

HFMA GREATER ST. LOUIS CHAPTER

KEY COMPLIANCE ISSUES FOR 2011

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KEY COMPLIANCE ISSUES FOR 2011

- Compliance is a fact of life
- Alphabet soup of regulatory agencies includes CMS, OIG, and IRS
- Hospitals, physicians and other health care providers need to spend time, energy and resources on compliance.



HEALTH CARE REFORM

- The latest word on repeal.
- Don't stand still worrying about repeal.



HEALTH CARE FRAUD – PREVENTION AND ENFORCEMENT ACT TEAM (“*HEAT*”)

- President Obama’s FY 2011 budget request includes an additional \$62 million in funding for the *HEAT* program.



ENFORCEMENT STATISTICS FYE JUNE 30, 2009

- Charges filed against more than 800 defendants.
- Obtained 583 criminal convictions.
- Opened 886 new civil health care fraud matters.
- Obtained 337 civil administrative actions against parties committing health care fraud.
- Recovered more than \$2.5 billion.



ZONE PROGRAM INTEGRITY CONTRACTOR (“ZPIC”) PROGRAM SAFEGUARD CONTRACTOR (“PSC”) AND RECOVERY AUDIT CONTRACTOR (“RAC”) AUDITS OF MEDICARE CLAIMS

- Private contractor reviews of Medicare claims is big business.
- RACs use data-mining software to identify claims with the highest potential for overpayment.



ZPICs, PSCs AND RACs CONTINUED

- If the RAC finds an improper payment, the fiscal intermediary or carrier adjusts Medicare reimbursement
- The RAC receives a contingency fee of 9%-12.5%.
- 3 year look-back period.



RAC PILOT PROGRAM

- CMS ran a 3-year RAC pilot program in CA, FL, NY, MA, SC, and AZ.
- RACs collected over \$1.3 billion in overpayments, and returned almost \$38 million in underpayments to providers.
- RACs were paid \$187.2 million by CMS.
- 85% of overpayments were collected from inpatient hospitals.
- RAC program is going national.



RAC PILOT PROGRAM...CON'T

- Targeted reviews of claims most likely to contain overpayments.
- Most improper payments involved claims that did not comply with Medicare's medical necessity criteria (40%) or coding rules (35%).
- Examples of inadvertent errors that led to overpayments:
 - Billing for a procedure multiple times/duplicate claims.
 - Incorrectly coded procedures.



IN 2011 MOST COMMENTATORS PREDICT

- Number of ZIPC, PSC and RAC audits of providers of all types will greatly increase.
- When is the last time you conducted an internal review of billing/coding practices.



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OIG WORK PLAN FISCAL YEAR 2011

- Describes audits and evaluations underway or planned for 2011.
- Also provides general focus areas for investigative, enforcement, and compliance activities.



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SURVEY OF SOME TARGET AREAS

- Provider-based status for inpatient and outpatient facilities.
- Hospitals that receive provider-based status receive higher reimbursements.
- Increased reimbursement means greater scrutiny.



DUPLICATE GRADUATE MEDICAL EDUCATION PAYMENTS

- No intern or resident may be counted by the Medicare program as more than one FTE.
- Assessment of CMS Intern and Resident Information system in preventing duplicate payments.



MEDICARE SECONDARY PAYOR RULES

- Per Section 1862(b) of the Social Security Act, Medicare payments are required to be secondary to certain types of insurance coverage.
- Review of Medicare payments.
- Evaluation of procedures for identifying and resolving credit balances which occur when payments from Medicare and other payors exceed the provider's charges on allowed amounts.



HOSPITAL READMISSIONS

- Review of trends in hospital readmissions (patient readmitted less than 31 days from discharge).
- Per CMS Medicare Claims Processing Manual, if a same-day readmission occurs for symptoms related to or for evaluation or management of the prior stay's medical conditions, the hospital is entitled to only one DRG payment, and should combine the original and subsequent stays into a single claim.



PAYMENTS FOR DIAGNOSTIC RADIOLOGY SERVICES IN HOSPITAL EMERGENCY DEPARTMENTS

- As far back as 2005, CMS reported concerns about potential overuse of diagnostic radiology services in hospital emergency departments.
- Be prepared to show that diagnostic radiology interpretations and reports contributed to the diagnosis and treatment of emergency department patients.



HOME HEALTH AGENCIES

- Increased scrutiny of enrollment applications.
- Requirement that physicians actually see patient.



SKILLED NURSING FACILITIES

- Prior OIG reports found that 26% of all claims had Resource Utilization Groups that were not supported by the patient's medical records.
- This year OIG will review whether claims were medically necessary, sufficiently documented, and coded correctly.



HOSPICE

- Recent OIG reports find 82% of hospice claims for patients in nursing facilities did not meet Medicare coverage requirements.
- Med PAC report noted that hospices and nursing facilities have incentives to admit patients likely to have long stays.
- Review of business relationships between nursing facilities and hospices that have high utilization patterns of Medicare hospice care.



OTHER PROVIDERS

- Part B evaluation and management services – does the documentation support the service reported.
- Imaging services in physicians' offices – review of utilization rates.
- Billing patterns of providers of portable x-ray services.



OTHER PROVIDERS...CON'T

- Sleep studies – Medicare payments increased from \$62 million in 2001 to \$235 million in 2009.
- Independent diagnostic testing facilities – compliance with standards in regulations, including training and credentials of technical staff, and physician supervision requirements.



DURABLE MEDICAL EQUIPMENT

- Frequency of replacement supplies.
- Review of payments to suppliers of power wheelchairs.
- Review of suppliers that actually solicit physicians to prescribe.
- Appropriateness of home blood glucose test strips.



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PHYSICIAN HOSPITAL RELATIONS

- OIG focus is whether one party is offering remuneration (i.e., something of value) to the other party in exchange for referrals.
- Multiple safe harbors available.
- Advisory opinion process.



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KEY AREAS OF SCRUTINY OF PHYSICIAN-HOSPITAL RELATIONSHIP

- Offering free services, staff, or equipment to physician.
- Paying for services that are not really needed or rendered. Medical director must perform legitimate services.
- Paying too much/too little (e.g. rent).
- Providing employee-type benefits to non-employed physicians.



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ACCOUNTABLE CARE ORGANIZATIONS (“ACO”)

- ACOs are described under health care reform.
- Encourage coordination by allowing hospitals and physicians to share responsibility for providing care for Medicare patients.
- ACOs would create savings incentives when providers keep costs down and meet specific quality benchmarks.



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ACOs

- Formal legal structure to receive and distribute shared savings.
- 5,000 patients.
- Sufficient number of primary care professionals.
- Three-year commitment.
- Clinical and administrative systems.
- Defined processes to promote evidence-based medicine, report data to evaluate quality and cost measures, and to coordinate care.



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ACOs...CON'T

- As of January 18, 2011, regulations had not been issued.
- ACOs raise Anti-Kickback, Stark, tax-exemption, and anti-trust concerns.
- Stay tuned.



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