

# MEDICARE COMPLIANCE

## Outlook 2010: Enforcers Have More Funds, Better Tools to Fight Overpayments, Fraud

The twin engines of enforcement and guidance are revving up as the new year starts to unfold. Medicare program integrity auditors of different stripes are ramping up, False Claims Act cases continue at a fast pace and HHS and the Department of Justice are flexing their combined anti-fraud muscles, while CMS plans to intensify efforts to articulate Medicare billing and documentation standards.

A phenomenal amount of activity is taking place in the enforcement and program integrity arenas. Zone program integrity contractors (ZPICs) — CMS's data-driven fraud and abuse hunters — have begun audits in Texas, Oklahoma and New Mexico, says former Texas Medicaid Inspector General Brian Flood. The ZPICs, which do intense reviews, are focused now on short hospital stays and durable medical equipment, says Flood, now managing director with KMPG. "Providers will feel the touch of the government more often," he says.

Recovery audit contractors (RACs), which recently began coding and DRG validation audits (*RMC 12/14/09, p.1*), will also ratchet up scrutiny in 2010. Connie Leonard, director of the CMS Division of Recovery Audit Operations, tells *RMC* that CMS has given one RAC (for Region D) the green light to do probe audits for complex coding and medical necessity. Probe audits, which are mini-audits that indicate whether an area is worth delving into further, are the first step toward the complex medical reviews that providers dread because of their potentially devastating financial consequences.

"Later on this year, we expect to let RACs do medical necessity [audits]," Leonard says. But perhaps the most controversial RAC audits — which challenge the site where a service is performed (e.g., inpatient vs. observation) — won't be tackled during this first round of medical-necessity probe audits, Leonard notes.

Meanwhile, the Department of Justice will keep churning out fraud cases, and compliance officers and lawyers expect more of them to focus on hospital-physician relationships and quality of care. The combined force of DOJ-HHS in the Health Care Fraud Prevention and Enforcement Action Team (HEAT) will become an increasing threat. "You have the current administration putting \$311 million into HEAT [and other Medi-

care and Medicaid program-integrity activities] for fiscal year 2010, which is 50% more than last year," says Washington, D.C., attorney Paul Danello, with Baker & Daniels. "Obama is projecting in his budget that over the next five years, [the anti-fraud efforts] could save \$2.7 billion that was illegally paid to providers. That will come out of the skin of hospitals and physicians."

And innovative uses of data mining and analysis will make all the auditors, investigators and enforcers more effective in identifying fraud and abuse and overpayments. "There are so many different characters in this compliance play and they are so much more coordinated than we have seen before," says San Francisco attorney Judy Waltz, with Foley & Lardner. "They are looking at so many more issues."

For health care organizations frustrated by the complex and sometimes convoluted Medicare rules, there will be some relief this year. George Mills, director of the CMS Provider Compliance Group, which includes medical review, data analysis, error rate measurement and the RACs, tells *RMC* that more education on specific risk areas is in the works. "We will be issuing guidance and having open door forums on documentation issues we are seeing that are clearly preventable," Mills says. "What we are trying to do is chop it into digestible pieces." *Among the topics:* admitting patients versus ordering observation services; fixing medical records to address problems identified in OIG reports; and addressing errors identified by CMS's comprehensive error rate testing (CERT) contractor (e.g., missing and illegible signatures). Mills adds that the RAC team will tape training sessions and put them on the Web.

### 'Good Year for False Claims Act'

Predicting heightened enforcement isn't just an annual ritual. The money is now there to back up the words. "I see an uptick in everything — there will be increased enforcement, more whistleblower cases and more investigations because more resources are available," says former top DOJ attorney John Kelly, now with Fulbright & Jaworski.

"It's going to be a good year for the False Claims Act," says Pat Burns, spokesman for Taxpayers Against Fraud. "We are on a good trajectory already." For ex-

ample, some major pharmaceutical companies are setting aside hundreds of millions of dollars to settle allegations involving off-label marketing of drugs, he says. The enormous fines and recoupments keep the DOJ and HHS war on health fraud and abuse churning; the funds are recycled back to them through the federal government's Health Care Fraud and Abuse Control program.

A settlement of the false claims lawsuit against Christi Sulzbach, former Tenet Healthcare Corp. chief compliance officer and general counsel, is also expected this year, Burns says. "That will happen this spring because both sides moved for summary judgment" in spring 2009. In the unprecedented case, the U.S. attorney's office in Miami accused Sulzbach of helping a Tenet hospital in Florida collect undeserved Medicare reimbursement. According to the complaint, Sulzbach twice signed corporate integrity agreements attesting to the hospital's compliance with all legal requirements even though she allegedly knew some hospital-physician contracts violated Stark physician self-referral rules (*RMC 9/24/07, p. 1*). Sulzbach's attorney has called the allegations wrong both "legally and factually."

In the provider arena, relationships with referral sources will attract more enforcement actions. "Everyone should look at issues around physician arrangements," says Susan Walberg, corporate compliance officer for MedStar Health, which has hospitals in Maryland and Washington, D.C. "This area is gathering steam." It's not enough to have a contract in place for administrative services, such as medical directorships, she notes. Health care organizations should ensure they possess documentation to support payments and to show that physicians actually provided services for which they are compensated.

Mark Pastin, president of the Council of Ethical Organizations in Alexandria, Va., also sees physician arrangements as a false claims growth industry. The increasing risk means compliance officers should examine them in greater detail. First, "compliance officers are often kept away from this topic; they are told that legal handles it," he says. This hands-off attitude may stem from management's fear that compliance officers see the world in black and white and will veto too many deals.

Second, there are more false claims lawsuits built around Stark and/or anti-kickback violations. These types of lawsuits "are particularly appealing to physician-whistleblowers who feel that other physicians are being treated more favorably. And since it is the natural condition of physicians to feel other physicians are treated more favorably, we are seeing a lot of these al-

legations," Pastin says. Compliance officers will have to "break down the wall to legal to do their job."

### Hospitals to Grapple With Self-Discovered Errors

And with compliance officers more effective at investigating complaints than they were five years ago, they are more likely to identify problems and try to resolve them. "What makes this all work" is when senior management supports necessary corrective action in response to compliance officers reporting problems, Pastin says. Otherwise, compliance officers could become a source of whistleblowers.

Whether or not they are DOJ targets, "a lot of hospital systems will have to deal with their own internally discovered Stark noncompliance," says Denver attorney Jeffrey Fitzgerald, with Faegre & Benson. With the prevalence of mature compliance programs, hospitals over the next two years "will be developing a process for resolving Stark hiccups." For example, if they have a physician contract that expired and wasn't signed immediately, there is an alternate path to compliance that doesn't require disclosure to the government. But hospitals need procedures to address near misses and violations.

HEAT is increasingly a force to be reckoned with. It marshals the combined administrative, civil, criminal and asset-seizure powers of DOJ and HHS in the war on fraud and abuse, Kelly says. "They are trying to brand their health care fraud initiative," he says. The strike forces in Tampa, Baton Rouge, Detroit, Houston, Los Angeles and Miami are only one part of HEAT. Already numerous civil and criminal cases are attributable to HEAT. For example, HEAT gets credit for DOJ's December settlement with Mercy Medical Center in Sioux City, Iowa. The hospital agreed to pay \$400,000 to settle a false claims allegations that it inflated charges for heart patients' care to trigger Medicare "outlier" payments, according to the U.S. attorney's office in Cedar Rapids.

HEAT and other health fraud enforcers will thrive in the coming years due to recent changes to the False Claims Act in the Fraud Enforcement and Recovery Act (FERA) of 2009, Danello says. For example, FERA established explicit liability for retention of Medicare overpayments, extended the statute of limitations and significantly changed the definition of a "claim," among other things. The effect of a more potent FCA in the hands of enriched HEAT will be "a game changer" for 2010, Danello says. "The game is running highly in favor of DOJ and whistleblowers and highly against hospitals and other providers."

Expect OIG and the Department of Justice to pursue more quality-related False Claims Act cases and other enforcement actions this year and beyond, says

Los Angeles attorney Cheryl Wagonhurst, with Foley & Lardner. Health care organizations may be hit for allegations of medically unnecessary services; services not rendered, not rendered as prescribed or for substandard care that rises to the level of a failure of care; never events (serious medical errors); unreliable hospital-reported quality measurement data; and flaws in Medicaid statistical information system data reporting, she says.

“A quality-of-care enforcement action is probably the worst kind a provider can imagine. It has far greater ramifications than a Stark or kickback action” in terms of the impact on a provider’s reputation and stock prices, Wagonhurst says. The OIG 2010 Work Plan also puts a “significant focus on quality of care” and the integrity of data reporting, she notes. DOJ just announced a major criminal and civil settlement with a nursing home chain over substandard care (see Briefs, p. 8). Wagonhurst says the government has made it clear that quality of care enforcement actions will expand to other types of facilities.

### **Pressure to Reduce Errors Will Filter Down**

Pressure is building to reduce payment errors since the Obama administration announced in November 2009 that the Medicare fee-for-service error rate doubled to 7.8% between 2008 and 2009 (*RMC 11/23/09, p. 1*), Waltz and Wagonhurst say. CMS has made it easier to reject claims based on flaws that it may have tolerated in the past, the lawyers say. For example, a patient’s history can’t be used to compensate for documentation gaps; missing or illegible signatures will no longer be tolerated. Also, President Obama issued an executive order that requires a reduction in improper Medicare and Medicaid payments.

Waltz and Wagonhurst say these developments — and a 2009 report by Thomson Reuters citing \$700 billion worth of waste annually across the U.S. health care system (e.g., unnecessary care, fraud, inefficiencies) — will perpetuate an already powerful recoupment trend.

RACs are already gunning for payment errors, but it will be a new experience for hospitals to face ZPIC auditors. Flood says that ZPICs, which will be auditing in all states by the end of the year, are a different animal than RACs. They visit hospital-targets in person, “and expect nearly instantaneous access to your medical records,” he says. So far, CMS hasn’t capped the number of medical records that ZPICs can demand from hospitals, or limited the number of years of claims they can audit, Flood says. In one case, the ZPIC showed up at a hospital asking for 200 medical records. After the hospital explained its limitations, the ZPIC gave the hospital 30 days, Flood says.

But these contractors focus on egregious conduct — “considerable abuse or fraud,” Flood notes. ZPICs get data-mined referrals from CMS, and then conduct coding, overutilization and medical-necessity audits. When there are potential cases of fraud or abuse, they will be referred to OIG and DOJ.

### **Medicaid Is a Growing Risk Area**

Medicaid program integrity auditors also are building up momentum. Several states now have Medicaid inspector generals, a sign that states are ramping up their war on Medicaid fraud and abuse. The states are New York, New Jersey, Kansas, Texas, New Mexico, Florida, Georgia and Illinois, according to Waltz and Wagonhurst.

New York Medicaid Inspector General Jim Sheehan is capitalizing on data mining and analytics to identify aberrant billing patterns and other undesirable activity. “Data mining is getting better all the time,” Sheehan says. “More information sources are being added” — including death data from the Social Security Administration, vital statistics and hospital discharge data — to Medicare and Medicaid databases. HHS Inspector General Daniel Levinson told Congress in June 2009 that the “integrated data repository” being constructed by CMS will “contain a wealth of data” that cuts across several CMS programs.

### **Ineligible Docs: ‘Where Are They Now?’**

For example, New York’s Office of the Medicaid Inspector General (OMIG) has a data-mining project underway called “Where are they now?” It’s designed to identify the location of physicians who have been kicked out of Medicaid in another state to ensure they can’t get a new provider number under a different name (or to identify if they are already billing under a legitimate provider’s number). “There are ways to track them even [when they are] using a fake identity,” Sheehan says. It’s called entity analytics — “when people disappear from the grid, they don’t change everything. Maybe they change their first name, but certain things are predictable” (e.g., using their mother’s maiden name as a new last name).

Sheehan says that during the coming year, OMIG will focus more on the effectiveness of compliance programs, which are mandatory for hospitals and many other Medicaid providers in New York state. “Last year was about getting a compliance program up and running. This year we’ll be working with provider groups on how it’s running,” he says. For example, Sheehan wants to confirm that organizations check employees for Medicare and Medicaid sanctions and other black marks, and make sure screening is done well. Sheehan says many organizations use vendors to perform

screening, but they may not check both state and federal sanction lists. "We know there are problems," he says. There are 6,000 people currently excluded from New York Medicaid and their names are posted on OMIG's Web site. But Sheehan says organizations must ensure that trained, competent people use the tool properly or the effort won't do much to promote compliance.

With all the pressure from the government, health care organizations will have to leverage hospital resources to compensate for compliance budgets that don't grow fast enough, says Roy Snell, CEO of the Health Care Compliance Assn. "Get people outside the compliance program to help with compliance," he says. For example, internal auditors may conduct a whole slew of audits that never approach legal or regulatory issues, and they can be solicited to spend some of their time in the compliance arena. "Befriend them and get them interested in [compliance] audits," Snell says. "It's not against the law to pay a vendor twice," but large RAC recoupments, false claims lawsuits or Medicare exclusions are significant body blows to organizations.

Finally, a major new challenge for compliance officers in the coming year will be adapting their moni-

toring and investigation skills to electronic medical records. With electronic systems, "it's hard to tell if a code or documentation was changed before or after a claim was rejected," Pastin says. White-out used to be the tool of choice for documentation manipulation — false claims lawsuits have cited charting parties as evidence that providers tampered with records — but that is moot with EMRs. For example, "a lot of health plans are assigning codes to various complaints and not preserving the original written documents. All of a sudden, that basic unfungible data are turned into something that can be easily manipulated," Pastin contends. "Some compliance officers don't yet have the tools they need to replicate [with EMRs] what they have learned to do in the paper environment," including auditing, monitoring and investigating.

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