

Health Law ADVISORY

Current legal insights for health care executives

February 27, 2009
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The “Everything You Need to Know About RAC Audits” Series - First Installment: History and Basic System

The RAC Expansion Schedule shows RACs coming to Iowa and Nebraska in August, 2009. A series of articles on RACs and RAC Audits will be published in the Baird Holm Health Law Advisory over the next several months, as providers prepare to be held accountable for Medicare billings under this system. The Baird Holm website will contain archived editions of the Health Law Advisory to be used as a research file as RAC questions arise.

- Recovery Audit Contractors (RACs) were established by Congress as a 3-year demonstration project in California, New York and Florida, beginning March 2005.
- The objective was to create a cost-effective means of identifying Medicare under- and overpayments, and recovering overpayments.
- In FY2007, \$371.5M in improper Medicare payments were identified from among claims made October 1, 2002 through September 30, 2006.
 - \$247.4M were recovered to the

Medicare Trust Fund.

- RAC costs for the project were \$77.7M.
- 85% of the Medicare recovery was from inpatient hospitals.
- Only 4% of improper payments were underpayments (\$14.3M).
- The Tax Relief and Health Care Act of 2006 required HHS to make the RACs permanent and nationwide by 1/1/2010.
- CMS divided the US into four regions, and solicited proposals by private contractors to be awarded RAC contracts for each region.
- RACs are paid on a contingency fee for identifying under-and overpayments.
- RACs were selected based on:
 - Level and quality of claim analysis and detail.
 - Exceptional customer service.

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- Conflict of interest reviews.
- Lowest contingency fee.
- RACs have been selected, but the bid process has been challenged retrospectively.
- New RAC requirements based on retrospective evaluation of demonstration project:
 - Must employ a medical director to assist in claims review.
 - Types of issues under review will be listed on RAC websites.
 - Ongoing outreach efforts will be monitored so that no provider feels unreasonably burdened.
- Focus of RAC efforts:
 - Incorrect payment amounts (except where CMS directs RACs otherwise).
 - Noncovered services (including those not reasonably necessary).
 - Incorrectly coded services (including DRG miscoding).
 - Duplicate services.
- Not subject to RAC review:
 - Services provided under a program other than Medicare fee-for-service.
 - Cost report settlement process.
 - Claims more than 3 years past the initial determination date.
 - Claims paid dates earlier than 10/1/2007.
 - Claims where provider is without fault.
- Random selection of claims.
- Claims with special processing numbers.
- Prepayment review.
- Medicare policies guiding RACs:
 - National coverage determinations (NCDs).
 - Coverage provisions in interpretive manuals.
 - National coverage and coding articles.
 - Local coverage determinations (LCDs).
 - Local coverage/coding articles in their jurisdictions.
 - Relevant joint signature memos supplied by CMS.
- There are two types of RAC reviews:
 - Automated Review: Claim determination at the system level without human review of medical record.
 - Complex Review: Human review of medical record is included.
- Automated Review used when:
 - Service clearly not covered or incorrectly coded; and
 - A written Medicare policy, article or sanctioned guideline exists.
 - Or “clinically unbelievable” issue.
- Complex Review used when:
 - Automated Review requirements not met; and

RACs have been selected, but the bid process has been challenged retrospectively.

- High probability (not certainty) that service is not covered; or
- No Medicare policy article or sanctioned coding guideline exists.

Barbara E. Person

This language was in line with CMS’s preamble commentary to the provider-based rules interpreting the phrase “on hospital premises” to include “on campus” provider-based departments. Thus, CMS extended its policy of finding sufficient physician supervision existed in on campus provider-based departments regardless of whether there was actual physician presence in the department at the time the service was being rendered:

“We assume the physician supervision requirement is met on hospital premises because staff physicians would always be nearby within the hospital. The effect of the [provider-based regulations] is to extend this assumption to a department of a provider that is located on the campus of a hospital.”²

Although dubbed a “clarification,” in the final 2009 Outpatient Prospective Payment System (“OPPS”) rulemaking, CMS reversed its policy in this matter. As a result, CMS’s interpretation of the phrase “on hospital premises” in connection with physician supervision no longer includes on campus provider-based departments. CMS’s new position is that, in order for the physician supervision standard to be satisfied in an on campus provider-based department, the supervising physician must satisfy the traditional “direct supervision” standard. That is, the physician must be physically present at the provider-based location when the therapeutic service is performed.

CMS’s commentary on the new OPPS rule states:

“[W]e require direct supervision for therapeutic services provided in the hospital or in provider-based

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CMS Policy Reversal - Physician Supervision for Therapeutic Services Provided in On Campus Provider-Based Locations

As recently as the fall of 2008, the Medicare Benefit Policy Manual stated that, with regard to outpatient therapeutic services performed “incident to” physician services by hospital staff, “[t]he physician supervision requirement is generally assumed to be met where the services are performed on hospital premises.”¹

¹ Publication No. 100-02, Medicare Benefit Policy Manual, 100-002, Chp. 6, § 20.5.1

² 65 FR 18525 (April 7, 2000)

departments of the hospital. . . .
The definition of direct supervision in § 410.27(f) requires that the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. . . . This means that the physician must be present in the provider-based department.”³

Mandatory Arbitration Provisions in Nursing Facility Resident Contracts

As a result of this change in policy, if there is not a physical physician presence in on campus provider-based departments at all times that therapeutic services are provided, the service will be deemed to be medically unreasonable and unnecessary, and a provider may not be eligible for reimbursement for those therapeutic services.

This policy only affects outpatient therapeutic services provided “incident to” a physician’s service. It does not impact physical therapy, occupational therapy or speech-language pathology or ESRD services furnished to hospital outpatients. Thus, depending on providers’ current policies and practices regarding physician supervision levels in on campus provider-based departments, this reversal in policy may significantly impact the operations, the cost effectiveness and feasibility of providing therapeutic services in on campus provider-based departments.

Andrew D. Kloeckner

Many nursing facilities have not included mandatory arbitration provisions in admission agreements with their residents. Nursing facilities should consider such provisions to decide whether their possibly significant benefits outweigh their disadvantages.

Two recent judicial decisions, one from Missouri and one from Nebraska, make it especially timely for nursing facilities to consider arbitration provisions for their resident contracts.

The Missouri case highlights a potential shortcoming such provisions may suffer if poorly drafted or improperly presented to residents--a court may deem the provisions invalid because they are “unconscionable.”

Historically, a contract was considered unconscionable if its provisions were the result of unequal bargaining power and were so onerous that no one with a genuine choice and possession of his or her senses would agree to them. Such unconscionability sometimes arises when the party with the stronger hand drives too hard a bargain. The Missouri Supreme Court evaluated whether the son of a deceased resident should be compelled, as provided in the resident admission contract, to arbitrate a claim alleging wrongful death.

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³ 73 FR 68704 (November 18, 2008)

Although the court decided the case on a legal theory unrelated to the enforceability of the provision, one of the justices wrote a separate opinion expressing his view that the admission contract's requirement that all personal injury claims be arbitrated was "unconscionable." Although the justice observed that the decision to place an individual in a nursing facility is often emotional, a key legal point in his view was that "an average individual seeking nursing home care would not reasonably expect" that any personal injury claims arising out of the facility's care would be arbitrated, rather than litigated in court.

This does not mean that nursing facilities' arbitration agreements with residents are always unenforceable. On the contrary, federal laws governing interstate commerce specifically favor arbitration of disputes and call for upholding mandatory arbitration provisions except in cases where the contract itself could be invalidated (e.g., fraud, duress, or unconscionability). A nursing facility desiring to include an arbitration provision in its resident contracts should explain the provision to each resident or the resident's legally authorized representative before the contract is signed.

The Nebraska case referred to state law regarding arbitration clauses. Although this judicial ruling did not involve a nursing facility, it serves as a reminder that Nebraska contracts are more likely to be enforceable if they contain certain cautionary language, in all capital letters "adjoining the signature block" of the contract. The Nebraska Supreme Court did not require such a caution in a contract involving interstate commerce. But a nursing facility should not assume its services will be considered to involve interstate commerce and instead should increase its chances of enforcing an arbitration provision with its resident by including the properly-worded cautionary statement.

Why might a mandatory arbitration provision benefit your nursing facility? First, mandatory arbitration provisions help forestall litigation by parties hoping to "hit the jackpot" by suing a facility over a supposed personal injury, selecting a pro-plaintiff jury, and obtaining a verdict much larger than most objective observers would award or under circumstances that most juries would find favor the facility. Second, in many situations, arbitration is an efficient alternative to potentially expensive and protracted jury litigation.

Nursing facilities that desire mandatory arbitration should draft such provisions carefully. The mandatory arbitration provisions should include only those disputes for which arbitration is likely to be beneficial. For example, because many disputes arise from straightforward debt collections of money owed to the facility by the resident, the facility probably should exclude payment disputes from the scope of an arbitration provision.

A knowledgeable lawyer can help with drafting an arbitration provision and procedures to implement it. Such procedures should take into account state law and federal Medicare and Medicaid regulations, as applicable. For appropriate types of matters, your nursing facility can benefit by obtaining what often is a quicker resolution through binding arbitration, in contrast to a long and expensive "day in court."

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