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Medical Billing Compliance
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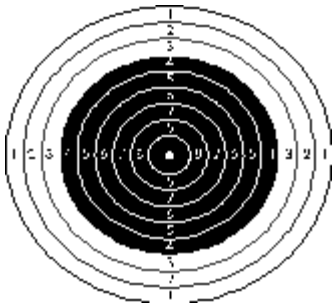
OIG Audits Take Aim



For fiscal year 2005, the Office of the Inspector General is focusing their audit efforts on the items named below:

1. Modifier 25 – Is there separate documentation that is over and above the procedure for the visit which would warrant the use of modifier 25?

2. E&M coding – Medicare paid 29 billion for E&Ms in 2003. Were the visits coded appropriately for level?

3. Wound care services – Medicare payments have increased from 98 million to 147 million for wound care services. Were these services medically necessary and billed according to Medicare requirements?

4. Medicare payments to **VA physicians** – Have physicians billed Medicare for services during their tour of duty hours at the VA?

5. Cardiography and Echocardiography services – Are providers billing globally when only performing the interpretation?

6. Mental health services – Were the services provided in physician's offices medically necessary?

7. Physician pathology services – Are the relationships between physicians who furnish pathology services in their offices and outside pathology companies bonafide arrangements?

The complete OIG workplan can be found at:
http://oig.hhs.gov/publications/docs/workplan/2005/2005WPCMS.pdf

Extra Payment for "Quality"

During a one year demonstration project by CMS, office-based oncology practices can receive additional payments for patients who receive intravenous infusion or push chemotherapy. CMS is collecting data on the intensity of the patient's symptoms as they relate to pain, nausea, vomiting and fatigue. The oncologists who ask the patients these questions can bill for these services through the use of special G codes. By using the G codes, oncologists can self-enroll in the pilot project.

Middlesex Health System of Middletown, CT was selected by CMS for a new initiative to pay health care providers for the quality of care they provide to seniors and the disabled. Ten large physician groups from around the country were selected through a competitive process based on the group's care management strategies to:

- anticipate patient needs,
- prevent chronic disease complications, and
- avoidable hospitalizations.

CMS also considered the group's organizational structure, operational feasibility, location, and implementation plan in their selection criteria.

These demonstration projects may be related to recent recommendations by MedPac, an advisory group to the Centers for Medicare and Medicaid Services (CMS), regarding quality measurements in physicians' offices. MedPac recommended that CMS require the reporting of lab values and prescription claims data, which could be combined with physician claims to provide a more complete picture of patient care for quality of care performance payments.

Do You Want To Be A Medicare Medical Director?

Our local Medicare carrier, First Coast Service Options (FCSO), is seeking physicians for employment opportunities to support their Medicare operations. Dr DelliCarpini's position as the Medicare Medical Director for the State of Connecticut will be open as of May 1, 2005. The duties of a Medicare medical director are to facilitate the creation of local medical policies, conduct medical review and participate in provider education.

In addition, FCSO is looking for nine (9) physicians to fill part time positions for a new contract awarded by CMS to perform the Medicare appeals function. Dr DelliCarpini will be leading the appeals contract. The contract is for the western part of the U.S. The part time positions entail 20

hours a week and once trained, physicians may be able to work offsite. The FCSO office is located in Meriden, CT. The physicians hired for the appeals contract will be reviewing Medicare Part A (hospital) appeals. Training will be provided.

Further information can be obtained by contacting Dr. DelliCarpini at (203) 634-5410.

Medicare Goes Back To The Future

Due to provisions in the Medicare Modernization Act (MMA), several changes are underway for traditional Medicare fee for service operations. Traditional fee for service continues to be the most popular option for Medicare beneficiaries for health care insurance.

Plans include consolidating contracts for Medicare Part A (hospital insurance) and Medicare Part B (physician services) so that one entity will process all Medicare benefits for a patient. Currently there are three separate contractors to process hospital claims, physician claims and claims for durable medical equipment. Under the unified, standardized administrative services approach, CMS expects one-stop shopping for both patients and providers.

Under Medicare contracting reform, CMS will:

- Allow payments to contractors as performance incentives when they are more efficient, innovative and cost-effective. Currently contractors are paid on a cost basis.
- Re-compete contracts at least once every five years.

The government anticipates that these and the planned upgrades to Medicare's IT systems will improve the level and quality of service for providers and patients. These changes are mandated to be in place by October 2011.

In the News

St. Francis Hospital Pays Fine

A Hartford, Connecticut based hospital, Saint Francis Hospital and Medical Center, agreed to pay nearly three-hundred-thousand-dollars to resolve allegations that it billed the government for childhood vaccines the hospital received for free. The hospital also will reimburse private insurance companies about six-thousand-dollars under the civil settlement. Saint Francis agreed to the settlement without admitting any liability.

The case was part of "Operation Free Shot," an ongoing federal investigation that focuses on Connecticut health care providers who bill Medicaid and other insurance programs for childhood vaccines the providers received for free from the Vaccines For Children program, a joint federal and state program.

Case Against YNHH Dismissed

On February 8, 2005 a Connecticut federal court dismissed claims that Yale New Haven Hospital engaged in improper charity care practices. The case was one of several cases brought as part of a litigation initiative against non-profits by Richard Scruggs, an attorney from Mississippi. (Rivera vs. YNHH, Inc)

COMPLIANCE PROGRAMS-PREVENTATIVE MEDICINE FOR HEALTH CARE PROVIDERS
Find the Alert at http://yalemedicalgroup.org/comply

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