Teaching Physician Compliance ALERT

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How Much will that Hospital Stay Cost?

For the first time, data has been released that gives consumers information on what hospitals charge. Currently, consumers don't know what a hospital is charging them or their insurance company for a given procedure, like a knee replacement, or how much of a price difference there is at different hospitals, even within the same city. The data will help fill this gap. The data reveals significant variation throughout the country and within communities in what hospitals charge for common inpatient services. The data is provided by the Health and Human Services (HHS) agency to increase health care cost transparency and accountability.

The data posted on CMS's website includes information comparing the charges for services that may be provided during the 100 most common Medicare inpatient stays. Hospitals determine what they will charge for items and services provided to patients and these "charges" are the amount the hospital generally bills for an item or service.

These amounts can vary widely. For example, for services that may be provided in connection with a joint replacement, average inpatient charges range from a low of $5,300 at a hospital in Ada, OK, to a high of $223,000 at a hospital in Monterey Park, CA.

Even within the same geographic area, hospital charges for similar services can vary significantly. For example, average inpatient hospital charges for services that may be provided to treat heart failure range from $21,000 to $46,000 in Denver, CO, and from $9,000 to $51,000 in Jackson, MS.

To make this data useful to consumers, HHS is also providing funding to data centers to collect, analyze, and publish health pricing and medical claims reimbursement data. The data centers' work helps consumers better understand the comparative price of procedures in a given region or for a specific health insurer or service setting. To view the report, please visit:

http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/index.html

Don't Forget to Document this Important E&M Datapoint

When a patient is seen for the first time, either in the hospital or office, the physician frequently has to review old records. This could take the form of office notes sent over from the referring physician, or a review of the old chart when the patient is seen in the hospital. In order to claim the two data points that are awarded on the E&M score card under medical decision making, the physician must record his or her findings in the chart after the record is reviewed. The best practice would be to include a special section in your note. For example:

Review and Summation of Old Records

"I reviewed the patient's chart dating back for the past five years. He was most recently admitted for CHF exacerbation about six months ago. At that time, his creatinine was 1.8. Looking back over previous admissions, his creatinine has been running 1.5 to 1.8 range. There have been no episodes of ARF in the past."

Do you Work with APRNs or PAs?

In many areas of our practice, Advanced Practice Registered Nurses (APRN) and Physician Assistants (PA) work collaboratively with our physicians in the office, outpatient hospital, and inpatient hospital setting. For billing purposes, a physician may NOT utilize the documentation of an APRN or PA in determining the level of visit to bill unless the APRN or PA is employed or leased by the Yale Medical Group. The Yale Office of General Counsel has created a lease template that the clinical departments may use for this purpose. The APRN and PA must also be credentialed with insurers in order for shared documentation and billing to occur. In addition, APRNs need a collaboration agreement and PAs need a delegation agreement agreement with their designated physician. Unless all three of these components are in place –

- Employment or lease agreement
- Credentialing
- Collaboration or delegation agreement

– we cannot use the documentation or bill for the services the APRN or PA renders.

"Sunshine" Rule Increases Transparency in Health Care

On February 1, CMS announced a final rule that will increase public awareness of financial relationships between drug and device manufacturers and certain health care providers. The program is called the "National Physician Payment Transparency Program: Open Payments".

This rule finalizes the provisions that require manufacturers of drugs, devices, biologicals, and medical supplies covered by Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) to report payments or other transfers of value they make to physicians and teaching hospitals to CMS. CMS will post that data to a public website. The final rule also requires manufacturers and group purchasing organizations (GPOs) to disclose to CMS physician ownership or investment interests.

Collaboration among physicians, teaching hospitals, and industry manufacturers can contribute to the design and delivery of life-saving drugs and devices. However, while some collaboration is beneficial, payments from manufacturers to physicians and teaching hospitals can also introduce conflicts of interest. Increased transparency is intended to help reduce the potential for conflicts of interest that physicians or teaching hospitals could face as a result of their relationships with manufacturers.

CMS Proposes New Safeguards and Incentives to Reduce Medicare Fraud

On April 24, CMS issued a proposed rule that would increase to, as high as $9.9 million, the rewards paid to Medicare beneficiaries and others whose tips about suspected fraud lead to the successful recovery of funds. The proposed changes are similar to the IRS whistleblower program that has resulted in recoveries of over $2 billion since 2003.

CMS is proposing to increase the potential reward amount for information that leads to a recovery of Medicare funds from 10 percent to 15 percent of the final amount collected. The current program caps the reward at $1,000, meaning CMS pays a reward on the first $10,000 it collects as a result of a tip. CMS is also proposing to increase the portion of the recovery on which CMS will pay a reward up to the first $66 million recovered – this means an individual could receive a reward of $9.9 million if CMS recovers $66 million or more.

The False Claims Act (FCA) also incentivizes those with knowledge of health care fraud to blow the whistle. The FCA permits individuals to file lawsuits on the government's behalf in order to recover financial damages suffered by the government as a result of fraud, particularly relating to a false claim. Under the provisions of the FCA, the whistleblower can receive 15% to 30% of the amount recovered by the government.

The proposed rule would also expand Senior Medicare Patrol activities to educate Medicare beneficiaries on how to prevent, detect, and report Medicare fraud, waste, and abuse. Lastly, the proposed rule would allow CMS to deny enrollment of providers who are affiliated with an entity that has unpaid Medicare debt, deny, or revoke billing privileges for individuals with felony convictions, and revoke privileges for providers and suppliers who are abusing their billing privileges.

IN THE NEWS

Excluded CT Dentist Charged in $20 Million Medicaid Fraud Conspiracy

Gary Anusavice was previously a registered dentist in Massachusetts and Rhode Island who sustained a felony conviction in Massachusetts for submitting false health care claims and was subject to disciplinary proceedings in both Massachusetts and Rhode Island. Based on these proceedings, the U.S. Department of Health and Human Services notified Anusavice in April 1998 that he was being excluded from participation in Medicare and state health care programs, including Medicaid. As part of that notice, Anusavice was informed that, as an excluded individual, he could not "submit claims or cause claims to be submitted" for payment from the federal Medicaid program and that Medicaid reimbursement payments would be prohibited to any entity in which he served as an "employee, administrator, operator, or in any other capacity...."

From 2009 to April 2011, Anusavice owned and operated several dental clinics in Connecticut, but used a licensed dentist, Mehran Zamani, to act as the nominal head of the dental clinics. The clinics included Landmark Dental in West Haven, Dental Group of Connecticut in Trumbull, and Dental Group of Stamford. The Medicaid Provider Enrollment Applications failed to disclose Anusavice's ownership or control interest in the dental clinics and Anusavice's disciplinary history. The dental practices subsequently received nearly $21 million in Medicaid reimbursements from the Connecticut Medicaid program. These payments were prohibited given Anusavice's exclusion from the Medicaid program.

As alleged in a previously filed criminal complaint, at the dental clinics, Anusavice was involved in reviewing patient charts, suggesting dental procedures to be performed, reviewing billing records, reviewing income reports, interviewing and hiring dentists, and providing overall management direction to the offices.

Source: U.S. Attorney's Office May 24, 2012

Radiologists Violate Teaching Physician Rule

Two University of Missouri School of Medicine radiologists, including one with a criminal history, have been fired after an internal investigation found they had allegedly billed Medicare for radiologic studies that only residents read; the two attending radiologists, Dr. Kenneth Rall and Dr. Michael Richards, did not over read the studies, yet billed Medicare as if they had. The medical school dean Bob Churchill, a radiologist who hired Rall in spite of a criminal past, is retiring in October.

It is unclear how much money the department accepted from Medicare as a result of these practices by the two radiologists or how long ago the alleged fraudulent practices began. Dr. Rall was the chairman of the department of radiology until December 2011, when he resigned because of the investigation. A month after his resignation, the Columbia Tribune also discovered that 62.5% of imaging studies within the department did not have legitimate physician orders.

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