

# Top 10 Issues Facing Practices in 2010

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1. Medicare and Medicaid EHR Incentive Payments
2. New service line opportunities created by Medicare coverage of cardiac, intensive cardiac and pulmonary rehabilitation
3. Physician supervision requirements for hospital outpatient services
4. Recovery audit contractor audits
5. 2009 Federal False Claims Act Amendments
6. Future of the Stark in-office ancillary services exception
7. Fraud and Abuse Provisions included in Health Care Reform
8. HIPAA privacy and security compliance and enforcement
9. Security breach notification under HITECH Act
10. Heightened interest in physician employment by hospitals

- HITECH Act authorized incentive payments for eligible professionals (including physicians) who demonstrate “meaningful use” of “certified EHR technology”
- Medicare will pay incentive payments to eligible professionals in the form of enhanced reimbursement under the traditional Medicare fee-for-service program, commonly known as Medicare Part B, beginning CY 2011
- State Medicaid programs will make incentive payments to Medicaid eligible professionals beginning CY 2011
- CMS will make incentive payments to certain Medicare Advantage organizations under the Medicare Part C

- Eligible professionals participating in Medicare Part B may receive incentive payments equal to an additional 75% of the Medicare allowable charge under the Medicare Physician Fee Schedule for covered professional services, for up to five years beginning as early as CY 2011
- Annual incentive payments are subject to annual caps which allow for incentive payments totaling \$44,000 per physician over the five-year incentive period
- Medicare Eligible Professionals include doctors of: medicine or osteopathy; dental surgery or dental medicine; podiatric medicine; optometry; or chiropractry
- Regulations provided that hospital-based physicians who provide 90% or more of their services in a hospital inpatient or outpatient setting are not eligible for incentives, but amendment to HITECH Act expected to expand eligibility so that only physicians who practice in an hospital inpatient or emergency department setting are excluded

- State Medicaid programs may receive payments from the federal government known as federal financial participation for 100 percent of their expenditures for EHR incentive payments to Medicaid eligible professionals and eligible hospitals
- Unlike the Medicare incentives, the Medicaid incentive program allows eligible providers to receive an incentive payment even before they have begun to meaningfully use Certified EHR Technology, if they are engaged in efforts to adopt, implement, or upgrade to Certified EHR Technology

- The following types of Medicaid-participating professionals are eligible for Medicaid EHR incentives for a six-year period:
  - physicians
  - dentists
  - certified nurse-midwives
  - nurse practitioners
  - physician assistants practicing in federally qualified health centers (FQHCs) or rural health clinics (RHCs) that are led by a physician assistant

- To qualify for an EHR incentive payment, a Medicaid eligible professional must meet one of the following patient volume thresholds:
  - have a minimum 30 percent patient volume attributable to individuals receiving Medicaid;
  - have a minimum 20 percent patient volume attributable to individuals receiving Medicaid, and be a pediatrician; or
  - practice predominantly in a FQHC or RHC and have a minimum 30 percent patient volume attributable to Medicaid patients and other “Needy Individuals”
- Hospital-based professionals exclusion similar to Medicare

# Medicaid Incentives to Professionals (cont'd)

- Under the Proposed Rule, Medicaid incentive payments to qualified Medicaid eligible professionals are equal to 85 percent of Net Average Allowable Costs (as defined below) for Certified EHR Technology (and support services for the technology), subject to statutory caps of \$21,250 in the first payment year and \$8,500 in the five subsequent years
- The maximum aggregate incentive payment for the six-year period is \$63,750, provided that the first payment year is no later than 2016

- “Average Allowable Costs” is defined as \$54,000 for the first Medicaid incentive payment year and \$20,610 for the five subsequent years based on data from various studies
- To determine “Net Average Allowable Costs,” Average Allowable Costs must be reduced by any payment to the Medicaid eligible professional that is from a source (other than a state or local government) and directly attributable to payment for Certified EHR Technology or support services
- Eligible professionals must elect to receive incentives from either the Medicare or a state Medicaid program, but not both

- The 2010 MPFS implements new Medicare Part B benefits:
  - *Cardiac rehabilitation (CR)* is defined as a physician-supervised program that furnishes physician prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment
  - *Intensive cardiac rehabilitation (ICR) program* means a physician-supervised program that furnishes cardiac rehabilitation and has shown, in peer-reviewed published research, that it improves patients' cardiovascular disease through specific outcome measurements
  - *Pulmonary rehabilitation (PR)* means a physician-supervised program for chronic obstructive pulmonary disease (COPD) and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy

- The CR/ICR benefit is available to patients with certain medical histories, including an acute myocardial infarction within the preceding 12 months, coronary bypass surgery, and stable angina pectoris, among others
- Additional qualifying cardiac histories/conditions to be specified by National Coverage Determination (NCD)
- The programs are covered in the physician office setting provided that there is direct (i.e., in the office suite) supervision
- Prospective ICR sites must apply to enroll as approved ICR program sites
- ICR programs approved by NCD process
- Supervising physician must have expertise in cardiac pathophysiology
- Coverage up to 72 sessions

- The 2010 MPFS implements new Medicare coverage for PR
- PR is a physician-supervised program for COPD and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy
- The benefit initially only covers PR for patients with moderate to severe COPD, though additional indications may be covered by NCD
- PR programs include physician-prescribed exercise, education/training, psychosocial assessment, outcomes assessment and an individual treatment plan
- The benefit is covered in the physician office so long as there is direct supervision by a physician with expertise in respiratory pathophysiology
- Coverage up to 72 sessions

# Medicare Clarifies Physician Supervision in Hospital Outpatient Setting

- The 2010 Medicare Outpatient Prospective System (OPPS) final rule amends and clarifies Medicare requirements for the supervision of outpatient hospital services
- Therapeutic services on the hospital campus or in an off-campus, provider-based department requires direct supervision, i.e., present, as applicable, on the campus or in the off-campus facility
- Diagnostic tests on or off-campus require the same level of supervision as required for the test under the Medicare Physician Fee Schedule

- RACs review claims on a post-payment basis
- RACs use the same Medicare policies as MACs: NCDs, LCDs and CMS Manuals
- Two types of review:
  - Automated (no medical record needed)
  - Complex (medical record required)
- RACs will not be able to review claims paid prior to 10/1/07
- RACs may look back three years from date claim was paid

- Review improper payments found by the RACs:
  - Demonstration findings: [www.cms.hhs.gov/rac](http://www.cms.hhs.gov/rac)
    - Key issues for medical practices include: excessive/multiple units; duplicate claims; incorrect coding of injectibles
  - Permanent RAC findings: will be listed on the RACs' websites
    - CGI is the RAC for Region B (including Illinois)
- Review improper payments found in OIG and CERT reports
  - OIG reports: [www.oig.hhs.gov/reports.html](http://www.oig.hhs.gov/reports.html)
  - CERT reports: [www.cms.hhs.gov/cert](http://www.cms.hhs.gov/cert)
- Nationwide RAC 101 Call for Physicians on 5/12/2010

- Conduct an internal assessment to identify if you are in compliance with Medicare rules
- Learn from past experiences
  - Keep track of denied claims
  - Look for patterns
  - Implement corrective action for patterns of improper payments

- The appeal process for RAC denials is the same as the appeal process for MAC/carrier denials
- Do not confuse the “RAC Discussion Period” with the appeals process
- If you disagree with the RAC determination,
  - Do not stop with sending a discussion letter and
  - File an appeal before the 120<sup>th</sup> day after the Demand letter

- The FCA is a civil statute that permits the U.S. Government to recover monetary damages and penalties from parties who submit false or fraudulent claims for payment to the U.S. Government
- Private whistleblowers (Relators) may bring suits on behalf of the U.S. Government, using private plaintiff's counsel, and receiving a percentage of any award
- Penalties include potential exclusion from Medicare, Medicaid and other federal health care programs, treble damages and penalties of \$5,500 to \$11,000 per claim
- Fraud Enforcement and Recovery Act of 2009 amendments to Federal False Claims Act (FERA), signed into law on May 20, 2009, included significant amendments to the FCA which expanded the scope of liability under the FCA

- Three ways to violate the FCA:
  - Submission of a false or fraudulent claim for payment
  - Submission of a false statement to get a claim paid
  - Avoiding or concealing an obligation to return funds. (i.e., a reverse false claim)
- FERA expands “reverse false claim liability” by specifying that an entity violates the FCA if it “knowingly and improperly avoids or decreases an obligation” to pay money to the U.S., including an obligation based on an “established duty ... arising from ... the retention of any overpayment.”
- Health care reform law provides that overpayments must be returned within 60 days of identification of the overpayment to avoid FCA liability
- Result is that an innocent error can be converted into fraud if provider knowingly fails to return overpayment to government within 60 days

- A physician group is doing a revenue enhancement review and determines that it can charge two CPT codes for a certain service, when before only one CPT code had been used
- The physician group implements the new coding and claims are submitted to Medicare and Medicaid
- It later determines that the second CPT code was bundled into the first code and, therefore, was not separately billable
- The group has an obligation to return the excess payments received as a result of the second CPT code
- Any “knowing and improper” failure to do so is a violation of the FCA’s enhanced reverse false claim liability

- Stark Law prohibits a physician from making a referral for certain Medicare-covered designated health services (DHS) if:
  - A physician (or an immediate family member)
  - Has a “financial relationship” with an entity (including physician’s group practice),
  - The physician may not make a “referral” to that entity
  - Unless an exception applies
- Stark group practice/in-office ancillary services exception excepts group members’ DHS referrals to the group from the self-referral prohibition

# Future of Stark In-Office Ancillary Exception (cont'd)

- The health care reform law, the Patient Protection and Affordable Healthcare Act, amends the Stark in-office exception to require a referring physician to
  - inform a patient in writing, at the time of a referral, that the patient may obtain specified advanced diagnostic imaging services (MRI, CT and PET) or other DHS as designated by HHS from a supplier other than the referring physician, a physician who is a member of the same group practice, or an individual who is supervised by the physician or by another physician in the group
  - Provide the patient a list of suppliers who furnish the imaging services in the area where the patient resides
- Compliance date: January 1, 2010

# Future of Stark In-Office Ancillary Exception (cont'd)

- Medpac, the federal body that advises Congress on Medicare payment issues, is exploring reforms to the in-office ancillary services exception to prevent perceived over-utilization of diagnostic radiology tests, radiation therapy and outpatient rehab services
- Options under consideration include:
  - Exclusion of radiation therapy and outpatient rehab from the exception
  - Exclusion of diagnostic imaging or clinical laboratory tests from the exception unless provided on the same day as other services

# Future of Stark In-Office Ancillary Exception (cont'd)

- Additional Options under consideration include:
  - Exclusion of radiation therapy, outpatient rehab, diagnostic imaging and clinical laboratory tests unless group practice satisfies clinical integration requirements
  - Lower payment rates for physicians who self-refer for imaging and clinical lab tests

# Other Anti-Fraud and Abuse Provisions of Health Care Reform

- HHS required to establish a Stark Law self-disclosure protocol and permitted to settle for less than full Stark Law penalty (i.e., Medicare collections resulting from prohibited referrals)
  - HHS may reduce penalties for Stark violations
- The Law imposes limits on physician-owned hospitals:
  - Physician-owned hospitals that do not have a provider agreement prior to December 31, 2010 will not be able to participate in Medicare
  - Prohibits increases in physician ownership percentages
  - Restricts ability of such hospitals to add ORs, procedure rooms and beds
- Drug, device, biological and medical supply manufacturers must report gifts and other transfers of value made to a physician and/or a teaching hospital

- The HITECH Act made a number of changes to HIPAA statute and regulations, including:
  - Increased penalties for violations of HIPAA regulations by Covered Entities (CEs) and penalties apply to Business Associates (BAs) for the first time
  - New authority to conduct compliance audits
  - New restrictions on use of PHI for marketing
  - BAs required to comply with HIPAA security standards

- **Tiered Penalty System**: Civil penalties increase in tiers depending on whether the violation was committed (1) unknowingly and by exercising reasonable diligence would not have known of violation – min. \$100/violation, (2) due to reasonable cause – min. \$1000/violation, (3) willful neglect and corrected within 30 days – min. \$10K/ violation or (4) willful neglect coupled with a failure to correct within 30 days – min. \$50K/violation
- **Increased Penalties**: Maximum civil penalty has increased from \$25,000 to \$1,500,000 annually for identical violations in each tier
- **Expansion of Liability**: Criminal liability for wrongful disclosure of PHI extends to any individual who, without authorization, obtains or discloses PHI maintained by a CE
- **State Attorneys General**: Authorized to bring civil action in federal district court against individuals who violate HIPAA with HHS having right to intervene
- **Mandatory Compliance Audits**: As of February 17, 2010, HHS will be required to perform periodic audits of CEs and BAs

- The HITECH Act amends the HIPAA privacy standard for “marketing” to prohibit a CE from receiving a direct or indirect payment in exchange for making most communications to encourage an individual to purchase or use a product or service, except (1) for payments for communications that only describe a drug or biologic that is currently being prescribed for the recipient of the communication or (2) with individual’s authorization
- Since “payment” is not defined, it is not clear whether it includes expense reimbursement or items and services provided in kind

## ■ Examples of prohibited marketing:

- Payments by a pharmaceutical company to a pharmacy to send marketing literature regarding products competitive to the drug currently prescribed to the patient
- Payments by a DMEPOS supplier to a physician for sending letters to physician's patients about items of DMEPOS even if the items are medically necessary for the patient

## ■ Examples of permissible marketing:

- Communications about alternative treatments, therapies or providers for which the provider does not receive a payment
- Communications about health-related products or services included in a health plan's plan of benefits and plan receives no payment
- Payments by pharmaceutical companies to pharmacies for drug refill reminders
- Payments by a health plan to a BA to perform disease management activities on behalf of health plan
- Payments by a health care provider to a BA to market the provider's services

- HHS issued an interim final rule on security breach notification pursuant to HITECH effective 9/23/2009
- Rule requires physician groups and other CEs to notify every individual affected by a “Breach” of “Unsecured Protected Health Information” without unreasonable delay and in no case later than 60 days after discovery of Breach
- BA must notify CE of a Breach without unreasonable delay and in no case later than 60 days after discovery of Breach
- Rule contains content requirements for notice

- In the event that the Breach involves PHI from 500 or more individuals from a state or other jurisdiction, the CE must also notify prominent media outlets in the jurisdiction
- The CE must also concurrently notify the Secretary of HHS if the Breach involves 500 or more individuals or within 60 days of the end of the calendar year if Breach involves fewer than 500 individuals

- Unsecured PHI” means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals *through the use of technology or methodology specified by HHS*
- “Breach” means the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule which poses a significant risk of financial, reputational or other harm to the individual, except:
  - PHI which excludes “direct identifiers,” date of birth and zip code
  - Unintentional use by employees or agents of the disclosing CE/BA
  - Inadvertent disclosures to similarly situated individuals within the same facility
  - Unauthorized recipient would not reasonably be able to retain PHI

- In order to determine whether there has been a “significant risk of harm” to an individual, CEs and BAs must undertake a risk assessment
- Risk assessment factors include:
  - Who impermissibly used and/or received PHI?
  - Mitigation steps
  - Was PHI returned prior to being accessed improperly?
  - What was the type and amount of PHI involved? Was it the type of information that alone or in combination with other disclosed data is likely to pose a significant risk of harm?

- According to MGMA, a majority of physician practices are no longer physician owned
- Trend toward physician employment by hospitals and health systems driven by:
  - Changes in reimbursement policy by governmental and nongovernmental payors, including global fees for facility and professional services
  - Employment aligns physician and hospital interests
  - Stark Law exception and Anti-Kickback Statute employment safe harbor are easy to meet relative to other exceptions/safe harbors
  - Cost of adopting EHRs

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