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One Year Later: The Impact of Health Care Reform on Health Care Provider Audits and Compliance Programs

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The Patient Protection Affordable Care Act ("PPACA"), or the health care reform law, has focused program integrity efforts on detection and prevention of health care fraud and abuse. To achieve this end, the federal government has increased its Medicare and Medicaid provider billing audit activity. Included in the increased audit activity has been an increase in audits performed by independent Recovery Audit Contractors ("RAC").

Who Are the Auditors?
Audits are not only performed by RACs, but also by Medicare Administrative Contractors, Program Safeguard Contractors, Zone Program Integrity Contractors and Medicaid Integrity Contractors. PPACA mainly expanded the auditing power of RACs.

More on RACs
RACs are paid a percentage of the overpayments they collect from providers. It is not surprising that some providers claim that RAC audits lack objectivity. The RAC program began as a demonstration program in 2005, and, as a result of its "success," Congress passed legislation in 2006 to establish the permanent RAC program in all 50 states. The country is divided into four RAC regions, with one RAC assigned to each region. Florida is located in RAC Region C, and the RAC for Florida is Connolly Consulting.

Historically, RACs had the power only to conduct audits with respect to claims made under Medicare Part A (hospital services) and Part B (physician services, outpatient services and other services not covered by Part A). PPACA significantly -- An automated review is used when a RAC is certain that a service is not covered or was incorrectly coded. A complex review is more common, and involves a human review of the provider's medical records. If "medical necessity" is at issue, a RAC is required to have a registered nurse or therapist make the determination.

The appeals process for RACs and other Medicare auditors is governed by federal law and other Medicare rules.

Medicare Administrative Contractors ("MAC"), Program Safeguard Contractors ("PSC") and Zone Program Integrity Contractors ("ZPIC")
MACs handle claims processing and administration for Medicare (the MAC in Florida is First Coast Services Options), and frequently audit providers through various programs. Typically, MACs first identify potential problems through data analysis and then conduct probe audits of targeted providers.

PSCs (currently in transition to being classified as ZPICs) conduct audits under the Medicare Benefit Integrity Program, which is designed to identify suspected fraud. PSCs and ZPICs often receive audit referrals from other contractors, but also conduct their own data analysis to identify alleged overpayments.

The letter sent to the provider typically will set forth the type of contractor that is conducting the audit. This information is quite useful to the provider's counsel, as defense strategies and procedures vary based upon the auditing entity.

Medicaid Audits
The Deficit Reduction Act, a precursor to PPACA, created federal oversight of state Medicaid programs through the Medicaid Integrity Program ("MIP"). Medicaid Integrity Program contractors ("MICs") function like RACs. However, in contrast to the three-year RAC look-back period, MICs have a five-year look-back period.

MICs are not paid on a contingency-fee basis, and are not responsible for collecting overpayments. MICs simply identify the alleged overpayments. The state is responsible for collecting the overpayment, and the federal government collects its share of the overpayment directly from the state.

As with the RAC program, once overpayments are identified, provider reimbursement may be suspended until the amount owed is repaid. Appeals for Medicaid payments are made through a process that is governed by state law. The Centers for Medicare and Medicaid Services ("CMS") recently released a proposed rule providing guidance to states for the establishment and implementation of the Medicaid RAC program. States will be required to establish a Medicaid RAC program.

The Medicaid RAC program is a fraud enforcement tool, to be used in addition to, and not in place of, the MIP and other state fraud initiatives such as MICs. This increase in audit mechanisms suggests that Medicaid providers should expect an increase in audits in the coming year.

Retaining Identified Overpayments
As reported in a prior Trenam Kemker *Health Law Alert*, PPACA also requires each provider to return an overpayment of federal reimbursement it has received, and to notify the appropriate entity (e.g. CMS, AHCA, etc.) of the reason for the overpayment. The return must occur within 60 days from "the date on which the overpayment was identified." Notably, PPACA does not define when an overpayment is "identified."

Because the False Claims Act ("FCA") was revised in 2009 to make it a violation to knowingly retain money that belongs to the federal government (e.g. reimbursement from Medicare or Medicaid), retention of the payment beyond the 60-day period creates the possibility of a violation of the FCA. A violation of the FCA includes significant monetary penalties (up to $11,000 per claim, payment of government's costs and attorney's fees), possible exclusion from state and federal health care programs and criminal penalties.

These changes raise a number of questions with regard to the audit appeal process. Does a negative appeal determination create an "identified" overpayment? When during the audit appeal process is the overpayment return obligation triggered? What if the provider does not have the funds to repay the amount owed within 60 days?

These have not been answered by the government at this time. Presumably, the answers will come in future rule-making or court decisions.

Mandatory Compliance Plans
PPACA also mandates that all health care providers and suppliers adopt a compliance plan as a condition of enrollment in Medicare, Medicaid and other federal programs. The compliance plan must be centered around yet-to-be-defined "core elements." PPACA charges the Secretary of Health and Human Services ("Secretary") with establishing by rule the "core elements" that the compliance plans of providers or suppliers within particular industries or categories must meet. The Secretary also will determine the timeline for the establishment of these core elements.

At this time, PPACA does not specify whether compliance plans will be required of currently enrolled providers and suppliers or only those seeking initial enrollment in Medicare, Medicaid or similar programs. Nevertheless, all providers and suppliers currently enrolled or planning to enroll in these programs should have in place a compliance program that meets the currently recommended criteria for their industry and that can evolve to meet new requirements imposed by the PPACA. Having such a program in place now will give providers and suppliers a head start when the new required core elements are adopted.

What Does This Mean for Providers?
State and federal audit appeal rules heavily favor the auditor, and auditors are thus taking a very hard-lined approach in settlement discussions and during appeal.

Nevertheless, auditor findings are often incorrect. A successful defense is a reality, but the process is very technical, time-consuming and expensive. The best approach for providers is to (1) adopt a compliance plan, and (2) work the plan regularly, with internal audits to ensure compliance. Proactivity for providers offers the same beneficial effect that preventive medicine does for patients.

Create a culture of compliance – educate physicians and other employees on proper recordkeeping in an effort to stop an audit before it starts.

Not only will implemented compliance plans soon be required for all Medicare and Medicaid providers, but effective compliance plans and compliance plan implementation minimize the risk that an audit will occur and can minimize the fines and penalties when an audit occurs.

What Can Providers Do When Audited?
When the audit comes, engage counsel right away, on receipt of a records request or other notice about an audit or investigation – the defense begins at that time. Delay in securing counsel, or going it alone, substantially increases the likelihood of bad results.