Navigate Medicare’s RACs and Medical Necessity Maze
(How to Maximize Compliance and Minimize Risk of an Audit)
June 4, 2008
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Today’s Speakers

- Don May, Vice President Policy – American Hospital Association
- Robert Corrato, M. D., M.B.A, President & CEO – Executive Health Resources
- John Joseph, Partner – Post & Schell and former Assistant United States Attorney
- Moderator: Polly Mulford, Director – AHA Solutions
Rob Corrato, M. D., M.B.A, President & CEO
Executive Health Resources
The Perfect Storm

- CMS is mandated to vigorously collect overpayments and aggressively seek out provider fraud - $10.8 billion in 2006 & $10.8 billion in 2007.
- One of the largest reasons the last two years for overpayment has been “lack of medical necessity.”
- QIOs initiate focuses 1, 2, and 3 day stay review programs as part of 8th Scope of Work, which mandates HPMP be part of QIO mission.
  - This pushes hospitals toward more liberal use of observation and strict UR criteria to avoid scrutiny.
- Medlearn Matters on Condition Code 44 demonstrates CMS is committed to “prior to discharge” requirement.

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The Perfect Storm

- Medicaid Integrity Plan (MIP) (July 2006) uses same audit tactics and approach but for Medicaid instead of Medicare. Audits to commence no later than Summer 2008.
- “Observational Medicine” is leveraged by commercial payors to pay “observation” reimbursement for care delivered in the acute setting.
  - This confuses everyone by mixing regulatory and contractual rules while using similar terminology.

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What are RACs?
- Used successfully in other government programs
- Medicare Modernization Act created a 3-year demonstration project in April 2005, completed March 27, 2008
- Recover overpayments and identify underpayments—payment mistakes
- 3 states selected based on highest per capita Medicare utilization: NY, CA and FL
- Payment made on a contingency fee basis
RAC Demonstration – Who Are The RACs?

<table>
<thead>
<tr>
<th>Name of RAC</th>
<th>Jurisdiction (start date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connolly Consulting</td>
<td>New York (March 2006)</td>
</tr>
<tr>
<td>(New York)</td>
<td>Massachusetts (July 2007)</td>
</tr>
<tr>
<td>Health Data Insights</td>
<td>Florida (March 2006)</td>
</tr>
<tr>
<td>(Florida)</td>
<td>South Carolina (July 2007)</td>
</tr>
<tr>
<td>PRG-Schultz</td>
<td>California (March 2006)</td>
</tr>
<tr>
<td>(California)</td>
<td>Arizona (July 2007)</td>
</tr>
</tbody>
</table>

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RAC Demonstration – How They Work

- RACs use automated software programs to identify potential payment errors.
- Types of payment review include:
  - Duplicate Payments
  - FI Errors
  - Coding Errors
  - Medical Necessity
- Complex Case Review: The RACs analyze claims data using “proprietary” software and identify claims that *clearly* contain improper payments and those that *likely* contain improper payments.
  - In the case of clearly improper payments, the RAC contacts the provider and requests a refund of any overpayment amounts.
  - In the case of likely improper payments, the RAC requests the medical record from the provider, reviews the claim and medical record and then makes a determination as to whether the claim contains an overpayment, and underpayment, or a correct payment.

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Don May, Vice President Policy
American Hospital Association
Medicare RAC Demo Results

**RAC Demo Performance: 2005 - 2008**

Overpayments Collected in 2004-2006: = $68.6m

Overpayments Collected in 2007: = $357.2m

Total RAC Collections March 2005 to March 2008 = $980 million*

*SOURCE: RAC Data Warehouse, CMS presentation on 5/13/08, preliminary estimate
Where Did RACs Find Overpayments?

Most overpayments were collected from inpatient hospital services for medical necessity and coding.

Inpatient Hospital 84%

Outpatient Hosp/IRF/SNF 14%

DME 1%

Physician/Ambulance/Lab/Other 1.5%

Medically Unnecessary 40%

Incorrectly Coded 35%

No/Insufficient Documentation 8%

Other 17%

95% or more from Hospitals

SOURCE: RAC Data Warehouse, CMS presentation on 5/13/08
RAC Target Areas

Coding Targets:
- Correct coding for debridement (excisional or not)
  - DRG 263/MSDRG 573 and DRG 217/MS-DRGs 463, 464 and 465
- DRGs designated as complicated or having comorbidity with only one secondary diagnosis
  - DRGs 079, 416, 468, 475, 477 and 483
- Correct coding of discharge status for PAC transfer
- Unit Coding
  - grams vs. milligram,
  - number or procedures per day (e.g., appendectomy)

Medical Necessity Targets:
- Inpatient admissions for procedures that are eligible for outpatient surgery (e.g. laparoscopy, cholecystectomy)
- One-day stays
  - Chest pain
  - Back Pain: DRG 243/MS-DRG 551
- Three-day stays to qualify for SNF careg
- Inpatient rehabilitation (joint replacement patients)
Impact on Medicare Revenue

Percent of Hospital FY 2007 Medicare Revenue Impacted by RACs

- New York
- Florida
- California

- No Offsets: 60.4%, 43.4%, 23.2%
- 0% to 2.5%: 70.4%, 31.8%, 25.0%
- 2.5% to 5%: 5.0%, 2.0%, 5.2%
- 5% to 10%: 1.4%, 0.5%, 1.4%
- > 10%: 18.2%, 14%, 3.9%
RAC Rollout Schedule

- Demo evaluation report expected in late May or early June
- 4 new RACs announced early July
- CMS/RACs to conduct outreach to hospitals in first round of RAC rollout
  - 4-6 weeks if existing RAC
  - 8-12 weeks if new RAC
- RAC audits begin 4-6 weeks after CMS/RAC education with state hospital association
Implementation Timeline
Hospital View

- Hospitals strive for accuracy in service, billing, and coding
- Hospitals support program integrity efforts
- Lot’s of overlap by auditors
- RACs’ bad behavior unacceptable

**CMS Auditors**

- Fiscal Intermediaries (FIs)
- Carriers
- Medicare Administrative Contractors (MACs)
- Program Safeguard Contractors (PSCs)
- Comprehensive Error Rate Testing Program (CERT)
- Hospital Payment Monitoring Program (HPMP) (Run by QIOs)
- OIG Investigations
CMS Response to RAC Problems

- Staggered expansion of RACs
- Requirement for a web-based application by January 1, 2010
- Notification of target areas on RAC website
- No funds recouped during first 2 stages of appeals process, if denial appealed within 30 days
If appeal within 40 days – NO Recoupment

If denied, appeal must be filed within 120 days

If denied, appeal must be filed within 180 days

If denied, appeal must be filed within 60 days

If denied, appeal must be filed within 60 days

Provider must respond within 45 days to RAC (provider can request an extension). Claim is automatically denied if provider does not respond in 45 days.

If RAC has 60 days to make its determination

The appeals process can take 12-24 months per claim
CMS Response to RAC Problems with Medical Necessity Review

- Required to have a medical director
- Limits on the number of medical records a RAC can request per month
- New issue review process
- Audit of RAC performance
AHA Strategy

- Push CMS for administrative changes
  - Letters and continual discussions with CMS
  - RAC improvements for permanent program
- Push Congress for legislative relief
  - Advocacy – STOP and Fix-it
  - Capps-Nunes legislation (HR 4105)
- Member Education
  - Collaboration and education with state, metro and regional hospital associations
  - Member advisories and education
  - RACTrac: Collect data and examples of egregious behavior
RAC Legislation

H.R. 4105
The Medicare Recovery Audit Contractor Program Moratorium Act of 2007

- 87 Co-sponsors
  - (19R’s and 68D’s)
- 1-year Moratorium
- CMS Report
- GAO Study
CBO Score: $1 billion over 5 years

*Cosponsor list updated as of May 28, 2008*
Message to CMS and Congress

- **STOP and Fix-it**
- Slow down
- Reduce or remove contingency method of payment
- Exclude medical necessity from RAC review
- Reduce look-back to 12 months
- Centralized electronic tracking platform of RAC denials and appeals
- Exemption from “timely billing” rules
- Improved CMS management and transparency of RAC program
  - RAC and Provider education
- Bigger focus on UNDERpayments
AHA Resources on RACs

February 2008
The Honorable XXXX
U.S. House of Representatives
XXXX House Office Building
Washington, DC 20515

Dear Congressman XXXX:

I am writing to express my strong support for the Medicare Recovery Audit Contractor Program (MRA) and to ask that you cosponsor this important legislation.

Authorized by the Medicare Modernization Act of 2003, the Medicare Recovery Audit Contractor (RAC) program was established as a demonstration project in selected states (NY, CA, FL) to identify improper Medicare payments, both overpayments and underpayments. The flawed and troubled Care Act of 2006 made the RAC program permanent and authorized the Center for Medicare & Medicaid Services (CMS) to expand the program to at least 30 states by 2010. CMS already has expanded the program to South Carolina and Massachusetts, and as of March, 15 additional states are scheduled to begin the program. By January 2009, CMS plans to expand the RAC program to all 50 states.

Throughout the three-state demonstration, RACs have aggressively targeted provider payments with little administrative oversight from CMS. For instance, an independent review of a sample of California RAC records found that 40 percent were unsecured. In addition, a median payment of as much as 30 cents of every Medicare dollar recovered by the contractor has resulted in incentives for abusive behavior by RACs toward Medicare providers.

Despite these problems, CMS intends to continue to expand the program nationwide. (Some state AGs) are scheduled to close under RAC review in March/October 2008/January 2009. H.R. 4185, introduced by Rep. Lois Capps (D-CA) and Debbie Wasserman (R-CA), would place a moratorium on all RAC activities for a year, allowing CMS time to address ongoing problems with the overall RAC program while giving the Government Accountability Office the opportunity to evaluate the effectiveness of the program as a whole. CMS needs to slow down the implementation of the RAC program, and a moratorium would give the agency the opportunity to assess and evaluate how the demonstration has worked as well as provide time to make improvements in program operations. It is critical that the problems encountered during the demonstration program be resolved before the proposed nationwide roll out moves forward, including a much-needed, expansive program of provider education.

Thank you again for your attention to this important issue. I look forward to working with you on some of our most important issues of the day.

Sincerely,
Your RAC Data Is Key To Our Advocacy Efforts

- Understanding the impact of RACs on your hospital is key to our advocacy efforts
- AHA to launch RAC Data collection effort in Summer 2008 – RACTrac
- Secure, Online Data Collection Effort
- Key Goals:
  - Quantify the high administrative burden imposed by the RAC
  - Document the overturn rate
  - Provide information on trends in RAC activity (types of services, reasons for denials)
- To be successful in our efforts, we need to quantify the activity of the RACs and document our success in appeals
Prepare for RACs Today!

- Establish internal RAC team
  - Interdisciplinary Team: Coders, Finance, Clinical, Utilization Review, Case Management
- Identify RAC point of contact for internal and external RAC communications
- Develop a central tracking mechanism for all RAC correspondence
  - Incoming and Outgoing
- Conduct a self audit to identify potential problems
- Participate in RAC trainings
Rob Corrado, M.D., M.B.A., President & CEO
Executive Health Resources

John Joseph, Partner
Post & Schell and former Assistant United States Attorney
RACs: A Wake Up Call for Hospitals

- Requires that we identify/defend/correct past actions
- Also creates an “incentive” to implement future processes to avoid future problems

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Pros and Cons of Internal and External Counsel

- Attorney-Client Privilege
  - Most in-house counsel wear several hats
- White Collar expertise
  - Experienced investigators
  - Understand what OIG cares about
  - Existing relationship with government
- Enhanced credibility with law enforcement as “objective” outside party
The Legal Checklist

- Auditing?
  - UR Committee review?
- Case Managers
  - Trained case managers
  - Nurses?
- CM Protocol?
  - Are patients promptly screened?
  - Are physician advisors consulted?
- Interqual?
  - Up-to-date materials?
  - Observations status?

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Why is Getting Admission Status Correct Such An Important “Medical Necessity” Issue?

- Incorrect overuse of Inpatient
  - Inpatient short stays that are deemed not appropriate create a compliance and potential False Claims issue if no compliant process is in place
  - Eventual loss of revenue on audit and loss of opportunity for appropriate OBS APC and ancillary charge payment

- Incorrect overuse of Observation
  - Huge revenue loss of avg. $4-5K/medical case (millions of dollars a year)
  - Length of stay artificially elevated
  - Transfer DRG payment impact
  - Qualified stay impact on patient skilled care benefit
  - Unexpected patient financial responsibility & potential Stark violations
    - E.g.- self administered medication charges
  - Potential Limitation on Liability impact resulting in denial of ALL hospital reimbursement

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How Do Most Hospitals Manage Medical Admission Review?

- Decision to admit is made in the emergency room
- Admitting (or ED) Physician checks off a box – “Admit to Inpatient’ or “Admit to Observation” or writes an order
- Case or Utilization Management Nurse reviews case
- UR inpatient screening criteria are applied
- If case does not meet inpatient criteria, call sometimes made to treating physician to ask for more information

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How Do Most Hospitals Manage Medical Admission Review?

- Final claim certification made based solely on meeting or not meeting UR screening criteria without subsequent review with trained UR physician
- Little/no documentation as to this process in the chart
- Physician Advisor/UR Committee rarely gets involved while patient in house
- Rare that this process itself happens 7-days-a-week, 365-days-a-year

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Why All The Confusion?

- Most Case Managers use established screening criteria (as guidance suggests) to judge medical necessity.
- Criteria use Severity of Illness (SI) and Intensity of Service (IS) to establish medical necessity.
- Criteria are screening tools with high false positive errors (Approx 20%).
- Secondary Physician Review is REQUIRED.
Criteria Disclaimers

- (criteria) reflect clinical interpretations and analyses
- “cannot alone either resolve medical ambiguities of particular situations or provide the sole basis for definitive decisions.”
- “are intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services”
- “not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided to a patient.”

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So, who ultimately is in control of the admission review decision making process?
...The Physician!

- 42 CFR 482.12(c)(2)
  - “Patients are admitted to the hospital only on a recommendation of a licensed practitioner permitted by the State to admit patients to a hospital.”

- Medicare State Operations Manual
  - “In no case may a non-physician make a final determination that a patient’s stay is not medically necessary or appropriate.”

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What Are The Standards and Regulations Regarding Medical Necessity as Determined by the Physician?

Section 1879(a) of the Social Security Act (Limitation on Liability) provides where:

“(1) a determination is made that… payment may not be made under part A or part B of this title for any expenses incurred for items or services furnished an individual by a provider of services …, and (2) both such individual and such provider of services…did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such part A or part B, then to the extent permitted by this title, payment shall…be made…as though the coverage denial…had not occurred.”

42 CFR §411.406(e) provides

“that a provider that furnishes services that are not reasonable and necessary is considered to have known that the services were not covered if it is clear that the provider could have been expected to have known that the services were excluded from coverage on the basis of notification of PRO screening criteria specific to the condition of the beneficiary for whom the furnished services are at issue or its knowledge of what are considered acceptable standards of practice by the local medical community.”

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Medicare contractors, in determining what "acceptable standards of practice" exist within the local medical community, rely on published medical literature, a consensus of expert medical opinion, and consultations with their medical staff, medical associations, including local medical societies, and other health experts. "Published medical literature" refers generally to scientific data or research studies that have been published in peer-reviewed medical journals or other specialty journals that are well recognized by the medical profession, such as the "New England Journal of Medicine" and the "Journal of the American Medical Association." By way of example, consensus of expert medical opinion might include recommendations that are derived from technology assessment processes conducted by organizations such as the Blue Cross and Blue Shield Association or the American College of Physicians, or findings published by the Institute of Medicine.

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Best Practices for Admission & Continued Stay Review
(HPMP Compliance Workbook pg 33)

“Because it is not reasonable to expect that physicians can screen all admissions, continued stays, etc. for appropriateness, screening criteria must be adopted by physicians that can be used by the UM staff to screen admissions, length of stay, etc. The criteria used should screen both the severity of illness (condition) and the intensity of service (treatment). There are numerous commercial screening criteria available. In addition, some QIOs have developed their own criteria for screening medical necessity of admissions and procedures. CMS does not endorse any one type of screening criteria.”

“Cases that fail the criteria should be referred to physicians for review. For your UM program to screen medical necessity appropriately, the decision to admit, retain, or discharge a patient should be made by a physician, either through the use of physician approved or developed criteria, or through a physician advisor.”

Note that “physician approved or developed criteria” means an evidence based, literature backed, regulatory compliant protocol – not just an opinion.

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1st Level Criteria Screen vs. Physician Advisor Review

What if the patient was 75, female, has 4 cardiac risk factors including diabetes, a history of CAD status post stent placement a few months ago, is on an antiplatelet drug, also has sweats, and states the shortness of breath was similar to that when she had her NSTEMI that required stenting of her LAD post PTCA?

In this case, might “inpatient” be the correct setting???”

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Evaluating Potential Past Error & Validating Compliance Moving Forward
Do a PEPPER Analysis to Focus In On Potential Problem DRGs: Look at Volume & Denials

1. DRG 143 – chest pain
2. DRG 182 – esophagitis, gastroenteritis, and misc. dig disorders w/ cc
3. DRG 243 – medical back problems
4. DRG 296 – nutritional and misc metabolic disorder w/ cc
5. DRG 183 – esophagitis, gastroenteritis and misc dig disorders w/o cc
6. DRG 125 – circulatory disorders ex AMI, w card cath w/o comp
7. DRG 524 – transient ischemia
8. DRG 174 – GI hemorrhage w/ cc
9. DRG 127 – heart failure and shock
10. DRG 012 – degenerative nervous system disorder

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Do A Screening Criteria Review Audit

- Audit the accuracy of 1st Level criteria screen
  - Are our Case/Utilization Managers going outside the criteria?
  - Are we incorrectly applying the criteria?
Do A Secondary Review Audit

Example Audit Results

<table>
<thead>
<tr>
<th>1 Day IP Stays</th>
<th>Incomplete Documentation</th>
<th>Low Acuity</th>
</tr>
</thead>
<tbody>
<tr>
<td>N= 195</td>
<td></td>
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</tr>
<tr>
<td>Percent</td>
<td>21%</td>
<td>5%</td>
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</table>

<table>
<thead>
<tr>
<th>Observation Stays</th>
<th>Clear Evidence for Inpatient</th>
<th>Borderline Evidence for Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>N= 254</td>
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<tr>
<td>Percent</td>
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<td>28%</td>
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<tr>
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<td>72</td>
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</tbody>
</table>

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Review & Determine Reason for Past Process Failures & Ensure Updated Process Fix

- Common past problems:
  - CMs “making the call” outside criteria
  - CMs misapplying criteria
  - Confusion between private payor contractual and Medicare regulatory requirements
  - Attending Physician alone makes uninformed admission status determination
  - Poor communication between those making medical necessity status determinations and those submitting the claim

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Recognize that this is about daily tactics:

- Case Management strictly applies inpatient admission criteria to 100% of Medicare cases placed in a hospital bed and documents this review in an auditable format.
- ALL cases that do not meet inpatient criteria (regardless of admission order status) are referred to a Physician Advisor who is an expert in CMS rules and regulations and clinical standards of care.
- Physician Advisor reviews case, speaks with admitting physician when needed, renders final decision based upon UR Standards and documents decision in auditable format on chart or in UR documentation.
- Attending Physician changes order as appropriate.
- Must run 7-days-a-week/365-days-a-year
- Must audit Case Management & Physician Advisor decision making process regularly and provide education/remediation as necessary.

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Aggressively Manage Your Rights of Appeal

- Concurrent admission review process provides SSA protections
- Appeal process familiarity is key
- Appeal whenever possible on Medical Necessity
- Keep up-to-date on applicable points of law
- Establish focused admin & physician appeal expertise
- Work closely with AHA & other orgs to collect experience data

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Ten Techniques to Achieve Medicare Review Compliance & Audit Preparedness

1. Do an audit looking critically at observation and one day stays- use your PEPPER data
2. Confirm that 100% of cases are being reviewed by case management (many times we just think this is happening) & ensure (thru audit) appropriate use of UR screening criteria
3. Support case manager first level review occurring as close to time of admission H&P as possible & 7-days-a-week during peak hours
4. Have a trained Physician Advisor Team 7 days a week, 365 a year to provide second level review & create an enduring & auditable document of the process that lives in the chart

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Ten Techniques to Achieve Medicare Review Compliance & Audit Preparedness (cont’d)

5. Have the UR committee create policy consistent with the daily regulatory review requirements guidance and create a retrospective review policy for high risk DRGs
6. Tell the QIO and MAC about your compliant & valid process – invite their cooperation as you implement
7. Run a report on how procedures are being classified- share this with your surgeons and work on how to separate Medicare and Medicaid classification and create an airtight process
8. Stop trying to teach physicians what observation means – and start having your physician advisors assist them (at the time of patient care) to appropriately document their expectations and concerns.

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9. Regularly review your PEPPER report with Case Management, HIM/Coding, Finance and Compliance – and do a reality check before taking any action

10. Educate Case Management about Medicaid policies on short stays and treat Medicaid Compliance as seriously as you do Medicare Compliance

BONUS: Reward those who identify cracks in the system – because they are there!!! Remember, careless ignorance is reckless disregard.
False Claims Provisions

  - 3 x single damages **PLUS**
  - $5,500 to $11,000 penalty PER False Claim, **PLUS**
  - Attorneys’ fees, if it is a *qui tam* suit

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False Claims Provisions

- Liability if:
  - "Knowingly" submitted, or caused to be submitted a false claim for payment or approval by the government
  - Knowingly = Reckless Disregard
  - Standard of Proof = Preponderance of the Evidence

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Whistleblowers

- Qui Tam Provisions allow:
  - Private citizens to bring an action on behalf of the government
  - The actions need not be based on first-hand information
  - The “relator” can recover up to 30% of the recovery, plus attorneys’ fees

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Case Study:
A Hospital Experience
Useful Compliance Publications

- CMS 2007 RAC Status FY 2007
- Appendix 3 – RAC Expansion Schedule 11-7-07
- Revised Statement of Work RAC Program 11-7-07
- GAO report on QIO accuracy
- RAC report on First Year
- Legislation Expanding RACs
- Medlearn Matters on Condition Code 44
- Medicaid Integrity Program legislation
- Expansion of Admit to Case Management Protocol Article
- Surgical Setting Report Template
- Transfer DRG White Paper
- To access the Compliance Library, log onto www.ehrdocs.com, select Resource Center, Compliance Library

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Questions?

Thank you for participating in this educational event. Do you have any questions for our panel?
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Rob Corrato, MD, MBA: Dr. Corrato founded EHR in 1997 and has since served as EHR's President and Chief Executive Officer. Prior to founding EHR, Dr. Corrato held the post of Deputy Director of the Office of Health Policy and Clinical Outcomes at Thomas Jefferson University, Philadelphia, Pa. An internist with extensive outpatient, inpatient, academic and community-based clinical practice experience, he is one of only six physicians in the U.S. to have completed medical fellowship training in managed care/administrative medicine. Dr. Corrato often serves as a featured speaker at healthcare industry events, has been published in leading healthcare journals, including the Journal of the American Medical Association, sits on the editorial boards of numerous healthcare publications, and has served as a peer reviewer for the Annals of Internal Medicine. Dr. Corrato earned his MBA from the Wharton School of Business at the University of Pennsylvania and received his medical degree from the Medical College of Pennsylvania.
About Executive Health Resources

EHR® received the elite Peer Reviewed designation from the Healthcare Financial Management Association (HFMA) for its suite of Medicare and Medicaid Compliance Services, including Medical Necessity Certification, Continued Stay Review and Denial Review and Appeal.

The American Hospital Association has exclusively endorsed Executive Health Resources’ Medicare Compliance Management, Length of Stay Management, Retrospective Clinical Denials and Concurrent Clinical Denials Programs.
**Featured Speaker**

**Don May:** Don May is Vice President for Policy at the American Hospital Association. Don directs the AHA’s policy development activities for Medicare and Medicaid funding of hospitals and health systems. Prior to joining the AHA, he was a Senior Manager with The Lewin Group where he managed projects with the AHA and other state and national associations on topics such as the impact of the BBA, trends in hospital financial performance, Medicaid payment adequacy, and community health. Prior to joining The Lewin Group, Don served as Assistant Hospital Program Administrator for the Ohio Medicaid Program. Don has his Master’s in Public Administration from the Ohio State University and a Bachelor’s in Political Science from Ohio University.
Featured Speaker

**John Joseph:** John Joseph is a partner at Post & Schell in the firm's White Collar Defense, Compliance & Risk Management Practice Group and former Assistant United States Attorney. He possesses extensive complex investigation and trial experience in significant civil and criminal cases. His area of practice includes White Collar Defense, Compliance and Risk Management; Health Law; Environmental Regulation and Litigation; and Business Law and Litigation. In 1998, Mr. Joseph became Deputy Chief, Affirmative Litigation for the Civil Division of the U.S. Attorney's Office for the Eastern District of Pennsylvania, supervising all litigation brought under the federal False Claims Act, including healthcare and defense contractor qui tam actions. He also served on DOJ’s National Fraud Working Group, setting policy and conducting training for the department’s nationwide efforts to fight corporate and national healthcare fraud. Mr. Joseph’s prosecutorial credits include a $16 million healthcare fraud settlement with a national dialysis provider for over-utilization claims. Mr. Joseph has been widely published on healthcare-related fraud and compliance topics.
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