Compliance Matters

NOW MORE THAN EVER, DIAGNOSTIC AND INTERVENTIONAL RADIOLOGY PRACTICES MUST SCRUTINIZE AND IMPROVE THEIR COMPLIANCE EFFORTS TO AVOID AUDITS, REFUNDS OR WORSE.

BY THOMAS W. GREESON AND PAUL PITTS[1]

The coming year will bring many changes to the delivery of health care services in communities around the country. The health care system, including the practice of IR, will continue to undergo significant reforms as physicians and hospitals work to control cost, integrate care delivery systems and adapt to changes resulting from implementation of the Affordable Care Act. Meanwhile, the U.S. government will continue to investigate and prosecute fraud and abuse within the health care system. Most observers expect the government to double down on its enforcement activities. After all, 2012 was a banner year for its collection of overpayments and penalties recovered from individuals and entities participating in federal health care programs.

Attorney General Eric Holder and Health and Human Services Secretary Kathleen Sebelius reported as recently as Feb. 11 that, for every dollar spent on health care-related fraud and abuse investigations in the last three years, the government recovered $7.90. For fiscal year 2012, the federal government recovered approximately $6.9 billion from fraud-related audits and investigations, including $923.8 million in audit receivables and $6 billion in investigative receivables.[2] During this same period, 3,131 individuals and entities were excluded from participation in federal health care programs, which involved 778 criminal actions and 367 civil actions, including false claims and unjust-enrichment lawsuits, civil monetary penalties settlements and administrative recoveries related to provider self-disclosure matters. Some of these matters involved major networks of criminal activity, while others involved small providers and suppliers. One nationwide takedown alone identified $452 million in false billing stemming from operations in seven cities. The effort resulted in charges against 107 individuals for their alleged participation in Medicare fraud schemes.

With the increase in government audits, investigations and prosecutions, diagnostic and interventional radiology practices must scrutinize and improve their own compliance efforts, avoiding errors and mistakes that can lead to trouble.

With the financial solvency of the Medicare and Medicaid programs at stake, the government clearly needs to find and prosecute instances of fraud and abuse. The challenge for radiology and physician practices nationwide is to maintain compliance across a web of coverage, billing, and coding laws and regulations.

With the increase in audits, investigations and prosecutions, diagnostic and interventional radiology practices must—now more than ever—scrutinize and improve their own compliance efforts, avoiding errors and mistakes that can lead to trouble.

Audit Contractors

The Centers for Medicare and Medicaid Services (CMS) contracts with recovery audit contractors (RACs), Zone Program Integrity Contractors (ZPICs) and Comprehensive Error Rate Testing (CERT) auditors to review claims for underpayment and overpayment. RACs are particularly

effective at recovering overpayments from Medicare providers due in part to the fact that they are paid a contingency fee based on the amount of money collected from or reimbursed to providers. In fiscal years 2009 and 2010, the contingency fees ranged from 9.0 percent to 12.5 percent.

With significant contingency fees at stake, more radiology practices are likely to become subject to a RAC audit in 2013. Since 2010, RAC activity has increased dramatically: Medical record requests are up 22 percent and the number of denials is up 24 percent; the dollar value of denials is up 21 percent.

Although proactively avoiding a RAC audit can be difficult, physicians can identify the issues currently under review by RAC auditors by visiting the CMS Web site at ***www.cms.hhs.gov/RAC*** or the Web site of the RAC auditor responsible for their geographic location. A RAC audit can be a costly experience for a physician practice, requiring submission of detailed documentation and appeals of denials valid claims. In a recent study, nearly two-thirds of medical records reviewed by RACs did not contain an improper payment. According to an American Hospital Association (AHA) survey, hospitals reported appealing more than 40 percent of all RAC denials, with a 75 percent success rate in the appeals process.

CMS is under pressure to reform the RAC program. In November 2012, the AHA filed a lawsuit against the Department of Health and Human Services over the policies of the RAC auditors to deny payment for Medicare beneficiaries treated as inpatients when the RAC auditor determines that outpatient setting was more appropriate. Separately, the American College of Radiology (ACR) and the Radiology Business Management Association (RBMA) have added their voices to the chorus of concerns raised about the RAC program. The ACR and RBMA have focused their concerns on the administrative burdens required to respond to a RAC audit, lack of coordination between RACs, Medicare Administrative Contractors and CMS, and errors the RAC auditors have made in interpreting the Medicare physician payment rules.

Office of Inspector General (OIG)

An important resource for IR practices reviewing their compliance program is the Office of Inspector General (OIG) work plan. This work plan, which is available on the OIG Web site (***https://oig.hhs.gov/reports-and-publications/workplan/index.asp***), identifies the issues the OIG intends to review for possible fraud and abuse in the coming year. The list for fiscal year 2013 is similar to that of prior years with a few additional categories of particular interest to IRs, including "place of service" codes and "incident-to" rules.

"Place-of-service" Errors. The OIG continues to review place-of-service assignment for services rendered in ambulatory surgical centers and outpatient departments of hospitals. Since physician reimbursement is paid at a higher rate when services are rendered in a nonfacility setting such as the office, the OIG is concerned that physician practices are not assigning the correct place of service when patients receive care in outpatient departments of a hospital or other nonoffice settings.

As more hospitals have acquired physician practices and imaging centers across the country, the place of service designation has become more important. When a physician practice becomes integrated with a hospital as a department or facility, Medicare patients are considered hospital outpatients and their visits are billed with an outpatient place of service code. For some interventional radiology services, this can mean a lower Medicare rate applicable to the facility setting.

Useful Web Resources for Compliance Matters

Office of Inspector General
https://oig.hhs.gov/

Health Care Fraud Prevention and Enforcement Action Team (HEAT) Provider Compliance Training
https://oig.hhs.gov/compliance/provider-compliance-training/index.asp

Recovery Audit Program
www.cms.hhs.gov/RAC

CMS Provider Compliance Group Interactive Map
www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html#tx

"Incident-to" Services. The OIG continues to scrutinize services billed under the physician's name but performed by physician extenders such as radiology assistants (RAs) or other auxiliary personnel (so-called "incident-to" services).

Medicare defines incident-to as the services or supplies that are furnished as an integral yet incidental part of the physician's professional services. To qualify for payment, the service must be an integral part of the physician's plan of care and include both ongoing physician involvement and direct personal supervision by the physician. The requirement for the physician to be present in the office suite and immediately available if needed may be the most often overlooked prerequisite to billing services as incident-to. Services performed without this level of supervision are not eligible for coverage and payment as incident-to a physician's services. It is also worth noting that the service must be provided in the office, the home or other non-hospital setting. A physician practice cannot bill the services of physician extenders as incident-to if the service is performed in a hospital setting. If these requirements for incident-to services are met and the person performing the service is qualified under state law to perform the service, the practice may bill the physician service under the supervising physician's name and NPI.[3]

Practices billing incident-to services should periodically review and audit their documentation processes and procedures. To support Medicare claims for incident-to services, the documentation should include the name of the physician whose care plan is being followed, the reason for the visit, an accurate description of the services being rendered and the name of the physician who supervised the performance of the service. Note that diagnostic tests cannot be billed as incident-to services.

A compliance plan should help a practice optimize its documentation of claims, minimize billing errors, and increase communication and dialogue within the practice, all of which are needed in order to reduce the of instances of non-compliance.

Part B Imaging Services on the OIG's Radar. The OIG's 2013 work plan indicates that the OIG will continue to review Part B imaging services to determine whether the services reflect expenses incurred and whether the utilization rates reflect industry practices. In addition, the OIG indicates that medical necessity will continue to be reviewed for high-dollar imaging as well as reviews of duplicate services being ordered by different specialists.

Ounce of Prevention...

Although compliance plans and internal audits can't prevent a RAC, ZPIC or CERT audit or guarantee compliance with the complex regulations governing the delivery of physician services, an effective compliance program can identify potential problems and help a practice avoid major setbacks. At a minimum, a compliance plan should help a practice optimize its documentation of claims, minimize billing errors, and increase communication and dialogue within the practice, all of which are needed in order to reduce the of instances of noncompliance. As 2013 gets underway, now is a good time to reassess compliance plans with a special focus on those areas the enforcement agencies have identified for special review.

ENDNOTES

1. The authors are attorneys at Reed Smith LLP and members of the firm's Life Sciences Health Industry Group.
2. Semiannual Report to Congress (April 1, 2012–September 30, 2012), Office of the Inspector General, available at ***https://oig.hhs.gov/reports-and-publications/semiannual/index.asp***.
3. See the Medicare Benefit Policy Manual (pub 100-2), Chapter 15, Covered Medical and Other Health Services, Subsection 60, Service and Supplies for more information.

Thomas W. Greeson *(tgreeson@reedsmith.com)* is a partner resident in the firm's Falls Church, Va., office.

Paul Pitts *(ppitts@reedsmith.com)* is a partner resident in the firm's San Francisco office.