Medical Practice Compliance ALERT

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

June 14, 2010 | Vol. 22, Issue 11

IN THIS ISSUE

Warning: Look out for compliance challenges from CMS's program integrity auditors

It's bad enough you have to worry about the permanent recovery audit contractor (RAC) program gaining in intensity. You also need to prepare for audits from zone program integrity contractors (ZPICs) – formerly the program safeguard contractors (PSCs). These audits are already in full swing, potentially much more insidious, and specifically targeting physicians.

The primary purpose of the ZPIC program is to deter fraud and abuse, according to Tim Johnson, with Jackson Davis Healthcare in Denver. The ZPICs conduct investigations, refer cases to the Office of Inspector General or Department of Justice, and take administrative actions, such as referring overpayments to claims processors for collection. In 2007, PSCs referred overpayments totaling $835 million to MACs and other claims processors, according to two companion reports released by the OIG in May 2010.

There were 18 original PSCs, now being transitioned to seven ZPICs, which will handle claims from all provider types aligned …

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

Senate tackles Red Flag Rules, gains another enforcement delay

Thanks to members of Congress, you need not worry about enforcement of the Red Flag Rules just yet. Enforcement did **not** begin on June 1 as had been planned. In a May 28 press release, the Federal Trade Commission (FTC) announced it would delay enforcement until Dec. 31, 2010. **But be warned:** You could still be at risk before the end of the year.

Congress requested another delay because it is still working on legislation to limit the scope of the Red Flag Rules. On Oct. 20, 2009, the House of Representatives unanimously passed H.R. 3763, a bill that would automatically exempt physician practices with 20 or fewer employees from the Red Flag Rules and allow others to request an exemption.

*(see **Red Flag Rules**, pg. 6)*

Requests for records: Handle with care

At first glance an attorney's request for medical records didn't raise any red flags. Such requests are a common feature of a practice's paperwork. The urge to get this cumbersome chore done as quickly as possible is natural, but dangerous. When an Ohio medical practice received a request for medical records from an attorney, it called its legal counsel, just to make sure everything was on the up and up. It turned out the request came from an attorney for a patient's spouse; the attorney was after information that could be used against the patient in a divorce proceeding.

This practice's close call illustrates how savvy you have to be when you receive a request for medical records.

Keep this principle in mind: The physician has the absolute duty to keep the patient's information secret, unless the law clearly states the physician *must* release the information, says Scott P. Sandrock, an attorney with Brennan, Manna & Diamond in Akron, Ohio.

Even when your practice receives a subpoena for medical records from an attorney acting on the patient's behalf, you can create more work for yourself if you send the information.

Example: Your practice receives a subpoena from a law firm in another state, requesting medical records for one of your patients. Apparently the patient was in a traffic accident in another state and has filed suit there. Should you send the records?

No, Sandrock says, and here's why: As a matter of law, subpoenas are only valid in the state they originate from.

Remember: Under the latest HIPAA rules, sending records in response to an invalid subpoena violates HIPAA, Sandrock says. If you make a mistake, you'll have to notify the patient, investigate the breach and self-report to HHS. Even when the patient wanted you to send the records, you'll still have to do the extra work.

"The first question you should ask: Is the subpoena in my jurisdiction?" Sandrock says. Next you should ask how the subpoena was delivered. If it wasn't sent in accordance with state law, the subpoena still isn't valid. **Example:** In Ohio, subpoenas sent via regular mail are not valid.

TIP: Distribute the Responses to Requests for Medical Records list on pg. 8 to your staff to reduce the chance your practice will commit a records-sharing error.

3 tips for responding to medical record requests

Even when you're sure the request is valid, you still must take steps to control the information you release, notes Debbie Shirley, business office manager for Houston Cardiovascular Associates in Houston. Make sure staff responsible for responding to these requests are aware of these three tips:

Subscriber Services

Editorial:
Scott Kraft – 1-301-287-2361 *skraft@decisionhealth.com*
Marla Durben Hirsch – 1-301-299-6155 *mhirsch@decisionhealth.com*
Julia Kyles – 1-301-287-2651 *jkyles@decisionhealth.com*
Sean Weiss – vice president, DecisionHealth Professional Services
sweiss@dhprofessionalservices.com

Marketing:
Elise Yore – 1-301-287-2274 *eyore@decisionhealth.com*

Subscriptions:
For direct questions about newsletter delivery and account status, please contact DecisionHealth® at 1-877-602-3835, or email us at: *customer@decisionhealth.com*

Compliance Listserv:
To join our free Internet forum on fraud and abuse issues, go to *http://listserv.ucg.com/cgi-bin/listserv/listserv.pl/fraud-l*, click on the "Join the Fraud & Abuse Discussion Group" link, and follow the instructions.

Reprints:
To request permission to make photocopy reprints of *Medical Practice Compliance Alert* articles, or to obtain information on our copyright waiver, multiple copy and site license programs, please call us at 1-866-265-0148, or email Gary Belski at: *gbelski@decisionhealth.com*.

Medical Practice Compliance Alert **is published 24 times per year by:**

DecisionHealth® (a UCG company)
Two Washingtonian Center
9737 Washingtonian Blvd., Suite 100
Gaithersburg, MD 20878-7364

ISSN: 1047-1863
Price: $547 per year
DecisionHealth®, LLC

1. Only accept signed, written requests for records, Shirely says. In a busy office sending records off without even this basic level of verification can increase the chances you'll respond to an invalid request.

2. Make sure there is signed release of medical records on file. **TIP:** If your practice is on an electronic medical record system, scan the document into your system. "That way it's part of the permanent record," Shirley says.

3. Take the time to go through the record and only send information that is pertinent to the request. **Note:** Instruct staff to be alert to particularly sensitive information about the patient, such as mental illness, Shirley warns. Even when the information is going to another physician, if it isn't relevant to the request, leave it out.

10 ways to make your in-office compliance training more effective

You know you need to train your employees about compliance, but the hard part is figuring out how to do it in an effective way that works for your staff. Here are 10 tips from compliance experts to help you design your training program and enhance the compliance education in your office:

1. Start with an attention-getter. Start your billing compliance training with examples of denied claims and the reasons for the denials, such as incorrectly executed ABNs and chest x-rays denied by Medicare as not medically necessary, advises Donna Beaulieu, compliance officer for Quality Physician Services in Stockbridge, Ga. Beaulieu then shows her trainees how a correctly executed ABN or correct bill for x-rays should look. "To get their attention, I hit them in the pocketbook and then lead them to the dry stuff," she explains.

2. Use memorable stories. Act out scripts or scenarios with staff members at meetings, then discuss mistakes made and how to correct them, says attorney Russ Berland with Stinson Morrison Hecker, Kansas City, Mo. Berland is a former compliance officer at consulting firm Bearing Point, and designed videos with scripted scenarios – you'll act them out because you probably have fewer resources. He showed the videos at his compliance training meetings. After each three to five minute video, he'd have an executive critique the actions of the characters. **Example:** After the video on sexual harassment, the head of human resources pointed out what behavior was appropriate and inappropriate and discussed Bearing Point's sexual harassment policies.

3. Customize training for your practice. Create webinars using case presentations that are representative of what staff would likely encounter at a practice that is similar to yours in size or specialty to train employees, suggests Kathy Bulgarelli, Director of Compliance at Arcadia Healthcare in Southfield, Mich. Berland made sure his videos used the same industry buzzwords used in his company and visual clues, such as cans of Red Bull. "I wanted a sense of recognition that 'this has happened to me' and tie into their emotions. That's what makes the training sticky. A lot of time training is death by PowerPoint, and that's not effective," he says. You can use generic tools but augment with information specific to your practice.

4. Use real examples. A physician practice client of David Zetter, president of Zetter Healthcare Management Consultants in Mechanicsburg, Pa. left a patient's chart in view of another patient, who reported it. Zetter incorporated the incident in his HIPAA training for all of his physician practice clients. "I used it as an opportunity to educate," he says.

5. Make training funny. Berland made his characters over-the-top archetypes so that they'd be amusing – and memorable. "What you want is for people to remember [the training]," he explains. Employees ended up looking forward to upcoming videos.

6. Include the physicians and any other senior management. "You need to exhibit a top down commitment to compliance. If you don't, lower level staff won't see compliance as important, warns Wayne van Halem, president, the van Halem Group, Atlanta.

7. Train continually. Zetter sends out emails and memos to his practices regarding compliance issues in the news, sometimes even using cartoons, to keep compliance in front of staff. Consider sharing stories and information from *Medical Practice Compliance Alert*. As changes in the plan or policies occur (such as a change in the procedure for submitting claims or the addition of a new service), the practice will need to update staff, suggests attorney Mark Nelson, with Drinker Biddle in Chicago.

8. Train in smaller chunks of time. It may be easier for employees to digest compliance if it's presented in little pieces. One family medicine practice Zetter knows of meets every morning for seven minutes, and the office

manager speaks for a minute on compliance. "That's a best practice [to cover compliance this often]," he notes.

9. Test employees after conducting training, suggests Roy Snell, CEO, Health Care Compliance Association, Minneapolis. Test staff a week or so after the training. "You might be shocked as to the results. It will help document the need for more training or more frequent training," he notes. Some education tools commercially available, such as computer based learning self-study modules, include pre-and-post competency testing. Also use the compliance quizzes *Medical Practice Compliance Alert* provides to test staff.

10. Document your training. Keep a paper or electronic file of memos and other education that you've disseminated and logs of who attended training sessions (for a sample sign in sheet, see the email attachment for this issue). This shows that you've conducted training and that you're sincere about compliance, says Zetter. "Law enforcement loves that kind of stuff. You're making an effort," he notes.

Prepare now for more RAC activity

Despite poor reviews from the HHS Office of Inspector General and the Government Accountability Office *(MPCA 4/19/10, 3/8/10)* don't turn your back on Recovery Audit Contractors (RACs). Information from CMS and your peers show they're just getting up to speed.

Get ready for physician record review

The RACs already are in full swing with audits of hospital medical records, but will extend the scope of their medical record reviews to physicians as soon as CMS sets limits on the number of medical records the RACs can request at a time.

Once that occurs, expect complex reviews of your medical records to begin immediately, CMS revealed in an information session held in May. "Record requests for doctors should be expected any time now," says Amy Reese, CMS' Project Officer for RAC Region C.

RAC unit shows practices aren't safe

A small practice in RAC region D tells *Medical Practice Compliance Alert* through its subscriber-exclusive *RAC Rapid Response Unit,* program that it has already had a brush with its RAC.

The practice reports that it has already received an overpayment demand for spine infusion pump services from its RAC. However, the story does have a happy ending: The practice got the refund demand overturned.

Since the inception of the permanent RAC program, some members of the health care community believed the RACs would go after hospital claims and leave physician claims alone.

Supporters of this theory cited the fact that RACs get paid on a contingency basis. Given the choice between the potentially huge amounts that could be recovered from a hospital and the relatively small amounts it could recoup from doctors, they argued, a RAC wouldn't waste time on physician claims.

Information received through the *RAC Rapid Response Unit* lays this belief to rest.

Important notice: If you signed up for the *RAC Rapid Response Unit* on or before June 9, 2010, you should have received two Alerts.

This first alert warning network is the ideal way to receive and share information about RAC activity. Join the *RAC Rapid Response Unit*, a free, completely anonymous service available only to *Medical Practice Compliance Alert* subscribers. To join please send your email address to: *jkyles@decisionhealth.com*, subject line: RAC Unit.

ZPIC

(continued from pg. 1)

with that region's Medicare Administrative Contractor (MAC), says Wayne van Halem, president, the van Halem Group and audit advisor to Waterloo-Iowa based VGM Group. The ZPICs will look at all Part A and Part B claims and the connections between them, he notes.

CMS has transitioned three ZPICs so far; Health Integrity for Zone 4 (Colo. NM, Okla., and Tex), AdvanceMed for Zone 5 (Ala., Ark., Ga. La. Miss., NC, SC, Tenn. Va., and West Va.), and SafeGuard Services for Zone 7 (Fla., PR, and VI). The transition should be finished nationwide in 2010.

Why ZPICs should worry you

The ZPIC focus on fraud is an alarm for your practice, even when you know your conduct is not fraudulent. "They all have benefit integrity units, which are there to

initiate fraud investigations. Every audit has the potential to be a fraud referral [to law enforcement]. That's scary," warns Johnson. They conduct random reviews, but it is likely they've identified a billing error or specific issue from either data analysis or a complaint that triggers an audit. "About 90% of ZPIC audits are a direct result of proactive data analysis. The rest is from complaints made to the MACs, which then refer the issue to the ZPIC," says van Halem.

The data shows the ZPICs seem to be **gunning for physicians.** The OIG said that Part B overpayments accounted for a whopping 89% of the ZPIC overpayment dollars referred for collection. Physician practices were responsible for $336 million of those overpayments.

Expect ZPIC activity to ramp up in 2010. The fiscal year 2010 federal budget earmarks $311 million for these program integrity activities, a 50% increase from 2009, says van Halem. The OIG also has chastised the PSCs for not having collected more overpayments, so expect more aggressive auditors.

You risk standing out to a ZPIC when your physicians bill at a higher level than the national averages. But it's not just claims they eye, ZPICs will also review your contracts, licenses and files to ensure Medicare compliance, says attorney Rafael Gaitan, with Gaitan Morales, Miami, Fla.

TIP: You need to understand when you're dealing with a ZPIC and understand know your rights because you are facing a potential fraud investigation.

Note: In the next issue of *Medical Practice Compliance Alert* we'll share the story of one practice's $4 million dollar ZPIC audit ordeal.

On the Internet:

- Collection Status of Medicare overpayments Identified by Program Safeguard Contractors, *http://oig.hhs.gov/oei/reports/oei-03-08-00030.pdf*
- Medicare Overpayments Identified by Program Safeguard Contractors, *http://oig.hhs.gov/oei/reports/oei-03-08-00031.pdf*

ZPICs have and use more power than the RACs

When a Zone Program Integrity Contractor audits you, it usually starts with a letter requesting documentation on a number of claims (see story, pg. 1). You usually get 30 days to comply. When it finds an overpayment, the ZPIC will notify your MAC, which sends you a demand letter. You can repay the money, have it taken via recoupment or appeal, but you must act within 30 days to avoid interest.

The five-level appeals process – redetermination, reconsideration, administrative law judge hearing, Medicare Appeals Council, and federal court review - is the same as the RAC appeals process *(MPCA 1/25/10)*. Overpayment collection is prohibited during appeals at the first two levels.

But the ZPICs have greater powers than the RACs:

1. ZPICs are allowed to conduct prepayment reviews. If the ZPIC determines your billing error rate is too high, some or all of your claims may go on prepayment review. There is no time limit on the ZPIC for processing these claims; claims that previously took two weeks could take months, reports attorney Rafael Gaitan, with Gaitan Morales, Miami, Fla. You stay on prepayment review until your error rate drops to the auditors' satisfaction. "This can significantly hold up your cash flow," says Wayne van Halem, president, the van Halem Group and audit advisor to Waterloo-Iowa based VGM Group. He and Gaitan know of providers with sudden cash flow problems due to prepayment reviews who have laid off staff or considered closing.

2. ZPICs use extrapolation when justified by the error rate found, says van Halem. The ZPIC takes a statistical sampling of claims to audit, and applies the percentage of billing errors found to all similar claims for that time period, exposing you to potentially millions of dollars in repayment demands based on a 2-4% sample size, says Tim Johnson, with Jackson Davis Healthcare in Denver. It's unclear how RACs will use extrapolation.

3. ZPICs are authorized to conduct unannounced site visits – and do. "The auditors take photos, copies of drivers' licenses, and records, and turn the entire place upside down," says Johnson.

4. ZPICs operate under a cloak of secrecy. Example: When AdvanceMed, the ZPIC for zone 5, audited Eye Specialty Group, an eight-physician ophthalmology practice in Memphis, Tenn., it told the practice it was conducting a routine audit. It wasn't until four years later, at the third level of appeal, did AdvanceMed admit that the audit was an integrity audit triggered by a report by an employee that the practice was conducting unnecessary cataract surgery, according to Thomas Brown, the practice manager for Eye Specialty Group. However, AdvanceMed based its $4 million overpayment assessment on supposed coding errors, not its cataract surgery practices; the 120 charts it asked to audit did not include cataract surgeries. "For four years the auditors never asked for and reviewed those charts," he says.

Red Flag Rules

(continued from pg. 1)

The bill went to the Senate's Committee on Banking, Housing, and Urban Affairs on Oct. 21, 2009. But, the Senate didn't introduce S. 3416 until May 25, 2010.

According to the FTC, "a limited further postponement is warranted so that it does not begin to enforce a regulation that Congress plans to supersede." However, the FTC states it will **start enforcement** before the end of the year if Congress passes a law with an earlier effective date.

The Red Flag Rules requires all creditors, or those who provide goods or services and allow customers to pay later, to prepare an Identity Theft Prevention Program.

Note: A federal judge may have the final say on whether physicians are subject to the Red Flag Rules. On May 21, 2010, the AMA and the American Osteopathic Association filed a lawsuit against the FTC with the United States District Court for the District of Columbia. The plaintiffs seek to bar the FTC from applying the Red Flag Rules to physicians.

On the Internet:

- S. 3416: *http://tinyurl.com/Senate3416*

Quick Compliance Facts

- **Warn your patients about a new wave of scams.** The health care reform law has brought the scam artists out of the woodwork. HHS has received reports that fraudsters are using the historic law to trick beneficiaries into handing over their social security numbers, health insurance numbers and even bank account information. During a webchat on Health Care Reform and fraud on June 2, HHS Secretary Sebelius and other officials warned of two scams. In one, someone masquerading as an insurance sales person tried to talk a Medicare patient into switching to a new insurance plan called "Obamacare." The second scam involves the $250 payment for the Medicare Part D doughnut hole. Patients have received calls or visits from people offering to help them get the payment. Both offers are bogus, Sebelius pointed out. The government will not contact patients to sell insurance and eligible patients will receive the $250 payment automatically. Warn patients about these scams and to be wary of any attempt to get their personal information. They can report suspected fraud to the HHS Office of Inspector General's fraud hotline: 1-800-447-8477. TTY: 1-800-377-4950.

- Learn the quickest ways to implement all seven mandatory elements of the compliance plan by joining health care compliance expert Betsy Nicoletti for an all-inclusive webinar. To register for ***Your guide to the 7 elements of health care reform's mandatory compliance policy rule*** on July 14, 1:00 – 2:30 p.m. Eastern Time call 1-866-620-5939**.**

On the Internet:

- HHS webchat: *http://tinyurl.com/HHSWebChat*
- Get ready for mandatory compliance plans: *www.decisionhealth.com/conferences/A1979*

From the
DECISIONHEALTH® PROFESSIONAL SERVICES
Case Files

Case #36: The case of the concurrent care confusion

The client: A multi-specialty practice in the Southeast.

The audit: DecisionHealth Professional Services was brought in to conduct a basic chart review and identify lost revenue opportunities.

The compliance risk: Practice staff erroneously thought they could never submit claims for non-consult E/M services when another provider treated the patient on the same day. Not only were they regularly leaving money on the table, but they weren't billing patients for their services. The Patient Protection & Affordable Care Act places strict limits on free services, including a requirement that providers first determine the patient can't afford to pay (see Case File #13, The Case of the Copay Waiver Gone Wild, *MPCA 6/29/09*).

Background: Concurrent care – when two physicians treat the same patient on the same day – can spark denials if a carrier decides the care of one of the physicians wasn't medically necessary. This can make claims submission a competition, with the different doctors racing to get their claim to the carrier first. However, this shouldn't isn't necessary when different doctors treat different conditions. In deciding to pay for concurrent care, your carrier will look at whether or not:

- More than one doctor should play an active role in a patient's treatment.
- The patient's medical conditions justify two doctors.
- The specialties and subspecialties of the doctors have overlapping areas of expertise.

The rule: Concurrent care exists where more than one physician renders a service other than a consult, during a period of time. The reasonable and necessary services of each physician rendering concurrent care could be covered when each is required to play an active role in the patient's treatment.

Note: The physicians' specialties can indicate the necessity for concurrent services, but the carrier will also consider the patient's condition and the inherent reasonableness and necessity of the services.

Example: Cardiology is a sub-specialty of internal medicine. Therefore the treatment of both diabetes and of a serious heart condition might require the concurrent services of two physicians – a cardiologist and an endocrinologist – each practicing in internal medicine but specializing in different sub-specialties.

The investigation: We determined members of the practice did not understand concurrent care rules. Staff believed that if two providers both rendered an E/M service to the same patient on the same day, only the doctor who saw the patient first could bill for the service.

Recommended Corrective Action Plan: We met with clinical and reimbursement staff and explained that multiple providers may evaluate the same patient on the same calendar date as long as they are of distinct specialties and, generally speaking, for distinct diagnostic purposes.

Example: A pulmonologist sees a patient for acute respiratory failure and an internist evaluates the same patient for the management of his underlying chronic conditions. Both providers should submit claims for their respective services and both claims should be considered payable.

Warning: If both providers use the same ICD-9 code, the first claim received will likely be paid while the other may be denied. Doctors can avoid these denials by coding to the highest level of specificity.

Example: A patient complains of shortness of breath. An internist evaluates the patient for shortness of breath and a pulmonologist diagnoses acute respiratory failure. If both doctors report ICD-9 code **786.05** (shortness of breath) on the claims for their individual E/M services, the carrier will reject the second claim it receives. However, if the internist selects 786.05 and the pulmonologist selects ICD-9 code **518.81** (acute respiratory failure), this should be sufficient to demonstrate the medical necessity and distinct nature of the two doctors' services.

On the Internet:

- CMS 100-02, Chap. 15, sec. 30(E): *www.cms.gov/manuals/Downloads/bp102c15.pdf* (pg. 14)

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

From the Compliance Toolbox

Responses to requests for medical records

The rules regarding responses for requests for medical records vary from state to state, but the following checklist, provided courtesy of Scott P. Sandrock, an attorney in the health care law practice in the Akron, Ohio office of Brennan, Manna & Diamond, LLC will be a sound roadmap for responding to most requests for medical records *(see story, pg. 2)*. The physician has the absolute obligation to protect the patient's information and the physician can be liable for damages if information is released contrary to law.

1. **Adopt an Internal Response Protocol.** We recommend you designate a single person such as the compliance officer, practice manager, or record supervisor, to be the only person in your office to review and respond to requests. This person should have this checklist or some training in how to respond.
2. **Copies.** In most cases, produce only copies, not the original records. Any electronic records should be in a PDF or other non-alterable format.
3. **Written Authorization From Patient.** You may release the requested records, provided the authorization is in a HIPAA compliant form and the form is dated within one year.
4. **Authorization Request from Custodial Parent of a Minor Child.** You may generally release the information, unless the minor was permitted to seek medical treatment without the consent of the parent. In such case, you will need to check on the law in your state. In the case of non-custodial parents, you may need to check your state law.
5. **Authorization from Guardian of Patient.** You may release the information after you verify the guardian's authority, such as a court order or a signed form from a parent permitting the guardian to act on behalf of the patient.
6. **A Subpoena or Request from an Attorney with an Authorization from the Patient Included with the Request.** You may release the requested information.
7. **Attorney's Letter Requesting Information, But Without the Patient's Authorization.** You may not release information absent further inquiry → See #9.
8. **Subpoena Requesting Records Without a Patient's Authorization.** You may not release records without further inquiry → See #9.
9. **Duty to Inquire.** In many states, an exception to the patient-physician privilege rule exists by statute that provides a patient waives the privilege when the patient's medical condition is an issue raised in a specific lawsuit. For example, if a patient is involved in a traffic accident claim raising personal injuries, under these statutes, the patient waives the privilege and the physician who treated the patient would be required to release information regarding that treatment, even without the patient's prior consent. In those states, the burden is on the physician to verify that the complaint actually contains allegations regarding those injuries, and limit the disclosure solely to the treatment for that condition, and not the patient's entire records.
10. **Ask for More Information and Protective Orders.** If it is not clear to the physician that the record request or authorization permits disclosure, the physician may request additional information. If it is unclear even after they receive more information, the physician may need to consider filing a request with the court for a protective order. The motion would ask the court to decide whether the information should be released. If a court orders the release of information, the physician would generally be protected from a claim by the patient because the patient would have the opportunity to raise any objections in the court proceedings.
11. **Contact Experienced Health Care Counsel.** If you have any doubts, contact experienced health care counsel. Remember that if the physician makes a mistake, even in good faith, the physician can be financially liable to the patient.

How did you get this email?

Copyright notice