G-2 Compliance Report

WASHINGTON G-2 REPORTS

Issue 1-11/January 2011

For Hospitals, Laboratories and Physician Practices

Congress Averts 25 Percent Cut in Physician Payments

Pathology 'Grandfather' Extended for Another Year

As expected, the House and Senate in mid-December passed legislation stopping the 25 percent cut in Medicare reimbursement for physicians that was supposed to take effect Jan. 1. President Obama is expected to sign the bill.

The measure, H.R. 4994, also makes changes in other Medicare payment policy, including extending the ability of independent clinical laboratories to receive direct payments for the technical component of certain pathology services through Dec. 31, 2011.

The Medicare and Medicaid Extenders Act of 2010 freezes physicians' reimbursement for all of 2011, averting the 25 percent cut that was scheduled to take effect Jan. 1. The physician payment policy would cost $14.9 billion, according to a summary of the legislation from the Senate Finance Committee.

Congress recently has passed a series of very short-term payment fixes—some as short as one month—rather than longer ones, because

Continued on page 2

Kimberly Scott, Managing Editor,
kscott@ioma.com

Inside this issue

www.g2reports.com

FTC Challenging LabCorp's Acquisition of Westcliff

The Federal Trade Commission (FTC) is challenging LabCorp's acquisition of Westcliff Medical Laboratories, saying the deal would lead to lower quality and higher prices in the Southern California region.

In a complaint filed Dec. 1, the FTC alleges the acquisition "will have the effect of substantially lessening competition for the sale of clinical laboratory testing services to physician groups in Southern California." It notes that LabCorp, based in Burlington, N.C., and Westcliff, based in Santa Ana, Calif., were two of only three significant clinical laboratory testing service vendors for the vast majority of physician groups in Southern California. The transaction allegedly would leave LabCorp and Quest Diagnostics in control of approximately 89 percent of the market.

The commission indicated that it plans to seek injunctive relief in a district court to prevent LabCorp from integrating Westcliff assets while the case is litigated in the administrative proceeding. LabCorp had agreed on June 25 to hold Westcliff assets separate during the

Continued on page 9

Congress Averts 25 Percent Cut, *from page 1*

of the high cost associated with longer fixes. Physician groups continue to push for a long-term solution to the problem.

H.R. 4994 also would extend reasonable cost reimbursement for Part B lab services to hospital patients in certain rural areas until July 1, 2011. Other extensions include, in part, the Medicare Modernization Act (MMA) Section 508 hospital geographic reclassifications, the Medicare work geographic adjustment floor, and the exceptions process for Medicare therapy caps. In addition, the measure includes a repeal in the delay of Version Four of the Resource Utilization Groups (RUG-IV) for nursing homes.

The total price of the bill is $19 billion. It would be paid for by modifying policy concerning overpayments of the health care affordability tax credit in the health care reform law.

Stakeholders Continue Discussion on Oversight of Lab-Developed Tests

Officials of the Food and Drug Administration (FDA) met with lab industry stakeholders in November to discuss the agency's plan to use its enforcement discretion to expand regulation of laboratory-developed tests (LDTs) and what it portends for stakeholder operations.

The public forum, held Nov. 22 in Washington, D.C., was sponsored by eight organizations and drew more than 250 attendees representing lab interests of all stripes: clinical, hospital, and public health labs; professional laboratory organizations; and diagnostic manufacturers.

LDTs are in vitro diagnostics manufactured by and offered in the same laboratory certified under the Clinical Laboratory Improvement Amendments (CLIA). The tests number in the thousands and include genetic tests and others used to prevent, diagnose, and treat patients with a wide range of cancers, cardiovascular and neurological disease, Alzheimer's, and many other serious health conditions.

The FDA announced in July that it plans to expand its regulatory reach to include LDTs based on the level of risk associated with the test and solicited comments from stakeholders on how it should proceed. Currently, the agency has limited its enforcement discretion to analyte-specific reagents and in vitro diagnostic multivariate index assays (IVDMIAs) using a proprietary algorithm to produce patient-specific results.

But the agency's new policy on LDTs has raised anxiety within the laboratory community that lengthy approval procedures would delay the introduction of new tests, stifle innovation, raise development costs, and, as a result, limit patients' access to potentially beneficial assays.

At the recent forum, FDA official Alberto Gutierrez, Ph.D., sought to allay some of those concerns. "We are in a process to develop a draft regulatory framework" on the policy change and how and when it will play out. Meetings with stakeholders are part of that process to craft draft guidance, he said. "We're not coming after LDTs tomorrow."

Gutierrez, who is director of the FDA Office of In Vitro Diagnostic Device Evaluation and Safety, and other participating officials from his office, were restricted in discussing details of the draft guidance because it has not yet been released.

While the forum did not tackle concerns over a risk-based classification scheme and evidence requirements for ranking risk, it did spark give-and-take between the FDA participants and attendees over how the FDA should proceed.

In devising an enforcement framework, Gutierrez noted there are very different types of tests to look at, but the initial scrutiny will be on those that pose high risk to patients, and "we want the lab community to help us identify those tests." He suggested that one way would be to have panels of experts from stakeholders to help the FDA decide the level of risk and oversight for particular tests.

Gutierrez said the agency is open to the idea of using third-party reviewers and inspectors but "fuzzy" on how to do it.

It is important to "get the lay of the land," he said, "how many LDTs are out there, what they are, and what claims are made for them." On this point, several participants said this information is already available from the CLIA program, which certifies some 10,000 clinical labs that provide LDTs as well as the genetic testing registry at the National Institutes of Health.

The draft guidance will be coming soon, Gutierrez said, but he could not specify a date certain since the document is subject to review above his office. But "there will be plenty of time to comply," he assured the audience, and there likely will be another meeting with stakeholders after the guidance is released to solicit further feedback.

One participant questioned why the FDA was using the guidance approach rather than the formal rulemaking process, which is more interactive, more clear-cut, and binding as to the rights and responsibilities of all parties. Gutierrez replied, "We will respond in the same way under the guidance route as under rulemaking. We will address all comments as possible as if it were a rulemaking." The guidance will be a draft, subject to change, he emphasized.

Others urged the FDA to consider whether adding regulatory processes adds value to the service or if this is better achieved through existing mechanisms such as strengthened oversight under CLIA and FDA postmarket surveillance.

Does the FDA have the resources to expand oversight at a time of budget cuts and other restraints and avoid lengthy registration and approval delays over LDTs subject to review, one participant asked. Gutierrez replied, "It depends on how big a bite we want to take." Well-established tests and low-volume tests for rare diseases or health conditions are not at the top of the list for FDA scrutiny, he said. That spot is reserved for tests the agency considers high risk.

Would the FDA consider outside involvement in any expanded LDT regulation? Answering that question, Gutierrez said the agency is open to the idea of using third-party reviewers and inspectors but "fuzzy" on how to do it. This approach has not proven productive with IVDMIAs. But if the agency goes this route, it would train the inspectors and reviewers in medical device review and have the final sign-off on their reports.

CMS Using Technology to Fight Health Care Fraud

Agency Shifting From Pay-and-Chase to Prevention

The Centers for Medicare and Medicaid Services (CMS) is looking for technology solutions that can address such fraud-fighting areas as predictive modeling, case management, screening, and data integration, Peter Budetti, deputy administrator for program integrity at CMS, said Nov. 18.

"We're committed to advanced technology. We're piloting certain techniques, and we have a process under way to procure technology in several innovation areas," Budetti said, speaking at the National Health Care Anti-Fraud Association annual training conference in Las Vegas. Any solutions that CMS selects must be risk-based, metric-enabled, and scalable, and all solutions must have low false positive rates, he said.

The emphasis on technology is part of an overall effort to integrate program integrity efforts at CMS and become much more proactive toward health care fraud, Budetti said. CMS pays over 4.4 million Medicare claims a day, he said, and receives nearly 19,000 provider applications per month.

"Two things were wrong with the pay-and-chase model for fighting health care fraud," Budetti said. "It's inefficient, and it's reactive. Our intent is to go beyond pay and chase and into prevention. We're exercising new authorities to suspend payments, and we're working on predictive analytics and prepayment review systems."

New Direction

The new strategic direction at CMS, Budetti said, includes a number of shifts, such as:

- pay and chase model shifts to prevention and detection models;
- one-size-fits-all approach to fraud shifts to a risk-based approach;
- legacy processes shift to innovation processes;
- inward-focused communication shifts to transparency and accountability;
- government-centric approach shifts to engaged public-private approach; and
- stand-alone program integrity initiatives shift to coordinated and integrated program integrity initiatives.

CMS has made several additional strategic and technological changes recently, Budetti said, including redesigning the Medicare Summary Notice for beneficiaries. "We're making them simpler to understand, which will allow patients to identify fraud and other problems much easier," he said. The new notices are expected to be out this winter.

A voice response system has also been added to 1-800-MEDICARE, and CMS recently partnered with the Recovery Accountability and Transparency Board (RATB) to create a fraud-detection tool. CMS gave the RATB a number of data sets, including information on providers who were most often reported through 1-800-MEDICARE, Budetti said. The RATB system was able to look at the providers in much greater detail than standard screening methods, he said.

COMPLIANCE PERSPECTIVES

Get Ready for Multiple CPT Coding Changes and New Policy on Lab Requisitions in 2011

Rick Oliver, JD, CHCO, CPC, MT (ASCP), is director of compliance laboratory, and pathology, for McKesson Revenue Management Solutions.

Donna Beasley, DLM (ASCP), is national director, McKesson Revenue Builder™ for Labs.

Multiple Current Procedural Terminology (CPT®) coding changes become effective on Jan. 1, 2011. It is important for laboratories to take time now to review and edit the chargemaster lists to ensure accurate billing and full compliance in 2011. The chargemaster is the data file that contains the laboratory pricing and coding information used to populate professional service claims. Outdated information in the file can cause a claim to be rejected and quickly affect cash flow.

The CPT coding update from the American Medical Association (AMA), effective Jan. 1, 2011, adds 16 new codes, revises seven codes, and deletes 13 codes in the Pathology and Laboratory Medicine Section. In addition, the Centers for Medicare and Medicaid Services (CMS) adds four new health care common procedure coding system (HCPCS) codes, revises one code, and deletes one code for 2011. Additionally, the new CMS requirement for "signatures on requisitions" by the ordering practitioner will impact operational workflow and ultimately billing success.

CPT Coding Update

- **Drug Testing–CPT 2011: one new code and one new HCPCS code**

  Drug screen testing will see significant changes in reimbursement from CMS now that the HCPCS drug-screening codes are tied to the Clinical Laboratory Improvement Amendments (CLIA) complexity levels. While the AMA introduced the new CPT 80104 codes to represent multiple drug classes performed by other than chromatographic methods, CMS will not recognize that code for drug screening testing. CMS felt that code did not prevent improper payment for this testing category and that the new G0434 or G0431 codes would be used for Medicare patients instead. Therefore, CMS deleted the G0430 code, edited the descriptor for G0431 to indicate the use of a CLIA high-complexity test method, and created a new code G0434 to indicate use of a waived or moderate-complexity test method. Codes G0434 and the revised G0431 unit of service are "per patient encounter," whereas the 2010 definition used for G0431 was "each drug class." Based on a typical 11-test drug panel, reimbursement would drop approximately from $229 to $104.

- **Chemistry–CPT 2011: three new chemistry codes**

  82930 – *Gastric analy w/pH ea spec*

  83861 – *Microfluid analy tears*

  84112 – *Placenta alpha micro IG C/V*

  Gastric acid analysis was previously coded with CPT codes 89130, 89132, 89135, 89136, 89140, and 89141 respectively. AMA has deleted these for 2011 and replaced them with codes based on "collection" of the specimen and "analysis" of the specimen. The new collection codes are listed in the Surgery/Digestive system of the codebook—CPT 43754-43755—while the new analysis code, 82930, is to be used for the gastric acid analysis.

- **Hematology/Coagulation and Transfusion Medicine–CPT 2011: two new hematology/coagulation codes and one new transfusion medicine code**

  85598 – *Hexagnal phosph pltlt neutrl*

  86481 – *TB AG response T-cell susp*

  86902 – *Blood type antigen donor ea*

  Currently labs use CPT 85597 to represent the hexagonal phospholipid testing although that code does not designate "hexagonal" platelet testing. The new 85598 code will allow the laboratories to select a more precise code that fits the phospholipid neutralization for hexagonal phosopholipid. The new 86481 code will allow labs to more precisely code for the tuberculosis T-cells suspensions that are "enumerated," whereas the paired code 86480 represents a nonenumerated testing. AMA deleted code 86903 and replaces it with the 86902 code.

- **Microbiology–CPT 2011: four new microbiology codes and three updated HCPCS codes**

  87501 – *Influenza DNA amp prob 1+*

  87502 – *Infectious agent DNA/RNA influenza 1st 2 types*

  87503 – *Infectious agent DNA/RNA influenza 1+ types ea addl (List separately in addition to code for primary procedure)*

  87906 – *Genotype DNA HIV reverse T (e.g., integrase, fusion)*

  G0432 – *EIA HIV-1/HIV-2 screen*

  G0433 – *ELISA HIV-1/HIV-2 screen*

  G0435 – *Oral HIV-1/HIV-2 screen*

  Due to the past and continued growth of molecular diagnostic testing, the AMA is introducing new codes in this category. Currently the codes for infectious disease testing by molecular diagnostics were based on "kit" methods only identifying whether the procedure was performed by amplified probe or direct probe. It is likely the AMA will continue to add new codes in this section to keep up with the rapid increase of molecular diagnostic testing being performed. In the case of codes 87501-87503, the added verbiage of "reverse transcription" was added to the descriptor to represent this step in the testing process. Codes for HIV testing for infectious agent genotyping of the HIV-1 (87906) were added. While the listed HCPCS codes are not new, they are updated (initially implemented in December 2009) to represent applicable methodologies for various methods of screening for HIV-1/HIV-2.

- **Cytopathology and Surgical Pathology–CPT 2011: three new cytopathology codes and one new surgical pathology code**

  88120 – *Cytp urine 3-5 probes ea spec*

  88121 – *Cytp urine 3-5 probes cmptr*

  88177 – *Cytp C/V auto thin lyr addl (List separately in addition to code for primary procedure)*

  88363 – *XM archive tissue molec anal (e.g., KRAS Mutational Analysis)*

  The AMA introduces CPT 88120 and 88121 specifically to represent the flouresecent in situ hybridization (FISH) testing by morphometric analysis on urinary tract specimens, both manual (88120) and computer assisted (88112). These two codes will replace the use of CPT 88367-88368 codes when the source of the specimen is urinary tract. They have limited the number of probes that can be billed to a maximum of five and a minimum of three. When a lab performs less than three probes, it appears they will continue to use CPT 88367-88368. For more than five probes they are instructed to use the unlisted 88399

code. This code could present problems with the various payers since they will likely require additional documentation or explanation on the claim to allow for reimbursement for an unlisted code. CMS reimbursement for the 88120-88121 services will see a significant drop from the current reimbursement of CPT 88367-88368 by approximately 52 percent.

Significant changes will occur for fine needle aspiration (FNA) adequacy checks in 2011. The AMA revised the 88172 code to represent the first evaluation episode (i.e., first pass) for each site. They then introduced the new 88177 code to represent any "additional evaluation(s)" (i.e., passes) from the same site. This change will, in essence, eliminate the multiple units of service for the revised code 88172 when the specimens are from the same site. Code 88172 should continue to be used in multiple units when there are specimens from different sites for the first evaluation on each of the different sites. Even though the AMA has introduced this new code it did not change CMS's mind in regard to billing for FNA adequacy checks. CMS continues to require that "only" one unit of service may be billed for 88172 when the source of the specimen is from the "same site," regardless of the number of evaluations (i.e., passes) done on that specimen. Therefore for Medicare and Medicaid patients, the new 88177 code will likely never be used. The only exception to the CMS rule is if the specimen is from a "different site," which would preclude you from using the new 88177 code as it is described as additional evaluation, same site.

Finally, the AMA introduced the new 88363 code to represent those tissue preparation services by the laboratory when the specimen is being referred to another laboratory for analysis. In 2010 the AMA introduced two codes (88387 and 88388) to represent "fresh tissue" preparation for molecular diagnostic studies referred to an outside laboratory for testing. However the descriptors for those codes didn't include specimens that had previously been processed or diagnosed by the laboratory. This left the lab holding the bag for the cost of preparing those previously processed specimens that the treating physician may have requested additional molecular studies on after the initial testing and reports were provided to the physician. This new 88363 code would be used for those previously processed specimens. While the code descriptor does not specifically indicate that flow cytometry or microbiology testing is excluded like we saw in the descriptor for the 88367-88368 codes, it would appear that the same limitations would also apply to this new code 88363.

Major Changes Regarding Requisition Signature Requirements

On Nov. 2, 2010, CMS released the final rule for the 2011 Medicare physician fee schedule. The new policy for signatures on requisitions will significantly impact order requirements for services paid under the Clinical Laboratory Fee Schedule (CLFS). Also note this new policy did not change the long-standing requirement that when an "order" for a physician diagnostic service is requested, the ordering practitioner must sign the "order." As set forth in the calendar-year 2010 PFS final rule, an order may be delivered via any of the following forms of communication:

- A written document signed by the treating physician or nonphysician practitioner (NPP), which is hand-delivered, mailed, or faxed to the testing facility.
- A telephone call by the treating physician or NPP, or his or her office, to the testing facility. If the order is communicated via telephone, both the treating physician or NPP, or his or her office, and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.
- An electronic mail, or other electronic means, by the treating physician or NPP, or his or her office, to the testing facility.

Prior to this new rule, a physician's signature was not required on requisitions for

clinical diagnostic tests paid on the basis of the CLFS, providing it was evident that the physician ordered the services, typically through documentation in the patient's medical record. The 2011 final rule reverses this policy. Effective Jan. 1, 2011, a physician signature will be required on requisitions for all clinical diagnostic laboratory tests paid on the basis of CLFS. During the proposed rule phase, the laboratory industry rallied to discuss the differences between order and requisition. CMS finalized by standing firm that a written order—which may be part of the medical record—and the requisition are two different documents, although a requisition that is signed may serve as an order. Expressions of continued confusion over the difference between an "order" and a "requisition" prompted CMS to develop the single policy for all outpatient laboratory services, without distinguishing between those paid under the CLFS and the physician fee schedule (PFS).

It should be noted that orders generated and transmitted electronically from the physician to the laboratory are not impacted by the new rule. The new policy does not concern electronic or telephonic requests because CMS does not consider these types of requests to be "requisitions." According to CMS, a requisition is solely the actual paperwork, such as a form, that is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient. Phone or electronic orders would, however, require that the ordering practitioner make note of the order in the medical record to support the services being ordered.

The new policy does not concern electronic or telephonic requests because CMS does not consider these types of requests to be "requisitions."

Impact on Labs

This major change will alter workflow for both physicians and laboratories. The impact of the new policy may affect the beneficiaries' access to timely care and increase laboratory administrative burdens. Specimens received into the lab via couriers will be a significant issue, since lab staff will have to deal with specimen integrity time issues and determine whether to actually do the test when a signature is not on the requisition. Generally, when a laboratory receives a requisition, the laboratory will perform the test, regardless of whether a physician signature is present.

Laboratories also will be responsible for validating physician signatures on all order requisitions prior to submitting claims for services. As a result, laboratories may expect to receive requests from the contractor overseeing the Comprehensive Error Rate Testing (CERT) Program for an original requisition slip signed by the ordering physician. If they are not identified during the CERT audit process, the services performed from that requisition order will be deemed not medically necessary. This will result in a request for refunds for those services. The lab, therefore, runs the risk of repaying significant sums.

To affirm that a medical service is ordered, an actual signature is required. A preprinted signature or letterhead will not equal a signature and will not meet the signature requirement by CMS, even if a physician or NPP has confirmed the contents. CMS requires this to discourage fraud and abuse and CMS holds firm that the new policy does not affect physicians or NPPs who choose not to use requisitions to request clinical diagnostic laboratory tests paid under the CLFS. Physicians or NPPs can continue to request those tests by other means, such as by using the annotated medical records, documented telephonic requests, or electronically.

Rick Oliver and Donna Beasley can be reached at McKesson Revenue Management Solutions, 1145 Sanctuary Parkway, Suite 200, Alpharetta, GA 30009. Rick Oliver, 615-837-1851, rick.oliver@mckesson.com. Donna Beasley, 850-902-1010, donna.beasley@mckesson.com.

FTC Challenging LabCorp's Acquisition, *from page 1*

FTC staff's investigation of the transaction. A trial before an administrative law judge is scheduled to begin on May 2, 2011.

"Competition is one of the keys to keeping health care costs under control and ensuring that patients receive high-quality care, and laboratory services are an essential part of that," said Richard Feinstein, the FTC's Bureau of Competition director. "Physicians use lab testing to help diagnose patients and accurately evaluate their conditions, and the FTC is committed to protecting competition in this important sector."

Challenged Conduct

The agency's complaint alleges that the merger agreement and acquisitions violate the Federal Trade Commission Act and the Clayton Act. According to the complaint, an immediate impact of the integration of the Westcliff assets "is that LabCorp intends to increase prices to Westcliff customers." When Westcliff competes head-to-head with LabCorp, the complaint maintains, consumers benefit. "Westcliff has been willing to extend low-priced capitated contracts to customers that LabCorp and Quest have been unwilling to service in that manner," the complaint says.

Further, the elimination of a price-cutting maverick competitor means that the acquisition, if completed, will allow LabCorp to exercise market power both unilaterally by increasing prices on its own, or in coordination with its only remaining significant competitor, Quest. The FTC notes it is unlikely that a new competitor would enter or expand into the Southern California market for the sale of clinical laboratory testing services to physician groups sufficient to restore the competition lost as a result of LabCorp's acquisition of Westcliff.

DOJ Recovers Record $2.5 Billion Related to Health Care Fraud in FY 2010

The Department of Justice announced Nov. 22 that it recovered a record $2.5 billion in fiscal year 2010 from False Claims Act cases related to health care fraud. That figure tops FY 2009's $1.6 billion in recoveries.

"The government has taken a very aggressive approach toward health care fraud," which has helped boost recovery amounts, Assistant Attorney General Tony West, head of DOJ's Civil Division, said at a Nov. 22 briefing.

The record recoveries are due in part to the Fraud Enforcement and Recovery Act of 2009, which strengthened the FCA and gave the government more tools to fight health care fraud, West said.

Coupled with the administration's Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, an interagency task force created in May 2009 to combat health care fraud, the additional resources have bolstered enforcement efforts. The HEAT program built on a joint DOJ effort with the Department of Health and Human Services begun in March 2007.

West said that since January 2009, the DOJ has recovered $4.6 billion in fraud-related funds stemming from FCA cases against health care providers and suppliers, securing 25 criminal convictions along the way.

FCA cases in FY 2010 involved several off-label drug marketing issues, including a $2.3 billion settlement with Pfizer Inc. that led to the recovery of $669 million for federal health care programs. Another off-label marketing case involved AstraZeneca, which reached a settlement that led to the recovery of $300 million, in addition to $218 million returned to state Medicaid programs, West said.

West also mentioned a $108 million settlement with the Health Alliance of Greater Cincinnati over a former hospital, which was the largest single-hospital anti-kickback statute recovery. West said that the health care fraud recoveries accounted for 83 percent of all civil fraud recoveries in FY 2010 and that the bulk of the cases involved Medicare and Medicaid.

Out of the overall $3 billion in civil fraud recoveries, West said that $2.3 billion were recovered due to qui tam lawsuits involving whistleblowers. Whistleblowers received $385 million in FY 2010 for their participation.

OIG Issues Fraud and Abuse Guide for New Physicians

The Health and Human Services Office of Inspector General (OIG) in November released a guide designed to assist physicians in understanding how to comply with Medicare and Medicaid fraud and abuse laws by identifying "red flags" that could lead to potential liability in law enforcement and administration actions.

The Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse summarizes the five main federal fraud and abuse laws (the False Claims Act, the anti-kickback statute, the Stark law, the exclusion statute, and the Civil Monetary Penalties Law) and provides tips on how physicians can comply with these laws in their relationships with payers, vendors, and fellow providers.

The *Roadmap* also offers new physicians guidance regarding compliance program creation and where to go for help if they suspect they may have a potential compliance problem.

The* Roadmap *also offers new physicians guidance regarding compliance program creation and where to go for help if they suspect they may have a potential compliance problem.

The *Roadmap* was developed as a result of an OIG survey of medical school deans and designated officials at institutions that sponsor residencies and fellowships to learn the types of instruction medical students, residents, and fellows receive on Medicare and Medicaid fraud, waste, and abuse. In its October 2010 report, *Medicare and Medicaid Fraud and Abuse Training in Medical Education*, the OIG reported that nearly all respondents (92 percent of deans and 90 percent of designated institutional officials) indicated a preference for OIG-generated training material.

The OIG report also indicated that despite the lack of a federal requirement, 44 percent of medical schools and 68 percent of residency and fellowship programs provided instruction on Medicare and Medicaid fraud and abuse laws in 2010. The *Roadmap* tool should be a helpful tool in all new physician training programs.

The *Roadmap* is available at *www.oig.hhs.gov/fraud/PhysicianEducation/*.

States Must Establish Medicaid RACs by End of 2010

States would be required to establish a Medicaid Recovery Audit Contractor (RAC) program by Dec. 31 under a proposal by the Centers for Medicare and Medicaid Services (CMS). The programs would not have to be implemented until April 1, 2011.

The proposed rule would implement Medicaid RAC provisions contained within the Patient Protection and Affordable Care Act. Comments are due by Jan. 10, 2011.

"We are using many of the lessons that we learned from the Medicare RAC program in the development and implementation of the Medicaid RACs, including a far-reaching education effort for health care providers and state managers," Donald Berwick, the CMS administrator, said in a statement.

The Medicaid RAC programs would be modeled on the existing Medicare RAC program and would be designed to audit Medicaid claims, identify underpayments, and identify and recover overpayments, the proposed rule said. Unlike the Medicare RACs, which are administered by CMS, the Medicaid RACs would be administered by the individual states.

The Medicaid RAC programs would be modeled on the existing Medicare RAC program and would be designed to audit Medicaid claims, identify underpayments, and identify and recover overpayments

Medicaid RACs would function on a contingency-fee basis, the proposed rule said, with fees based on a percentage of the recovered overpayments. States would only be able to pay Medicaid RACs a contingency fee equal to the highest Medicare RAC contingency fee rate. Any payment over this would have to come from the state alone, unless a waiver was provided that allowed for federal financial participation.

Individual states would be responsible for establishing a process for providers to appeal Medicaid RAC findings.

Regulatory Impact, Help for States

CMS estimates the proposed rule would be economically significant, defined as containing economic effects of $100 million or more in a single year. The proposed rule would therefore be deemed a major rule under the Congressional Review Act.

The proposed rule estimated that the Medicaid RAC program could realize potential net savings to the federal Medicaid program of $80 million in fiscal year 2011, $170 million in FY 2012, $250 million in FY 2013, $310 million in FY 2014, and $330 million in FY 2015. "We plan to refine the estimated impacts in the final rule's analysis," CMS said.

CMS said that the proposed rule should have a limited financial impact on providers due to the fact that large amounts of improper payments are not common. The CMS release noted that on Oct. 1, the federal agency released a letter to state Medicaid directors which provided initial guidance regarding the RAC program. That letter was posted online by the National Association of State Medicaid Directors.

News-At-A-Glance

LAWMAKERS NARROW SCOPE OF RED FLAGS RULE: The House Dec. 7 cleared a bill to narrow the scope of the Federal Trade Commission's red flags rule, which requires a broadly defined group of "creditors"—including health care providers—to have identity theft prevention programs in place by year's end. The legislation (S. 3987) was passed by voice vote and now awaits the president's signature. It would limit the definition of creditor under the Fair Credit Reporting Act to entities that use consumer reports, furnish information to consumer reporting agencies, or advance funds to or on behalf of a person. The measure would exclude the controversial aspect of the FTC's definition of creditor, which swept up a variety of entities by including any entity that "advances funds on behalf of a person for expenses incidental to a service provided by the creditor to that person." American Medical Association President Cecil Wilson said the bill will help eliminate the current "confusion" about the rule's application to physicians. The FTC previously had defined the creditor category as including law firms, health care practices, retailers, utility companies, telecommunications firms, and automobile dealerships. It said it could not exempt entities such as law firms and health care providers from the rule without a legislative fix.

MEDICARE FFS ERROR RATE DOWN: The payment error rate in the Medicare fee-for-service program decreased to 10.5 percent in fiscal year 2010, the Centers for Medicare and Medicaid Services announced Nov. 16. CMS said the rate of 10.5 percent translates to $34.3 billion in estimated improper claims payments, a decrease from the previous year. In FY 2009, the error rate was 12.4 percent, or $35.4 billion in improper payments. Officials attributed the decrease to improved efforts to fight fraud, abuse, and waste within the Medicare system, as well as to educating providers about avoiding errors. For FY 2009, CMS instituted a stricter policy for calculating the Medicare FFS improper payment rate—including that past claims histories not be allowed to stand in for missing documentation—and the same policy was used for FY 2010. The primary causes of errors in Medicare FFS for FY 2010 were insufficient documentation and medically unnecessary services, according to the agency.

 G-2 Compliance Report (ISSN 1524-0304) is published by Washington G-2 Reports, 1 Phoenix Mill Lane, Fl. 3 , Peterborough, NH 03458-1467 USA. Tel: 973-718-4700. Fax: 973-622-0595. Web site: www.g2reports.com.

Kimberly Scott, Managing Editor; Dennis Weissman, Executive Editor; Heather Lancey, Designer; Beth Butler, Marketing Director; Dan Houder, Chief Marketing Officer; Doug Anderson, VP & Publisher; Joe Bremner, President

Receiving duplicate issues? Have a billing question? Need to have your renewal dates coordinated? We'd be glad to help you. Call customer service at 973-718-4700.