Farrell Fritz, P.C.

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Welcome!

Given the current economic recession, it is not surprising that managed care companies, Medicaid and Medicare are all taking a hard look at healthcare service provider reimbursement costs and procedures. Providers are under increasing pressure to develop and maintain effective compliance programs aimed at eliminating fraud and abuse and detecting billing and payment errors.

The CMS has issued a final rule that makes it more difficult for physicians who order and purchase diagnostic tests from outside suppliers to mark up those fees. In this issue, we highlight these matters, along with important considerations for those engaged in the practice of telemedicine.

As always, please feel free to contact us with your comments, questions and suggestions about topics that are of particular concern or interest to you. We welcome your feedback.

Christopher J. Kutner, Esq.
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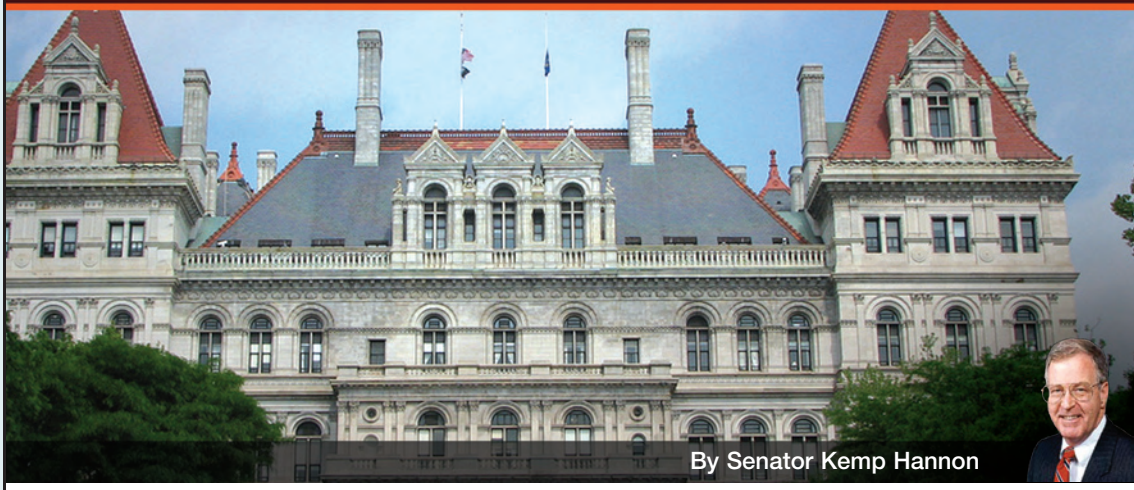
Health Impacts of Recent Federal and New York State Actions



By Senator Kemp Hannon

The financial crisis is generating many budget actions by federal and state governments. As of mid-February, the major elements are beginning to take shape.

New York State Budget Proposals

On the state level, the proposed budget for April 1st was presented as if the federal stimulus package did not exist. Severe monetary cuts to hospitals, nursing homes and home health care were put forward. Now these cuts should be eliminated or substantially mitigated.

Remaining proposals involve the "rebasing" for all sectors. Formula changes for graduate medical education, inpatient reimbursement and charity care loom for hospitals; for nursing homes, an unspecified "rebasing" is proposed to replace the recently enacted rebasing. Home health care is to receive a prospective payment system. Each of the reforms would have the effect of reducing the money New York pays for the system affected.

State Expenditure Reductions

New York has had two "deficit reduction" laws pass recently – one in August 2008 and another in early February 2009. Accompanied by administrative actions, about $2.5 to $3 billion in expenditures were pared or rescinded. The August reduction totaled $450 million to health care, and in February the principal health effect was the hike in the "covered lives" assessment (imposed on the health care insurance premium) and the hike in the assessment to run the Insurance Department (3/4 of which is paid by health insurers). It is always difficult to translate cuts into impact on a facility, but the August action will decrease money to Nassau University Medical Center by $13 million in the first eighteen months of effectiveness.

New Medicaid Funds

Adding money and new programs, whatever its economic impact, is more interesting than cuts. A major cash infusion is increased Medicaid payment to New York (30% of which will go

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Provider Alert

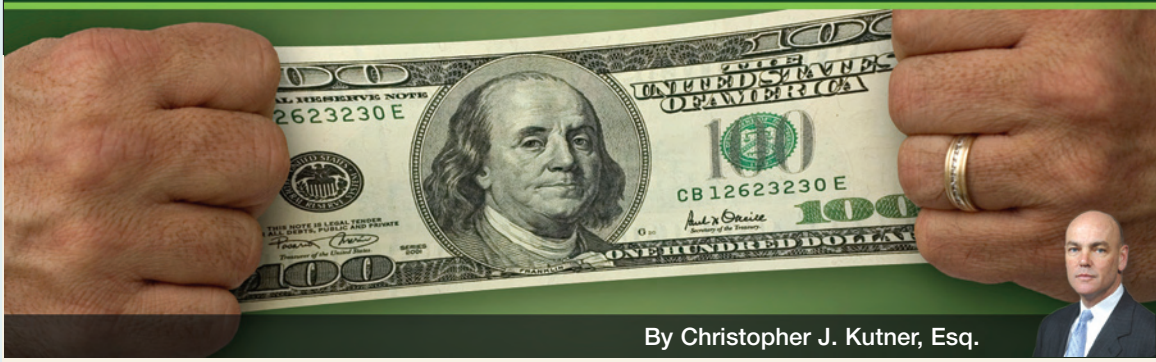
Take Special Pains When Practicing Telemedicine

Are you a medical provider who occasionally treats patients via electronic communication devices, also known as telemedicine or telehealth? The practice of telemedicine poses great potential for improving the speed and quality of healthcare for millions of patients. Telemedicine is defined on www.telemedicine.com as "the ability to provide interactive healthcare utilizing modern technology and telecommunications. Basically, telemedicine allows patients to visit with physicians live over video for immediate care or to capture video/still images; and patient data are stored and sent to physicians for diagnosis and follow-up treatment at a later time."

From a risk management standpoint, providers of telemedicine need to be aware of a number of issues that such treatment poses. For example, a patient chart should be created and maintained to memorialize care rendered. It is crucial to confirm that your medical malpractice insurance covers your telemedicine practice; if it does, are there any geographic or other restrictions? When a medical provider renders treatment from one state to a patient who is located in another state or country, in the event of a claim related to that care, professional liability can be created in one or both jurisdictions. State laws vary. Know whether or not you are required to be admitted or licensed to practice medicine in the patient's jurisdiction. Similarly, does the patient's insurance cover treatment rendered via telemedicine? Are there any restrictions?

The laws governing telemedicine are still being shaped. Stay tuned for developments.

Payors 'Clawing Back' With Retroactive Claims Audits



By Christopher J. Kutner, Esq.

In these difficult economic times, managed care companies are aggressively employing a strategy – retroactive audits of reimbursed claims – to recover some of the money they have paid out.

If you are a healthcare provider, you may already have received a letter from Medicaid, Medicare or a commercial payor with which you participate asking to review your patient charts in connection with medical claims that were submitted and reimbursed. Payors in all these categories are now looking not only to cut costs, but also to recover amounts which they believe have been overpaid or should not have been paid in the first instance. Based upon content in the medical charts or coding errors, payors are increasingly asking for refunds.

When providers receive such letters from their managed care companies, the Medicaid Inspector General of New York or their area's Medicare contractor, they would be wise to consult with an attorney well-versed in the healthcare reimbursement arena before cavalierly submitting the patient charts under the posture, "I provided the services, and I was entitled to the reimbursement." It is assumed that services were provided and thus some reimbursement is warranted, but the question becomes: do the medical charts support the precise reimbursement codes submitted and paid?

We are seeing more activity by government and commercial payors attempting to "claw back" amounts already reimbursed based upon retroactive claims audits. In these audits, the claims previously submitted are compared to the actual patient charts produced by a provider. An audit report is then issued on the appropriateness of reimbursement.

In some cases, the results of the few patient charts actually audited are extrapolated to the entire universe of claims submitted (including charts not reviewed) to infer a conclusion. Providers must now be even more meticulous in documenting all services rendered to ensure that the patient chart justifies the reimbursement codes submitted on the claim form. The rule holds that if the service is not documented in the chart, even if the service was provided, it did not occur and should not have been billed or reimbursed. In those cases, the payors will likely prevail in their efforts to recover the reimbursement made based upon inadequate or deficient recordkeeping or erroneous coding.

It is understood in these times, when reimbursement is decreasing rather than increasing and thus providers must attempt to increase patient volume to maintain a certain revenue, that documenting every service provided is a challenge. There are some very good strategies available for ensuring that patient records are adequately documented so that in the event you receive an audit letter from XYZ Managed Care Company, your records will be consistent with that required for the reimbursement issued. For more ideas on defending claims audits or preparing for them before they happen, do not hesitate to contact one of the partners in the healthcare group at Farrell Fritz, P.C.

Medicare Providers: Are You Meeting Your Compliance Program Requirements?

By Christopher J. Kutner, Esq.

In 2006, when the laws establishing the New York Office of the Medicaid Inspector General ("OMIG") were created, a new Social Services Law Section 363-d was enacted requiring that Medicaid providers develop and implement compliance programs concerning their participation in the Medicaid program. It is believed that providers may be able to detect and correct payment and billing mistakes and fraud if they are required to develop and implement a compliance program. It is also the intent that payment discrepancies and inaccurate billings, among other things, may be detected more efficiently and resolved more expeditiously through the imposition of systemic checks and balances inherent in a compliance program.

Those providers for whom the Medicaid program "constitutes a substantial portion of their business operations" must implement a compliance program. Certain Medicaid providers have no choice and are automatically covered by the law; these include Article 28 and Article 36 entities formulated under New York's Public Health Law, as well as Article 16 and Article 31 entities formulated under New York's Middle Hygiene Law.

Effective January 1, 2007, OMIG became authorized to define applicability of this new law to Medicaid providers in general. OMIG will be adopting regulations that outline the types of providers that will be responsible for adopting and implementing a compliance program.

The compliance program must be designed based upon the size and particular characteristics of the Medicaid provider involved. At a minimum, the program must be applied to billings submitted to, and payments received from, the Medical Assistance Program. The minimum requirements of a program generally follow the requirements established by the U.S. Department of Health and Human Services Office of Inspector General. Providers will be required to adopt a compliance program within 90 days following the effective date of the new regulations currently under development. Providers with existing compliance programs following the OIG's guidance should review that program and ensure that such compliance program meets the minimum requirements of the new regulations by OMIG.

New CMS Anti-Markup Regulations in Effect

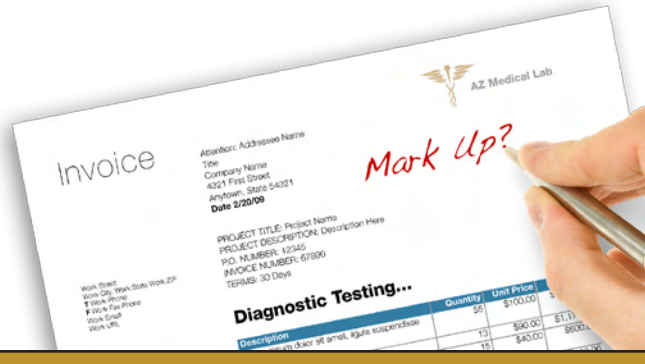
By Michael E. McDermott, Esq.

Physician services rendered as of January 1, 2009 are regulated by the 2009 Physician Fee Schedule Final Rule issued by the Centers for Medicare and Medicaid Services ("CMS"). In the Final Rule, CMS significantly modified regulations relating to the anti-markup policy. Previously, if a physician purchased the technical component ("TC") of a diagnostic test from an outside supplier and billed for that service, the physician's TC charge to Medicare could not be "marked up." The new final anti-markup rule prohibits the markup of both the TC and the professional component ("PC") of diagnostic tests purchased from outside suppliers if the following conditions are not met.

As of January 1, 2009, CMS allows marked-up billing for diagnostic test services when the physician who supervises the TC and/or performs the PC performs "substantially all" (at least 75% for the twelve month period before and after the furnishing of the test) of his or her professional services for the billing physician or other supplier. Alternatively, if this requirement is not met, the services are eligible for marked-up billing if they are performed in the "same building" as the office of the billing physician or supplier.

CMS clarified that the "office of the billing physician or other supplier" does not include diagnostic testing space that is in a building separate from where the ordering physician sees patients. CMS is not willing to include diagnostic testing space in a "centralized building" as satisfying the "same building" requirement. CMS did state the requirement can be met if the diagnostic testing occurs on one floor and the ordering physician sees patients on another floor of the same building. CMS also declined to include mobile vans that use parking lots of the ordering physician's building as falling within the definition of "same building."

In summary, the new anti-markup provisions require physician practices to review how they purchase and bill for the TC and the PC of outside diagnostic tests and to ensure that the arrangements they have with outside suppliers comply with these new requirements.



Provider Alert

Medicare Providers of DMEPOS New Surety Bond Requirement:

If you are a Medicare provider of durable medical equipment/ prosthetics/orthotics supplies, take heed that there is a new requirement imposed by CMS that requires you to post a surety bond in the amount of $50,000. The effective date of that requirement is May 4, 2009 for newly enrolling suppliers; existing suppliers must comply by October 2, 2009. This new requirement is aimed at reducing risk to the Medicare program. It is due, in part, to the alarming fraud and abuse among suppliers of DMEPOS, estimated to be in the range of $1 billion for 2007.

Events Calendar

March 25, 2009

"Compliance with New OMIG NY State Medicaid Regulations" Webinar, Presented by Christopher J. Kutner, Esq. Hosted by Compliance 360

For information and to register, please visit: www.compliance360.com/Mailers/webinar_NYMedicaid_Mar09_Fritz.asp

Legislative Update (Continued from page 1)

to New York City and the counties). Starting on October 1, 2008, funding will be approximately $11 billion over 27 months – $1.9 billion in 2008-09; $5 billion in 2009-10; and $4.2 billion in 2010-11. There's a maintenance of effort (as of 7/1/08) provision as well as a prohibition of the new money going into rainy day accounts.

New Technology Measures

A major impact will be felt from the extensive health information technology provisions. Backed by $19 billion, the new powers, regulatory authority, grants, privacy and security measures extend existing structures in significant, and sure to be impactful, fashion. A "National Coordinator HIT" is being created. The Senate-House Conference Report has an extensive section discussing the details.

Additional Legislative Highlights

- "Smaller" initiatives include: community health centers ($2 billion nationwide); Health-Service Corps ($500 million); NIH ($10 billion); "Comparative Effectiveness Research" ($1.1 billion); Prevention/Wellness Fund, with $300 million to the Centers for Disease Control and Prevention, $50 million to the states for infection reduction, and $650 million for evidence-based prevention and wellness.
- Assistance for those using COBRA survived (60%), although the proposed Medicaid for the unemployed did not.
- Reauthorization of Children's Health Insurance was signed 2/4/09, increasing New York's allotment by $70 million; and eligibility was expanded.
- New acronyms, new programs and new regulations abound. Contact us for specifics (or a dictionary!).

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