INTERNATIONAL MEDICAL BILLING
MANAGEMENT AND CONSULTING, INC.

Changes 2012

"There is nothing wrong with change, if it is in the right direction"

Winston Churchill

New tools provided by the Affordable Care Act are strengthening the Obama administration's efforts to fight health care fraud. As a result of Affordable Care Act Provisions:

• Criminals face tougher sentences for health care fraud,20-50 percent longer for crimes that involve more than $1 million in losses

• Contractors that police the Medicare program for waste, fraud, and abuse will expand their work to Medicaid, Medicare Advantage, and Medicare Part D Programs

• Government entities, including states, the Centers for Medicare & Medicaid Services (CMS), and law enforcement partners at the Office of the Inspector General (OIG) and DOJ, have greater abilities to work together and share information so that CMS can prevent money from going to bad actors by using its authority to suspend payments to providers and suppliers engaged in suspected fraudulent activity

Fraud and Abuse

Health care fraud and abuse enforcement activity is at an all-time high yet many physicians and other providers lack a basic understanding of the key healthcare fraud and abuse statutes that apply to them. Although each state may have its own fraud and abuse laws, any healthcare provider that receives federal funds should be familiar with three significant federal fraud and abuse statutes: the anti-kickback statute, the federal false claims act and the physician self-referral law (also known as the Stark law).

Each of the statutes imposes a different set of prohibitions on healthcare providers and each carries separate but significant penalties for violation.

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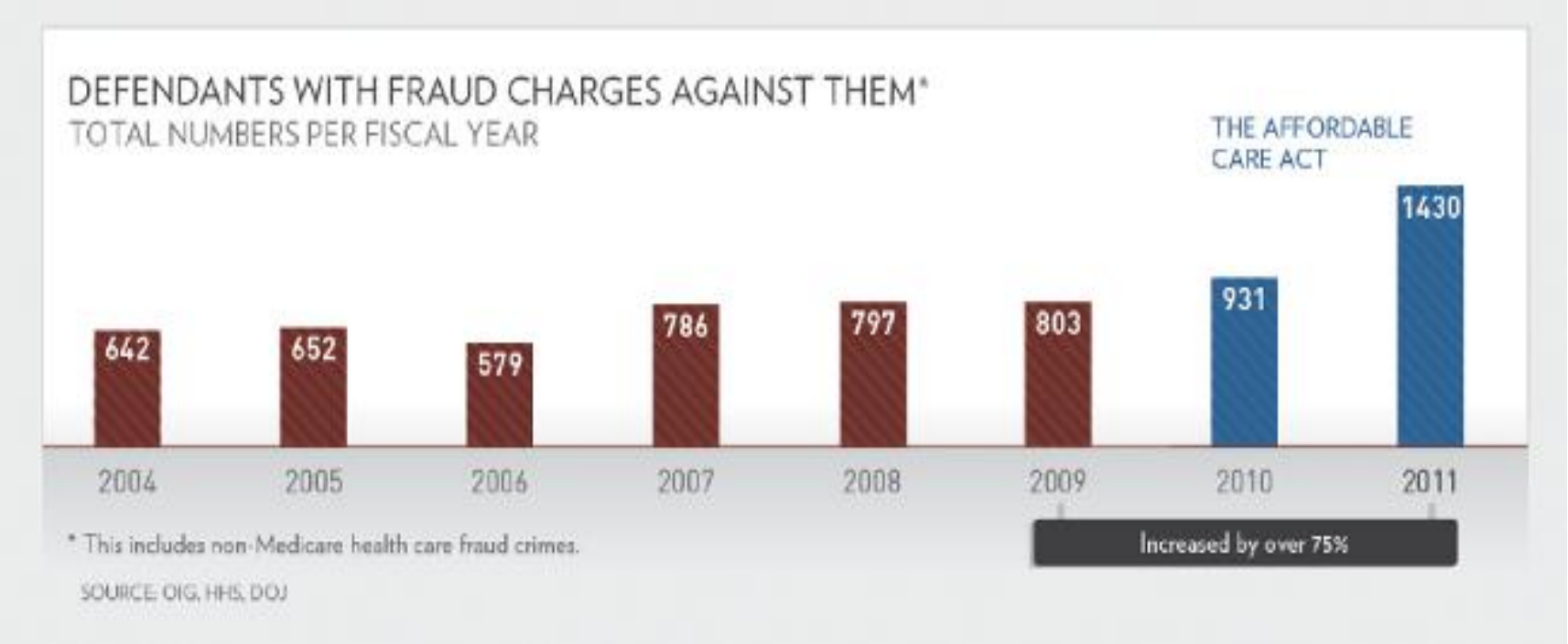
DEFENDANTS WITH FRAUD CHARGES AGAINST THEM*
TOTAL NUMBERS PER FISCAL YEAR
THE AFFORDABLE CARE ACT
642
652
579
786
797
803
931
1430
2004
2005
2006
2007
2008
2009
2010
2011
* This includes non-Medicare health care fraud crimes.
Increased by over 75%
SOURCE: OIG, HHS, DOJ

According to the USA Today article, federal healthcare prosecutions for 2011 are on track to increase 85% over 2010, and fraud prosecutions have gone up 71% from five years ago. In addition, according to Justice Department statistics, there have already been more Medicare fraud trial convictions in the first eight months of 2011 than there were in 2010.

The spike in fraud investigations and prosecutions should come as no surprise given that the Obama administration has placed heavy emphasis on fraud, waste and abuse recoupment as a means of funding new healthcare reform legislation. On top of this, healthcare enforcement authorities are using new and more advanced means (e.g., enhanced technology and cooperative task force operations) to identify fraud and abuse.

Too few physicians appreciate the fact that running afoul of Medicare billing and coding requirements or entering into an arrangement which is a violation of the federal stark or anti-kickback statutes could result in significant overpayments which must be refunded to the Medicare program or even worse, massive civil money penalties or false claims liability.

Secondary Payer Medicare

Automobile/No-Fault or Liability Insurance: When Medicare is the secondary payer to automobile medical/no-fault or liability insurance, you may, but are not required to, bill Medicare for conditional payment. Conditional payment means Medicare will pay the claims as if we had primary responsibility. We will, however, actively pursue recovery of the funds paid by Medicare from the responsible person's auto or liability insurance. When you have reason to believe that you have provided services to a beneficiary for which payment under liability insurance may be available:

Bill only the liability insurer during the 120-days after you have provided services unless you have evidence that the liability insurer will not pay within the time period.

If you have evidence that the liability insurer will not pay within the 120-day timeframe*, you may, but are not required to, bill Medicare for conditional payment. If you bill Medicare within the 120-day time period, supply documentation to support that payment will not be made promptly.

After the 120-day timeframe has ended, you may, but are not required to, bill Medicare for conditional payment if the liability insurance claim is not resolved. At this point, the 120-day payment documentation is no longer required; however, we still need the liability insurer's name and address.

*Note: The 120-day timeframe is defined as the earlier of the following:

The date a claim is filed with an insurer or a lien is filed against a potential liability settlement.

The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

Sometimes providers file liens in auto and liability cases and wait for a settlement before submitting a bill to Medicare-this is not considered a conditional payment, as you are not requesting that Medicare pay. However, the 120-day timeframe is still to be followed. If you choose to bill Medicare after the 120-day period you must withdraw claims against the liability insurer or liens placed on the beneficiary's settlement. The Medicare reimbursement must be accepted as payment in full and you may charge the beneficiary only for applicable deductible, coinsurance, and non-covered services. When the claim you are filing includes a trauma diagnosis and an auto or liability insurance is involved, please include the name, policy number and address of the liability insurer if requesting a secondary or a conditional payment. If liability insurance payment is made, Medicare will not pay secondary unless benefits are exhausted.

Workers Compensation

Workers Compensation: If the services you provide to a beneficiary are related to an injury that is covered under workers compensation, you must bill the worker's compensation insurance for payment. If the workers' compensation benefits are exhausted, you may bill Medicare secondary. If the beneficiary is a Federal employee, the Department of Labor should be billed first. Medicare should be billed only if the claim is denied or contested by the Employer or if you are not required to accept the Workers Compensation payment as payment in full.

Black Lung

Black Lung: Applies to all Medicare beneficiaries and deals with services rendered for a condition attributable to lung disease/conditions caused by mining. The Department of Labor should be billed if the diagnosis is black lung related. If the diagnosis is not black lung related, Medicare should be billed. If the Department of Labor does not pay for the services after being billed, the claim should be filed to Medicare with the Department of Labor's denial information.

The address for billing to the Department of Labor is:
Federal Black Lung Program
P.O. Box 740
Lanham, Maryland 20706

Black Lung Diagnosis Codes

001.9	*417.0	492.0	*785.0
031.0	*417.1	493.9	*786.09
039.1	*428.0-428.9	*494.0	*786.1
115.05	466.0	496	786.3
116.0	466.1	*500	*786.50
162.2-162.9	480.9	510.0-510.9	*786.52
231.2	481	511.0-511.9	786.6
*276.2	482.0-482.9	512.0	793.1
*276.3	483	513.0	799.1
415.0	484.0-486.0	*516.3	
*415.1	487	518.0	

Delays on ICD-10 2014

In April, the Department of Health and Human Services (HHS) announced that it would extend the deadline for physicians to begin using a new and expanded set of diagnostic codes called the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision*, or ICD-10, from October 1, 2013, to October 1, 2014. Organized medicine has decried the code set as overly complex and costly to implement

Legal & Ethical Coding

*Upcoding- This is when using a code that indicates that a higher level of service was performed than documentation substantiates

*Double Billing –This constitutes fraud if charge has already been billed

*Unbundling- This is using individual service code when a combination code is available

Understanding the Terminology

Patient: Person receiving services

Policyholder: Know as insured

Insured: The Family member that holds coverage for family

Responsible party: Know as guarantor

Guarantor: Person who agrees to pay the provider balance for services

Medical Necessity

Insurance carriers sometimes require prior authorization and information about medical necessity for the more extensive types of medical treatment, including care, equipment or medication. Medical necessity is a clinical term used to describe the need for this insurance coverage. Insurance carriers often require specific documentation to prove medical necessity

Sending records most times do not cover the request for additional information that is being requested. Since timely issues are becoming increasingly more of an issue it is important not to delay in supplying this information. If you do it increase your chances of not being reimbursed.

Some insurance carriers have standardized forms, while others require a detailed letter explaining why the treatment is necessary

To prevent an unfavorable decision, the physician and the insured should be aware of the insurance carrier's rules

Medical Necessity

* Not an experimental procedure

* Not an elective procedure

*Not at the convenience of provider, facility, or provider

*Prevalent standard of care guidelines for treatment given

Avoid deactivation of Medicare payments

Find out whether you have been sent a revalidation request by using the search option featured on First Coast Service Options' popular enrollment status lookup, available at http://medicare.fcso.com/Enrollment/NPIandPTANLetterInput.asp. You may search for revalidation requests by entering your NPI or your PTAN.

Medical Billing Compliance

For your outsourcing needs it is imperative that you choice of billing company has a structured plan for all entities of billing to prevent any unethical or illegal conduct.

•The following elements are the foundation of a medical billing compliance program:
• Written standards and policies
•Designation of a compliance officer
•Training & Education
•Communication
•Auditing and monitoring compliance
•Procedures for responding to violations
•Disciplinary policies

Our company has a full compliance manual in place for training our staff to assure that the high standards that our clients have experienced will continue. Our office is fully compliant with HIPAA regulation. This insurers all of your data is managed in the most secure and private settings. Our office is compliant with all regulations, rules and technology available in the industry.

The Electronic Prescribing (eRx)

The Electronic Prescribing (eRx) Incentive Program is a reporting program that uses a combination of incentive payments and payment adjustments (penalties) to encourage electronic prescribing by eligible professionals. The program provides an incentive payment to practices with eligible professionals (identified on claims by their National Provider Identifier [NPI] and Tax Identification Number [TIN]) who successfully e-prescribe for covered Medicare Physician Fee Service Schedule (MPFS) services for Medicare Part B Fee-for-Service (FFS) beneficiaries

What You Need to Do to Comply for E-Prescribing in 2012

2012 is the first year of the Electronic Prescribing (eRx) Incentive Program that features both incentive payments and adjustments (penalties). Eligible professionals that successfully reported eRx measures in 2011 will receive a bonus payment from Medicare in 2012 equal to 1 percent (1%) of their total Medicare Part B payments in 2011.

<u>If a physician fails to report one of the following, they will be subject to a 1 percent payment penalty for all Medicare payments in 2012, which *will be assessed in 2013.*</u>

at least 25 prescribing events via claims for at least 10 unique denominator eligible eRx events for services provided January 1, 2012 through June 30, 2012

or report the G8553 code via claims for at least 10 unique denominator eligible eRx events for services provided January 1, 2012 through June 30, 2012

or apply for an exemption

The eRx measure 2012

The eRx measure (G8553) only qualifies for the incentive bonus when submitted with one of the following exam codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

Incentives and Penalties

If you successfully e-prescribe medications and report the eRx measure in 2012 (by generating and reporting one or more electronic prescriptions associated with a minimum of 25 unique patient visits from January 1, 2012- December 31, 2012) **you will earn incentives** (in 2013) **equal to 1 percent of your total Medicare payments for 2012.** (You will obtain payment bonuses after the conclusion of the calendar year in which you e-prescribed for your Medicare patients, not as an immediate payment). **The incentive payment decreases to .5% of your total Medicare Part B payments for calendar year 2012.**

Participating in the Medicare Electronic Health Records (EHR), Physician Quality Reporting System (PQRS) and eRx Programs Simultaneously you are not able to obtain incentives from both the Medicare eRx and the Medicare EHR incentive programs simultaneously. However, you may participate in the PQRS and eRx programs at the same time. Also, you may participate in the Medicaid EHR incentive program and still qualify for incentives under the eRx program.

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/index.html?redirect=/ERxIncentive/01_Overview.asp

The newly finalized exemption groups are:

Practice in a rural area without adequate high-speed internet access,

Practice in a location without enough available pharmacies for e-prescribing,

Physicians who are already registered to participate in the Medicare or Medicaid EHR Incentive Program and who have adopted certified EHR technology, or

Physicians who are unable to electronically prescribe due to local, State, or Federal law or Regulation (e.g., prescribes controlled substances), or

Physicians who infrequently prescribe (e.g., prescribe fewer than 10 prescriptions between January 1, 2011 – June 30, 2011), or

Insufficient opportunities to report the e-prescribing measure due to program limitations.

The eligible professional (EP) must be the person completing and submitting the hardship exemption form; office staff may not complete the form on the EPs behalf

	Incentive	Penalty
Calendar Year of E-Prescribing	Incentive Amount (%)	Penalty Amount (%)
2011	1	-1
2012	1	-1
2013	.5	-1.5
2014	N/A	-2 and each subsequent yr.

Hardship Exemptions

Eligible Professionals may apply for a hardship exemption from CMS that would exempt them from penalties in 2013 based on 2012 claims.

Physicians have to apply for the exemption from the 2013 penalty by June 30th, 2012.

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