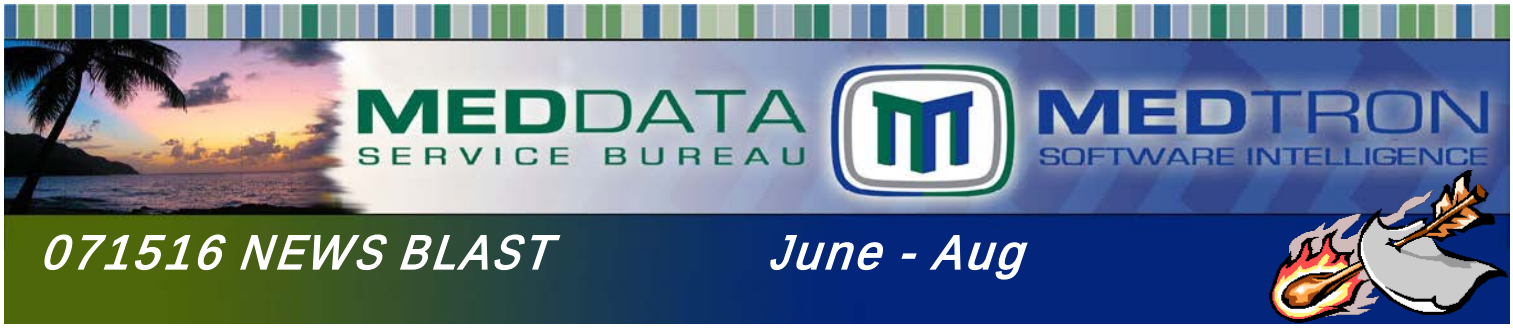

FALSE CLAIMS ACT & MID-YEAR OFFICE OF INSPECTOR GENERAL (OIG) WORK PLAN

FALSE CLAIMS ACT

A Supreme Court decision last month; on the applicability of the False Claims Act may encourage prosecutors to come after providers for fraud not directly related to Medicare regulations — including such seemingly irrelevant errors as failing to maintain proper licensure on Non-Physician Practitioners (NPPs).

Universal Health Services v. United States ex rel.Escobar, for which the Supreme Court issued a ruling on June 16, in which the case turned on whether a health care entity accepting federal money could be held in violation of the False Claims Act on the basis of violations that were not directly related to federal conditions of payment on a claim, such as the staff's licensure, via "implied false certification." Implied false certification, Justice Clarence Thomas explained in his decision on behalf of a unanimous Court, obtains if a claim "fails to disclose the defendant's violation of a material statutory, regulatory or contractual requirement," and ruled that this "does not turn upon whether those requirements were expressly designated as conditions of payment."

In other words, a provider may have provided the service correctly, but if the practice was in violation of federal or other legal standards at the time of the service — think state medical professional licensing requirements, for example — a prosecutor might find the claim fraudulent on that basis. A concern exists that under the Escobar that conditions of participation, not just conditions of payment, are grounds for [False Claims Act]. That means the facility's exposure, depending on how 'intent' is interpreted, is practically unlimited. Violations that might once have only resulted in a fine and a corrective plan might now be grounds for a false claims charge. It is suggested that providers should watch not only the licensure of their NPPs, but also their incident-to supervision. In addition, If a provider believes they might be out of compliance on anything — including certification of your medical equipment, handling of medical waste, DEA regulations, etc. — act on it.

MID-YEAR OFFICE OF INSPECTOR GENERAL WORK PLAN

Revisions and new items added to the HHS Office of Inspector General's 2016 Work Plan as part of the mid-year update are more likely to hit hospitals and home health agencies than physician practices, but there are still a handful of key changes that affect physician groups. The biggest revision in the mid-year update might be what is going away — the OIG completed its review of the early results of enhanced screenings for enrollment applications in April, and the findings suggest the agency is likely to continue to scrutinize applications closely. Enhanced screening, which was performed in 2012 and 2013 and included review of physicians and non-physician practitioners for a past history of overpayments, reduced total applications for enrollment and increased the rate of approval, signs to CMS that its efforts are deterring fraudulent enrollment applications.

Other changes impacting physician practices…

- The OIG will review the number of provider-based facilities owned by hospitals and whether CMS has the ability to effectively oversee provider-based sites, which often include physician groups owned and operated by hospitals. Medicare payments for services at provider-based clinics are often higher than for the same service at an office-based clinic, including higher patient co-insurance costs. The Medicare Payment Advisory Committee (MedPAC) has recommended CMS look for ways to equalize the payments.

- Review of the new payment system for clinical diagnostic lab tests, which is based on the payments made to laboratories by private payers, rather than the previous Medicare Clinical Lab Fee Schedule.

- Assess the approval process of Medicare Administrative Contractors (MACs) use when determining whether to cover "off-label" uses of Part B drugs. Medicare generally covers drugs based on the label indications, but the MACs have latitude to add additional coverage; and the OIG wants to ensure Medicare is not paying for drug usages that are not universally accepted.

- Assess if CMS assigned patients to the right accountable care organizations (ACOs) as part of shared savings programs. This review also aims to ensure that Medicare is not making duplicate payments for the management of the same patient's conditions in shared savings programs.

Contact Software Support for assistance or any questions via:
From **MED**PM or **MED**EHR Sign On screens, double click on 'support@medtronsoftware.com' to compose an email to the Software Support Dept.
-OR-
Phone: (985) 234-0599 (local)
(800) 978-0599 (toll free)
-OR-
Fax: (985) 234-0609