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How to Interact with a Medicare Contractor when Compliance Issues Arise

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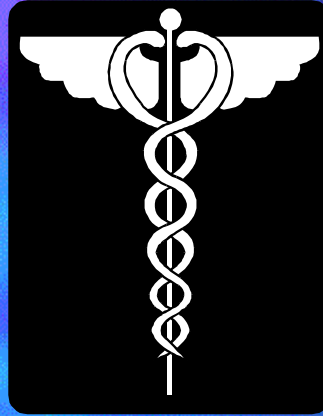
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This presentation is really a discussion of business “reasonableness” in today’s health care marketplace and the type of measures that must be instituted by health care providers, suppliers and payers to restore marketplace credibility. We will furnish a description of how, depending on the facts presented, contractors will make their best efforts to use the appropriate tools to assist the pertinent government entities in protecting the Medicare program and how these insights should allow providers to better interact with contractors.

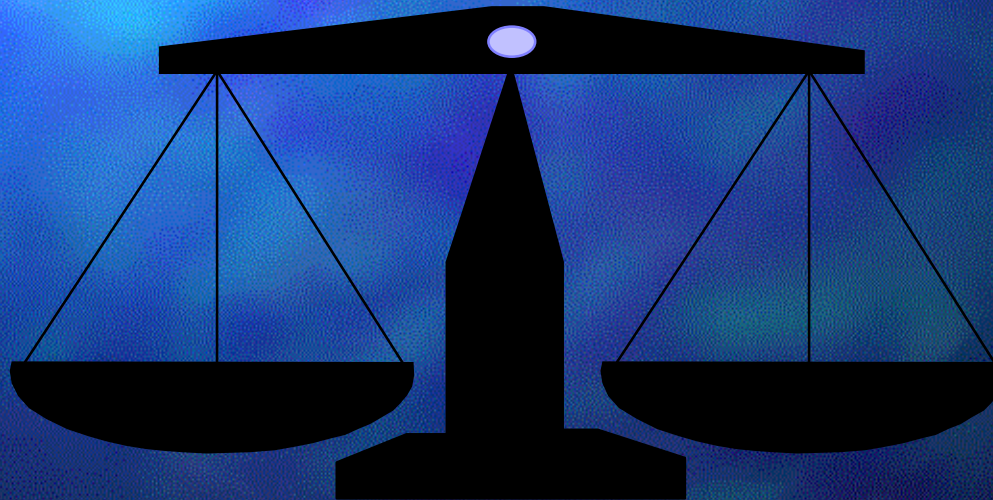
The Health Care Industry Must Ask

How did we get here?

What can we do to change that
image?



THE BUSINESS ENVIRONMENT



Realizing Today's Reality

Three Perspectives on Fraud & Abuse

- Government's perspective
 - declared war on fraud and abuse in 1993
 - many legislative and other investments
 - real progress being made, error rate cut in half
- Health Care Industry's perspective
 - problem blown out of proportion
 - innocent billing errors, unavoidable
 - investigators misguided
- Consumers' perspective
 - do not believe either of the above

Compliance: Preparation for the Present

Why?

1. It's the right thing to do
2. The comfort of knowing that you have nothing to hide - nothing to fear
3. Somebody is watching you
 - Government
 - Contractor
 - Competitors
 - Patients
4. The Health Care environment: Pick your game show
 - Greed
 - Who Wants to be a Millionaire?

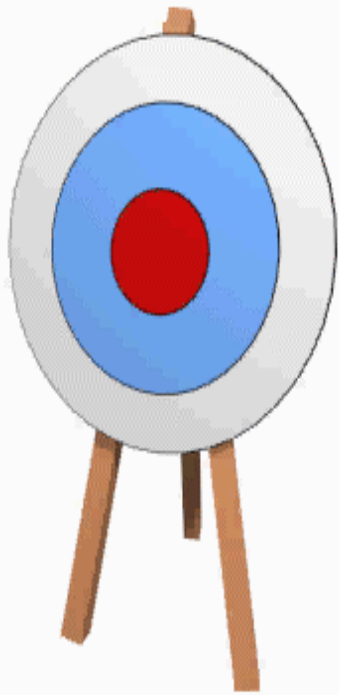
The reality...file law suits, win big prizes

 - Focus on medical errors
 - Qui tam litigation
 - Beneficiary incentive program

Identifying Expectations and Establishing Reasonable Business Practices

- Requirements
- Benchmarking
- Best Practices
- Continuous Improvement
- Assessing Risks
- Prioritization

Voluntary Disclosures



One fact that has encouraged us in our efforts to protect the Medicare trust funds is the fact that more providers and suppliers have been coming forward to us and voluntarily disclosing issues to us. This still requires some verification efforts by us in conjunction with the Office of the Inspector General, but it does evidence an encouraging trend of providers taking responsibility. Similarly, the fact that some of the professional societies in our jurisdiction are making referrals to us is also an encouraging sign that the health care industry is taking the first steps towards policing itself better.

CONTRACTOR'S ROLE IN PROVIDER VOLUNTARY DISCLOSURES

- Whether to Disclose
- Four Basic Components of Any Compliant Operation
 - Know
 - Don't Lie
 - Return
 - Learn
- Who to Disclose to and When
(Integrity Agreement or Not)
- Full and Complete Disclosures

**FAILURE TO RETURN
OVERPAYMENTS
TO WHICH THE RECIPIENT
IS NOT ENTITLED
(42 U.S.C. § 1320A-7B(A)(3))**



Statutory, Regulatory & Contractual Basis for Contractor Actions

(42 U.S.C. § 1395u(a))

Amongst the functions Medicare contractors are obligated to perform are to:

- make such audits of the records of providers of services as may be necessary to assure that proper payments are made...
- assist providers of services ... for which payment may be made under this part in the development of procedures relating to utilization practices...
- assist in the application of safeguards against the unnecessary utilization of services furnished by providers of services ...to individuals entitled to benefits...

Regulatory and Program Instruction

Through regulation and instructions, CMS has set forth criteria through which carriers are to meet these obligations. See for example, the Program Integrity Manual (PIM) which establishes criteria for:

- Medical Review
- Medical Policy Development
- Fraud Investigations
- Provider Audits

CONTRACTOR ADMINISTRATIVE ACTIONS

- **Local Medical Review Policy Development**
- **Prepayment and Postpayment Medical Review Activities**
- **Fraud Investigations/Referrals**
- **Reimbursement Suspensions**
- **Coordinating Administrative Overpayment Demands & Collections**
- **Involvement in the administrative appeal process**
- **Handling Voluntary Disclosures**
- **Provider Audit**

Identifying Potential Problems

Given limited resources and the desire to make the best use of resources in examining and, where warranted, correcting problems as they are identified, we use a myriad of different resources to prioritize our efforts. We believe that this activity allows us to proactively identify areas of concern and improve education where necessary. These processes also ensure that providers and suppliers of items and services are appropriately examined in conjunction with their peers. Some of the different approaches utilized as part of the prioritization process are:

Education

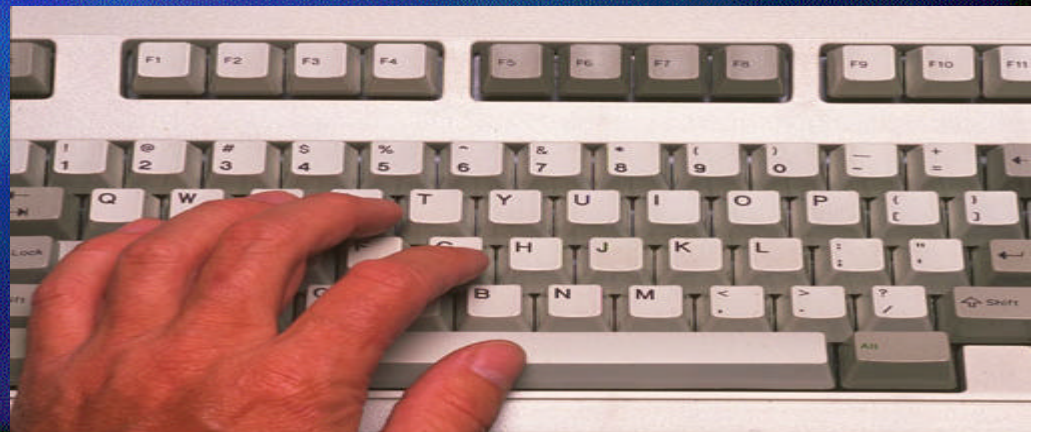
Contractors serve as a repository of information regarding previous educational efforts. We issue publications that advise health care professionals in our respective jurisdiction regarding various Medicare issues. This information is significant in any assessment of the significance of compliance matters. Increasingly such information is available on internet sites (e.g., www.hgsa.com).

Other Web Sites

www.marylandmedicare.com

www.medicare.gov

www.hhs.gov/progorg/oig/



Medical Review

This is the primary means through which a contractor looks behind the information submitted for reimbursement on the claim. Unnecessary delay in the processing of claims is not a desired result. There is limited funding for this activity, so it only occurs on a very small percentage of the claims a contractor receives for processing. The percentage of medical review is an amount negotiated with CMS and the contractor.

The Process

What areas would contractors look at in focusing utilization review resources?

- Aberrancies in services/dollars (by individual/industry)
- Government Reports
- Complaints

The Medical Review Process

PROGRESSIVE CORRECTIVE ACTION

- CMS Mandate
- To ensure more consistency in the corrective actions taken by contractors;
- Corrective action specific to level of severity of infraction against Medicare rules or LMRPs
- Utilization of Probe reviews:
 - provider specific
 - wide spread procedure specific

Postpayment Review of Claims

Why initiated on a postpayment basis as opposed to prepayment basis?

What are the different options a contractor has to use in conducting a postpayment review?

What are the criteria a contractor uses in conducting a statistically valid random sample (SVRS)?

What about extrapolations and consideration of undercoding in final results?

Why would I choose a consent settlement option rather than a SVRS?

What happens when no documentation is found supporting the claim?

What other purpose does the audit results letter serve and how does it relate to compliance?
(Notice)

How are final overpayments from postpayment Medical Review audits collected? (Legislation)

What impact could bankruptcy have on the process?

Is the Progressive Corrective Action initiative going to make a difference?

Medical Review Prepayment Review

General Rule: Rely on good faith on the provider's claim information.

Why initiated?

- Aberrance in data (local versus national) (individual versus peers)
- High risk of Program vulnerability from a service type standpoint
- Random selection

What is the scope of the audit? (i.e., type of services/items, 100% or less of those services, time period, etc.)

What is the impact (financial/operational) on the processing of my claims?

What happens if documentation for an audit requires information from third parties?

What happens to a claim after the medical review takes place? Does that mean a claim is definitely going to be paid?

Will the audit's scope remain the same until the audit is lifted?

If the audit can be modified, what determines when the audit is modified?

- Results

How can an entity facilitate reaching the end of the audit process?

What are some potential alternative outcomes (i.e., additional administrative action) from the audit results?

Why will truly random audits be done on a prepayment basis?

Medicare Payment Suspensions

- I. Scope of Suspensions
 - A. Whether in whole or in part
- II. Basis for Suspensions - Is prior notice required?
 - A. Not required when:
 - 1. Failure to furnish information
 - 2. Harm to the Trust Fund
 - 3. Fraud or misrepresentation
- III. Rebuttals - Suspension based upon prior notice versus those without
 - A. What is material to response?
- IV. Post-Suspension Activities
 - A. Determining whether an overpayment exists
 - B. Reasonable efforts to expedite overpayment
- V. Time Limits to Suspension
 - A. Initial 180 days
 - B. Second 180 days
 - C. DOJ requested extension
- VI. Disposition of Suspended Payments and Appeal Rights during period
- VII. Amount of Payments Suspended

Audit Relief

- Positive Results
- Efforts at Compliance
- Financial Satisfaction

Benefit Integrity

- Sources
 - Medical Review
 - Audit & Reimbursement
 - Proactive Data Analysis
 - Fraud Alerts
 - Complaints

Benefit Integrity

Examining Allegations

- Developing Facts to Assist in Establishing Whether There is Requisite Intent to Warrant Investigation
 - Did the provider have actual knowledge?
 - Did they act in deliberate ignorance or reckless disregard?

Benefit Integrity

- What prior education did the provider receive?
 - Provider Bulletins
 - Newsletters
 - Education letters
 - Local medical policies

Benefit Integrity

- Dollars may dictate how the issue is handled (some jurisdictions)
 - Small dollars versus large dollar amounts
 - Quality of care is always a consideration

Interacting with a Contractor When a CIA is Involved

- A copy of the CIA is provided to both the Benefit Integrity Unit and Audit & Reimbursement Department
- Audit & Reimbursement conducts a review of all providers under a CIA
 - Specific areas under review include legal and accounting costs which may or may not be related to the providers defense of the fraud case.

Interacting with a Contractor When a CIA is Involved

- We also now look for the fine & penalty itself placed on the cost report.
 - Provider X once put the entire penalty under legal fees under “ambulance payable” and charged it back to Medicare.
- Other Contractors have assisted the OIG in various ways in monitoring the CIAs
- CMS has also contracted with a Program Safeguard Contractor to specifically examine CIA

Interacting with a Contractor When a CIA is involved

- Audit & Reimbursement requests additional invoices or documentation as needed.
- If costs were related to the original fraud case are found, a referral with this information is sent to the Benefit Integrity Unit.

Interacting with a Contractor When a CIA is Involved

- The OIG General Counsel is notified. An OIG special agent is assigned. The U. S. Attorney's office is brought in the loop.
- A joint decision is made whether to bring the provider in for a meeting or if the contractor will handle the costs administratively.

Summary

We have highlighted numerous means in which a provider which is committed to compliance will, out of necessity, interface with a contractor to have an effective, comprehensive compliance program. We recognize that it is important that we as contractors work with providers to assist them in meeting their compliance obligations.

SOLUTION

- Join together - end the war by having good health care providers work with the government to police their profession and industry.

QUESTIONS?