

# MEDICAL SOCIETY OF NEW JERSEY

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## *Auditing, Extrapolation and Writing an Effective Compliance Plan*

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# Patient Protection and Affordable Care Act (PPACA)

Enacted March 23, 2010

- includes several new and amended provisions designed to assist the US government in curbing fraud & abuse in Federal healthcare programs

**PPACA** impacts the delivery of healthcare services by its new and amended provisions in areas such as:

Anti-Kickback Statute ("AKS")

False Claims Act ("FCA")/ Reverse False Claims ("overpayments")

Stark Laws/ Self Referral Disclosure Protocol "SRDP")

OIG Exclusion Authority

Civil Monetary Penalties ("CMPs")

# False Claims Act

## 31 U.S.C. §§3279-3733

- is a civil statute
- although there is also a complementary criminal statute (18 U.S.C. § 287)
- ▶ Provides for penalties & damages for presenting false or fraudulent claims
- ▶ **Intended to recover funds for the government**

# Civil Fraud Claims

- ▶ Civil portion of the FCA does **not require a specific intent** to defraud the government
- ▶ Thus the absence of intent is not a defense
- ▶ Rather, the simple existence, and knowledge of, the error or mistake is enough to impose liability and impose penalties
- ▶ 10 year Statute of Limitations

FERA and PPACA amendments have broadened definitions of “false claims” and given the Federal & State governments more tools and discretion to go after violators

“Knowledge” of a false claim is broad:

- actual knowledge
- deliberate indifference
- reckless disregard

# Key determination is whether the provider is lawfully entitled to retain the payment

Typical reasons for overpayment include:

- failure to refund credit balances
- deceased patient
- provider lacked required license or certificate
- excluded servicing or ordering person
- billing system error
- an unenrolled provider "billing through" an enrolled provider

PPACA requires providers to report & return overpayments ("**reverse false claims**")

- within 60 days of being identified (or when a corresponding reconciliation report is due)
- must advise of the reason for the overpayment
- "overpayments" defined as funds received or retained to which the provider is not entitled (after any applicable reconciliation)
- an overpayment retained after the deadline for reporting & returning it is deemed an "obligation" for purposes of the FCA

# Penalties can include:

1. Civil Monetary Penalties (“CMPs”)
  - imposed by Civil Monetary Penalties Law (“CMPL”) §1128A of the Social Security Act
2. Exclusion from participation in the Federal & State programs
  - mandatory (where criminal conduct)
  - permissive (discretion of OIG)
3. Jail time if prosecuted under criminal statute

# Civil Monetary Penalties

## 42 U.S.C. § 1320a-7a

- ▶ Delegated by DHHS Secretary to the OIG
- ▶ Can range from \$10,000 to \$50,000 per violation
- ▶ Each claim submitted falsely or fraudulently constitutes a violation
- ▶ Can include treble damages

**PPACA § 6402(d)(2)** creates 3 new CMPs:

- a) \$10,000 plus treble damages for ordering or prescribing while excluded from the program
- b) \$50,000 plus treble damages for false statements in an application or bid to enroll or participate as a provider in a Federal health care program
- c) \$10,000 plus treble damage for failing to report an overpayment

**PPACA § 6408(a)** creates 2 new CMPs:

- a) \$50,000 for false statements in response to or delaying an OIG investigation
  
- b) \$15,000 per day for delaying or hindering an investigation

## PPACA § 6402(d)(1)

adds a new permissive exclusion authority applicable to providers who make **false statements or misrepresent material facts** in an application or other document **in the enrollment process**

## PPACA § 6406(c)

amends the existing permissive exclusion authority applicable to providers who **fail to provide payment** information as requested by the Secretary **or who fail to permit examination** of its' records; as amended the exclusion is no longer limited only to those who furnish the items or services but **now also extends to those who order, refer or certify the need for such items** or services

# *There is some good news:*

## **PPACA § 6402(k)**

expands the scope of waivers of mandatory exclusions the Secretary may grant to providers who are a **sole community provider** or **sole source of essential specialized services** in a community

# BEWARE:

\*\*\*Excluded physicians may not bill directly for treating Medicare and Medicaid patients and their services also may not be billed indirectly through an employer or practice group

# Important considerations

- ▶ Recognize that the **OIG relies upon** the healthcare industry to **self-police itself**
- ▶ Recognize that OIG's **stepped up efforts** to identify and prosecute fraudulent conduct can **result in claims against physicians** who have mistakenly failed to devote adequate resources, staff & training to ensure proper billing and coding practices, notwithstanding the **absence of any intent to defraud**
- ▶ Review (and adopt as much as possible of) the **OIG's compliance program guidelines**

# OIG Compliance Programs

- ▶ Modeled after the United States Federal Sentencing Guidelines
- ▶ Based upon the principle that healthcare providers self-monitor their compliance with proper coding & billing practices, by identifying and monitoring their practices for high risk areas of potential fraud and abuse
- ▶ Further based upon principle that healthcare providers will self-report and self-correct errors & mistakes

# Elements of OIG's Compliance Program

1. designate a Compliance Officer or Committee
2. create and maintain policies & procedures, including a compliance code of conduct
3. conduct internal auditing to assess risks and avoid fraudulent billing practices
4. maintain open & confidential means of reporting compliance concerns

5. training & education of staff to ensure adherence to federal program requirements
6. create method to detect & correct errors
5. enforce disciplinary action against violators of program

**\*\* a successful compliance program will:**

- minimize the risk of being subject to an enforcement action; and
- mitigate the damages/ reduce penalties assessed if there is a violation

# Designating a Compliance Officer and Committee

- ▶ Officer should have a strong understanding of all coding & billing principles
- ▶ Full time or assigned responsibility as part of existing position, or more than one (depends on size of practice)
- ▶ Should have direct access to physicians/providers of services
- ▶ Should have regularly scheduled meetings to discuss compliance activities
- ▶ Should keep minutes of meetings (to show proof of compliance program if questioned)

# Policies & Procedures

- ▶ Ensure continuing education & training
- ▶ Disciplinary plan for unethical behavior
- ▶ Method of reporting concerns (without fear of adverse consequences)
- ▶ Procedure for making repayments
- ▶ Procedure for responding to investigations
- ▶ Record retention policy (for both medical & business records)

# Code of Conduct

- ▶ Should be a clear statement of your practice's basic principles
- ▶ Should establish the authority & responsibility of the Compliance Officer
- ▶ Should set forth the basic operation of the practice's compliance plan
- ▶ Should cover day-to-day compliance activities

# Internal Auditing

- ▶ Primary goal is to **identify** your practice's **most likely areas of risk**, by:
  - analyzing practice's top reimbursable services
  - reviewing history of denied claims
  - reviewing claims that have resulted in overpayments

# Types of Internal Reviews

1. Standards & Procedure review
  - make sure are current and up to date
  - ensure using current CPT codes and delete use of outdated codes (CPT manual is published annually for Jan 1 effective date)
2. Claims Submission audit
  - ensure claims coded correctly, that documentation complete and services rendered were reasonable & necessary

# Open & Confidential Reporting

- ▶ Establish an “open door” policy
- ▶ Encourage good faith reporting (and that failure to do so is itself a violation)
- ▶ Establish a consistent process for reviewing any reported concerns
- ▶ If using a third party billing entity, ensure means for communication between that entity and your compliance officer

# Training & Education

- ▶ Provide consistent training and education to all staff, not only compliance officer
- \*\* will not only improve accuracy of coding & billing, but can also improve your practice's revenue stream and cash flow

# Detecting & Correcting Errors

- ▶ Most billing errors are “coding errors”; not any intentional effort to defraud
- ▶ Most processing errors are the result of outdated software or billing systems
- ▶ Most documentation errors are the result not adequately documenting the patient encounter and behavior taken

**\*\*When an error is detected, must take swift & decisive action to rectify & prevent going forward**

# Disciplinary Measures

- ▶ Program in place to ensure all violations handled in a consistent manner
- ▶ Yet should be flexible enough to allow for mitigating (or aggravating ...) factors
- ▶ After rectifying an error, your practice should review the chain of events resulting in the error to prevent a reoccurrence

# Medicare Integrity Program: Using Extrapolation to Safeguard Against Fraud and Abuse

- ▶ MIP grants CMS authority to contract with 3<sup>rd</sup> party entities to ensure integrity of CMS programs.
- ▶ Significant focus on combating Fraud and Abuse by providers, while paying for PPACA, through audit programs.
- ▶ Conducted by Zone Program Integrity Contractors (ZPICS)

# ZPICs Responsibilities Defined

- ▶ Pre or post pay medical review of claims
- ▶ Data analysis
- ▶ Benefit integrity and/or fraud detection
- ▶ Cost report audits
- ▶ Provider education
  
- ▶ Directly responsible for operating areas such as investigation, case development, administrative solutions and referral to law enforcement
  - FRAUD AND ABUSE IMPLICATIONS - Reporting to DOJ and OIG

# Extrapolation - Reclaiming Overpayments

- ▶ The use of a statistical sampling of a provider's claims in an audit to calculate and project overpayments made in connection with Medicare claims.
- ▶ ZPICS (Zone Program Integrity Contractors) seek out errors in a statistically relevant sample of claims and calculate the "error rate" to the entire universe of claims during a set time period.

# CMS Extrapolation: The Process

- ▶ ZPIC Audits: The CMS Medical Review Process
  - Analyze data for billing errors concerning coverage and coding by providers
  - Take action to prevent and/or address the identified errors including provider outreach/education
  - Refer identified overpayments for demand for repayment letter of overpayment

# ZPIC Audit Outcomes

- ▶ Medicare Modernization Act 2003 (MMA)
  - Extrapolation may be used to calculate and project amounts of overpayments on claims
  - Must be a determination of sustained or high level of payment error, or documentation that educational intervention has failed to correct payment error
  - ZPIC Appeals: Generally difficult; burden is on the provider; may be based on statistical invalidity arguments, other statutory requirements and Medicare guideline arguments

*For any questions, concerns or requests for  
additional information or advice,  
please feel free to reach out to us at*

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