PHYSICIAN'S
COMPLIANCE HOTLINE™
THE PHYSICIAN'S ESSENTIAL ALERT FOR PRACTICE COMPLIANCE
MONDAY
FEBRUARY 1, 1999

Feds, physicians near settlement on E/M regs

American Medical Association to issue final recommendations to HCFA by the end of the month

Months of haggling between HCFA and a host of physician groups over the touchy subject of evaluation and management guidelines may finally be coming to an end. Although the final shape of the new guidelines remains unknown, many physicians remain only guardedly optimistic, especially considering what many perceived as the government's overzealous use of the old guidelines in its controversial PATH initiative.

If you thought only physicians at teaching hospitals were likely to be affected, think again: In its 1999 workplan, the Office of the Inspector General announced that this year it will take a hard look at "whether physicians are correctly coding evaluation and management services in locations other than teaching hospitals."

That means that the government could apply the aggressive tactics it developed in the PATH initiative to your group practice by the end of the year. **(See related story, page 3.)**

According to **Robert Dantuono**, assistant vice president for health care affairs at the Washington, DC-based American Association of Medical Colleges, the new timeline for the development and implementation of HCFA's final evaluation and management guidelines looks like this:

♦ This month, the Chicago-based American Medical Association's (AMA) CPT editorial panel will meet to give final consideration to the recommendations of the various physician specialty

*See **E/M guidelines**, page 3*

Understanding the maze of Stark II regulations

The recent release of advisory opinions by the OIG regarding the Stark II physician self-referral laws have some experts wondering if, finally, the government will get down to codifying a final set of workable regulations. Best estimates, however, are that final regs are still a year away. In the meantime, many group practices continue to struggle to understand how Stark II applies to them. Here are some key areas covered by the regulations that your practice needs to address:

1. Referrals by hospital physicians to

*See **Stark II**, page 4*

OIG again warns physicians in new DME model plan

Physicians take heed: the Office of Inspector General last Thursday released a model compliance plan for durable medical equipment companies that reiterated warnings to physicians it issued in a DME fraud alert two weeks ago.

The model plan covers some of the same ground, hammering home the OIG's demand that suppliers — and the physicians they deal with — must be accountable for appropriately certifying the medical necessity of all prescribed equipment.

Indeed the first two risk areas listed in the guidance are billing for items or services not provided, and billing for medically unnecessary services, which the OIG defines as "seeking reimbursement for a service that is not warranted by the patient's current and documented medical condition."

Certifications of medical necessity (CMNs) are required for fourteen items or services: home oxygen therapy; hospital beds; support surfaces; manual and motorized wheelchairs; continuous positive

*See **DME plan**, page 2*

INSIDE:

DME plan

Continued from page 1

airway pressure devices; lymphedema pumps; osteogenesis stimulators; transcutaneous electrical nerve stimulators; seat lift mechanisms; power operated vehicles; infusion pumps; and parental nutrition and enteral nutrition.

While DME suppliers may fill out parts A and C of the certification, section B may be completed only by the treating physician, a non-physician clinician involved in the care of the patient or a physician employee who "is knowledgeable about the patient's treatment." If a physician employee completes the form, the treating physician or another authorized person must review the form to ensure its accuracy. Section D, the attestation statement, may be signed only by the treating physician or another person authorized to order equipment for the patient. Suppliers who complete section B themselves are subject to minimum civil monetary penalties of $1,000 per case, in addition to other civil or criminal liability.

The guidance warns physicians not to sign CMNs unless sections A through C are completed and correct. And signature and date stamps aren't acceptable.

"Physicians need to take some time before they fill these forms out," says **Sue Raines**, executive director of the Athens-based Georgia Association of Medical Equipment Suppliers. "[Errors] aren't necessarily being made purposely, but they need to make sure that what they're filling out is correct, because they are liable."

With regard to physician orders, the guidance stipulates that DME suppliers must write into their policies a statement that they won't bill for an item or service unless the treating physician or another authorized person orders it in writing. If a supplier receives a verbal order, it must document the verbal order and have the treating physician confirm it in writing prior to billing Medicare.

OIG also recommends that DME suppliers draft policies on what can and can't be included in a cover letter to the treating physician that accompanies a CMN. Specifically, the OIG doesn't want to see any diagnostic information on a cover letter. Such letters should only address issues related to policy changes from HCFA or a DME regional carrier, brief descriptions of the items being provided and changes in the patient's treatment regimen.

DME suppliers also aren't supposed to distribute completed "sample" CMNs to physicians. The guidance recommends that suppliers retain a copy of any cover letter it sends; and physicians might take the same advice.

Like other DME representatives, Raines supports federal efforts to rein in the fraud and abuse that analysts say has been rampant in the industry. She notes, however, that it's becoming more difficult for fraudulent suppliers to prosper, thanks to new licensure laws in some states and the government's new practice of verifying that DME suppliers have a physical location. "Things are tightening up, the way they should have a long time ago," Raines says. "Fraud and abuse have been a black eye on those people who are doing the right thing." ■

Court won't review carrier suit

On January 19, The U.S. Supreme Court refused to hear the case of Kailash C. Pani, MD, who alleged that the improper actions of Medicare carrier Empire Blue Cross and Blue Shield of New York exposed him to civil and criminal liability for fraud.

The U.S. Court of Appeals held that fiscal intermediaries and carriers can't be sued by providers on the basis of how they investigate and report Medicare fraud. Pani accused Empire of negligence and breach of contract. ■

Physician's Compliance Hotline™ is published every two weeks by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Opinions expressed are not necessarily those of this publication. Mention of Products or services does not constitute endorsement. *Physician's Compliance Hotline* is a trademark of American Health Consultants®, a Medical Economics Company.

Editor: **Russell Underwood** (803) 781-5153 (russ.underwood@medec.com)
Executive Editor: **Susan Hasty** (404) 262-5456 (susan.hasty@medec.com)
Publisher: **Brenda L. Mooney** (404) 262-5403 (brenda.mooney@medec.com)

SUBSCRIBER INFORMATION
Please call **(800) 688-2421** to subscribe or if you have fax transmission problems. Outside U.S. and Canada, call **(404) 262-7436**. Our customer service hours are 8:30 a.m.-6:00 p.m. Monday-Thursday, 8:30 a.m.-4:30 p.m. Friday EST.

E/M guidelines

Continued from page 1

societies. Following this, the panel will send its own final recommendations to HCFA.

- In March, HCFA will "edit" the recommendations and formulate a process for pilot testing a draft of the final guidelines. The process should last through June.
- HCFA will probably publish the final guidelines before the end of August, but they won't take effect until the end of the year. The intervening months will be used as an "educational period" for practices to get up to speed on the new regulations.

The biggest point of contention is with regard to the use of quantitative numerical formulas in E/M documentation procedures. "We don't yet know whether or not they'll scale back the numeric counting requirements in a way that we're recommending," Dantuono says. "I don't have a sense of where they're going to go."

Neither does the AMA, which remains concerned by what it characterizes as "HCFA's insistence on retaining some quantitative formulas" - even though in its last official statement on the matter, HCFA did hint that it might consider minimizing the use of such formulas this time around. One thing is clear: The final guidelines are likely to be accompanied by a detailed clarification on standards for sanctions or prosecution for suspected fraud and abuse. The clarification is expected to stress that physicians won't be held accountable for honest mistakes.

"We've made it very clear," says a HCFA spokeswoman. "We want to continue to work with the physician community to develop E/M guidelines that meet all of the interested parties' needs. We need for there to be accountability in the program, and physicians need to help us meet that need. Meanwhile, physicians want guidelines that aren't disruptive to patient care, and we recognize that. We've said that we're committed to taking the time necessary to get this important work done correctly."

While the government and physician groups try to hammer out a workable compromise, physicians are left with the option of adhering to either the 1995 or 1997 version of HCFA's E/M guidelines. Experts warn, however, that physicians who opt to use the simpler 1995 guidelines run the risk of being left behind on the learning curve when it comes time to adopt the update, says **Catherine Fischer**, reimbursement policy advisor for the Marshfield (WI) Clinic. That's important because, this fall, you may only have four months to educate yourself on the new guidelines before they take effect. ■

OIG sets sights on 'visit codes'

This year, auditors from the Office of the Inspector General are expected to begin work on a project to determine "whether physicians are correctly coding evaluation and management services in locations other than teaching hospitals and whether carriers are adequately monitoring physician coding," according to the agency's 1999 work plan. These additional locations include non-teaching hospitals, nursing homes, outpatient clinics, the home setting, and other locations at which physicians might visit patients, says **Judy Holtz**, spokeswoman for the OIG.

According to the work plan, "Previous work by OIG has found that physicians do not accurately or uniformly use visit coding." The audit report, originally scheduled for late 1998, "will build upon this previous work and add more definitive data on the accuracy of physician visits coding." ■

HCFA tightens ambulance medical necessity regs

Less than two weeks after federal fraud investigators spotlighted physician laxity in certifying the medical necessity of home health and DME services, HCFA is imposing more medical necessity regulations, this time with regard to ambulance services. Effective late February, the new regulations require that physicians certify in writing the medical necessity of "nonemergency ambulance transport" of beneficiaries. While the real onus seems to be on ambulance service providers, the regulations may force more physicians to be involved in ambulance transport decisions and better educated as to what types of services qualify as medically necessary.

Medicare only pays for nonemergency ambulance service if "other means of transportation are contraindicated." Service is medically necessary if

the patient is "bed-confined," meaning that he or she can't get up without assistance, can't ambulate, and can't sit in a chair. Also, Medicare won't pay unless the ambulance supplier obtains a physician's written order certifying that the beneficiary must be transported in an ambulance. That order must be less than 60 days old.

Responding to complaints that physicians may not be aware of the coverage requirements for ambulance services, HCFA states that "if the decision to use ambulance services is based on the convenience of the beneficiary, the beneficiary's family, the beneficiary's physician, or some other element of personal preference," Medicare coverage isn't available.

The final rule makes no specific mention of the False Claims Act, though false certifications of medical necessity fall within its purview.

Some ambulance companies and providers also complain that the stricter certification requirements might lead to unnecessary delays. HCFA addresses the concern by allowing that in some cases "the written physician certification can be obtained 48 hours after transportation has been furnished." ■

Stark II

Continued from page 1

hospital-owned home health agencies are forbidden if the physician has any partial ownership. Generally, under the Stark II rules, physicians with an ownership interest in a hospital cannot refer patients to a hospital-based home health agency if they have any financial relationship (through ownership in the hospital or otherwise) with the home health agency, says **Edward Kornreich**, JD, a health care specialist with Proskauer Rose LLP in New York City.

As a result, many physicians and hospitals may need to consider spinning off their home care services operations to avoid possible violations.

2. A group's legal structure is important. A medical group must be organized as a single legal entity. But it may not be an aggregation of individual docs holding themselves out to the public as a group practice, or experts.

3. Physicians who are members of the group must furnish at least 75% of the group's patient care services. These services must be billed under a billing number assigned to the group. For purposes of this rule, HCFA assumes group physicians work a standard 40-hour week.

However, in a departure from Stark I, HCFA claims that patient encounters with physicians who are independent contractors don't count toward the 75% requirement, says Kornreich.

4. Physicians considered members of your group must meet the "full range of services" requirement. According to Stark II, to be a group member, a physician also must furnish the group with "substantially the full range of services which the physician routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment and personnel."

5. Watch how your group's billing number is used. A group can have more than one billing number as long as the additional number has been assigned to the group. A billing agent or management services organization can bill using a number assigned to a group practice, but only under certain conditions. Most notably, a billing agent's compensation agreement "cannot be tied to the amounts billed or collected," he says.

6. You must have a "previously determined" method for distributing group costs and revenue. According to HCFA, "previously determined" means "determined prior to the time period the group has earned the income or incurred the cost." Group practice physician payments may be made based on services personally rendered, but not on referrals. The same applies to any physician incentive payment plans.

7. A practice must distribute its overhead, expenses, and income according to methods that would be used by a unified business. "This means the group must have a centralized decision-making process, pool of expense, and revenues," says Kornreich. "It also means its revenue distribution system cannot be based on each satellite office operating as if it were a separate enterprise."

8. While certain productivity bonuses are acceptable, others are not. Stark's group practice definition provides that members of the group cannot receive compensation based on the volume or value of their own referrals. However, physicians are allowed to receive a share of overall profits of the group or a productivity bonus. ■