded from review:

- Evaluation and management services that are incorrectly coded,
- Services provided under a program other than Medicare fee-for-service,
- Claims made during the prior 12-month period or where Medicare doesn't have the authority to reopen the claim,
- Claims previously or currently under review by another Medicare contractor or law enforcement, or that are involved in a potential fraud investigation,
- Claims from the cost report settlement process,
- Claims where the beneficiary is liable for the overpayment because a provider is without fault with respect to the overpayment, and
- Randomly selected claims.

Screening health care providers and suppliers

Are they on the OIG — or state — exclusion list?

Federal and state agencies have the authority to exclude certain health care providers and suppliers from participating in government health care programs. Exclusion may be a result of a conviction related to federal health care programs, patient abuse or state licensing authority actions.

In the process of employing, contracting or affiliating with health care providers, hospitals and other institutions must screen the individuals or entities to ensure they aren't excluded from federal or state health care programs. The fact that an individual or entity has been issued a Medicare provider number is not proof that they have not been excluded from participation. Contracting or otherwise associating with an

excluded person or entity may result in repayment obligations, civil monetary penalties and, in certain cases, program exclusion.

The federal and state lists

The Department of Health and Human Services Office of Inspector General (OIG) maintains a list of excluded individuals and entities (LEIE), which include hospitals, group providers, physicians, nurses, nurse assistants, physical therapists, durable medical equipment providers, billing companies, and other licensed and nonlicensed individuals involved in the delivery of health care. (To view the list, go to http://oig.hhs.gov/fraud/exclusions/listofexcluded.html.) The General Services Administration (GSA) also maintains a list of entities that are excluded from receiving federal contracts, subcontracts, assistance or benefits. You can find this list at www.epls.gov. Notably, the LEIE database contains only exclusion actions taken by the OIG and doesn't report actions taken by other agencies, including those at the state level.

An increasing number of state agencies, however, maintain their own lists of individuals and entities that are excluded from participating in state programs, including Medicaid. Depending on the basis for exclusion from the state program, the excluded individual or entity may or may not also appear on the LEIE.

Harsh penalties

The consequences of failing to identify excluded individuals or entities can be severe. Federal health care program payment won't be made for items or services furnished, directed or prescribed by an excluded individual or entity. This also applies to all forms of reimbursement, including payments resulting from cost reports, itemized claims and fee schedules. Civil monetary penalties may be assessed against a provider that submits claims for items furnished, ordered or prescribed by an excluded individual or entity, if the provider knows or should have known of the exclusion.

State agencies may institute their own penalties or repayment obligations for services or items furnished by excluded providers under state health care programs.

Routine verification policies

Because the consequences of hiring or contracting with excluded individuals or entities can be harsh, make sure you verify — before and after employing, credentialing or contracting with a physician, vendor or other health care provider — that the individual or entity is not on the OIG's or GSA's exclusion lists. Additionally, determine whether your state agency administering the Medicaid program maintains a separate excluded provider list, and if so, verify that the individual or entity is not excluded under the state's list.

Implement policies and procedures that allow for periodic reviews of all employees and contractors subject to exclusion. For example, review the exclusion lists when you employ, contract or credential any individual or entity that is subject to exclusion, and then reverify at least once a year thereafter.

Your policies and procedures should address not only the initial and periodic exclusion checks, but also how to respond to situations where a current employee, contractor or affiliate is excluded, so that you can better assess your liability for repayments, civil monetary penalties and/or exclusion. If you discover excluded individuals or providers, immediately remove them from patient-related services and responsibilities and notify your legal counsel and Corporate Responsibility officer.

Start checking now

While many hospitals and health care institutions are already reviewing the OIG and GSA exclusion lists to ensure that its providers and contractors are not excluded, they may not realize that many states maintain separate excluded provider lists, which should also be reviewed. To make sure your hospital or practice is complying with the law, go online regularly to view both the federal and your state's lists. <

Value-driven health care initiative gains momentum

Department of Health and Human Services (HHS) Secretary Michael Leavitt has been actively marketing his value-driven health care initiative. As part of this initiative, HHS has implemented two programs to foster public and private collaboration at local and regional levels in an effort to improve the quality and value of health care.

BQI project

The Better Quality Information for Medicare Beneficiaries (BQI) project is a pilot program that seeks to improve quality of care by aggregating physician performance data and making it available to the public. In the spring of 2007, these regional health care collaborative groups were selected to serve as the initial demonstration sites for the BQI project:

- California Cooperative Healthcare Reporting Initiative (San Francisco, Calif.),
- Indiana Health Information Exchange (Indianapolis, Ind.),
- Massachusetts Health Quality Partners (Boston, Mass.),
- Minnesota Community Measurement (Minneapolis, Minn.),
- Phoenix Healthcare Value Measurement Initiative (Phoenix, Ariz.), and
- Wisconsin Collaborative for Healthcare Quality (Madison, Wis.).

The six groups will pool data from private and public sources to assess the performance of individual providers. Performance will be based on quality measures established by the AQA (formerly known as the Ambulatory Care Quality Alliance) that relate to Medicare beneficiaries.

Previously, these groups had access to data only from private sources, such as employers, health insurance plans, providers and, in some cases, Medicaid. Under the BQI project, the pilot sites also will be allowed access to Medicare claims information, enabling them to create a more comprehensive data source for evaluating physician performance.

HHS believes that the BQI project will improve the quality of health care in two ways: 1) physicians will be able to use the information gathered to aid them in improving individual performance, and 2) the results of the BQI assessment will be available online, giving Medicare beneficiaries and the general public the opportunity to select their physicians based upon quality data.

Community leaders and value exchanges

The second HHS initiative is to create a nationwide network of independent, nonprofit, local and regional collaboratives to stimulate measuring and reporting of quality information. Based on the level of the collaborative's development, it may be recognized by HHS as either a "Community Leader" or a "Value Exchange."

Pilot sites can access Medicare claims information, enabling them to create a comprehensive data source for evaluating physician performance.

Community Leader status is granted to multiparticipant, less developed, local or regional collaboratives that comply with HHS criteria and seek to increase quality assessment capacity and stakeholder participation. Community Leader status is considered a stepping-stone to receiving the Value Exchange designation. As of May 2007, HHS has formally recognized more than 20 Community Leaders.

Value Exchange status is granted to more highly developed regional collaboratives that are already designated as Community Leaders and that meet additional HHS criteria. The HHS noted in a press release dated Feb. 28, 2007, that in such collaboratives "local area physicians, nurses, hospitals and

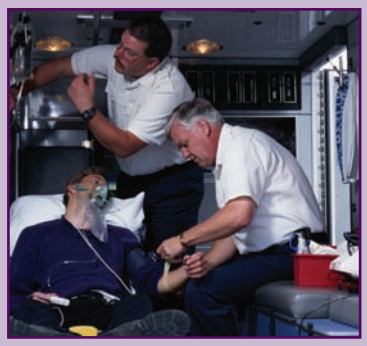
other health care providers are working collaboratively with health plans, employers, unions and other health care purchasers to achieve reliable public reporting on quality and cost of care."

Collaboratives recognized as Value Exchanges may participate in the HHS Agency for Healthcare Research and Quality's Learning Network, which provides access to tools, information and support to expand and share quality improvement techniques. Finally, qualified Value Exchange collaboratives may be granted access to the Medicare claims data to measure provider performance.

Moving health care forward

Health care providers and their patients all stand to benefit from the HHS initiatives being undertaken. If you'd like additional information on HHS's value-driven health care initiative, go to www.hhs.gov/transparency/. <

Be careful with subsidy programs: OIG advisory opinion raises concerns



The Department of Health and Human Services Office of Inspector General (OIG) issued an advisory opinion in early March 2007 concluding that a hospital's proposal to subsidize ambulance transportation costs for patients who reside outside of its local area may violate both the civil monetary penalty (CMP) provisions of the Social Security Act and the antikickback statute.

The proposed arrangement

The hospital is part of an integrated nonprofit health care system. Patients are periodically transferred to this hospital from other facilities outside its local area because it's recognized as a leader in cardiovascular services. The hospital's local Medicare carrier began denying payment for the excess mileage associated with transferring patients to the hospital, on the grounds that less distant hospitals satisfied the Medicare rules that nonlocal transportation costs be paid for transport only to the nearest institution with appropriate facilities.

In response, the hospital proposed an arrangement under which it would pay ambulance providers a negotiated fee to transport patients residing outside the local area and then submit the claims for reimbursement directly to the payors, including Medicare and Medicaid. Under the arrangement, the hospital would absorb any costs that weren't reimbursed by the payors.

Although the hospital anticipated that most of the patients benefiting from the arrangement would be cardiac patients, the subsidy would be available to all patients. Moreover, the hospital wouldn't advertise the subsidy.

The OIG's analysis

In reaching its conclusion that the proposed arrangement could constitute grounds for CMP and antikickback statute violations, the OIG noted that the payment or subsidy of any expense that would normally be the patient's responsibility — such as the excess mileage charges — would constitute impermissible remuneration. Plus, the hospital acknowledged that the subsidy of transportation costs was likely to generate federal health care program business unrelated to that of the patient involved.

The OIG also indicated that the lack of advertising wasn't a meaningful safeguard, because physicians could serve as "indirect channels of information dissemination" due to their awareness of the subsidy, and that the subsidy could influence patients' choice of hospitals, ambulance suppliers and physicians.

Caution is warranted

Although this Advisory Opinion is limited to the facts and circumstances surrounding the proposed arrangement, providers should be aware that any type of subsidy program may raise CMP and antikickback concerns.

Employee education on false claims recovery

CMS issues final guidance

Section 6032 of the Deficit Reduction Act of 2005 (DRA) amended the Social Security Act to require health care entities that make or receive more than $5 million annually under the state Medicaid program to establish written policies for their employees, contractors and agents. The policies should include details about federal and state laws on false claims, false statements and whistleblower protections, as well as the entity's policies and procedures to detect fraud and abuse.

In March 2007, CMS issued its final guidance on Sec. 6032 requirements. The guidance — in the form of a letter to state Medicaid directors — contains "Frequently Asked Questions" (FAQs) that address some key questions, though many others remain unanswered. Let's look at some of the most critical elements of the guidance.

Defining an entity

For organizations that are made up of multiple subsidiaries, the CMS FAQs note that an "entity" is the largest separate organizational unit that furnishes Medicare health care items or services and includes all organizational subunits that furnish such items and services, even if the subunits are located in different states or are separately incorporated.

In the case of health systems, however, CMS considers the parent corporation and its subunits to be integrally involved in providing Medicare items or services. Therefore, the entire organization is considered an entity subject to the provisions of the DRA. But CMS's definition of a "health system" remains unclear and may be subject to interpretation by the states.

Calculating the $5 million threshold

Payments received from Medicaid-managed care organizations and patient cost-sharing amounts aren't considered in the threshold calculation. Payments made by Medicaid for deductibles or coinsurance for dual-eligible individuals or qualified Medicare beneficiaries should be included, however.

The threshold is calculated based on the federal fiscal year, and each state determines whether to use the date of payment or the date of service to calculate the threshold.

Deriving policy content

Don't look for help from CMS when drafting your policies and procedures, as CMS has not provided model language for policies required under Sec. 6032.

Entities must disseminate their policies in paper or electronic form to all their employees, contractors and agents. Although CMS isn't requiring entities to amend their contracts with contractors and agents to include Sec. 6032 language, each state has the discretion to determine how it will decide whether an entity is complying with the law.

To determine your state's requirements for the manner and frequency of contractor and agent notification, review your state's plan or contact your state Medicaid agency.

Complying is critical

CMS reiterates that entities must comply with Sec. 6032 as of Jan. 1, 2007. However, each state had until March 31, 2007, to amend its state plan to implement DRA requirements.

Even if your state's Medicaid plan hasn't been released, you should make a good-faith effort to comply with DRA requirements. Individual states are charged with the responsibility for implementing and enforcing the requirements of the DRA, so providers that qualify as entities should ensure that their policies, procedures and employee handbooks comply with CMS guidance and the applicable state plan. <

A message to our clients and friends:

Hall Render is pleased to provide you with this issue of ***Practical Health Law***. This newsletter will be sent to you bi-monthly compliments of our health law attorneys; each issue will also be housed in the **Articles and Newsletters** section of **www.HallRender.com**.

We understand the value of good information when making sound business decisions. ***Practical Health Law*** is written by Hall Render's health law attorneys, each with extensive experience handling the legal issues of health care providers. We trust the information in each issue will be a valuable resource. Our attorneys stand ready to respond promptly to your questions and needs; please contact us if there are specific topics you'd like to see addressed.

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