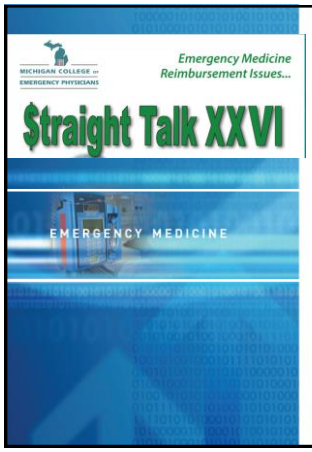

Payors Gone Wild Are Back—plus compliance, documentation & coding issues

November 2017

Ed Gaines, JD, CCP
Chief Compliance Officer
Emergency Medicine Division
Zotec Partners, LLC
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Greensboro, NC
877-271-2506

2

What do the "Fast and Furious" movies and my "Payors Gone Wild" (PGW) themes have in common?

- Perhaps PGW should be re-titled the "healthcare lawyers full employment act".

3

Objectives and Outline for discussions:

- **Describe payor bad practices & possible strategies**
  - **Commercial: UHC X 2 + Aetna + Anthem BCBS**
  - **Medicaid fee for service: Illinicare Health**
  - **Medicaid managed care: Centene**
  - **The good news: KS Medicaid**
- **Highlight compliance challenges & responses: front & back end issues.**
- **Documentation & coding issues in addition to payor bad practices:**
  - **UHC (again)**
  - **Aetna**

4

What is a "balance bill"?

- Clinician "charges" vs. the health plans' "allowable" vs. "in network allowables" and "out of network (OON) allowables"
- Applies when patients see an out-of-network provider, especially at an in-network facility
- States do not restrict billing patient "cost sharing", e.g. co-insurance, deductible or co-payments

5

What is a "balance bill"?

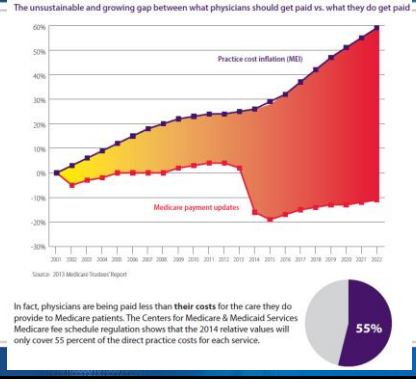
The difference between:

1. the out-of-network provider's "usual & customary" (U&C) charge and
2. the amount reimbursed by the insurance carrier for an out-of-network service

U&C CPT 99285 Charge:	$800
OON Insurance "Allowable"	$223
Balance	$577

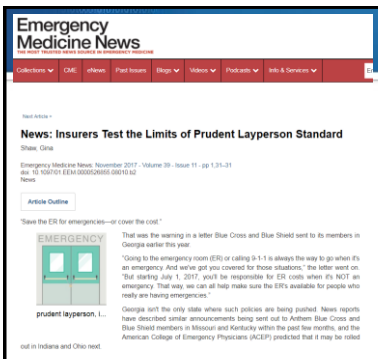
6

Why accepting Medicare across the board is not sustainable for EM:



7

Prudent Lay Person (PLP)



http://journals.lww.com/em-news/Fulltext/2017/11000/News__Insurers_Test_the_Limits_of_Prudent.1.aspx

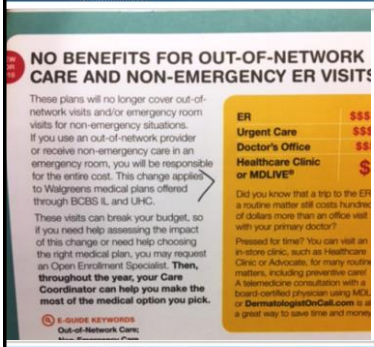
- 1 of EM's fundamental protections is under assault by health plans—commercial and Medicaid MCEs.
- Anthem=largest BCBS plan in US—14 states

8

PLP Primer:

- **Federal statute: Balanced Budget Act of 1997 (BBA '97):**
  1. Applicable to Medicaid MCOs Oct. 1997 & Medicare May 1998.
  2. Prior authorization for ED svs cannot be required**
  3. Defines the "emergency medical condition" (EMC)—
     a. EMTALA EMC is different—stable for discharge.
     b. "Severe pain" is key—health plans fought us.
     c. "reasonably expect the absence of immediate medical attention"
     d. could lead to "serious impairment or dysfunction of a bodily organ or part."
     e. Section 1852(d) and 1932(b) of Social Sec. Act
  4. Then HCFA (now CMS) Letters interpreting PLP—1998, 1999 and 2000. On the ACEP website. (Appendix)
  5. **So what? No prior authorization concept enacted in ACA.

Walgreen plans sent this notice to benies effective 1/1/18: for plans offered via BCBSIL and UHC



NO BENEFITS FOR OUT-OF-NETWORK CARE AND NON-EMERGENCY ER VISITS

These plans will no longer cover out-of-network visits and/or emergency room visits for non-emergency situations. If you use an out-of-network provider or receive non-emergency care in an emergency room, you will be responsible for the entire cost. This change applies to Walgreens medical plans offered through BCBS IL and UHC.

These visits can break your budget, so if you need help assessing the impact of this change or need help choosing the right medical plan, you may request an Open Enrollment Specialist. **Then, throughout the year, your Care Coordinator can help you make the most of the medical option you pick.**

E-GUIDE KEYWORDS
Out-of-Network Care;

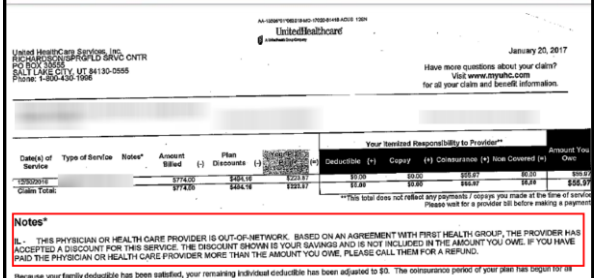
ER $$$
Urgent Care $$$
Doctor's Office $$
Healthcare Clinic or MDLIVE® $

Did you know that a trip to the ER for a routine matter still costs hundreds of dollars more than an office visit with your primary doctor?

Pressed for time? You can visit an in-store clinic, such as Healthcare Clinic or Advocate, for many routine matters, including preventive care. A telemedicine consultation with a board-certified physician using MDLIVE or DermatologistOnCall.com is a great way to save time and money.

- **Sent to Dr. Lisa Maurer, FACEP, by a friend in WI who has UHC commercial insurance.**
- **Note: No OON benefit for "non-emergencies"—full charge to the Pts.**

Example: UHC false & misleading EOB information to the Pt. (OON allowable 125-130% Medicare)



UnitedHealthcare

January 20, 2017

Have more questions about your claim?
Visit www.myuhc.com
for all your claim and benefit information.

Your Itemized Responsibility to Provider**

Date(s) of Service	Type of Service	Notes*	Amount Billed	(-)	Plan Discounts	(-)	(=)	Deductible (+)	Copay (+)	Coinsurance (+)	Non Covered (=)	Amount You Owe
12/20/2016			$774.00		$484.16		$289.84	$0.00	$0.00	$55.87	$0.00	$55.87
Claim Total:			$774.00		$484.16		$289.84	$0.00	$0.00	$55.87	$0.00	$55.87

**This total does not reflect any payments / copays you made at the time of service. Please wait for a provider bill before making a payment.

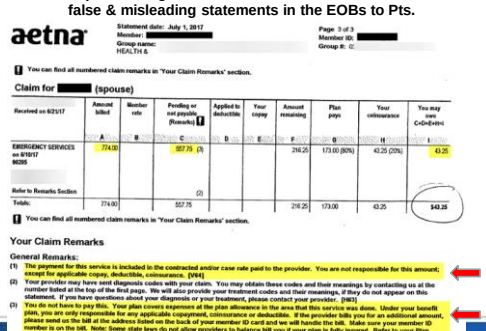
Notes*

IL - THIS PHYSICIAN OR HEALTH CARE PROVIDER IS OUT-OF-NETWORK. BASED ON AN AGREEMENT WITH FIRST HEALTH GROUP, THE PROVIDER HAS ACCEPTED A DISCOUNT FOR THIS SERVICE. THE DISCOUNT SHOWN IS YOUR SAVINGS AND IS NOT INCLUDED IN THE AMOUNT YOU OWE. IF YOU HAVE PAID THE PHYSICIAN OR HEALTH CARE PROVIDER MORE THAN THE AMOUNT YOU OWE, PLEASE CALL THEM FOR A REFUND.

Because your family deductible has been satisfied, your remaining individual deductible has been adjusted to $0. The coinsurance period of your plan has begun for all covered members of your family.

Bad payor practices + false and misleading statements:

- **Issue #1:health plans using Medicare as the OON reimbursement standard + false & misleading statements in the EOBs to Pts.**



aetna

Statement date: July 1, 2017
Member: [redacted]
Group name: HEALTH &
Page 3 of 3
Member ID: [redacted]
Group #: G

You can find all numbered claim remarks in 'Your Claim Remarks' section.

Claim for [redacted] (spouse)

Received on 6/21/17	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan pays	Your coinsurance	You may owe C+D+E+H+I
	A	B	C	D	E	F	G	H	I
EMERGENCY SERVICES on 6/16/17 99285	774.00		557.75 (3)			216.25	173.00 (80%)	43.25 (20%)	43.25
Refer to Remarks Section			(2)						
Totals:	774.00		557.75			216.25	173.00	43.25	$43.25

You can find all numbered claim remarks in 'Your Claim Remarks' section.

Your Claim Remarks

General Remarks:

(1) The payment for this service is included in the contracted and/or case rate paid to the provider. You are not responsible for this amount; except for applicable copay, deductible, coinsurance. [V04]

(2) Your provider may have sent diagnosis codes with your claim. You may obtain these codes and their meanings by contacting us at the number listed at the top of the first page. We will also provide your treatment codes and their meanings, if they do not appear on this statement. If you have questions about your diagnosis or your treatment, please contact your provider. [N83]

(3) You do not have to pay this. Your plan covers expenses at the plan allowance in the area that this service was done. Under your benefit plan, you are only responsible for any applicable copayment, coinsurance or deductible. If the provider bills you for an additional amount, please send us the bill at the address listed on the back of your member ID card and we will handle the bill. Make sure your member ID number is on the bill. Note: Some state laws do not allow providers to balance bill you if your plan is fully insured. Refer to your Plan Summary to confirm your plan's funding. You can also go to Aetna.com, select Disclosure Information, then State Specific Information for the state's regulation. [M39]

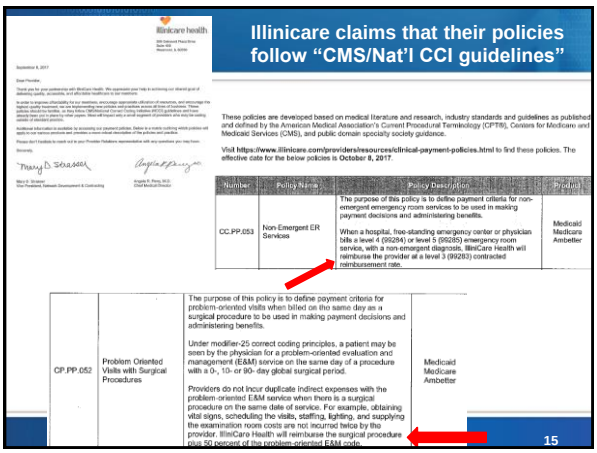
Case study: Anthem's "non-emergent" diag. lists GA & MO

- Over 1900 ICD-10s
- Approx. 1K codes are relevant to EM
- Nearly 400 of those are unspecified codes.
- Issue: whether Anthem will allow any of the charges for listed code?
- If no, Pt is 100% liable for ED charges.
- Current
  - Kentucky
  - Missouri
  - Georgia
  - Virginia? (working to confirm)
- Jan 2018
  - Ohio
  - Indiana
  - New Hampshire

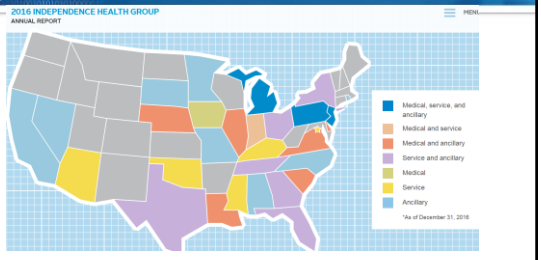
More walk back by the BCBSGA President

- P&P limited to ACA exchange insurance.
- No plans to extend P&P to employer sponsored or state employee/teacher health plans
- PLP will be complied with but does not say how.
- http://news.wabe.org/post/blue-cross-blue-shield-ga-president-discusses-new-er-policy

Illinicare claims that their policies follow "CMS/Nat'l CCI guidelines"



Case study: IBC implements the 50% E/M cut on -25 modifier procedures for commercial & Medicare Advantage— *Part B News* (PBN) 8/28/17



- IBC, QCC Ins. Co., Keystone Health Plan and AmeriHealth
- Article states policies apply to a provider's office—not POS specific.
- 25 states & DC impacted

The UHC reality distortion field.

UnitedHealthcare
EMPLOYER & INDIVIDUAL

REIMBURSEMENT POLICY
CMS-1500

Evaluation and Management (E/M) Reimbursement Policy

Policy Number	2016R5007A	Annual Approval Date	4/21/2016	Approved By	Payment Policy Oversight Committee

E/M Services Performed in an Emergency Department (ER/ED) Place of Service

CPT codes 99281-99285 are used to report E/M services rendered in an ER/ED place of service. Evaluating for level of care appropriateness for these codes in an ER/ED place of service includes a review of the tests and management options that are available to be performed during the initial visit.

The 1995 CMS Documentation Guidelines state that the number of diagnoses and management options that must be considered "...is based on the number and types of problems addressed during the Encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician." Additional Work-up Planned is an element of review which includes a number of diagnoses and management options. The Additional Work-up Planned' element contributes to indicating the complexity of a patient based on the clinician's utilization of diagnostic tests. UnitedHealthcare utilizes the industry standard guidelines to determine the appropriate level of care is as follows:

A. Number of Diagnoses and Management Options	Points Assigned
Self-Limiting or minor Problems (stable, improved or worsening)-Max of 2 points can be given	1
Established Problem – stable improved	1
Established Problem – Worsening	2
New Problem – No Additional Work-up Planned. Max of 1 point can be given	3
New Problem – Additional Work-up planned	4

A provider receives 3 points for "New Problem, No Additional Work-Up Planned," and 4 points for "New Problem, Additional Work-Up Planned". This one-point difference can affect whether a level 4 or level 5 code is appropriate. Please note that all Encounters with ED patients are considered "New Problem"

17

And UHC continues in their reality distortion field:

Encounters for purposes of scoring.

An example of Additional Work-up Planned, is if the physician schedules testing him/herself or communicates directly with the patient's primary physician or representative the need for testing *which is to be done after discharge from the ED*, and the appropriate documentation has been recorded. Credit for "Additional Work-up" Planned is granted (4 points assigned). Credit is not given for the work up if it occurs during the ER Encounter. This interpretation is consistent with the level 5 code description that "... Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function..." Patients admitted to the hospital under the care of a physician other than the ER physician may have testing done as part of the admitting physician's care for that patient. The ER physician will not receive credit for the Additional Work-up Planned done under the care of the admitting physician.

Definitions	
Additional Work-up Planned	Any testing/consultation/referral that is being done beyond that Encounter to assist the provider in medical decision making.
Encounter	Interaction between a covered member and a health care provider for which evaluation and management service or other service(s) are rendered and results in a claim submission

18

And another thing ….. From UHC:

Questions and Answers

1	**Q:** When a separate written report for diagnostic tests/studies is prepared by the same individual performing the E/M service, should this be considered as a factor in the E/M code selection? **A:** No. Any specifically identifiable procedure reported separately from the E/M service should not be considered in the selection of E/M service level reported.
2	**Q:** Will UnitedHealthcare require medical records for all reported E/M services? **A:** No. There may be occasions where UnitedHealthcare could request medical records to determine the appropriate level of E/M service has been reported.

- **How are these policies binding?**
- **Is the group contracted or not with UHC?**

v) Medical Group has been given an opportunity to review the Protocols and Payment Policies and acknowledges that it is bound by the Protocols and that claims under this Agreement will be paid in accordance with the Payment Policies.

19

Despair not, my fine ladies and gentleman:

United will give Medical Group 90 days written or electronic notice of non-routine fee schedule changes which will substantially alter the overall methodology or reimbursement level of the fee schedule. In the event such changes will reduce Medical Group's overall reimbursement under this Agreement, Medical Group may terminate this Agreement by giving 60 days written notice to United, provided that the notice is given by Medical Group within 30 days after the notice of the fee schedule change.

9.2 **Termination.** This Agreement may be terminated under any of the following circumstances:

i) by mutual written agreement of the parties;

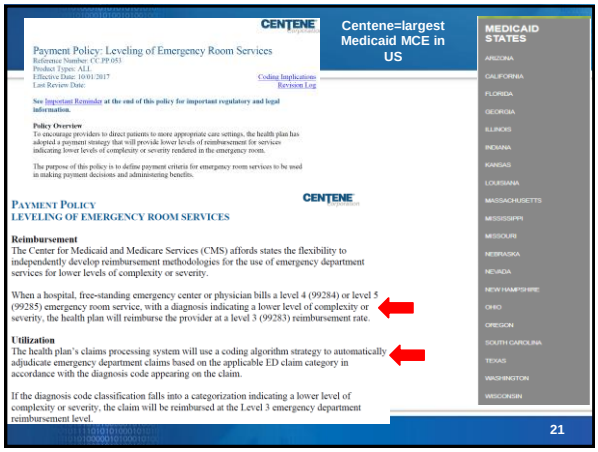
ii) by either party, upon at least 120 days prior written notice, effective at the end of the initial term or effective at the end of any renewal term;

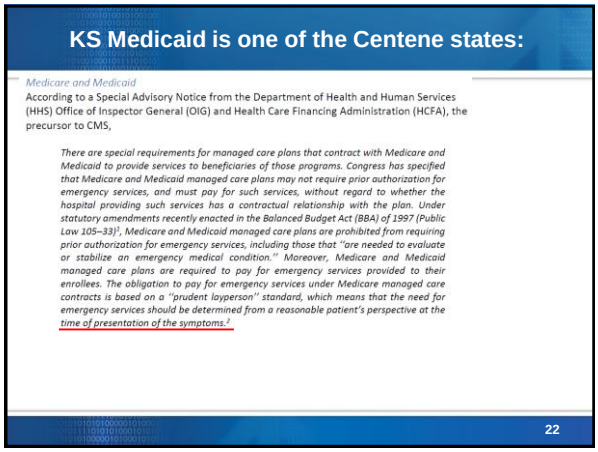
iii) by either party upon 60 days written notice in the event of a material breach of this Agreement by the other party, except that such a termination will not take effect if the breach is cured within 60 days after notice of the termination; moreover, such termination may be deferred as further described in Article VIII of this Agreement;

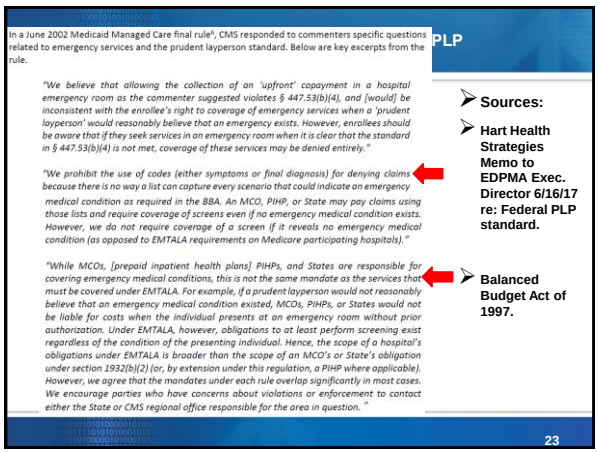
iv) by either party upon 10 days written notice in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement, or fails to have insurance as required under section 5.6 or section 6.2 of this Agreement; or

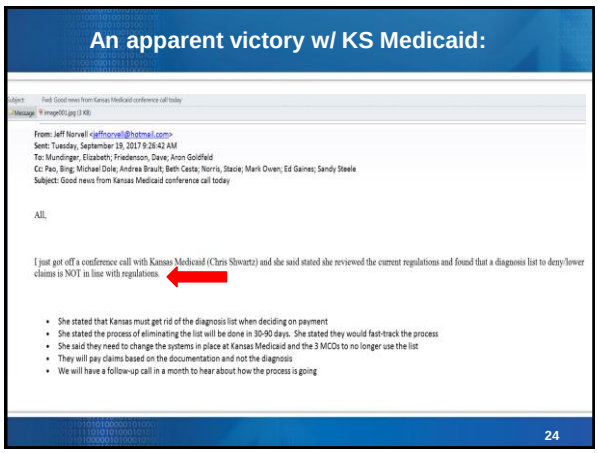
v) by Medical Group, as described in section 7.4 of this Agreement in the event of a non-routine fee schedule change.

20


CENTENE
Payment Policy: Leveling of Emergency Room Services
Reference Number: CC.PP.053
Product Types: ALL
Effective Date: 10/01/2017
Last Review Date:
Coding Implications
Revision Log
See Important Reminder at the end of this policy for important regulatory and legal information.
Policy Overview
To encourage providers to direct patients to more appropriate care settings, the health plan has adopted a payment strategy that will provide lower levels of reimbursement for services indicating lower levels of complexity or severity rendered in the emergency room.
The purpose of this policy is to define payment criteria for emergency room services to be used in making payment decisions and administering benefits.
CENTENE
PAYMENT POLICY
LEVELING OF EMERGENCY ROOM SERVICES
Reimbursement
The Center for Medicaid and Medicare Services (CMS) affords states the flexibility to independently develop reimbursement methodologies for the use of emergency department services for lower levels of complexity or severity.
When a hospital, free-standing emergency center or physician bills a level 4 (99284) or level 5 (99285) emergency room service, with a diagnosis indicating a lower level of complexity or severity, the health plan will reimburse the provider at a level 3 (99283) reimbursement rate.
Utilization
The health plan's claims processing system will use a coding algorithm strategy to automatically adjudicate emergency department claims based on the applicable ED claim category in accordance with the diagnosis code appearing on the claim.
If the diagnosis code classification falls into a categorization indicating a lower level of complexity or severity, the claim will be reimbursed at the Level 3 emergency department reimbursement level.
Centene=largest Medicaid MCE in US
MEDICAID STATES
ARIZONA
CALIFORNIA
FLORIDA
GEORGIA
ILLINOIS
INDIANA
KANSAS
LOUISIANA
MASSACHUSETTS
MISSISSIPPI
MISSOURI
NEBRASKA
NEVADA
NEW HAMPSHIRE
OHIO
OREGON
SOUTH CAROLINA
TEXAS
WASHINGTON
WISCONSIN
21


KS Medicaid is one of the Centene states:
Medicare and Medicaid
According to a Special Advisory Notice from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) and Health Care Financing Administration (HCFA), the precursor to CMS,
There are special requirements for managed care plans that contract with Medicare and Medicaid to provide services to beneficiaries of those programs. Congress has specified that Medicare and Medicaid managed care plans may not require prior authorization for emergency services, and must pay for such services, without regard to whether the hospital providing such services has a contractual relationship with the plan. Under statutory amendments recently enacted in the Balanced Budget Act (BBA) of 1997 (Public Law 105–33)[1], Medicare and Medicaid managed care plans are prohibited from requiring prior authorization for emergency services, including those that "are needed to evaluate or stabilize an emergency medical condition." Moreover, Medicare and Medicaid managed care plans are required to pay for emergency services provided to their enrollees. The obligation to pay for emergency services under Medicare managed care contracts is based on a "prudent layperson" standard, which means that the need for emergency services should be determined from a reasonable patient's perspective at the time of presentation of the symptoms.[2]
22


In a June 2002 Medicaid Managed Care final rule[6], CMS responded to commenters specific questions related to emergency services and the prudent layperson standard. Below are key excerpts from the rule.
"We believe that allowing the collection of an 'upfront' copayment in a hospital emergency room as the commenter suggested violates § 447.53(b)(4), and [would] be inconsistent with the enrollee's right to coverage of emergency services when a 'prudent layperson' would reasonably believe that an emergency exists. However, enrollees should be aware that if they seek services in an emergency room when it is clear that the standard in § 447.53(b)(4) is not met, coverage of these services may be denied entirely."
"We prohibit the use of codes (either symptoms or final diagnosis) for denying claims because there is no way a list can capture every scenario that could indicate an emergency medical condition as required in the BBA. An MCO, PIHP, or State may pay claims using those lists and require coverage of screens even if no emergency medical condition exists. However, we do not require coverage of a screen if it reveals no emergency medical condition (as opposed to EMTALA requirements on Medicare participating hospitals)."
"While MCOs, [prepaid inpatient health plans] PIHPs, and States are responsible for covering emergency medical conditions, this is not the same mandate as the services that must be covered under EMTALA. For example, if a prudent layperson would not reasonably believe that an emergency medical condition existed, MCOs, PIHPs, or States would not be liable for costs when the individual presents at an emergency room without prior authorization. Under EMTALA, however, obligations to at least perform screening exist regardless of the condition of the presenting individual. Hence, the scope of a hospital's obligations under EMTALA is broader than the scope of an MCO's or State's obligation under section 1932(b)(2) (or, by extension under this regulation, a PIHP where applicable). However, we agree that the mandates under each rule overlap significantly in most cases. We encourage parties who have concerns about violations or enforcement to contact either the State or CMS regional office responsible for the area in question."
PLP
Sources:
Hart Health Strategies Memo to EDPMA Exec. Director 6/16/17 re: Federal PLP standard.
Balanced Budget Act of 1997.
23

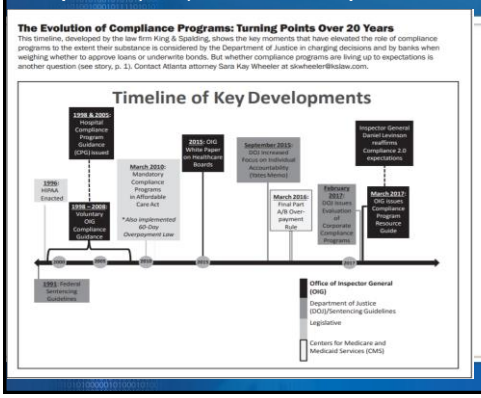

An apparent victory w/ KS Medicaid:
From: Jeff Norvell <jeffnorvell@hotmail.com>
Sent: Tuesday, September 19, 2017 9:26:42 AM
To: Mundinger, Elizabeth; Friedenson, Dave; Aron Goldfeld
Cc: Pao, Bing; Michael Dole; Andrea Brault; Beth Cesta; Norris, Stacie; Mark Owen; Ed Gaines; Sandy Steele
Subject: Good news from Kansas Medicaid conference call today
All,
I just got off a conference call with Kansas Medicaid (Chris Shwartz) and she said stated she reviewed the current regulations and found that a diagnosis list to deny/lower claims is NOT in line with regulations.
She stated that Kansas must get rid of the diagnosis list when deciding on payment
She stated the process of eliminating the list will be done in 30-90 days. She stated they would fast-track the process
She said they need to change the systems in place at Kansas Medicaid and the 3 MCOs to no longer use the list
They will pay claims based on the documentation and not the diagnosis
We will have a follow-up call in a month to hear about how the process is going
24

Key Agencies/Players in compliance and fraud and abuse (F&A)

- Executive Branch
- Secretary of Health and Human Services (HHS)
- US Attorney General
- The Centers for Medicare & Medicaid Services (CMS)**
- HHS Office of The Inspector General (OIG)
- The US Attorney's Office (USA)
- Medicare Administrative Contractors (MACs)

1. F&A recovers $11.60 for every $1
2. **Fraud Prevention System"= over Bs in $ saved.
3. FPS= 22% of fraud investigations, *FierceHealthcare 10/2/17*

Evolution of healthcare compliance: *Report on Medicare Compliance* (RMC) 10/2/17 or "Compliance 2.0"



The Evolution of Compliance Programs: Turning Points Over 20 Years

This timeline, developed by the law firm King & Spalding, shows the key moments that have elevated the role of compliance programs to the extent their substance is considered by the Department of Justice in charging decisions and by banks when weighing whether to approve loans or underwrite bonds. But whether compliance programs are living up to expectations is another question (see story, p. 1). Contact Atlanta attorney Sara Kay Wheeler at skwheeler@kslaw.com.

Timeline of Key Developments

1998 & 2005: Hospital Compliance Program Guidance (CPG) issued

1996: HIPAA Enacted

1998 – 2008: Voluntary OIG Compliance Guidance

March 2010: Mandatory Compliance Programs in Affordable Care Act

*Also implemented 60-Day Overpayment Law

2015: OIG White Paper on Healthcare Boards

September 2015: DOJ Increased Focus on Individual Accountability (Yates Memo)

March 2016: Final Part A/B Overpayment Rule

February 2017: DOJ Issues Evaluation of Corporate Compliance Programs

March 2017: OIG Issues Compliance Program Resource Guide

Inspector General Daniel Levinson reaffirms Compliance 2.0 expectations

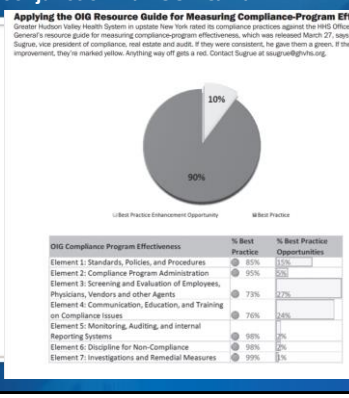
1991: Federal Sentencing Guidelines

Office of Inspector General (OIG)
Department of Justice (DOJ)/Sentencing Guidelines
Legislative
Centers for Medicare and Medicaid Services (CMS)

- **"You have essentially the same people there," former DOJ Deputy Chief of Fraud Section.**
- **"Funding is stable" b/c fines & penalties recycle back through.**

HHS OIG's resource guide for measuring compliance effectiveness, in conjunction w/ HCCA 3/27/17

- **"Any attempt to use this as a standard or a certification is discouraged by those who worked on this project; one size truly does not fit all."**
- **Tip: avoid the CCP being "siloed" in 1 dept/function.**
- **https://oig.hhs.gov/compliance/101/files/HCCA-OIG-Resource-Guide.pdf**



Applying the OIG Resource Guide for Measuring Compliance-Program Effectiveness

Greater Hudson Valley Health System in upstate New York rated its compliance practices against the HHS Office of Inspector General's resource guide for measuring compliance-program effectiveness, which was released March 27, says Stephen Sugrue, vice president of compliance, real estate and audit. If they were consistent, he gave them a green. If there is room for improvement, they're marked yellow. Anything way off gets a red. Contact Sugrue at ssugrue@ghvhs.org.

OIG Compliance Program Effectiveness	% Best Practice	% Best Practice Opportunities
Element 1: Standards, Policies, and Procedures	85%	15%
Element 2: Compliance Program Administration	95%	5%
Element 3: Screening and Evaluation of Employees, Physicians, Vendors and other Agents	73%	27%
Element 4: Communication, Education, and Training on Compliance Issues	76%	24%
Element 5: Monitoring, Auditing, and internal Reporting Systems	98%	2%
Element 6: Discipline for Non-Compliance	98%	2%
Element 7: Investigations and Remedial Measures	99%	1%

Examples from the OIG resources guide:

	Accountability:	
1.8	Accountability	Policy Coordinator designated
1.9	Ownership and accountability of policies	Audit process of how policies get enforced by chain of command when compliance is not the final approver. Is management taking responsibility for implementing and following policies?
1.10	Routine policies and procedures	Confirm that listed owner of each policy and procedure is the actual owner.

	Code of Conduct:	
1.41	Code of Conduct	Audit: Review dates, board approvals, distribution processes, attestations, survey employees for understanding, conduct focus groups.
1.42	Compliance program awareness and communication	Survey employees to determine the extent to which they know the content of the Standards of Conduct (SOC) and how to access it.
1.43	Integrate mission, vision, values, and ethical principles with code of conduct	Compare code with mission and vision statements to see if it includes elements/statements. Check to see if code is accessible to employees
1.44	Maintenance of code of conduct	Is code written, posted for employees, documented frequency of reviews, and survey/test employees on ability to locate it
1.45	Distribution	Documentation of Code of Conduct distribution tracking and results over past two years for all employees, employed physicians, allied health professionals, independent (contracted) physicians, volunteers and vendors/contractor/consultants in the organization
1.46	Orientation	Audit to ensure all employees receive orientation to the SOC and compliance policies within 30 days of hire.
1.47	Staff understanding of code of conduct and policies and procedures	• Review test scores after training. • Conduct interviews.

MAC initiated Targeted Probe & Educate Medical Reviews (TPEs), nationwide 10/1/17

- MACs to conduct medical reviews (MRs), e.g. outlier analysis.
- 20-40 claim probe MR of provider/supplier claims
- MAC letters will outline the probe & educate process (see appendix)
- Up to 3 rounds or review including individualized education during a round to address specific issues
- MACs to phase out all other medical record reviews—not RACs.
- Non-responses are counted as "errors"
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1919OTN.pdf
- Strategies: 855 Medicare enrollment addresses are current + follow timelines + take the education/use it to educate

29

The MAC's new TPE:

Q5. How are providers/suppliers identified for review?

A5. MACs will focus only on providers/suppliers who have the highest claim denial rates or who have billing practices that vary significantly from their peers. These providers/suppliers and specific services/items are identified by the MAC through data analysis. TPE claim selection is different from previous P&E programs. Previously, the first round of reviews included all providers that billed a particular service; TPE claim selection is provider/supplier-specific. This eliminates burden to

providers/suppliers who, based on data analysis, are already submitting claims that are compliant with Medicare policy.

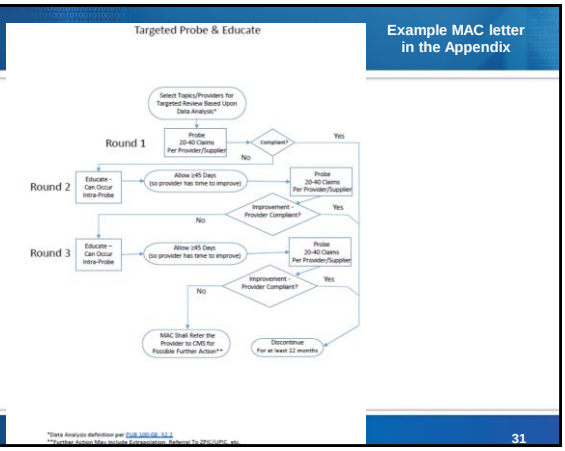
Q6. How are services/items selected for review?

A6. The MACs will select claims for services/items that pose the greatest financial risk to the Medicare Trust Funds and/or those that have a high Medicare Fee-For-Service improper payment rate as measured by the Comprehensive Error Rate Testing program.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/TPE-QAs-10-25-17f.pdf

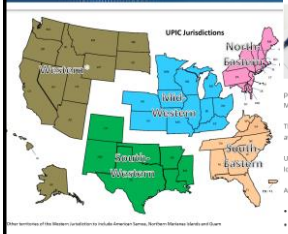
30

Example MAC letter in the Appendix



31

New Uniform Program Integrity (UPIC) Contractors Awarded July 2016—AdvanceMed for MI



The Centers for Medicare and Medicaid Services has awarded positions on a potential 10-year, $2.5 billion contract vehicle to seven companies for program integrity support services intended to help CMS and its partners identify instances of healthcare fraud, waste and abuse in Medicare and Medicaid.

CMS consolidated prior anti-waste and abuse services carried out by multiple contractors into the new *Unified Program Integrity Contract* program in an effort to anticipate and adapt to changes in healthcare fraud methods across the Medicare and Medicaid program continuum, according to a FedBizOpps summary.

The agency announced its selections of the contractors in a series of May posts to FedBizOpps and will award task orders for services across five geographic areas with multiple states as defined by CMS.

UPIC contractors will also coordinate activities with CMS and other agencies at the federal, state and local government levels; as well as other CMS partners and contractors.

Awardees include:

- AdvanceMed
- Health Integrity LLC
- HMS Federal
- Noridian Healthcare Solutions
- Safeguard Services LLC
- StrategicHealthSolutions LLC
- TriCenturion

CMS awarded UPIC's first task order to AdvanceMed for services in the contract vehicle's Jurisdiction 1 area that encompasses Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky, Iowa, Missouri, Nebraska and Kansas.

http://www.govconwire.com/2016/07/cms-awards-potential-2-5b-medicare-medicaid-anti-fraud-services-contract-vehicle/

32

"So what? Why do I need a culture of compliance and ethics in my group/company?"

The Federal False Claims Act (FCA)

Sources of liability,

Whistleblowers and Qui Tam Relators.

33

What are the main federal laws regulating physician payments & hospital/physician relationships?

- **Federal False Claims Act (FCA) (31 USC Sec. 3729-3733).**
  - **Ultimate "hammer" for feds. as minimum penalties are $5,500 per gov't payor claim.**
- **Anti-kickback Statute (AKS) (42 USC Sec. 1320a-7b(b).**
- **Physician Self Referral Law (Stark) (42 USC Sec. 1395nn)**
- **EMTALA (42 USC Sec. 1395dd)**
  - **http://www.acep.org/News-Media-top-banner/EMTALA/**

34

FCA Penalties—who's liable and for what?

- **FCA penalties ($5500 min. per claim pre 8/1/16) apply if 1 or more of the 3 standards are met.**
- ***"knowingly presents, or causes to be presented*, a false or fraudulent claim for payment or approval" 31 USC Section 3729**
- **So FCA penalties apply jointly/severally to the Physician Group AND to the revenue cycle management (RCM) company.**

35

In addition to the FCA penalties …

- **Treble damages (3 X the overpayment).**
  - **99285 ($175) less 99284 ($119) (2016)= $56 X 3= $168**
  - **Overpayment is the ED Group's liability.**
- **FCA has specific "anti-retaliatory" provisions in addition to employment discrimination laws that protect against retaliation.**
- **"Relators"=*Qui Tam* provisions of the FCA**
  - **15-30% of the FCA recovery.**
  - **+ attorney's fees.**

36

What is at stake in terms of the FCA multiplier impact on an ED group? (cont.)

- **Example (pre 8/1/16):** 100,000 annual visit two-hospital system, 30% Medicare/Medicaid/Champus payor mix (or 30,000).
- False Claims Act (FCA) multiplier = 1% "knew or should have known" or "deliberate ignorance" or 300 claims.
- Minimum: 1% or 300 X $5,500 min.=$1.65 Million
- Maximum: 1% or 300 X $11,000 max.=$3.3 Million

Post 8/1/16 FCA updates:

- Minimum : 300 X $10,781=$3.244 Million
- Maximum: 300 X $21,562=$6.468 Million

37

Case study: ED POS & compliant APP coding and billing—plus a helpful FCA reminder

- Rad Onc., ED vs. clinic & APP services were at issue.
- Allegation that hospital "systematically billed a minor care clinic as if it were an ED…"
- Also that APP services were coded & billed as if they were physician services "from the beginning of time".
- APP services alone w/ no documented "shared visit"=85% of the MPFS.
- Whistleblower: $1.202M on qui tam & $850K on wrongful termination=
  - $2,052,637
  - https://www.justice.gov/usao-sc/pr/anmed-health-agrees-pay-7-million-settle-false-claims-act-allegations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U.S. Attorney's Office
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FOR IMMEDIATE RELEASE Wednesday, September 27, 2017

AnMed Health Agrees to Pay $7 Million to Settle False Claims Act Allegations

Columbia, South Carolina —AnMed Health, a South Carolina hospital based in Anderson, South Carolina, has agreed to pay over $7 million to resolve allegations that it violated the False Claims Act by submitting false Medicare claims. The settlement announced today resolves allegations that AnMed Health knowingly disregarded the statutory conditions for submitting claims to the Medicare program for a variety of services, including radiation oncology services, emergency department services, and clinic services.

Specifically, the United States alleged that AnMed Health billed for radiation oncology services for Medicare patients when a qualified practitioner was not immediately available to provide assistance and direction throughout the radiation procedure, as required by Medicare regulations. The settlement also resolves allegations that AnMed Health systematically billed a minor care clinic as if it was an Emergency Department, and billed Emergency Department services as if they were provided by a physician when, in fact, the services were rendered by mid-level providers. Each of these billing practices resulted in higher reimbursements to AnMed Health.

"Our goal in pursuing Medicare fraud is not only to protect taxpayers, but also to ensure that Medicare beneficiaries receive the quality care they deserve," said Barbara Bowens, Civil Chief for the U.S. Attorney's Office for the District of South Carolina.

38

Case studies: NY Anesthesiology Medical Specialties (NYAMS) in Syracuse NY, *RMC* 10/9/17

After Missing Alerts on Sedation Billing, Practice Settles Case for $1.9M

New York Anesthesiology Medical Specialties in Syracuse, N.Y., has agreed to pay $1.94 million to settle false claims allegations that it overbilled for moderate sedation services, the U.S. Attorney's Office for the Northern District of New York said Oct. 3. The settlement tells a story of missed opportunities to learn the requirements for billing the time-based codes from the Medicare administrative contractor (MAC) and external audits.

New York Anesthesiology Medical Specialties (NYAMS), a physician practice that performs pain management and spine and back procedures, billed Medicare for moderate sedation when the physician didn't spend at least 16 minutes face to face with the patient "and/or when the medical record did not document that there had been at least 16 minutes of face-to-face time" from Jan. 1, 2012, to Jan. 3, 2016, according to the settlement. NYAMS used a billing company, Specialists Operations Consulting Services (SOCS), to code and submit its claims.

https://www.hcca-info.org/Portals/0/PDFs/Resources/Rpt_Medicare/2017/rmc100917.pdf?ver=2017-10-06-111558-930

- Coding & billing for MS prior to the CPT coding change 2017.
- CPT 99143 (Pts under 5 YO) & 99144 (Pts > than 5): 30 mins. of intra-service time pre-2017.
- The "16 minute rule" face to face time
- Strike 1: CPT Assistant Article—RCM did not subscribe.
- Strike 2: MAC, NGS, posted the 16 min. rule on its website for a year.
- Strike 3: NYAMS did not subscribe to NGS list serv.
- Strike 3.1: RCM folks were on the list serv but did not inform their client.

39

Case study: E/M outlier analysis

- FHG (medical group) initial hospital care CPT 99223, (highest level code) at 87% vs. CMS at 67%.
- FHG, discharge day management CPT 99238 at 5% & 99239 at 95%, vs. CMS 99238 at 52% & 48% for 99239, respectively—w/ the "239" code reimbursing about $30+.
- Allegations in the complaint (not mentioned in the settlement) that *locum tenens* was abused as well.
- How many years have we discussed outlier analysis?
- MACs have "comprehensive billing reports" (CBRs) also


Report on
MEDICARE COMPLIANCE
Weekly News and Compliance Strategies on CMS/OIG Regulations, Enforcement Actions and Audits

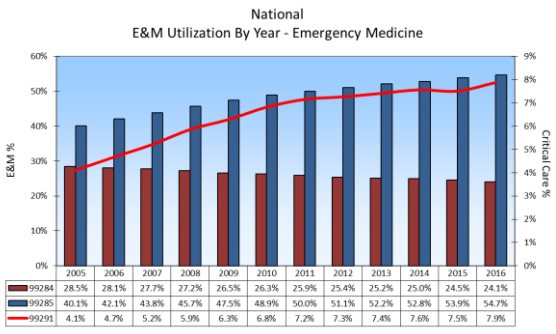
Contents

Hospitalist Group Settles FCA Case Over E/M Coding that Diverges from CMS Averages

https://www.hcca-info.org/Portals/0/PDFs/Resources/Rpt_Medicare/2017/rmc061217.pdf?ver=2017-06-09-104139-603

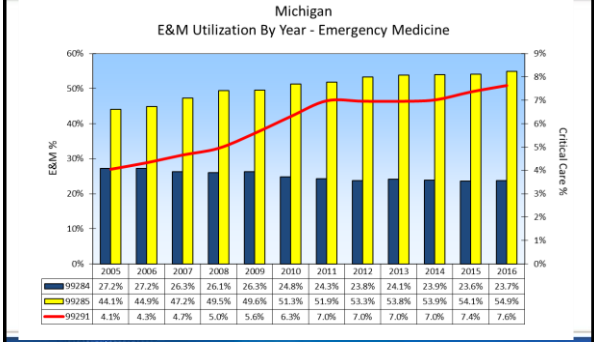
40

CMS' Part B National Summary Data File for Specialty 93 (EM docs): FP, IM & Peds. are not in these figures



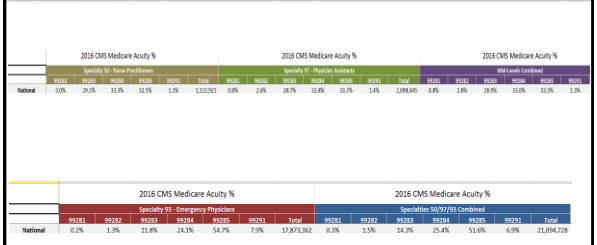
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
99284	28.5%	28.1%	27.7%	27.2%	26.5%	26.3%	25.9%	25.4%	25.2%	25.0%	24.5%	24.1%
99285	40.1%	42.1%	43.8%	45.7%	47.5%	48.9%	50.0%	51.1%	52.2%	52.8%	53.9%	54.7%
99291	4.1%	4.7%	5.2%	5.9%	6.3%	6.8%	7.2%	7.3%	7.4%	7.6%	7.5%	7.9%

MI data (note the Maize & Blue color scheme ;)



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
99284	27.2%	27.2%	26.3%	26.1%	26.3%	24.8%	24.3%	23.8%	24.1%	23.9%	23.6%	23.7%
99285	44.1%	44.9%	47.2%	49.5%	49.6%	51.3%	51.9%	53.3%	53.8%	53.9%	54.1%	54.9%
99291	4.1%	4.3%	4.7%	5.0%	5.6%	6.3%	7.0%	7.0%	7.0%	7.0%	7.4%	7.6%

Strategy: make sure the MAC is comparing "apples to apples" & APP numbers are separated.



	2016 CMS Medicare Acuity %							2016 CMS Medicare Acuity %							2016 CMS Medicare Acuity %						
	Specialty 93 - Nurse Practitioners							Specialty 97 - Physician Assistants							MM Levels Combined						
	99282	99283	99284	99285	99291	Total		99281	99282	99283	99284	99285	99291	Total	99281	99282	99283	99284	99285	99291	
National	3.0%	29.3%	33.3%	32.5%	1.1%	1,522,921		0.8%	2.6%	28.7%	32.8%	33.7%	1.4%	2,098,445	0.8%	2.8%	28.9%	33.0%	33.3%	1.3%	

	2016 CMS Medicare Acuity %							2016 CMS Medicare Acuity %						
	Specialty 93 - Emergency Physicians							Specialties 50/97/93 Combined						
	99281	99282	99283	99284	99285	99291	Total	99281	99282	99283	99284	99285	99291	Total
National	0.2%	1.3%	11.8%	24.1%	54.7%	7.9%	17,873,362	0.3%	1.5%	14.3%	25.4%	51.6%	6.9%	21,094,728

Mirth break!

Case study: if in non-ED settings like urgent care clinics (UCCs), new vs. established Pt issue is …(well) HUGE!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Weekly News and Compliance Strategies on CMS/OIG Regulations, Enforcement Actions and Audits
Contents
Erasing Doubt, CMS OKs Admissions by Mid-Level Practitioners Without M.D. Co-Signing
Compliance Officer Allegedly Instigated Upcoding at Hospital that Settled FCA Case

- New vs. established Pt primer—it is clinician specific and NOT TIN/EIN specific.
- Hospital acquired cardiologist group.
- Productivity bonus based on wRVUs if they exceeded targets.
- CCO + certified coder told group to bill Pts as new since becoming W-2s of hospital.
  - Physician questioned it--$123K settlement
- New/est. is not relevant to the ED

Case study: Back end compliance issues—ACA's stat. mandate for repayment of gov't refunds w/in 60 days of "identification"


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FOR IMMEDIATE RELEASE
Friday, October 13, 2017
Jacksonville Cardiovascular Practice Agrees To Pay More Than $440,000 To Resolve False Claims Act Allegations For Failing To Reimburse Government Health Care Programs

- FERA statute 2009—failure to refund is "a reverse false claim"
- ACA 2010: statutory requirement of 60 days w/ 6 year look back.
- "Recoupment P&Ps alone are not enough"—must have a Q/A process including audits.
- This case… "despite repeated warnings…."
- Whistleblower: former employee of the medical group
  - https://www.justice.gov/usao-mdfl/pr/jacksonville-cardiovascular-practice-agrees-pay-more-440000-resolve-false-claims-act

Other hot topics in coding, documentation and compliance: lightening rounds

- eClinicalWorks $155M settlement—false meaningful use (MU) certifications—urgent care clinic (UCC) issues.
  - CMS will not proceed against clients of the firm.
  - OIG is auditing on MU.
- "Personal Supervision" issues for Norman, OK hospital's radiologists & RPAs caused $1.6M settlement.
  - Hospital + physicians were jointly & severally liable for settlement.
  - Physician=whistleblower.
- -59 modifier abuse by UT pain management physicians caused $400K settlement.
  - Allegation that the -59 was abused to by-pass Medicare edits that would prevent billing for more than 1 urine drug test per day.
- And this one ……

Case Study of Joint and Several Liability of the Physician Group & Revenue Cycle Mgmt. (RCM)

- Center for Advanced Pelvic Surgery, Dr. Labib E. Riachi, Westfield, NJ OB/GYN.
- OIG alleged:
  - Pelvic floor therapy (PFT) services were never performed.
  - MD did not provide required direct supervision of medical assts.
  - MD's employees were not qualified by Medicare to perform invasive procedures (which included insertion of a balloon & pressure sensor in the rectum to evaluate sphincter reflex).
- https://oig.hhs.gov/newsroom/news-releases/2016/riachi.asp

The Unlicensed/Unqualified Rectal Procedures example continues …..

- RCM company, Millennium Billing, owner Susan Toy, was alleged to knowingly assist in the fraudulent billing.
- Several interesting aspects of settlement:
  - OIG's data mining function (FPS) raised issues about the physician.
  - DOJ/OIG assessed $5.25M in FCA against MD.
  - RCM was fined $100K in civil monetary penalties.
  - RCM agreed to 5 yr. exclusion from gov't programs.
  - MD agreed to a 20 yr. exclusion from gov't programs.
  - https://aishealth.com/archive/rmc120516-05
  - http://my.clevelandclinic.org/services/rehabilitation-sports-therapy/specialty-therapy-services/pelvic-floor-rehabilitation

Summary:

- Payor assaults continue & will require vigilance/engagement & concerted action via state chapters, ACEP & EDPMA.
- De-contracting may have to be used to avoid arbitrary & capricious coding and reimbursement policies.
- Medicaid and Medicaid MCEs will require advocacy as de-contracting is not an option—PLP is a bright line and it should be enforced.
- Compliance 2.0 is here—don't be caught in the 1.0 time warp.
- MAC TPE may have educational benefit—both ways.
- Learn from the case studies.
- No whining—this is EM!

Emergency Medicine Reimbursement Issues...

Straight Talk XXVI

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Emergency Medicine Div.

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919-641-4927

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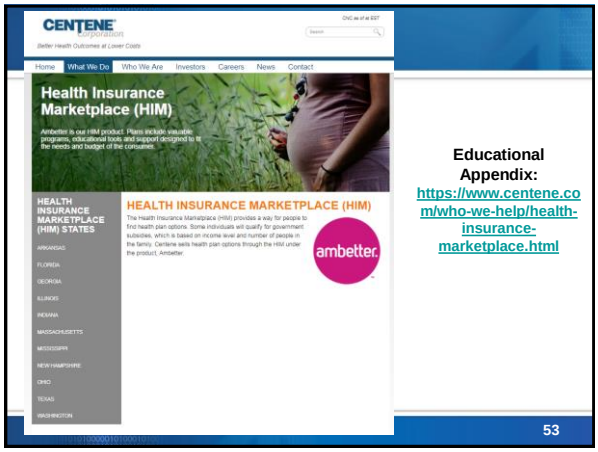
@EdGainesIII

http://twitter.com/EdGainesIII

Appendix: applicability of PLP to other payors:

- Federal Employees Health Benefit Plan (FEHBP): 1998 Executive Order /s/ by Pres. Clinton.
- VA: Vet. Millennium Health Care and Benefits Act of 1999—and 38 CFR 17.1002 (b) & (c)
- ACA: Section 2719A extended PLP to enrollees in ACA exchange plans, 42 CFR 2590.715-2719A.
- ERISA plans: 29 CFR 2560.503-1.
- SCHIP: 42 CFR 457.10
- State laws generally cover commercial health plans licensed in that state, and may apply to PPOs and TPAs
- *Source:* EDPMA memo from Hart Health Strategies, Inc., 6/16/2017



53

Educational Appendix:
https://www.centene.com/who-we-help/health-insurance-marketplace.html

Appendix: sample MAC TPE letter


MAC Header Here

EXAMPLE LETTER

PROVIDER NAME
PROVIDER ADDRESS
CITY ST ZIP

Mail Date (ex. December 14, 2014)

Case Number: Case #
Provider NPI Number: Provider NPI

RE: Notice of Review - Targeted Probe and Education

Dear Medicare Provider or Supplier

In order to fulfill our contractual obligation with the Centers for Medicare & Medicaid Services (CMS), <Select>, your Jurisdiction <Select> Medicare Administrative Contractor (MAC), performs reviews in accordance with the CMS instruction. CMS has authorized Jurisdiction <Select> to conduct the Targeted Probe and Educate (TPE) Pilot review process. The TPE review process includes three rounds of a prepayment probe review with education. If there are continued high denials after three rounds, <Select> will refer the provider/supplier to CMS for additional action, which may include 100% prepay review, extrapolation, referral to a Recovery Auditor, etc. Note, discontinuation of review may occur at any time if appropriate improvement is achieved during the review process.

This letter serves as notification of the TPE process and to notify you of the initiation of the review. The purpose of the claim review is to ensure documentation supports the reasonable and necessary criteria of the services billed and follows Medicare rules and regulations.

Reason of Review
Your facility was selected for review based on <Select>. A prepayment review has been initiated to probe a sample of your claims billed with the following <Select> code(s):

- Procedure Code/HCPCS Code - Short Description

The previous medical review resulted in an error rate of XX%. A small sample of randomly selected claims are chosen to determine if a provider is billing and coding according to Medicare guidelines and to ensure services are reasonable and medically necessary.

Additional Documentation Requests

Please do not send any documentation at this time. Your facility will be notified with an Additional Documentation Request (ADR) letter on each claim selected for review. This letter will include a list of specific elements needed to support the service on review. Please ensure the process for routing these documents to the person(s) responsible for submission is timely and effective. Inform your staff responsible for receiving the ADR letters and submitting the required documentation for this review. Authorization for the release of this information is included in Federal Law regulations reference 42 CFR 411.24(a), 424.5(a)(6) and 44 USC 3101.

If the requested documentation is not returned within 45 days, the claim will be denied due to lack of documentation which will contribute to your error rate. It is your responsibility as a provider to provide the requested documentation within the allotted time frame. Additionally, if providers/suppliers do not respond to the ADR request, MACs have the option to refer to the RAC or ZPIC/UPIC as a result. <Select> will review your claim within 30 days. After all claims selected for the probe are reviewed, you will receive a letter that includes specific findings of our review.

Education
Upon completion of the claim sample, the nurse reviewer will contact you to schedule a 1:1 educational session regarding any errors noted during the claim review. <Select> offers webinars, which are web-based presentations using Internet technology. If your office does not have internet capabilities, a traditional teleconference will be offered. We can offer other methods of direct communication if these methods are not convenient. Medical Review will also provide you written notification at the end of the review to include your results. This letter will include the number of claims reviewed, the number of claims allowed in full, the number of claims denied in full or in part and limited education on the results.

In Closing
Thank you for your participation with this review. Please email <Email for contact person(s)> referencing the case number above upon receipt of this letter to provide the name of a contact person, if not already communicated, or with any questions regarding the information in this letter.

Sincerely,

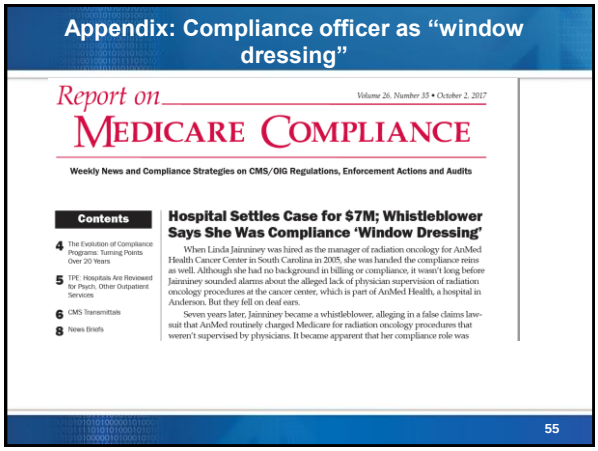
<Select> MAC Jurisdiction <Select> Medical Review

cc: <CMD and Titles>
Contractor Medical Director
enc: TPE Process Flowchart
Dear Ordering/Referring Physician Letter
Comprehensive Error Rate Testing (CERT)

MAC Footer May Be Included Here

54

Appendix: Compliance officer as "window dressing"


Report on
Volume 26, Number 35 • October 2, 2017
MEDICARE COMPLIANCE

Weekly News and Compliance Strategies on CMS/OIG Regulations, Enforcement Actions and Audits

Contents

4 The Evolution of Compliance Programs: Turning Points Over 20 Years
5 TPE: Hospitals Are Reviewed for Psych, Other Outpatient Services
6 CMS Transmittals
8 News Briefs

Hospital Settles Case for $7M; Whistleblower Says She Was Compliance 'Window Dressing'

When Linda Jairuniney was hired as the manager of radiation oncology for AnMed Health Cancer Center in South Carolina in 2005, she was handed the compliance reins as well. Although she had no background in billing or compliance, it wasn't long before Jairuniney sounded alarms about the alleged lack of physician supervision of radiation oncology procedures at the cancer center, which is part of AnMed Health, a hospital in Anderson. But they fell on deaf ears.

Seven years later, Jairuniney became a whistleblower, alleging in a false claims lawsuit that AnMed routinely charged Medicare for radiation oncology procedures that weren't supervised by physicians. It became apparent that her compliance role was

55