Medical Practice Compliance

News, tools and best practices
to assess risk and protect physicians

ALERT

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IN THIS ISSUE

New rule makes enrollment harder for physicians, payment suspension easier for CMS

Make sure you're in compliance with all applicable Medicare provider, licensing and billing requirements now. A recently finalized rule will tighten enrollment requirements for your physicians and make it easier for CMS to halt your payments.

The new rule, effective March 25, implements tools authorized by the Patient Protection and Affordable Care Act (ACA) to enable CMS to fight fraud and abuse before it pays an improper claim. The rule creates new screening procedures on providers enrolling or reenrolling in Medicare, using three tiered categories based on the risk of fraud and abuse by the enrollee.

The good news: Physicians were placed in the lowest risk category by CMS, which means screening will include verification of any provider-specific requirements established by Medicare, verification

*(see **enrollment**, pg. 4)*

Conscience protection final rule decreases compliance requirements, adds clarity

HHS' final rule released Feb. 18 on the federal Healthcare Provider Conscience Protection laws changes the way your providers demonstrate compliance, establishes a route for discriminatory complaints and clarifies some language from the 2008 final rule. The final rule goes into effect 30 days after its release date.

When the 2008 final rule was implemented in January 2009, a written certification requirement was created but never implemented because it was subject to the information collection approval process. That certification requirement has now been eliminated.

After receiving public feedback, HHS felt requiring a written certification put an unnecessary burden on you. The final rule now reads that HHS will now "require grantees to acknowledge that they will comply with the provider conscience laws."

"HHS believes that it can achieve the goal of certification, which was to raise awareness of the provider conscience laws, through a

*(see **conscience protection**, pg. 5)*

Choosing sample size and reviewing causes to common problems in self audits

Auditors can cause real financial damage to your practice when you're not prepared. Conducting a claims submission self audit shows auditors you are making an effort to correct any problems within your claims.

When conducting your practice's first self audit it can be tricky determining how many records to review, how far back in your claims history to go and how to determine the cause and assess the scope of problems you find.

Recovery Audit Contractors (RACs) typically audit recently filed records, says Floyd Boyer, Affordable Healthcare Consultants, Autryville, N.C. However, minus evidence of fraud RACs can legally review claims going back four years. Several health care experts told *Medical Practice Compliance Alert* to audit claims dating back a year if you're self auditing for the first time.

Auditing 100 claims over the past year or 25 claims in the past quarter is a sufficient sample size, advises Wayne van Halem, president of The van Halem Group, Atlanta. Some practices in rural environments may not have that number of claims, so van Halem suggests auditing records over the past three years.

"If you have the volume you can go back a year and get a good universal sample, if your volume is low, three years would be a good benchmark," he says.

The Office of the Inspector General (OIG) recommends five or more medical records per federal payer or five to ten medical records per physician *(MPCA 8/23/10)*.

Once a problem is found, your next step is to determine the cause, which will vary depending on the problems. Below are some examples of common problems providers tend to make on claims.

Example: If the problem is with evaluation and management (E/M) claims and you're billing different levels of services with different levels of coding, compare those codes to the average breakdown by code level for your specialty, says Betsy Nicoletti, Medical Practice Consulting, Springfield, Vt. When comparing the E/M claims to your provider's specialty, look for codes billed outside the norm of the provider's specialty, recommends Denise Hall, partner at Pershing Yoakley and Associates P.C., Atlanta. Then look at any recent training the physician received and determine if that was a factor in the incorrect claims, says Nicoletti. You may discover an overcoding or undercoding issue at your practice.

One way to determine the cause of a problem found in your self audit is to compare data, advises Nicoletti.

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Your encounter forms may also cause problems.

TIP: Minor procedures are often billed incorrectly because the provider abbreviates the procedure on the encounter form and does not give a complete description of what service was rendered, warns Nicoletti.

Example: A family practice may write "cryosurgery," which is surgery involving the selective destruction of tissues by freezing them with liquid nitrogen, on an encounter form. This doesn't tell the coder or billing staff what was destroyed and therefore what type of code to bill for, she adds.

Another problem with your encounter forms is maybe use of standard ICD-9 codes on the back. These codes are updated annually, which is more frequently than providers tend to update their encounter forms, says Hall. Your billing staff may be looking at the outdated ICD-9 codes and billing incorrectly.

Other problems may be caused by changes made at your practice, whether it be a change in staff, type of work your practice does and internal policies or regulatory changes, says Hall.

"Change of any sort in your practice is an easy mark to find the cause of a problem," notes Hall.

Some problems are caused by a lack of training or education.

Example: If you have a modifier issue and multiple members of your billing team are making the same mistake, then they were not properly trained and need additional training and/or education to correct the problem, says Boyer. The type of training varies depending on the issue, he adds.

Once the cause of the problem is discerned, you need to learn the scope of the problem. Nicoletti recommends looking at a couple of factors, including the frequency of services and length of time you've offered the services. Focus on the past three years to determine how long the problem has been occurring, advises Hall.

If you have an error rate of 5% or over, Hall believes you have a significant problem at your practice. If you have hundreds of claims that were filed incorrectly over several years, Nicoletti suggests hiring an attorney to negotiate how to rectify the situation with the payer.

Once the corrective action is determined to fix the problem, create a timeline to have it implemented, appoint a member of your staff to make sure the action was implemented and conduct a follow-up audit to make sure the problem is resolved, says van Halem.

OIG recommends conducting audits at least once a year to maintain compliance in the *Federal Register* OIG Compliance Program for Individual and Small Group Physician Practices, *www.oig.hhs.gov/authorities/docs/physician.pdf*.

Diligence, strategy needed to steer clear of excluded providers, entities

You need to know when anyone you do business with or anyone on your own staff is excluded or in the process of being excluded from Medicare or Medicaid, and you need to take precautions to not put your practice in jeopardy. When your practice bills and gets paid for services provided by an excluded provider, directly or indirectly, that money is considered an overpayment (*MPCA 9/20/10*).

Being "excluded" means that a provider cannot receive payment for any federal health care program for services furnished, explains OIG's website defining the exclusion program.

You need to check exclusion lists routinely to make sure you're not doing any kind of business with an excluded individual or entity.

TIP: If you discover an executive of an entity is excluded, look further into why the person was excluded, says Beth Ann Jackson Esq. LLC, McMurray, Pa. If the executive has a health care fraud conviction, it may only be a matter of time before the entity itself is excluded.

Sometimes a provider or entity will be on one list and not another, says Jackson. **Example**: A client had hired a provider who practiced for years before it was discovered the provider was on an excluded list, Jackson says. The excluded provider was not discovered sooner because he was on an online exclusion list, but not on the downloadable version.

TIP: Check both federal and state lists because an individual or entity may be on one and not the other, advises Meghan O'Connor, von Briesen Roper, Milwaukee, Wis.

"They may be excluded through state law and not by the OIG," she says.

TIP: Not only should you be checking if providers or entities you do business with are excluded, you need to make sure no one on your staff is excluded, says Jackson.

"Check for anyone in your practice, not just physicians, but clerical staff, NPPs (non-physician practitioners), everyone," says Jackson.

TIP: Include an automatic termination clause that requires the prospective provider to disclose if they are excluded, or in the exclusion process when you hire or otherwise contract with another provider, advises Jackson and O'Connor.

This is crucial because if an individual or entity you may contract with won't be on any of the exclusion lists if they are in the exclusion process and have not been convicted.

TIP: Check annually to see if any provider you do business with is on the exclusion list. A good time to do it is when you renew his or her contract, advises Jackson. She adds that if you have any reason to suspect someone of exclusion during the contract, check the lists again.

There is no specific timeframe for an exclusion case, said an OIG official. Factors include the complexity of the case, whether the individual or entity appeals the decision and the bureaucratic delay often involved in these cases. The same OIG unit that determines whether to exclude an individual also determines whether to exclude an entity.

TIP: When searching the lists for excluded providers do not use middle initials, says Jackson.

Rep. Wally Herger (R-Calif.) and Rep. Pete Stark (D-Calif.) have recently reintroduced legislation that would give the OIG authority to exclude corporate executives from Medicare programs if their companies are convicted of fraud after they have left the company.

The proposed legislation also holds parent companies who commit fraud through shell companies to be liable, says O'Connor. This could lead to an increased number of excluded providers, and more risk to you of doing business with them.

On the Internet

- Background on OIG exclusions: *www.oig.hhs.gov/fraud/exclusions.asp*
- OIG exclusion authorities: *www.oig.hhs.gov/fraud/exclusions/authorities.asp*

enrollment

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of licenses, social security numbers and national provider identifiers (NPIs), and database checks of death records, the National Practitioner Data Bank and other databases.

You won't have to endure unannounced site visits to enroll these physicians, which are required for providers in the moderate risk category or fingerprint-based criminal history checks, required in the high risk category. You also avoid application fees for physicians.

However, when your physicians choose to enroll as DMEPOS suppliers, they will be placed in the high-risk category; those who are existing DME suppliers will be part of the moderate risk category. Those physicians will be required to pay application fees and undergo the additional screening, notes attorney Debra McCurdy, with Reed Smith in Falls Church, Va.

But your physicians are not immune from having their risk category increased from low risk to moderate or high, warns attorney Adrienne Dresevic, with The Health Law Partners, Southfield, Mich. Here are some factors that will lead CMS to adjust a screening level.

- CMS has imposed a payment suspension on the provider during the past 10 years.
- The physician has had his billing privileges revoked by a Medicare contractor within the last 10 years and is trying enroll as a new physician or new practice location.

The agency backed off of its original proposal to adjust risk categories based on denial of Medicare billing privileges in the previous 10 years.

There is some additional good news: CMS decided not to check providers' tax delinquency status as part of its screening process, since it was not prepared to operationalize that, according to McCurdy. CMS also didn't adopt its proposal to raise a physician's risk level if a physician is subject to identity theft, she adds.

Loss of billing privileges, suspension of payments

The final rule retained the lower standard enabling CMS to suspend your payments pending an investigation

of just a "credible allegation of fraud," which can come from claims data mining, fraud hotline tips, patterns identified during an audit, and law enforcement investigations. Previously CMS needed more reliable information to suspend the payments. The suspension can be for 18 months, and can be extended in certain situations.

Your payments won't be suspended just because a disgruntled employee or patient leaves an anonymous tip on a hotline, CMS says. Suspension determinations will be made on a case-by-case basis, and CMS will "act judiciously when corroborating information and investigating allegations of fraud, especially when the source of the allegation is an anonymous fraud hotline complaint," CMS says. You would have a chance to submit information to show why a suspension is unjustified.

But the agency did make clear that it has the right to suspend payments even when it may have been an overpayment due to billing errors and not outright fraud. "We will determine on a case-by-case basis whether a suspension of payments is appropriate in cases that do not involve fraud," CMS says. In those situations CMS will also look to see if the MAC made errors in claims processing and the provider's billing history.

The rule does not ignore Medicaid: CMS can now also revoke your Medicare billing privileges if your Medicaid enrollment or billing privileges have been terminated, revoked or suspended, says Dresevic.

Mandatory compliance regulations forthcoming

CMS opted not to address the requirements of mandatory compliance programs, also required by the ACA. CMS will address that in a separate rulemaking "at a later date," says McCurdy.

conscience protection

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number of efforts less burdensome for health care providers, including requiring all grantees to attest that they will comply with the law in grant requirements," says an HHS official.

Health care providers who wish to participate in Medicare and Medicaid must agree they will comply with civil rights laws; this includes the provider conscience statutes. So participants in Medicare and Medicaid don't need to do anything extra to be compliant.

Providers seeking enforcement of their conscience protection rights now file complaints through HHS' Office of Civil Rights. In the 2008 final rule, complaints could be made through a number of different agencies.

There were some language amendments in the final rule to add clarity. The term "abortion" was not defined in the 2008 final rule and there was some confusion that "abortion" included "contraception." The current final rule reads that "there is no indication that the federal health care provider conscience statutes intended that the term 'abortion' included contraception."

Another confusing bit of language in the 2008 final rule concerned whether providers could refuse treatment of patients or groups based on the patient's or group's religious or moral views. This is not the case.

Commenters on this issue raised concern that providers would refuse to help AIDS patients, provide STD screenings to single women or fertilization therapy to unmarried couples, says an HHS official.

The final rule reads "The federal provider conscience statutes were intended to protect health care providers from being forced to participate in medical procedures that violated their moral and religious beliefs. They were never intended to allow providers to refuse to provide medical care to an individual because the individual engaged in behavior the health care provider found objectionable."

Federal health care conscience protection laws have been in place for decades. The recent final rule does not change provider's rights those statutes imply. However, the 2008 final rule did broaden provider's rights to refuse to participate in certain health care activities *(MPCA 1/10/11)*.

On the Internet:

- Final rule on Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws: *www.ofr.gov/OFRUpload/OFRData/2011-03993_PI.pdf*

Quick Compliance Facts

• **HHS Imposes a $4.3 Million Civil Money Penalty for Violations of the HIPAA Privacy Rule.** HHS' Office of Civil Rights (OCR) has issued a Notice of Final Determination on Feb. 22, 2011 finding that Cignet Health in Maryland violated the HIPAA Privacy Rule. HHS imposed a civil money penalty (CMP) of $4.3 million for the violations, the first CMP issued by HHS for a HIPAA Privacy Rule violation. The CMP is based on the violation categories and increased penalty amounts of the Health Information Technology for Economic and Clinical Health (HITECH) Act. OCR found that Cignet violated 41 patients' rights by denying them access to requested medical records between September 2008 and October 2009. OCR also found that Cignet failed to cooperate with OCR's investigations from March 17, 2009, to April 7, 2010. See the complete Notice of Final Determination and Notice of Proposed Determination at *www.hhs.gov/ocr/privacy/hipaa/news/cignetnews.html*.

• **Massachusetts General Hospital settles potential HIPAA violations.** Massachusetts General Hospital has agreed to pay a $1 million penalty to settle potential HIPAA Privacy Rule violations, HHS announced Feb. 24. The hospital signed a Resolution Agreement with HHS that requires it to develop and implement a comprehensive set of policies and procedures to safeguard the privacy of its patients. The settlement follows an investigation by the HHS Office for Civil Rights (OCR), which enforces the HIPAA Privacy and Security Rules. The incident involved the loss of protected health information (PHI) of 192 patients of Mass General's Infectious Disease Associates outpatient practice, including patients with HIV/AIDS. OCR opened its investigation after a patient complaint. The impermissible disclosure of PHI involved the loss of documents consisting of a patient schedule containing names and medical record numbers for a group of 192 patients, and billing encounter forms containing the name, date of birth, medical record number, health insurer and policy number, diagnosis and name of providers for 66 of those patients. These documents were lost on March 9, 2009, when a hospital employee commuting to work left them on the subway. They were not recovered. The hospital also agreed to enter into a Corrective Action Plan (CAP).The HHS Resolution Agreement and CAP can be found on the OCR website at *www.hhs.gov/ocr/privacy/hipaa/news/mghnews.html*.

• **BlueCross BlueShield of Illinois to pay $25 million.** BlueCross BlueShield of Illinois, a division of Health Care Service Corporation, has agreed to pay a $25 million penalty to settle False Claims Act allegations,

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Align with a hospital… and protect your autonomy

Declining reimbursement, uncertainty over health care reform, increased competition, the need to access capital and the overall economy are driving practices like yours to align themselves in some way with hospitals.

It may be necessary, but it's a *huge* step to take. It's a step fraught not only with uncertainty over your practice's autonomy, physician compensation and the future culture of your office, but one that will affect the financial health of your practice more than all the other decisions you make, combined, in any given year.

At **Physician-Hospital Alignment Strategies 2011**, you'll get the answers you need from top authoritative experts, buyers and other practices that have already aligned. They'll teach you how to navigate the maze of alignment options to find and negotiate the best possible deal that is right for your practice. Join them at Caesars Palace in Las Vegas, June 6-8, 2011, to:

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- **Find out just how much your practice is worth** – and make sure how you assessed it passes legal muster
- **Prepare thoroughly for due diligence** – don't lose a great deal at the last minute to an overlooked detail
- **Work successfully with your hospital after the deal has closed** – how to set yourself up for good day-to-day relations

To see the full agenda, speakers and find out how to register, visit the website at *www.practicealignment.com*, or call 1-855-CALL-DH1 (1-855-225-5341).

From the
DECISIONHEALTH® PROFESSIONAL SERVICES
Case Files

Case 54: The case of the wrongly unbundled E/M services

The client: A mid-sized multi-specialty group in the Southeast.

The audit: DecisionHealth Professional Services performed chart audits for every physician and non-physician practitioner at the practice, focused on accuracy of E/M billing as well as the accuracy of billing for procedures performed at the practice.

Overall, the practice's E/M code selection during encounters when only an E/M service was billed was decent, with isolated instances of overcoding and undercoding by some providers.

The problem we did uncover at the practice was a pattern of routinely billing E/M services along with minor procedures, without clear evidence in the documentation that the separately billed E/M service was justified. In these instances the practice included modifier **25** (separately identifiable E/M service) alongside the E/M code, but it did not appear to be justified by the record.

These E/M services were considered to be overpayments, as the documentation suggests the E/M service would be bundled into the procedure.

The background: Virtually all minor procedures do not allow you to also bill for an E/M service during the same encounter unless the E/M service was to treat a condition other than the one being addressed by the minor procedure, or the E/M service itself led to the decision to immediately perform the minor procedure.

Correct Coding Initiative (CCI) edits published by a Medicare contractor and updated quarterly list billing scenarios when two codes cannot be separately paid. In many of these instances, you are allowed to use an appropriate modifier when you belief payment for each service is justified.

In the case of this practice, there was a pattern of billing an Unna's boot application with code **29580** and also billing a **99212** with modifier 25. By using the modifier, the practice signaled to the payer that each service should stand on its own and be paid separately.

But the documentation for the service reflected only the application of the Unna boot, a treatment for venous stasis ulcers or other venous leg issues.

In order for the E/M service to be payable, the documentation needed to reflect treatment for a different condition that was able to stand on its own. Had the practice also treated the patient for congestive heart failure, for example, it would have been justified to bill the E/M service with the modifier if reflected in the documentation.

Recommended Corrective Action Plans: We trained each member of the practice in the proper use of and justification for modifiers, as well as how the CCI edits work and what CMS considers to be appropriate E/M service payment rules.

We stressed the emphasis on "significant, separately identifiable" services needed to be in the documentation and gave the practice case studies and examples of services that would permit the use of a separate modifier and others that would not support the separate E/M service and the modifier.

On the Internet:

- CorrectCodeChek: *www.correctcodechek.com*
- CMS Correct Coding Policy from Internet Only Manual Pub. 100-04, Chapter 12, Section 30: *www.cms.gov/manuals/downloads/clm104c12.pdf*

Sean M. Weiss, vice president & chief compliance officer of DecisionHealth can be contacted directly at *sweiss@dhprofessionalservices.com* or at 1-770-402-0855. DecisionHealth Professional Services provides full-scale medical consulting services. To learn more about our services visit us at *www.dhprofessionalservices.com* or contact us at 1-888-262-8354.

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the Justice Department announced Feb. 24, 2011. The settlement resolves claims that BlueCross BlueShield of Illinois wrongly terminated insurance coverage for private duty skilled nursing care for medically fragile, technologically dependent children, to shift the costs to the Medicaid program. Under the agreement, BlueCross BlueShield of Illinois will pay $14.25 million to the state of Illinois and $9.5 million to the United States. The company will also pay $1.25 million to Illinois for allegations under the state consumer fraud statute. This resolution is part of the government's emphasis on combating health care fraud under its Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative. The Justice Department has recovered more than $5.5 billion since January 2009 under the False Claims Act in cases involving fraud against federal health care programs.

- **Medicare Fraud Strike Force Charges 111 Individuals for More Than $225 Million in False Billing.** The Medicare Fraud Strike Force charged 111 defendants in nine cities, including doctors, nurses, health care company owners and executives and others, for their alleged participation in Medicare fraud schemes involving more than $225 million in false billing. The joint Department of Justice and HHS (DOJ-HHS) Medicare Fraud Strike Force is designed to combat Medicare fraud through the use of Medicare data analysis techniques and an increased focus on community policing. In addition to making arrests, agents also executed 16 search warrants across the country in connection with ongoing strike force investigations. DOJ and HHS also announced the expansion of Medicare Fraud Strike Force operations to two additional cities - Dallas and Chicago. This operation is the largest-ever federal health care fraud takedown. View the complete release at *http://go.usa.gov/g86*.

- **Affordable Care Act controls costs for early retiree coverage.** Health and Human Services Secretary Kathleen Sebelius released a new report March 2, 2011 showing that the Early Retiree Reinsurance Program (ERRP) created by the Affordable Care Act is reducing health care costs for early retirees on March 2. As of December 31, 2010, more than 5,000 employers had been accepted into ERRP, more than $535 million in health benefit costs have been reimbursed through the program, and those payments have helped benefit more than 4.5 million Americans. This funding provides financial assistance for health plan sponsors – including state and local governments, for-profit companies, schools and other educational institutions, unions, religious organizations and other non-profits – to help early retirees and their families maintain access to quality, affordable health coverage. The largest share of 2010 reimbursements went to governments, including state and local governments, school districts and other local agencies. A list of approved plan sponsors, updated on January 27, 2011, is available online at *www.HealthCare.gov/law/provisions/retirement*.

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