Government Targets

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Financial Disclosure

Howard E. Bogard has no financial interest to disclose.

Kirk A. Mack acknowledges a financial interest in the subject matter of this presentation.

OIG 2015 Report

- Questionable Billing for Medicare Ophthalmology Services (http://oig.hhs.gov/oei/reports/oei-04-12-00280.pdf)
- Reviewed 2012 services provided by ophthalmologists
  - Wet AMD – $2.2 billion
  - Cataract - $3.5 billion
  - Modifiers 22, 24, 25
- Nine (9) measures were evaluated

Wet AMD Treatment

1. Lucentis injections more often than 28 days per eye
   - FDA label reflects 28 days per injection
2. Lucentis injections beyond the maximum annual dosing per eye
   - Maximum of 12 to 13 injections per year per eye
3. Laser surgeries with concurrent biologic injections or drug administration
   - Laser surgeries within 28 days of Lucentis injections or drug administration in same eye
Wet AMD Testing

4. High number of fundus photos annually per patient
   - Threshold 2 per patient yearly
5. High number of ophthalmoscopy exams per patient
   - Threshold 5 per eye yearly
6. High number of fluorescein or ICG angiography per patient
   - Threshold 5 per eye yearly

Analysis

- 44,960 providers were evaluated
  - Ophthalmologists, optometrists, ASCs and other
  - 1,726 providers (4%) exceeded at least 1 of 9 measures

<table>
<thead>
<tr>
<th>Number of Measures of Questionable Billing for Which Providers Exceeded Thresholds, 2012</th>
<th>Number of Providers</th>
<th>Percentage of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1,653</td>
<td>95.8%</td>
</tr>
<tr>
<td>2</td>
<td>64</td>
<td>3.7%</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>0.4%</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>&lt;0.1%</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>&lt;0.1%</td>
</tr>
<tr>
<td>6 or more</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,726</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>


Complex Cataract Surgeries & Modifiers

7. High percentage of claims for complex cataract surgery
8. High percentage of claims with modifiers 24 & 25
9. High percentage of claims with modifier 22

Analysis

- 17,270 ophthalmologists were evaluated
  - 1,189 ophthalmologists (7%) exceeded at least 1 of 9 measures

<table>
<thead>
<tr>
<th>Specialty Strata</th>
<th>Number of Measures for Which Providers Exceeded Thresholds of Questionable Billing</th>
<th>Number of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmologists</td>
<td>1</td>
<td>1,120</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>1</td>
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<td>1</td>
</tr>
<tr>
<td></td>
<td>6 or more</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,189</strong></td>
<td></td>
</tr>
</tbody>
</table>
**Wet AMD Treatment Analysis**

- 206 providers provided Lucentis more often than every 28 days
- 6 providers exceeded annual Lucentis dosing
- 41 providers delivered laser surgeries with concurrent drug administration
- $90 million in payments

**Wet AMD Testing Analysis**

- 201 providers performed more than three (3) fundus photographs annually
- 76 providers performed more than five (5) ophthalmoscopy exams annually
- 19 providers performed more than five (5) fluorescein angiograms and/or ICGs annually
- $23 million in payments

**Complex Cataract Surgery & Modifier Analysis**

- 460 providers exceed threshold for complex cataract surgeries
  - Threshold of 36.3% - Range 36.4% - 100%
  - $24 million in payments
- 242 providers exceed threshold for modifiers 24, 25
  - Threshold of 41.9%, - Range 41.9% - 100%
  - $12 million in payments
- 19 providers exceed threshold for modifier 22
  - Threshold 0.8%, Range 0.8% - 4.9%
  - $0.2 million in payments

**Documentation – Intravitreal Injections**

- Operative report
  - Indications
  - Diagnosis
  - Procedure steps – preparation, injection details, post operative
  - Drug information – drug, dosage, units used, units wasted, lot number(s)
  - Physician signature
Documentation – AMD Testing

- Diagnostic testing
  - Monitor frequency and medical necessity
  - Physician’s order (Medical necessity)
  - Date performed
  - Test findings
  - Assessment, diagnosis
  - Impact on treatment, prognosis
  - Physician’s signature

Documentation – Complex Cataract Sx

- Distinguish complex and conventional cataract surgery
  - Complex (66982)
    - Iris hooks
    - Expansion device
    - Sutured haptics
    - Piggyback IOLs
    - Trypan blue, ICG
    - Sphincterotomies
    - Capsular tension ring
  - Conventional (66984)
    - Extra viscoelastic
    - Intracameral meds
    - Premium IOLs
    - Anterior vitrectomy
    - Extra phaco time

- Include indications, techniques, and devices in op report

Documentation – Modifiers

- Modifier 22 – Increased procedural services
  - Use with a code that closely describes what was done, but the actual procedure is much more complex than usual.
  - Your patient presents with an embedded corneal foreign body. Because of the FB’s location and potential for significant pain during the removal, the patient was brought to the ASC for the procedure. The removal required multiple maneuvers over a period of one hour.
  - 65220 - 22

Documentation – Modifiers

- Modifier 24 – Unrelated evaluation and management services by the same physician or other qualified health care professional during a postoperative period.
  - You performed CEIOL OD 3 weeks ago. Today, the patient presents with an infection in the other eye.
  - 92012 -24
Documentation – Modifiers

Modifiers

- Modifier 25 – Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service.
- Your patient returns for 4 week reevaluation of wet AMD OU. You find increased edema OD, improved OS. You perform intravitreal injection with Avastin OD today and F/U exam 1 month.
- 92012 -25

OIG Recommendations to CMS

- Increase monitoring of ophthalmology services
- Increase oversight of questionable Lucentis billing
- Develop thresholds for AMD testing
- Develop thresholds for complex cataract surgery
- Build these measures into fraud-prevention system
- Create national policies to align with these criteria
- Refer names of all providers with questionable billing to CMS. CMS to take appropriate action.
- CMS concurred with all OIG recommendations

Fraud and Abuse – Statistics and Numbers

- Fiscal Year 2015 - $1.9B recovered from Medicare False Claims Act fraud initiatives
- Fiscal Year 2015 - $3.35B recovered from Medicare investigations and audits
- The return on investment over the last three years (2012-2014) is "$7.70 returned for every $1.00 expended.” Third highest on record. HCFAC Press Release, March 19, 2015
- HHS – two-pronged strategy:
  - leveraging new authorities under the ACA to "prevent" health care fraud instead of old "pay and chase" models, and
  - using real-time data analysis instead of subpoena and account analysis (HHS Report, July 14, 2015 – analysis identified or prevented $820M in improper payments over 3 years)
- 4,112 entities and individuals excluded in FY 2015 for matters related to Medicare and Medicaid fraud
OIG Findings – Ophthalmology Services

- For CY 2012, four percent (4%) of providers billed Medicare for ophthalmology services demonstrated at least one of the nine (9) measures of questionable billing.
- 1,726 providers were paid $768M for ophthalmology services, of which $171M was for services associated with questionable billing = 22.2% Error Rate
- Medicare paid $2M for ophthalmology services to 821 providers that were not listed as eye care specialists in the CMS databases.

Federal Government Audit Entities

- CERT – Comprehensive Error Rate Testing Program
- DOJ – Department of Justice
- HEAT – Health Care Fraud Prevention and Enforcement Action Team
- MAC – Medicare Administrative Contractor
- MFCU – Medicaid Fraud Control Unit
- MIC – Medicaid Integrity Contractor
- MIP – Medicaid Integrity Program
- OIG – Office of Inspector General
- OMIG – State Office of Medicaid Inspector General
- RAC – Medicare Recovery Audit Contractors
- ZPIC – Zone Program Integrity Contractor

60 Day Repayment Rule

- Once a provider has "credible information" of an overpayment it must investigate
  - must act with "reasonable diligence" to timely and in good faith investigate
  - must "look back" six years for credible information of overpayment
  - investigation cannot exceed 6 months, absent extraordinary circumstances
- Medicare overpayments must be reported and returned within 60 days of a provider "identifying" the overpayment
  - identified means the overpayment has been "quantified"
- Failure to timely report and return an overpayment can subject a provider to False Claims Act liability
  - $5,500 to $11,000 penalty per false claim

Application of 60 Day Repayment Rule

- September 2010 – Medicaid audit determined that four NY Hospitals mistakenly billed Medicaid
- February 2011 – Hospital's employee (Bob Kane) identified $1M in 900 erroneous claims, sent report to management; Bob fired 4 days later
- February 2011 to March 2013 – Hospital repaid only 300 claims
- Bob filed a qui tam lawsuit and NY State intervened; $24M in damages sought
- Court: An entity has "identified" an overpayment when it "has determined, or should have determined through the exercise of reasonable diligence" that it has an overpayment (emphasis added); no actual knowledge required
Application of 60 Day Repayment Rule

- Pediatric Services of America (Georgia)
  - FCA Settlement for $6.8M (August 3, 2015)
  - One of the allegations was a failure to report and return overpayments regarding credit balances
  - U.S. Attorney for ND Georgia: "Participants in federal health care programs are required to actively investigate whether they have received overpayments and, if so, promptly return the overpayments" (emphasis added)

Steps to Reduce Audit Risks

- Review relevant guidance
  - Medlearn articles
  - MAC & Commercial Payers emails/publications
  - OIG Reports
  - RAC website
- Identify Outliers/Risk Areas
- Develop appropriate policies and procedures
- Train relevant personnel
- Conduct your own billing audits
  - Hire third-party
  - Every 6-12 months
- Understand the False Claims Act

False Claims Act

To "knowingly" present a false or fraudulent claim means that the provider:

1. has actual knowledge that the information on the claim is false;
2. acts in deliberate ignorance of the truth or falsity of the information on the claim; or
3. acts in reckless disregard of the truth or falsity of the information on the claim.

Examples of Potential False Claim Activity

- Incorrect coding
- Double billing
- Billing for services not rendered
- Misrepresentation of services/supplies
- Medically unnecessary services/quality of care
How to Prepare for a Medicare Audit

1. Identify audit contact for your practice
   • Update PECOS if needed
2. Review audit letter
   • Who is the auditor?
   • Is this a first-time audit or a follow-up audit?
   • Is this a medical record request or on-site visit?
   • What information is requested? (medical records, policies, financial, medication lists)
   • What is the time-frame?
   • Look for common factors
3. Consider consulting with a healthcare consultant and/or attorney
4. Gather up all requested information
   • Make sure records are complete
   • Any missing information?
   • Legible?
5. Timely submit information
   • Electronically or by Overnight Mail (need proof of delivery)
   • Always keep exact copy of submitted information
6. If an on-site audit
   • Designate "point-person"
   • Are interviews requested?
   • Designate separate room for auditors
   • Check auditor identification – keep copy or write down information
   • If interviewed, be prepared. Don't guess.
   • Ask questions of auditors to obtain information
   • Keep notes of discussions with auditors

Questions?

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