Medicare Compliance ALERT

News, tools and best practices to minimize risk and maximize reimbursement

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Dear Reader

HHS' Office of Inspector General (OIG) just made it harder for you to self-report potential fraud violations.

OIG announced March 24 in "An Open Letter to Health Care Providers" that it was refining its Self-Disclosure Protocol (SPD) in two significant ways:

1. You can no longer self-disclose a matter that involves only liability under the Stark law in the absence of a "colorable" anti-kickback statute violation. The

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In This Issue

Congress to CMS: Go fight Medicaid fraud

It's bad enough to have to worry about **Medicare's** new Recovery Audit Contractor (RAC) program demanding you return an overpayment. You now have to prepare for audits from **Medicaid's** answer to the RAC program: The Medicaid Integrity Program (MIP).

The MIP, part of the Deficit Reduction Act of 2005, creates the first national Medicaid provider audit program to identify and fight Medicaid fraud, according to attorney Judith Waltz, formerly with CMS and now with Foley & Lardner in San Francisco. "Congress slapped it on to Medicaid since [the RAC program] did so well with Medicare," she explains. The program, operated by CMS, is in addition to any state Medicaid fraud control units or other state antifraud activities, points out Bill Hammock, vice president and senior consultant for Marsh USA, Nashville *(see box, pg. 3)*.

The program greatly increases CMS' fraud-fighting resources, including the infusion of millions of dollars in funding to MIP and the addition of up to 100 new employees, according to David Frank, director of the Medicare Integrity Group for CMS in Baltimore.

The RAC program and MIP are similar in that they both are part of CMS, use data mining to find fraud, and utilize contractors, which are called Medicaid Integrity Contractors, or MICs, in the Medicaid program. "The MICs are just as scary as the RACs. There's a huge vulnerability there, especially if you do a lot of Medicaid," warns Hammock.

The Medicaid Integrity Program is structured differently from Medicare's RAC program in several significant ways. For one, the MIP is hiring many more contactors, who will specialize in reviewing providers, auditing providers, or educating state Medicaid agencies and providers regarding fraud. Unlike the RACs, the MICs won't be paid on a contingency basis, and don't have the authority to directly collect overpayments from providers, says Hammock.

The audit process is also expected to take longer and be more complicated. After a MIC conducts an audit, the contractor will share the draft report with the applicable state Medicaid agency

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and then with the provider. The report will be revised as necessary, shared again with the agency, and then finalized, says Frank. Since CMS doesn't have a direct relationship with Medicaid providers, the state will pay the overpayment portion owed to CMS and then pursue and collect the amount from the providers under state law, says Waltz. Providers will have the right to appeal under state law.

The program is at the starting gate, says Frank, with provider audits just beginning in four out of 10 of CMS' regions (regions 3, 4, 6 and 8). CMS expects to have awarded all contracts by Sept. 30, 2009. CMS had conducted test audits in Florida, Texas, Mississippi, Washington state and Washington, D.C.; those audit reports are in the process of being finalized.

Unfortunately, some providers don't take Medicaid compliance as seriously as they do Medicare compliance. "Certain Medicaid providers aren't good at billing and may not document well, if at all," points out consultant Kip Piper, President, Health Results Group, Washington, D.C.

Don't underestimate this program. Be prepared for more audit and enforcement activity. State Medicaid agencies and the MICs plan to share their provider fraud data, and the MICs will be required to share their findings with the HHS Office of Inspector General (OIG), warns Hammock. So an investigation by one agency may trigger one from another agency. Since the MICs will cover multiple states in the search for Medicaid fraud, a discrepancy or problem uncovered in one state can be extended and identified throughout the country within hours, says Waltz.

CMS has published some information on the program on its website and is performing outreach to educate providers, although not in as formal a manner as the RAC program, says Frank.

"Every Medicaid provider is now in CMS' audit plans," Waltz notes.

On the internet:

- General information on MIP: http://www.cms.hhs.gov/MDFraudAbuseGenInfo/
- Contact CMS about MIP: Medicaid_Integrity_Program@cms.hhs.gov

Dear Reader: OIG limits self-disclosure

(continued from page 1)

OIG previously discouraged but didn't prohibit a self-disclosure that involved only Stark.

2. There is now a minimum settlement amount of $50,000 for kickback-related submissions accepted into the SDP.

How You Can Redistribute *MCA*

The OIG reiterated it will "continue to analyze the facts and circumstances of each disclosure to determine the appropriate settlement amount consistent with our practice … and generally resolve the matter near the lower end of the damages continuum…."

You should not draw any inferences about the government's approach to enforcement of the physician self-referral law due to the change, according to OIG.

"It looks like OIG wants to direct its resources on self-disclosure toward more abusive and blatantly illegal types of arrangements and leave the technical Stark violation cases (e.g. no signed contract or lease) to CMS, and the carriers and intermediaries, to deal with," says attorney Bill Mandell, with Pierce & Mandell, Boston, Mass.

Note: Providers who wish to report Stark violations will have to await further guidance from CMS. The agency is in the process of reviewing the letter. "Anything we could say would be premature," says a CMS spokesperson

The SDP was last refined in April 2008. For more information

States also busy fighting Medicaid fraud

CMS' Medicare Integrity Program (MIP) may be the new enforcement kid on the block, but states have been fighting Medicaid fraud for years and are ramping up those efforts.

"State Medicaid Agencies are likely to become more aggressive as they search for revenues desperately needed to cover budget gaps triggered by the recession," explains attorney Robert Belfort, with Manatt, Phelps & Phillips, New York City. "The numbers [of cases] are ballooning. State attorneys general want to make their mark," notes attorney Martie Ross, with Lathrop & Gage, Kansas City.

Many states have passed their own state False Claims Acts (FCAs), which give the states "powerful" tools to fight fraud, which has caused them to become "more aggressive," according to attorney Fred Cohen, with Goldberg Kohn in Chicago. The federal government gives bonuses to states with effective FCAs, he points out, which in turn enables the states to devote more money to enforcement activities.

Thirteen states have earned that bonus: California, Georgia, Hawaii, Illinois, Indiana, Mass., Nevada, New York, Rhode Island, Tennessee, Texas, Virginia and Wisconsin). A large number of states have enacted FCAs that are in effect but that have not yet met the federal criteria to qualify for the bonus.

"Many states, including New York, California and Florida are becoming hotbeds of enforcement," says attorney Cheryl Wagonhurst, Foley & Lardner, Los Angeles.

In addition, the country's 50 Medicaid Fraud Control Units (MFCUs), the agencies through which states investigate and prosecute Medicaid provider fraud, have been very successful in combating fraud. They recovered more than $1.1 billion in court-ordered restitution, fines, civil settlements, and penalties, according to the Office of Inspector General's latest annual report for MFCUs released June 24, 2008. This eclipses CMS' success in recovering improper payments via its recovery audit contractor's (RAC) pilot program, which recovered $1.03 billion in improper Medicare payments between 2005 and March 2008, according to a report released by CMS January 2009.

The MCFUs also obtained 1,205 convictions and 805 exclusions from the Medicare and Medicaid programs. For a peek at the providers investigated and penalties imposed, go to the reports on the website of the National Association of Medicaid Fraud Control Units (NAMFCU), at: http://www.namfcu.net/publications/medicaid-fraud-reports.

"If they can extract thousands, millions from providers, governments will do it. [They want] to get providers to change behavior. We'll see more of this," says Wagonhurst.

Watch out for whistleblowers

Don't think you're off the hook because your state isn't currently investigating you for Medicaid fraud. Expect more **private** whistleblower lawsuits filed by disgruntled individuals claiming that providers committed Medicaid fraud – even if the government doesn't intervene in the lawsuit. Many state FCAs are required to notify state employees and the public that they can become whistleblowers and receive a percentage of any monies recouped.

In the past, if the government didn't intervene, the whistleblower dropped the lawsuit because the he or she didn't have the resources to proceed. The government sometimes turns down good cases because its own resources aren't unlimited, according to attorney David Chizewer, also with Goldberg Kohn. But more law firms have become willing to put their own resources into these lawsuits and proceed with these cases. "Firms are perking up interest in this," he points out.

Example: A whistleblower filed a lawsuit against Amerigroup Illinois, alleging Medicaid fraud. Both the state and federal governments opted not to intervene. The whistleblower decided to continue anyway. The governments reconsidered and joined the lawsuit after evidence was uncovered showing the extent of the fraud, says Cohen. Amerigroup subsequently agreed in 2008 to pay $225 million to settle the lawsuit. Cohen and Chizewer were two of the attorneys representing the whistleblower in the case.

on self-disclosure, see *MCA* January 12, 2009.

On the internet

- OIG's Open Letter to Health Care Providers: www.oig.hhs.gov/fraud/docs/openletters/OpenLetter3-24-09.pdf.

GAO uncovers illegal payments, kickbacks

Contracts with healthcare vendors such as drug and medical implant producers aren't the only arrangements that can potentially expose providers to accusations of fraud *(*MCA, *3/23/09)*. A recent report by the Government Accountability Office (GAO) should serve as a wake up call to doctors who serve as medical directors for home health agencies.

The GAO report titled "Improvements Needed to Address Improper Payments in Home Health," released March 13, 2009, revealed home health agencies in several states were engaged in a number of fraudulent and abusive activities, including upcoding, billing for services not provided and paying kickbacks to physicians. All eight sample cases against HHAs cited in the report included kickbacks or other illegal inducements to physicians.

Even if the physician who serves as a HHA's medical director has no idea the organization is defrauding Medicare, it could be very difficult to convince an investigator or a prosecutor that his hands are clean. Here are two things to consider as you review existing arrangements or consider signing a contract with HHAs:

Can you 'show your work'? "A physician may refer some patients to the HHA but also serve as medical director," says healthcare attorney Michael Apolskis, Michael G. Apolskis, P.C., Chicago. "However, the medical director may not be able to show actual work to justify the fee." When there's no apparent explanation for the money a physician receives from the home health agency it can raise concerns that the position exists solely to disguise kickbacks for referrals, Apolskis says.

How many medical directors are on the payroll? OIG might also be concerned if an HHA hires several medical directors but can only justify paying for the services of one. Apolskis says.

How many medical directors are on the payroll? OIG might also be concerned if an HHA retains several medical directors but can only justify paying for the services of one. Apolskis says.

On the Internet:

- GAO Report - Medicare: Improvements Needed to Address Improper Payments in Home Health: http://www.gao.gov/new.items/d09185.pdf

CMS: Providers must reveal financial ties

CMS' efforts to enforce compliance with the Stark physician referral rule will now require your practice to keep patients informed of any financial relationships your doctors have with hospitals.

Management Implication Reports have a ripple effect

A single sentence in a Change Request from the Centers for Medicare & Medicaid Services (CMS) shed light on how one provider's actions can bring extra scrutiny to all providers from the HHS Office of Inspector General (OIG) and CMS *(*MCA, *4/6/09)*.

The Management Implication Report (MIR) on misuse of modifier 79 was triggered by the investigation of one provider and the upshot is Medicare Administrative Contractors (MACs) began reviewing their data for all claims with modifier 79 in mid-March, according to the CMS transmittal.

Some *Medicare Compliance Alert* readers also wondered what an MIR is and whether they could expect increased MAC scrutiny of their claims as OIG issued more MIRs based on the actions of one provider.

In reality, this has probably happened in the past but providers weren't aware because references to MIRs are very rare. A search of OIG's Web site turned up one hit. According to an OIG spokesperson, OIG conducted 18 MIRs in 2008.

Where Medicare is concerned, MIRs can be used to quickly identify and close loopholes in the system that have allowed providers to exploit Medicare in the past and may allow further exploitation if they aren't quickly addressed says Gary Thompson, senior counsel for Akin Gump in Washington, D.C.

MIRs are prepared by agents in OIG's Office of Investigations and "may serve as an early warning to agencies of a problem that requires their action to correct," Marc Wolfson, public affairs director for OIG. Wolfson notes that they are not publicly released. "They provide a "root cause" analysis sufficient for managers to facilitate correction of problems and to avoid similar issues in the future," says former Medicare Fraud Analyst Wayne van Halem, principal of Wayne van Halem Consulting in Atlanta.

On the Internet:

- CMS 100-02, Change Request 6334: http://www.cms.hhs.gov/transmittals/downloads/R442OTN.pdf.

Physician-owned hospitals must "require each physician who is a member of the hospital's medical staff to agree, as a condition of continued medical staff privileges, to disclose, in writing, to all patients the physician refers to the hospital any ownership or investment interest in the hospital held by the physician," CMS says in a Change Request. The rule goes into effect June 8, 2009.

Hospitals are also required to inform patients that they are physician-owned and keep a list of "physician owners or immediate family members of physicians," to be given to the patient upon request.

CMS won't ask physician-owners for proof that they tell patients about their financial ties to the hospital, says healthcare attorney Don Romano, partner with Arent Fox, Washington, D.C. Instead, CMS will use its ability to deny or yank provider agreements with provider-owned hospitals to make sure the hospital keeps an eye on referring doctors.

Note: This requirement applies to all physician-owned hospitals however, "As a practical matter this will affect specialty hospitals," Romano says.

"The whole goal … is to make sure patients can actively participate in decision making," about their health care explains Lisa Ohrin, partner with Sonnenschein, Nath & Rosenthal in Washington, D.C. Prior to entering the private sector Romano and Ohrin were, respectively, director and deputy director of CMS's Division of Technical Payment Policy, the section responsible for implementing Stark rules.

CMS is likely to track compliance through channels already in place. That means regularly occurring audits and surveys as well as patient complaints, says Ohrin. Romano gives the example of the type of "Monday morning quarterbacking," that can occur if a patient has a surgery in a provider-owned hospital and something goes wrong." He also warns that a competitor could rat the facility out to CMS.

Be ready to prove you inform your patients. The Change Request doesn't offer much in the way of guidance as to how hospitals and physicians can prove they're abiding by the patient notification rule Ohrin notes that hospitals could require doctors to keep a log or implement a policy of spot checks: Asking patients referred by physician owners if the doctor told them.

Ownership interest is a family affair. Keep in mind Stark also applies to the physician's immediate family members. Immediate is defined as a spouse, parent, child or sibling; stepparent, stepchild, stepsibling; parent-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law; grandparent or grandchild; and the spouse of a grandparent or grandchild.

On the Internet:

- CMS 100-01, Change Request 6306: http://www.cms.hhs.gov/transmittals/downloads/R58GI.pdf

FOR THE ANONYMOUS CO: YOUR QUESTIONS ANSWERED HERE

Q&A

Don't discriminate against whistleblowers

Q We're updating our compliance policy to address how we'll respond if an employee files a whistleblower law suit against our organization. Would it be appropriate to *ask* (not tell) the employee to stay out of the workplace and refrain from speaking to his or her co-workers until a full investigation has taken place? If this issue ever arose, we think the employee would like the option of staying away.

A No. You cannot discharge, demote, suspend (with or without pay), threaten, harass or in any other manner discriminate against an employee who files a *qui tam* (whistleblower) suit. Employees who are treated in this manner are entitled to relief which includes reinstatement with the same seniority, two times the amount of back pay, interest on the back pay and compensation for any damages, including attorney's fees. It would be better to incorporate a policy of non-retaliation into your compliance plan.

Remember: A healthy compliance program requires effective channels of communication. This means your organization must have some way to allow staff to communicate concerns – anonymously if at all possible – to someone in your organization who is in a position to investigate and take steps to address the problem. Whistleblower suits often arise when an employee has become frustrated because he or she feels there's no one to tell about the problem or no one is responding to a complaint.

Have a question you'd like to ask anonymously? Send it to jkyles@decisionhealth.com. Medicare Compliance Alert *will not print any information that could identify your organization or your client.*

From the
DECISIONHEALTH® PROFESSIONAL SERVICES
Case Files

Case #9: The audit that would not go away

Compliance Risk Identified:
The client: A Florida single-specialty practice
The audit: The provider wanted assistance with a Medicare Administrative Contractor (MAC) audit of their claims for physical therapy code **97110** and appeals of the audit's findings. Initial post-payment audits by the MAC showed a 100% error rate. As a result, the practice was placed on pre-payment review. The audit resulted in a request for back payment of more than $226,000 for services spread over three years.

DecisionHealth Professional Services was able to identify a number of denials that we will be able to appeal for the client. However, there are a number of denials that it wouldn't be reasonable to appeal. The client will have to return the money to Medicare as a direct result of staff negligence.

Background:
Many physical therapy groups struggle with how to correctly code for therapeutic activities and therapy services. The MAC auditor suggested the practice did not properly identify patient functionality, such as reduced walking distance or incapability to do housework, to justify the services billed.

Activities of Daily Living include but are not limited to: Bathing, dressing, grooming, oral care, toileting, transferring, walking, climbing stairs, eating, shopping, cooking, managing medications, using the phone, housework, doing laundry, driving and managing finances. While there are six primary ADLs, others have been added to address "real life" effects of people turning 65. Even activities such as golf or bike riding can measure functional ability for patients over 65, an argument we often make successfully at the Administrative Law Judge (ALJ) level of appeal.

The investigation:
We began the process by reviewing claims audited by the carrier to identify holes in its findings. Areas identified as problematic by the carrier included:

Therapy prior to initial evaluation:
No patient should begin a therapy regimen without first being evaluated by a qualified therapist to establish patient goals and tolerance. You could face loss of payment and medical liability for performing therapy without a medical evaluation.

Therapeutic exercises (97110)
We found a problem – time was being counted while the patient was on the traction table. The code description includes range of motion work, but the MAC's local coverage determinations (LCDs) block range of motion from the payment. Medical necessity is extremely subjective and LCDs are constantly changing. This discrepancy gives your practice a strong case to win at the ALJ level of appeal.

Recommended corrective action plan:
Billing and coding for physical therapy services can be tricky and significantly impact your reimbursement. Physical therapy services are only covered if they are medically necessary. Coverage based on the diagnosis and the patient's condition should also be determined. It is not uncommon for a therapist's diagnosis to differ from that of the referring physician. To ensure proper reimbursement of your claims, both the plan of care established by the therapist and the duration of care must be carefully determined and the documentation must support the type and length of treatment.

Note: The referring physician must establish a written treatment plan for physical therapy services. This must be reviewed every 30 days and must be re-certified should the patient need to continue physical therapy.

The following are some commonly used codes, mistakes providers make when they report and bill for these services, along with some tips for avoiding them:

Commonly billed procedures:

97001 Physical Therapy Evaluation.

97002 Physical Therapy Re-Evaluation.

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Case Files

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97110 Therapeutic procedure, one or more areas, each 15 minutes.

97112 Neuromascular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and or standing activities.

97116 Gait Training (includes stair climbing).

97124 Massage, including effleurage, petrissage and/or tapotement. (For Myfascial release, use 97140).

97140 Manual Therapy Techniques, one or more regions, each 15 minutes.

97150 Therapeutic procedure(s), group (2 or more individuals). Report 97150 for each member of the group.

Common billing errors

1. Billing code 97110 for three units on each line of the claim form when only three units were done in total.
2. Improper reporting of number of units for timed codes/services.
3. No referring physician information on the claim.
4. Poor Medical Documentation.

When billing timed services such as 97110, 97140 and 97112:

- Do not report any service done less than 8 minutes
- 8 minutes to 22 minutes is billed as 1 unit
- 23 minutes to 37 minutes is billed for 2 units
- 38 minutes to 52 minutes is billed for 3 units
- The length of all timed services must be documented on the medical record of the patient.

TIP: If two modalities are used on the same treatment day, for example 97110 (39 mins.) and 97112 (23 mins.) for a total treatment time of 62 minutes (4 units of PT services), report: 97110 for 3 units; 97112 for 1 unit. Assign more units to the PT service that took more time.

When billing trigger point injections, documentation should include the evaluation that lead to the diagnosis of the trigger points, specific identification of the affected muscle(s). You should also document the reason why injections are the chosen as a treatment option.

Sean M. Weiss, vice president of DecisionHealth Professional Services can be contacted directly at sweiss@dhprofessionalservices.com or at 770-402-0855. DecisionHealth Professional Services, is a service of DecisionHealth and provides full-scale medical consulting services in the areas of practice management, compliance and coding as well as health law services. To schedule a DecisionHealth Senior Consultant to come onsite to your practice or to learn more about our services visit us at www.dhprofessionalservices.com or contact us at 888-262-8354.

From the Compliance **TOOLBOX**

Red Flag Rules: Suggested Resolution Procedures

Here's a partial list of scenarios that could be a patient identity theft 'red flag' and possible steps you can take to resolve the situation *(*MCA, *4/6/09)*. This list is part of The American Hospital Association's Sample Policy on the Red Flag Rules. The entire list is attached to the e-mail version of this week's *Medicare Compliance Alert*.

IDENTITY THEFT RED FLAG	**PREVENTION/MITIGATION PROCEDURE**	**RESOLUTION OF RED FLAG** ***[ONLY SUGGESTIONS]***
Documents provided for identification appear to have been altered or forged.	Stop the admissions/billing process and require applicant to provide additional satisfactory information to verify identity.	Additional documentation must be provided to resolve discrepancy and continue admissions/billing process.
The SSN provided is the same as that submitted by other persons opening an account or other customers.	Stop the admissions/billing process and require applicant to provide additional satisfactory information to verify identity.	Additional documentation must be provided to resolve discrepancy and continue admissions/billing process.
Patient has an insurance number but never produces an insurance card or other physical documentation of insurance.	Stop the admissions/billing process and require applicant to provide additional satisfactory information to verify identity.	Additional documentation must be provided to resolve discrepancy and continue admissions/billing process. Contact insurance company as necessary. If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified with patient.
Records showing medical treatment that is inconsistent with a physical examination or with a medical history as reported by the patient (e.g., inconsistent blood type).	Investigate complaint, interview individuals as appropriate, review previous files for potential inaccurate records. Items to consider include: Blood type, age, race, and other physical descriptions may be evidence of medical identity theft.	Depending on the inconsistency and review of previous file, either delay/ do not open a new covered account, or terminate services. If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified with patient.
Complaint/inquiry from an individual based on receipt of: • A bill for another individual. • A bill for a product or service that the patient denies receiving. • A bill from a health care provider that the patient never patronized. • A notice of insurance benefits (or Explanation of Benefits) for health services never received.	Investigate complaint, interview individuals as appropriate	Terminate treatment/credit until identity has been accurately resolved; refuse to continue attempting to collect on the account until identity has been resolved. Notify law enforcement as appropriate. If the results of the investigation do not indicate fraud, all contact and identifying information is re-verified with patient.