OIG releases 2003 Work Plan
Less emphasis on billing errors, more on quality of care

Providers investigated by the Office of Inspector General (OIG) over the next year could face steep penalties for quality of care violations as hospital quality oversight makes its debut in the agency’s 2003 Work Plan.

The OIG also expects to increase the number of individuals and entities it excludes from government health care programs in 2003, according to the new Work Plan released in October. And quality of care, a hot topic in hospitals and nursing homes recently, could trip up several institutions if they’re not careful.

The OIG plans to examine the current status of accreditation, Medicare certification, and the Centers for Medicare & Medicaid Service’s (CMS) activities for improving hospital oversight. “If a potential quality-of-care violation occurs at your organization, we will make a visit,” said Stephen Morreale, PhD, an assistant supervisory agent coordinator in the OIG’s Boston office.

In nursing homes, the OIG will focus on whether the Medicare and Medicaid programs have been improperly billed for medically unnecessary services and services not rendered as prescribed.

“There is nothing more

Moving beyond Enron: Compliance plans for today’s corporate culture

Enclosed with this month’s issue

• Check out the special report on the OIG’s 2003 Work Plan
• Find a four page sample policy and procedure on ABNs

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important than nursing home quality of care in my viewpoint,” Morreale said during an OIG town hall meeting this fall with members of the Region I provider community.

The OIG will continue to pursue civil monetary penalties (CMP) for cases related to kickbacks. In fact, the OIG is looking for ways to invigorate its use of CMPs, said Inspector General Janet Rehnquist. Rehnquist spoke in October during the Fraud and Abuse Forum, sponsored by the Health Care Compliance Association and the American Health Lawyers Association.

For the second year, the OIG will not allocate funds to investigate simple errors on claims submitted to the Medicare and Medicaid programs. Instead, the OIG will work with contractors to identify patterns of misconduct by reviewing Medicare Part A and Part B claims.

E/M services

While there aren’t too many surprises in the new Work Plan, there are a few. Some of next year’s projects for physicians raise interesting and potentially disturbing questions, says William Sarraille, Esq., an attorney with Arent Fox’s Washington, DC, office.

Accuracy of evaluation and management (E/M) coding has been a government concern for some time. The OIG plans to examine whether physicians are accurately coding E&M services. The agency will also assess the adequacy of controls in place to identify physicians with aberrant coding patterns, specifically those coding disproportionately high volumes of high-level E/M codes that result in greater Medicare reimbursement.

However, the OIG’s focus on improper billing practices that result in high reimbursement is troubling, Sarraille says, because the Department of Health and Human Services has acknowledged that the E/M coding system has created confusion and inconsistency, and that adequate guidance for such coding is not in place.

Pharmaceutical fraud

The OIG will continue to investigate illegal schemes to market, obtain, use, and distribute prescription drugs. It will focus on stopping the inflated drug prices common in the pharmaceutical industry and protecting the Medicare and Medicaid programs from making improper payments. “There clearly is no bigger priority for the OIG,” Sarraille notes.

Investigations could focus heavily on pharmaceutical manufacturers’ manipulation of the average wholesale price, Morreale said. In fact, this was one of the main risk areas the OIG listed for pharmaceutical manufacturers when it released its compliance program guidance for the industry, just days before it released the 2003 Work Plan.

Editor’s note: See the special report included with this month’s issue for more coverage of the OIG’s 2003 Work Plan.
You’ve got to know when to code ’em

Outpatient rehab: Avoid the five biggest mistakes in coding

For some therapists, coding is the most difficult part of a patient’s visit. “The whole age of getting reimbursed for health care has changed, and it’s not going to get any less complicated,” says Helene Fearon, PT, president of Fearon Physical Therapy in Phoenix.

Consider the following tips to overcome the most common mistakes in therapy coding:

1. Orthotics. These custom-made devices support abnormal foot structure and control the foot’s position, motion, and alignment, says Kathy Spratt, director of marketing and communication for DeRoyal Industries of Powell, TN.

Billing for custom-made orthotics is often the biggest speed bump between the therapist and provider, says Fearon. “The orthotics fitting and training code, CPT 97504, is not meant to be a supply code,” she explains. “It was meant to be the clinical intervention that is provided to patients. It is the service of training the person on how to use a properly fitted orthotic or prosthetic.”

Because custom-made orthotics reimbursement depends on payer and setting, contact your payers on how to bill for it. Some payers pay for the device only, while others pay for the device and the training, says Spratt.

2. Cognitive codes. “One of the challenges is making payers understand that occupational therapists (OT) provide services for cognitive and psychosocial problems, and to recognize and pay for the codes,” says Judy Thomas, director of reimbursement and regulatory policy for the American Occupational Therapy Association (AOTA).

“Medicare review guidelines clearly mention OTs working on physical and cognitive functional loss,” she says. Payers often raise a red flag with cognitive codes because they are not aware that these services are covered.

To prevent this, the Centers for Medicare & Medicaid Services (CMS) last year released Program Memorandum AB-01-135 reminding payers that Medicare covers services for Alzheimer’s disease and other cognitive impairments. The new cognitive code is CPT 97532.

Even with CMS’ announcement, some providers and therapists have been slow to recognize the change. Stop rejections with good documentation, says Thomas. You should document and code cognitive services according to the practice guideline examples available from AOTA.

3. Group codes. Coding for group therapy still confuses many veteran therapists. Consider these tips to stay current:

• Use CPT 97150, the group therapy code for therapeutic procedures, when you have a patient who needs constant attention, but does not need one-on-one patient contact, says David Lane, president of CBL Solutions of Oviedo, FL.

Mad about modifiers

1. The most popular modifier therapists use is -59. You should use this modifier to demonstrate that you’ve done two services on the same day, says Helene Fearon, PT.

2. However, too much modifying can signal trouble. When Fearon reviews documentation and sees a lot of modifiers, therapists (or the people doing the coding) usually tell her that the payer told them to code that way, but they are not sure why. Check each modifier’s definition and purpose before using one, Fearon says. You can find a list of modifiers in the American Medical Association’s CPT book.

3. An incorrect modifier can slow down a claim. Modifiers are a red flag for provider scrutiny, so it is important that your documentation support them, Fearon says.- flawed -
update your compliance plan to ensure that it addresses the evolving environment in which you operate, Berman said. “Just as you would not rely on the same business plan year after year, you cannot indefinitely rely on the same compliance plan.”

Updating your compliance plan will allow you to reeducate your employees about potential organizational risk areas and new areas of government focus. “A compliance plan that does not address today’s problems will not help prevent tomorrow’s investigation,” said Berman.

**Respond to government investigations**

Though you should respond quickly and intelligently to government agents, always call an attorney first. Unless the agents have a search warrant, they do not have the right to access your records on demand. Assure them that you want to cooperate, but tell them you will make an appointment to talk with them later.

If your organization receives a subpoena from the government, ask your attorney to contact the appropriate agency to find out what it is investigating. Until

**Expanding your role in business ethics issues**

While the role of ethics has always been part of a compliance officer's responsibility, says Kristin Jenkins, Esq., compliance and quality officer for JPS Health Network in Fort Worth, TX, the plight of Enron has brought this issue to the forefront. Many compliance officers are now serving as ethical advisors to their hospital’s board and senior management.

**Managing conflicts of interest**

As her role within the organization has expanded beyond compliance, Jenkins has crossed lines into all areas of the organization. And as her role expanded, Jenkins addressed potential conflicts of interests between her duties as compliance officer and additional responsibilities.

During a recent audioconference sponsored by the Health Care Compliance Association, Jenkins explained how she managed the following two potential conflicts of interest:

1. **Find outside help.** For a short time, Jenkins served as head of the medical records department in addition to her compliance officer role. But she says her department head role conflicted with her job as the organization’s auditor. To preserve the integrity of the coding audits, she decided, along with the board, to hire an outside auditor to conduct coding audits.

2. **Discuss conflicts with the board.** Other conflicts are manageable if they are disclosed. Jenkins is responsible for JPS’ quality program, including accreditation. So when surveyors from the Joint Commission on Accreditation of Health Care Organization’s (JCAHO) assess JPS, Jenkins, in her role as compliance officer, says she must be up-front and complete with her responses from a business ethics standpoint. She has no problem doing this as a compliance officer. However, as head of the quality department, Jenkins has an incentive to be more discreet with what she shows the JCAHO surveyors.

To combat this conflict, she discussed potential ethical scenarios with the JPS board. Together, they put reporting requirements and checks in place to allow Jenkins to perform her duties as quality manager.

These checks assured board members that Jenkins would represent the organization’s interests from an ethical standpoint.
you have proof otherwise, it's best to assume that all government inquiries concern criminal investigations of your organization and of senior management. “After you receive a subpoena, you need to discover, as soon as possible, what the government is looking to find and why they subpoenaed you. Do not lightly assume that you are not the target,” Berman said. Even investigations that are clearly about other companies can be dangerous—often, investigations start with one organization and end with others.

**Communicate with employees**

Your outside counsel should investigate all employee claims of fraudulent billing—don’t just ignore a chronic complainer. “Unless you have proof that the employee’s claim is frivolous, do not dismiss such a whistle-blower lightly,” Berman said. “If you ignore the claim, and it turns out to be true later, the government will use your knowledge of the employee’s accusation as proof of your organization’s—and your own—knowledge of the fraud.”

Always be careful when advising employees on whether they should talk to the government; your answer could prove crucial to the case.

For example, if an employee tells you that she received a call from a government agent asking questions about the organization, you cannot imply that she should not talk to the government. If you advise the employee to avoid the government’s investigators, your organization could face obstruction of justice charges. These, said Berman, are easier to prove than Medicare fraud charges.

If the employee in this case wants to talk to the government, suggest that she might feel more comfortable with an attorney present. Strongly consider offering to have the organization pay for an attorney so you can remain informed and involved in all stages of the investigation, said Berman.

The ground rules: Your attorneys should tell the government that they represent the company and all employees. Government agents are not allowed to speak to people represented by attorneys without the attorney present, said Berman.

*Editor’s note: The New Hampshire Health Care Compliance Forum was sponsored by the Health Care Compliance Association, Region I.*

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**New law offers guidelines for audit committees**

**Apply the Sarbanes-Oxley Act to your operations**

Private health care organizations can use the rules in a new law that Congress enacted July 30 to reform their audit committees. The Sarbanes-Oxley Act of 2002 modifies existing guidelines for the independence and financial expertise of audit committee members, adopted by the stock exchanges in December 1999.

Although the rules only apply to publicly traded companies, consider incorporating the following mandates to enhance your organization’s audit committee:

- Do not allow outside auditors to provide non-audit services to your organization, such as bookkeeping, financial information systems design, internal audit outsourcing services, and legal services unrelated to the audit
- Require all outside auditors to report all critical accounting policies and practices they will use in the audit, other written communications between the accounting firm and your organization’s management, and all alternative financial information treatments directly to your organization’s audit committee
- Require the audit committee to approve current audit and non-audit services and pre-approve all future services your auditor will provide
- Do not retaliate against employee whistleblowers and government informants

*Editor’s note: Go to news.findlaw.com/hdocs/docs/gwbush/sarbanesoxley072302.pdf to download the Sarbanes-Oxley Act.*

*Source: Joseph Savage, Esq., an attorney with Testa, Hurwitz & Thibeault, LLP in Boston.*
Once your software upgrades are in place, the fun begins: Test each transaction to make sure you are sending and receiving it appropriately. Use the following guidelines:

**Internal testing**
- Does the upgrade address all data gaps?
- Are bi-directional interfaces working?
  - Does the front-end (admissions/registration) system communicate with the back-end (patient financial/accounting system)?
  - Does the back-end communicate with the front-end?
- Are operational and workflow changes needed?
  Are changes that have already been made working?

**External testing**
- Focus on these six levels of transactions testing:
  - Syntax integrity according to X12N
  - Implementation guide requirements (e.g., size, attributes)
  - Balancing of amounts
  - Code sets and valid values
  - Situational requirements (e.g., Medicare crossover)
  - Specialty line of business requirements (e.g., durable medical equipment)
- Look for the following when testing with trading partners:
  - Transaction confirms accurate function of systems
  - Entity-specific focus on areas of greatest risk
  - Round-trip test ensures integrity
- Plan on three months per transaction

**Certification**
Do your transactions have the appropriate data elements in place? Certifications will help you find out. Conduct certifications before testing directly with each trading partner or payer; this will probably reduce your testing time and slice the number of tests that you have to run. Use the following guidelines:

- Consider requiring all partners to certify prior to B2B testing
- Assure clearinghouses will certify the following:
  - Transactions you send them
  - Transactions they send to the payer

Source: Steven Lazarus, PhD, FHIMSS, president and cofounder of Boundary Information Group.
preliminary staff education, said Amatayakul.

Next, talk to your vendors. Find out when they expect to come through with the software upgrades and how much the upgrades will cost. In addition, ask vendors the following questions:

- **What standards are included in the upgrades?**
  Vendors may not plan to offer upgrades for every standard in their software upgrades.

  Many vendors will charge extra for the capability to conduct certain transactions. Others may not be capable of conducting certain transactions at all, said Amatayakul.

  Amatayakul gave the following examples of potential vendor positions on upgrading certain transactions:

  - 837 Claim—Most vendors consider this part of their contracted obligations, as long as the contract says the vendor will provide upgrades for any federal regulatory changes.

  - 835 Remittance—Many vendors consider the remittance from claims as part of their federal regulatory obligation.

  - 270/271 Eligibility—Many vendors will supply this, but at an additional cost. Eligibility verification makes good sense, but most providers can access this through the Web for many of the major payers, said Amatayakul.

  - 276/277 Claim status inquiry—Many vendors are prioritizing their system upgrades and do not have the capability for you to use this standard yet.

  - 287 Referral certification and authorization—Most vendors are prioritizing this transaction last.

- **Do you provide content or formatting?**
  Find out whether your vendors will give you the ability to capture transactions data with your software, or will help you format the data into the valid codes and fields.

  Some vendors will only supply places to put the data, instead of supplying the complete code sets or providing edit capability for data entry.

- **Do you provide transmission capability?**
  Some vendors will supply data-capture capability only, but not transmission capability.

  These vendors assume you will continue to use their clearinghouse to send claims and make eligibility inquiries, Amatayakul said.

2. **Operational assessment.** Find out which of your facility’s operations need tweaking by doing the following:

  - Conduct a data gap analysis of your billing system to determine the amount of missing data element.

  - Identify internal implementation issues and develop a work plan to address them

  - Consider and decide whether to use a vendor or another contractor to assist your organization in achieving compliance

3. **Development and testing.** Start this phase by doing the following:

  - Finalize the development of applicable software and install it

  - Complete staff training on how to use the software

  - Start and finish all software and systems testing

  Most organizations conduct internal testing for upgrades. However, providers must also conduct external testing and certification to ensure compliance. Verify that the upgrade includes everything you need. If you don’t complete a gap analysis on the front end, it is an essential part of the testing.

  See the box on p. 6 for more information on testing transactions.
Master medical necessity: It’s essential to compliance

Hospitals are losing millions of dollars each year due to medical necessity denials. Hospitals can expect these denials to increase dramatically as local medical review policies (LMRP) become firmly cemented into Medicare cost-control, according to Darren Carter, MD, president and chief executive officer of Provistas in New York City.

“The expansion of the outpatient prospective payment system has made LMRPs very important,” Carter said during a recent audioconference from HCPro, publisher of SHCC. LMRPs outline the medical necessity rules for each state.

To avoid denials and improve your reimbursement program, closely follow Medicare contractors as they implement medical necessity edits, Carter said. If your facility receives a medical necessity denial, make sure the medical necessity rule existed on the date of service. Providers who do not ensure that all items and services paid for by Medicare are reasonable and necessary won’t lose reimbursement alone—they could also get slammed with citations and financial penalties.

Medical necessity doesn’t apply to all medical services, however. It only applies to outpatient fee-for-service medicine, not inpatient services, Carter said.

Advanced tips for using ABNs

When a service doesn’t meet medical necessity requirements, Medicare won’t pay. Providers must use an advance beneficiary notice (ABN) to inform beneficiaries that Medicare probably won’t cover the test or service before it is performed. ABNs are designed to outline the test or service that Medicare does not find reasonable and estimate the cost of each test for which the beneficiary is financially responsible, said Stacie L. Buck, RHIA, LHRM, president of Health Information Management Associates, Inc, in Florida. Buck also spoke during HCPro’s audioconference. Just using an ABN isn’t enough—providers need to complete it correctly. Use the following guidelines as you fill out each required section of the ABN:

1. **Why Medicare probably won’t pay**
The ABN must explain to the patient why Medicare is not going to pay for the service. For example, simply listing “diagnosis” as the reason Medicare may not pay for a service is not enough—provide a detailed explanation. Keep in mind the Medicare patient’s ability to understand the information written on the form, said Buck.

2. **The estimated cost of the service**
Be careful when you’re estimating a procedure’s cost, said Buck. You’ll run into problems if someone writes an incorrect amount on the form. “Once you state a particular amount to patients, that’s what they expect to pay.”

3. **The patient’s options**
Patients must decide whether they will agree to receive and pay for the service or test. However, they have another option: They can express a desire to receive the test, but refuse to sign the ABN. In this case, you can have two people witness that the patient refused to sign the form, according to the Centers for Medicare & Medicaid Services. This shows Medicare that you gave the patient notice, and allows you to bill the patient for the service.

See the box on p. 9 for more information on implementing an ABN process.

Compliance concerns for 2003

Though the Office of Inspector General (OIG) didn’t include ABNs in its 2003 Work Plan, providers should remain cautious in this area, advised Buck. “The ABN issue is not any less important now that the OIG has pulled it off the Work Plan, especially since CMS has implemented a standardized ABN form that makes
all previous forms invalid.”

Providers who offer patients kickbacks by removing charges for noncovered services may also find the government at their doorsteps. CMS interprets this as a ploy providers use to induce future business from the patient for services that Medicare does cover. “If consumers know they can come to you and not pay for services, they’ll keep coming back,” explained Buck.

Editor’s note: For more information on managing medical necessity, order the book Medicare Medical Necessity: A Guide to Accurate Reimbursement and Full Compliance, written by Darren Carter, MD, president and chief executive officer of Provistias in New York City. Call 877/727-1728 to order.

Tips for setting up an ABN process

Providers must have an advance beneficiary notice (ABN) process in place in order to comply with Medicare’s medical necessity requirements. Use these five tips to jump-start your ABN implementation process:

1. **Determine who will be involved in the process.** You need to determine who comes in contact with patients before they have a test performed. Look at the following groups:
   - Scheduling department. Patients come in contact with the scheduling department early on. At the time of scheduling, these departments have direct access to physicians’ offices.
   - Registration department. Tell registration staff to check whether the patient’s service is medically necessary.
   - Service providers. Once a patient makes it past registration, the next opportunity to check medical necessity occurs when they meet the people actually performing the service, such as laboratory personnel and radiology technologists.

2. **Educate all staff involved.** The more people who understand the rules and regulations, the easier it is to manage medical necessity and ABNs. Your key education group will probably be a physician’s office staff. Staff members call and schedule appointments, so if you can establish a good rapport, that’s your best line of defense. Teach the office staff about federal regulations and Medicare and Medicaid requirements for ordering diagnostic tests.

3. **Implement a review process.** Review all test orders for the required information and medical necessity when the patient arrives for the exam. Contact the referring physician’s office immediately for missing information. Also, implement a process to follow-up on incomplete test orders when the staff cannot reach the referring physician for additional information.

When the patient arrives, review each test order to make sure it includes all of the information necessary to prove medical necessity. Also, routinely review claims denials to make sure carriers are using appropriate denial codes and following local medical review policy guidelines.

4. **Set up an auditing program.** Make sure everything that needs to occur does. If you have problems, pinpoint a communication breakdown by backtracking through the process.

Perform an audit of Medicare patients to identify which exams carriers and intermediaries frequently deny for lack of medical necessity. From there, determine whether your facility offers ABNs for these services when appropriate.

5. **It’s go time!** Make sure your standardized requisition forms are user-friendly and accommodate the required referral information. Educate your referring physician on the coding guidelines. And watch the codes you have on the requisition form to prevent “code jamming” (see story on p. 8 for more on this).

Source: Stacie L. Buck, RHIA, LHRM, president of Health Information Management Associates, Inc., in Florida.
What’s stopping potential relators from bringing frivolous qui tam suits? Not much.

There are few economic disincentives to filing a False Claims Act (FCA) case—even when the case is weak. And while many qui tam cases have merit, disgruntled employees and physicians appear to be using the civil FCA to retaliate against hospitals.

Other avenues to court

In the past, disgruntled physicians were more likely to allege some type of antitrust violation or breach of the hospital’s medical staff bylaws, which are contractual in many states. The courts have almost universally rejected these suits.

Health care antitrust cases generally fall into two categories:

1. “Per se” (i.e., price fixing). Any conduct under the price fixing category is considered illegal; as a result, hospitals are not permitted to offer any justifications for their actions. However, it is extremely rare for this standard to govern health care antitrust cases.

2. “Rule of reason.” This standard is more common. In this category, the plaintiff must, through extensive and costly market analysis, prove that the conduct has affected competition. Antitrust economic experts are not cheap, and an antitrust analysis could run a plaintiff from $25,000 to $100,000 by trial.

Similarly, courts have been unsympathetic to cries from disgruntled physicians of bylaws violations. In these cases, courts will only look at whether the hospital followed an appropriate procedure in taking whatever action the employee is challenging. The court will not look at a hospital’s substantive decision.

Enter the civil FCA arena. The only prerequisite for filing a FCA case is that the relator file the complaint under seal first to give the Department of Justice the opportunity to prosecute the case. If the government decides to take over prosecuting the case, the relator’s task is simple: Wait until the government obtains a settlement and collect a percentage of that settlement. This is every relator’s dream, as it takes most of the attorney and expert costs out of the equation. The relator receives a slightly smaller settlement share when the government is involved, but that’s more than offset by the higher government settlements. In addition, physicians or employees may be entitled to reimbursement for costs and attorneys’ fees if they prevail.

Potential sanction for frivolous claim

There are two mechanisms that could deter frivolous claims:

1. Dismissal. The government has the authority to intervene and dismiss the case outright. However, this action is unprecedented.

2. Fee awards against qui tam relators. The second avenue is for defendants to request attorneys’ fees at the conclusion of the case. A defendant’s ability to recover attorneys’ fees depends on which party prosecuted the case: the relator or the government. If the relator presses the case, the test is whether the claim was clearly frivolous or brought only to harass the defendant. In a government case, the defendants must prove that the government lacked “sub-
substantial justification” for bringing the case.

The court, according to section 31 U.S.C. § 3730(d)(4) of the FCA, may award defendants their reasonable attorneys’ fees and expenses if they prevail under the following circumstances:

- If the government intervenes, its position was not substantially justified
- If the government does not intervene, the court finds that the claim of the person bringing the action is clearly frivolous, or brought merely to harass the defendant.

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**United States ex rel. Mikes v. Strauss, 274 F.3d 687 (2d Cir. 2001)**

Mechanisms to prevent frivolous claims have little teeth because the standard is so high, says Philadelphia-based attorney Mark Mattioli. They provide little disincentive against frivolous qui tam actions. And, even in victory, defendants in the federal false claims case described here, lost. Here’s how:

**Background:** The federal appellate court upheld the award of attorneys' fees in this case against a physician who filed a frivolous false claims action against her former employers. The relator here alleged that her former group submitted false claims for spirometry tests because it failed to calibrate the machines appropriately. The court rejected this claim and the defendants requested $400,000 in costs and attorneys’ fees.

For its ruling, the court looked at whether an “objective” person would determine that the claims lacked merit. The court based its ruling on whether the claims were “objectively frivolous.” Accordingly, the defendant did not need to prove that the relator believed the claims were frivolous, only that the physician pressed the false claim despite this belief. A claim is frivolous when it has no reasonable chance of success and no reasonable argument can be made that a change in the law is warranted.

**Decision:** The court awarded the defendants $5,000. This is consistent with the courts’ reluctance to shift fees to a prevailing defendant. Remember, the court can refuse to award attorneys’ fees even when it believes that claims are frivolous.

**Equal Access to Justice Act:**
When the government intervenes, the award of attorneys fees to the defendant is governed by the Equal Access to Justice Act [28 U.S.C. § 2412(d)(1)(A)]. In these situations, the test is whether the government’s case is “substantially justified.” The defendant does not need to prove that the claim was frivolous. Instead, the test is whether the government knew or should have known that its position lacked substantial justification. Moreover, defendants are not entitled to an award of attorneys fees solely because they won.

Moreover, courts are less likely to award attorneys’ fees—when the question at issue revolves around an interpretation of law, as opposed to the existence of a fact.
Specialty

- Use CPT 92508 for codes involving speech, language, voice, communication, or auditory processing disorder, Lane says.
- Do not include group treatment time in counting minutes and calculation of units for the timed CPT codes for a visit. Group therapy is a nontimed CPT code.

4. Evaluation codes. Some payers don’t recognize that an evaluation and therapy can occur on the same day.

Often, they believe one procedure per day, suspect the other procedure occurs when a therapist sees a patient for the first time, or think you’ve incorporated the therapy into the evaluation code, Thomas says. Use persistence to get this code combination recognized.

5. Wound care. Two distinct codes—CPT 97601 and CPT 97602—are required when you treat patients who have an ulcer or sore that is difficult to heal. A majority of these sores and ulcers don’t respond to normal healing, so therapists provide a special dressing and ointment, explains Lauren Jandroep, OTR, CPC, CCS-P, CCS, owner and senior instructor for A+ Medical Management & Education, a coding certification training school in Absecon, NJ.

These codes involve the following selective and nonselective debridement techniques to promote healing:

- Use the selective code, 97601, when you pull specific tissue off the body
- Use the nonselective code, 97602, for a general washing or light scrub of the area
- Report the billing for wound care dressing per session, not according to time

Jandroep once did billing for a wound-care specialist who had problems getting reimbursed for supplies, such as gauze, bandages, and tape. “He billed on a regular payment form, but had to use a certificate of medical necessity form, too,” she says.
Medicare medical necessity and advance beneficiary notice

Effective Date: October 1, 2002

Purpose:
To provide guidance on the utilization of the advance beneficiary (ABN) notice for Medicare patients in accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines.

Policy statement:
Medicare will only pay for services that are determined reasonable and necessary. An ABN must be obtained for tests/services ordered that do not meet medical necessity requirements of Local Medical Review Policy (LMRP) as defined by the Fiscal Intermediary (FI) or Part B Carrier. National Coverage Limitations as defined by CMS should be used in the absence of LMRP.

Policy:

I. Determining medical necessity

A process must be implemented for screening the medical necessity of services for Medicare patients at the time of registration. CMS’ National Coverage Limitations and LMRPs issued by the FI or Part B carrier must be obtained and made available to those individuals responsible for registering the patient.

The following process should be used when determining medical necessity of services at the time of registration:

- The individual performing registration must review the signs, symptoms/diagnosis provided by the physician according to the LMRP’s or National Coverage Limitations when processing all orders for Medicare patients.

- Verify whether the test(s) has an LMRP or National Coverage Limitations.

- If the test/service to be performed does not have limited coverage under a policy, proceed with the registration process and perform the test(s) ordered.

- If the test/service to be provided does not meet medical necessity requirements, an ABN must be completed.
II. ABN

An ABN must be obtained when one or more of the following circumstances exist:

- The test/service provided does not meet medical necessity requirements according to an LMRP or National Coverage Limitations
- The test/service may only be paid for a limited number of times within a specified time period and the visit may exceed that limit
- No diagnosis, sign, symptom, or ICD-9-CM code is provided
- The test/service is for investigative or research use only

Note: An ABN is not needed for statutorily noncovered services.

Advance notice must be given in writing on the appropriate CMS-approved form—CMS-R-131-G for general use or CMS-R-131-L for laboratory use. All fields on the ABN form must specify why the service may not be covered in terms understandable to the beneficiary.

When presented with an ABN, the patient has two choices: receive the services(s) and agree to be responsible for payment or refuse to be responsible for payment and not receive the service(s).

If the patient refuses to sign the ABN and demands services, two staff members must sign the ABN form witnessing the patient’s refusal to sign and document “patient refused to sign” on the form. The patient will be held financially responsible for the test.

A copy of the signed ABN form should be given to the patient and a copy should be retained for billing purposes.

Note:
- ABNs must be obtained prior to a service being rendered.
- Routine use of the ABN is prohibited. There must be a specific reason to believe Medicare may deny the test/service in order to request a beneficiary sign an ABN.

III. Billing Requirements

A. Part A FI (UB-92)

1. Signed ABN on file:

   If the services are not medically necessary and an ABN was obtained prior to rendering the services, enter occurrence code 32 on the UB-92 in one of the fields numbered 32 through 35. Occurrence code 32 is mandatory; it must be used anytime a signed ABN is obtained. This code indicates the date the ABN is given to the beneficiary. It is the occurrence code 32—not any condition code—that indicates to the FI that an ABN has been issued.
Condition code 20 (the demand bill condition code) should not be entered on the UB-92, except where otherwise required to use condition code 20 for claims (home health or skilled nursing facility claims) that require 100% complex manual medical review.

2. **No ABN on file for services not medically necessary:**
   If the services are not medically necessary and an ABN was not obtained prior to rendering the noncovered services, the charges for services should not be submitted to Medicare. The charges should be written off as noncovered/nonallowable.

3. **Statutorily noncovered services:**
   An initial determination, for statutorily excluded services may be submitted if the beneficiary requests it. On claims for statutorily excluded services, enter a condition code 21 on the UB-92 in one of the fields numbered 24 through 30 to indicate that furnished services are excluded, but a denial notice is being requested from Medicare.

**B. Part B carrier (HCFA-1500)**

1. **Signed ABN on file:**
   CMS has developed modifier GA (waiver of liability statement on file) to let carriers know that this notice is on file. It must be maintained in the provider record and be available to the carrier upon request. If multiple services are rendered that may be subject to the ABN requirements, each procedure must be billed with the GA modifier.

2. **No ABN on file for services not medically necessary:**
   The GZ modifier must be used to indicate that it is expected that Medicare will deny an item or service as not reasonable and necessary and an ABN has not been signed by the beneficiary.

3. **Statutorily noncovered services:**
   The GY modifier must be used to indicate that the item or service is statutorily noncovered (as defined in the Program Integrity Manual [PIM] Chapter 1, §2.3.3.B) or is not a Medicare benefit (as defined in the PIM, Chapter 1, §2.3.3.A).

*References: CMS Transmittal AB-02-114—www.cms.hhs.gov/medlearn/refabn.asp*


*Editor’s note: This policy may also be found on the SHCC Policy and Procedure Roundup page at www.complianceinfo.com/ccofficer/login.cfm. SHCC readers can access this page with the password and username found in each issue of SHCC. For the month of December, the username is mistletoe and the password is 095476.*
Implementing medical necessity checks

When implementing medical necessity checks, all components must be in place from patient care to billing. Unless the parts coordinate well, any work done is for nothing. It cannot be stressed enough that a medical necessity solution that does not include all parts of the process cannot be considered a solution.

Having a well-documented plan for medical necessity compliance can help you prove that your facility is working to achieve compliance. The overall process to compliance for medical necessity should dovetail with other compliance efforts. Your overall policies and procedures for compliance should address medical necessity standards. In its compliance program guidance, the Office of Inspector General says a full compliance plan should address medical necessity.

Ingredients in a preservice check
Several elements are essential to the making of a medical necessity determination. First are the preservice medical necessity determinations that may compel you to obtain an advance beneficiary notice (ABN) from a patient. The components are laid out in the following:

- The procedure code for the service or item being prescribed
- Billable diagnosis code(s) including the principal diagnosis for the test and other related diagnoses
- Access to local medical review policy information from one or two contractors
- Staff who are able to interpret the codes with respect to the LMRP
- (most important) A patient

To obtain an ABN from a patient, the benefits determination must be made prior to preparing the patient for a test. The important part about compliance with respect to preservice checks is not providing free care to patients simply because the provider is unable to perform a preservice check. This could violate anti-kickback laws.

However, there needs to be intent involved with anti-kickback laws that the free care is to induce patients to seek more care from the provider. This part of the anti-kickback law would be difficult to prove for a provider who was simply not obtaining ABNs due to the complexity of the process. Still, one cannot underestimate how a free cardiac catheterization (no co-pay or deductible) can influence not only a patient’s choice of provider, but the patient’s friends as well.

Compliance
Most Medicare compliance has to do with billing and the documentation that leads up to it. Providers that are performing preservice checks without seeking documented reimbursable diagnosis codes or obtaining ABNs mostly jeopardize reimbursement, not compliance.

The main concern with not obtaining ABNs is that anti-kickback laws view this act as an unfair inducement to patients to obtain further care from a particular provider. Due to the arbitrary nature of medical necessity denials, though, it would be hard to make the case against an institution.

By continually billing services that do not meet medical necessity rules, providers could be at risk for committing abuse, which is defined as consistently incorrect billing practices that result in unnecessary costs to the Medicare program. Thus, at minimum, medical necessity compliance would include a post-service check so that procedures that do not meet medical necessity rules would be billed on noncovered claims with the condition code 20.

In addition, there is no guarantee that your contractor is going to identify all the procedures that should be denied for reasons of the medical necessity. Receiving reimbursement for such services would suggest that the provider is receiving overpayments. Future audits could result in providers needing to pay back this money.

Editor’s note: This story is an excerpt from the book Medicare Medical Necessity: A Guide to Accurate Reimbursement and Full Compliance, written by Darren Carter, MD. Go to www.hcmarketplace.com/Prod.cfm?id=1314 for more information on ordering this book.