


MARSH
REVENUE MEDICAL RISK
 CLAIMS CONSULTING



Using Collaborative Case Management, Risk Management, and Clinical Documentation Specialists to Mitigate RAC, MAC, MIC, ZPIC, and OIG/DOJ Risks

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The Players

RACs	MACs	MICs
<ul style="list-style-type: none"> • Recovery Audit Contractors • Medicare Part A&B • Contingency Fees 	<ul style="list-style-type: none"> • Medicare Administrative Contractors • Formerly: Fiscal Intermediaries • Enroll health care providers/suppliers in the Medicare program • Educate providers about billing requirements • Handle claims appeals • Answer provider inquiries directly • Answer beneficiary inquiries referred by the 1-800 MEDICARE call center 	<ul style="list-style-type: none"> • Medicaid Integrity Contractors • Medicaid • No Contingency Fees But More Scary Than RACs In Many Ways

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Background

- Section 306 of the Medicare Modernization Act (MMA)
 - Three year, three state demonstration project (2001-2005)
 - Allowed investigation of Medicare claims payments using Recovery Audit Contractors (RACs)
- Sec. 302 of the Tax Relief and Health Care Act of 2006
 - RAC program made permanent
 - Expand to all 50 states by no later than 2010
- Overall strategy to prevent Medicare fraud and abuse
 - Do not replace other review efforts of fiscal intermediaries, government, or other monitoring programs

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Findings

- Recouped > \$1.03b in improper Medicare payments
 - Approximately 96% (\$992.7m) were overpayments collected from providers
 - 4% (\$37.8m) were underpayments repaid to providers
- Return on investment: 318%
 - Program cost: 22 cents for each dollar collected in 2007
- CMS Payments to RACs
 - Contingency basis for all accurately identified/recovered overpayments
 - Percentage basis for all underpayments identified

Assessing the RAC Risk

- Organizational risk exposures of are significant
 - Legal/regulatory risk
 - Reputational risk
 - Financial risk
- Risk mitigation strategies can be employed
 - Reduce risk
 - Maximize reimbursement

Who's at Risk?

- Any provider who bills Medicare fee-for-service programs is subject to review by RACs...and is subject to all laws, regulations which govern reimbursement programs
 - Hospitals, Physicians, IP &/or OP, SNF, Rehab Facilities, DME providers, Home Health, Ambulance, ASC, etc...

Spectrum of Fraud and Abuse Detection

How to Select a False Claims Act Attorney
5
Tips for Whistleblowers



False Claim Recoveries

Focus on fraud

Health care fraud recoveries, much of it through the help of whistle-blowers, continue to make up the bulk of the government's recoupment under the federal False Claims Act. With additional resources being allocated to fight health care fraud, experts expect that to continue.

	2006	2007	2008	2009
Total recoveries	\$3.1 billion	\$2.0 billion	\$1.3 billion	\$2.4 billion
Health care recoveries	\$2.2 billion	\$1.5 billion	\$1.1 billion	\$1.6 billion
Whistle-blower case recoveries	\$1.3 billion	\$1.5 billion	\$1.0 billion	\$2.0 billion

Note: Health care cases and whistle-blower cases can overlap, thus adding up to more than the total.

Source: U.S. Dept. of Justice

Federal Priority

- **Healthcare fraud is the next stated priority of the Department of Justice (DOJ) following terrorism and violent crime**
- Deficit Reduction Act of 2005
 - States with False Claims Acts are granted a portion of any federal Medicaid funds recovered through Medicaid-related actions
- **OIG Self-Disclosure Program recovered nearly \$120m for the Medicare Trust Fund**
- Investigating *healthcare* fraud is a major operating directive of the FBI

Federal False Claims Act

- **A false claim is a claim for payment of services that were**
 - not provided specifically as presented, or
 - for which the provider is otherwise not entitled to payment.
 - [31 U.S.C. §§ 3729-3733](#)
- State FCA's mirror Federal FCA

Civil Liability and the FCA

- Any person or entity who **knowingly**:
 - Files a false or fraudulent claim for payment to Medicare, Medicaid or other federally funded health care programs;
 - uses a false record or statement to obtain payment on a false or fraudulent claim
 - conspires to defraud Medicare, Medicaid or other federally funded health care program by attempting to have a false or fraudulent claim paid
- "Knowingly" (knew or should have known)
 - Actual knowledge
 - Deliberate ignorance
 - Reckless disregard

Penalties

- **Penalty for violation of the FCA:**
 - \$5,500 to \$11,000 for each false claim
 - Triple damages
 - Possible criminal charges



Data Mining Risks

- The RAC Data Warehouse will be accessible by *multiple* auditors
 - QIOs
 - Program Safeguard Contractors
 - Medicare Integrity Program Contractors
 - **OIG**
 - **FBI**
- “Other” auditors are not limited by the October 1, 2007 look-back time frame

RAC Risks

- Failure to investigate and correct systemic problems may have False Claims Act implications
 - Review RAC findings that indicate a *systemic* problem resulting in overpayments and *take action*
- RAC appeals of incorrect findings can indicate the existence of a legal dispute
 - Determining the validity of overpayment during the dispute resolution may raise issues of *knowledge of falsity* under the FCA

Voluntary Disclosure Risks

- *Appropriate* self-disclosure can keep case out of the RAC Data Warehouse
- No guarantee that penalties will not be substantial
 - Should be less
 - Active involvement of legal counsel

Voluntary Disclosure Risks

- Lesser damages can still = big \$\$
- **April 15, 2008 – OIG for DHHS Open Letter Provider Self-Disclosure Protocol** (modified existing PSDP)
 - <http://oig.hhs.gov/fraud/docs/openletters/OpenLetter4-15-08.pdf>
- **Requirements of the PSDP:**
 - Thorough and complete investigation
 - Estimate of the damages to the federal health care program and the methodology used to calculate them
 - <http://www.oig.hhs.gov/authorities/docs/selfdisclosure.pdf>
- **N/A** where overpayment is discovered to be an honest mistake (overpayment does not suggest a violation of law)

OIG and Voluntary Disclosure

- **Not bound by any findings made by the disclosing provider and there is no requirement for the OIG to resolve the matter in any particular manner (63 Fed. Reg. 58401)**
- Will **not** guarantee further protection from other civil, criminal, or administrative actions
- Reserves the right to remove providers from the SDP
- Will "generally" not require a Corporate Integrity Agreement or Certificate of Compliance Agreement
 - Reaffirmed commitment to settle self-disclosed violations at the lower end of the damages spectrum

If Ongoing Fraud is Discovered

- If an "ongoing fraud scheme" is discovered, the provider should immediately disclose to the OIG, but take no further steps to investigate or quantify the scope of the problem (other than to sequester all records and materials to prevent tampering and destruction).

Be Proactive

- Mock RAC Audit
 - Proactive risk assessment of potential RAC risks
 - Confidential
 - Protected
 - Case Management and Gatekeeping Program Evaluation
 - Revenue Recovery Analysis
 - Role Definition and *Collaboration*
 - Risk Management
 - Case Management
 - Clinical Documentation
 - Compliance



Establish the Right Team

- Case Management
- Risk Management
- Coding
- Clinical Documentation Specialists
- Quality Management
- Legal
- Health Information Management
- Information Technology
- Compliance
- Accounting
- Finance
- Physician Liaison



Preparing for The RAC

- Conduct Internal Assessment
 - Internal control systems
 - Gate keeping systems
 - Audits (coding and financial, compliance)
 - Identify Silos
 - Assess Collaboration
 - Data mining
 - High risk case types – focus on known CMS, OIG and RAC targets
 - Program for Evaluation Payment Pattern Electronic Reports (PEPPER Reports)
 - Comprehensive Error Rate Testing (CERT Reports)



Preparing for RACs


- Educate your stakeholders
 - Governing body
 - Leaders
 - Physicians
 - Departments impacted
 - RAC team
 - Community



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You Need to Know!

- What improper payments have been identified in general?
- Is my organization submitting claims for improper payments?
- False claims language: "...know or should have known..."



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Plan Communication Systems

- Create central repository for all communication between facility and RAC
- Customize RAC correspondence address to avoid inadvertent, automatic denials
- Correct internal mail inefficiencies to prevent delays
 - Avoid potential appearance of non-compliance with medical record requests RACS (60 days)
 - No appeal rights after 45 days of records request date unless an extension is filed
- Develop effective RAC Team process communication
- Check RAC websites regularly
- Call the RACs directly

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Evaluate External Resource Needs

- Consultants
 - Mock RAC Audit
 - Case management reengineering
 - HIM/coding validation
 - Education and training
 - RAC tracking software
- Legal
 - Voluntary repayment options
 - Appeals



So.....

- We have our team
- We know our exposures
- Now who's responsible?



Strategic Collaborations



Who will lead what part of the process?

Collaboration

- Team Approach vs. Silos
 - Risk Management
 - Quality Management
 - Case Management / Clinical Documentation
- All are working towards the same goal:
 - Provide quality care, excellent patient outcomes and high satisfaction.
 - Which in turn, strengthens the reputational and financial well being of the hospital.
- Collaboration is key to:
 - Preparing for a RAC / MIC / ZPIC Audit
 - Ensuring the most favorable results during an audit
 - Identifying and correcting fractured processes that create exposures
 - Mitigating and eliminating future risks
 - Eliminating bottlenecks and duplicative efforts

Collaboration

- Risk Management
 - RAC / MAC / MIC / ZPIC / OIG are all significant risks to your healthcare organization
 - These exposures will very quickly eclipse your malpractice claims in terms of financial exposure and loss
 - Driven by patient care and positive outcomes
 - Reputational Risk
 - Key member of the RAC Team / Committee
 - Enterprise Risk Management




Collaboration

- Quality Management
 - RAC / MAC / MIC / ZPIC / OIG will ultimately question the care provided to your patients
 - Documentation driven reimbursement
 - Driven by patient care and positive outcomes
 - Key member of the RAC Team / Committee




Effective Case Management Program

- Concurrent care management – NOT just UR and DCP
- 7 day per week program
- Preadmission review
- Effective gate keeping integration
- Concurrent documentation improvement



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Effective Preadmission Case Management



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    graph TD
      A[BED REQUEST RECEIVED] --> B{CRITERIA MET FOR LOC ORDERED?}
      B -- No --> C[CONTACT MD & DOCUMENT ADDNL CRITERIA OR IDENTIFY ALTERNATIVE SETTING]
      C --> D{CRITERIA NOW MET FOR LOC ORDERED?}
      D -- Yes --> E[APPROVE AND COORDINATE WITH ADMISSIONS]
      D -- No --> F[CANNOT APPROVE. REFER TO ADMINISTRATOR, PHYSICIAN ADVISOR OR UR COMMITTEE MEMBER]
  
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