Audits

CMS Update: Your Old Records Now Fair Game for MAC Claims Review

CMS nixes the one-year lookback period effective June 26.

Part B MACs now have more flexibility than ever in requesting older documentation from your practice during claims audits, according to a new CMS transmittal, which removes the 12-month lookback timeframe.

**Background:** Currently, if a MAC requests your records related to claims that are under review, the MAC can collect documentation “related to the beneficiary’s condition before and after a service, but shall not request documentation dating from more than 12 months prior to the date of service unless an exception exists,” according to Section 3.2.3.4 of the *Medicare Program Integrity Manual*.

**New way:** Last week, CMS issued Transmittal 422, which will go into effect on June 26. The directive will do away with that 12-month lookback period, and does not replace it with a new one. Therefore, the Manual implies that records can be requested indefinitely from the date of service, although it’s not completely clear in the document whether any deadline will be introduced to replace the previous 12-month limit.

**Example:** You perform a hip replacement on July 1, 2012. In the past, your MAC could request the documentation from that surgery until July 1, 2013, but now you shouldn’t be surprised if you get a record request in August — or afterward.

The reality is that you most likely retain medical records for much longer than one year anyway, since state statutes of limitation dictate how long you must retain them. In New York, for example, even if a patient leaves your practice you must keep his records for six years after the last visit, whereas in Michigan the records must be kept for seven years.

ICD-10

Check Out What The Experts Have To Say About ICD-10’s Benefits

3 hidden advantages make the learning curve worthwhile.

If the sheer volume of new diagnosis codes in ICD-10 has got you worried about the prospect of transitioning to the new coding system, then here’s the good news. ICD-10 offers hidden benefits that could help rather than hinder your claims processing — and make your life easier.
You’ve likely heard that ICD-10 will offer greater specificity, but check out these three additional reasons that ICD-10 could help your practice significantly from Richard Tuck, MD, FAAP, pediatrician at PrimeCare of Southeastern Ohio in Zanesville.

1. More detail for preauthorization medical review. Anyone who has ever sought insurance preauthorization is well aware of the hurdles involved. Thanks to ICD-10, that process might be a little easier, since the payer will get a more complete story of the patient’s condition due to the detail in ICD-10 codes. With more information, the payer will be less likely to return to you for additional information, which can slow approvals and payment, as well as create additional work for you.

2. Improved ability to measure health care services. Due to ICD-10’s specificity, payers will be able to determine the number of patients with certain conditions who are seeking specific services. In cases where payers are on the fence about whether to pay for particular procedures, the use of ICD-10 will assist in showing the insurers the value of payment for these services.

3. Supports patient-centered primary care. With the expansion of the diagnosis code set, physicians will have more detail to support effective engagement and interventions, and will be able to more accurately communicate the patient’s conditions to other practitioners involved in the patient’s care.

Don’t Let Your Financial Arrangements Get You Into Sticky Situations

Keep an eye open for these compliance minefields.

That the OIG means business is clear from the recent takedown which put over 100 health care professionals out of business. You too can ensure that your compliance plan is airtight with these quick tips to keep your practice out of hot water.

Helping With Copays Could Hurt You

With insurance restrictions on many Part B procedures, your office might be tempted to assist patients by offering discounts or even waiving copayments or deductibles. But protecting your patient’s pocket could seriously jeopardize the health of your practice.

Perhaps the best advice when it comes to discounting or waiving fees is that you should avoid it if you can, but if you insist on treading into this area, you need to do so extremely carefully.

Reason: Financial arrangements that differ from the billing obligations laid out in your contract with
government or third-party payers can result in fraud charges, penalties, and loss of carrier contracts.

Example: A new patient is left with a balance following a comprehensive exam. The total charge for the service was $125, with insurance covering 80 percent ($100). The patient fails to pay the remaining 20 percent. To assist the patient, you waive the remaining $25 balance.

This scenario illustrates how quickly you can get into hot water. By discounting the service, you are effectively saying that your office’s charge for the comprehensive exam is not $125 but actually $100. The waiver could put the claim in violation of the Federal False Claims Act because the practice misrepresented the charge to the payer.

Learn the Law to Steer Clear of Violations

According to the OIG, “the routine waiver of Medicare coinsurance and deductibles can violate the Federal anti-kickback statute if one purpose of the waiver is to generate business payable by a Federal health care program.” (http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/fa021904hospitaldiscounts.pdf).

In addition, offering inducements such as cost-sharing waivers to Medicare patients that you know might be likely to influence that patient’s selection of provider can violate separate statutes, the OIG says.

You also want to be careful of the volume and dollar amount of discounts you offer to patients. The OIG will keep an eye out for patterns of routine waivers, and with the exception of hardship cases, you don’t want to discount services below the allowable Medicare rate.

Don’t do it: The age-old practice of “professional courtesy,” or extending free or discounted services to other physicians or their families, may be a violation under the Federal False Claims Act. You could also put yourself in jeopardy under the Stark statute if Medicare perceives that your office received referrals by extending the courtesy.

Consider What’s at Stake

Best bet: If you ever encounter a situation in which you think a waiver or discount of fees is legally and ethically appropriate, contact your payer or a health care attorney to ensure that the arrangement would be in compliance with the payer’s contracts and policies.

Brush Up On Your POS 22 Rules To Keep Your Practice In The Clear

Starting in October you need to focus on where the face-to-face service was performed.

If you’re in the dark about a new CMS place of service (POS) rule you could be attracting unwanted scrutiny for your face-to-face physician services, come October.

The skinny: The new rule is that the POS code you report for your physician should reflect the “setting in which the beneficiary received the face-to-face service,” according to Transmittal 2435. CMS has created exceptions to the rule, however, so be sure to read the rule in full and pay attention to each element.

Important dates: The effective date is October 1, 2012 — this is a delay from the previous implementation date of April 1.

Under CMS’s announced rule, providers performing the PC [professional component] of interpretation of tests must use the POS where the face-to-face service — test — was performed, i.e. outpatient facility, ASC [ambulatory surgical center], etc.

In case you have any question about whether the rule applies to diagnostic imaging, CMS clearly states in MLN Matters article 7631 that if the patient has an imaging exam at one site and the physician interprets the exam at his office, the POS should reflect where the patient had the exam. You should not base your POS code on where the physician provided the interpretation.

For physician claims, you must decide whether to report office POS 11 for where the physician provided the service or POS 22 for the outpatient hospital where the patient had the exam. Under the new rule, you should report POS 22 because that’s where the patient had the outpatient exam.

Caution: Although you designate the outpatient hospital as the place of service, you should report the office’s ZIP code in Item 32 of the CMS 1500 (or electronic equivalent), states Transmittal 2407, CR 7631. Using the appropriate ZIP is important both for compliance with CMS instructions and for ensuring payment based on the physician’s location.

An Inpatient Is Always an Inpatient for POS

The MLN Matters article indicates two exceptions to the rule that the face-to-face service location decides the POS.

(Continued on next page)
Medical practices across the country have come under OIG scrutiny resulting in millions being recouped from oversight efforts, recommendations, investigative efforts, and audit recovery. The OIG has reported in its 2012 Semiannual Report, that the agency recouped $1.2 billion from Medicare overpayments through as many as 1,264 exclusions and 388 criminal actions.

The report, which covers OIG actions between Oct. 1, 2011, and March 31, 2012, outlines common enforcements, such as those on durable medical equipment (DME) suppliers, as well as new targets.

“We are using advanced data analytics to help us conduct risk assessments; more effectively pinpoint our oversight efforts; and significantly reduce the time and resources required for audits, investigations, evaluations, and other program integrity activities,” said Inspector General Daniel R. Levinson in the report.

In addition to collecting billions, the OIG may also request refunds based on additional recommendations published in the report.

### Enforcement

**OIG Bags $1.2 Billion For Medicare in Massive 6-Month Dragnet**

Medical practices across the country have come under OIG scrutiny resulting in millions being recouped from oversight efforts, recommendations, investigative efforts, and audit recovery. The OIG has reported in its 2012 Semiannual Report, that the agency recouped $1.2 billion from Medicare overpayments through as many as 1,264 exclusions and 388 criminal actions.

The report, which covers OIG actions between Oct. 1, 2011, and March 31, 2012, outlines common enforcements, such as those on durable medical equipment (DME) suppliers, as well as new targets.

Some Money Not Yet Collected

In addition to collecting billions, the OIG may also request refunds based on additional recommendations published in the report.

---

**Why Pay Full Price?**

**Get Value Packs & Save up to 50%!**

Get the training you need from coding veterans with top-notch webinars that won’t bust your budget.

Now you can save more with our new value pack pricing. Choose from specialty-specific packs, or topic-specific packs, such as our HIPAA Value Pack and ICD-10 Value Pack. Or maybe a market-specific pack like our Hospice Value Pack and Home Health Value Pack is the right option for you.

And why not try our Annual Subscription Pack? You can choose from six customizable subscription options to suit your training needs.

Log on to [www.audioeducator.com/special-offers](http://www.audioeducator.com/special-offers) for more info. Call 1-866-458-2965 or email to customerservice@audioeducator.com for help!
For example: With a renewed focus on fraudulent suppliers opening shop all over the country, the OIG recommends that CMS conduct site visits “for the highest paid new suppliers,” the report indicates.

Consider These Examples

Following is a sampling of a few of the OIG’s recoveries as outlined in the report:

> $12 million was identified in overpayments for outpatient services during an audit of TrailBlazer Health Enterprises (a Part B payer) for problems such as incorrect HCPCS codes, lack of documentation, and unallowable services.
> Medicare paid portable x-ray suppliers for “questionable return trips to nursing facilities” and reimbursed for services that were ordered by non-physicians — and therefore should not have been covered.
> A nursing service owner had to pay over $30 million in restitution after he was found paying kickbacks to Medicare beneficiaries and recruiters and billing Medicare for services not rendered.

To read the OIG’s Semiannual Report, visit the HHS Web site at: http://oig.hhs.gov/reports-and-publications/semianual/index.asp.

**Home Health Reimbursement**

**Pull The Plug On These Common Working File Errors**

Inaccuracies in the CWF jeopardize your Medicare pay.

Home health or hospice providers who depend on the Common Working File to reflect the patient’s history could be risking their Medicare reimbursement, since CMS officials claim that their hands are tied by the statutory language.

CMS officials pointed this out in the May 23 Open Door Forum for home health, hospice and durable medical equipment providers. When you admit a home health or hospice patient or furnish DME or supplies to a patient and her CWF history comes up clear, that won’t necessarily mean you’re entitled to the Medicare payment you think you’ll be receiving.

Why: When another home health or hospice provider serving the patient doesn’t bill promptly, the CWF won’t show that the patient is under a home health or hospice plan of care, noted CMS’s Katie Lucas in the forum. So you’ll bill for the reimbursement you believe you’re entitled to, then have the claim shot down or have reimbursement taken back when those late-billed claims show up in CWF.

Hospices check the CWF for notices of election (NOEs) and claims, one provider told CMS. When NOEs and claims turn up later, the current hospice’s benefit period is no longer correct, and certification and face-to-face dates are no longer timely, the hospice complained.

CMS’s hands are tied when this happens, Lucas related. For any reason, if the F2F encounter didn’t occur, the certification isn’t complete and the episode isn’t covered. “While we share your frustration about providers who are slow to post their notice of elections, we are limited by the statutory language in what we can do to address this issue.” she said.

For example: When settling such a dispute, HHH MAC CGS checks the patient record to see whether the HHA printed a screen shot of the ELGA/ELGH screen. It also requires the HHA to contact the other agency at least three times before stepping in. See CGS’s other requirements online at www.cgsmedicare.com/hhh/education/materials/hh_transfer.html.

Play Detective During Admission

Don’t rely solely on the CWF for your patient’s history, Thronset urged forum participants. “There are different avenues besides just looking at the CWF systems,” he said.

(Continued on next page)
Talk with the patient and/or her representatives to find out what services she has received, Lucas advised. Document those conversations, she added.

CGS encourages HHAs to include information in their admission paperwork, explaining that only one agency can be in the home during an episode of care, and any other agency won’t get paid. “This documentation is important if a dispute occurs,” the MAC says.

**Plus:** Bill timely yourself, so other providers know what they are dealing with, CMS urges providers. □

## Medical Review

### Denial Rates For Long-Stay Patients On The Rise

Ensure that your documentation for patients living longer than the six-month prognosis stands up to scrutiny.

With Medicare clamping down on payments for long-stay hospice patients, you need to figure what when your patient no longer qualifies for the terminal diagnosis before an edit hits you and you are faced with a denial.

**Examples:** Home Health & Hospice Medicare Administrative Contractor CGS has revealed the results of two edits of long-stay patients. Under edit topic code 5037T, CGS reviewed claims for hospice patients with lengths of stay greater than 730 days and denied 81 percent of reviewed claims. Under edit topic code 5048T, CGS reviewed claims for hospice patients with LOS greater than 999 days and denied a whopping 97 percent of claims.

The stats suggest that medical reviewers are getting tougher on long-stay patient claims. The denial rates are up from 69 and 73 percent from the year-ago time period, respectively, CGS reports.

“The majority of the denials received by providers were related to the six-month [180 days] terminal prognosis not being supported in the documentation,” CGS says in its provider newsletter. “Documentation is essential in supporting the beneficiary meets this prognosis, especially for patients that have remained on the hospice benefit for an extended length of time, or those patients that have chronic illnesses or general decline.”

**Remember:** “These diagnoses alone may not support a six-month or less life expectancy, and documentation is dependent upon showing why the patient is hospice appropriate,” CGS tells providers.

Figuring out when a long-stay patient no longer qualifies can be tricky. But “if a patient improves or stabilizes sufficiently over time while in hospice such that he/she no longer has a prognosis of six months or less from the most recent recertification evaluation or definitive interim evaluation, that patient should be considered for discharge from the Medicare hospice benefit,” says CGS’s Local Coverage Determination (LCD), “Determining Terminal Status” (L32015).

Hospices protest that patients end up being penalized for stabilizing under hospice care. But “such patients can be re-enrolled for a new benefit period when a decline in their clinical status is such that their life expectancy is again six months or less,” CGS says in the LCD.

Not all patients who stabilize need to be discharged, however, the LCD allows. “Patients in the terminal stage of their illness who originally qualify for the Medicare hospice benefit but stabilize or improve while receiving hospice care, yet have a reasonable expectation of continued decline for a life expectancy of less than six months, remain eligible for hospice care.” □

## Reader Questions

### Shifting Between MD Supervision and Direction

**Question:**

Four certified registered nurse anesthetists (CRNAs) from our group were working on separate cases under the anesthesiologist’s medical direction. An emergency patient comes in, and the anesthesiologist takes the case. He is no longer available to medically direct the CRNAs. How do I code the CRNA cases?

**Answer:**

CMS states that a medically directing anesthesiologist can perform certain other services concurrently and retain his or her medical direction status. One example is “Addressing an emergency of short duration in the immediate area.”

The answer for your situation depends on whether the anesthesiologist’s involvement in the emergency case was of...
“short duration” and whether he remained in the immediate area. If so, the anesthesiologist is still medically directing the CRNA cases and should submit his participation in the cases with modifier QK (Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals). Report each CRNA’s case with modifier QX (CRNA service: with medical direction by a physician).

If the emergency case took more of the anesthesiologist’s time and he is not available to the medically directed CRNAs, he cannot bill for his involvement in those cases. Submit the claims for the CRNAs with modifier QZ (CRNA service: without medical direction by a physician).

Know CRNA Choices for Colonoscopy

**Question:**
Is a certified registered nurse anesthetist (CRNA) allowed to bill Medicare for anesthesia during a colonoscopy? Are there certain requirements?

**Answer:**
Yes, a CRNA can bill Medicare for colonoscopy, although several carriers do not recognize anesthesia as medically necessary for endoscopies. If you file a claim, the correct code depends on the type of sedation administered.

» For general anesthesia or monitored anesthesia care (MAC), report 00810 (Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum). Reporting MAC is appropriate if the carrier recognizes that anesthesia service is medically necessary for the procedure or if you plan to bill the patient. If the payer requires MAC modifiers, append as applicable: QS (Monitored anesthesia care service), G8 (Monitored anesthesia care [MAC] for deep complex, complicated, or markedly invasive surgical procedure) or G9 (Monitored anesthesia care for patient who has history of severe cardiopulmonary condition).

» For moderate sedation, choose from 99148 (Moderate sedation services [other than those services described by codes 00100-01999], provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; younger than 5 years of age, first 30 minutes intra-service time), 99149 (...age 5 years or older; first 30 minutes intra-service time), and +99150 (...each additional 15 minutes intra-service time [List separately in addition to code for primary service]). Your choice will be based on the patient’s age and the procedure length.

**Take note:** The October 2011 *CPT Assistant* clarified that the CPT® standard for time measurement applies to moderate (conscious) sedation codes 99143-99145. Per CPT®, the provider reaches a “unit of time” when he passes the midpoint. For example, a one hour unit of time is attained when 31 minutes have elapsed.

**AMA ‘Evaluating ICD-11’ As ICD-9 Alternative**

The American Medical Association (AMA) has made no secret of the fact that it is less than enthralled with the proposition of adopting ICD-10 as the new diagnosis coding system. Not only did the AMA’s House of Delegates vote last year to repeal ICD-10 (which CMS did not adopt), but the group also applauded the news earlier this year that ICD-10 would be delayed from its original implementation date of 2013.

Now the AMA has taken additional steps to express its disillusionment with ICD-10, announcing on June 19 that its House of Delegates adopted a policy to evaluate ICD-11 as a potential “alternative” to replace ICD-9, an AMA news release noted.

“ICD-10 coding will create unnecessary and significant financial and administrative burdens for physicians,” said AMA President-elect Ardis Dee Hoven, MD in a June 19 statement. “It is critical to evaluate alternatives to ICD-9 that will make for a less cumbersome transition for physicians and allow physicians to focus on their primary priority — patient care. AMA voted today to consider ICD-11 as a possible alternative. The policy also asks the AMA and other stakeholders, such as the Centers for Medicare and Medicaid Services, to examine other options.”

CMS has not yet responded to the AMA’s news. Keep an eye on these pages for more on this story.

**92980 May Be Out the Door in 2013 as Part of a Major PCI Overhaul**

If you like to be the first to know about potential new codes, we’ve got a site you need to know.

(Continued on next page)
Industry Notes (Cont.)

To find summaries of CPT® Editorial Panel meeting actions — such as accepting code proposals — check out the documents at www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/cpt-summary-panel-actions.page.

What’s in store for cardiology? “Once again, it looks as though the cardiology specialty will be heavily impacted with code changes for 2013. Looking at the proposed changes for new codes and revised codes, we are looking to take another hit on reimbursement. The goal over the past few years, it appears, is to completely streamline component coding for cardiology related procedures,” says Terry A. Fletcher, BS, CPC, CCS-P, CCS, CEMC, CCC, CMCS, CMC, of California-based Terry Fletcher Consulting.

Remember: These changes are tentative. The final CPT® 2013 codes won’t be finalized until the fall of 2012.

Percutaneous coronary intervention (PCI) codes are on the list for possible overhaul, notes Fletcher. And that means you could say so long to some of your most commonly used codes.

CPT® may delete:

» 92980-92981, Transcatheter placement of an intracoronary stent(s) …
» 92982 and 92984, Percutaneous transluminal coronary balloon angioplasty …

» 92995-92996, Percutaneous transluminal coronary atherectomy …

To fill the void, you could see 13 new PCI codes. You can get a sense of how big a change could be from the panel’s reference to accepting “revisions of cross references which restructures the entire section.”

NJ Doctor Confesses To Accepting Cash For Imaging Referrals

Accepting cash in exchange for referring patients to an imaging facility won’t just net you some extra cash — it can also get you some jail time.

A New Jersey-based doctor admitted last week that she accepted cash kickback payments from an MRI center in exchange for patient referrals. She is the fourth physician charged with participating in the scheme, which netted her payments for every MRI and CAT scan she referred to the facility.

The doctor accepted just over $3,000 from the facility, but could face five years in prison and a $25,000 fine.

To read more about the government’s charges against the doctor, visit www.justice.gov/usao/nj/Press/files/Deguzman,%20Daisy%20Plea%20News%20Release.html.