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Medicaid Task Force: Providers Under More Scrutiny

findings in the range of hundreds of thousands of dollar are common. Generally speaking, OMIG targets are good programs which otherwise may have failed to dot an "i" or cross a "t," but did in fact render the challenged service. Moreover, no allegations of poor quality of care need accompany the findings which lead to a payback demand.

The OMIG's method of operation in taking the low hanging fruit apparently is a result of the thresholds established by the federal government in its F-SHRP grant to New York State. To avoid paying money back to the federal government, for fiscal year 2008, the State needed to recover $215 million. New York exceeded that benchmark and recovered $551 million. (The target for fiscal year 2010 is $644 million).

Thus, it appears that the collection of overpayments is the OMIG's mission rather than the detection and prosecution of fraud. It is difficult to believe there is no "criminal fraud" in the State's Medicaid Program where individuals or groups engage in intentional criminal conduct to steal taxpayer's dollars. We know there is. It's time for OMIG, as well as the Medicaid Fraud Control Unit, to stop nickel and diming providers and go after real fraud.

Gregory J. Naclerio is a partner in Health Law Department at the law firm Ruskin Moscou Faltischek. He can be reached at 516-663-6633 or gnaclerio@rmfpc.com. **Seth I. Rubin** is a partner in the Health Law Department at the law firm Ruskin Moscou Faltischek. He can be reached at 516-663-6691 or srubin@rmfpc.com.

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Department Members
Melvyn B. Ruskin, Esq.
Gregory J. Naclerio, Esq.
Ellen F. Kessler, Esq.
Seth I. Rubin, Esq.
Leora F. Ardizzone, Esq.
William J. McDonald, Esq.

Department Chairs
Alexander G. Bateman, Jr., Esq.
Jay B. Silverman, Esq.

RUSKIN MOSCOU FALTISCHEK P.C.
Smart Counsel. Straight Talk.
East Tower, 15th Floor
1425 RXR, Uniondale, NY 11556-1425
516.663.6600 ▼ www.rmfpc.com

HEALTH LAW UPDATE
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The common denominator among the three articles that make up this edition of the RMF Health Law Update *is more scrutiny by the government of your day-to-day operations. Like it or not, these kinds of intrusions are not going away. However, forewarned is forearmed. If there are vulnerabilities in your business operation, it is more important than ever to identify and deal with them yourself, before the government does it for you. An effective healthcare compliance program can do just that. If we can be of any assistance in implementing one for you or with any other questions you may have, feel free to contact us. Please contact newsletter editor Seth Rubin or Gregory J. Naclerio if you have comments or questions, or if you have suggestions for future issues.*

Inside **Update**

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Medicaid Task Force: Providers Under More Scrutiny

by Gregory J. Naclerio, Esq. and Seth I. Rubin, Esq.

Gregory J. Naclerio

Seth I. Rubin

New York's Medicaid program is enormous, and is second in the nation in enrollment, trailing only California. Even faced with increasing budgetary issues, it has been projected that over $52 billion will be spent on Medicaid in New York in the 2010-11 fiscal year.

As a result of the size and complexity of the state's Medicaid program, the New York State Senate Republican Leader Dean Skelos created a Senate Republican Task Force in early 2010 on Medicaid fraud. At the time, Chair of the Senate Health Committee, Sen. Kemp Hannon, noted that Medicaid fraud is costing taxpayers of the state "billions of dollars." The mission of the task force was to "investigate whether or not the fraud prevention system is working at an optimal level." Longer term, the task force focused on how the state can better deliver Medicaid services to the elderly and needy in a way that is more effective for them and the taxpayers.

In 2006, legislation sponsored by Senator Skelos was passed, which created the Office of the Medicaid Inspector General (OMIG). OMIG was expected to ensure that the counties were active players in the effort to control fraudulent and wasteful spending. Unfortunately, the 2006 law seems to be having less impact than was expected; as a result, the task force recommended more than a dozen ways to further improve fraud prevention, prosecution and recovery.

Additional state action seems assured in light of budgetary pressures and the fact that the comptroller's office has shown that $92 million in Medicare overpayments resulted from billing errors alone. This, coupled with the fact that, according to HHS, New York ranks 26th in the nation in Medicaid fraud recovery based on fraud dollars recovered per Medicaid dollars spent certainly suggests that new anti-fraud initiatives will be on the horizon.

Perhaps one reason for the rather poor report card for New York is that the state Medicaid Fraud Control Unit and OMIG are looking for fraud in all the wrong places. The OMIG trend is to audit providers with an eye toward highlighting "program violations" and calling those violations "fraud." For instance, in the days before the creation of OMIG, if a home health agency or substance abuse program failed to have treatment plans updated as required by the regulations, the respective oversight agency (DOH or OASAS) would note the violation in a survey of the program and a plan of correction would be submitted by the provider. In rare instances, a fine would be imposed by the regulator. Now, OMIG sees the "program violation" as a fraudulent bill and takes the violation as an adverse audit finding. To add insult to injury, OMIG then takes the "finding" in a sample of cases and extrapolates this finding across all of the billing submitted by the program. Hence,

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Required Compliance With Red Flags Rule Is Fast Approaching

by Seth I. Rubin, Esq.

In November 2007, the Federal Trade Commission ("FTC") issued a set of regulations, widely known as the "Red Flags Rule" which requires certain entities to create and implement identity theft prevention and detection programs designed to protect consumers from identity theft. These programs must be in writing and comply with specific regulations promulgated by the FTC. The FTC has, once again, delayed the enforcement date of the Red Flags Rule – this time until December 31, 2010 – to give Congress a chance to consider limiting the scope of businesses covered by the Rule. Notwithstanding the multiple delays in enforcement, businesses should be ready to comply with the Rule now because the FTC has announced that if Congress passes final legislation with respect to the Rule before December 31, 2010, the FTC will commence enforcement of the Rule on such date.

The Purpose of the Red Flags Rule

The purpose of the Red Flags Rule is to protect against the theft of a person's personal identifying information – name, social security number, insurance enrollment, etc. Physician practices, in particular, are focused on the issue of medical identity theft, which can occur when some part of a person's identity (e.g., insurance information) is used without that person's knowledge to obtain or make false claims for medical goods and services. This type of identity theft can take various forms, ranging from incorrect entries in medical records to the creation of false records in the victim's name.

Does the Rule Apply to Physicians?

The Red Flags Rule applies to any institution which is deemed a "creditor" under the regulations. This includes "any person who regularly extends, renews, or continues credit; any person who regularly arranges for the extension, renewal or confirmation of credit..." In the view of the FTC, physicians who accept insurance or allow payment plans are creditors and are, therefore, subject to the Red Flags Rule. The FTC believes that physicians are subject to the Rule when they extend credit by allowing deferred payment until services are rendered and insurance is collected. While certain lobbying groups, most notably the American Medical Association, argue that the intent of the legislation was not to apply it to physicians, these groups have been unsuccessful in preventing applications of the rule to physician practices. As a result, beginning December 31, 2010 – barring another delay in implementation of the Rule – physician practices which accept insurance or allow payment plans must have adequate policies and procedures in place, or face a penalty of up to $2,500 for each "knowing violation" of the Rule.

What is a Red Flag?

A red flag is a pattern, practice or specific activity that suggests the possibility of some kind of identity theft. The FTC has highlighted the following items as red flags:

- Alerts, notifications or warnings from a consumer reporting agency
- Suspicious documents or personal identifying information – e.g., an inconsistent address or non-existent social security number
- Suspicious activity relating to, or unusual use of, a patient account
- Notices of possible medical identity theft from patients, victims of medical identity theft, or law enforcement authorities

HIPAA and the Red Flags Rule

The Health Insurance Portability and Accountability Act ("HIPAA") was designed to protect the personal health information of patients. It was implemented for security and privacy purposes. While such personal health information is covered by the Red Flags Rule, that is not all that is covered. The Rule also covers additional types of personal and sensitive information including:

- Social Security numbers and taxpayer identification numbers (business identification numbers and employer identification numbers)
- Credit card information
- Insurance claim information
- Background checks for employees and service providers

Simply because a physician practice complies with HIPAA does not mean that it automatically complies with the Red Flags Rule. HIPAA policies and procedures and red flags policies and procedures should complement one another.

What Is a Physician Practice to Do?

Don't wait another minute! While there have been several delays in implementation of the Red Flags Rule, physician practices should not count on another delay. Physician practices should develop and implement policies and procedures immediately which will identify, detect and respond to identity theft red flags. A specific staff member should be assigned to oversee the implementation of red flags policies and procedures and all staff should receive training on these matters. Red flags policies and procedures should be periodically updated (at least once a year) to make sure that appropriate steps are taken to protect the personal health information of patients. For assistance in developing and implementing appropriate policies and procedures, be sure to consult with counsel experienced in regulatory compliance.

Seth I. Rubin is a partner in the Health Law Department at the law firm Ruskin Moscou Faltischek. He can be reached at 516-663-6691 or srubin@rmfpc.com.

RUSKIN MOSCOU FALTISCHEK, P.C. ▼ HEALTH LAW UPDATE

Health Care Reform Act Provides New Tools to Fight Fraud

by Gregory J. Naclerio, Esq.

The Patient Protection and Affordable Care Act, signed into law by President Obama on March 23, 2010, has been vigorously discussed in terms of its requirement that most Americans have health care coverage. Lost in the debate have been the anti-fraud provisions of the new law, which contain critical tools to enhance government efforts to prevent, detect and act against fraud. This article highlights some of the key provisions contained in the Act.

Provider Screening

Under the new law, the Department of Health and Human Services (HHS) now has the ability to screen providers enrolled in Medicare, Medicaid and CHIP. This screening will include:

- Criminal background checks
- Fingerprinting
- Unscheduled and unannounced site visits, including pre-enrollment site visits
- Data bank checks

In addition, states must also comply with this screening for Medicaid providers. These procedures are intended to stop fraud similar to that found in southern Florida, where a tiny medical supply company billed Medicare $2 million in July 2009 out of an empty office.

Period of Enhanced Oversight

New Medicare providers can be subject to "enhanced oversight" for not less than 30 days or not more than one year. DME providers will receive 90 days of enhanced oversight for initial claims for supplies and equipment.

Authority to Deny Enrollment

The HHS Secretary may deny enrollment in Medicare initially or upon revalidation of enrollment if she concludes that a provider's "previous affiliation" poses an undue risk of fraud. Such "previous affiliates" include direct or indirect affiliation with a provider who has a debt due to Medicare, or has been subject to a payment suspension or excluded from Medicare/Medicaid.

Temporary Moratorium

The HHS Secretary now has the power to impose a temporary moratorium on enrollment of new Medicare providers. The law also states that "there shall be no judicial review" if a moratorium is imposed.

Compliance Plans

States are now required to have Medicaid providers adopt compliance plans. In New York, 18NYCRR Part 521 already requires providers who meet certain threshold to have an "effective compliance program" and to certify such at least once a year.

ALERT

The Office of the Inspector General for Health and Human Services recently published a booklet entitled: "Avoiding Medicare and Medicaid Fraud and Abuse." While targeted to new physicians, the booklet addresses fraud and abuse concerns affecting all physicians.

We urge you to visit the OIG website at www.oig.hhs.gov/fraud/physicianeducation/ to review this most important document. After you have reviewed it, if you have any questions or issues you wish to discuss, please feel free to call Alex Bateman at 516-663-6589 or Gregg Naclerio at 516-663-6633.

Disclosure of Providers Terminated by Medicare

Within 30 days of a provider being excluded from Medicare, that information must be communicated to the States Medicaid Program. While Medicaid exclusions generally follow Medicare exclusion, this will speed up the process.

Reporting and Returning Overpayments

Within 60 days of an overpayment from Medicare or Medicaid being identified, the provider must report the overpayment and return those funds. Failure to do so subjects the provider to action under the Federal False Claims Act with its treble damages and a $5,500 to $11,000 penalty per claim.

Permissive Exclusion from Medicare

Any person who makes a false statement, omission or misrepresentation of a material fact in a Medicare or Medicaid application can be excluded from both programs. Hence, the days of getting your office manager to fill out your provider application or re-enrollment should be over. Do it yourself and be careful.

Kickbacks

Taking or paying a kickback for a Medicare/Medicaid patient referral subjects a person to criminal, civil and administrative actions. Now, that person can be subject to a Federal False Claim Action with its enhanced damages and penalties.

Suspension of Payments

If there is a "credible allegation" of fraud, Medicare and Medicaid can suspend provider payments. Such action will obviously be disastrous to a provider's cash flow and can put him or her out of business.

Conditions of DME Payments

A prescription for durable medical equipment must have supporting documentation that the physician, physician assistant or nurse practitioner "had a face-to-face encounter other than an encounter incident to patient services, within 6 months of writing the DME order."

Gregory J. Naclerio is a partner in Health Law Department at the law firm Ruskin Moscou Faltischek. He can be reached at 516-663-6633 or gnaclerio@rmfpc.com.