AFFORDABLE CARE ACT FRAUD & ABUSE PROVISIONS EVERY PHYSICIAN SHOULD KNOW ABOUT

On June 28, 2012 the United States Supreme Court issued its long awaited Decision regarding the constitutionality of the Patient Protection and Affordable Care Act (“ACA”). The Court decided that, under Congress’ taxing power, the individual mandate requiring most Americans to maintain “minimum essential” health insurance coverage is constitutional. The Court rejected the position that the individual mandate could be justified as an exercise of Congress’ power to regulate commerce. The more significant ruling, however, was the Court’s decision that –while affirming the expansion of the Medicaid program as an exercise of Congress’s spending power— Congress did not have the power to cut off Medicaid funding for states that refused to comply with ACA’s eligibility rules.

The Supreme Court’s ruling resolved uncertainty about whether ACA would continue to be the law of the land in the short term. Physicians must be aware of certain key ACA fraud and abuse provisions as follows:

1. No Actual Knowledge or Specific Intent Necessary to Violate Anti-kickback Statute. ACA amends the federal Medicare/Medicaid Anti-Fraud and Abuse Statute to lower the criminal intent standard for violation of the Anti-Kickback Statute. The Anti-Kickback Statute prohibits the knowing and willful offer and acceptance of remuneration in cash or in kind to induce the referral of patients for the furnishing of items or services reimbursed by Medicare or Medicaid. ACA Section 6402(f)(2) provides that, “a person need not have actual knowledge of this section or specific intent to commit a violation of section.” Furthermore, ACA Section 6402(f)(1) provides that claims arising out of violations of the federal Anti-kickback statute violations constitute false claims under the federal False Claims Act.

2. 60 Day Deadline for Reporting/Returning CMS Overpayments. Pursuant to ACA Section 6402, providers that receive a Medicare or Medicaid overpayment are required to report and return the overpayment to Centers for Medicare and Medicaid Services (CMS), the State, an intermediary, a carrier or contractor, as appropriate and notify CMS, the state, an intermediary, a carrier or contractor to whom the overpayment was returned in writing of the reason

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of the overpayment. All overpayments must be reported and returned by the later of 60 days after the date on which the overpayment was identified or the date any corresponding cost report is due. Those found in violation are deemed to have filed a false claim under the False Claims Act. Liability under the False Claims Act includes treble damages, plus penalties up to $11,000 per false claim. False claims also generate liability of $10,000 per claim under the Civil Monetary Penalties law, and could also result in exclusion from participation in federal healthcare programs.

3. Medicare Self Referral Disclosure Protocol (SRDP). Section 6409(a) of ACA requires the Department of Health and Human Services (HHS), to establish a SRDP that sets forth a process to enable providers of services and suppliers to self-disclose actual or potential violations of the physician self-referral statute, i.e. Section 1877 of the Social Security Act (42 U.S.C. 1395nn) (“ Stark”) . The general provisions of Stark are as follows:

(a) Prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies;

(b) Prohibits the entity from presenting or causing to be presented claims to Medicare (or billing another individual, entity, or third party payer) for those referred services; and.

(c) Establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse.

DHS Includes, but is not limited to clinical laboratory services, imaging services, DME, home health services, and inpatient and outpatient hospital services.

The SRDP is intended to facilitate the resolution of only matters that, in the disclosing party's reasonable assessment, are actual or potential violations of Stark.

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The Clark County Medical Society, established in 1955, is the local affiliate of the Nevada State Medical Association.

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Thus, a disclosing party should make a submission under the SRDP with the intention of resolving its overpayment liability exposure for the conduct it identified. As provided in the physician self-referral law, no payment may be made for DHS that are provided in violation of Stark.

The SRDP was revised on May 6, 2011, to clarify that in addition to reporting the actual or potential amount due or owing, the SRDP now requires that as part of the initial submission to CMS, disclosing parties should provide the total amount of remuneration a physician(s) received as a result of an actual or potential violation(s) during the applicable "look back" period.

(d) Expansion of the Recovery Audit Contractor (RAC) Program. Section 6411(a) of the ACA amended section 1902(a) (42) of the Social Security Act to require that States and territories establish Medicaid Recovery Audit Contractor (RAC) programs by December 31, 2010. States are required by statute to contract with one or more RACs to identify overpayments and underpayments and to recover overpayments from Medicaid providers.

(e) Disclosure of Certain Self-Referred Imaging Services. Under ACA Section 6003, physicians who order MRI, CT, and PET services to be performed within their group practice in reliance on the Stark in-office ancillary services exception are required to inform their patient in writing that the services can be obtained elsewhere, and must provide patients with a list of suppliers of imaging services.

(f) New Requirements for Physician Owned Hospitals. Under ACA Section 6001(a)(3), beginning January 1, 2012, any hospital with a physician owner must annually disclose the identity of each physician owner to HHS and ensure that referring physician-owners disclose their ownership interest to their patients prior to admission.

(g) January 1, 2014 Improvements to the Physician Quality Reporting System. Pursuant to the Physician Quality Reporting Initiative, eligible professionals who satisfactorily report data on specified quality measures can receive an incentive payment. Section 3002, ACA extends these incentive payments through 2014. Beginning in 2014, eligible professionals who do not satisfactorily submit quality information will face a penalty in the form of percentage reductions in reimbursement rates.

(h) Eligibility Certifications for Home Health Services and DME. For certifications made after April 1, 2011, under ACA Section 6404, physicians must document that they had a face-to-face encounter with the Medicare or Medicaid beneficiary prior to issuing a certification for home health services and/or DME.

There are specific time constraints with respect to the face-to-face encounters.

While the future of ACA is still uncertain, there is no doubt that development and enforcement of fraud and abuse provisions related to the Medicare and Medicaid programs will continue. Physicians are, therefore, wise to understand fraud and abuse law and implement compliance programs.

By Constance L. Akridge, partner with the Holland & Hart law firm in the areas of Insurance Regulation and Health Law. She is the Immediate Past President of the State Bar of Nevada.

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