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CMS NATIONAL FRAUD PREVENTION PROGRAM

FROM "PAY AND CHASE" TO PREVENTION AND DETECTION:

ROUNDTABLE DISCUSSION WITH PETER BUDETTI, M.D., J.D., CMS DEPUTY ADMINISTRATOR FOR PROGRAM INTEGRITY

BY KATHLEEN L. DEBRUHL, ESQ. AND LINDSEY E. SURRATT, ESQ.

On February 6, Kathleen L. DeBruhl & Associates, L.L.C., participated in a roundtable discussion led by Peter Budetti, M.D., J.D., the Centers for Medicare and Medicaid Deputy Administrator for Program Integrity. The Center for Program Integrity ("CPI") is the division of CMS charged with preserving the financial integrity of the Medicare, Medicaid, and CHIP Programs through identification of program vulnerabilities to fraud and abuse, and audits and payment reviews of providers and contractors. The CPI also collaborates with the Department of Justice ("DOJ"), the Department of Health and Human Services Office of Inspector General ("OIG"), and other State and federal law enforcement agencies to detect, deter, monitor, and combat Medicare and Medicaid fraud and abuse.

Dr. Budetti discussed the goals of the National Fraud Prevention Program and CMS' new approach to preventing fraud. Until recently, CMS would put suspected fraudulent providers on prepay review and attempt to recover overpayments, usually after a significant amount of claims had already been paid. Now, CMS has the ability to deny individual claims, use prepay review as an investigative tool, revoke provider billing privileges for improper practices, and collaborate more efficiently with State and federal law enforcement agencies at all stages, through the National Fraud Prevention Program and the Patient Protection and Affordable Care Act ("PPACA"), adopted March 23, 2010.

The technological workhorse behind CMS' increased fraud prevention efforts is the Fraud Prevention System ("FPS"), a computerized data network implemented on June 30, 2011, which monitors all claims for Medicare Part A, B, and DME services on a daily basis, and generates risk-based alerts regarding certain providers. CMS also implemented the new Automated Provider Screening System for provider enrollment on December 31, 2011, which checks a variety of data sets, including compromised NPI numbers and valid location addresses, and identifies high-risk providers, such as new DME and Home Health Providers. These two systems will facilitate CMS' dual approach to preventing fraud and abuse through earlier identification of fraudulent claims and more rigorous screening of providers during the enrollment process.

Going forward, the CPI seeks to detect both fraudulent claims and fraudulent providers as early as possible to minimize the amount of fraudulent claims paid, and to keep fraudulent providers from entering and re-entering the Medicare and Medicaid Programs. While Dr. Budetti stated that the goal of the CPI is to have a "0% False Positive Rate" for providers falsely identified by the new systems, it does not appear that

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CMS has a definitive process in place to restore quickly the billing privileges of falsely identified providers outside of the existing appeals process.

ABOUT THE AUTHORS

Kathleen L. DeBruhl & Associates, L.L.C., is a regional healthcare law firm with a national client base which offers its physician and other healthcare provider clients strategic and legal expertise on their healthcare business needs including corporate organization, joint ventures, mergers and acquisitions, and contractual and financial arrangements. The Firm counsels and defends clients on highly complicated healthcare regulatory matters involving physician ownership and financial relationships, reimbursement, fraud and abuse, and compliance with the myriad of laws and regulations imposed upon the healthcare industry by both federal and state governments.

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