G2 Compliance Report

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For Hospitals, Laboratories and Physician Practices

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Inside this issue

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Dermatologist Settles False Claims Case Involving Path Lab; Doc to Pay $26.1 Million to Federal Government

A Florida dermatologist has agreed to pay $26.1 million to the federal government to resolve allegations that he violated the False Claims Act by accepting illegal kickbacks from a pathology laboratory and billing the Medicare program for medically unnecessary services.

The settlement is the largest ever with an individual under the False Claims Act in the Middle District of Florida and one of the largest with an individual under the False Claims Act in U.S. history.

The government alleged that, in or around 1997, Steven Wasserman, M.D., a dermatologist practicing in Venice, Fla., entered into an illegal kickback arrangement with Tampa Pathology Laboratory (TPL), a clinical laboratory in Tampa, Fla., and Dr. Jose SuarezHoyos, a pathologist and owner of TPL, in an effort to increase the lab's referral business.

Under the agreement, Wasserman allegedly sent biopsy specimens for Medicare beneficiaries to TPL for testing and diagnosis. In return,

Continued on page 2

HHS Updates HIPAA Privacy, Security, Enforcement Provisions and Increases Penalty Cap

The omnibus final rule updating provisions of the Health Insurance Portability and Accountability Act (HIPAA) released Jan. 17 is designed to enhance a patient's privacy protections, provide individuals new rights to their health information, and strengthen the government's ability to enforce the law.

"Much has changed in health care since HIPAA was enacted over 15 years ago," said Kathleen Sebelius, secretary of the Department of Health and Human Services. "The new rule will help protect patient privacy and safeguard patient's health information in an ever-expanding digital age."

The rule, published in the *Federal Register* Jan. 25, contains final modifications to the HIPAA privacy, security, and enforcement rules mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act. Specifically, these modifications:

Continued on page 9

Dermatologist Settles False Claims Case Involving Path Lab, *from page 1*

TPL allegedly provided Wasserman a diagnosis on a pathology report that included a signature line for Wasserman to make it appear to Medicare that he had performed the diagnostic work that TPL had performed. The government alleged that Wasserman then billed the Medicare program for TPL's work, passing it off as his own, for which he received more than $6 million in Medicare payments. In addition, the government asserted that Wasserman substantially increased the number of skin biopsies he performed on Medicare patients, thus increasing the referral business for TPL.

The government further alleged that, in addition to his involvement in the alleged kickback scheme, Wasserman also performed thousands of unnecessary skin surgeries known as adjacent tissue transfers on Medicare beneficiaries. Adjacent tissue transfers are complicated and often time-consuming procedures physicians sometimes use to close a defect resulting from the removal of a growth on a patient's skin. The government alleged that Wasserman performed many of these procedures in order to obtain the reimbursement for them and not because they were medically necessary.

"Doctors who take illegal kickbacks and perform unnecessary procedures not only put their own financial self-interest over their duty to their patients, they raise the cost of health care for all of us as patients and as taxpayers," said Stuart Delery, principal deputy assistant attorney general for the Civil Division of the Department of Justice.

"This settlement represents a watershed achievement in our district's civil health care fraud enforcement program," said Robert O'Neill, U.S. attorney for the Middle District of Florida. "Schemes of this magnitude require extraordinary remedies, and we are proud to have reached such an outstanding resolution for the taxpayers and their health programs."

The allegations resolved by this settlement were initiated by a lawsuit originally filed by Alan Freedman, M.D., a pathologist who formerly worked at TPL. Under the False Claims Act, a private party may file suit on behalf of the United States for false claims and share in any recovery. The United States has a right to intervene in the action, which it did in this case, filing its own complaint in October 2010. Freedman will receive more than $4 million of this settlement.

The United States previously settled with TPL and SuarezHoyos for $950,000 to resolve the allegations asserted against them in the same lawsuit.

New Jersey Doctor Sentenced to Prison For Receiving Kickbacks for MRI Referrals

A federal court in New Jersey Jan. 31 sentenced physician Daisy Deguzman to six months in prison and six months of home detention for accepting illegal kickbacks in exchange for referring patients to an outpatient diagnostic medical imaging facility, federal prosecutors said (*United States v. Deguzman*).

Judge Clare C. Cecchi of the U.S. District Court for the District of New Jersey in Newark also ordered Deguzman to serve two years of supervised release, pay a $20,000 fine, and forfeit $23,595.

Deguzman pleaded guilty in June 2012 to one count of violating the federal health care anti-kickback statute. She was arrested in December 2011, along with 12 other

physicians and a nurse practitioner, all of whom were charged in separate complaints with accepting kickbacks from Orange Community MRI LLC (OCM) in Orange, N.J., in exchange for referring Medicare and Medicaid patients and patients with private insurance to the facility for diagnostic imaging.

One of the facility's executives was also charged in connection with his participation in the scheme. He and a total of eight of the health care providers have pleaded guilty.

Deguzman is the first to be sentenced. The other defendants await trial.

Cash for Referrals

Federal prosecutors allege that OCM generated monthly reports that showed, for each patient, the date of service, the type of test performed, the referring physician, and the kinds of insurance to be billed.

Starting in 2010, the facility began making monthly cash payments to Deguzman for each Medicare or Medicaid beneficiary she had referred to the facility for an MRI or CT scan the month before, according to the government.

Federal prosecutors said Deguzman received three payments from a cooperating government witness during the course of the investigation, including $1,700 in cash in October 2011 for her September referrals, $1,130 in November 2011 for her October referrals, and $1,000 in December 2011 for her November referrals.

OSU Spends More Than $700,000 to Keep Lab Open After Proficiency Testing Referral Violation

Ohio State University's Wexner Medical Center so far has spent $450,550 in legal fees as part of its successful effort to keep its clinical laboratory certified and open, according to a report in the *Columbus Dispatch*.

The university in January agreed to pay the federal government $268,000 to settle allegations that its lab violated proficiency testing laws. The agreement allows the lab to stay open and under OSU control. Between the legal fees and the settlement payment, the university has incurred at least $718,550 in case-related expenses.

The Centers for Medicare and Medicaid Services levied sanctions this past summer after the lab sent six proficiency-test samples to the Mayo Clinic and to another OSU lab for testing. Federal law prohibits a lab from sending such samples to another lab, even within the same hospital system.

The sanctions could have cost OSU millions of dollars in Medicare and Medicaid reimbursement.

As part of the settlement, the university appointed a new clinical laboratory director, Daniel Sedmak, M.D., a professor of pathology, who has replaced Amy Gerwitz, M.D. In addition, the lab staff will undergo additional training.

The university faces more expenses related to the settlement, according to the *Dispatch*. It has yet to hire an outside firm to conduct a "root-cause analysis" to determine what led to the improper referrals, as stipulated in the settlement.

In 2011, the university's medical laboratory network performed 9.1 million patient tests, 7.24 million of which were performed at the lab in question. It is central Ohio's only fully automated hospital lab.

Health Care Chief Compliance Officers Average $125,000 in Compensation: Survey

Health care chief compliance officers (CCOs) averaged $125,000 in annual salary in 2012, with higher salaries earned by CCOs working at large organizations, according to a report from the Health Care Compliance Association (HCCA) and the Society of Corporate Compliance and Ethics released Jan. 16.

The 2012 Health Care Chief Compliance Officers Salary Survey, the first of its kind, was completed in December 2012 and collected responses from 762 CCOs responsible for compliance activities at health care organizations ranging from less than 100 employees to more than 15,000.

Overall, an e-mail questionnaire was sent to roughly 45,000 compliance officers. HCCA received 1,858 completed responses, but only 762 satisfied the three criteria they established for inclusion:

- The CCO had to work for a health care provider;
- The CCO had to be responsible for seven out of the 10 elements of an effective compliance program; and
- The CCO had to be responsible for at least 26 percent of an organization's legal and regulatory risk.

"The demand for skilled compliance professionals is skyrocketing," HCCA Chief Executive Officer Roy Snell said Jan. 17. "It is imperative that we have solid compensation data at hand."

Compliance Budgets

CCOs responsible for annual compliance budgets of more than $1 million (105 respondents) had average annual salaries of $195,000, the report said, compared with average annual salaries of $89,000 for CCOs managing compliance budgets of less than $100,000 (151 respondents).

The report said there was a direct correlation between CCO salary and the size of the annual compliance budget.

CCO salaries were also higher at organizations with large numbers of employees. CCOs at organizations with more than 15,000 employees had average annual salaries of $214,000, compared to average annual salaries of $105,000 for CCOs at organizations with less than 100 employees.

In addition, CCOs responsible for compliance at organizations with revenue of more than $1 billion (104 respondents) had average annual salaries of $197,000, compared to average annual salaries of $90,000 for CCOs at organizations with revenues of less than $5 million (58 respondents), the report said.

Experience also played a role in determining CCO salaries, the report said. For example, CCOs with one year of experience in their role earned an average annual salary of $96,000, while CCOs with 16 or more years of experience earned an average annual salary of $161,000.

Only 10 percent of respondents said they were under a contract with their organization.

The report is available online at *www.hcca-info.org*.

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COMPLIANCE PERSPECTIVES

Administrative Simplification Requires Interoperability, New Financial Management Platforms

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Administrative simplification has an aggressive timetable, with far-reaching consequences for laboratories, providers, and payers and new demands for information exchange and technology infrastructures.

The administrative simplification provision under Section 1104 of the Patient Protection and Affordable Care Act requires new operating rules that improve the exchange and standardization of electronic data transactions governed by the Health Insurance Portability and Accountability Act (HIPAA). The goal of the provision is to specify how HIPAA standards should be implemented across the health care system to reduce administrative costs, create uniformity in transaction processing, and improve efficiency by reducing the clerical burden on patients, providers, and payers.

The Department of Health and Human Services (HHS) estimates that 12 percent of every dollar received from patients goes to "cover the cost of excessive administrative complexity" and that the new operating rules have the potential to save providers and health plans $13 billion to $15 billion over the next 10 years.

The operating rules supplement existing HIPAA transactions and guidelines (ASC X12 version 5010) and govern compliance by covered entities such as payers, health care clearinghouses, and certain health care providers conducting electronic administrative transactions. The new operating rules are intended to further improve interoperability, including real-time, Internet-based transactions for eligibility verification and claim status, as well as changes to electronic funds transfers (EFTs), and electronic remittance advices (ERAs).

HHS selected the Council for Affordable Quality Healthcare's (CAQH) Committee on Operating Rules for Information Exchange (CORE) to develop several sets of operating rules. The rules define responsibilities, transaction formats, and other requirements for electronic information exchange between payers and providers. The rules were released in separate "Phase" documents. Phase I focuses on the patient eligibility transaction, and Phase II adds rules for the claims status transaction plus additional rules regarding patient matching, infrastructure requirements, and connectivity for both eligibility and claims status. Phase III introduces new rules regarding the use of CARCs (claim adjustment reason codes) and RARCs (remittance advice remark codes). Phase III also addresses EFT and ERA issues, such as requiring the electronic enrollment of EFT and ERA, and enhancing bank reconciliation.

The timetable required for health care administrative simplification is aggressive. The final operating rules will be phased in from 2012 through 2016 as follows:

Jan. 1, 2013: Point-of-care eligibility and claims status operating rules (Phases I and II)

Jan. 1, 2014: Electronic funds transfer and electronic remittance advice (Phase III)

Oct. 1, 2014: Implementation of ICD-10 coding set

Jan. 1, 2016: Claims and encounters, enrollment/disenrollment, premium payments, referral certification/authorization, and claim attachments

Point-of-Care Eligibility and Claims Status

Many health insurers are already compliant with the CAQH/CORE Phase I and II operating rule requirements regarding the information received from an electronic eligibility request and are electronically confirming patient benefit coverage, copays, coinsurance, and base deductibles at the point of care. This information helps estimate patient costs up front before the patient is treated and empowers providers with key information to discuss treatment options with patients. Eligibility also allows providers to collect patient deductibles and coinsurance immediately at the point of service.

The widespread, real-time availability of patient eligibility information reduces both the time and costs associated with administrative tasks. More importantly, real-time eligibility information enables more informed decisionmaking by providers. The key to this empowerment is timely access to data contained within the payers' systems.

With the effective date for Phases I and II already past, HHS is in position to impose penalties for noncompliance. However, CMS announced a 90-day period of enforcement discretion. This does not change the effective date; it only delays the penalties. Additionally, payers are required to file a statement with HHS certifying that their data and information systems are in compliance with all new standards and operating rules by Dec. 31, 2013. The certification date carries a separate penalty for noncompliance. Providers are strongly encouraged to reach out to payers, system software vendors, and clearinghouses to determine compliance with new operating rules.

Standards for Electronic Funds Transfer and Remittance Advice Transactions

Payers, providers, health care clearinghouses, and technology vendors use EFTs and ERAs to process and manage claims payments and claims remittance advice with the Automated Clearing House (ACH) network carrying the electronic payment information between providers and payers.

A significant challenge for health care providers is reconciling their bank statements with the payers' remittance advice. At issue is that the payment information from the bank may have to be processed manually because the EFT is not yet a mandated format. Even when an EFT is available, it is transmitted separately (over the ACH network) to the bank, while the ERA that explains the detail of services that have been paid is sent to the provider through electronic data interchange channels.

Another significant obstacle is that an ERA and an EFT may be separated from each other and from the payment effective remittance date by up to a day. Additionally, if either of the other transaction files is not received due to an error, it can take days to replace the missing file. This lack of synchronization in electronic information flow and reconciliation negatively impacts providers' financials as they try to manually reconcile the vast combination of manual checks, electronic funds transfers, explanations of benefits (EOBs) and ERAs in order to apply and book their cash receipts accurately and in compliance with Generally Accepted Accounting Principles.

HHS aims to streamline this process by requiring that a single electronic file format known as CCD+ be used by all health plans and that the CCD+ and ERA be transmitted within three business days of the payment effective entry date.

New CCD+ Format Required

The CCD+ format was adopted as the HIPAA standard format required to transmit an EFT transaction. The CCD+ format is a National Automated Clearing House Association ACH payment standard with a place specifically for the reassociation trace number from the ERA. For health care claims, the CCD+ provides a vast improvement over paper claims because the transaction reassociation trace number can now be linked to the EFT by the provider's accounts receivable (A/R) system.

Private-sector payers are required to use the CCD+ format with health care providers by Jan. 1, 2014, and are allowed to request that providers be able to accept ACH payments instead of paper checks. All Medicare payments are also required to eliminate paper check processing and move to using only ACH electronic payment by Jan. 1, 2014. Payers who do not comply with requests by providers to conduct EFT using the ACH network may be subject to fines.

The potential benefits to providers in using EFTs and ERAs under the new operating rules are tremendous: faster payments, improved response times on claims, reduced processing costs, the ability to better manage claims denials, improved productivity through automation, and automated bank reconciliation.

New Financial Technology Frameworks Needed

To be effective, administrative simplification will require the end-to-end electronic processing of financial management functions, and many providers will have to make upgrades or changes to their A/R and financial management technology infrastructure to compete in the marketplace. The operating rules allow providers to work with any vendor of choice.

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There is no question that today's labor-intensive revenue cycle management (RCM) workflow needs to be streamlined and automated. For example, in many instances, a provider's clinical information and financial information is housed in two different information systems, requiring billing staff to compile data from disparate systems to process claims.

Traditional RCM systems that are accessible only by the billing department of the laboratory will be inadequate. Diagnostic service providers cannot effectively implement the operating rules or remain competitive if the data needed in their financial system is only accessible by a limited number of people, during 9-to-5 business hours. The RCM system must be accessible and interoperable in real time with other departmental systems in the health care setting. While traditional RCM systems have achieved some degree of interoperability, they often rely on batch updates at regular intervals (as opposed to real time), leading to lags in data accuracy between systems. Additionally, since most RCM systems are bill generators rather than financial accounting packages and thus lack financial controls and referential integrity, the quality of the data can also be questionable. Legacy system infrastructures cannot communicate in real time or be easily altered to integrate new information-sharing systems required of the new operating rules.

A more cost-effective approach is to implement next-generation financial management systems that can automatically query and exchange billing information with other systems in real time to optimize claims processing and A/R manage-

ment. Using standard Internet interoperability and health care security protocols, next-generation financial management platforms enable information exchanges between disparate, distributed systems through use of cloud-based Web services. This interoperability enables a two-way conversation between systems regardless of source, operating system, or programming language.

This framework reduces workload on clerical and billing staff by reducing duplicate data entry and allowing access to up-to-date data in real-time as well as enabling self-service functionality.

Providers who invest in new financial system frameworks by 2014 will benefit tremendously from the accuracy, timeliness, and breadth of data available via real-time sources, eliminating significant back-office costs and streamlining workflow efficiency for improved net revenue.

IT Options

The A/R and financial management systems landscape has evolved significantly over the years. Traditional, off-the-shelf purchased software where the provider owns and maintains the software, rules, and data used by their internal billing staff continues to be an option, albeit one that is impossible to maintain at the level necessary to keep up with technology in our rapidly changing environment. Another option is a completely outsourced model whereby the provider contracts with a vendor to provide the billing staff; own and maintain the software, rules, and data; process claims on their behalf; and buffer the technology gap with manual labor.

Cloud-based, "Software-as-a-Service" is the model of the future that offers the best of both worlds, where the vendor retains management and continual development of the system, and the provider's staff access it remotely via the Internet. This hosted model has a superior total cost of ownership requiring no up-front costs, capital expense, equipment or licenses, IT personnel costs, data centers, or maintenance, while still allowing internal staff daily, hands-on interaction. The management of electronic files is significantly reduced. Additionally, the software is always at the latest version with the most recent payer rules, settings, and regulatory configurations.

Implementation of administrative simplification will be challenging for all stakeholders.

The demands and competing administrative projects impacting the industry over the next several years—the transition to the new operating rules, including managing to the new HIPAA 5010 standards, migrating to new ICD-10 code sets, and complying with numerous regulatory mandates—will significantly impact both IT resources and billing staff. Providers will require extensive investments in training and financial management technology to ensure the compliance and interoperability needed for effective information exchange to be successful. Payers, too, will be required to invest in technology to enable the information exchange mandated by the operating rules.

Those that rethink the role offered by interoperable financial management systems that stay ahead of technology requirements will be poised to succeed in the health care system of tomorrow including active participation in high-quality data interchange, improved responsiveness to ongoing regulatory changes, and measurable financial gains.

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HHS Updates HIPAA Rules, *from page 1*

- Make business associates of covered entities directly liable for compliance with certain of the HIPAA privacy and security rules' requirements;
- Strengthen the limitations on the use and disclosure of protected health information (PHI) for marketing and fund-raising purposes and prohibit the sale of protected health information without individual authorization;
- Expand individuals' rights to receive electronic copies of their health information and to restrict disclosures to a health plan concerning treatment for which the individual has paid out of pocket in full;
- Require modifications to, and redistribution of, a covered entity's notice of privacy practices;
- Modify the individual authorization and other requirements to facilitate research and disclosure of child immunization proof to schools and to enable access to decedent information by family members or others; and
- Adopt the HITECH Act enhancements to the enforcement rule not previously adopted in the Oct. 30, 2009, interim final rule, such as the provisions addressing enforcement of noncompliance with the HIPAA rules due to willful neglect.

The final omnibus rule also adopts changes to the HIPAA enforcement rule to incorporate the increased and tiered civil money penalty structure provided by the HITECH Act, originally published as an interim final rule on Aug. 24, 2009. This increased CMPs and caps maximum annual penalties at $1.5 million, up from $25,000.

The rule also replaces the breach notification for unsecured protected health information under the HITECH Act with a new harm threshold that encompasses a more objective standard and incorporates the final rule modifying the HIPAA privacy rule as required by the Genetic Information Nondiscrimination Act to prohibit most health plans from using or disclosing genetic information for underwriting purposes.

Business Associates' Compliance

While HIPAA privacy and security rules have concentrated on health care providers, health plans, and health clearinghouses, the changes in the new rule expand many of the requirements to business associates of these entities that receive protected health information, such as contractors and subcontractors. Some of the largest data breaches reported to HHS have involved business associates.

Historically, a *business associate* has been defined as a person who, on behalf of a covered entity or an organized health care arrangement, performed or assisted in the performance of a function or activity regulated by HIPAA and involving the use or disclosure of individually identifiable health information. The definition included, by way of example, various functions that a business associate may provide, including legal, actuarial, accounting, consulting, management, administrative, or financial services.

Various changes have been made to this definition in the final rule. For one, patient safety activities have been added to the list of functions and activities that a person may undertake on behalf of a covered entity that give rise to a business associate relationship.

In addition, the definition of a *business associate* now includes both a list of activities that constitute business associate activities and those that specifically fall outside the definition of a business associate. The following are now specifically included in the definition as examples of business associates:

- A health information organization, e-prescribing gateway, or other person that provides data transmission services with respect to PHI to a covered entity and that requires access to such PHI on a routine basis;
- A person who offers a personal health record to one or more individuals on behalf of a covered entity; and
- A subcontractor that creates, receives, maintains, or transmits PHI on behalf of the business associate.

Data Breach Incidents

HHS replaces the harm standards for data breach incidents, requiring notification to individuals unless there is a low probability the data were compromised. This may be the biggest change, analysts say, since the interim final rule required entities to notify individuals that their protected health information had been breached only if they determined through a risk assessment that the individuals could suffer financial, reputational, or other harm.

Patients' Rights

Individual rights are expanded in the new rule as follows:

- Patients can ask for a copy of their electronic medical records in an electronic form;
- When individuals pay by cash they can instruct their provider not to share information about their treatment with their health plan;
- New limits are set on how information is used and disclosed for marketing and fund-raising purposes; and
- An individual's health information cannot be sold without his or her permission.

Effective Dates

The rule becomes effective March 26, but covered entities and their business associates have until Sept. 23 to comply with most provisions. In the case of existing business associate agreements, covered entities have until September 2014 to make changes.

The omnibus final rule is available at *www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf*.

Experts Say RAC Program Flawed Despite Report to Congress

The Recovery Audit Contractor (RAC) program may be over-reporting the amount of improper Medicare payment recoveries, as well as increasing administrative burdens for hospitals, say health care industry experts.

The comments came after the Centers for Medicare and Medicaid Services (CMS) sent its second annual RAC report to Congress Feb. 5.

According to the report, which covered fiscal year 2011, RACs identified and corrected $939 million in improper Medicare hospital payments, a jump from FY 2010, when RACs identified and corrected $92 million in improper payments. RACs also returned $488 million to the Medicare Trust Fund in FY 2011, the report said, a figure that was not available in the FY 2010 report.

Robert L. Roth, an attorney with Hooper, Lundy & Bookman PC, Washington, D.C., told Bloomberg BNA Feb. 7 the jump in recoveries from FY 2010 to FY 2011 "may not be quite the unqualified success that CMS seems to want to portray in its report

to Congress." Bloomberg BNA is the parent company of Kennedy Information, of which G2 Intelligence is a division.

Roth said that much of the growth in recoveries is most likely attributable to the RAC program's transition from a six-state demonstration project to a national program.

Short-Stay Recoveries

He said some of the recoveries in the report also may be short-lived, particularly those associated with hospital short stays, which the report said represented a significant part of the FY 2011 recoveries.

Roth said the short-stay recoveries "are based on the recovery of the full amount Medicare paid for the inpatient stay, whereas ALJs [administrative law judges] are now routinely remanding appeals of those recoveries for a determination of how much would have been paid if the services had been provided in an outpatient setting (assuming the inpatient stay was not medically necessary)."

Roth also said he expected that future reports would show more RAC claims denials overturned. The FY 2011 report said that out of 903,000 claims that were identified as containing overpayments, providers filed appeals for 61,000 claims, and 43.6 percent (26,000) of the appealed claims were overturned.

"Given the 43.6 percent error rate and the recent spate of short stay remands to determine payments to be made to the hospitals, providers would be well-advised to be proactive with regard to appealing RAC denials, which could result in a somewhat different report for 2013," Roth said.

Increased Administrative Burdens

Robyn Bash, senior associate director for federal relations at the American Hospital Association, told BNA that although AHA recognizes the need for a claims review program, RACs have significantly increased the administrative burden for hospitals.

Bash said "a flood of new auditing programs are drowning hospitals with a deluge of duplicative audits, unmanageable medical record requests, and inappropriate payment denials."

AHA, along with four hospital systems, filed a complaint against the Department of Health and Human Services (HHS) on Nov. 1, 2012, arguing that RACs have improperly demanded hospitals return Medicare payments.

The complaint, filed in the U.S. District Court for the District of Columbia, asked the court to prohibit an HHS policy that allows RACs to deny claims because a service should have been provided on an outpatient basis, as opposed to an inpatient setting.

Inaccurate Claims Denials

Hospitals are experiencing a growing number of RAC claims denials that are proving to be inaccurate, Bash said, adding up "to hundreds of thousands of dollars in unjust recoupments of payments for medically necessary care."

She said hospitals have a 74 percent success rate when they appeal their RAC denials, according to the October 2012 AHA RACTrac survey. Bash said not all hospitals have the necessary resources to appeal RAC denials, however, and Medicare lacks the resources to resolve appeals in a timely fashion.

"CMS must increase its oversight of contract auditors to prevent inaccurate payment denials and make its overall auditing effort more transparent, timely, accurate, and administratively reasonable," Bash said. G2

News-At-A-Glance

GENETIC COUNSELOR'S SCOPE OF PRACTICE: The New Jersey Assembly has unanimously approved a bill to remove genetic counselor's statutory authority to interpret genetic tests and other diagnostic studies from their scope of practice. Pathology groups have maintained that the clinical interpretation of laboratory tests requires a complete medical assessment of the patient and requisite clinical training that a genetic counselor is not trained to perform. The bill also clarifies that physicians are categorically exempt from the genetic counselor license law. According to the College of American Pathologists (CAP), passage of the bill is the result of a two-year collaboration between the New Jersey Society of Pathologists and CAP to ensure the New Jersey state law conforms to the scope of practice agreement between CAP and the National Society of Genetic Counselors. The measure is now on its way to the governor for his signature.

RECORD FRAUD RECOVERY: The federal government's health fraud enforcement and prevention efforts recovered a record $4.2 billion in fiscal year 2012, the departments of Justice and Health and Human Services said Feb. 11. This compares to recovery of $4.1 billion in FY 2011. In the new announcement, HHS and DOJ also said that over the past four years, the Obama administration's enforcement efforts have recovered $14.9 billion, compared with a $6.7 billion recovery over the prior four-year period. In addition, the departments said that the Health Care Fraud and Abuse Control (HCFAC) program, which is 16 years old, has returned more than $23 billion to the Medicare trust funds. In FY 2012, DOJ opened 1,131 criminal health care fraud investigations involving 2,148 potential defendants, and a total of 826 defendants were convicted of health fraud-related crimes during the year. In addition, the two departments opened 885 civil investigations in FY 2012. The departments also released a report on HCFAC that said the return-on-investment (ROI) for the program over the past three years (2010-2012) is $7.90 returned for every dollar spent. "This is $2.50 higher than the average ROI for the life of the HCFAC program since 1997," the report said.

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