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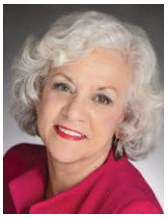
May you never meet the OIG: The Work Plan



EVERY MONTH, DERMATOLOGY WORLD covers legal issues in "Legally Speaking." This month's authors, attorneys Daniel F. Shay, Esq. and Alice G. Gosfield, Esq., are health care attorneys at Alice G. Gosfield and Associates, P.C.

In March 2012, we addressed the issue of why compliance plans are more important now than ever. The government's focus on enforcement has not abated at all and is certainly increasing. (To re-read that article, visit www.aad.org/dermatology-world/legally-speaking/2012/march.) The Office of the Inspector General (OIG) of the Department of Health and Human Services is one of the primary enforcers of the fraud and abuse laws. Frequently, the OIG joins with the Department of Justice resolving false claims and anti-kickback settlements. In addition, the OIG has the authority to impose civil money penalties for a host of legal transgressions. The OIG has investigative as well as audit divisions. It offers the safe harbor regulations under the anti-kickback statute. It offers a 1-800 hotline to accept tips from anyone with regard to fraudulent activities to investigate. It offers advisory opinions under the anti-kickback statute. Advisory opinions are also made public and provide guidance to the industry about the thinking of the OIG regarding enforcement.

The authority of the OIG is considerable. As it has focused more on preventing fraud, it has made more information available to advise the industry, including videos, podcasts, and webcasts (https://oig.hhs.gov/compliance/101/index.asp). Among the publications that it offers annually is the Work Plan. This document identifies those problem areas on which the OIG will be conducting informational investigations. Based upon these investigations, it makes recommendations to the Medicare administrative contractors about recommended policy changes as well as investigation and audit targets. The Work Plan offers an excellent opportunity for physicians to review the specific topics in which the OIG is

interested. For the 2013 Work Plan, the OIG is addressing three critical issues for dermatologists:

(1) reassignment;
(2) incident to billing; and
(3) potentially inappropriate evaluation and management services payment.

All dermatologists should understand the implications of these issues.

REASSIGNMENT

The right to be paid by Medicare belongs to the beneficiary. The beneficiary may assign his or her right to payment to the treating physician, which is the way the physician is paid directly by Medicare. Physicians who agree to accept assignment 100 percent of the time typically agree to "participate" in Medicare, which obligates them to always accept assignment. Physicians who do not want to take assignment 100 percent of the time are considered non-participating. This does not mean that they cannot be paid by Medicare, but that they may accept assignment or not on a claim-by-claim basis. Those physicians who do not participate are paid at 5 percent less than the participating physicians for the same services when they accept assignment. If they do not accept assignment and are paid directly by the patient, then the patient gets paid 5 percent less than what would otherwise pertain. Physicians can choose to "opt out" of the Medicare program, in which case neither they nor their patients will be paid for Medicare services, but this is a relatively complicated process with some administrative pitfalls.

The assignment, which the beneficiary must make in writing, is to the individual physician. For the physician to have the payment made to his or her corporation, employer, or anyone other than himself, he must effectively "reassign" payment. Beginning in 1972 under the "anti-factoring" rules that prevented physicians from selling their Medicare accounts receivable to bill collectors, there have been specific rules defining the circumstances and conditions associated with reassignment.

Generally speaking, a physician can reassign payment to his or her employer or to another entity with which he or she has a contractual relationship (e.g. independent contractor), provided that the arrangement allows him access to all claims submitted on his behalf during the relationship and provides for joint and several liability (meaning both parties are responsible individually and together) for any overpayments made pursuant to the reassignment. These are the primary bases on which physicians reassign in Medicare, although there are others.

Reassignment is part of the enrollment process, the rules of which have becomes much stricter in recent years. The individual physician must be recognized by the Medicare administrative contractor to which he will be submitting claims, which occurs by virtue of his completing the 855I form. The reassignment occurs by him completing the 855R form. (For more information on the pitfalls in the enrollment process, see the April 2011 *Dermatology World* at www.aad.org/dermatology-world/legally-speaking/2011/april.)

The OIG is concerned with physician failure to comply with assignment rules and the extent to which beneficiaries are inappropriately billed in excess of the amounts allowed by Medicare. To forestall liability, physicians should review the forms that they have submitted to Medicare for reassignment to make sure they are current and accurate. They should assure themselves that beneficiaries have signed effective assignments that physicians have on file. Non-participating physicians should be careful not to exceed the limiting charge which Medicare imposes on them when they do not accept assignment. This is 115 percent of the amount that Medicare would pay to a participating physician. In some states where "no balance billing" laws have been enacted, physicians should investigate whether the law allows them to bill to the full extent of the limiting charge.

INCIDENT TO

When Medicare was originally enacted in 1966, most physicians were in solo or small practices supported by ancillary personnel that performed a wide variety of functions, including reception, billing, taking vital signs, and performing almost all of the support activities for the physicians. If Medicare had adopted a rule that it would pay only for the physicians' personal hands on the patient, participation by physicians would have been very limited. Instead, the Medicare rules recognized that these ancillary personnel were an "integral, although incidental, part of the physician's personal professional service to the patient." This rule has been in place since then. Therefore, when these types of services are provided in the office, the ancillary personnel are invisible on the claim form and the claim is submitted as if the physician rendered the service.

Although at the advent of Medicare, the ancillary personnel were usually either medical assistants, a laboratory technician, or, in very fancy practices, a registered nurse, today, there are a host of ancillary personnel that might be working in physician offices. Some of them are now recognized by Medicare as eligible to bill on their own under certain circumstances. These include nurse practitioners (NPs) and physician assistants (PAs).

When physicians bill for services incident to their own, there must be an initial service by the physician to which the incidental services relate. The physician need not see the patient on each visit, but the services must relate to a course of treatment established by the physician. One of the biggest pitfalls for physicians, a breach for which dermatologists have been charged criminally, is that a physician in the practice must be on premises, in the office suite, and immediately available to assist at all times the ancillary personnel are rendering services that are billed to Medicare. If these services are rendered by NPs, PAs, or clinical nurse specialists, the practice may bill to the full extent of the evaluation and management code that has been provided, as long as it is within the scope of the non-physician practitioner's license. For any other personnel, including registered nurses, the highest level of code that may be billed is a 99211. If a visit entails more than 50 percent counseling or coordination of care and therefore is billed on the basis of the time with the patient, the only time that counts for these services is the time of the face-to-face interaction between the physician and the patient.

Where nurse practitioners and physicians assistants are used in the practice, if no physician is available, their services will be paid at 85 percent of the physician fee schedule. To bill this way, the NPs or PAs must have their own NPI numbers. The NP also reassigns on an 855R. PAs do not reassign because Medicare will only pay the employer of the PA.

The issue of incident to services has been in the OIG's Work Plan for years. In 2013, the OIG will be reviewing physician billing to determine whether payments for these services have a higher error rate than for non-incident to services. It will also assess Medicare's ability to monitor services billed as "incident to." In 2009, the OIG found that when Medicare reviewed physicians billing for more than 24 hours of services in a day, half of the services were not performed by a physician. It also found that unqualified non-physicians (medical assistants and the like) performed 21 percent of the services that physicians did not personally perform. The OIG finds incident to services to be a "program vulnerability" since they do not appear in claims data and can be identified only by reviewing the medical record, and suspects that these services may also be vulnerable to overutilization and expose beneficiaries to care that does not meet professional standards of quality.

EVALUATION AND MANAGEMENT SERVICES

In 2013, the OIG will determine the extent to which CMS made potentially inappropriate payments for evaluation and management (E/M) services in 2010. It will also look at the consistency of E/M medical review determinations and will review multiple E/M services for the same providers and beneficiaries to identify electronic health records documentation practices associated with potentially improper payments. Apparently, Medicare contractors have noted an increased frequency of medical records with identical documentation across services. The OIG is concerned about this since Medicare requires providers to select a code for the service on the basis of the content of the service. The Work Plan notes that physicians must have documentation to support the level of services billed.

The issue of the extent to which electronic health records are creating higher levels of billing has been noted in the *New York Times* ("Medicare Bills Rise as Records Turn Electronic," Sept. 21, 2012). However, with the increasing standardization of care in accordance with the evidence base, the fact that documentation is similar for patients with similar conditions should not be problematic. However, the OIG's interest in this topic should motivate physicians to review carefully the extent of their documentation for the levels of visits that they are billing to Medicare. While templatized documentation can create efficiencies, it is critical that physicians document patient-specific data in all templatized documentation.

The OIG has significant powers and authorities. The Work Plan offers obvious guidance to physicians about topics on which they should assure that they are compliant. In this context, prevention is everything. All physicians should hope that the OIG never learns their name. ***dw***