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RACs LIKELY TO EXPAND RESPONSIBILITIES TO REFERRING FRAUD

The Centers for Medicare and Medicaid Services (“CMS”) contracts with recovery audit contractors (“RAC”) to identify improper payments of Medicare Part A and Part B claims. RACs conduct post payment reviews to identify overpayments and underpayments and recoup any overpayments they identify. The RACs then receive payment based on the amount of improper payments identified.

On February 19, 2010 the Department of Health and Human Services Office of Inspector General issued a report on a pilot program entitled Recovery Fraud Contractors’ Fraud Referrals. This emanated from a CMS 3-year RAC demonstration project for the period March 2005 through March 2008 that was designed to:

1. Detect and correct past improper payments in the Medicare fee-for-service program; and
2. Provide information to CMS and to the Medicare claims processing contractors that could help protect the Medicare trust funds by preventing improper payments.

This demonstration project included three RACs covering California, Arizona, Florida, South Carolina, New York and Massachusetts. More than \$1.03 billion in Medicare improper payments were identified and subsequent to the demonstration project, CMS awarded contracts to four companies to serve in the permanent program which is now underway. RACs are not responsible for reviewing claims for fraudulent activity, however, they are responsible for referring to CMS any instances of potential fraud that are identified during their reviews. OIG’s report took a look at what, if any, fraud referrals occurred during the demonstration period. The results indicated that one RAC claimed to have referred two cases of potential fraud to CMS; however, CMS reported that no specific provider

referrals were received. Another RAC commented that although it did not make specific referrals that it had notified CMS of numerous claims it identified involving improper payments. The third RAC did not refer any cases of potential fraud to CMS. During the demonstration project the OIG noted that CMS “did not provide any formal training to RACs regarding the identification and referral of potential fraud; however, CMS did provide the permanent RACs with a presentation about fraud.” The report did state that CMS “is planning to provide the permanent RACs with further education and training on the identification of potential fraud.”

In its recommendations the OIG commented that “because RACs do not receive their contingency fees for cases they refer that are determined to be fraud, there may be a disincentive for RACs to refer cases of potential fraud.” The OIG’s recommendations to CMS included:

- Conduct follow-up to determine the outcomes of the two referrals made during the demonstration project;
- Implement a data base system to track fraud referrals;
- Require RACs to receive mandatory training on the identification and referral of fraud.

CMS has concurred with all three of the OIG recommendations and has subsequently researched the two cases identified by the RAC for potential referral and determined they should be referred to the OIG for further development. It also noted that it is in the process of developing a system to track the RAC claims review process and that they have already provided two training sessions to the RACs and is in discussion with the OIG and Department of Justice on additional training.

The two RAC referrals involved rehabilitation service providers and both involved suspected alterations of medical records after the services were rendered. Another RAC did not make any formal fraud referrals but notified CMS that it had identified "multiple claims involving millions of dollars in improper payments to physician practices for Intravenous Immune Globulin (IVIG) treatments in Florida." CMS directed the RAC to close down its review of these claims. The RAC reported that CMS then referred these claims to law enforcement agencies.

As the emphasis on attacking "fraud, waste and abuse" of federal healthcare resources continues to grow, it would seem to be a natural evolution of RACs to become involved more heavily and more directly in the referral of potential fraud cases and the hope that you escape the RAC audit lottery does not seem to be a reasonable approach in this area. Tightly monitored compliance programs and efforts, should enable an organization to limit its exposure to RAC risk from both the intentional and unintentional error. Make sure you have the right systems and personnel to carry out the task.

CMS MANDATES ACCREDITATION FOR IMAGING PROVIDERS

The Centers for Medicare and Medicaid Services announced in the January 26, 2010 federal register that three organizations had been approved to accredit advanced diagnostic imaging suppliers: The American College of Radiology, The Joint Commission, and the Intersocietal Accreditation Commission.

Providers of advanced diagnostic imaging services who bill for the technical component, including physicians, must become accredited by a designated accreditation organization by January 1, 2012, in order to be reimbursed by Medicare, according to CMS. This includes computed tomography, nuclear medicine, positron emission tomography and magnetic resonance images. X-Rays, ultrasound, fluoroscopy, and diagnostic and screening mammography are excluded from the definition.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) provides that the criteria for accreditation shall include:

- Standards for qualifications of non-physician medical personnel furnishing the technical component.

- Qualifications and responsibilities of medical directors and supervising physicians.
- Procedures to ensure the safety of persons furnishing or receiving the technical component of services.
- Procedures to ensure reliability, clarity and accuracy of diagnostic images.
- Procedures to assist the beneficiary in obtaining imaging records.
- Procedures to notify CMS of changes subsequent to accreditation.

ATTORNEY – CLIENT PRIVILEGE – LESSONS LEARNED

In a recent article published by the American Health Lawyers Association and written by Shannon DeBra, Bricker & Eckler LLP, the potential lessons learned from The Christ Hospital whistleblower case were discussed regarding attorney-client privilege issues. To the non-attorney the concept of attorney-client privilege is difficult to fully understand. This discussion around a U.S. District Court for the Southern District of Ohio court case (United States ex rel. Fry v. Health Alliance of Greater Cincinnati, No. 1:03-cv-167 (S.D. Ohio Dec. 11, 2009)) goes into a review of the facts and court decision on the determination of which documents were or were not covered under the attorney-client privilege. Ms. DeBra concludes "that any written communications (including emails and notes taken during meetings) discussing legal advice or the intent to seek legal advice about an issue include enough information to establish that legal advice was discussed or that an intent to seek it existed. A mere assertion later that such intent existed or that legal advice was discussed, without more explicit evidence, may not be sufficient to protect the document from discovery under the attorney-client privilege." (See attached full article)

It may be useful to make sure that key decision makers in your organization are educated in the concept of attorney-client privilege so that appropriate caution and documentation is considered, if you intend to use that consideration down the line. Again, knowledge and understanding of issues can only help make sure that decisions and the supporting evidence are ultimately what you intended and can be easily understood when looked at after the fact.

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