

Health Law ADVISORY

Current legal insights for health care executives

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Julie A. Knutson, Editor

The Fraud Enforcement Recovery Act of 2009

The Fraud Enforcement Recovery Act (FERA) has been passed by both houses of Congress and is expected to be signed by President Obama. The Act includes a number of amendments to the civil False Claims Act (FCA); the first significant amendments since 1986. The Act also includes financial and other enhancements to government enforcement of the civil FCA in the form of an additional \$245 million per year over the next two years to hire additional investigators, prosecutors, forensic analysts and support staff to “rebuild” white collar enforcement capacities. Although FERA was part of the flurry of legislation related to the economic crisis and various “recovery” bills directed to mortgage lenders and financial institutions, it is expected to have a significant effect on health care providers as well.

The greatest impact on health care providers is likely to be the amendments to the FCA (31 U.S.C. § 3729) which would reverse two important court rulings which have provided defenses for contractors under government FCA prosecutions. FERA also amends criminal money laundering statutes (18 U.S.C. § 1956-57). Senator Patrick

Leahy’s¹ office released a statement about the legislation which explained in part that FERA would:

“--Amend the criminal money laundering statute to make clear that the proceeds of specified unlawful activity include the gross receipts of the illegal activity, and not just the profits of the activity; [and]

--Improve the FAC to clarify that the Act was intended to extend to any false or fraudulent claim for government money or property, whether or not the claim is presented to a government official or employee, whether or not the government has physical custody of the money, and whether or not the defendant specifically intended to defraud the government.”

FERA also amends the scope of the international money laundering statute to include tax evasion. The money laundering case is *United States v. Santos*, 128 S.Ct. 2020 (2008) which limits the scope of current money laundering statutes to the “profits” of illegal activity, rather than to all proceeds derived from the alleged misconduct.

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¹ Senator Chuck Grassley and Senator Patrick Leahy introduced FERA in the Senate.

Significantly, the amendments to the FCA would overturn the holdings of the courts in *Allison Engine Co. v. United States ex rel. Sanders*, 128 S.Ct. 2123 (2008) and *United States ex rel. Totten v. Bombardier Corp.*, 380 F.3d 488 (D.C. Cir. 2004) which provided defenses based on lack of “presentment” of the claim to the government. In *Allison Engine*, the Court held that Section 3729(a) (2) of the FAC requires the government to prove that the defendant must have intent for the Government itself to pay the claim in order for there to be a violation of the Act, e.g., no FCA liability when an allegedly false claim was submitted to a contractor rather than directly to the government. The Court in the *Totten* case held that there is no FCA liability unless the claim is “presented to an officer or employee of the United States Government,” not merely to a government grantee.

The increased resources and legal changes initiated under FERA are expected to result in significant financial recoveries that will more than pay for the costs of the Act. The Congressional Research Service reported that, in FY 2007, the Government recovered \$2 billion in settlements and judgments in FCA cases, with more than 75% of the recoveries coming from health care entities.²

Julie A. Knutson

Changing EEO Landscape

Recent changes to the Americans with Disabilities Act (ADA) and other federal employment laws, coupled with the current economic situation, have increased the

potential for discrimination claims filed with state and federal agencies following an adverse employment action against an employee. When an employer receives a charge of discrimination filed with the Nebraska Equal Opportunity Commission (NEOC), the U.S. Equal Employment Opportunity Commission (EEOC), or another administrative agency, any information and/or admissions that are part of an initial response by the employer during the administrative process can be used against them in the event of a lawsuit, all too often to the employer’s detriment.

These changes to federal law make it increasingly difficult and risky for employers to respond to charges of discrimination without the advice of counsel. One undesirable result is that the charge will not be resolved at an administrative level and will result in a lawsuit due to flaws in the management of the initial responses to the charges. This article provides an overview of some of the important changes to federal law in employment matters that employers need to know about *now*.

Overview

The perfect place to begin is with an understanding of equal employment laws. In particular, the following legislation protects certain eligible employees from discriminatory acts:

1. Title VII of the Civil Rights Act of 1964 (race, color, religion, sex, national origin)
2. Pregnancy Discrimination Act (amended Title VII)
3. Age Discrimination in Employment
4. Older Workers Benefit Protection Act
5. Anti-Retaliation provisions
6. Americans with Disabilities Act
7. Equal Pay Act

There have been significant changes in the landscape of employment discrimination laws in the last year and within even the last

The Congressional Research Service reported that, in FY 2007, the Government recovered \$2 billion in settlements and judgments in FCA cases, with more than 75% of the recoveries coming from health care entities.²

² CRS Report For Congress , November 6, 2008, *quoting* Robert Wolin and B. Scott McBride, *The Feds Pick Up a New Cudgel*, National Law Journal (August 11, 2008).

few months. This article focuses on two distinct laws—both of which were effective in January 2009.

ADAAA

On January 1, 2009, the ADA Amendments Act (ADAAA) went into effect, making sweeping changes to the Americans with Disabilities Act of 1991 and overturning U.S. Supreme Court decisions which limited the scope of the law. Congress sent a clear message in passing the ADAAA that courts must construe the ADA broadly and provide more employees with protection. Under the new law, millions more employees will be considered disabled, resulting in an even greater burden on employers to accommodate employees in the workplace.

With the amendments to the ADA, employers will undoubtedly see an increase in disability-related litigation because more employees will be considered disabled. Now, more than ever, employers and their managers/supervisors need to be aware of ADAAA requirements and take a proactive approach by addressing policies and practices impacted by the changes. The amendments make clear that the Congressional intent is “that the question of whether an individual’s impairment is a disability under the ADA should not demand extensive analysis.” Instead courts should give primary attention to “whether employers have complied with their obligations under the ADA.”

The key changes under the ADAAA are: (i) courts may no longer take into account the ameliorative effects of mitigating measures in determining if an individual has a “disability,” (ii) an impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active, (iii) an impairment that substantially limits one major life activity need not limit other major life activities to be a disability, and (iv) the list of “major life activities,” previously included only in the EEOC’s regulations.

This means that the ADAAA will invalidate numerous court decisions, including those that have held that an impairment such as diabetes may not be a “disability” if the symptoms of the diabetes are controlled by insulin or that monocular vision is not a disability if the individual is no longer limited because she has adapted to the use of one eye. The law does, however, make clear that courts may still take into account mitigating measures of ordinary eyeglasses and contact lenses.

For the first time, the statute lists “major life activities” and “major bodily functions,” which include activities such as “bending,” “concentrating,” and “thinking.” The impact of this statutory list will undoubtedly be to increase the number of individuals considered to have a disability.

Even before the effective date of the ADAAA, the Equal Employment Opportunity Commission (EEOC) received 19,453 charges of disability discrimination and resolved 15,708 disability discrimination charges, recovering \$57.2 million in monetary benefits for charging parties and other aggrieved individuals (not including monetary benefits obtained through litigation). <http://www.eeoc.gov/types/ada.html>. Employers must be diligent in continuing to engage in the interactive process with employees who request reasonable accommodations and should not be quick to dismiss a request because of skepticism over whether the employee has an actual disability. Questionable situations regarding whether or not an employee has a disability should be resolved in consultation with legal counsel in view of these expanded definitions.

Lilly Ledbetter Fair Pay Act

On January 29, 2009, President Barack Obama signed into law the “Lilly Ledbetter Fair Pay Act,” Pub. L. 111-2. This Act amends Title VII and the Age Discrimination in Employment Act (ADEA) to declare that an unlawful employment practice occurs not only upon

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adoption of a discriminatory compensation decision or practice *but also* when the individual becomes subject to the decision or practice as well as each additional application of the decision or practice. This Act came as a direct response to the Supreme Court's decision in *Lilly Ledbetter v. Goodyear Tire and Rubber Co.*, 550 U.S. 618 (2007), *overturned by* Pub. L. 111-2 (Jan. 29, 2009), where the Court held that even though the plaintiff was paid progressively less than the men in her same position over a 19-year period, the later effects of a past wage discrimination claim do not restart the clock for filing an EEOC charge, and, therefore, because the plaintiff did not file an EEOC charge after the discriminatory pay decision, her claims were time-barred. The Lilly Ledbetter Fair Pay Act overturned this decision and provides that the statute of limitations period for filing an equal-pay lawsuit regarding pay discrimination "resets" with each new discriminatory paycheck; significantly extending the statute of limitations period.

This Act has also raised serious concerns about record retention. Typically, employers destroy employment records after a set period of time keyed to previous understandings of the statute of limitation. With the extended statutory period in which to file a lawsuit provided by this Act, employers may have destroyed the documents necessary to defend against an act of alleged discriminatory pay that occurred after the traditional retention periods.

Spike in EEO Charges

In January 2009 alone, the changes in employment laws brought about strictly by the ADAAA and the Lilly Ledbetter Fair Pay Act will have a significant and long-term impact on health care employers. Because of the changes in these laws and the current economic situation that has lead to numerous lay-offs and discharges, health care employers will see an increase in the number of EEOC or NEOC charges of discrimination. Increases in charges of

discrimination, tends to lead to increased numbers of cases proceeding to trial accompanied by increased defense costs even if the employer is ultimately absolved of any wrongdoing. There are certain steps that health care employers should take to prepare and defend against these types of charges/lawsuits:

- Make sure employment policies and procedures are up to date;
- Review and update job descriptions;
- Train managers/supervisors about existing and changing employment law;
- Document the interactive process for disability claims;
- Document signed statements regarding inappropriate conduct by employees;
- Address claims of harassment immediately and appropriately;
- Document the reasons for the termination and the supervisors/co-workers involved; Do not make careless admissions in the administrative process that can harm the employer later; and
- Seek legal counsel early when in doubt.

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Teleradiologist Credentialing - A (Still) Unsettled Issue

In the January 30, 2009 edition of the *Health Law Advisory*, we described current requirements for credentialing

teleradiologists and other telemedicine providers. The requirements can be burdensome because that the “proxy” credentialing option offered by the Joint Commission for general acute care hospitals is not permitted by the CMS Conditions of Participation for (Acute Care) Hospitals as stated in a 2004 Survey & Certification Letter. The Joint Commission similarly permits proxy credentialing by Critical Access Hospitals (CAHs). Although the CMS Survey & Certification letter does not apply to CAHs, the CAH Conditions of Participation set out a number of provider credentialing requirements with no option of proxy credentialing, leading us to conclude that the CMS rule applies to both acute care and critical access hospitals.

“Proxy” credentialing generally permits the site where the patient is located (the “originating site”) to accept the credentialing of the site where the telemedicine practitioner is located (the “distant site”) if the distant site is Joint Commission accredited, if the practitioner is privileged at the distant site for the services to be provided at the originating site and the distant site sends certain evidence of its review of the practitioner’s performance to the originating site. See MS.13.01.01, Comprehensive Accreditation Manuals for Hospitals and Critical Access Hospitals.

Although the requirements have not yet changed, there have been two developments that may impact these credentialing requirements in the future:

- Legislation was introduced in the U.S. House of Representatives (HR2068) that would permit a telemedicine practitioner “that is credentialed by a hospital in compliance with the Joint Commission Standards for Telemedicine” [to] be considered in compliance with “Medicare conditions of participation and reimbursement credentialing requirements for

telemedicine services.”

If adopted as proposed, this legislation would seem to resolve the conflict that currently exists between the Joint Commission standards and the Conditions of Participation for both general acute care hospitals and critical access hospitals.

- The May 2009 Edition of *The Joint Commission Perspectives*, reported that The Joint Commission has been in “active dialogue” with CMS regarding the credentialing of telemedicine providers. The Joint Commission acknowledged the important differences between its standards for telemedicine credentialing and the approach of CMS, indicating that developments stemming from the discussions would be the subject of future announcements.

Taken together, these developments strongly suggest that the issue of credentialing teleradiologists may be on the road to resolution. It is important to keep in mind, however, that state licensure rules for physicians and Medicaid regulations also bear on teleradiology practice when the teleradiologist performs services from another state. Such licensure and payment rules are not affected by these developments.

Stay tuned . . .

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Julie A. Knutson

RAC SERIES: Vulnerability Issues and Medical Records Requests

This article is the fourth in the series on Recovery Audit Contractor (RAC) Audits. In the first parts of this series, we covered the basic facts and history of the RAC program, the key steps in preparing for RAC audits, and strategies for defending RAC denials. This article describes the RACs' responsibilities for identifying "vulnerability issues" and its authority and responsibilities with regard to medical records requests necessary to carry out its reviews.

1. Identification of Vulnerability Issues.

Promptly after being awarded their contracts, the RACs were required to submit a Project Plan for the base contract year. The primary component on the Project Plan is a "detailed quarterly projection by vulnerability issue." Vulnerability issues are used by RACs to identify "improper payments," whether overpayments or under payments. The vulnerability issue is identified typically by clinical procedure (e.g., excisional debridement). The required detail includes

- a. The incorrect procedure code and the correct procedure code
- b. The type of review (automated, complex, extrapolation)
- c. The type of vulnerability (medical necessity, incorrect coding, noncovered service, duplicate service, etc.)

For each identified vulnerability issue, the RAC is required to support CMS

in developing an Improper Payment Prevention Plan to help prevent similar overpayments from occurring in the future. This will take the form of recommending new Local Coverage Determinations, system edits, provider education, etc.

The vulnerability issues are not necessarily static for the contract year. The RACs are required to submit monthly administrative progress reports, which will include an update of the vulnerability issues being reviewed in the next month, corrective actions for vulnerabilities, an update on how vulnerability issues were identified and which potential vulnerabilities cannot be reviewed because of potentially ineffective policies.

2. **Provider Outreach Plan.** The second component of the Project Plan is the Provider Outreach Plan, by which the RAC will roll out the Project Plan for its respective region through associations, providers, Medicare contractors and other applicable Medicare stakeholders. The objective of this outreach is to notify provider communities of the RAC's purpose and direction. Thus, it is anticipated that identified vulnerability issues will be announced to the Medicare stakeholders through the Provider Outreach Plan.

Interestingly, the RAC Scope of Work makes it clear that the proactive education of providers concerning Medicare coverage and coding rules is not the responsibility of the RACs. This responsibility is assigned to Fiscal Intermediaries, Carriers and Medicare Administrative Contractors.

3. **Limits on RAC Identification of Improper Claims.** There are a number of types of improper claims which are excluded from the RACs' scope of work:

- a. Services provided under a program

For each identified vulnerability issue, the RAC is required to support CMS in developing an Improper Payment Prevention Plan to help prevent similar overpayments from occurring in the future.

other than Medicare fee-for-service; e.g., Medicare Managed Care, Medicare drug card program or drug benefit program

- b. Improper payments resulting from Indirect Medical Education and Graduate Medical Education payments.
- c. Claims more than three years past the claim paid date. The look back period is counted from the claim paid date to the date the RAC issues the medical record request letter (for complex review) or the date of the overpayment notification letter (for automated review).
- d. Claim paid dates earlier than October 1, 2007.
- e. Claims where the beneficiary is liable because the provider is without fault with respect to the overpayment (e.g., the beneficiary signed an Advance Beneficiary Notice).
- f. Random selection of claims. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 prohibits random claim selection for any purpose other than to establish an error rate. So RACs may not use random review to identify cases for review. The RACs must use data analysis techniques to identify the claims most likely to contain overpayments or, “targeted review.” RACs may not target claims because they are high dollar, but they may target claims because they are high dollar AND contain other information suggesting they are likely to contain overpayments.

by going on-site with the provider or by requesting records by mail, fax or secure transmission (in accordance with the CMS business systems security manual). If a provider refuses access during an on-site visit, that refusal cannot be the basis for the RAC issuing a denial. In such a case, the RAC must request the records in writing.

RACs are required to ensure that the number of medical records requested does not negatively impact the provider’s ability to provide care. Limits have been adopted on the number of records that can be requested by provider location and type, per 45 days for FY2009:

- a. Inpatient Hospitals, IRFs, SNFs and Hospices: 10% of average monthly Medicare claims (maximum of 200).
- b. Other Part A Billers (Outpatient Hospital, Home Health): 1% of average monthly Medicare services (maximum of 200).
- c. Physicians:
 - Solo practitioner: 10 medical records
 - Partnership of 2-5 individuals: 20 medical records
 - Group of 6-15 individuals: 30 medical records
 - Large Group (16+ individuals): 50 medical records
- d. Other Part B Billers (DME, Lab): 1% of average monthly Medicare services.

Medical record requests may not be bunched by RACs. For example, if no requests were made in January and February to a Large Group of Physicians, the RAC could not request 150 records in March.

All requests must identify the “good cause” for reopening the claim, such as OIG report findings, data analysis

RACs may review medical records by going on-site with the provider or by requesting records by mail, fax or secure transmission (in accordance with the CMS business systems security manual).

4. Requests for Medical Records. RACs may review medical records

findings, comparative billing analysis, etc.

Each provider will be permitted to customize its address and point of contact. For example, a provider may identify a contact individual and department at one of its multiple provider locations.

- 5. Payment for Medical Records.** RACs are required to pay for the copies of medical records it requests from acute care inpatient PPS hospitals with regard to DRG claims and long term care hospital claims. The payment rate is the applicable formula created by state law or other current formula. RACs are required to pay copying fees on at least a monthly basis, and they must be paid within 45 days of receiving the medical record. Payment amount is the same for paper records as for electronic or imaged records.

RACs may, but are not required to, pay for medical records requested from other types of providers, and has discretion to establish its own payment formula under those circumstances.

RACs are required to have systems in place to receive imaged medical records sent on CD or DVD, and, beginning in 2010, medical records sent via the 277 Transaction Record. They are required to remain capable of accepting faxes and paper medical records indefinitely.

- 6. Denials/Assessments for Failure to Provide Requested Records.** RACs may find a claim to be an overpayment if medical records are requested but not received within 45 days. The RACs are instructed to initiate one additional contact with the provider prior to issuing a denial on this basis.

In summary, we recommend:

- a. Each provider should identify a RAC coordinator, who will attend Provider

Outreach programming, provided by HDI, the RAC for Region D.

- b. The RAC coordinator will stay on top of vulnerability issues identified by the RAC to the extent that those can be instructive for prospective claims as well as preparing the provider to receive medical record requests related to that particular issue.
- c. The coordinator will coordinate the process externally and internally, notifying the RAC of the single point of contact for all communication from the RAC.
- d. The coordinator can ensure that the 45 day deadline is not missed and establish a system to track and document each medical record request and the precise medical records sent in response.
- e. At the time of request, it will be worthwhile to evaluate the record to determine whether a denial is likely and/or defensible.
- f. Retain a hard copy or electronic images of documents sent in response to the request.
- g. Include a cover letter with each submission, identifying the records enclosed or otherwise transmitted.
- h. The system will also track denials and the appeal process as described in prior articles in this RAC Series.

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