

## Session 501: Managing Risks: The Latest on Federal Fraud and Abuse Efforts in Home Care

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## Fraud and Abuse Activity

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- Claims
- Provider enrollment
  - Compliance
  - Enforcement of Fraud and Abuse Concerns
- Health Reform

## Government Focus on Claims

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- Use of data analysis to identify billing anomalies
- Both Medicare and Medicaid
- Claim denials + sample, extrapolated overpayment

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## Medicare

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- PSCs, ZPICs, RACs

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## Program Safeguard Contractors (PSCs)

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- To identify potential fraud
- Transfer of intermediary & carrier fraud units to PSCs
- Most PSCs have access to both Part A & B claims data
- Home health outliers and high therapy utilization
- Hospice long LOS and beneficiary not terminal

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## Zone Program Integrity Contractors (ZPICs)

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- To identify potential fraud
- Transfer from PSCs started 2008; consolidation PSCs + Medicare Drug Integrity Contractors (MEDICs)
- ZPICs will also have Managed Care (Part C) and Medicare Prescription Drug (Part D) data
- Part A cost report and reimbursement to be added
- Data for entire beneficiary claim history

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## ZPICs

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- 5 “hot spot” zones
  - California, Florida, Illinois, New York and Texas
  - Align with existing Program Integrity field offices
  - Focus on quick response to fraud and administrative action
- 2 other zones
  - 24 states with limited incidence of fraud
  - Using PSC processes
- 2 contracts awarded to Safeguard Services, LLC for Zone 7 (Florida); Health Integrity, LLC for Zone 4 (Texas +)
- Challenge by Cahaba to Zone 2 contract awarded to Advance Med (Northwest)
- Challenge by Cahaba to Zone 5 contract awarded to Advance Med (Southern States)

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## PSCs & ZPICs

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- Data collection and analysis
  - Claims, cost reports, PS&Rs
  - Reports, complaints

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## What are PSCs/ZPICs Looking For?

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- Aberrant patterns outside the norm
  - High utilization of services or items
  - High cost services or items
- High number claims denials
- High referring physicians

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## RACs (Recovery Audit Contractors)

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- Detect & correct past improper payments
- Claims data mining, OIG, GAO, CERT reports
- CMS to approve new issues
- Contingent fee for OP; payment for UP per contract

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## RAC Reviews

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- Automated without medical records
  - Clear policy always OP
  - Medically unbelievable service
- Complex with medical records
- Limit 3 year look-back; no earlier than 10/1/07
- 04/06/10: **CMS Announces Series of Nationwide RAC 101 Calls.**
- May 4, 2010 1:00pm - 2:30pm EST: Nationwide RAC 101 Call for Home Health and Hospice Providers, 1-877-251-0301

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## 4 RACS

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- Region A - Diversified Collection Services of CA - Providers in Northeast (CT, Delaware, D.C., Maine, Maryland, Massachusetts, N.H., N.J., N.Y., PA, R.I., VT)
  - New Issues: <http://www.dcsrac.com/issues.html>
- Region B - CGI Technologies Solution of VA - Providers in Midwest (Minnesota, Wisconsin, Michigan, Illinois, Indiana, Ohio, Kentucky)
  - New Issues: <http://racb.cgi.com/Issues.aspx?st=1>

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## 4 RACS (Cont'd)

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- Region C - Connolly Consulting Services of CT - South/Southwest (Alabama, Arizona, CO, FL, GA, Louisiana, Mississippi, North Carolina, New Mexico, Oklahoma, South Carolina, TN, TX, VA, West Virginia)
  - New Issues: [http://www.connollyhealthcare.com/RAC/pages/approved\\_issues.aspx](http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx)
- Region D - HealthData Insights of Las Vegas - Providers in West (Alaska, Arizona, CA, Hawaii, Iowa, Idaho, Kansas, Missouri, Montana, North Dakota, Nebraska, Nevada, Oregon, South Dakota, Utah, WA, Wyoming, Guam, American Samoa, Northern Marianas)
  - New Issues: <https://racinfo.healthdatainsights.com/Public1/NewIssues.aspx>

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## HealthData Insights Issues Related to Home Health and Hospice

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- NOT directed at home health and hospice
- Medical supplies submitted on DME claims while patient is under home health consolidated billing
  - CMS approved 1/6/10
  - Claims paid on or after 10/1/07

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## HealthData Insights (Cont'd)

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- Hospice Related Services - B
  - Services related to hospice terminal illness billed separately to Part A or Part B
  - CMS approved 9/11/09
  - Claims paid on or after 10/1/07
- DME related to hospice terminal illness billed separately on DME claims while patient is under hospice
  - CMS approved 12/22/09
  - Claims paid on or after 10/1/07

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## Health Reform

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- RACs to expand to
  - Medicare Advantage
  - Medicare Part D
- Requires States to contract by 12/31/2010 with one or more RACs re: Medicaid

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## Health Reform Provisions re: Claims

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- Physician Face-to Face Encounter Prior to Certification of Home Health Services
  - Effective for certifications after 1/1/10
  - May include telehealth
  - Includes certified nurse mid-wife, PA, NP or clinical nurse specialist
  - Within reasonable time per CMS
  - Medicare and Medicaid home health services
  - Similar requirement for DME

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## Mandatory Requirement for NPI on All Medicare and Medicaid Claims (Health Reform)

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- By January 1, 2011
- For all providers and suppliers
- Medicare Home health and DME wrinkle
  - Physician certifying need for services must be Medicare-enrolled
  - Applicable to written orders and certifications made on/after July 1, 2010
  - Authorizes CMS to extend this to other items and services
  - Confirm certifying physician is enrolled:  
[http://www.cms.gov/MedicareProviderSupEnroll/06\\_MedicareOrderingandReferring.asp#TopOfPage](http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp#TopOfPage)

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## Reduction to 1 Year to Submit Medicare Claims (Health Reform)

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- 1 Calendar Year after date of service
- Services furnished on or after 1/1/10
- Must file bill or request for payment by  
12/31/10 for services furnished before 1/1/10

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## Mandates the Integrated Data Repository of CMS Include Claims and Payment Data (Health Reform)

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- Medicare, Medicaid, VA, Indian Health  
Service for potential fraud and abuse
- OIG and DOJ access to claims and payment  
databases
- Effective 3/23/10

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### Provisional Period of Enhanced Oversight for New Medicare, Medicaid, CHIP Providers (Health Reform)

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- 30 days - 1 year
- May include prepayment review and payment caps
- For provider types determined by CMS
- CMS authorized to do this via program instructions

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### False Claims Act, 31 U.S.C. §3729

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- Act with knowledge, deliberate ignorance or reckless disregard
- Submitting or causing submission of false claims
- Making false statements to get or keep government funds
- Treble damages
- Penalty of \$5,500 to \$11,000 per claim
- Whistleblower protections

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## Fraud Enforcement and Recovery Act of 2009 (“FERA”)

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- Enacted May 20, 2009
- Multiple changes broadening FCA
- Improperly retaining overpayment violates FCA even when no false statement or record is used

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## Health Reform Revises FCA Liability

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- Effective March 23, 2010
- Medicare or Medicaid overpayment must be reported and returned within LATER of
  - 60 days of identity, OR
  - Date corresponding cost report is due
  - Repayment to contractor
  - “Overpayment” - receipt or retention of Medicare/Medicaid funds, that after applicable reconciliation, not entitled to

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## Providers Need Effective Process and Procedure

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- Audit to identify potential overpayments
- Refund identified overpayments

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## Health Reform - Providers or Suppliers with Same Tax I.D. Numbers

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- Past-due Medicare obligation of one provider/supplier may be collected through adjustments to another provider/supplier
- Effective March 23, 2010
- Some previous activity through HIGLAS

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## Medicare Focus on Provider Enrollment Compliance

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- ❑ Failure to disclose information
- ❑ Failure to report information
- ❑ Non-compliance with enrollment requirements to maintain Medicare billing privileges
- ❑ Falsification of information
- ❑ CMS Program Integrity through FIs/MACs; OIG concerns; potential criminal
- ❑ Denial enrollment, revocation Medicare billing privileges; criminal

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## 36-Month Rule

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- ❑ HHA only (1/1/10)
  - CMS stated concern re: “turn-key” transactions
  - CMS concern re: HHA fraud and abuse
  - Change of ownership (assets/stock) w/n 36 months of prior change in ownership
    - ❑ HHA must enroll as initial applicant
    - ❑ Survey/accreditation
    - ❑ Billing gap
  - CMS Guidance, Trans. 318, CR 6750, very broad application: <http://www.cms.hhs.gov/transmittals/downloads/R318PI.pdf>
  - NAHC (and others) convinced CMS not to apply rule retroactively, MLN MM6750 Revised: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6750.pdf>

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## Capitalization (HHA Only)

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- Initial enrollment
- 42 C.F.R. §489.28- HHA must have funds to operate HHA for 3 months after provider agreement becomes effective
  - Prior practice: FI resolved capitalization amount when 855A filed
  - New Practice: FI reassesses capitalization amount after R.O. issues tie-in notice, but before FI turns on billing privileges
    - Requests larger capitalization amount
    - Capitalization evidence must be furnished w/n 30 days, or denial enrollment
  - CMS: <http://www.cms.hhs.gov/transmittals/downloads/R312PI.pdf>
  - Cahaba: <http://www.palmettogba.com/palmetto/providers.nsf/vMasterDID/7ZMMTG2827?open>

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## Deactivation of Medicare Billing Privileges

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- Non-submission Medicare claims for 12 consecutive months
- Fails to report change of information within 90 days of the change, including
  - change in practice location
  - change of any managing employee
  - change in billing services
- Fails to report change in ownership or control within 30 days

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## Reactivation after deactivation

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- File complete 855A enrollment form
- HHAs only (effective 1/1/10)
  - Must be surveyed or accredited
  - HHA must submit survey/accreditation results to contractor to have its billing privileges reactivated

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## Provider Enrollment Health Reform Provisions

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- Medicare, Medicaid and CHIP Provider Screening Requirements
  - Must include licensure screening
  - May include criminal background checks, fingerprinting, unannounced pre-enrollment site visits, database checks, other screening
  - Screening fee to be assessed: 2010 fee for institutional providers: \$500; possible hardship exception for certain Medicaid providers
  - Screening to be performed for new providers not enrolled as of 3/23/10 on or after one year of that date
  - Screening to be performed for providers enrolled as of 3/23/10 on or after two years of that date
  - Within 180 days of 3/23/10: to apply to revalidation

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### Increased Disclosure Requirements for Medicare, Medicaid and CHIP providers (Health Reform)

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- Enrollment or revalidation on or after March 23, 2011 shall disclose current or previous affiliation (direct or indirect) with a provider or supplier that has
  - Uncollected debt
  - Payment suspension
  - Excluded from Medicare, Medicaid or CHIP, OR
  - Billing privileges denied or revoked
- CMS to determine whether such affiliation poses fraud and abuse risk
  - If so, shall deny enrollment
  - Appeal rights apply

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### Temporary Moratorium of New Medicare, Medicaid and/or CHIP Providers or Suppliers (Health Reform)

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- All or categories of providers or suppliers
- To combat fraud and abuse
- Not subject to judicial challenge

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## Mandatory Establishment of Compliance Program (Health Reform)

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- Condition of enrollment in Medicare, Medicaid, CHIP
- Core elements to be determined by CMS and OIG

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## Revocation of Medicare Enrollment for Failure to Maintain Physician Ordering Documentation (Health Reform)

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- HHA must maintain and provide access to written certification for home health services and furnish access to this information when requested
- DME suppliers also must maintain written orders
- Effective for orders, certifications made on/after 1/1/10
- Prior regulation, 42 C.F.R. §424.516(f), effective 1/1/09: all providers/suppliers must maintain ordering and referring documentation for **7 years** from the date of service

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## Mandatory Registration with State and HHS (Health Reform)

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- Agents, clearinghouses or others that submit Medicaid claims on behalf of providers
- Effective 1/1/11 unless State legislation is required

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## Mandatory Medicaid Termination of Participation (Health Reform)

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- If Medicare termination of participation OR
- Termination by other Medicaid program
- Effective 1/1/11 unless State legislation is required

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## Mandatory Medicaid Exclusion (Health Reform)

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- Individual or entity that owns, controls or manages an entity
- That has unpaid overpayments determined to be delinquent, OR
- That is suspended, excluded or terminated, OR
- Is affiliated with a suspended, excluded or terminated individual or entity
- Effective 1/1/11 unless State legislation is required

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## Resources

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- Health Reform Legislation:
  - [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111\\_cong\\_bills&docid=f:h3590enr.txt.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf)
  - <http://finance.senate.gov/issue/?id=07CDCA4E-7368-489B-8A51-575BE1D56A23>

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