RACs TO BEGIN EXTRAPOLATING AND DEFENDING APPEALS

At the recent American Health Lawyers Association’s Institute on Medicare and Medicaid Payment Issues conference, the Centers for Medicare & Medicaid Services (CMS) officials provided insight into future Recovery Audit Contractor (RAC) plans for the coming year, including an effort to move away from the term RAC to Recovery Auditor and plans to update the CMS website.

In troublesome news for providers, RACs will be encouraged to flex their atrophying extrapolation muscles. RACs always have had the ability to extrapolate overpayments, even during the demonstration project, but traditionally have failed to exercise that right. Officials at the conference indicated that RACs will be actively encouraged to take advantage of their ability to extrapolate overpayments within the coming year. Extrapolation uses sampling of a specific set of statistics to project a global error rate to a universe of claims to determine overpayment amounts made to a facility. The focus supposedly will be on small dollar claims identified in the Comprehensive Error Rate Testing (CERT) program. RACs thus will be following in the footsteps of their bigger, badder cousins, Zone Program Integrity Contractors (ZPICs), who routinely extrapolate overpayments to the tune of millions of dollars. Accordingly, providers will need to reevaluate their defense strategies in light of these coming changes: a single $200 claim denial, which previously may not have been cost-effective to defend, suddenly may have multiplier implications which could cost providers significantly more.

CMS officials also shared predictions regarding RAC involvement in appeals. Generally, RACs have avoided involvement as parties or participants in appeals; providers thus had the benefit of the strategic position of arguing against no one because the opposing side rarely showed up. CMS officials indicated that this will change and that RACs will become involved in appeals in the coming year, particularly at the administrative law judge level. This is further evidence in support of providers continuing to review their response and defense strategies against evolving RAC actions.

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BE CAREFUL TO IDENTIFY NOTICES FROM ZPICs AND PSCs

CMS traditionally has relied heavily on contractors to assist in the administration of the Medicare and Medicaid programs. Recently, CMS has begun hiring contractors to focus, not on administrative support, but rather on program integrity, identifying overpayments and investigating improper payments. This diverse breed of contractors includes CERT contractors, Medicaid Integrity Contractors (MICs), RACs, Program Safety Contractors (PSCs) and ZPICs. Medicare Administrative Contractors (MACs) also have a role to play in recovering overpayments.
While the attention lately has been on RACs and their bounty-hunter style overpayment audits, providers should not lose sight of significant consequences that a ZPIC or PSC review could cause. ZPICs and PSCs focus on fraud and abuse and, to that end, conduct data analysis, investigations and, upon discovering potential fraud, may refer the issue to the Office of Inspector General (OIG), U.S. Department of Justice or Federal Bureau of Investigation. ZPICs and PSCs also routinely amplify audit findings through the use of statistical sampling and extrapolation of overpayments. Thus, by applying their error rates to a larger universe of claims, they are able to identify a much larger overpayment for collection. Therefore, the effect of ZPIC or PSC review can be far-reaching and have dire consequences, possibly resulting in large overpayments, sanctions, civil monetary penalties or criminal prosecutions.

CMS currently is transitioning from using PSCs to ZPICs so as to better coordinate with MACs and encompass larger geographic areas. It is important that providers be aware of the players in their region and act accordingly. For example, AdvanceMed, ZPIC for Zones 2 and 5 and PSC in certain areas not yet converted to the ZPIC system, was recently acquired by NCI, Inc. for $62 million. The acquisition may not result in a name change; however, providers should expect AdvanceMed’s proficiency in data-mining and investigations to continue to grow with the added boost of NCI’s information technology expertise.

With so many contractors frolicking on the program integrity landscape, providers should promptly identify the entity with which they are dealing to assess the nature of the review, be prepared to respond in a targeted manner and seek legal counsel, if necessary.

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JOINT VENTURE COMPANY ADVISORY OPINION

The U.S. Department of Health and Human Services (HHS) OIG on April 7 issued OIG Advisory Opinion No. 11-03, in which it concluded that the formation and operation of a new long-term care pharmacy to be owned by an employee of a sponsoring long-term care pharmacy along with long-term care facility owners could potentially constitute a kickback.

Under the proposed venture, shares of a new pharmacy would have been issued to referring long-term care facility owners in proportion to the amount of capital each invested. The employee of the sponsoring pharmacy forming the pharmacy was to be given shares at a nominal price as an incentive for bringing in new investors and contracting with additional long-term care facilities on behalf of the new pharmacy. Any dividends or distributions were to be paid in proportion to share ownership. As is typical in these types of arrangements, the sponsoring long-term care pharmacy would enter into a management agreement with the new pharmacy to provide all personnel and day-to-day services necessary for the new pharmacy to serve its long-term care facility customers. In addition, the new pharmacy would purchase most of its noncontrolled substances from the sponsoring long-term care pharmacy.

The OIG reiterated its longstanding concerns about joint venture arrangements between those in a position to refer business, such as nursing homes, and those furnishing items or services for which Medicare or Medicaid pays, especially when all or most of the business of the joint venture is derived from the joint venturers in a related line of business. The OIG’s concern was heightened because the long-term care facility owners’ actual financial and business risk would be minimal or nonexistent, because they would control the amount of business they would refer to the new pharmacy and the sponsoring long-term care pharmacy was an established pharmacy providing the same items and services as the new pharmacy.
Based on these facts, the OIG stated that the proposed arrangement could have been designed to permit the sponsoring long-term care pharmacy to do indirectly what it cannot do directly; that is, to pay the long-term care facility owners a share of the profits from the referral of their patients for pharmaceutical products and services. The OIG stated "there is a significant risk that the Proposed Arrangement would be an improper joint venture that would be used as a vehicle to reward the [long-term care] [f]acility owners for their referrals."

This opinion highlights the risks associated with joint venture arrangements between parties in referral relationships and the need for careful analysis and structuring. However, it must be remembered that the failure to comply with an anti-kickback safe harbor or the OIG's refusal to issue a favorable advisory opinion does not mean that an arrangement is, in fact, illegal or improper.

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MEDICAL NECESSITY: A MEDICAID COST BATTLEGROUN

Treating physicians typically make assessments of patients' medical needs and prescribe a course of treatment. In many cases, state Medicaid agencies engage review teams or organizations to examine whether eligibility requirements have been satisfied, assess whether requested services are medically necessary and determine the amount of services that should be provided to recipients, also based on medical necessity.

In a recent case, the Georgia Medicaid Agency's contractor reduced the number of hours of nursing care a recipient received based upon its determination of medical necessity. Moore v. Reese, 11th Cir., No. 10-10148, April 7, 2011. Not surprisingly, the recipient appealed the determination. The district court concluded that the state must provide all of the services the recipient's treating physician deems medically necessary based upon provisions of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program which require states provide to Medicaid-eligible children "[s]uch other necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan."

In the first appeal of the case, the Eleventh Circuit reversed the district court and held that the treating physician's word on medical necessity was not dispositive. The Eleventh Circuit's first decision, however, did not address how conflicting opinions about medical necessity between a treating physician and the state's medical expert were to be resolved.

On remand, the state argued to the district court that the state is the final arbiter of medical necessity and has the authority and discretion to determine medical necessity, as well as to determine the amount, scope and duration of services provided by Medicaid. Nevertheless, the district court held that the state could review a treating physician's determination of medically necessary services only for fraud or abuse of the Medicaid system and whether the services are within the reasonable standards of medical care. The state appealed to the Eleventh Circuit again.

In the second appeal, the Eleventh Circuit held, consistent with prior decisions, that a state may adopt a definition of medical necessity that places limits on a physician's discretion and may establish standards for individual physicians to use in determining what services are appropriate in a particular case. In particular, the court held that a state may review treating physician medical necessity determinations and make its own reasonable determination of medical necessity, so long as the state's limitations do not discriminate on the basis of "diagnosis, type of illness, or condition" and the services provided are sufficient in amount and duration to reasonably achieve their purpose. However, the state's determination must be reasonable and is subject to judicial review.

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U.S. SUPREME COURT TO REVIEW MEDICAID PHYSICIAN PAY CUTS

The U.S. Supreme Court has granted the state of California's petition for writ of certiorari in three cases where the Ninth Circuit Court of Appeals granted injunctions prohibiting the state from implementing pay cuts to the Medi-Cal program. The high court consolidated the three cases and limited the state's appeal to whether Medicaid recipients and providers may sue a state under the Supremacy Clause to enforce the federal Medicaid law that preempts a state law. The lawsuit is a result of California legislation passed in 2008 that would cut Medicaid reimbursement rates to some providers by up to ten percent. The providers were successful in securing an injunction in the Ninth Circuit on the grounds that the rate cuts were preempted by 42 U.S.C. § 1396a(a)(30)(A), which requires state Medicaid programs to “assure that payments are
consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." This issue remains relevant across the country as state legislatures engage in contentious budget debates. After the lower courts’ rulings, CMS denied California’s State Plan Amendments that would implement the rate cuts. HHS has announced its intention to promulgate a notice of proposed rulemaking this month with respect to the statutory provision at issue, which was added to the Medicaid Act in 1989.

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NEW ADDITION TO HEALTH INDUSTRY TEAM: LYNN SESSIONS

Healthcare attorney Lynn Sessions recently joined Baker Hostetler in the Houston office from Texas Children’s Hospital where she served as in-house counsel and Director of Risk Management, Environmental Health and Safety, and Emergency Management and Interim Director of Audit Services. She has over 17 years of health law experience representing providers in healthcare litigation, working at Cowles & Thompson, P.C. and Stinnett Thiebaud & Remington, L.L.P. prior to going in-house at Texas Children’s.

Lynn’s scope of practice focuses on all aspects of healthcare operations, including healthcare liability, consent issues, credentialing, peer review, HIPAA, Joint Commission accreditation, committee structure, medical staff matters, adverse patient events, quality, EMTALA and healthcare information security. She also has expertise in risk financing, healthcare litigation, insurance and enterprise risk management. Lynn has unique experience in healthcare emergency preparedness and environmental health and safety.

Lynn received her law degree from Baylor University School of Law, where she was selected to the Order of Barristers. She also is a proud graduate of Texas A&M University. Lynn received certification in Executive Education in Medical and Healthcare Management from Rice University, Jesse H. Jones School of Management Executive Education, Advanced Quality Improvement and Patient Safety from Texas Children’s Hospital and Strategic Leadership from Development Dimensions International. Lynn serves on the Board of Directors for Children at Risk, an advocacy group for at-risk children in the state of Texas.

Lynn Sessions can be reached at lsessions@bakerlaw.com or 713.646.1352.

Events Calendar

April 14

Houston partner Susan Feigin Harris will speak on "Healthcare Reform: Shifting Political Winds and the Impact, One Year Later" at the 23rd Annual Health Law Conference sponsored by the University of Texas School of Law in Houston.

April 15

Houston partner Donna Clark will speak on "Stark Law Self-Disclosure Protocol and Recent Developments" at the 23rd Annual Health Law Conference sponsored by the University of Texas School of Law in Houston.

April 28

Cleveland partner Steve Eisenberg will speak on "Health Care Reform: Where Are We Going, What Should We Do and Where Does the Challenge Stand" before the Northeast Ohio Association of Corporate Counsel in Cleveland.

April 29

Cleveland of counsel Tom Campanella will speak on "Health Care Reform Status Update" at the Annual Health Care Law Institute of the Cleveland Metropolitan Bar Association in Cleveland.
May 3

Cleveland of counsel Tom Campanella will speak on "An Overview of Health Care Reform" at the Annual Employee Benefits Conference sponsored by the Northeast Ohio Chapter of ISCEBS (Certified Employee Benefits Specialists) in Cleveland.

May 18

Cleveland of counsel Tom Campanella will speak on "Health Care Reform Update" at the Regional HFMA (Health Care Financial Management Association) of Northeast Ohio Annual Leadership Institute in Cleveland.

Cleveland of counsel Tom Campanella will participate in a panel discussion on the topic "National Health Reform Begins: Workforce Development in Northeast Ohio" at Cleveland State University’s Levin College Forum in Cleveland.