Teaching Physician Compliance ALERT

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OIG semi-annual report

The Health and Human Services (HHS) Office of Inspector General (OIG) recently released its semi-annual report to Congress. The report covers the first half of fiscal year 2014 which started on October 1, 2013 and includes some impressive results.

In six months, the OIG collected $3.1 billion and excluded 1,720 individuals and entities from federal health care programs. During the same period, the OIG initiated 465 criminal actions and 266 civil actions involving health care providers. These actions range from individuals who made up fictitious patients to billing for misrepresented services.

The OIG also made recommendations to the Center for Medicare and Medicaid Services (CMS) concerning vulnerabilities in the electronic medical record (EMR) and how the Medicare contractors should audit EMR documentation. The OIG stated that although EMR technology may make it easier to commit fraud, CMS and its contractors have not adjusted their practices for identifying and investigating fraud in EMRs. They reported that few contractors review EMRs differently from paper medical records. In addition, some contractors report that they are unable to identify copied language or over documentation in a medical record. CMS has provided limited guidance to Medicare contractors as far as EMR fraud vulnerabilities and the OIG recommended that CMS provide better guidance to its contractors on detecting fraud associated with EMRs. In addition, CMS should direct its contractors to use providers' audit logs when reviewing medical records. Audit log data distinguish EMRs from paper medical records and could be valuable to CMS's contractors when reviewing medical records.

The OIG also found that the regional home health intermediary for six New England states made approximately $25.1 million in Medicare overpayments because it did not deny claims that home health agencies (HHAs) submitted without the required Outcome and Assessment Information Set (OASIS) data, which is a condition of payment. The OIG recommended that CMS complete a process that would allow the claims processing system to interface with state survey agency systems to identify, on a prepayment basis, HHA claims without accepted OASIS data submissions and encourage its contractors to conduct periodic postpayment reviews of HHA claims, to include ensuring that OASIS data support claims until sufficient prepayment controls are established.

Concurrent care policy for E&M services on the same date of service

National Government Services (NGS) recently issued a clarification after identifying a pattern of claim submissions for concurrent care. According to Medicare regulations, only one E&M service may be billed per day, per patient, per physician.

In some instances, physicians may see a patient multiple times on a given day or in multiple settings. Except in rare circumstances, only the highest level of E&M service rendered on that date should be billed. For example, if a patient is examined in the office and later examined and admitted into the hospital, the physician would report the hospital admission as the E&M service rendered for that day.

If a physician submits two E&M services for a patient in a single day, Medicare will deny the claim for the second service. For unrelated office services that could not have been provided at the same time, physicians need to request a redetermination with supporting documentation for the second E&M service. A redetermination for an inpatient visit followed by critical care would also need to be requested.

In the case of group practices, Medicare pays for one E&M visit in a day provided to a patient by the same physician or a member of the same group with the same specialty. If multiple visits are provided, the group should select a level of service that is representative of the combined visits and submit the appropriate code for that level. This does not apply to physicians who are in different groups or physicians in the same group with different specialties.

Coding guidelines from the American Medical Association (AMA) current procedural terminology (CPT) indicate that advanced practice nurses and physician assistants working with a physician are considered to be of the exact same specialty or subspecialty as that physician. This means that any advanced practice nurses and physician assistants working in a group cannot bill for a second visit on the same day as a physician within that group.

A "different recognized specialty" refers to a subspecialty for which the physician has received formal additional training in a recognized program and for which there is generally separate board recognition. In those cases, in which the Medicare processing system does not maintain a specific subspecialty designation, the claim may be denied during the initial processing, and the provider may need to request an appeal identifying the subspecialty training and designation.

CMS clarifies when a clinical trial can be labelled as 'qualifying'

The Association of American Medical Colleges recently contacted the Center for Medicare and Medicaid Services (CMS) to obtain clarification on when a clinical trial may be considered CMS-approved and qualify for Medicare coverage of the study-related 'routine costs'. 'Routine costs' include those medically necessary study-related items and services that are:

- generally covered by insurers outside of a clinical trial
- required to administer the investigational product
- necessary to monitor the effects of an investigational product or prevent complications
- needed to diagnosis or treat complications
- not promised free of charge in the consent; and not paid for by another funding source

This clarification was sought after several people reported any trial being conducted by NIH centers or cooperative groups as considered 'deemed' to meet CMS's seven characteristics of a 'qualifying' trial, even if the trial itself was not reviewed by the FDA and/or funded by a NIH, CDC, AHRQ, CMS, DOD, VA.

CMS's response indicated that it wants to "allow the most expansive access to clinical trials by Medicare beneficiaries, while ensuring that they participate in trials that are of the highest quality". They reiterated that the following criteria must be met to consider a drug or diagnostic intervention clinical trial as CMS-approved:

1. The subject or purpose of the trial must be the evaluation of an item or service that falls within a Medicare benefit category.
2. The trial must not be designed exclusively to test toxicity or disease pathophysiology. It must have therapeutic intent.

3. Trials of therapeutic interventions must enroll patients with a diagnosed disease rather than healthy volunteers. Trials of diagnostic interventions may enroll healthy patients in order to have a proper control group.
4. The following seven desirable characteristics must be met:
   - The principal purpose of the trial is to test whether the intervention potentially improves the participants' health outcomes.
   - The trial is well-supported by available scientific and medical information, or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.
   - The trial does not unjustifiably duplicate existing studies.
   - The trial design is appropriate to answer the research question being asked in the trial.
   - The trial is sponsored by a credible organization or individual capable of executing the proposed trial successfully.
   - The trial is in compliance with federal regulations relating to the protection of human subjects.
   - All aspects of the trial are conducted according to the appropriate standards of scientific integrity.

Currently a clinical trial is deemed to automatically meet the seven desirable characteristics if it is (i) funded by the NIH, CDC, AHRQ, CMS, DOD and VA; (ii) **supported by centers or cooperative groups that are funded by NIH, CDC, AHRQ, CMS, DOD and VA**; (iii) conducted under an investigational new drug application (IND); or a drug trial exempt from having an IND under 21 CFR 312.1.

CMS clarified that, if a trial is conducted at a center that is part of a cooperative center or research center funded by the NIH, CDC, AHRQ, CMS, DOD or VA, it is considered as a trial 'supported by centers or cooperative groups that are funded by one of those agencies' and believed to be likely to have the seven desirable characteristics of a 'qualifying' trial. CMS listed examples of some "centers" they consider as supporting trials with these qualities. These included the NCI Clinical Trials Cooperative Groups, the NIDDK Urology Cooperative Research Centers Program, the NIAID Cooperative Centers from Translational Research on Human Immunology and Biodefense, or the VA Cooperative Studies Program. Their feedback suggested when a trial is being conducted at a "center" that CMS considers part of a group considered likely to engage in research meeting specific standards, the center may make the determination if the trial meets all of the seven desirable characteristics' without reviews of the trial by the FDA, NIH, CDC, AHRQ, CMS, DOD, VA, and/or other centers participating within the cooperative group.

More information about clinical trials billing may be found at: http://ycci.yale.edu/comply/index.aspx

High E&M error rate identified by Medicare

Our Medicare contractor, National Government Services (NGS), recently reported the results of their prepayment analysis for 99215 (established patient office visit level 5), 99223 (initial hospital visit level 3), and 99233 (subsequent inpatient visit level 3). These results reflect provider billing activity in Connecticut, Maine, New Hampshire, Massachusetts, New York, Vermont and Rhode Island.

The chart below reflects the error rate from June 2013 through March 2014.

CPT CODE	ERROR RATE (%)
99215	70.9
99223	78.7
99233	68.5

During the same time period, YMG received approximately 1,215 Medicare prepayment requests. Given the high error rate, NGS will likely continue to review documentation before payment is made for these CPT codes.

In the News

Misrepresentation of services

A Greenwich doctor has agreed to reimburse Medicare $300,000 after it was claimed he billed for services he did not provide to his patients. Authorities claim that Jun Xu, M.D., owner of the Rehabilitation Medicine and Acupuncture Center at 1171 East Putnam Avenue, Greenwich, violated the False Claims Act by billing Medicare for one-on-one physical therapy services from January 1, 2007 to December 31, 2009 when he actually provided group therapy. It is also alleged that Dr. Xu submitted claims to Medicare for therapy services under his name when they were actually performed by massage therapists.

Source: U.S. Attorney's Office

Dentist back in the news

A dentist who was sentenced to three years in jail for illegally prescribing painkillers in 2008, was in trouble with the law again after he allegedly collected almost $100,000 in Medicaid payments he was barred from receiving. Paul Dengelegi, D.M.D., 51, was arrested in July by inspectors from the Medicaid Fraud Control Unit in the Office of the Chief State's Attorney. He was charged with one count of larceny in the first degree by defrauding a public community and insurance fraud. The Medicaid Fraud Control Unit received a complaint from the Connecticut Department of Social Services alleging that Dengelegi billed for Medicaid services while he was excluded from the program. Dengelegi was excluded from the program in August 2009, but between April and October 2011, he improperly submitted 989 claims and was paid $94,792.84.

Source: https://oig.hhs.gov/fraud/enforcement/state/

Stamford dentist charged with Medicaid fraud

A Stamford dentist who operated a mobile clinic that provided dental services to seniors in nursing homes has been charged with Medicaid fraud after billing for services he did not perform. The State Division of Criminal Justice charged Georgy Bester, D.D.S. with first-degree larceny by defrauding a public community and insurance fraud. An investigation by a Division of Criminal Justice investigator revealed that Betser allegedly billed Medicaid $25,661 over a two-month period from late 2012 to early 2013 for dental services never rendered.

Betser owned and ran Advanced Dental LLC on Summer Street. He submitted multiple claims to Medicaid for services rendered on January 31, 2013 totaling $17,759 for providing 261 dental procedures on 71 patients at four different locations in Bridgeport, Hartford, New Britain and New Milford on that single day. When the investigator went to the nursing homes and checked the records of each of the patients Betser was supposed to have seen, there was no indication that he had been there or seen 59 of the 71 patients. Four days later, Betser, who was first licensed to perform dentistry in Connecticut in 2006, billed Medicaid $11,414 after claiming he saw 87 patients on February 4, 2013 and claiming he performed 225 procedures in nursing homes in East Hartford and New Haven. The investigators determined that Betser did not see 75 of the patients he billed for on February 4, 2013.

Source: http://blog.ctnews.com/stamford411/2014/06/19/stamford-dentist-charged-with-medicaid-fraud/

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