Summary of Anti-Fraud Provisions in the Affordable Care Act
Before we begin...

- Reminder that phone lines are muted
- Direct your questions to the Chat box or the Q&A box (to host/presenters) – we’ll cover at the end as time allows
- CLE forms have been distributed via email (and in person)
- 3 codes to be announced verbally over the duration of the program for NJ and NY and VA (remote viewers only)
- Look for future alerts & webinars & guidances
- Share any email addresses for others within your organization that would like to be on our ACA update list
- Any questions offline – please email seminars@leclairryan.com
- CLE forms are to be returned to CLE@leclairryan.com.
Today’s presenters

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The Patient Protection and Affordable Care Act

More commonly known as the Affordable Care Act, enacted in 2010, provides tools to prevent, detect and take strong enforcement action against fraud in Medicare, Medicaid and private insurance.
The Affordable Care Act (ACA) seeks to improve anti-fraud and abuse measures by focusing on prevention rather than the traditional “pay-and-chase” model of catching crooks after they have committed fraud. There are four principle ways the ACA seeks to make changes:

1. More money to prevent and fight fraud
2. Better screening and compliance
3. New penalties
4. Better data sharing
1. More money to prevent and fight fraud

The ACA provides $350 million over 10 years (FY 2011 through FY 2020) through the Health Care Fraud and Abuse Control Account (HCFAC).

The ACA also allows these funds to support the hiring of new officials and agents that can help prevent and identify fraud.
2. Better screening and compliance

The ACA allows the Centers for Medicare and Medicaid Services (CMS) to conduct background checks, site visits, and other enhanced oversight to weed out fraudulent providers before they starting billing the program.

The ACA makes changes in the following areas:
2. Better screening and compliance (cont.)

a) Screening and Disclosure.

Creates a national pre-enrollment screening program for all providers, and requires disclosure of prior association with delinquent providers or suppliers. States will have to screen providers to determine if they have a history of defrauding government.

Those types of providers and suppliers that have been identified in the past as posing a higher risk of fraud (such as durable medical equipment suppliers) will be subject to a more thorough screening process.
2. Better screening and compliance (cont.)

b) Licensing, Background Checks.
Increases oversight of providers and suppliers participating or enrolling in Medicare and Medicaid through

- mandatory licensure checks,
- fingerprinting of high-risk providers,
- site visits and
- criminal background checks

before a provider can begin billing Medicare or Medicaid.
2. Better screening and compliance (cont.)

c) **Temporary Moratorium.**
Allows the Health and Human Services (HHS) Secretary to prohibit new providers from joining the program where necessary to prevent or combat fraud, waste or abuse in certain geographic areas or for certain categories of services.
d) **Withholding Payments.**

Allows the HHS Secretary to temporarily withhold payment to any Medicare or Medicaid provider if a credible allegation of fraud has been made and an investigation is pending.
2. Better screening and compliance (cont.)

e) High-Risk Controls.
Places new controls on high-risk programs, like home health services or durable medical equipment, to ensure that only Medicare and Medicaid providers in good standing can provide these services.

Providers and suppliers who order or refer DME or home health for Medicare beneficiaries must enroll in Medicare and maintain documentation on orders and referrals.
2. Better screening and compliance (cont.)

f) **Recovery Audit Contractors.**

Expands the Recovery Audit Contractors (RACs) program to Medicaid, Medicare Advantage (Part C) and Medicare drug benefit (Part D) programs.

Recovery Audit Contractors are CMS contractors that are used to detect and correct improper payments *after* Medicare has paid a bill.

RACs will help identify and recover over and underpayments to providers under Medicare and Medicaid.

Part C and Part D providers and suppliers must report and return Medicare and Medicaid overpayments within 60 days of identification.
2. Better screening and compliance (cont.)


g) National Provider Identifier.
Requires providers to include their National Provider Identifier on all applications and claims.

h) Surety Bonds.
Strengthens the government’s authority to require surety bonds as a condition of doing business with Medicare.
2. Better screening and compliance (cont.)

i) **Compliance Plans.**
Requires providers and suppliers to establish compliance plans ensuring that they are aware of anti-fraud requirements and utilize good governance practices.

j) **Claims Filing Limit.**
Require providers and suppliers to file fee-for-service claims within 12 months of providing the item or service.
3. New Penalties to Deter Fraud and Abuse

The ACA better prevents unscrupulous providers from participating in Medicare and Medicaid in the first place and includes strict new fines and penalties.

The ACA makes changes in the following areas:
3. New Penalties to Deter Fraud and Abuse (cont.)

a) OIG Authority.

Provides the Office of Inspector General (OIG) with the authority to impose stronger civil and monetary penalties on providers who have committed fraud, including $50,000 for each false statement or misrepresentation of a material fact and $50,000 of triple the amount of the claim involved for providers who know of an overpayment but do not return it.
3. New Penalties to Deter Fraud and Abuse (cont.)

An ACA provision directs the Sentencing Commission to increase the federal sentencing guidelines for health care fraud offenses by 20-50% for crimes that involve more than $1,000,000 in losses.

c) Overpayments.
Allows new fines and penalties against providers who identify an overpayment from Medicare or Medicaid but do not return it within 60 days.
3. New Penalties to Deter Fraud and Abuse (cont.)

d) **Recapture.** Makes it easier for the government to recapture any funds acquired through fraudulent practices.

e) **New Penalties.** Creates new penalties for submitting false data on applications, false claims for payment, or for obstructing audits or investigations related to Medicare or Medicaid.
3. New Penalties to Deter Fraud and Abuse (cont.)

f) **Marketing Penalties.**
Establishes new penalties for Medicare Advantage and Part D plans that violate marketing regulations or submit false bids, rebate reports, or other submissions to CMS.

g) **Nursing Homes.**
The ACA makes it easier for the Department of Justice (DOJ) to investigate potential fraud or wrongdoing at facilities such as nursing homes.
4. Data sharing to identify fraud

The ACA expands the CMS “integrated data repository” to incorporate data from all federally supported health care programs.

The ACA makes changes in the following areas:
4. Data sharing to identify fraud (cont.)

a) Claims Data.

Requires certain claims data from

- Medicare, Medicaid and CHIP,
- the Veterans Administration, the Department of Defense,
- the Social Security Disability Insurance program, and
- the Indian Health Service

to be centralized, thereby making it easier for agency and law enforcement officials to identify criminals and prevent fraud on a system-wide basis.
4. Data sharing to identify fraud (cont.)

b) Data Bank.

Creates a comprehensive Medicare and Medicaid Provider/Supplier Data Bank to conduct oversight of suspected utilization, prescribing patterns, and complex business arrangements that may conceal fraudulent activity.
4. Data sharing to identify fraud (cont.)

c) **False Front Providers.**

Allows use of the centralized database of compromised or stolen beneficiary and provider numbers to identify “false front” providers to prevent or recover overpayments, trigger administrative actions and support seizures by law enforcement.
4. Data sharing to identify fraud (cont.)

d) **Data Access.** Gives the DOJ and OIG clearer rights to access CMS claims and payment databases.

e) **Medicaid Data.** Allows the HHS Secretary to require states to report additional Medicaid data elements with respect to program integrity, program oversight and administration.

f) **Termination Data.** Requires sharing information about providers who have been terminated from the Medicare program with state Medicaid agencies within 30 days of provider termination.
ACA Fraud Prevention Provisions by Sector: Focusing on high risk areas

DME Fraud
To help reduce opportunities for DME Fraud, the ACA:
- Requires a physician, nurse practitioner, clinical nurse specialist, or physician assistant to have a face-to-face encounter (including via telehealth) with an individual before issuing a certification for DME.
- Requires that DME supplies must be ordered by an enrolled Medicare eligible professional or physician.
- Requires more thorough screening of those types of providers and suppliers that have been identified in the past as posing a higher risk of fraud.
- Allows HHS to prohibit new DME providers from joining the program in certain geographic areas or where necessary to prevent or combat fraud, waste or abuse.
ACA Fraud Prevention Provisions by Sector: Focusing on high risk areas

Home Health Fraud
To help reduce opportunities for fraud in home health, the ACA:

- Requires physicians who order home health services to be enrolled in Medicare.
- Requires a face-to-face encounter within 90 days prior to the home health start of care date.
ACA Fraud Prevention Provisions by Sector: Focusing on high risk areas

Hospice Fraud

To help reduce opportunities for fraud in hospice, the ACA:

- Requires face-to-face encounters with every hospice patient to determine continued eligibility at the 180-day recertification, and prior to each recertification and an attestation that such a visit took place.
ACA Fraud Prevention Provisions by Sector: Focusing on high risk areas

Medicare Advantage Fraud
To help reduce opportunities for Medicare Advantage program fraud, the ACA:

- Establishes new penalties for Medicare Advantage and Part D plans that violate marketing regulations or submit false bids, rebate reports, or other submissions to CMS.
- Phases out overpayments to private Medicare Advantage plans to bring payments more in line with traditional Medicare.
ACA Fraud Prevention Provisions by Sector: Focusing on high risk areas

Nursing Home Fraud
To help reduce opportunities for fraud in nursing homes, the ACA:

- Requires that Skilled Nursing Facilities (SNFs) and nursing facilities (NFs) make available information on ownership of the facility, including
  - a description of the facility’s governing body,
  - director, officers, partners, trustees, managers
  - and anyone else associated with the facility.
Nursing Home Fraud
To help reduce opportunities for fraud in nursing homes, the ACA (cont.)

- Requires SNFs and NFs to operate a compliance and ethics program that will effectively prevent and detect criminal, civil, and administrative violations.
- Requires a nationwide program for national and state background checks on prospective direct patient access employees of long-term care facilities and providers. The government’s Nursing Home Compare Medicare website (www.medicare.gov/NHCompare/) includes information on the number of instances of judicial review of criminal violations by a facility or its employees.
- Makes it easier for the DOJ to investigate potential fraud or wrongdoing at facilities such as nursing homes.
ACA Anti-Fraud Compliance Strategies for High Risk Sectors
ACA Anti-Fraud Compliance Strategies for High Risk Sectors

- Licensed Healthcare Providers
- DME Suppliers/Prescribers
- Home Health Agencies
- Skilled Nursing Facilities
- “RAC” Audit Strategies
Licensed Healthcare Providers

- Enhance New Provider “Due Diligence”
  - Current or previous affiliation with another provider or supplier that has uncollected debt?
  - Subject to a payment suspension under a federal health care program?
  - Excluded from participation under Medicare, Medicaid, or CHIP?
  - Billing privileges denied or revoked at the time of initial enrollment or revalidation of enrollment?
Licensed Healthcare Providers

- Establish/Update Compliance Plans
  - outpatient rehabilitation facilities
  - hospice organizations
  - independent diagnostic testing facilities
  - independent clinical laboratories
  - physical therapy
Licensed Healthcare Providers

- Conduct Internal Audits of Billing and Payment Practices
  - Ask “why is that provider or that service different?”
    - Dramatic Increase in Patient Volume
    - Surge in particular Diagnostic Tests, PT, DME
    - New Referral Sources
DME Suppliers/Prescribers

- October 1, 2013 - Physician/patient face-to-face encounter within 6 months prior to physician’s order
- If DME ordered by an NP, PA or CNS, physician must document face-to-face encounter by signing/co-signing medical record.
- Physicians provided an additional payment (code G0454) for signing/co-signing
DME Suppliers/Prescribers

- Develop a face-to-face encounter form.
- Ensure appropriate personnel understand the new documentation requirements & signature requirements.
- Educate staff on the DME subject to the new requirements.
- Conduct Internal Audits
Home Health Agencies

- Review Physician Certification Policies and Procedures
- Pay Close Attention to Outcome and Assessment Information Set (OASIS) data
- Conduct Pre-billing Audits
- Train Personnel on Hire and Update Training on Regular Basis; Document!
Home Health Agencies

Hospice

- Tighten Certifications and Eligibility Documentation
- Do Not Document Only “Patient Decline” (e.g., “Charting Toward the Negative”)
- Scrutinize Medical Director Agreements
  - Beware of hidden referral inducements
- Assure RNs Focus on Palliative Care
  - Other services may suggest “kickbacks”
Skilled Nursing Facilities

- Corporate Compliance Plans in Place By March 2013: **STILL AWAITING FINAL RULE**
- Compliance and Ethics Programs Still Required
- OIG Compliance Plans Helpful Guide in Absence of CMS Final Rule
Skilled Nursing Facilities

- Establish compliance standards “that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations”;
- Designate “high-level personnel” who have “the responsibility to oversee compliance” and have “sufficient resources and authority to assure” compliance;
- Communicate standards and procedures to “all employees and other agents” via training programs
Skilled Nursing Facilities

- Exercise due care “not to delegate substantial discretionary authority to individuals the organization knew, or should have known...had a propensity to engage in criminal, civil, and administrative violations”;
- Employ “reasonable steps to achieve compliance,” e.g. monitoring and auditing systems “reasonably designed to detect violations;”
Skilled Nursing Facilities

- Consistently enforce compliance standards,
- If compliance offense occurs, take all “reasonable steps to respond appropriately” to prevent further similar offenses;
- Periodically reassess compliance program to identify any necessary changes reflective of changes within the organization and its facilities.
RAC Audit Strategies

- Key Areas of Emphasis
  - Evaluation & Management Coding
  - Office injectables
  - Services incident to a physician’s services
  - Certifications by physicians with financial relationships with DME suppliers
  - Consultations
RAC Audit Strategies

- Log and respond to records and refund requests.
- Track deadlines for document production and appeal requests.
- Be cognizant of role of hospitals & other physicians involved in the joint care of patients under RAC review.
RAC Audit Strategies

- Ensure patient records are clear and complete with medical histories and appropriate signatures.
- Review options for rebilling items that are miscoded.
- Focus on areas of vulnerability based on past coding, billing and reimbursement complications
Question and Answer Session

Reminder to send forms to CLE@leclairryan.com
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