

IN THE

KNOW

What are the inherent risks to healthcare providers when faced with a Medicare/Medicaid audit? Could an audit contractor put you out of business?

By Dan Kuczek, LUTCF

Recent amendments to the False Claims Act (“FCA”) under the Fraud Enforcement and Recovery Act of 2009 (“FERA”) and the Patient Protection and Affordable Care Act of 2010 (“PPACA”) have the potential to place health care providers at risk with respect to alleged fraud by receiving overpayments from Medicare and Medicaid. While protecting Medicare and Medicaid from fraud and keeping them solvent through integrity audit programs are essential, have the changes in the law given private third party liability contractors (Recovery Audit Contractors, Program Safeguard Contractors, Zone Program Integrity Contractors, etc.) too much power to collect on the government’s behalf? Is there potential for reverse abuse as a result of the economic incentives afforded to the audit contractors? How do healthcare providers know if they are parties to false claims, and could they unintentionally be victims of circumstance?

Background

The goal of Medicare/Medicaid integrity programs is to reduce fraud and abuse. The Medicare Integrity program was created out of HIPPA in 1996, and the Medicaid Integrity Program was a product of the 2005 Deficit Reduction Act. Incidentally, HMS, one of the country’s leading private third party liability contractors, helped draft language for the Centers for Medicare/Medicaid Services in the Deficit Recovery Act. These third party liability contractors are paid a portion of the monies recovered on behalf of Medicare/Medicaid under the provisions of the False Claims Act (FCA) and the Fraud Enforcement and Recovery Act (FERA) of 2009. FERA created civil monetary penalties for failure to return undeserved reimbursements within sixty days. Each violation is subject to a fine of \$50,000.00.

Of particular concern are the following amended definitions of the terms “knowing” and “knowingly” to the FCA by way of FERA:

“In Section 4, under Liability for Certain Acts (a), (1) ...“any person who”- (B) knowingly makes, uses, or causes to be made, a false record or statement material to a false or fraudulent claim;

(1) the terms ‘knowing’ and ‘knowingly’--

(A) mean that a person, with respect to information--

(i) has actual knowledge of the information;

How do healthcare providers know if they are parties to false claims, and could they unintentionally be victims of circumstance?

(ii) acts in deliberate ignorance of the truth or falsity of the information; or

iii) acts in reckless disregard of the truth or falsity of the information; and

(B) require no proof of specific intent to defraud.”

The terms “knowing” and “knowingly” may really be synonymous with the terms “unintentional” and “unknowingly” as a matter of practicality. Whereas no proof of specific intent to defraud is required, an argument could be made against virtually any healthcare provider that may have overbilled unintentionally and unknowingly. This is not to advocate that unintentional overbilling is excusable, and while the law clearly spells that out, forcing compliance through the school of hard knocks regardless of the circumstances opens up a potential Pandora’s Box of financial consequences for providers. Certainly the desired outcome is accurate, fair, and appropriate billing through improved quality standards and procedures, but controlling the possibilities for error and abuse in the real world may be difficult to achieve. For example, while physicians may document diagnosis and procedure codes, seldom do they bill for themselves. Most health care providers rely on their staff or an outside service to bill for them. Consider the what-ifs: What if a third party billing service commits a series of mistakes, or the in house office biller is corrupt, or the coding is systematically inaccurate because of a programming error, or the coding was misunderstood or poorly communicated. Could you argue that most healthcare providers “act in deliberate ignorance of the truth” or “act in reckless disregard of the truth” because of this? By virtue of the phrase “no proof of specific intent to defraud required,” it doesn’t matter. And while the “what-ifs” beg for a quality solution, the financial consequences go beyond designing procedural solutions to paying for investigations, lawyers, expert witnesses, civil monetary penalties, and settlements with the audit contractors on behalf of the government.

Did you hear the one about...

A Louisiana physician who lost many records due to hurricane Katrina was audited by a Zone Program Integrity Contractor (ZPIC) and was found to have been overpaid by over \$50,000 from statistical sampling. However the statistical sampling error rate was extrapolated to an overpayment of over \$2.4 million dollars!!! The ZPIC contractor focused on this practice because they ranked highly in the amount paid for radiographic studies billing for CPT code 78465 with ICD-9 chest pain diagnosis, and they performed their own imaging. Amid the alleged infractions were improper or incomplete documentation, and billing and software issues that listed the owner physician as the supervising physician; the UPIN of the billing physician did not match the treating physician; and claims were billed under the group’s billing number. After years in the appeal process and great expense, an administrative law judge finally reversed the findings of the ZPIC contractor and concluded that Medicare had the necessary information to pay the claims.

How do you manage the risk?

Create a compliance program. Among all other remedies, a compliance program is the single most important way to mitigate the risk, and should be the playbook that outlines other remedies. Create a team and point person to lead. Identify the operational challenges, develop and implement the solutions, install internal audit procedures, update regularly, and train continuously.

Third party hold-harmless agreements. If you are using a third party billing service, you may try to negotiate a hold harmless agreement with the vendor to cover their billing errors. While hold harmless agreements are viable contractual risk transfer mechanisms, the liabilities associated with audits and overpayments are ultimately the responsibility of the first party. Much like tax liability, you can have someone prepare your return, but you will still have to pay the tax even if the preparer erred. This does not preclude professional liability on the part of a third party billing vendor, but you would have to sue for recoveries outside the hold harmless agreement (subject to certain exceptions, see insurance coverage below).

Insurance coverage. Within a hold harmless agreement, it is possible to negotiate terms with a third party billing service to provide insurance coverage for your benefit by endorsement through their insurance carrier. However, what if the errors originated with your organization? First party insurance coverage is available to cover Medicare/Medicaid and commercial payor audits associated with billing errors, and will also cover Stark violations, Emergency Medical Treatment Active Labor Act (EMTALA) violations and penalties, and some data breach coverage. This is a viable risk transfer mechanism available at a reasonable rate, but would also be dependent on an internal risk management and compliance program.

At Mason McBride we support our commitment to our clients through a Statement of Services that customizes the level of resource each client requires. Our collective knowledge and research of the marketplace, breadth of client base, and global network provides us with unique insight on issues and trends in our business. We deploy a variety of risk management analysis and audit tools to design customized solutions for our clients. These include traditional and alternative risk transfer approaches. As an independent organization, our advice follows a disciplined process independent of product or platform, and we assume the role of advocate for our clients.

Sources:

<http://www.opencongress.org/bill/111-s386/text>

http://en.wikipedia.org/wiki/Fraud_Enforcement_and_Recovery_Act_of_2009

http://en.wikipedia.org/wiki/False_Claims_Act

http://www.hms.com/our_services/services_program_integrity.asp

http://www.hms.com/about_us/about_timeline.asp

New ZPIC Medicare Audits: The Latest CMS Enforcement Mechanism Against Fraud, Paula G Sanders, Esq., Post & Schell PC, January 11, 2011.

Dan Kuczek brings 20 years of experience to his clients. He has worked in multiple areas of the insurance industry, including both the agency and company side. He is a graduate of Western Michigan University. Dan has earned the designation of Life Underwriting Training Council Fellow.

We're here for you.

Contact:

Mason-McBride, Inc.
3290 West Big Beaver Road, Suite 503
P.O. Box 7028
Troy, Michigan 48007
248-822-7170 phone
248-822-7150 fax
www.Mason-McBride.com