Abbey & Abbey, Consultants, Inc.

Medical Reimbursement Newsletter

A Newsletter for Physicians, Hospital Outpatient & Their Support Staff Addressing Medical Reimbursement Issues

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APC/APG Update

Activities on the APC front should be relatively quiet for the time being. The next update for the APC grouper and HCPCS codes will occur on April 1, 2012.

Medicare Enrollment Revalidation

All providers and suppliers who enrolled with Medicare before March 25, 2011 will be subject to the current initial revalidation process. The revalidation process is an outgrowth of the proposed rule issued on April 25, 2003, with the final rule issued on April 21, 2006.[1] CMS had proposed a 3-year revalidation process and then, due to public comments, decided to use a 5-year revalidation process.

The initial revalidation is now under way and the original completion date for CMS was March 2013. CMS has now relented and has moved the completion date for the initial revalidation out to March 2015. As with other initiatives from CMS, the true volume and scope of this overall revalidation process has become evident. The increased workload for the Medicare administrative contractors has been duly noted. Also, as with most bureaucratic processes, a number of challenges have been encountered.

Some suppliers, particularly physicians, have already received their letters requesting the revalidation of their enrollment with the Medicare program. Needless to say, there have been some significant challenges in that the letters do not always get to the intended destination in time. This means that enrollment can be suspended or revoked without the knowledge of the physician.

While physicians are currently the main focus, hospitals, nursing facilities, home health agency, ambulatory surgery centers and other providers and suppliers will certainly be addressed in the near future. If for any reason you think that you should have received a request for revalidation, be certain to contact your Medicare administrative contractor to check on your status. This is simply a safeguard, just in case!

So what is the major issue? The challenge is with the CMS-855 forms. There are now six forms:

- CMS-855-A – Hospitals and Institutional Providers (Part A)
- CMS-855-B – Clinics (Part B)
- CMS-855-I – Individual Physicians and Practitioners
- CMS-855-O – Ordering or Referring Physicians/Practitioners
- CMS-855-R – Reassignment
- CMS-855-S – Durable Medical Equipment

Several of these forms are long and fairly complex. The newest CMS-855 is the form for ordering or referring physicians. CMS has long wanted to implement their requirement that claims contain identification for the ordering or referring physician/practitioner. What CMS did not realize is that there are many physicians that have never enrolled in the Medicare program because they do not ordinarily bill the Medicare program. Thus, the requirement for identifying ordering or referring physicians cannot be implemented until all of them are enrolled in the Medicare program. This is no small task.

Note that on July 1, 2011 CMS released the latest revision to the different CMS-855 forms. This release was virtually without any sort of announcement! They just appeared at the CMS website. Of course, there were changes in the forms including some new information. For instance, on the CMS-855-A there is now a reporting requirement that the exact percentage of management responsibility must be listed. What this requirement really means is not completely clear. CMS has indicated that this data does not currently need to be

[1] These two *Federal Register* entries are almost exactly three years apart. The final rule was rushed to publication because of the three-year limitation that was included in the Medicare Modernization Act (MMA) of 2003.

reported. Note that the exact percentage breakdown of ownership does need to be reported.

Here is a quote from one of CMS's web sites:

Update for Providers on Completing the Medicare Enrollment Application (CMS-855A)

The July 2011 version of the CMS-855A application contains various new data elements in sections 5 and 6. This message notifies providers that they need not complete the following data elements on either the paper or Internet-Based PECOS versions of the CMS-855A application:

Section 5 OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATONS)

- *"Exact percentage of operational/managerial control this organization has in the provider"*

Section 6 OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

- *"Exact percentage of control as an Officer this individual has in the provider"*
- *"Exact percentage of control as a Director this individual has in the provider"*
- *"Exact percentage of management control this individual has in the provider" (under the "W-2 Managing Employee" heading)*
- *"Exact percentage of this contracted managing employee's control in the provider"*
- *"Exact percentage of operational/managerial control this individual has in the provider"*

In addition, under the "Other ownership or control/interest" headings in sections 5 and 6, the "Exact percentage of ownership or control/interest " data element need not be completed if the organization/individual does not have an ownership, partnership, mortgage, security, or other quantifiable interest in the provider.

See the following website:

https://www.cms.gov/FFSProvPartProg/EmailArchive/list.asp

Add to the mix PECOS, the Provider Enrollment, Chain, and Ownership System. This is the on-line system that can be used to file and/or update the various CMS-855 forms. CMS is making strides in improving this system. CMS is also providing periodic updates to the data base of those providers and suppliers that are in this system.

While embarrassing, you may not know for certain exactly what information is on file with Medicare let alone whether you are in PECOS. Now is the time to find out! For all providers and suppliers your main concern at this point is to make certain that you have the right person or persons who have the knowledge and understanding of your organization to revalidate and keep these forms up-to-date. Yes, these forms must be updated within specific time periods. For changes in ownership or management (e.g., board members) the time limit is 30 days.

Also, through the Affordable Care Act (ACA) there are now risk levels for various providers and suppliers. Physicians and hospitals are generally in the low risk category with initially enrolling home health agencies and DME suppliers being in the high risk category. While CMS has not yet started fingerprinting and criminal checks for the high risk category, this process will certainly come in the future.

While enrollment is not likely to become a RAC issue, certainly other governmental auditing entities will want to look at the accuracy of the information being provided through the CMS-855 process. Conceivably, if there were significant deficiencies and/or inaccuracies in your enrollment information, recoupment of payments could be pursued.

Also, there are associated questions such as the provider-based rule reporting requirement and whether or not the CMS-855 forms address this additional compliance issue. Virtually any information you would file in a report to your MAC concerning provider-based status and any changes would also be reported through the CMS-855 process. For instance, your hospital may be added a new provider-based clinic that is an extension of a current provider-based clinic. This fact would certainly be reported through the CMS-855 process as a new practice location. This reporting would also clearly indicate that the new location was a provider-based clinic.

So, do you also have to file a separate report to your MAC relative to this change in provider-based status? This certainly seems the case given the language found at 42 CFR §413.65(c):

(c) Reporting of material changes in relationships. A main provider that has had one or more facilities or organizations considered provider-based also may report to CMS any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that would affect the provider-based status of the facility or organization.

As usual with the provider-based rule, this reporting requirement seems fuzzy. However, in these days of high anxiety in the compliance area, hospitals and other healthcare providers really need to know exactly what is or is not required of them.

Editor's Note: Be certain to follow the revalidation process with care. Many of you are either responsible or may become involved in the various CMS-855 forms. If you have questions that cannot be resolved, be certain to contact your Medicare administrative contractor. In theory they should have the answers.

Reporting & Returning Overpayments

On February 16, 2012 CMS published a ***proposed rule*** in the *Federal Register*. See 77 FR 9179-9187. The comment period to this proposed rule closes on April 16, 2012. This FR entry is in response to §6402 of the Affordable Care Act (ACA).

All coding, billing and compliance personnel for all providers and suppliers should read through this FR entry. While this proposed rule does provide some clarity in certain situations, to some extent CMS is proposing to raise the bar relative to a number of issues in this area.

Here are some of the key issues:

- Identification of Overpayments – 60-Day Period
- Reporting and Repayment Process
- Definition of Overpayment
- Ten Year Look Back Period
- Extended Repayment
- Anti-Kickback Complications

Notes:

1. Everything in this proposed rule pertains to overpayments. A reasonable comment to this rule would be to include all the same rules (whatever rules are implemented) to apply to any identified underpayments as well.
2. This proposed rule addresses only providers and suppliers under Part A and Part B. Other payment processes will be addressed later, but CMS certainly hints at the fact that all healthcare providers under Medicaid should carefully address the concepts in this proposed rule.
3. See also the self-reported overpayment process as found in CMS Publication 100-06, Chapter 4.

Once an overpayment is identified, then the 60-day reporting and repayment period starts. What does it mean to identify an overpayment? *"... we [CMS] propose that a person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment."* (77 FR 9182)

Well, what if a situation arises that requires significant investigation as to whether an overpayment situation exists? In this case CMS is providing some latitude for investigation, but such investigations must proceed *with all deliberate speed*. Obviously this particular phrase will end up in court in litigation.

Also, what is an overpayment? Overpayments involve Medicare payments that a person receives or retains to which the person is not entitled. CMS gives some examples:

- Payments for non-covered[2] services,
- Payments in excess of the allowable amount,
- Errors and non-reimbursable expenditures in cost reports,
- Duplicate payments,
- Improper payments when Medicare is secondary.

CMS also gives some examples. (See 77 FR 9182)

- *A provider of services or supplier reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement.*
- *A provider of services or supplier learns that a patient death occurred prior to the service date on a claim that has been submitted for payment.*
- *A provider of services or supplier learns that services were provided by an unlicensed or excluded individual on its behalf.*
- *A provider of services or supplier performs an internal audit and discovers that overpayments exist.*
- *A provider of services or supplier is informed by a government agency of an audit that discovered a potential overpayment, and the provider or supplier fails to make a reasonable inquiry.*
- *A provider of services or supplier experiences a significant increase in Medicare revenue and there is no apparent reason—such as a new partner added to a group practice or a new focus on a*

[2] Presumably non-covered would include services that were provided that were not medically necessary.

particular area of medicine—for the increase. Nevertheless, the provider or supplier fails to make a reasonable inquiry into whether an overpayment exists.

Clearly CMS is considering the identification of overpayments broadly.

Note that certain providers and suppliers are cost-based reimbursed, specifically Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). Possibly, the interim payment rate for a given entity may be too high so that overpayment has occurred during a given cost-reporting year. In these cases, the 60-day period has little meaning. Such possible overpayments (as well as underpayments) are reconciled at the time of cost report settlement.

What do you need to report? Besides identification information such as the provider name, TIN (Tax Identification Number), and HICN (Health Insurance Claim Number), there are nine pieces of information.

(1) How the error was discovered;
(2) a description of the corrective action plan implemented to ensure the error does not occur again;
(3) the reason for the refund;
(4) whether the provider or supplier has a corporate integrity agreement (CIA) with the OIG or is under the OIG Self-Disclosure Protocol;
(5) the timeframe and the total amount of refund for the period during which the problem existed that caused the refund;
(6) Medicare claim control number, as appropriate;
(7) Medicare National Provider Identification (NPI) number;
(8) a refund in the amount of the overpayment; and
(9) if a statistical sample was used to determine the overpayment amount, description of the statistically valid methodology used to determine the overpayment.

Now there is not anything startling new in this listing. Virtually all of this information is currently required in the CMS self-disclosure protocols. However, there are still some significant situations that might arise. Let us consider a simple case study out at the fictitious Apex Medical Center.

Case 1 – ***Inpatient DRG Review*** – The Apex Medical Center has just received the consultant's report concerning an inpatient DRG review. The review involved 150 Medicare cases from two years ago. The results were quite favorable: 7 cases were adjusted, two cases involved an underpayment and 5 cases involved overpayment. However, of the 5 cases involving overpayment, 4 of these cases occurred in one of the problem sequences of DRGs and each of them involved the choice of principal diagnosis.

Certainly Apex should repay the overpayment in the 5 cases. The actual amount of total overpayment was only in the neighborhood of $1,000.00. There are at least two questions for consideration:

1. How much detail should be included in the report to CMS?
2. Because there were four similar errors, should this invoke the need for further auditing?

Because there was a high degree of coding accuracy, the five cases could just be reported as resulting from a routine audit in which there was a minimal overpayment. The cause of the overpayments involved coding errors. Or should there be more detail indicating the possibility of a systemic error in coding certain types of cases? Should the report simply indicate routine coding errors that are addressed through additional education and training?

In particular, note items (2) and (7) in the above listing. The information requested seems to suggest that more rather than less information should be provided.

Notice also item (9) in which statistical extrapolation may have been used to analyze a given billing problem that generated overpayments. If you are going to rely on extrapolation, make certain that your auditors and consultants are following rigorous guidelines. A statistician or mathematician should assess the extrapolation approach and certify the propriety of the process.

Amazingly, ***CMS is proposing a ten year look back period!*** From page 9184:

"…we [CMS] are proposing that overpayments must be reported and returned only if a person identifies the overpayment within 10 years of the date the overpayment was received. We selected 10 years because this is the outer limit of the False Claims Act statute of limitations. We believe that the proposed 10-year lookback period is appropriate for several reasons. First, we believe that providers and suppliers should have certainty after a reasonable period that they can close their books and not have ongoing liability associated with an overpayment. We also believe that the length of the lookback period is long enough to sufficiently further our interest in ensuring that overpayments are timely returned to the Medicare Trust Funds."

Granted, ten years has basically been the de facto limit used by the OIG and DOJ. For healthcare, this is a long look back period. If you have thoughts on a different look back period, then you should be commenting to this proposed ten year period. The three year look back for the RACs (Recovery Audit Contractors) appears reasonable in comparison.

In some circumstances, particularly if you are dealing with a systemic issue that requires statistical extrapolation, the possible repayment amount could become significant. Care should be taken to avoid having the specter of a large repayment delay the recognition of a problem. If there are financial constraints, then the already existing Extended Repayment Schedule process should be used. This process was previously called the Extended Repayment Plan.

The last issue that we will address is that of prohibited kickback arrangements. CMS indicates that there may be innocent providers or suppliers who have no knowledge of overpayments arising from inappropriate arrangements. This particular issue will probably be raised in the future.

Editor's Note: Readers are highly encouraged to comment to the February 16th Federal Register entry. Consider having underpayments included as well as overpayments. Also, if you think the 10 year look back period is too long, now is your chance to make your thoughts known to CMS.

Medicare Odds & Ends

The implementation of ICD-10 is again being postponed. Everyone has been working toward an October 1, 2013 implementation. The new date has not been announced by CMS but presumably will go on out into the 2015 time range. This is good news for all those seasoned coding veterans who have indicated that they will retire instead of moving to the new coding system. At the rate we are implementing new or changed coding sets, we may all retire before they change. For example, consider the National Drug Codes (NDCs).

The 'Doc Fix' is scheduled to go into effect for all of 2012. At the time this Newsletter is being prepared, Congress is taking final action to keep the MPFS (Medicare Physician Fee Schedule) conversion factor at the same level it was in 2011. The formula for updating the conversion factor is based on the sustainable growth rate (SGR) which has accumulated to a 27.4% reduction. The conversion factor for physicians will probably continue as a political hot potato for years to come.

Current Workshop Offerings

Editor's Note: The following lists a sampling of our publicly available workshops. A link for a complete listing can be found at:
www.aaciweb.com/JantoDecember2012EdCal.htm

On-site, teleconferences and Webinars are being scheduled for 2012. Contact Dr. Abbey at 515-232-6420 or e-mail at DrAbbey@aaciweb.com for information.

A variety of Webinars and Teleconferences are being sponsored by different organizations including the Georgia Hospital Association, Ohio Hospital Association, Florida Hospital Association, Instruct-Online, Texas Hospital Association, Colorado Hospital Association, Hospital Association of Pennsylvania, and the Eli Research Group. Please visit our main website listed above for the calendar of presentations for CY2012.

The Georgia Hospital Association is sponsoring a series of Webinars each month. For more information, contact Carol Hughes, Director of Distance Learning at (770) 249-4541 or CHughes@gha.org. The webinar scheduled for March 6th "***Meeting the Physician Supervision Rule"*** that will run from 9:30 a.m. to 11:00 a.m. EST.

Dr. Abbey's book:
"***The Medicare Recovery Audit Contractor Program: A Survival Guide for Healthcare Providers***" is now available for purchase. This is a companion volume to "***Compliance for Coding, Billing & Reimbursement: A Systematic Approach to Developing a Comprehensive Program***", 2nd Edition.

Both of these books are published by CRC Press of the Taylor & Francis Group. A 15% discount is available for subscribers to this Newsletter. For ordering information contact Chris Smith through Duane@aaciweb.com.

Also, Dr. Abbey has finished the third book in a series of books on payment systems. The first book is: "***Healthcare Payment Systems: An Introduction***". The second book addresses fee schedule payment systems and the third in the series addresses prospective payment systems. The fourth, and final, book in this series addresses cost-based, charged-based and contractual payment systems.

This series is being published by CRC Press of the Taylor & Francis Group. Contact information is provided below. Discounts for subscribers of this Newsletter are available.

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****** ACTIVITIES & EVENTS ******

Schedule your Compliance Review for you hospital and associated medical staff now. A proactive stance can assist hospitals and physicians with both compliance and revenue enhancement. These reviews also assist in preparing for the RACs.

Worried about the RAC Audits? Schedule a special audit study to assist your hospital in preparing for RAC audits. Please contact Chris Smith or Jane Wall at Abbey & Abbey, Consultants, Inc., for further information. Call 515-232-6420 or 515-292-8650. E-Mail: Chris@aaciweb.com.

Need an Outpatient Coding and Billing review? Charge Master Review? Concerned about maintaining coding billing and reimbursement compliance? Contact Jane Wall or Chris Smith at 515-232-6420 or 515-292-8650 for more information and scheduling. E-Mail: Duane@aaciweb.com