Codify
BY AAPC

MDS Alert

RISK MANAGEMENT: Watch Out for New False Claims Rules

A law cracking down on financial fraud can backfire for nursing homes.

If you're wondering what a law that targets mortgage and banking fraud could have to do with your SNF and MDS assessments, the answer, unfortunately, is plenty.

The Fraud Enforcement and Recovery Act (FERA) of 2009 includes a section entitled, "Clarifications to the False Claims Act (FCA) to Reflect the Original Intent of the Law," that makes several changes that apply to healthcare providers, including nursing facilities.

First, the law defines "obligation" to include the phrase "arising from statute or regulation, or from the retention of any overpayment," regardless of whether you originally submitted a "false claim." This suggests that you could be obligated under the False Claims Act if you have, for instance, created backdated medical records to support a claim you've already submitted, according to a release by **James G. Sheehan,** New York's Medicaid Inspector General.

"The law now explicitly creates liability for individuals who improperly avoid an obligation to return an overpayment to the government," says **Scot T. Hasselman** with Reed Smith in Washington, D.C. "So now the low intent standard of the FCA can be applied to a situation where a [provider] has been overpaid, and does not realize that it has been overpaid, if the failure to recognize the overpayment was a result of deliberate ignorance or reckless disregard of the truth."

In other words, the law makes it easier for the government to come after you, explains attorney **Robert Markette Jr.** with Gilliland & Markette in Indianapolis.

"The bottom line is that providers should ... have processes in place to regularly reconcile and return any overpayments to payers," Hasselman points out.

Implement These Strategies

To keep your SNF and yourself out of a world of trouble, consider these smart moves, experts advise:

• Check the MDS for accuracy before signing the attestation statement. "A repeated pattern of inaccurate information" on the MDS due to failure to use "due diligence, including audits and training," could establish a facility's liability, cautions attorney **Paula Sanders,** a partner with Post & Schell in Harrisburg, Pa. Also double check support documentation in the medical record.

• Review Medicare claims for technical glitches. Every SNF should develop checklists to help ensure they are meeting Medicare requirements before billing, suggests **JenniferWormington,** managingpartner with BKD LLP in Springfield, Mo. For example, BKD provides a checklist that directs SNF staff to double check that the physician has signed and dated the cert and recerts, as well as physician orders and the therapy plan of care.The facility also checks off that the MDS assessments on the bill have been accepted by the state repository (see the checklist on page 113). In addition, the reviewer makes sure that the RUG score generated by the MDS matches what's on the claim.

"We also look at whether the Medicare Secondary Payer assessment was performed. [Failure to do MSP assessments] can lead to overpayment situations because the SNF is simply billing Medicare for everything without determining if Medicare is the primary payer."

• Continue to focus on MDS 2.0 and RUG-III. People need to do that until the MDS 3.0 and RUG-IV go into effect, which is scheduled for Oct. 1, 2010, stresses **Rena Shephard, MHA, RN, RAC-MT, C-NE,** founding chair and executive editor of the American Association of Nurse Assessment Coordinators. "You don't want to take your eye off the ball. People have

worked too hard to avoid inaccurate payment or inappropriate coverage and RUG placement. You don't want to lose that game in the last year."

• Keep an eye on what the RACs and other auditors are identifying as overpayments, advises Sanders. And be aware of a brewing alphabet soup of auditors in play,including the RACs (Recovery Audit Contractors), MICs (Medicaid Integrity Contractors), and the ZPICs (Zone Program Integrity Contractors)." The latter "were previously the Program Safeguard Contractors," says Sanders. "CMS has consolidated Medicare [integrity reviews] for Part A, B, C, and D, and DMEPOS, and matched them up with the MACs, so there is a ZPIC for each MAC zone. There are also the PERMs (Payment Error Reduction Measurement) auditors for Medicaid," Sanders notes.