The Best of Manage My Practice – November, 2011 Edition

In between polishing off leftover turkey and stuffing, we're looking back over some of our most popular posts from the month in case you might've missed them the first go round. Thankfully Presenting, **The Best of Manage My Practice, November 2011**!

- Compliance: a critical issue for all practices, but a subject so expansive, where do you even begin? Learn the "Big Three" with Stark, False Claims and Anti-Kickback Laws: Easy Ways to Stay Compliant with the Big Three in Healthcare
- Are your record retention policies up to date? Can you say with confidence that you have hard copies of everything you should? Find out with Record Retention Simplified – The Ultimate Guideline
- Are you or someone you know thinking about Medical Coding as a a possible career? Follow along with Coder Bob in Tales of a Coder Part III: School Begins
- Are you the kind of leader that can see your group through the toughest of times? Bob Cooper asks practice managers in Are You a Resilient Leader?

We've started this monthly wrap-up to make sure you don't miss any of the great stuff we post throughout the month on Manage My Practice, but we also want to hear from you! What were your favorite posts and discussions this month? Did we skip over your favorite from November? Let us know in the comments!

Stark, False Claims and Anti-Kickback Laws: Easy Ways to Stay Compliant with the Big Three in Healthcare

In health care, we are "*blessed*" with an abundance of rules, policies, standards and laws. In Health Care Regulation in America: Complexity, Confrontation, and Compromise, **Robert I. Field**, professor of health management and policy at Drexel University School of Public Health, observes the following:

> *"**Regulation shapes all aspects** of America's fragmented health care industry, from the flow of dollars to the communication between physicians and patients. It is the engine that translates public policy into action. While the health and lives of patients, as well as almost one-sixth of the national economy depend on its effectiveness, health care regulation in America is bewilderingly complex."*

Here are some of the most important regulations in health care that you should not only know about, but should be actively managing with a robust compliance plan.

Stark Law (Physician Self-Referral)

When: Section 1877 of the Social Security Act, also known as the physician self-referral law, is commonly referred to as the Stark Law. When enacted in 1989, it applied only to physician referrals for clinical laboratory services. In 1993 and 1994, Congress expanded the prohibition to the additional designated health services listed below.

What: Stark Law "prohibits physicians from making referrals for designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies," according to the Centers of Medicare & Medicaid Services (CMS). Specifically covered designated health services include:

- Clinical laboratory services
- Physical therapy services
- Occupational therapy services
- Outpatient speech-language pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- Durable medical equipment (DME) and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

Penalties: Penalties for violating the Stark Law include denial of payment, refund of payment, imposition of a $15,000 per service civil monetary penalty, and imposition of a $100,000 civil monetary penalty for each arrangement considered to be a circumvention scheme.

*The following will help you **remain compliant with the Stark Law:***

1. Offer all patients a written list of choices for obtaining the care your physicians are recommending.

2. Disclose any financial relationship with any entity that is on the list offered to patients.

False Claims Act

When: Originally enacted during the Civil War, and sometimes known as the Lincoln Law, the False Claims Act (FCA) as we know it today was signed by President Reagan in 1986.

What: Under the FCA, those who knowingly submit – or cause another person or entity to submit – false claims for payment of government funds will be subject to liability. The FCA contains qui tam, or "whistleblower," provisions.

Penalties: Medicare and Medicaid fraud and abuse prohibit the knowing and willful making of a false statement that affects reimbursement under a federal health program. That provision imposes felony penalties of up to five years' imprisonment and/or fines up to $250,000 for an individual and $500,000 for an organization.

In addition to criminal penalties, the Office of Inspector General (OIG) may impose civil penalties under the Civil Monetary Penalties Act for submitting false claims. Civil penalties can be up to $11,000, plus three times the amount claimed. According to the Telehealth Resource Center, "The Civil Monetary Claims Act prohibits claims for services not provided as claimed; false or fraudulent claims; claims for physician services not furnished by physicians; or claims for services provided by an excluded physician or provider. The False Claims Act gives the federal government, as well as any person, a cause of action against any person who submits false claims to the government."

*To help your practice **remain compliant with the False Claims Act**, keep the following in mind:*

1. Perform background checks and obtain references on all potential employees, making sure they are not sanctioned by the OIG.

2. Have an audit performed by a third-party biannually to make

sure that your billing department is following your compliance policy to the letter.

Anti-Kickback Statute

When: Congress enacted the anti-kickback statute, 42 U.S.C. § 1320a-7b(b), in 1977 as a prohibition against the payment of kickbacks in any form.

What: The anti-kickback statute states that criminal penalties will be issued for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration intended to induce or reward referral of business reimbursable under any of the federal health care programs (Medicare, Medicaid, etc.)

Penalties: The anti-kickback statute is a criminal statute, the violation of which constitutes a felony punishable by a fine of not more than $25,000 per offense and/or imprisonment for up to five years. A conviction also will lead to mandatory exclusion from participation in federal health care programs. The OIG also may impose civil monetary penalties of up to $50,000 for each violation, plus damages of three times the amount of the remuneration.

*To help you **remain compliant the anti-kickback statute**:*

1. Seek the advice of an experienced health care attorney before entering into any agreements with parties to pay or receive payment for goods or services where a kickback might be construed.

2. Make sure your compliance plan addresses the acceptance of gifts by physicians and staff.

Put It All Together: Your Compliance Plan

A compliance plan does not have to be long or overly complex. The federal government recommends a **seven-component compliance plan** that covers the critical points in a simple and easy-to-understand way:

1. **Designate a compliance officer**, which can be the manager or a staff member.

2. **Implement compliance and practice standards**, and have all employees sign an agreement to comply with the standards. Make compliance training a part of new employee orientation and conduct annual re-training for all staff.

3. **Conduct initial compliance training** and education for physician and staff. Training can be outsourced, and is also available online. Document all training.

4. **Oversee internal monitoring and auditing**, and document the results.

5. **Respond appropriately to detected offenses** and develop corrective action plans. Document offenses and responses.

6. **Develop open lines of communication** and encourage employees to discuss compliance at staff meetings, or in one-on-one meetings.

7. **Enforce disciplinary standards** through well-publicized guidelines.

Make sure that your compliance plan is not just a binder on the shelf! *All employees must understand the seriousness of the penalties (There are lots of examples online to illustrate this.) and the importance of compliance to the success of your practice.*

Common Sense Billing and Coding Compliance

Compliance can be a little tricky to define, but in the context of health care billing and coding, compliance is all about what we don't do, rather than what we do. Here are 16 common sense and simply-worded rules:

1. Don't bill what wasn't documented.

2. Don't bill what wasn't done, thinking it probably was or will be.

3. Don't provide unnecessary services.

4. Don't name someone in the medical record or on the claim who wasn't there.

5. Don't double bill the payer.

6. Don't change the place of service to maximize payment.

7. Don't unbundle services that are part of a single service.

8. Don't charge for related services during the global period.

9. Don't upcode or downcode services.

10. Don't neglect or misuse modifiers that would change the payment.

11. Don't discount care to patients for referring other patients.

12. Don't waive patient balances unless a financial need is documented.

13. Don't keep the money if a patient or payer overpays.

14. Don't change the diagnosis to achieve payment if the payer denies payment based on the diagnosis.

15. Don’t accept money or gifts to prescribe drugs, refer patients, or order procedures or tests.

16. Don’t direct patients to the facility that you own for a necessary test or procedure without disclosing that you own part or all of the facility.

Do you have any compliance tips, guidelines, or maxims that help keep your group on track? Share them in the comments below!

The Right Way to Do Write-offs

A write-off is an amount that a practice deducts from a charge and does not expect to collect, thereby “writing it off” the accounts receivable or list of monies owed them by payers or patients.

There are lots of reasons why write-offs are taken, and it is common practice to divide write-offs into two major categories.

Necessary or Approved Write-offs

These are write-offs that you have agreed to, either in the context of a contract, or in terms of your practice philosophy.

Contractual write-offs are the difference between the practice fee schedule and the allowable fee schedule you’ve agreed to

accept.

Charity write-offs are the difference between the practice fee schedule and anything collected. Charity write-offs may be in accordance with a community indigent care effort, a policy adhered to in a faith-led healthcare system, or a financial assistance program.

Small balance write-offs are amounts left on the patient's account that may not warrant the cost of sending a bill, which has been estimated to cost about $12.00 each, taking into account the statement process, as well as the cost to receive the check, post it, and deposit it. Many practices write off the small balance (usually $15 or less) and collect it when the patient returns. Others run a special small balance statement run once a quarter.

Prompt payment discounts and **self-pay (no insurance) discounts** are write-offs for patients paying in full at time of service, and/or patients who receive a discount off the retail price because they do not have insurance coverage.

Unnecessary Write-offs

These are write-offs that you have not agreed to and you reluctantly reduce the charge based on billing mistakes or situations that you should have been able to control, but were not.

Timely filing write-offs are caused by filing the claim past the date required by the payer. Medicare requires that claims be filed no later than 12 months after the date of service to be paid. Medicaid varies from state-to-state. Commercial payers usually have very tight timely filing limits and most average three months. (Make sure you know your timely filing limits for each payer.)

Uncredentialed provider write-offs are those caused by filing a claim for a provider before they are credentialed with the payer.

Administrative write-offs are those approved by the manager based on service issues. For instance, if the practice assures the patient that they are participating with the patient's insurance, then it turns out that the practice is not in-network, the manager may approve a write-off based on the practice's error. If the patient has a very bad experience in the practice, the manager may want to discount the service or to write-off the charge completely. If you do discount the service, remember to submit the claim for the altered fee, as you cannot discount the fee to patient and charge the payer the full fee.

Bad debt write-offs are balances that you have decided to write-off and not pursue further. These are balances that for whatever reason, you are forgiving forever.

Collection agency write-offs are those that are written off the main A/R (accounts receivable) and transferred to a third-party collection agency to collect on your behalf. These balances are not forgiven. Some PM (practice management) systems maintain a separate collection bucket or A/R and others do not maintain collection accounts in the system. Most practices do not schedule appointments with patients that have a collection balance until that balance is satisfied or the patient is committed to a reasonable payment plan.

Some guidelines for managing write-offs

1. Start with the basic write-offs but add write-off categories as the need arises.

2. Decide which write-offs require managerial approval. Do not make staff get approval for routine write-offs, but do not completely relinquish approval for all write-offs as this is one place where staff could abuse their authority. Make sure write-offs are addressed in your compliance plan so staff understand their responsibilities.
3. Review all write-off categories monthly and pay attention to unusual spikes as well as creeping trends. Keep in mind that if you raise your fees and don't renegotiate your contracts, your contractual write-offs are going to escalate, and you'll need to account for that difference in your evaluation.
4. Audit write-offs periodically to make sure that they are being done correctly. Staff will know that their work is being checked and you can be sure the numbers you are making business decisions on are sound.
5. Best practices for unnecessary write-offs are no more than 5% of your total expected collections. The formula for expected collections is gross charges minus necessary/approved write-offs.

Dear Mary Pat: How Do I Handle Chart Audit Requests From Payers?

When a payer or health plan calls your practice and requests records or requests an on-site visit to review charts, follow this guideline:

1. Be professional at all times. Audits can be nerve-

wracking and can be a drain on internal resources, but there is always something to be learned from the process.

2. Ask for the request in writing, to include the names of the patients whose charts will be accessed, the dates of service covered under the audit, the name of the auditor, the specific reason for the audit, what the result from the audit will entail (warnings, sanctions, grading, etc.) and if the result will be published in any form anywhere. Request that the specific information culled from the audit be shared with your practice in an usable form.
3. Review your contract with the payer for any language related to the payer's rights to access information, the description of the information, and any payment due to the practice for the labor and resources used in producing the records. Check with your state insurance laws for any information regarding such requests. Note that Medicare Advantage plans do not have contracts with practices, so you do have the right to charge for the labor and resources necessary to produce records.
4. When the information arrives from the payer, confirm that the patients named in the audit have records in your practice.
5. If the explanation for the audit is unclear, request more in-depth information in writing.
6. Review records or charts requested by the payer and be sure to remove any documentation that does not specifically refer to the dates being included in the audit. Do not give the entire chart to the auditor.
7. For practices with EMRs, print the appropriate documentation for the auditor if they request an on-site visit. Do not give the entire chart to the auditor.
8. If you are satisfied that all requirements are being met by the payer, schedule the audit, or arrange for records to be sent. If coming on-site, arrange for a quiet place for the auditor to review records, preferably

close to you so you can observe, answer questions and ask questions.

9. Analyze the feedback received to improve any areas needed and document your effort as a part of your compliance plan. Have all practice employees sign off on any compliance plan updates.