

# Medicare Compliance

News, tools and best practices to minimize risk  
and maximize reimbursement

# ALERT

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## Dear Reader

Expect new Medicare requirements as the new stimulus law creates incentives and penalties regarding the use of health information technology.

President Obama signed the \$787 billion stimulus package, called The American Recovery and Reinvestment Act of 2009 (ARRA), on Feb. 17. The Act earmarks \$19 billion to develop and encourage the adoption of HIT and electronic health records (EHR).

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## Reduce compliance risks, expenses by thoroughly vetting potential hires

While good help may be hard to find, that doesn't mean you **can't** afford to exercise caution during the hiring process. Finding someone who has the requisite qualifications and is a good fit for your practice takes time and resources, but that can all go to waste if you hire someone without conducting an adequate background check. Worse still, you could face fines, patient lawsuits and other legal entanglements if you don't exercise due diligence before you make a job offer.

**Note:** Even though private medical practices aren't subject to the stringent state laws that regulate hospitals' credentialing process, healthcare attorneys warn that potential employees who will have contact with patients or their money should undergo some sort of background check. This doesn't mean you must or should hire a private investigator or run state-by-state criminal record checks for each potential employee. "The screening process should be scaled to the size of the practice, but more than a cursory check," says William Mandell, partner with Pierce & Mandell in Boston.

"It is definitely worth spending time and money wisely before hiring, rather than having to deal with a problem employee or a difficult termination," says healthcare attorney David Harlow of the Harlow Group in Newton, Mass. The key is finding an appropriate balance between an overabundance of caution and a lack of due diligence." Here are some tips to help you craft a background check policy that reveal problems before you make a job offer but won't offend that ideal employee.

## Start with OIG's Exclusion database

If you bill any federal healthcare program, you must run every potential employee's name through the HHS Office of Inspector General's (OIG's) List of Excluded Individuals/Entities. There are a number of ways a person can get excluded, ranging from accepting kickbacks to a misdemeanor conviction related to drug abuse. The scope and effect of an Exclusion is so wide it amounts to banishment from every federally funded healthcare program. A

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practice should not hire anyone who will be paid indirectly by federal funds, Harlow warns.

According to OIG: "No payment will be made by any federal health care program ... for anything that an excluded person furnishes, orders, or prescribes. This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider where the excluded person provides services, and anyone else." This prohibition encompasses everyone from medical clinicians and technicians to billers and coders. It applies even if they don't see, treat or interact with Medicare or other federal health-care patients because some of the practice's Medicare payments might make their way into the employee's paycheck.

**Caveat:** Providers that employ an excluded individual face steep civil money penalties: \$10,000 for each service submitted to a federal payor. The good news is you only need an internet connection to run this essential check. OIG maintains a database you can search using an applicant's first and last name. If you get a match, you can verify using the applicant's social security number. "It's too easy to check the database," Mandell notes, which is why OIG will be highly skeptical if a provider claims it had no way of knowing it had hired an excluded person.

**Caveat:** Don't assume you can hire an applicant who was excluded simply because the exclusion has expired. A person who is excluded must wait until the exclusion period ends and then apply to OIG in writing for reinstatement.

Even if the potential hire has sent the letter and is expecting a positive response from OIG, Harlow advises practices to hold off on bringing the person on board. Where clinicians are concerned Harlow points out it could lead to cash flow problems. "It is likely that other payors may ask about Medicare participation in their credentialing process and nonparticipation in Medicare may raise red flags," Harlow says.

### Check their references

It is standard practice to ask for references for any job application, but the list of names and phone numbers is worthless if you don't follow up with a phone call. "Some practices make job offers conditional on a good reference from former employers," Mandell says. This too is reasonable and provides another layer of screening.

### Protect your practice from patient lawsuits

More than fines from the federal government are on offer if you don't conduct a background check. You should make sure you're familiar with state laws. "In addition to

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checking the exclusion list, or ‘sin system’,” Harlow says, “providers are required by many states to run criminal background checks on anyone having patient contact, and should do the same for anyone with access to finances.”

This is no different than any other employer Mandell notes, but practices have a higher responsibility due to their duty to their patients. The duty and level of scrutiny increases in correlation to how much contact the employee will have with the patient.

**Note:** There are a couple of civil claims a bad hiring decision could create. One is straight vicarious liability: An employer can be held responsible for actions by an employee while he performs duties related to his employment. In addition to that a patient could have a claim for **negligent hiring**.

Mandell gives the example of an employee who was convicted for a crime such as assault and battery or credit card fraud in one state and gets hired by a group practice in another state. If the employee hits a patient or steals a patient’s credit card number, the patient could claim the practice is also responsible because it should have known about its new hire’s record. But for the practice’s failure to run a background check, a patient could argue, the assault or theft wouldn’t have occurred. Even if a lawsuit isn’t successful, the practice will still have to deal with the damage to its public image.

### Craft your criminal background checks

A criminal background check is worthwhile, provided you craft your search to the employee’s position and work history. “Each state’s

criminal history records system is different, and most providers do not go beyond state lines in running checks,” Harlow says. “For a more thorough check, private contractors can run multistate checks, which can be tailored to local geography or the prospective employee’s work history.” You also shouldn’t necessarily reject a candidate who seems otherwise perfect because he or she has had a run in with the law. “I would not be as concerned about a motor vehicle violation (absent a DUI component) as I would be about a check-kiting conviction,” Harlow says. “Neither relates directly to patient care, but the financial fraud should raise a red flag.”

**Remember:** The depth and scope of such a check can be based on specific facts and circumstances Mandell says. A doctor who has been practicing in the area for two decades doesn’t need as close an inspection as a doctor who has just arrived from another state. “You should also ask how much is this person moving around,” Mandell says. When an employee has lived in three states in as many years or changes employers frequently, this might be the sign of deeper problems.

### Don’t forget the credit check

Practices should also take a peek at a potential hire’s financial history though a credit check. “A default on any student loan repayment programs as that can impose payment obligations on the employer,” Mandell warns. “For example, the National Health Service Corps pays up to \$50,000 of outstanding student loan balances for certain employed doctors and other health professionals who commit to two years of full time service serving the needs

of underserved populations at approved sites.” If a provider goes into default, the practice might have to withhold some of his wages to make payments on the loan. Mandell also recommends that practices inquire about other financial obligations that can lead to wage garnishment, such as unpaid child support.

**Tip:** For more guidance on crafting a comprehensive background check for employees, see the checklist in the Compliance Toolbox on pg. 8. The checklist is based on a section of the physician employment agreement template that Pierce & Mandell uses for physician practices.

### On the Internet:

- OIG’s Searchable Exclusions Database: <http://exclusions.oig.hhs.gov/>

## Dear Reader: Stimulus Act provides \$19 Billion for HIT incentives

*(continued from page 1)*

The program, contained in the HITECH Act section of ARRA, allocates \$17 billion for incentive payments through Medicare and Medicaid to encourage physicians and hospitals to implement EHR systems for the next five years. Hospitals could potentially receive as much as \$11 million in incentives; physicians could get up to \$44,000.

The incentive payments are greater in 2011 and 2012; after that the incentive payment is reduced. There is no benefit for adopting EHR in 2015, and after that penalties will be imposed by increasing reductions of Medicare reimbursement if a hospital or physician has not become a “meaningful user” of EHR by then.

“Meaningful use” of an EHR will be determined by CMS, but the law states that the EHR must be certified, able to electronically prescribe, part of an electronic exchange and able to report quality measures. Physicians and hospitals will have to

demonstrate that they are a meaningful EHR user.

The law also offers incentives from Medicaid for providers who adopt EHR and \$2 billion to HHS’ Office of the National Coordinator of Health Information Technology

(ONCHIT) to help support health information exchanges, invest in national HIT infrastructure, provide implementation assistance to providers, and take other actions to advance the use of HIT.

These initiatives are expected to help be the catalyst to move to EHR, according to consultant John Parnigiani, Ellicott City, Md., who helped draft the original HIPAA security rule. “[Government] bodies are working together regarding standardizations. It’s a concerted effort to get to e-health care and make it more feasible,” he explains.

However, moving to a EHR system is still a painful, expensive process, according to attorney Shirley Morigan, with Foley & Lardner, in Los Angeles. “There is still a lot of patient and provider concern. You need stakeholders’ [buy] in. Don’t just dump it on people,” she says.

The programs still need some clarification, according to attorney Gerald “Jud” DeLoss, with Gray Plant Moody, Minneapolis.

**Example:** To qualify for the incentives, the provider must be using a “certified” EHR. However, HIPAA doesn’t require EHRs to be certified, and there isn’t one standard for certification, although the non-profit Certification Commission for Health Information Technology (CCHIT) currently operates a certification program. So it’s unclear if CCHIT’s program will become the certification program required by the incentive plans, or if other standards will be created, notes attorney Cynthia Stamer, Glast Phillips & Murray, Dallas.

HHS will clarify how the incentive and other programs will work in the coming months.

“By 2014 we’ll see EHR integrated throughout the country. That’s the

### Watch out for these ABN hotspots

With the new Advance Beneficiary Notice (ABN) form becoming mandatory on March 1, 2009, it’s more important than ever for you to know Medicare’s key rules concerning ABN use (*see The Case of the Abused ABN, pg. 7*). Here are some hot spots you should watch for:

- **Patient refuses to sign:** When a patient refuses to sign the ABN form and demands the service, the ABN form should be annotated with “patient refused to sign and demanded the service” and two witnesses must sign and date the form attesting that that the patient refused to sign. Submit assigned claims with the GA modifier as if the patient had signed the ABN form.
- **Need an ABN for emergency services:** ABNs can be obtained for ED patients after all EMTALA requirements have been met. Once the patient is stable and has the opportunity to be fully informed before signing the ABN, he/she can be asked to sign an ABN for services that may not be medically necessary from that point forward.
- **Repetitive services:** A single ABN can be used for an extended course of treatment. For standing orders the ABN must list the frequency and duration of the service(s) on the ABN. Issue a new ABN any time the standing order is changed or additional services added.
- **Charges for services with an ABN:** You are able to bill for your full charges (not restricted to the allowable) when Medicare does not cover a service and a signed ABN has been obtained. Keep in mind it is important that the estimate on the ABN form meet the guidelines of a “reasonable estimate” now specified by CMS.
- **Use of modifiers GA, GY and GZ on claims for ABN services:** Use modifier GA when a signed ABN is on file. If you don’t, you cannot bill the patient if the service is denied. Modifier GY is used when a service is never covered by Medicare under any circumstances. Use of GY is an optional modifier designed to speed a denial. Use modifier GZ when the service is not reasonable and necessary and an ABN has not been obtained. You can’t bill the patient and it is an optional modifier that CMS says “greatly reduces the risk of a mistaken allegation of fraud or abuse.” Some Medicare contractors have said use of GZ and GY are mandatory. (Verify the policy for your specific Medicare contractor.)

overriding theme of this legislation,” says DeLoss.

#### On the internet:

- The American Recovery & Reinvestment Act: [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111\\_cong\\_bills&docid=f:h1enr.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.pdf). The HITECH Act provisions begin on page 112.

## OID targets hot topics, management challenges

You have another key clue about where HHS will focus its efforts in 2009. The OIG has identified the nine most significant management and performance challenges facing HHS in the coming year, and “hot topics” that relate to these changes under heightened attention or scrutiny by the Administration, Congress, the public or others.

The 49-page document is published annually. Unlike the OIG Work Plan, which is an “outward-looking document” that outlines for HHS and providers what OIG hopes to accomplish in the coming year, the Top Management Challenges report is more of an internal roadmap, identifying to HHS what OIG believes are HHS’ biggest challenges in the coming year, explains OIG spokesperson Donald White. “It’s written for the benefit of HHS. It’s an assessment [as to whether] monies are being used efficiently,” he explains.

Experts agree. “[It gives you] a better sense of what areas you’ll see more activity in because that’s where the government will be more vigilant [in monitoring HHS],” says attorney Gabe Imperato, managing partner of the Fort Lauderdale, Fla., office of Broad & Cassel.

The report may be an even better indicator than the Work Plan of where the attention of the government will be focused. The problem

with the work plan is that it’s a snapshot of what the OIG is interested in and doesn’t show the OIG’s priorities. The Top Management Challenges Report is prioritized. You know the top stuff on the list,” says attorney Martie Ross, with Lathrop & Gage, Kansas City.

Several top management challenges and the associated hot topics identified include:

- Fraud and abuse safeguards in Medicare Part D.
- The failure to provide quality care.
- Transparency of provider financial interest in drugs and medical devices.
- Oversight of financial interests of clinical investigators and advisory board members.
- Medicare and Medicaid integrity, including DME fraud, home and community-based care and contractor oversight.
- Security of health information technology systems.

The Top Management Challenges report doesn’t immediately impact the Work Plan, warns White. But both documents are useful to help providers determine how to set their own compliance priorities, says Imperato.

Here are three ways to use the report to your advantage:

1. **See if the report lists anything specific that relates to you.** **Example:** If you have a financial relationship with a pharmaceutical company, shift your focus and evaluate whether it passes legal muster, says Ross. “This is a significant risk area,” she points out. The DME industry apparently has already followed this advice. Ross notes that one

of the hot topics listed is DME fraud and competitive bidding. “The DME industry obviously got wind of [the report]. It just posted that it will self-regulate fraud to try to avoid competitive bidding,” she explains.

2. **Compare the work plan to the report.** If you see something in both documents that affects you, you may want to elevate those priorities, suggests Imperato.
3. **Don’t put something on the back burner simply because it’s not listed as a hot topic in the report.** It might merely mean that OIG thinks HHS is already handling it adequately. **Example:** Billing and payment issues are always important to the OIG, but it’s likely not identified as a hot topic or top management challenge because the new recovery audit contractor (RAC) program is expected to target that, says Ross. The Stark law is also not listed, but there has been enforcement activity regarding Stark violations, so it’s likely OIG believes that HHS has this under control, she adds.

#### On the internet

- OIG’s Top Management Challenges Report: <http://www.oig.hhs.gov/publications/challenges.asp>

## CMS delegates PFFS payment disputes

Frustrated by underpayments from Medicare Advantage Private Fee-for-Service (PFFS) plans, but unsure how to challenge the low payment without running afoul of Medicare rules? CMS has decided to help.

The agency rolled out a new system for handling payment dis-

putes raised by providers who treat patients enrolled in PFFS plans. Effective Jan. 1, 2009, CMS has delegated the adjudication of these disputes to Jacksonville, Fla.- based First Coast Service Options, Inc., which also holds claims processing contracts with the agency. CMS used to handle these payment disputes internally.

To take advantage of this new process, you must first meet the following conditions:

- You must be a “deemed” or “non-contract” provider as defined under the PFFS program. That means that you don’t have an existing contract with the private payer for PFFS patients, knew that the patient was enrolled in a PFFS plan before furnishing the services and had access to the plan’s terms and conditions of participation;

- The payment is less than the payment amount that would have been paid under the PFFS plan’s terms and conditions, or the amount is less than would have been paid under original Medicare;
- You must have exhausted the internal appeals process with the PFFS plan.

First Coast cannot help you with services denied for coverage issues, national coverage determinations, medical necessity determinations or contract disputes.

To use this process, you need to file a payment dispute decision (PDD) request directly with First Coast within 180 days of the PFFS plan’s written decision regarding the payment dispute. You must submit the request in writing, preferably on a standard PDD form available at First Coast’s Web site. The information you need to file includes a copy

of the claim, the reason for the dispute, and your contact information.

PDDs can be mailed to First Coast at PFFS Payment Disputes, PO Box 33017, Jacksonville, Fla., 32231-4017 or faxed to (904) 361 0551. Alternatively, if the submission and associated documents don’t contain any protected health information (PHI) you can send the PDD via email: [IREPFFS@fscso.com](mailto:IREPFFS@fscso.com).

First Coast is supposed to issue a decision within 60 days unless it grants itself an exception. When it renders a decision and notifies the parties, it considers the case closed, according to CMS. However, you (and the plan) have the right to request a debriefing.

#### On the Internet:

- First Coast’s Standard PDD form: <http://www.fcso.com/139296.pdf>
- CMS’s announcement: <http://www.cms.hhs.gov/MLN MattersArticles/downloads/SE902.pdf>.

## FOR THE ANONYMOUS CO: YOUR QUESTIONS ANSWERED HERE

## Q&A

### Gifts to encourage screening exams

**Q** We want to offer patients a free cloth shopping bag if they come in for a colorectal cancer screening. Will this violate the anti-kickback rules?

**A** Normally you can’t offer or give remuneration to a Medicare or Medicaid beneficiary in order to get the beneficiary to use services or items from a particular provider. However, in a Special Advisory Bulletin issued August 29, 2002, OIG refined its definition of the types of patient remuneration that violate the Anti-Kickback Statute.

The agency spelled out what it considers an inexpensive gift, when more valuable goods and services may be offered and the actions that constitute inducement. Providers may offer inexpensive gifts to Medicare and Medicaid patients if individual gifts have a retail value of \$10 or less or the total retail value of gifts offered within a year is \$50 or less. This standard only applies to gifts. It does not apply to cash or cash equivalents.

In addition, remuneration does not include incentives given to people to promote delivery of preventive care services. Such services include prenatal services, post-natal well-baby visits, or services described in the current U.S. Preventive Service’s Task Force Guide to Clinical Preventive Services. Just make sure the incentive isn’t tied to the provision of other services reimbursed by Medicare or Medicaid and aren’t cash or items convertible to cash (such as gift cards) and of greater value than the service itself.

*Have a question you’d like to ask anonymously? Send it to [jkyles@decisionhealth.com](mailto:jkyles@decisionhealth.com). Medicare Compliance Alert will not print any information that could identify your organization or your client.*



From the

## DECISIONHEALTH® PROFESSIONAL SERVICES Case Files

### Case #6: The case of the abused ABN

#### Compliance Risk Identified:

A Florida group practice asked us to perform a comprehensive compliance analysis. During the chart review we found that all 50 charts we pulled contained an incomplete Advanced Beneficiary Notice (ABN) signed by the patient. We suspected the practice was asking patients to routinely sign ABNs.

We randomly pulled additional charts and found that of the more than 150 extra charts we pulled, each had an ABN. The majority of them were blank except for a patient signature.

#### Background:

ABNs are designed so practices can tell a patient they believe Medicare will not pay for a specific service for that particular patient. If Medicare does deny the payment the practice can charge the patient.

There are three options for when to use the current version of the ABN, which became mandatory March 1 (see box, pg. 4):

- The patient wants the service performed and is willing to pay, but wants a claim submitted to Medicare for an official decision.
- The patient wants the service performed, is willing to pay, and does not want a claim submitted to Medicare (patient waives appeal rights).
- The patient does not want the service.

If you don't complete an ABN you may not bill the patient for payment of the services. In addition the provider can't use ABNs "just in case" the carrier denies payment.

**Note:** The cost estimate field of the ABN is now mandatory. CMS says you must make a good faith effort to provide a reasonable estimate for those items and services listed on the ABN and expects it to be within \$100 or 25% of the actual costs, whichever is greater.

A valid ABN:

- Must be provided to the patient in advance of the service and in writing;
- Must describe the particular service(s); and
- Must contain the provider's reasons for believing Medicare will deny payment.

#### Recommendation(s) and Corrective Action Plan:

In the case of the Florida practice, any signed ABN that did not contain a specific service or the reason for the suspected denial was not valid and could not be used as justification to bill patients for denied services.

Each practice staff member was given training on the specific reasons for when Medicare allows use of an ABN. The training was based on the new ABN which became mandatory on March 1.

We also instructed the practice that it would be required to issue a refund to any patient who paid a balance for a denied service based on an improperly executed ABN, or face heavy fines and the possibility of exclusion from Medicare.

To learn more about ABN requirements and to download the new form and its instructions visit: [http://www.cms.hhs.gov/BNI/02\\_ABNGABNL.asp](http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp).

Sean M. Weiss, vice president of DecisionHealth Professional Services can be contacted directly at [sweiss@dhpprofessionalservices.com](mailto:sweiss@dhpprofessionalservices.com) or 770-402-0855.

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## From the Compliance **TOOLBOX**

### Employee background checks

There are a number of background checks you can conduct on potential job applicants (*see story, pg. 1*). This checklist gives you an overview of the type of information you need to know about an employee before you offer them a position at your practice. It was developed from a portion of the standard physician employment agreement Bill Mandell of Pierce & Mandell, Boston, uses for independent and hospital affiliated group practices.

- Malpractice suits, claims (whether or not filed in court), settlements, settlement allocations, judgments, verdicts or decrees against the Employee.
- Disciplinary, peer review or professional review investigations, proceedings or actions instituted against the Employee by any entity including licensure boards, healthcare facilities, professional societies or associations, third party payors or governmental agencies.
- Convictions of any felony or pleading *nolo contendere* to a felony, or the equivalent.
- Investigations or proceedings, whether administrative, civil or criminal, relating to any allegations against the Employee of filing false health care claims, violating anti-kickback laws, or engaging in fraud or abuse under any state, federal or private health insurance program ("Program").
- The inability of the Employee to perform the essential functions of his or her job duties.
- Investigations or proceedings based on any allegation against the Employee of violating professional ethics or standards, or engaging in any misconduct relating to the practice of medicine.
- Denial or withdrawal of an application in any state for licensure as a physician, for privileges at any health care facility, for board certification or recertification, for participation in any Program, for state or federal controlled substance registration, or for malpractice insurance if such a denial or withdrawal is related to the quality of care provided by the Employee or the Employee's compliance with any applicable rules or requirements.
- Suspension or exclusion from any Program.
- The existence of all ownership interests in or compensation relationships with any health care entity of the Employee and members of his or her immediate family.
- The existence of: all student loans or federal scholarships with the United States pursuant to the National Health Service Corps Scholarship Program, the Physician Shortage Area Scholarship Program (together, "student loans"); any default or notice of default by the Employee of a student loan; any repayment agreement between the Employee and HHS entered into because of a default on a student loan, and any default or notice of default on the loan.

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