Due Diligence Report

In anticipation of purchasing another practice, ABC Eyecare requested a due diligence review to assess the current level of compliance with rules and regulations associated with billing practices and operational issues of the practice to be acquired. This review was conducted by a billing consultant and a health care attorney. The findings reveal a series of issues to address.

1. Coding issues
2. Cataract surgery with FS laser
3. OIG exclusion concerns
4. Credit balances and refunds

Issue 1: Coding Issues

- Consultant found comparative billing report (CBR) revealing that cataract surgeon was “significantly higher” in the category of complex cataract surgeries, 66982.
- Surgeon percentage was 42%; “normal” is listed as 9%
- Claims submitted as 66982 were paid as 66982

Medicare Utilization Data Ophthalmology

- Cataract Sx w/IOL (66984) 1,626,871 claims 90%
- Complex Cataract Sx w/IOL (66982) 174,115 claims 10%

Source: 2014 CMS data – Specialty 18, Ophthalmology
Illustrative Chart Note

CC: Patient states “Difficulty driving farming equipment especially in bright sunlight” Last eye exam was 10 years ago
Exam: 3 ++ NSC / PSC; BCVA 20/200 OU; poor view of fundus due to dense cataracts
Assessment: Visually significant cataracts
Plan: Phaco w/IOL, OS, followed by OD; will need stain for capsule

Illustrative Operative Note

Pre-op Diagnosis: Mature cataract OS
Post-op Diagnosis: Pseudophakia OS

Body: Pre-templated op note for standard cataract surgery, no mention of staining

What did I do wrong?

What do I do now?

Criteria for Cataract Surgery

- Objective evidence of a cataract
- Reduced visual acuity
- Lifestyle complaints
- Good prognosis for improvement
  - Alternate – to aid in treatment of retina
- Patient can tolerate anesthesia
- Patient awareness

Source: AAO Preferred Practice Pattern, Adult Cataract

Medicare Coverage Policy – Example

For CPT code 66982, complex cataract extraction, to be reasonable and necessary, the procedure should require devices or techniques not generally used in routine cataract surgery. Please see examples below: . . .

The operative note indicates dye was used to stain the anterior capsule.

Source: NGS LCD L26853

To Refund or Not To Refund...That Is The Question

What is your obligation?

- ACA provided that knowingly retaining an overpayment creates liability under the False Claims Act
- Final regulations published in February explain that a provider has 60 days to refund under the broad definition of an “identified” overpayment
- Regulation provides that a provider has an obligation to conduct “reasonable diligence” once the provider has credible information of a potential overpayment, and that barring exceptional circumstances, that inquiry should take no more than 6 months
- 60 Day refund clock begins once the overpayment amount has been calculated
To Refund or Not To Refund…That Is The Question

Is this an overpayment?
- Do you know you have been overpaid?
- How much have you been overpaid?

Coding Issues
- Consultant found high number of new patient exams filed by an MD that had merged her private practice one year prior with practice being acquired.
- Billing office manager cites "new tax ID #" as rationale for new patient exam codes

Illustrative Chart Note
CC: Patient presents for itchy, burning eyes, worse in AM. Was treated for DES by Dr. MD 14 mos. ago in old office.
Dx: DES – restart gtts.
CPT code 92002

What did I do wrong?

What do I do now?

New Patient Definition
- “…one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past 3 years.”
- Ophthalmology – specialty 18
  - CMS makes no distinction between subspecialists
- Optometry – specialty 41

Source: CPT E/M Services Guidelines

Illustrative Chart Note
CC: Patient sees retina specialist for flashes and floaters; had been a patient of other MD who merged her practice
Dx: Vitreous detachment OD; educated about RD symptoms
CPT code 99203
MAC Guidance

Q10. Doctor A is new to our group. If a former patient sees Doctor A under our group, is this patient new or established? If the former patient has a visit with Doctor B, in our group with the same specialty as Doctor A, is the patient new or established?

A10. If Doctor A sees his/her former patient, the service is an established patient visit. Doctor A’s NPI shows the provider has seen the patient within the previous three years. If the patient sees Doctor B under the new group with the same specialty without seeing Doctor A first under the new group, then the patient is considered a new patient because the Tax ID is different.

Source: WPS
http://www.wpsmedicare.com/finanz/kb/newscenter/provider_types/2007_0
727_newpatientservices.shtml

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Issue 2: Cataract Surgery with Femto

Review revealed:
- Patient pays a flat fee for non-covered items and services that include charges for the surgeon, ASC, diagnostic tests, IOL, and Femto
- All patients are offered cataract surgery with the FS laser regardless of lens choice
- No financial waivers signed for premium services

What did I do wrong?

What do I do now?

Are there any restrictions on offering the FS laser to patients for medically necessary cataract surgery?

CMS guidance published November 16, 2012

“Medicare coverage and payment for cataract surgery is the same irrespective of whether the surgery is performed using conventional surgical techniques or a bladeless, computer controlled laser.

“If the bladeless, computer controlled laser cataract surgery includes implantation of a PC-IOL or AC-IOL, only charges for those non-covered services specified above may be charged to the beneficiary. These charges could possibly include charges for additional services, such as imaging, necessary to implant a PC-IOL or an AC-IOL but that are not performed when a conventional IOL is implanted.”

Does the patient know what the patient is paying for?

- Concern that patient does not know what amount of the payment goes to which provider for what service
- Each provider should bill independently, or
- The patient should receive a line item receipt reflecting each provider, the services provided by each provider, and the amount paid to each provider
Financial Waivers

- Voluntary ABN Uses
  - Medicare does not require ABNs for statutorily excluded care or for services Medicare never covers. However, in these situations, you may issue an ABN voluntarily.


Medicare Advantage Organizations

- Do not use an ABN
- Notice of denial of coverage issued by MAO (similar to a preauthorization)
- Pre-service organization determination from the MAO
  - Patient requested
  - Provider requested
- Check with MAO plans on process

Medicare Advantage Organizations

Key considerations:
1. May require itemized list of services with CPT codes and ICD-10 codes be submitted in advance
2. May require submission of codes for noncovered services on claim with modifiers GA and GY on same claim with covered services
3. Without denial notification prior to surgery, MAO could require physician to refund patient for noncovered items / services

Issue 3: OIG Exclusion Concerns

- As part of the due diligence for the acquisition, the administrator checks his employees against the OIG exclusion list. He has not done this routinely and is surprised to find that one of his newer technicians is on the list. He shares his findings with the attorney conducting the review.

What did I do wrong?

What do I do now?

[OIG link: http://oig.hhs.gov/](http://oig.hhs.gov/)

EXCLUSIONS DATABASE
Considerations About the List

- Don't think that ignoring it is a better option
  - The penalties are far greater if the OIG finds out from someone else.
- Checking the list is not a one-time obligation
  - Some programs require monthly screening
- If you find that an employee is on the list, the employee must stop providing services to federal program patients
- Don't think you are okay if you ask every employee to certify that they are not on the list.
  - It is still your responsibility to check the list

What is the Penalty for Employing Someone on the List?

- In theory, every claim for a service provided by that person is subject to imposition of a Civil Monetary Penalty (triple damages and penalty of up to $10,000)
- But generally, for those who make a voluntary disclosure, the OIG calculates the penalty by taking the total compensation of the individual (including benefits) during the period of employment (and exclusion), reducing it by the percentage of federal patients in the practice, and doubling that amount.
- But beware under the new 60 Day Rule: failure to make such a disclosure could trigger FCA liability.

Issue 4: Credit balances and refunds

- AR report revealed:
  - 25 pages of credit balances owed to patients ranging from $5 to $100
  - Numerous credit balances resulting from multiple secondary insurances paying on the same claim
  - Credit balances due to returned checks as a result of bad addresses or patient is deceased
  - Administrator shares results of a prior chart review indicating that some of the services were billed and paid in error.

What did I do wrong?

What do I do now?

Does This Qualify as an Overpayment?

- Do you know you have been overpaid?
- If so, do you know how much have you been overpaid?
- If the answer to either of the questions above is no, what is your obligation?

Conclusion

- Take compliance activities seriously
- Remember that rules and regulations are not static
- Stay informed
- Develop a formal compliance program
Thank you

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