

Follow the Money: Current Issues in Physician Reimbursement

**Health Care Compliance Association
Compliance Institute
Chicago, IL**

April 22, 2007

*Karen L. Collier, CCO
Emergency Physicians Billing Services
Medical Consultants, Inc.*

Physician Reimbursement – Current Compliance Issues

- Physician Compliance Overview – What's up (with your) docs?
- Physician Documentation
- Provider Enrollment/Carrier Issues
- New Audits/Enforcement Efforts
- PQRI = P4P = Here and Now
- Questions & Answers



Physician Compliance Overview – What's Up, Docs?

- Compliance Program Basics for Practices
- Deficit Reduction Act (DRA) False Claims Act policy/education requirements
- Hot Topic – Credit Balances and Refunds



Physician Compliance Programs

- All physician practices should have some compliance structure by now
- Compliance programs should focus on risks for that practice and basic elements of effective compliance
- Required to have False Claims Act and detection/correction policies



Physician Compliance Programs

- OIG Compliance Program Guidance, plus Supplemental Guidance for Hospitals best place to start
- Risk assessment – what can go wrong and how do we control it?
- Education/buy-in by physicians
- Incentives and discipline



Physician Compliance Programs

- Teach the docs the rules – update information regularly
- Coding and billing risk areas
- Credentialing/enrollment
- Sanctions/provider IDs
- Stark, self-referral, joint ventures, other specialty risks and regulations



Physician Compliance Programs

- Deficit Reduction Act (DRA) mandates that (some?) providers must implement and disseminate written compliance policies re: detection of fraud, waste and abuse
- Must include state and federal laws and False Claims Act whistleblower information



Physician Compliance Programs

- DRA §6032 is entitled “Employee Education About False Claims Act Recovery”
- §6032 says that mandatory compliance provision applies to entities that receive or pay \$5 million in Medicaid \$\$ annually
- Condition of participation in Medicaid



Physician Compliance Programs

- Providers must establish written policies that provide detailed information about Federal False claims Act, remedies for false claims and statements, state laws pertaining to false claims, whistleblower protections, the role of such laws in preventing and detecting fraud and abuse



Physician Compliance Programs

- Must also include detailed provisions regarding the practice's own compliance procedures for detecting and preventing fraud
- Must include compliance policies, state and federal laws and specific whistleblower protections in any employee handbook



Physician Compliance Programs

- DRA provisions says that policies must apply to any contractor or agent of the entity (*are you getting notices yet?*)
- This is raising the possibility that mandatory compliance will be applicable to all providers, regardless of size and receipt of \$\$, through contracts with health plans, others



Physician Compliance - Refunds

- Recent compliance hit on TN cardiology group for lack of adequate refunds/credit balances controls
- “Finders, Keepers” isn’t the law!
- Physician groups must have clear and consistent policies and procedures on handling of credit balances and refunds



Physician Compliance - Refunds

- All \$\$ inappropriately paid or received, whether due to provider error or not, must not be kept (or held for any period of time)
- Never ignore a request for a refund
- Appeal request if provider disagrees
- Work with payors on refund v. recoup



Physician Compliance - Refunds

- Refunds should be made within 60 days of discovery of overpayment if possible
- Medicare refund shuffle – some carriers ask for refund, then recoup before refund is processed
- Check credit balances regularly – run reports, keep track of accounts



Physician Compliance - Refunds

- Credit balances should be worked to spot overpayments and necessary refunds
- Overpayment = refund or recoup
- Credit balance may not = overpayment
- Unclaimed refunds
- Escheat laws



Physician Compliance - Refunds

- If your providers balk at paying back overpayments, show them the law
- 18 U.S.C. § 669
- Health care embezzlement applies to all payors (not just Medicare, Medicaid, other government programs)
- Keeping overpayments is Fed. crime



[Physician Documentation]

- Evaluation and management documentation, coding & billing always under scrutiny
- Technology and physician documentation – new compliance issues with each solution
- Teaching physician documentation update (new audits?)



Physician Documentation



- Documentation of E&Ms may be changing – carriers are coming up with variations on CMS guidelines
- Trailblazers, WPS
- ROS, audit tools

Physician Documentation

- WPS has published an article that says the physician must discuss elements of the PFSH with the patient before they can be used in the documentation of an E&M code
- Also, website said that “all other systems are negative” not allowed for complete review of systems (*retracted?*)



Physician Documentation

- Trailblazers has said that it is working on new E&M audit tool; will differ from CMS documentation guidelines
- Big outcry in ED world and discussion with CMS about carriers' ability to change documentation rules
- They say they are interpreting the guidelines, not changing them



Physician Documentation

- EMRs, templates, coding software all coming under compliance scrutiny
- Use of macros, pull-down menus, etc. not been thoroughly tested through an audit or investigation by OIG yet
- Watch for compliance issues with technology in documenting, reporting, coding and billing



Physician Documentation - Teaching Physician/Residents



- Medicare has specific rules for teaching physicians and residents
- Residents paid for services through GME or reasonable cost payment to hospital

Physician Documentation - Teaching Physician/Residents

- Teaching physicians may bill for their services to Medicare patients in a teaching setting when:
 - The services are personally performed by the teaching physician, or
 - The teaching physician was physically present during the critical or key portions of the service that a resident performs



Physician Documentation - Teaching Physician/Residents

- Physically present – the teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service
- Same requirement for procedures as for E&M services



Physician Documentation - Teaching Physician/Residents

- Critical or key portions of the service – that part (or parts) of a service that *the teaching physician determines* is (are) a critical or key portion.
- For E&M, three main elements: History, Exam, and Medical Decision-making are considered key
- Key portion of procedure up to T.P.



Physician Documentation - Teaching Physician/Residents

- Documentation by the resident of the teaching physician's participation is not enough
- Combined entries of the teaching physician and resident constitute the documentation for the service and must support medical necessity and required elements



Physician Documentation - Teaching Physician/Residents



- Residents may “moonlight” and provide services outside of their training program
- No teaching physician billing when resident is moonlighting

Physician Documentation - Teaching Physician/Residents

- Dictation macros for TPA – may be used by teaching physician “if he or she personally adds it in a secured or password protected system”
- Macros alone not enough, either the teaching physician or resident must provide customized information to support medical necessity



Physician Documentation - Teaching Physician/Residents



- Watch for Medicaid regulations and denials/audits of teaching physician services
- PATH may be dead, but TP audits and investigations are not

Physician Documentation

- “Cloned documentation” is becoming an audit issue, will be looked at more closely
- Teaching physicians and other physicians need to be careful when using or applying dictation macros, EMR macros, template checkboxes, etc.



Provider Enrollment - Carrier Issues

- Many Medicare Part B carriers experiencing long delays (4-6 months) in provider enrollment, causing cash flow problems for practices
- Avoid workarounds



Provider Enrollment - Carrier Issues

- New Medicare enrollment regulations require more documentation, more frequent updates to information
- Re-certification of all Medicare providers
- Add in National Provider Identifier (NPI) issues, crosswalk difficulties



Audit/Enforcement Efforts

- Expansion of Recovery Audit Contractors (RACs) nationwide
- Lots of new funding, data mining
- Emphasis on Medicaid audits, enforcement and compliance
- Public/private sharing of info and investigations (BC/BS, CMS, DOJ)



Audit/Enforcement Efforts – Recovery Audit Contractors

- RACs have been in pilot program in three states: New York, Florida, California
- Tax Relief and Health Care Act (TRHCA) requires use of RACs nationally no later than Jan. 1, 2010
- “Bounty hunters” on contingency



Audit/Enforcement Efforts - Medicaid

- Deficit Reduction Act requires states to bolster fraud and abuse efforts in Medicaid programs
- All states must have a “mini False Claims Act” to prosecute fraud by Medicaid providers
- More attention and manpower focused on Medicaid claims compliance



Audit/Enforcement Efforts - Medicaid

- Congress has been generous – lots of new money for Medicaid enforcement
- New money spending:
 - 2007 - \$87 million
 - 2008 - \$99 million
 - 2009 - \$136 million
 - 2010 - \$160 million (and annually thereafter)



Audit/Enforcement Efforts - Medicaid

- States are scrambling to comply with DRA, they can lose federal \$\$ match
- OIG is reviewing state false claims act legislation, not liking what it sees so far
- Pay close attention to your state's activities in this area
- Watch Medicaid bulletins, manuals



Audit/Enforcement Efforts - Medicaid

- DRA says states must enforce the mandatory compliance elements of Act
- Some states are doing a provider certification of compliance
- Many states aren't sure how to check for provider and health plan compliance, but they are working on it
- Condition of participation for providers



Audit/Enforcement Efforts - Medicaid

- Five new sources of review of Medicaid providers' reimbursement
- §6034 of the DRA
- PERM – Medicaid Payment Error Measurement
- MIP – Medicaid Integrity Program
- Medi-Medi, CMS PI group, OIG



Audit/Enforcement Efforts - Medicaid

- CMS-MIP = entire new division of CMS
- MIP contractors can suspend payments to providers during audit
- Also using contractors to take back payments and refer fraud prosecutions
- Audit error rates will go to Congress, for comparison between states



Audit/Enforcement Efforts - Medicaid

- PERM contractors will audit states' error rates for payments to providers
- PERM audits (FFS and managed care) will be contracted nationally:
 - Statistical contractor
 - Documentation/database contractor
 - Review contractor



Audit/Enforcement Efforts - Medicaid



- Don't forget! States will have their own audit and enforcement efforts ongoing as well
- We could see horrendous overlap in some states

Audit/Enforcement Efforts

- CMS has targets for states' referrals to Medicaid Fraud Control Units (MFCUs)
- Pressure on states to find fraud, abuse and waste means more pressure on providers
- RAC use for Medicaid recoveries and use of extrapolation of audit findings are “under advisement”



Audit/Enforcement Efforts

- Issues for audit have already been identified:
 - Managed care (no. 1 focus for 2008)
 - Nursing and personal care agencies
 - Prescription drugs
 - DME
 - “Improper claims for payment”



Audit/Enforcement Efforts

- OIG Work Plan items
- MMA Section 1011 (undocumented aliens program) audits ongoing
- Current investigations and focus
- *Job security for compliance officers!*



[PQRI = P4P]

- Just what is P4P?
- Why is all this happening?
- What is being measured, what is required, and what is at stake?
- What is coming in the future?
- PVRP is dead – Long live PQRI!

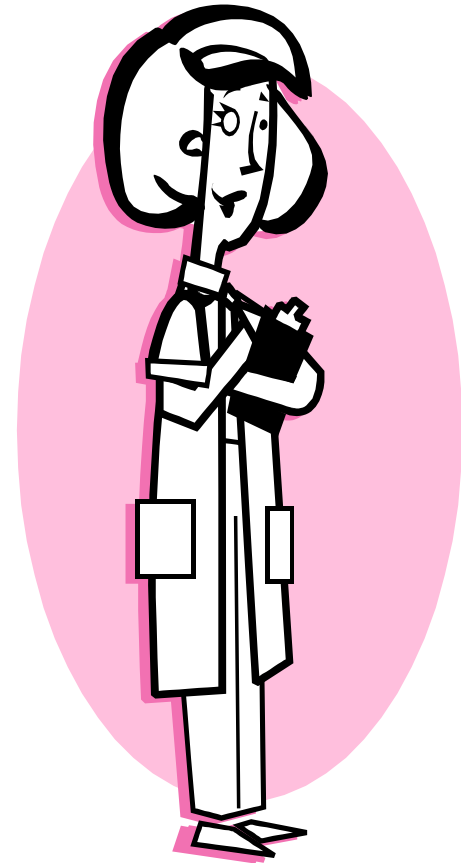
[PQRI = P4P]

- Pay for performance is a step on the way toward transparency in health pricing, consumer-driven health care, and most importantly, outcomes-based health care and payment
- Providers who deliver better quality care (better outcomes for patients) will get paid more \$\$ for their services



[PQRI = P4P]

- Voluntary reporting (PVRP)
- Voluntary reporting with \$\$ incentive (PQRI)
- Reporting tied to \$\$ payment (TRHCA)
- Pay for reporting?



[PQRI = P4P]

- CMS started Physicians Voluntary Reporting Program (PVRP) last year (2006)
- Started with only a few reporting measures (18), added more through the year
- PVRP ended with announcement of PQRI (no more reporting)



[PQRI = P4P]

- Tax Relief and Health Care Act (TRHCA) of 2006
- Eliminated scheduled cuts to Medicare PFS for 2007
- Also tied “voluntary” reporting of quality measures to 1.5% bonus, future bonuses and avoidance of cuts

[PQRI = P4P]

- Congress mandated CMS to start PQRI (Physicians Quality Reporting Initiative) by July 1, 2007 (TRHCA signed 12/26/06)
- Clock is ticking!



[PQRI = P4P]

- Eligible providers include physicians, dentists, optometrists, podiatrists, NPPs, and therapists who provide services under the MPFS
- Measures reported on individual claims
- CPT II codes (alpha-numeric) instead of PVRP's G-codes



[PQRI = P4P]

- No enrollment in PQRI or filing of notice of intent to participate is required
- Just start submitting codes on July 1, 2007
- Payments will be made at group level (by Tax Identification Number)



[PQRI = P4P]

- 74 proposed measures, may be a few more by July 1
- Practice must report on at least three measures if there are 3 or more that apply to its patient panel
- Must achieve 80% or better on each measure to get bonus (each doc in group must play to win)



[PQRI = P4P]

- Need sufficient detail on diagnoses, CPT codes to use as denominator and numerator for 80% calculation
- May need to advise physicians on careful choice of which measures to report so as to hit required compliance
- Not limited by specialty



[PQRI = P4P]



- If PQRI is set up like PVRP, there will be 3 HCPCS codes per measure (positive, negative, negative + reason/contraindication)
- *(Update?)*

[PQRI = P4P]

- TRHCA says there will be a cap on payments, no details yet
- Cap will probably consider frequency of Dx and reporting (if practice has one diabetic, reporting on 100% of measures for that one patient probably won't cut it for the full 1.5%)

[PQRI = P4P]

- Details coming out slowly at first, should pick up pace soon
- Finalized measures due by April 1 (according to TRHCA)
- Will definitely change for 2008
- Stay up-to-date with CMS PQRI website: <http://cms.hhs.gov/PQRI>



[PQRI = P4P]

- Compliance issues centering on documentation and coding
- What is sufficient documentation?
- Who has to document that the measure was performed (physician only, nurse's notes, orders, etc.)?
- Overlap with hospital measures – can docs rely on facility records?

[PQRI = P4P]

- Watch for overcoding of measures to qualify for bonus
- Also undercoding of related Dx codes to avoid having to report measures
- Audits likely – how will they be conducted? By whom? Pre-payment?
- False Claims Act implications?

[PQRI = P4P]

- 2007 PQRI payments should be made starting in mid-2008
- 2008 PQRI could look quite different
- Evolving measures, lessons learned
- NPRM by August, 2008; final measures/rule out in November, 2008
- \$\$ could be much more (10% cut?)

Follow the Money: Physician Reimbursement Issues

- Thank you for your time and attention!
- Questions and answers - discussion

