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QUOTE OF THE MONTH ...

"The best executive is the one who has sense enough to pick good men to do what he wants done, and self-restraint enough to keep from meddling with them while they do it"

SOME WARY OF RAC'S COUSIN...

The CMS is attempting to clarify the role of new federal contract audits being performed under Medicaid that providers fear will operate in a similar fashion to the controversial Recovery Audit Contractor program in Medicare.

Medicaid Integrity Contractors, or MICs, were designated by the Deficit Reduction Act of 2005 to help fulfill the federal government's ongoing quest to reduce fraud, waste and abuse in the entitlement programs. Medicaid in 2008 topped the federal agency list on improper payments at \$18.6 billion—beating out Medicare, which accumulated \$10.4 billion in inappropriate payments and even Medicare Advantage, which trailed behind at \$6.8

billion, according to the CMS.

The overarching goal of the contractors, who are expected to be operating nationwide in just a few months, is to identify overpayments in an effort to decrease inappropriate Medicaid claims. Activities under the MIC program include reviewing Medicaid claims to seek out potentially inappropriate payments; auditing Medicaid claims and identifying overpayments; and educating state Medicaid officials, providers and beneficiaries on payment integrity.

Unlike RACs, MICs do not work on a contingency basis. But some say they could be more

disruptive because the MICs operate under different rules. The CMS expects to spend \$50 million in fiscal 2009 on MIC audit, review and education. So far, the experience with the MIC process has not been very positive, said Diane Paschal, director, corporate compliance with the South Carolina Hospital Association. South Carolina is one of the first states to have MICs in operation.

"The MICs are going to make the RAC look like kindergarten. Unlike the RAC, there are no rules for these contractors. No record limits exist, and the time

Continued on pg. 3—RAC'S

DOZENS CHARGED IN MEDICAID FRAUD SCHEME

Forty-two people have been indicted in an alleged \$4.6 million Medicaid fraud ring in Southern California involving dozens of unlicensed caregivers treating severely disabled children.

The indictments are part of a two-year investigation involving the FBI, HHS' inspector

general's office, the U.S. attorney's office and the state attorney general.

According to law enforcement, Priscilla Villabroza, a Santa Fe, N.M.-based registered nurse, hired unlicensed people to provide care to disabled patients covered by Medicaid, called Medi-Cal in the state,

between 2004 and 2007. Many patients were children with cerebral palsy and other serious conditions. Villabroza pled guilty last year in federal court to five counts of healthcare fraud.

Continued on pg. 3—Fraud

NEW STUDY OF PHYSICIANS USING HIT IN HOSPITAL

When physicians in hospitals use health information technology (HIT) to its full potential there are fewer deaths, fewer complications, and lower healthcare costs, according to a study supported by the Commonwealth Fund.

The study was led by Dr. Ruben Amarasingham, associate chief of medicine at Parkland Health & Hospital System, Dallas, Texas and assistant professor of medicine at University of Texas Southwestern Medical

School; and Dr. Neil Powe, professor of medicine at the Johns Hopkins University School of Medicine, in Baltimore, Md.

They surveyed physicians from 41 hospitals in Texas treating a diverse group of patients across a variety of conditions including heart attack, heart failure and pneumonia.

The survey directly measures physicians using HIT in a hospital setting. Respondents were asked about their use of several

different types of HIT including electronic notes and records, order entry, and clinical decision support.

Researchers found that relatively modest increases in technology use had dramatic results — a 10-point increase in the use of electronic notes and medical records was associated with a 15 percent reduction in the likelihood of patient death.

Continued on pg. 3—HIT



CMS PROPOSES 21.5% CUT IN MEDICARE DOC PAYMENTS

Physicians would receive a 21.5% cut to their Medicare payments starting Jan. 1, 2010, under a proposed rule issued by the CMS. In a major step to revise the way it pays physicians, the agency is also proposing to remove physician-administered drugs from the formula used to calculate Medicare's physician fee schedule. The proposal to take drugs out of the formula won't prevent the anticipated cut in 2010, however, physicians will experience fewer years of negative

updates, if it is implemented. The American Medical Association, which has been pushing for this measure for years, applauded the proposal. "The removal of physician-administered drugs from the broken Medicare physician payment formula is a major victory for America's seniors and their physicians," J. James Rohack, president of the AMA, said in a written statement. "The AMA has been calling for this action since 2002 so that Congress

can afford to repeal the flawed Medicare physician payment formula."

The sustainable growth rate formula ties Medicare physician payments to several factors, including changes in the economy. Physicians would experience the 21.5% cut in 2010 unless Congress intervenes as it has in the past. In other provisions, the CMS is proposing changes that are expected to increase payment rates for primary-care services, such as revising the treatment of malpractice premiums.

The changes proposed to physician payment rates in 2010 will affect more than 1 million physicians and nonphysician practitioners who are paid under the fee schedule.

By [Jennifer Lubell](#)

Posted: July 1, 2009 (ModernHealthcare)

FRAUD...CONTINUED FROM PAGE 1

The caregivers, who were supposed to be licensed vocational nurses, administered medications, adjusted ventilators, and fed the children through gastronomy tubes. Some patients and parents reported to authorities that the caregivers lacked basic skills, according to authorities.

"Villabroza and her associates concocted a clever rip-off where they hired untrained and unlicensed nurses to provide care to children with serious health conditions," California Attorney General Jerry Brown said in a written statement. "At a time of budgetary crisis, they cheated California's welfare system and pocketed millions of dollars in

unauthorized state reimbursements."

By Rebecca Vesely
Posted: July 9, 2009
Healthcare Business News



RAC'S...CONTINUED FROM PAGE 1

allowed to respond is only 15 days." But because the program has yet to be rolled out in most parts of the country, Paschal and others in the industry acknowledge that many providers are adopting a "wait and see" approach to the MICs.

CMS officials contend the Medicaid audits will be fundamentally different from the RAC program. A lot of "misinformation" has been floating around about the emerging Medicaid audits, according to a CMS spokeswoman who spoke on the condition she not be identified. MICs and

Medicare RACs are alike in that both seek to identify overpayments to providers, using auditors procured and hired by the CMS, the spokeswoman said. But one chief difference between the RAC and MIC contractors is the MICs will not be compensated via contingency fees, unlike the RAC, which allows third-party auditors hired by the CMS to keep 9% to 12.5% of payments they identify as improper.

Awards on task orders for the MICs began in spring 2008, after being pilot-tested in four states. Actual audits began in a few states during the last

quarter of 2008 and have increased steadily throughout the first half of 2009, the spokeswoman said. The expectation is the agency will award task orders for Medicaid auditors in all 50 states by the end of fiscal 2009.

Molly Collins Offner, director for policy development with the American Hospital Association, said the AHA has been working with the CMS and state associations to educate hospitals on the new Medicaid audit program "so they know what's going on here."

What's not clear is who will lose financially, Collins Offner said. Unlike Medicare, where the payment process is more cut and dry, Medicaid involves the states as well as the providers. "If an overpayment is identified, it is the state that is responsible for processing and adjudicating the overpayment." How this will trickle down to the provider level, has yet to be determined.

By Jennifer Lubell
Posted: June 15, 2009 (ModernHealthcare)

DID YOU KNOW...

July 1, 1862 - President Abraham Lincoln signed the first income tax bill, levying a 3% income tax on annual incomes of \$600-\$10,000 and a 5% tax on incomes over \$10,000. Also on this day, the Bureau of Internal Revenue was established by an Act of Congress.

Birthday - American pilot Amelia Earhart (1898-1937) was born in Atchison, Kansas. She became the first woman to fly solo across the Atlantic and to fly solo from Hawaii to California. She perished during a flight from New Guinea to Howland Island over the Pacific Ocean on July 3, 1937.

HIT...CONTINUED FROM PAGE 2

And, when physicians electronically entered their instructions for patient care, there was a 55 percent reduction in the likelihood of death for some procedures.

Increased use of HIT was also linked to lower costs: hospitals with automated test results, order entry, and decision support experienced lower costs for all hospital admissions (-\$110, -\$132, and -\$538, respectively per

admission).

"These findings tell us, straight from the physicians using it, that this technology works to improve quality of care for patients – the first priority of health information technology," said Commonwealth Fund Vice President for Quality Improvement and Efficiency Dr. Anne-Marie Audet, "But, in

order to save lives and keep costs down, health information technology has to be used to its fullest extent."

Managed Care Information Center... July 9, 2009



"My doctor told me to avoid any unnecessary stress, so I didn't open his bill."

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MAKING A DIFFERENCE WHERE IT COUNTS...

ARE YOU PREPARED FOR RAC AUDITS?

If your organization has not yet received an **audit notice for RAC Audits**, you will most likely receive one soon.

According to the federal government the recovery audit contractors (RAC) program, will recover about \$3 billion in overpayments to providers.

RAC audits are going to be a test to healthcare providers. Failure to comply with RAC auditors, or inability to produce documentation upon request within the time frame specified by CMS, could lead to determinations of claims as overpayment. Being ready for these audits and in order to properly manage RAC audits, organizations need to:

1. Structure a team for effective RAC response.

2. Respond to RAC letters promptly.

3. Review overpayment determinations.

4. Track requests and ensure that deadlines are met.

5. Periodically conduct internal audits.

6. Make adjustments to processes to avoid future overpayment determinations.

American Healthcare Audit Professionals (AHAP) is prepared to assist your staff and your organization in preparation for these Audits. Our experienced Nurse Auditors and Certified Coders have been assisting healthcare providers with this very arduous task of audit preparations. They will provide audit outcomes to

our clients to identify areas of risk. AHAP Nurse Auditors and Certified Coders will provide staff education as deemed necessary and assisting the appropriate department managers and nursing departments with maintaining and/or developing charge protocols and policies in all revenue producing departments. So, be prepared by being proactive and establishing an audit program to prevent expediting corrective action plans after CMS has discovered your risk areas.

*Julie Doumad, RN, BSN, CMAS
Director of Audit Services.*

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