

Health Care Fraud and Abuse: Law Enforcement Viewpoint

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*Supervisory Special Agent
Federal Bureau of Investigation
Health Care Fraud Unit*

FBI Structure

Asset Forfeiture/Money Laundering Unit-Smaller Unit

Economic Crimes Unit-“Big” unit

National Mortgage Fraud Team

Health Care Fraud Unit –250 agents/200 support staff

1 unit chief/5 supervisory special agents/ 2 MPAs(Mgt Program Analyst)/1 financial analyst

Questions may be directed to field offices or to national level.

No money thresholds for cases per national FBI policy however regions may have limits that are in place for cases that they will begin investigations on.

Letter of Memorandum –

Must be shared with other law enforcement depts. of govt within 30 days. – HHS OIG/DOJ.

A “reasonable” belief needs to exist prior to a case being opened (a cluster of incidents/information needs to support reasonable belief).

What is Health Care Fraud?

The deliberate submittal of false claims to private or public health care plans.

The real difference between fraud and abuse is the person’s intent.

How Much?

Losses > \$130,000 billion annually.(National Insurance Crime Bureau)

This figure is a guess since CMS does not categorize their monies in easy to understand ways.

Current Top Initiatives:

DME

Home Health Care

Infusions

Medical Transportation

Podiatry Fraud

96.8 million billed each year for nail debridements.

1 in 4 cases sample had coumentation

7.3% of sampled documentation inadequate

Take Home Messages:

- 1. Don’t be afraid to be part of the solution. Look at law enforcement as being part of the solution. .*
- 2. Consider being a participant in a health care fraud working group in your locale.*

Health Care Reform Updates – Faye Frankfort

Reviewed APMA’s work since April 2009. These updates are available on the E-advocacy site and PPT will be available on the APMA website in a few days.

- ***Along with Title XIX inclusion emphasis was placed on inclusion of provider non-discrimination.***
 - ***MC Fees will not be reduced. Bill separate from HC reform has been introduced and most likely will be passed to change how the reimbursement SGR formula is used.***
 - ***Tort reform legislation is not included in current HC reform. Demonstration projects have been presidentially directed to start immediately.***
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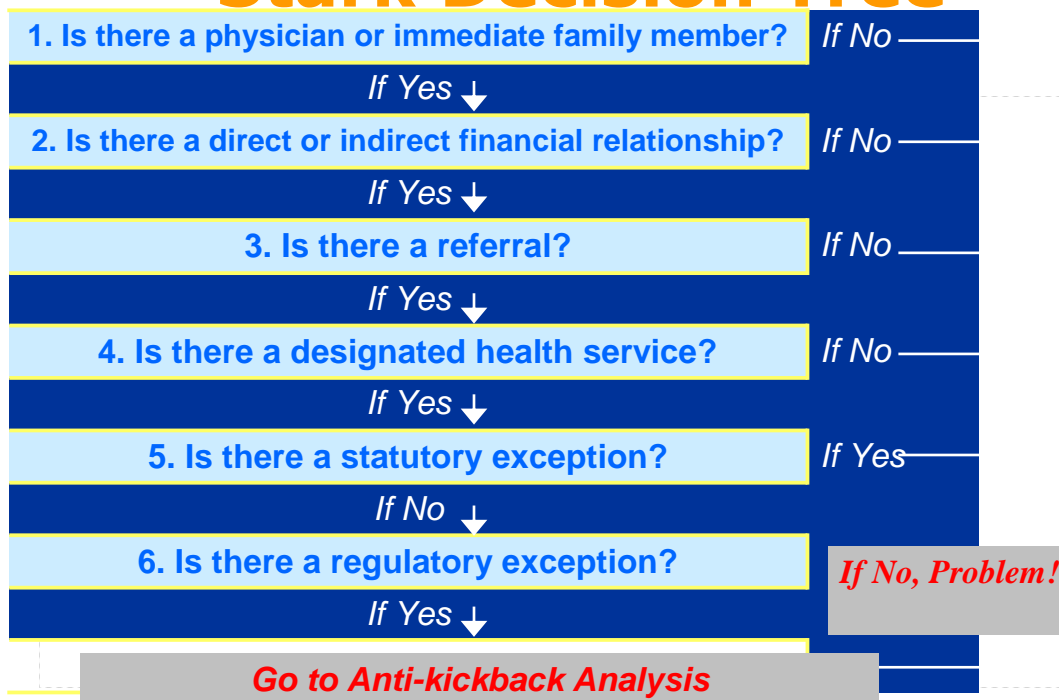
2010 Physician Issues updates:

- ***Reduction in Conversion Factor – required by statute.***
CMS is proposing removing injectable drugs from the formula to be effect in 2013. The SGR in legislation reform may go away....
Also reducing payments for high cost imaging services (equipment over 1 mil) and requiring providers of the technical component of advanced imaging services to be accredited. (CT, MRI, PET services must be accredited by 2012 in order to be reimbursed by MC.)
Historically, there have been loopholes to Stark to allow services to be utilized.
- ***Proposed for 1/1/2010-Elimination of all consultation codes except for telehealth. (Should know more after mid-November)***
Code instead as NP or est. pt CMS proposes to make change “revenue neutral”
 - ***Increase work RVUs for initial and established office visits by 6%***
 - ***Increase work RVUs for initial hospital and nursing home visits by 2%***

Issues with how “transfer of care “reports will be done will need to be decided on.

- *The “real” Stark*

Stark Decision Tree



Can a physician perform surgery on a MC pt in an ASC that you have a limited partnership agreement with? Yes – if the services provided at the ASC are bundled services.

Can a physician refer MC pt to imaging ctr that s/he has financial interest in? Probably not. If there is a group practice agreement with the imaging ctr then referral may be possible. (These relationships must be analyzed on individual basis.).

Overpayment changes –

OIG Voluntary Disclosures

- *March 24, 2009 Open Letter to Health Care Providers*
- *Focus resources on “kickbacks intended to induce or reward a physician’s referrals”*
- *Narrows the scope of OIG Self-Disclosure Protocol*
- *OIG will no longer accept disclosure “of a matter that involves only liability under [Stark] in the absence of a colorable anti-kickback statute violation”*
- *Minimum \$50,000 settlement amount*

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ASC –Significant activity in this area.

- *Conditions of Participation:*
- *42 C.F.R. Part 416*
- *CMS State Operations Manual: Appendix L*

Distinctions between offices and ASCs

- *ASC means “any distinct legal entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, has an agreement with CMS under Medicare to participate as an ASC, and meets the conditions set forth in Subpart B and C of this part.”*

Selected examples of conditions and standards

- *Space is used exclusively for ASC*
 - *Separate building is not required*
 - *“Semi-permanent walls and doors” are needed*
- *No overlapping use of common space or common functions*
 - *Common space may be used by ASC during periods of exclusive use*
- *Separate staff*
 - *ASC nurse may not also provide services at the same time to a hospital, clinic, or private office*
- *Separate recordkeeping*
- *Designated ASC governing body required*
- *Quality assurance process required with accountability and reporting*

Evidence of Accountability

- *Evaluation of appropriateness of care should include analysis of:*
 - *Anesthesia recovery;*
 - *Infection rates;*
 - *Pathology reports;*
 - *Nursing services;*
 - *Completeness of medical records;*
 - *Complications that have occurred; and*
 - *Stability at discharge.*

ASC Conditions of Coverage

- *ASC governing body will have additional obligations*
 - » *Oversight & Accountability of Quality Assessment & Performance Improvement Program*
 - » *Ensure that physicians performing surgery in ASC have hospital admitting privileges*
 - » *Adopt disaster preparedness plan*
- *Quality Assessment & Performance Improvement Program*
- *Must measure, analyze & track quality data*
- *Patient must be informed of their rights before surgery.*
- *Focus on Infection Control Practices*

- *Additional Patient Assessment Requirements*
 - » *At least 30 days prior to procedure*
 - » *Immediately before surgery*
 - » *Before discharge*
- *Post-op instructions and supplies for first 24 hours must be given to patient*

■ *Important ASC Reminders*

- *An ASC must be certified and approved to enter into agreement with CMS*
- *ASC must comply with state licensure requirements*
- *ASC space must be used exclusively for ambulatory services*
 - » *ASC should not mix functions with adjacent physician's office*
 - » *Must have entirely separate operations, records etc.*

Office of Inspector General

2009 Work Plan: ASCs

- *Place of Service Errors*
- *OIG review physician coding of place of service on Medicare Part B claims for services performed in ambulatory surgical centers (ASC) and hospital outpatient departments. Federal regulations at 42 CFR § 414.22(b)(5)(i)(B) provide for different levels of payments to physicians depending on where the services are performed. OIG will determine whether physicians properly coded the places of service on claims for services provided in ASCs and hospital outpatient departments.*
- *OIG will review the appropriateness of the methodology for setting ASC payment rates under the revised ASC payment system and will examine changes to the revised ASC payment system and the rate-setting methodology used to calculate ASC payment rates.*

ASC Payment Updates

- *October 2009 Update to ASC Payment System*
 - *Effective for dates of service on or after July 1, 2009: 11 new HCPCS drug and biological codes that are separately payable (eg. Skin substitutes: Alloderm and Integra Meshed Bilayer Wound Matrix).*
 - *Skin Substitute Alloskin will be eligible for separate payment when it is integral to a covered surgical procedure*
- *CMS Favorite Asked Question:*
 - *How should ASCs Report Bilateral Procedures under the revised ASC payment system?*
 - » *Should be reported as a single unit on two separate lines or with "2" in the units field on one line, in order for both procedures to be paid*
 - » *Modifier -50 not specifically prohibited however may result in incorrect payment*
 - *Reporting of Bilateral Procedures (Cont.)*
 - » *If the same procedure was done on the great toe of the right foot and on the great toe of the left foot report the procedure code once and append modifiers T5 (right foot, great toe) and TA (left foot, great toe) to the code.*

New ASC Survey Process

Health Care Associated Infection Initiative

- *50 million dollars from American Recovery and Reinvestment Act appropriated to reduce HAI*
 - *10 million given to State Survey Agencies*
- *Developed In response to:*
 - *increase in health care associated infections*

- » *2008 Hepatitis C outbreak in Nevada traced to poor infection control in ASCs*
- *Growing number of procedures being performed at ASC*
 - » *account for 43% of all same day surgery*

■ *Initially rolled out in 12 states*

- *Maryland, Michigan, Maine, New Jersey, North Carolina, Oregon, Utah, Wyoming, Arkansas, Indiana, Florida and Kansas*

■ *National Implementation scheduled to occur in 2010*

Working with Employers / Private Insurers

Eileen Quenell

Health & Welfare Consultant

Towers Perrin Human Capital Group

Fully Insured Plans – No Flexibility

Risk is retained by insurer

State mandated benefits

Standard plan offerings

Self-insured plans- Great Flexibility

Big 4: Aetna, BCBS, Cigna, UHC

Regional HMOs: Kaiser

Third Party administrators

Employer's plan goals

Simplicity Rules-

- *Comprehensive benefits*
- *Extensive provider networks with optimal discounts*

Design process-

- *Employers review benefit specifics only once q3 yrs... and only if they are changing vendors.*
- *Podiatry has no specific line item- generally found under specialty physicians.*
- *Employers rely heavily on vendor recommendations unless there is a unique characteristic of their business.*

Long term –

- **Improving health status is the only real means to control future costs.**

Health info tools and resources to support employees in their pursuit of healthy behaviors.

Demand that employees take personal accountability for their health status:

Mandatory HRAs and biometric screenings are becoming prerequisite for health plan enrollment

Back to the future: a return to risk-rating

Focus on fitness and exercise

It is estimated that obesity costs make up 11% of the total spending of US health care dollars – it is estimated that every excess pound costs \$25 to self-insurers.

31 states have BMIs >30.

8% of US population has been dxed with DM – up 13.5% for the period 2004-2007.

How is podiatry positioned to contribute to managing the cost of DM?

- *Partnering with insurers as aggregators for an enhanced seat at the table is the best way to access employers.*
- *Imbed podiatric services in vendor health promotion tools (fitness and exercise modules)*

Start with Cigna likely the most receptive – smallest of the 3 commercial vendors and most open to new ideas.

Then Aetna –

...United Healthcare- internally focused.

...BCBS

...Kaiser

Bottom line – ROI from employers viewpoint.

APMA funded study by Thompson-Reuters mining data on podiatry services – due to be completed end of year.

RUC

Frank Spinosa, DPM

RUC is an AMA committee consisting of:

- 28 specialty organizations
- 1 HCPAC Co-Chair
- 3 CMS representatives

RUC Purpose

- Value physician time and practice expense for any and all CPT codes
- Meets 3x per year, plus a 4th time for Five-Year Reviews

76880 – Diagnostic Ultrasound (Flagged)

- Predominantly performed by podiatry
 - APMA is asking CPT to report soft tissue US exams of the BLE & foot 7688x.
 - Re-survey code 76880
-

Chad Appel

State Advocacy Review

On-line resources – State Reference Manual

The Advocate – quarterly publication.

State Advocacy Handbook

State Advocacy Toolkit (not available on-line)

State Advocacy Forum

Jeff Ross, DPM –

Practicing Physician Advisory Council=Group advising CMS

Problems that have been discussed:

RAC and its focus on physician as suppliers of DME and accreditation process.

MEDPAC = group advising congress. No podiatrist currently on this committee.

Mark Block, DPM
Chair APMA Health Policy Committee

Oversees:

- HSC = Health Systems Committee
- Subcommittees – Coding, DME

HPC issues:

- Wisconsin Physician Services (MC Intermediary) – RFC
Meeting set-up 10/20 to discuss issue.
 - Dermagraft -58 modifier with use of 15365. RUC will be reviewing this.
CPT is having current discussion about this during this meeting. There is POV that -58 should only be used in facilities and
 - L30xx
Subcommittee tasked with reviewing these issues and making recommendations. The codes – descriptors are outdated. Meeting set with interested organizations on 10/19.
 - Provider Enrollment COS=reregistration process with MC
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Paul Kinberg, DPM
Chair, Coding Committee

- American Academy of Professional Coders is writing exam on behalf of APMA to write certification exam that is expected by year-end.
 - Reuters-Thompson Study
 - Seminars/Webinars
 - Coding changes
S0395 L & R modifiers-works with Cigna, BCBS, UHC.
 - Meeting for L30xx.
 - ICD-10 Review
 - New ICD -9 codes available in resource center- Neurolysis code, Gout Codes, E-codes. Proposed E-News on this topic.
-

BMAD Data 2008 – Will be posted on APMA website

Podiatry is the 22nd largest group that billed MC in 2008 (1.5% of all providers billing MC). In 2005, podiatry was 18th.

There are 79 MDs for every DPM on a national average.

A5500

Total \$107,081,492

#1- biller podiatry

#2 – MedicalSupply Company

#3 – Pharmacy

A5501

#1 – Certified orthotist

12 = #A5512 & A5513

#1 – Podiatry

#2 – Medical Supply Co.

11721 – Nationally ranked #1

NM =49

99213 = #2 nationally

NM = 101

99212 = #3 nationally

NM=48

64640 – injection txmt of nerve: Podiatry was leading biller 79%.

Denied or Modified Claims?

Franklin Kase, DPM

The Essentials of Appeals

Member, APMA Health Systems Committee

Contracts – READ THEM !

Specific provisions: Timely filing, penalties, timeliness of receipt of payment.

Predeterminations of benefits or preauthorizations should be written in contract that these services need to be paid. (May have State Consumer protection laws that cover this.)

Insurance violations – UHC/Pacificare

- Wrongful denials of covered claims
- Incorrect payment of claims
- Lost documents/medical records
- Failure to timely acknowledge receipt of claims
- Failure to respond to appeals
- Failure to resolve provider disputes

PROS AND CONS OF CONTRACTING WITH INSURANCE/HEALTH PLANS

PROS

- Fixed fees –may be able to negotiate
- Direct payment to provider from co.
- Marketing benefit-web site, provider directory
- Paid for add. Codes
- Less collection issues?
- Increase referrals from Health Plan docs

CONS

- Deep discounted fee
- Can't balance bill pt.
- Egregious provisions
- Unreasonable filing deadlines
- Silent PPOs
- Alteration of practice patterns

NON-CONTRACTED PROVIDERS (NCP)

PROS

- No fee limit
- Able to balance bill pt.
- No egregious contract provisions
- No Silent PPO's
- Able to practice at will
- May be ALLOWED a higher amount by HP

CONS

- May lose patients
- May lose referring docs from Health Plan (HP)
- Need to collect DIRECTLY from patient
- No marketing through health plan

APPEALS PROCESS – GENERAL INFORMATION

- Phone insurer – record person's name, date and time of call, tracking #
- Get to know supervisors/mgrs – they can get your claims paid.
- If you have a repetitive denial of payment, despite calls and/or preauth., record discussion.
- Get pts involved (e.g. 3-way call)
- Letter to Health Plan within 180 days of received EOB – Postmark date
Blue Shield, Cigna, HealthNet- 365 days
- Copy of original HCFA 1500
- Copy of EOB
- Clear explanation as to why payment should be made
- Supporting documentation – progress notes, operative report, etc.

APPEALS PROCESS – EXTENDING 180 DAY DEADLINE

- ***Send letter to health plan that states “I am protesting denial or modification of codes for services provided to patient ‘X’ on ___ date of service. A detailed demand letter will follow.***
- ***Extends deadline for 1 year***
- ***Return receipt mail***

APPEALS PROCESS – WHICH CLAIMS DO I APPEAL?

- **ALL codes that have been denied or modified**
- **Must be able to support your position with CLEAR medical records and proper computer inputted patient personal info.**
- **Must be educated as to CPT and ICD-9 Guides**
- **DO NOT APPEAL if you cannot justify your billing – should have not been billed in the first place**

WHEN WILL HEALTH PLAN DENY PAYMENT FOR APPEALED CLAIM?

- **Whenever they can!**
- **Issue is money – not about a dislike for you**
- **For profit companies – obligation to shareholders**

APPEALS PROCESS – When will a health plan pay an appealed claim?

- **Demonstrate they violated your contract with them**
- **Demonstrate they violated the law and/or accepted coding guidelines**
- **Demonstrate they have previously paid for the same procedure/service on other patient claims**

APPEALS PROCESS – WHAT IF THEY STILL DON'T PAY?

- **Request letter indicating criteria used for denial or modification of claim**
- **Request re-review by a Board Certified MD, DPM, DO**
- **Letter to State Dept. of Insurance**
- **Direct discussion with Director of Provider Relations and/or Medical Director**
- **Letter to Dept. of Managed Health Care**
- **Legal counsel – arbitration, lawsuit**
- **State Medical/Podiatric Medical Assn.**
- **www.naic.org (National Assn. Insurance Commissioners)- Maintain relationship with DOI.**

APPEALS PROCESS – PRIVATE HEALTH PLANS

- **Grievance Form – Web site or telephone**
- **Health Plan Provisions – Subscriber and Provider re: benefits and exclusions**
- **Policy re: modifiers, claims-editing, claims reviewers**
- **Regulated by California Department of Insurance – understaffed, but does keep records**

APPEALS PROCESS – PRIVATE HEALTH PLANS: ERISA

- **Specific Plans – rules and rights**
- **As per Dept. of Labor, Plan must pay or deny claim w/in 30 days; possible 15 day extension.**
- **ERISA – Regulations are Federally issued to protect employees**
- **Health Plan must have doctor in similar field review health claim**
- **Employee right to bring legal action , including demand for arbitration, against the Plan**

APPEALS PROCESS – HMO’s and MANAGED CARE PLANS

- **Filing an Appeal – similar to Private Health Plans**
- **Grievance Form or Dispute Resolution Form**
- **Supporting documentation**
- **Health plan provisions re: subscriber and provider – read contracts for benefits and exclusions**
- **Determine policies re: claims editing, modifiers, claims review**
- **Independent Physician Association – intermediary between HMO and provider – appeal first to the IPA, then if necessary, to the HMO**
- **Determine policies re: claims editing, modifiers, claims review**
- **Independent Physician Association – intermediary between HMO and provider – appeal first to the IPA, then if necessary, to the HMO**
- **Second appeal – copy to Department of Managed Health Care (DMHC)**
- **DMHC – more aggressive in pursuit of outliers than Department of Insurance**
- **Issue which is unresolved after 30 days after appeal is filed – may be eligible for Independent Medical Review (IMR)**

APPEALS PROCESS-MEDICARE

- **Federal law requires Medicare to pay 95% of clean claims within 30 days**
- **Appeals process is unique**
- **Multi-step process**
- **Must follow each step sequentially in order to reach the next level of appeal**
- **Levels of Appeal – After initial determination (i.d.) is reached**
 1. **Redetermination**
 - **file within 120 days of i.d.**
 - **no \$ limit**
 - **use appropriate form (available on-line)**
 - **use form CMS 20027**
 2. **Reconsideration-Qualified Independent Contractor**
 - **6 months of Redetermination findings**
 - **use Palmetto form at same website**
 - **fill out form on-line and print**
 3. **Admin. Law Judge -**
 - **file within 60 days of QIC findings**
 - **\$120 or more in question**
 - **QIC letter indicates where ALJ Appeal sent**
 4. **Departmental Appeals Board (DAB) Review**
 - **file within 60 days of ALJ decision (no \$ limit)**
 5. **Federal Court Review**
 - **file within 60 days of DAB decision**
 - **\$1,180 or more at issue**

APPEALS PROCESS-MEDICARE

Special Issue – Request for Overpayment

- 1. Submit redetermination appeal w/in 30 days of request; otherwise CMS contractor will withhold money and interest from future claim.***
- 2. Submit reconsideration appeal w/in 60 days of redetermination decision to QIC
Need to submit all your notes and supporting materials.***

- ***Special Appeal Method – Telephone Review***
- ***Should have appealed HCFA form present***
- ***Issues for telephone review include:***

- 1. number of services/units***
- 2. change, add, delete modifiers***
- 3. erroneous denials (duplicates)***
- 4. diagnosis codes***
- 5. procedure codes***
- 6. dates of service***

- ***Issues not for telephone review***

- 1. medical necessity denials***
- 2. analysis of medical documents-
op reports, clinical data requiring MD,DPM input***
- 3. overpayments***

- ***Requesting a Review – available to provider or beneficiary***
- ***Need to either complete Form CMS 1964 –***
- ***Written Request for Review – need data from original HCFA 1500 form, i.e.
dates of service, Medicare ID #,
claim number, etc.***

APPEALS PROCESS – WORKERS COMPENSATION

- ***Special situation***
 - ***Cannot recover denied monies from patient***
 - ***May file a lien against workers settlement or with WCAB***
 - ***Provider has legal remedy for recovery of denied claims monies***
 - ***Claims reviewed by companies designed to reduce or modify your claims***
 - ***Appeals usually go to ‘Review Company’***
 - ***Provider or patient can request a review by a doctor of ‘similar specialty’***
 - ***Usually of benefit to make direct contact with claims analyst or review
company’s analysts***
 - ***How to appeal a workers compensation claim***
 - ***Be familiar with OMFS***
 - ***If DME has a fee value under OMFS, no invoice necessary.***
 - ***Send copy of denied or modified claim***
 - ***Supporting documentation inc. progress notes, reports, labs, X-Ray reports, etc.***
 - ***Letter as to why the claim should be reconsidered***
 - ***Legal counsel***
-

Recovery Audit Contractors (RACs)

Terry Connors

*Vice President Health Care Service Group
A&T Systems, Inc.*

Schante Smith

*Director of Coding Support
A&T Systems, Inc.*

What does the RAC Review?

- *Review claims and medical records on a post payment basis*
- *Review claims paid after October 1, 2007*
- *RACs will be able to review medical records three years from the date the claim were paid*
- *Collect overpaid claims paid*

Fiscal Year 09

Medical Record Limits

Physicians

- *Single Practitioner: 10 medical records per 45 days per NPI*
- *Partnerships 2-5 individuals: 20 medical records per 45 days per NPI*
- *Groups 6-15 individuals: 30 medical records per 45 days per NPI*
- *Large Group Practices 16+ individuals: 50 medical records per 45 days per NPI*

Other Part B Billers (DME, Labs)

- *1% of the average monthly Medicare claims (max 200) per NPI per 45 days*

How to Prepare Your Providers – No one will be exempt.

- *Identify improper coding and billing that is based on documentation in the patients medical record*
- *Assist the providers with training programs that can ensure they are meeting Be available to assist the office in the event that the RAC communicates an audit*
- *Perform an independent assessment to identify areas of non-compliance with Medicare/Medicaid rules*
- *Identify any corrective actions required for compliance*
- *Implement any required changes to stay in compliance*

Importance of Documentation Compliance

- *The medical record or chart notes must match the codes you submit*
 - *Evaluation & Management (office visit)*
 - *Diagnosis*
 - *Injections*
 - *Supplies*
- *Medical Necessity must clearly state the need for all services provided or prescribed.*
- *Billing team must track all denied claims*

- *Identify all the issues*
- *Look for patterns*
- *Deploy any corrective actions to avoid improper payments*

When the RAC arrives

- *Must provide a clear response to the letter within 45 days.*
- *Retain a certified coder to review the records prior to submission.*
- *Send copies of the charts to the RAC- signature required notification of receipt.*
- *Digitized/electronic file of your charts and supporting documentation.*

WATCH THE MAIL FOR A RESPONSE

- *RAC will issue a Demand letter*
- *RAC will offer an opportunity for the provider to appeal the decision*

Demand letter comes from the (RAC)

- *Issue Remittance Advice*
 - *Remark Code N432: “Adjustment Based on Recovery Audit”*
- *Recoups by offset unless provider has submitted a check or a valid appeal*

Providers HAVE NO CHOICE...

THEY TAKE THE \$\$ DIRECTLY FROM YOUR MEDICARE CHECK

Disagreement –No Appeal

- *Send check on or before Day 30 -if do not appeal*
- *Recoupment by Medicare (overpayment + interest) on Day 41 and do not appeal*
- *Extended Payment Plan-Request or apply for extended payment plan (overpayment + interest) and do not appeal*

Appeals

- *Pay by check on or before Day 30 (interest is not assessed) and file an appeal by Day 120*
- *Allow recoupment (overpayment + interest) on Day 41 and file an appeal by Day 120*
- *Stop the recoupment by filing an appeal before Day 31*
- *Request or apply for extended payment plan (overpayment + interest) and appeal by Day 120*

Ask the auditor what E/M guidelines (95 or 97) are using? The provider may choose to use one or both and the auditor needs to use what the physician has been using.

What codes do What?

CPT assigned based on documentation.

Medical Necessity:

Documentation should support that the care provided was needed to reasonably treat and care for the pt and problems that are being addressed during that encounter.

Benefits are restricted to those drugs, devices, txmts or procedure for which the safety and efficacy have been proven procedures to be comparable or superior to conventional therapies.

Supporting Medical Necessity:

- ***The final Dx***
- ***The presenting signs/symptoms***
- ***Unconfirmed dxs (rule out and vs)***
- ***Any dx tests ordered (V-codes can be used)***
- ***The specificity of the dx***
- ***Coexisting and chronic conditions.***

Co-morbidities/underlying dx should only be considered in the E/M level when their presence significantly increases the complexity of the medical decision making. If chronic conditions are listed in PMH area the dx should be listed in the A/P area.

Higher levels of medical decision making (MDM) can be supported when the affect that the chronic condition has on the encounter is clearly documented.

On the CMS website – “Present on Admission”: lists the dxs that hospitals will not be paid for if condition was present upon admission.

Performing and Documenting a detailed or comprehensive H&P?

Think about this – the H7P will drive the medical necessity for the visit.

- ***Do what you need-to-do to take care of that pts needs at that time.***
- ***E&M is a valid reflection of the workload for that pt based on presenting problems and/or identified problems during the stay.***
- ***How long does a detailed or comprehensive H&P take?***

E&M calculation

- ***Table B of the E&M guidelines/CMS guidelines, the coder can assign a bullet for an “order” for labs, radiology and other tests.***
- ***Table C – Table of risk=the dx test ordered and has a major role in the level for table of risk.***

Review and/or order of clinical lab tests, radiology, and other tests.

Areas of Current Interest for CMS: On website and are categorized per interest area.

Wound care –units of care

Excisional and Debridement codes

Injections

Modifier-25 Basics

- *Significant, separately identifiable E&M service on the same day as minor procedure.*
- *Use modifier-25 when the E&M service is separate from that required for the procedure and a clearly documented, distinct and significantly identifiable service was rendered.*
- *Append to the R&M code no the CPT procedure code.*
- *Procedure and E&M must occur on the same day by the same provider.*
- *The dx for the E&M service can be the same as or different for the one for which the procedure was performed.*

Surgical Package

Minor – 0-10 day global

Major – 90 day global

Coders may not code dxs documented as probable, suspected, questionable, ruled out, or working dxs. They can only code conditions to suspected highest degree of certainty for that encounter/visit, such as symptoms, signs, or abnormal.

DM coding/Specificity

ICD-9 codes may have 3-5 digits. Each digit provides important information about the pt's condition.

Diabetic “neuropathy” NOS codes to 250.6X and 357.2

Diabetic “peripheral autonomic neuropathy” codes to 250.6X and 337.1

For reviewing Past Hx citing previous dates in current chart is acceptable.

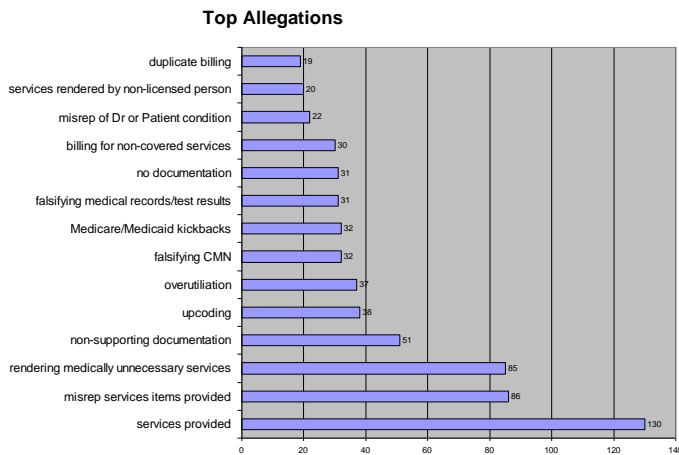
Medicare Audit Defense

Kevin West, Esq.

Law Office Hall, Farley, Oberrecht & Blanton, P.A.

Mr. West is a legal counsel for PICA and related that PICA policyholders do have some level of coverage for Audit legal assistance. Many policyholders of PICA may not know this.

Fraud Investigation Database



Physician Audits: 454 – Top specialties: Podiatry, Internal Medicine & Gastroenterology

Most Commonly Audited Codes

11720/11721 (nail debridement)
E/M Codes – all (-25 modifier)
11730 (nail avulsion)
11040 series (ulcer debridement)
11060/11061 (I&D of abscess)
11050 series (paring of skin lesions)
99241 series (consultations)

When the auditors identify a undercoded or overcoded claim, rarely will the claim be paid without the physician appealing the auditor decision.

RAC audits – Have not been seen frequently for podiatry – YET !

2 types: Automated review (w/o medical record)

Complex review (w/ Medical record)

Generally smaller dollar amounts at issue.

Reforms implemented in July 2008:

- ***Recouping before appeal is done***
- ***RAC contingent fees would be lost if appeal is found in favor of the physician.***

Program Safeguard Contractors

- ***Have taken over most of the audit functions previously performed by carriers.***
- ***Often do statistical sampling and extrapolated overpayments.***
- ***Review personnel often are poorly trained as to podiatry coding and billing.***

*Zone Program Integrity Contractors – taking over the Program Safeguard contractors.
Even further removed from the provider; more abusive.*

2009 OIG Work Plan

- *Place of service errors – NH, Asst care facilities.*
- *E/M services during global surgery period*
- *High utilization of ultrasound services*
- *DME*

New MC Audit Rules

- *Limitations on prepayment review*
- *Limitations on extrapolated overpayments without first “educating” the provider or documented high rate of error*
- *No recoupment of overpayment until second level of appeal (QIC) is completed*
- *Easier process to get extended repayment plans.*

1st Level –Redetermination

- *Conducted by the Medicare Carrier*
- *No hearing; just a “second look” by the carrier*

2nd level Reconsideration

- *Previously known as carrier fair hearing*
- *Carrier hearing officers replaced by Qualified Independent Contractors (QIC)*
- *In-person hearings usually not allowed*
- *Providers should not be without competent counsel at this level.*
- *Less due process at this level (No further evidence will be allowed to be introduced after this level.)*
- *QIC is bound by LCD’s, NCD’s, MCM*
- *All evidence must be submitted or may not be considered at next level of appeal*

3rd level – Administrative (Mr. West :”85% of cases won at this level”

- *ALJ’s now come from HHS instead of SSA (“cadre judges” are history)*
- *Telephone and video conference hearings the norm instead of in-person*
- *Medicare carrier can now participate*
- *Bound by NCD’s, but not LCD’s or MCM*

4th level – MC Appeals Council (Mr West: Increased numbers of cases are going to this level.”

- *Usually no hearing of any kind, just written submissions*
- *Very little due process (“black hole”)*
- *Many more appeals going to this level*
- *AdQIC appeals*

5th level – Federal District Court

- *Final level of appeal, to federal judge*
 - *Has precedential effect (unlike lower decisions)*
 - *Considerable deference given to lower decisions by ALJ and hearing officer*
-

Participating in Provider Networks

Kelli Back, JD

Law Offices of Mark S. Joffe

Primary Networks:

- Providers are considered “preferred providers.”*
- Members are given an explicit financial incentive, such as lower copayments or a lower coinsurance percentage, to see physicians in the primary network.*
- Incentives are specified in the members’ evidence of coverage (may be noted on their membership card)*
- Plans include primary network physicians in their preferred provider directories.*
- Physicians have a written contract specifying their rights and obligations.*

- Primary networks may be contracted directly by the health plan or they may be rented or leased from a network administrator, such as a PPO.*
- The contract between the network administrator and the physician or group sets forth the rights and responsibilities of the physician and administrator in such instances.*
- A health plan’s primary network may include both directly contracted and leased components, for example, in the case of a health plan that contracts directly with most providers but “leases” specialty networks, such as a podiatry network.*

Primary Network Participation:

- Some plans have begun “tiering” their primary network physicians.*
- Cannot tier unless such activity is consistent with contract.*
- Activity has been controversial; group of stakeholders came together to establish parameters. See the “Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs”*

Secondary Networks:

- Also known as “wrap” or “complementary networks.”*
- Plans access discounts when their members receive services from providers that are not in the plan’s primary network.*
- A written contract with a network administrator (generally a PPO) obligates the physician to furnish discounts to health plans (or in some cases, other network administrators) with which the administrator contracts.*
- Not considered “preferred providers;” services are subject to the “out-of-network” level of coinsurance or copayment under the health plan.*
Landscape has changed, largely as a result of patients increasingly enrolling in open access health plans like, HMO’s with a point of service option and PPOs. Secondary networks are a mechanism used by insurers to control expenses when members obtain services out of network. Organizations such as Beech Street and MultiPlan. Viant.com; look up white space solutions.

Secondary Network Participation:

- A contract with a network administrator obligates the physician to participate in such networks.*
- Many of the organizations that offer secondary networks also offer primary networks or, as in the case of MultiPlan’s acquisition of PHCS, a primary PPO network is acquired by an entity that also offers a secondary network.*
- Any contract that does not obligate the network or its contracted health plans to provide for some sort of member steerage mechanism, such as lower cost sharing, may open the physician to participation in a secondary network.*

The contract rarely explicitly addresses secondary networks.

Are there advantages to participate in 2nd Networks?

- Depends on how the network is administered and whether the payment is sufficient.*
- Some health plans will educate members that, if they see non-preferred physicians who are part of the secondary network, the member’s cost sharing will be less.*
- The member’s card may include the logo of the secondary network and members may be directed to a website to look up secondary network providers.*

In some cases, secondary networks are simply ways for health plan to obtain discounts on services from the broadest number of providers possible.

- Physicians who are part of a secondary network may be paid more promptly than if the health plan had no relationship with the physician.*
- If the amount of payment is not sufficient, participation in a secondary network will never be desirable.*
- Physicians are generally obligated to hold the member harmless and are prohibited from balance billing.*

What's the difference between a secondary network and a silent PPO?

- In short, a contract. Physicians have contracts that obligate them to provide discounts under a secondary network.*
- Silent PPOs take discounts they are not entitled to take.*
- Growing number of state laws have provisions outlawing silent PPOs or calling for transparency with secondary networks.*

Out-of-Network (“for real”)

Physicians who are truly out-of-network have no contractual obligation with the plan or a network administrator to participate in the health plan's primary or secondary networks.

- Regulated only by state and Federal law*
 - *For example, some states limit the amount that can be charged for emergency services*
 - *Medicare Advantage law limits the amount that can be charged to the amount you would have receive under original Medicare*
- Unless the law provides otherwise, you can bill charges*
- Unless mandated by law, there is no hold harmless obligation*

Understanding your participation status and avoiding unauthorized discounts

- Match patient health plans to any discounts claimed on the EOB. Copy patient membership cards and determine whether the discount being claimed is consistent with the plan under which the patient is covered.*
- Matching discounts claimed on the EOB with plan membership may help you identify if the networks with which you contract are offering health plans a secondary network product.*
- It will help you determine whether your claim has been unfairly discounted through a Silent PPO.*

If EOB and membership do not match

- When the discount claimed on the EOB does not match the member's health plan or the payment rate is not consistent with your contract, call to question the discount and to understand why the health plan believes it is applicable.*

This process should not only help you object to unauthorized discounts but will also help provide you with information necessary to determine which contractual relationships you wish to maintain and which you wish to terminate. When you call a health plan or network administrator, be sure to document your call or follow-up with a letter.

Assert your contractual rights:

- If you are surprised to find yourself participating in a secondary network, you should review your contract with the network administrator.*

- *The administrator must abide by the contract --- even if it purchased the network. If the contract obligates the administrator to provide for patient steering mechanisms, such as differential cost sharing, the network administrator may be in breach of the contract by including you in its secondary network.*
- *Check from time to time whether the rates of payment are consistent with your contract with the member's health plan (if you have one).*
- *Beware of instances in which you have a direct contract with the patient's health plan to participate in its primary network, but the plan is paying a lower rate than the direct contract calls for or claiming a discount through its leased secondary network.*

Considering new health plans or networks

- *Go online and look at the types of "products" the plan/network offers to health plans. If it includes out-of-network repricing or secondary networks, proceed with caution.*
- *If you wish only to participate in a primary network, be sure that the contract obligates the PPO or network administrator to make you a preferred provider by including you in the primary network provider directories and providing for advertised differentials in cost sharing in order to provide patient steering.*

Many of the contracts that bind physicians to unfavorable network arrangements are those they signed many years ago, before such arrangements were envisioned.

However, there are steps you can take to avoid entering into new agreements that raise such issues.

- *When examining a contract, determine to whom you are agreeing to provide discounted services. The contract may say that you are obligated to provide services to members of the PPO or that you provide services for all payors or members of payors. Read all related definitions. The narrower and clearer this obligation, the better.*
- *Carefully read the definition of "payor" or other term used in the contract to refer to the entities to which you must provide discounts. Do not agree to a definition that is overly broad. Payors should include only organizations that furnish health care benefits to their members and have entered into a payor agreement with the PPO or other network administrator.*
- *Make sure that the assignment clause is as narrow as possible to avoid allowing the network to inappropriately assign its ability to pay at discounted rates to other organizations.*
- *Ensure that you can terminate the contract without cause and avoid particularly long waiting periods to terminate the agreement. Make sure termination date is not tied to renewal dates. Want to see clean 60 or 90 day period.*

Ongoing protection

- *Keep all copies of the agreements you have signed. When you have questions about an organization's practices, refer to the contract to make sure that the*

organization is meeting its responsibilities. If you wish to terminate the agreement, do so in accordance with the termination provisions and obtain proof of receipt of your termination notice or proof that it was sent. With silent PPOs (i.e. Mutliplan), each of the gobbled up entities, need to be separately resigned from.

Durable Medical Equipment (DME) Issues

Paul Kesselman, DPM

Member, APMA DME Subcommittee

Member, APMA Coding Committee

4 MACs for DME:

**Region D – Cigna Medical Director:
Dr. Kesselman: “Pretty Reasonable”**

NSC Issues:

- *Enrolls DME Suppliers*
- *Podiatric Statistics (50% of DPMs) – 7500 enrolled.*
- *855S Forms –Complex forms. Inconsistencies with FA and Surety Bond. NCS Inspector issues – Obtain copy of “Proper” ID.*
- *Re-enrollment Issues- Do not throw out old enrollment forms until new ones are obtained.*
- *26 vs. 21 Supplier Standards: Currently not well understood since last 5 standards deal with accreditation that does not apply to physician offices.*
- *Accreditation and Surety Bond Exemption – Kudos to the “group” effort at getting these exemptions for podiatry.*
- *“Own Patient” definition (Fed/State/Liability Ins): The accreditation and Surety Bond Exemption only applies to “own Pt” definition. Current firestorm occurring with Optometry services. If colleagues are sending pts with Rx for AFO probably better to have colleague send request for consult for AFO.*
- *Closet Arrangements (Rental of space to disp DME supplies)-Stark and Anti-kickback concerns. MC states provider needs to be the billing entity. No 3rd party billing. Effectively ends the closet arrangements.*

Price Data Analysis Contractor (PDAC)

- *Contractor: Noridian*
- *www.dmepdac.com 1-877-735-1326*
- *Guide manufacturers and suppliers on HCPCS/NDC*
- *The PDAC director is not “practitioner friendly”.*

PDAC bulletins effecting DPMs:

- *Crow boots & AZ brace*
- *Cam walkers (A9283 vs. L4360, L4386)*
- *L1901 – not covered any longer.*

- *Surgically Sterility requirements – “All surgical supplies should be sterile in order to disp.) Currently these suppliers are reformulating their products.*
- *“Providers not using SADMERC approved products should voluntarily refund to the DME MAC”. Lack of legal authority to request refund.*
- *Therapeutic Shoe Policy Update Withdrawn.*

RAC & DME

- *Currently most of the RAC audits have been on the hospital services or SNF.*
- *Only 21% of RAC payments are related to physician DME.*
- *Have they targeted podiatry DME? No. Not yet !*

KX Modifier & AFO Devices

- *KX Modifier = complied w/LCD*
- *O&P HCPCS codes require KX & LT/RT.*
- *Lack of KX on Claim = rejection & cannot be refiled.*
- *Claims must be reprocessed*
- *D/C claims re-openings for lack of KX.*

Current MAC B Prepayment Probes

- *Foam Dressings:*
- *NPWT: 40% error rates in 2008 related to chart documentation.*
- *NPI numbers of dead doctors being used by suppliers.*
- *25% DME fraudulent across the board. (\$2.2 billion)*
- *Self referral to own entities.*
- *PECOS eligibility – Decrease fraud*

NPI vs. PECOS

NPI: Does not guarantee eligible prescriber. PECOS: Guarantees eligible prescriber.

NPI: Does not match licensure with provider. PECOS: Does match Licensure.

NPI: No Tax ID or Taxonomy check. PECOS: Proof of tax ID, taxonomy.

NPI Enroll <2003 = no PECOS

Enroll > 2003=PECOS

Enrollment Modificaion >2003=PECOS

Local carriers – MAC transition does not ensure enrollment in PECOS.

Lack of PECOS Enrollment by prescribing providers – Should be alerted if physician is not enrolled in PECOS. NDC does not know if physician is enrolled in PECOS.

BOTTOM LINE: Each physician needs to check PECOS status.

OIG Therapeutic Shoe Probe

- *KX modifier*
- *Supervisory statement (Certificate of Medical Necessity)*
- *MD/DO foot secondary findings: OIG not finding foot documentations in PCP chart.*
- *Solution: Send consult note to PCP and ask to have this note signed and faxed back for your chart.*

Private Insurance DME Concerns:

L3000 Audits: Have occurred in MD & NY

Recommendation: Make sure documentation of orthotics is available in chart especially with heel cup depths present. Copy of order form in chart.

APMA Staff/Consultants- Available to contact with questions or concerns.

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