

MEDICARE UPDATE

HEALTHCARE EDUCATION LEADERSHIP PROGRAM
02/02/2012

MEDICARE CHANGES at a glance

- ▶ December 1985 - Initiation of Harvard Study
- ▶ January 1992 - Medicare RBRVS implemented
- ▶ June 1998 - NPI instructions published
- ▶ April 2003- Privacy compliance deadline
- ▶ April 2005 - Security compliance deadline
- ▶ May 2007 - NPI compliance deadline
- ▶ September 2008 - Medicare changes to MAC
- ▶ February 2009 - RAC Companies Initiated

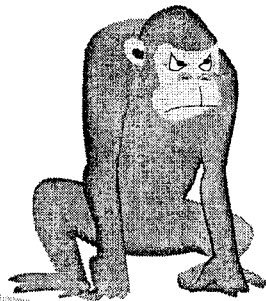
Medicare Changes

- ▶ January 2012 - 5010 compliance (3rd party)
- ▶ March 2012 - 5010 compliance (Medicare)
- ▶ 2011 - EMR incentive/penalty program
- ▶ 2011-2013 - EMR meaningful use incentive
- ▶ October 2013 - ICD-10

This is all leading somewhere....

Medicare Fee Schedule

› Due back to Congress March 1, 2012



OIG Workplan

- › Summary pertinent topics in packet
 - Compliance with assignment rules – providers not charging more than the allowed amount
 - High Cumulative Part B Payments (New) – edits in Medicare system to review providers with high dollar amounts, and high volume of re-visits
 - Place of Service Errors – facility/non facility, most common error in POS 22 vs 11
 - Incident To Services
 - Impact of Opting out of Medicare (new)

CRC Letters (CERT)

- › 2010 Annual report from the CRC (review committee) indicated Palmetto J1 had the highest overall paid claims error rates in the nation.
 - Probe reviews
 - Documentation Errors –
 - Level of service errors
 - Failure to respond to documentation requests

RAC Audits

- › Moving into provider areas
- › Many errors in the edits
- › Review refund request

3rd Party Payors Response

- › FIELD DAY...
- › Internal Audit companies requesting documentation
- › Re-calculating multiple procedure discounts
- › Global Period enforced – date surgery scheduled starts the global period

A Couple of Billing Tips

- › Review the documentation before you send it to the payor
- › Verify the cpt and icd codes
- › Use your billing system to your advantage –
 - Track payors who request information prior to payments, note type of service request triggers
 - Track payments to verify the same allowed amounts are being considered (contracted rates)
 - Review EDI report
 - Sample accounts

ICD-10 Code Sets

- ▶ ICD-10 CM/PCS consists of two parts:
 - ICD-10-CM for diagnosis coding in all healthcare settings
 - Describes left vs. right, initial vs. subsequent encounter, routine vs. delayed healing.
 - ICD-10 PCS for inpatient procedure coding in hospital settings
 - Provides detailed information on procedures and distinct codes for all types of devices.
- CPT coding for outpatient and office procedures is not affected by the ICD-10 transition.

The difference

- ▶ ICD-9-CM diagnosis codes = 14,432
- ▶ ICD-10-CM diagnosis codes = 69,101

- ▶ ICD-9 CM procedure codes = 3,859
- ▶ ICD-10-CM procedure codes = 71,957

Documentation

- ▶ ICD-10-CM will increase documentation activities about 10% to 20%. This translates into a permanent increase of 3% to 4% of physician time spent on documentation for ICD-10-CM. Research study notes:
 - *"This is a permanent increase, not just an implementation or learning curve increase. It is a physician workload increase with no expected increase in payment, due to the increased requirements to providing specific information for coding. Electronic health record systems will not be able to eliminate the extra time requirement."*

Doctor Report Cards – 2012

- › Qualified organization – one who has access to other payor data (all 3rd party), consumer groups, employer groups
- › The final rule:
 - \$40K gives access to Medicare billing data
 - Option to purchase a 5% national sample of claims for development of national benchmarks.
 - Allows 60 calendar days for physicians to appeal quality scores and request corrections
 - Qualified groups retain ability to copyright, but must provide free, confidential reports to physicians for review.

Claims Data

- › Use of data from 2009, 2010 and the first 2 quarters of 2011
- › CMS' view – "...in making our health care system more transparent and promoting increased competition, accountability, quality and lower costs".
- › Qualified groups must show that they have experience evaluating performance measures, analyzing claims data and safeguarding information. Must have access to claims data from other health payers (Medicaid, 3rd party)

Accountability

- › The final rule failed to create the mechanisms and safeguards needed to ensure that published information on doctors is correct.
- › Claims data may be distributed even if the accuracy of the information is in dispute and subject to an appeal.

How it works

- › Files sent to qualified organizations would encrypt patient information. Patient ID numbers would be used to identify services and track future services
- › Provider NPI numbers used to ID providers. Medicare also providing UPIN
- › CMS does not require qualified groups to provide doctors with patient lists
- › Qualified entities must provide preliminary reports to providers 60 days prior to release

FUTURE THOUGHTS

- › Looks like - quality and lower costs
- › Acts like - transparency and competition

- › EMR systems access to care
- › Managed care

Comments/Questions

- › Thank you

HHS OIG WORK PLAN

FY 2012

SUMMARY FOR PHYSICIAN PROVIDERS

THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES (HHS) Office of Inspector General (OIG) *Work Plan for Fiscal Year 2012* (Work Plan) provides brief descriptions of new and ongoing reviews and activities that OIG plans to pursue with respect to HHS programs and operations during the next 12 months and beyond.

The Work Plan is one of OIG's three core publications. The Semiannual Report to Congress summarizes OIG's most significant findings, recommendations, investigative outcomes, and outreach activities in 6-month increments. The annual Compendium of Unimplemented Recommendations (Compendium) describes open recommendations from prior periods that when implemented will save tax dollars and improve programs.

The OIG *Work Plan* outlines the current focus areas and states the primary objectives of each review. It also provides the internal identification code (if assigned) for each review, the year in which we expect one or more reports to be issued as a result of the review, and indicates whether the work was in progress at the start of the FY or is planned as a new start. Typically, a review designated as "work in progress" will result in reports issued in FY 2012, but a review slated to begin in FY 2012 ("new start") could result in FY 2012 or FY 2013 reports, depending upon when the assignments are initiated during the year and the complexity and scope of the examinations. Because we make continuous adjustments to the Work Plan as appropriate, we do not provide status reports on the progress of the reviews. The updated Work Plan is published annually, usually during the first week of October.

FOCUS AREAS SPECIFIC TO PHYSICIANS

THE WORK PLAN SAYS:

Physicians and Suppliers: Compliance with Assignment Rules

We will review the extent to which providers comply with assignment rules and determine to what extent beneficiaries are inappropriately billed in excess of amounts allowed by Medicare. We will also assess beneficiaries' awareness of their rights and responsibilities regarding potential billing violations and Medicare coverage guidelines. Physicians participating in Medicare agree to accept payment on an "assignment" for all items and services furnished to individuals enrolled in Medicare. (Social Security Act, § 1842(h)(1).) CMS defines "assignment" as a written agreement between beneficiaries, their physicians or other suppliers, and Medicare. The beneficiary agrees to allow the physician or other supplier to request direct payment from Medicare for covered Part B services, equipment, and supplies by assigning the claim to the physician or supplier. The physician or other supplier in return agrees to accept the Medicare-allowed amount indicated by the carrier as the full charge for the items or services provided. (OEI; 00-00-00000; expected issue date: FY 2013; new start)

Physicians and Suppliers: Compliance with Assignment Rules

SUMMARY

Medicare wants to make sure the providers are not charging the patient more than the allowed amount. Review was on prior work plans to be started in 2012 and reported in 2013.

THE WORK PLAN SAYS

Physicians and Other Suppliers: High Cumulative Part B Payments (New)

We will review payment systems controls that identify high cumulative Medicare Part B payments to physicians and suppliers. We will determine whether payment system controls are in place to identify such payments and assess the effectiveness of those controls. Medicare Part B services must be reasonable and necessary (Social Security Act, § 1862(a)(1)(A)), adequately documented (§ 1833(e)), and provided consistent with Federal regulations (42 CFR, § 410). A high cumulative payment is an unusually high payment made to an individual physician or supplier, or on behalf of an individual beneficiary, over a specified period. Prior OIG work has shown that unusually high Medicare payments may indicate incorrect billing or fraud and abuse. (OAS; W-00-12-35605; various reviews; expected issue date: FY 2012; new start)

SUMMARY

Medicare will flag their computers to track physicians who have a high volume of Medicare payments. Medicare is particularly interested in physicians with high volume of Medicare payments seeing the same patient multiple times during a specified period (not mentioned)

Be aware that Medicare will likely flag the provider for review, and may ask for medical documentation either prior to payment or after payment is made.

THE WORK PLAN SAYS

Physicians: Place-of-Service Errors

We will review physicians' coding on Medicare Part B claims for services performed in ambulatory surgical centers and hospital outpatient departments to determine whether they properly coded the places of service. Federal regulations provide for different levels of payments to physicians depending on where services are performed. (42 CFR § 414.32.) Medicare pays a physician a higher amount when a service is performed in a non facility setting, such as a physician's office, than it does when the service is performed in a hospital outpatient department or, with certain exceptions, in an ambulatory surgical center. (OAS; W-00-10-35113; W-00-11-35113; various reviews; expected issue date: FY 2012; work in progress)

SUMMARY

This review is ongoing. Medicare rates are based on the place of service (hospital vs. office). This type of review usually results in post payment reduction in payment.

THE WORK PLAN SAYS

Physicians: Incident-To Services (New)

We will review physician billing for “incident-to” services to determine whether payment for such services had a higher error rate than that for non-incident-to services. We will also assess CMS’s ability to monitor services billed as “incident-to.” Medicare Part B pays for certain services billed by physicians that are performed by non physicians incident to a physician office visit. **A 2009 OIG review found that when Medicare allowed physicians’ billings for more than 24 hours of services in a day, half of the services were not performed by a physician. We also found that unqualified non physicians performed 21 percent of the services that physicians did not perform personally.** Incident-to services represent a program vulnerability in that they do not appear in claims data and can be identified only by reviewing the medical record. They may also be vulnerable to over utilization and expose Medicare beneficiaries to care that does not meet professional standards of quality. Medicare’s Part B coverage of services and supplies that are performed incident to the professional services of a physician is in the Social Security Act, § 1861(s)(2)(A). Medicare requires providers to furnish such information as may be necessary to determine the amounts due to receive payment. (Social Security Act, § 1833(e).) (OEI; 00-00-00000; expected issue date: FY 2013; new start)

SUMMARY

Medicare has reviewed incident to services in the past. Since the 2012 Work Plan notes this review to be a “new start” the providers should be aware that Medicare auditors may request documentation. Attached to this document is the MLM Medicare guidance for Incident To Services.

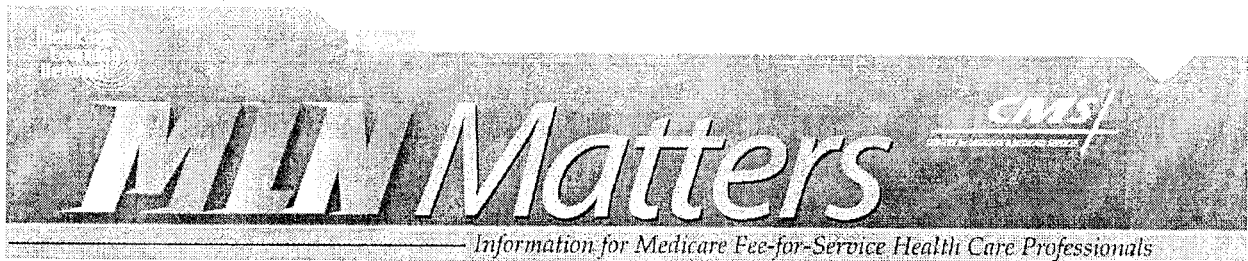
THE WORK PLAN SAYS

Physicians: Impact of Opting Out of Medicare (New)

We will review the extent to which physicians are opting out of Medicare and determine whether physicians who have opted out of Medicare are submitting claims to Medicare. We will also examine whether specific areas of the country have seen higher numbers of physicians opting out and its potential impact on beneficiaries. Physicians are permitted to enter into private contracts with Medicare beneficiaries. (Social Security Act, § 1802(b).) As a result of entering into private contracts, physicians must commit that they will not submit a claim to Medicare for any Medicare beneficiary. (OEI; 07-11-00340; expected issue date: FY 2012; work in progress)

SUMMARY

Medicare will monitor Physicians who terminate their relationship with Medicare, but continue to see patients under a private contract. This review does not have an impact on actively participating providers.



Related Change Request #: N/A

MLN Matters Number: SE0441

Effective Date: N/A

"Incident to" Services

Note: This article was revised to contain Web addresses that conform to the new CMS website and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

All Medicare providers of professional services

Provider Action Needed

None. This article is for your information only. It clarifies when and how to bill for services "incident to" professional services.

Background

The intent of this article is to clarify "incident to" services billed by physicians and non-physician practitioners to carriers. "Incident to" services are defined as those services that are furnished incident to physician professional services in the physician's office (whether located in a separate office suite or within an institution) or in a patient's home.

These services are billed as Part B services to your carrier as if you personally provided them, and are paid under the physician fee schedule.

Note: "Incident to" services are also relevant to services supervised by certain non-physician practitioners such as physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, or clinical psychologists. These services are subject to the same requirements as physician-supervised services. Remember that "incident services" supervised by non-physician practitioners are reimbursed at 85 percent of the physician fee schedule. For clarity's sake, this article will refer to "physician" services as inclusive of non-physician practitioners.

To qualify as "incident to," services must be part of your patient's normal course of treatment, during which a physician **personally performed an initial service** and remains **actively involved** in the course of treatment. You do not have to be physically present in the patient's treatment room while these services are provided, but you must provide **direct supervision**, that is, you must be present in the office suite to render assistance, if necessary. The patient record should document the essential requirements for incident to service.

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More specifically, these services must be all of the following:

- An integral part of the patient's treatment course;
- Commonly rendered without charge (included in your physician's bills
- Of a type commonly furnished in a physician's office or clinic (not in an institutional setting); and
- An expense to you.

Examples of qualifying "incident to" services include cardiac rehabilitation, providing non-self-administrable drugs and other biologicals, and supplies usually furnished by the physician in the course of performing his/her services, e.g., gauze, ointments, bandages, and oxygen.

The following paragraphs discuss the various care settings, which are important to note because the processes for billing vary somewhat depending on the care site.

Your Office

In your office, qualifying "incident to" services must be provided by a caregiver whom you directly supervise, and who represents a direct financial expense to you (such as a "W-2" or leased employee, or an independent contractor).

You do not have to be physically present in the treatment room while the service is being provided, but you must be present in the immediate office suite to render assistance if needed. If you are a solo practitioner, you must directly supervise the care. If you are in a group, any physician member of the group may be present in the office to supervise.

Hospital or SNF

For inpatient or outpatient hospital services and services to residents in a Part A covered stay in a SNF the unbundling provision (1862 (a)(14) provides that payment for all services are made to the hospital or SNF by a Medicare intermediary (except for certain professional services personally performed by physicians and other allied health professionals). Therefore, incident to services are not separately billable to the carrier or payable under the physician fee schedule.

Offices in Institutions

In institutions including SNF, your office must be confined to a separately identifiable part of the facility and cannot be construed to extend throughout the entire facility. Your staff may provide service incident to your service in the office to outpatients, to patients who are not in a Medicare covered stay or in a Medicare certified part of a SNF. If your employee (or contractor) provides services outside of your "office" area, these services would not qualify as "incident to" unless you are physically present where the service is being provided. One exception is that certain chemotherapy "incident to" services are excluded from the bundled SNF payments and may be separately billable to the carrier.

In Patients' Homes

In general, you must be present in the patient's home for the service to qualify as an "incident to" service. There are some exceptions to this direct supervision requirement that apply to homebound patients in

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medically underserved areas where there are no available home health services only for certain limited services found in Pub 100-02, Chapter 15 Section 60.4 (B). In this instance, you need not be physically present in the home when the service is performed, although general supervision of the service is required. You must order the services, maintain contact with the nurse or other employee, and retain professional responsibility for the service. All other incident to requirements must be met. A second exception applies when the service at home is an individual or intermittent service performed by personnel meeting pertinent state requirements (e.g., nurse, technician, or physician extender), and is an integral part of the physician's services to the patient.

Ambulance Service

Neither ambulance services nor EMT services performed under your telephone supervision are billable as "incident to" services.

Additional Information

To provide additional clarity, we present the following scenarios:

Must a supervising physician be physically present when flu shots, EKGs, Laboratory tests, or X-rays are performed in an office setting in order to be billed as "incident to" services?

These services have their own statutory benefit categories and are subject to the rules applicable to their specific category. They are not "incident to" services and the "incident to" rules do not apply.

Can anti-coagulation monitoring be provided "incident to" a physician's services in an office?

Yes, if the requirements are met, i.e., the services are part of a course of treatment during which the physician personally performs the initial service and is actively involved in the course of treatment, is physically present in the immediate office when services are rendered by the employee, and the service represents an expense to the physician or other legal entity that bills for the service.

If the treating physician (Doctor X) refers a patient to an anti-coagulation monitoring clinic, can Doctor X bill these services as "incident to"?

No, because the services are not being provided by an employee under supervision of Doctor X.

Can the supervising physician (Doctor Y) at the anti-coagulation monitoring clinic (a physician group) bill the services as "incident to" if Doctor Y directly supervises those services at the clinic?

No, because Doctor Y is not treating the patient for the underlying condition. However, if Doctor Y receives a referral from Dr. X, and Dr. Y performs an initial evaluation of the patient and then orders and supervises the services, they may be billed by Doctor Y incident to her initial service.

If you have further questions regarding this issue, please contact your carrier at their toll-free number, which may be found at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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