HCCA PHYSICIAN CONFERENCE
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TEN COMPLIANCE ISSUES FOR
PHYSICIAN PRACTICES 2013

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NEW COMPLIANCE OFFICER/INTEGRITY OFFICER-2011

• NEW YORK CITY HUMAN RESOURCES ADMINISTRATION
• Nation’s largest human services agency
• 13000 employees
• 3 million enrollees in human service programs (Medicaid, food stamps, cash, job training)
• 1200 employees (mostly investigators) report to position
HRA-WE’RE THE GOOD GUYS!

- BLOOMBERG ADMINISTRATION-EVIDENCE AND DATA DRIVEN PUBLIC POLICY
- PUBLIC BENEFIT PROGRAMS FOR PEOPLE IN NEED
- SOCIAL SAFETY NET
- ACCESSIBLE HEALTH INSURANCE
- WORK OPPORTUNITIES AND FAMILY SUPPORT
- PROGRAM INTEGRITY

WHAT YOU NEED TO KNOW FROM THIS PRESENTATION

• Significant changes in government approaches to compliance and enforcement
• Require assessment of your business practices and compliance program
• Requires you to know about government-identified issues in practice management, billing, recordkeeping, ordering, payment
COMING ATTRACTIONS

• The Small Business Jobs Act of 2010, signed Sept. 27, 2010 requires the Center for Medicare & Medicaid Services (CMS) to “adopt predictive modeling and other analytics technologies to identify improper claims for reimbursement and to prevent the payment of such claims under the Medicare fee-for-service program.”
• two year predictive modeling contest for hospital admissions. WSJ 3/16/11
• GAO Report GAO-11-409T 3/9/2011-5 steps to reduce M/M fraud, waste, abuse, including data mining, better predictive modeling, followup to RAC findings on providers

CMS PREDICTIVE MODELING

• Provider scoring
• Claims scoring
• Network analysis
• Outlier analysis
• Draws on experience in credit card and mortgage industries
• Soon-electronic medical records analysis
OLD-FASHIONED DATA MINING

• FOCUS ON CLAIMS
  - Edits
    • Pay and report
    • Don’t pay
  - Prior authorization
  - Diagnosis and service
  - Bundling/unbundling
  - Inpatient/outpatients same day

CURRENT DATA MINING-

• FOCUS ON PROVIDERS, PROVIDER BEHAVIOR, RECIPIENT BEHAVIOR, NETWORKS
• THE NETFLIX PRIZE FOR PREDICTING WHAT FILMS CUSTOMERS WILL LIKE
• THE PHARMACY EXAMPLE (because pharmacy data is most complete and most electronic)
  - Time of day
  - DUR/refill too soon overrides
  - forged prescriptions
  - Credited scripts
  - Where do abusers go to fill scripts
  - Networks with physicians
  - Where do patients go after provider taken out?
THE LEGAL FRAMEWORK FOR USING DATA MINING AND REPORTING

- DEFICIT REDUCTION ACT OF 2005 (DRA)
- FRAUD ENFORCEMENT AND RECOVERY ACT OF 2009 (FERA)
- THE AFFORDABLE CARE ACT OF 2010 (ACA)
- IMPROPER PAYMENTS ACT OF 2002/IMPROPER PAYMENTS ELIMINATION AND RECOVERY ACT OF 2010 (IPERA) (P.L. 111-204)

THE CHANGING LANDSCAPE OF “IMPROPER PAYMENTS”

- Presidential goal: reduce government-wide improper payments by $50 billion, and to recapture under existing criteria and authorities at least $2 billion in actual improper payments, by FY 2012
- Executive Order 13520 on Reducing Improper Payments - November 2009
- “Improper payments” focus of FY 2011 Presidential budget
- memorandum on intensifying and expanding payment recapture audits (75 FR 12119)-March 10, 2010
- Medicaid RAC audits included in Affordable Care Act, March 2010
- Improper Payments Elimination and Recovery Act (IPERA, Pub.L. 111-204) signed 7/22/2010
WHAT IS AN IMPROPER PAYMENT?

• “An improper payment is any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. An improper payment includes any payment that was made to an ineligible recipient or for an ineligible service, duplicate payments, payments for services not received, and payments that are for the incorrect amount. “

WHAT PROGRAMS MAKE IMPROPER PAYMENTS?

• From www.paymentaccuracy.gov/high-priority-programs (2010) 14 programs designated as high error, including:
  • Medicare $34.3 Billion (10.5% of total Medicare payments)
  • Medicaid $22.5 Billion (9.4% of total federal Medicaid expenditures—does not include state expenditures)
JIM SHEEHAN’S TOP TEN ISSUES FOR PHYSICIAN PRACTICES in 2013

• FRAUD, ABUSE, COMPLIANCE AND PRACTICE RISK
• THESE ARE RISK AREAS FOR THE GOOD GUYS TO BE AWARE OF AND ADDRESS
• IF YOU ARE A MIAMI HOME HEALTH COMPANY BILLING FOR FICTIONAL CLIENTS, THIS LIST WILL NOT HELP YOU.

#10 INFORMATION ABOUT PAYMENTS TO PHYSICIANS FROM INDUSTRY

• PUBLIC DATABASE OF PAYMENTS TO PHYSICIANS: “Dollars for Docs:
  How Industry Dollars Reach Your Doctors”
• http://projects.propublica.org/docdollars/
• Has Your Health Professional Received Drug Company Money?
• Searchable database by physician, city, institution, state
MEDIA FOCUS ON PHYSICIAN SPEAKERS TO INTENSIFY UNDER PPACA SUNSHINE ACT RULES

• Pro Publica mobile website will allow patients to check out their physician while in waiting room
• Pro Publica looks for speakers with:
  - State disciplinary actions
  - FDA warning letters
  - Criminal convictions
  - Multiple malpractice suits (on some state licensing websites)
  - False Claims suits/IRS 990 disclosures/govt. disclosure forms

#9 Tests, Results, Follow-up

• Does your practice have a system:
  - to track all tests ordered
  - to follow up on missing test results
  - to review all test results
  - To assure that labs are not providing results for tests not ordered?
  - To assure that test results are in patient file
  - to advise the patient of any abnormal test results, and record the advice?
  - To assure that the practice complies with Stark law in ordering tests?
TESTS, RESULTS, FOLLOW-UP

• 2013 OIG WORK PLAN
• Diagnostic radiology-necessity of high cost tests
• Electrodiagnostic testing-questionable billing
• Laboratory tests-billing characteristics and questionable billing-92% increase in ten years

#8-COMPLIANCE WITH ASSIGNMENT RULES IN BILLING BENEFICIARIES

• Limits on Medicare balance billing of patients directly when accepting assignment
• Limits on billing/acceptance of payment from third parties when accepting assignment
• Requirement to bill other payors first
• OIG 2013 WORK PLAN
• CMS initiative
#7-PHYSICIAN CERTIFICATIONS

- Hospital discharge (and readmission)
- “I have personally seen and examined this patient in the past 30 days.”
- Hospice certification (with narrative and face to face requirements)
- Nursing home certification for discharge from managed care because patient unlikely to return to community.
- OIG Audits

#6 RISKS WITH ELECTRONIC MEDICAL RECORDS

- Default entries (wnl)
- Cut and paste/importation of prior results without analysis
- Creation of record before patient is seen
- Charting to code
- Adoption of false or misleading diagnosis or history from outside record
- See 9/14/2012 letter from DOJ and HHS on electronic records; 2012 OIG Work Plan
ELECTRONIC RECORDS
QUESTIONS YOU DON'T WANT TO HEAR . . .

• Doctor, are you any more careful with your patients’ treatments than you are with the records of their treatment?

• Doctor, you have said that these inaccurate records were the result of a systems problem. What did you do to address the systems problem?

• How is it that your patient had the same pulse, weight, and blood pressure over six office visits?

#5 Medication Management

• Does your practice have a system:
  • to review and record current medications with the patient (including all over-the-counter medications)
  • To provide the patient with a written medication summary for new prescriptions that includes dosage, directions for use, and side effects
  • To determine who authorized prescriptions and refills
• REMEMBER—best records are drug records.
#4 DRUG SAMPLE MANAGEMENT

- Does your practice:
  - Track requests for samples
  - Track receipt of samples
  - Track distribution of samples
  - Track inventories of samples
  - Assure destruction of samples at expiration date
  - Prescription Drug Marketing Act requires sample management systems for manufacturers to identify individual physicians


- A distribution of drug samples may only be made:
  1. in response to a written request for drug samples made on a form
  2. under a system which requires the recipient of the drug sample to execute a written receipt for the drug sample upon its delivery and the return of the receipt to the manufacturer or authorized distributor of record.
- A written request for a drug sample required by subparagraph (A)(i) shall contain:
  1. the name, address, professional designation, and signature of the practitioner making the request,
  2. the identity of the drug sample requested and the quantity requested,
  3. the name of the manufacturer of the drug sample requested, and
  4. the date of the request.
DRUG SAMPLE MANAGEMENT

• Does your practice:
  - Allow physicians or staff to take samples for personal or family use?
  - Record sample distribution in patient record?
  - Advise patients of side effects and contraindications (since usual pharmacist role is not performed)
  - Keep samples in a locked area?

#3 Controlled Substance Prescription Management

• Does your office have a system:
  • to determine whether patient’s pain is being effectively managed
  • to review and record current controlled substance prescriptions with the patient, including those from other practitioners or
  • to review and alert patient to risks, signs of addiction
  • to consider whether patient’s supply of pain meds is being diverted by caregiver or family member
  • FDA-15,000 deaths per year connected to prescription opioid analgesics
### OFFICE RISKS-CONTROLLED SUBSTANCES

- Who within practice controls script pads?
- What inventory or control system is used for script pads?
- Is doctor’s “signature” for controlled substance prescriptions being entered by others?
- Is doctor’s name being used by patients for telephone authorizations?

### MAJOR STATE INITIATIVES ON CSs

- NEW REQUIREMENTS-Mandatory Reporting of Controlled Substances prescriptions to some state systems, mandatory checking of state database before prescribing opioids (see [http://www.pmpalliance.org](http://www.pmpalliance.org))

#2 CAN YOU RELY ON YOUR ATTORNEY’S ADVICE?

- US v. DeFries 129 F. 3d 1293 (DC Cir. 1997)
- A client often comes to his lawyer with a plan and asks him to find a way to implement it legally-large part of attorney function
- Client reliance in good faith on advice of attorney is defense to knowing or intentional violation, even if advice is wrong

CAN YOU RELY ON SOMEONE ELSE’S ATTORNEY?

- No-USA v. Stevens (D. Md. 2011) (need attorney-client relationship)
HOW TO RELY ON YOUR ATTORNEY

• What advice was sought?
• Were significant steps taken before seeking advice?
• Was there warning of illegality?
• Was there reliance after the advice that the conduct is legal?

CONFLICTING ADVICE

• ROESLER V. TIG INSURANCE 251 FED. APPX. 489 (10th Cir. 2007)
• Conflicting advice bears on whether defendant took action in good faith
HOW TO RELY ON YOUR ATTORNEY

• Accuracy of counsel’s recitation of facts and assumptions should be scrutinized and confirmed
• Client must “honesty” follow advice

#1 PHYSICIAN PRACTICE RISK

• REPORTING, REFUNDING, EXPLAINING OF OVERPAYMENTS WITHIN 60 DAYS OF IDENTIFICATION
• FALSE CLAIMS ACT LIABILITY FOR CONCEALING OR AVOIDING REPORTING
• NOTE: THERE IS AN ENTIRE SESSION DEVOTED TO THIS ISSUE- THESE ARE HIGHLIGHTS
FRAUD ENFORCEMENT AND RECOVERY ACT OF 2009

• 1) enhances whistleblower protection and right to recovery, defeats procedural motions
• 2) creates liability for person who “knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government” new 31 U.S.C. 3729(a)(1) (G)

PPACA SECTION 6402
MEDI CARE AND MEDI CAID PROGRAM INTEGRITY PROVISIONS.

“(d) REPORTING AND RETURNING OF OVERPAYMENTS.—
“(1) IN GENERAL.—If a person has received an overpayment, the person shall—
“(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
“(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.
SEC. 6402 (d) MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

- “(2) DEADLINE FOR REPORTING AND RETURNING OVERPAYMENTS.—An overpayment must be reported and returned under paragraph (1) by the later of—
  - “(A) the date which is 60 days after the date on which the overpayment was identified; or
  - “(B) the date any corresponding cost report is due, if applicable.

SEC. 6402 (d) MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

- “(4) DEFINITIONS.—In this subsection:
  - “(B) OVERPAYMENT.—The term ‘overpayment’ means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.
CMS PROPOSED REGULATION ON REFUND OF OVERPAYMENTS

• “We remind all stakeholders that even without a final regulation they are subject to:” (February 16, 2012 proposed regulation)
  - The requirements of 6402 (to report, refund, and explain)
  - Potential False Claims Act liability
  - Potential Civil Monetary Penalty Law
  - Potential exclusion from Federal health care programs for failure to report and return overpayment (77 FR 9180-9181)

WHEN IS AN OVERPAYMENT IDENTIFIED?

• CMS “We propose that a person has identified an overpayment if the person has actual knowledge of the existence of an overpayment or acts in reckless disregard or deliberate ignorance of the overpayment.” (77 FR 9182)
• “incentive to exercise reasonable diligence to determine whether an overpayment exists”
• Problem of corporate knowledge-no one person knows, but sum of knowledge of employees and systems
• Interaction with compliance obligations
“Overpayments”

• “Duplicate payments”
• “Receipt of Medicare payment when another payor had primary responsibility” (77 FR 9181) (Note: Existing penalty provision for failure to identify and refund Medicare payments when payment received from third party)

“Person”

• We propose that a person means a provider or supplier” (77 FR 9181) (for Medicare)
• Not managed care? (not a provider under 400.202, not a supplier of services under Medicare)
• Not managed care provider network entity?
• Not state or local government?
• Not Medicare intermediary or contractor?
• Not subcontractor?
• Not RAC?
Kickbacks

- “Compliance with the anti-kickback statute is a condition of payment.” (77 FR 9183)
- “To the extent that a provider or supplier who is not a party to a kickback arrangement has sufficient knowledge of the arrangement to have identified the resulting overpayment, the provider . . . must report the overpayment to CMS” (9183)
- Repayment obligation for non-party suspended pending CMS referral to OIG (9184) and resolution

CMS expectations

- “125,000 providers will report and return overpayments in a typical year”
- Typical provider would return “approximately” 3 to 5 overpayments
- CMS expects “it would take provider or supplier approximately 2.5 hours to complete the applicable form and return the overpayment.” No allowance for attorney costs
- Expected cost per disclosure: $37.10
- Ten year lookback-Capturing ten years of data
- “not an economically significant rule” (9186)
FALSE CLAIMS

• “Any overpayment retained by a person after the deadline for reporting is an obligation for purposes of 31 U.S.C. 3729”
• “a person must use the self-reported overpayment refund process set forth by the applicable Medicare contractor” (9187)
• “an overpayment must be reported and returned . . . If a person identifies the overpayment within 10 years of the date the overpayment is received.” (9187)
• False Claims Act exposure for person who “knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.”

STATES AND WHISTLEBLOWERs

• States
• -NY OMIG disclosure process- www.omig.ny.gov
• NJ disclosure process http://nj.gov/comptroller/divisions/medicaid
• Medicare contractors?
SAMPLE REPAYMENT FORM

• OVERPAYMENT REFUND/ NOTIFICATION FORM (link did not work 09/24/12)
  www.cahabagba.com/part_b/forms/overpayment_refund.pdf
• Distributed separately

PROVIDER MUST REPORT AND RETURN THE OVERPAYMENT AND STATE THE REASON, IN WRITING FOR THE PAYMENT

• PROPOSED CMS REGULATION 77 FR 9180-FINAL LIKELY 2013 (Medicare only)
• NJ Self-Disclosure Process www.nj.state.us/njomig
• Mass., Ct. Do not yet have disclosure protocols
• COMPARE WITH federal OIG self-disclosure protocol http://oig.hhs.gov/authorities/docs/selfdisclosure.pdf.
PROVIDER MUST REPORT AND RETURN THE OVERPAYMENT AND STATE THE REASON, IN WRITING FOR THE PAYMENT—WHAT ABOUT MANAGED CARE?

• “This protocol is equally applicable to managed care providers. Inappropriate payments made by managed care organizations (MCOs) to providers within their networks inflate the costs of providing care to MA recipients, and DPW retains its right and responsibility to identify and recover payments or take any other action available under law. While DPW will return to the applicable MCO any payments identified through this protocol, providers must make the self disclosure directly to DPW.” (Pa.)

“IDENTIFY”

• Need not know the amount of overpayment; need to have credible evidence that an overpayment has occurred

• CMS 2002 proposed regulation impact statement for mandatory disclosure:
  - Expect over 900,000 disclosures per year
  - Average time to report: 5 minutes
  - Draft reg. disclosure section withdrawn by CMS
CONSEQUENCES OF FAILURE TO REPORT

- False Claims Act imposes liability for a person who “knowingly” conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government” new 31 U.S.C. 3729(a)(1) (G) added by FERA
- “knowingly” includes reckless disregard, deliberate ignorance
- An overpayment which is timely reported and explained will not give rise to FCA liability even if the provider is unable to repay it within 60 days, unless there is evidence of improper “avoidance.”

WHO IS MOST LIKELY TO USE THE FERA FCA PROVISIONS TO ENFORCE THE 6402 ACA DUTY?

- WHISTLEBLOWERS AND THEIR COUNSEL
  - Data analysis for whistleblower case evaluation, supporting whistleblower allegation
    - Using your data and benchmarks
    - Matching exclusion lists against employee/contractor lists
    - Publicly available data on outliers
    - Discovery and access to govt. data and documents
    - Publicly available data on provider behavior
    - Best practices research
THANK YOU FROM A NEW COMPLIANCE OFFICER

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