



Medi-Data Service, Ltd.

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Illinois Medical Practice Act Changes

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Over the last several years cases have been brought to the legal courts concerning the interpretation of the Illinois Medical Practice Act of 1987 regarding contractual fee structures. The court decisions held that administrators for healthcare providers could not charge participating physicians a percentage of the physicians' medical fees (or provide a division/splitting of the fees) as payment for their administrative services. These decisions raised concerns that various contracts between physicians/practices and billing companies, credit card companies, practice managers, or IPA/PHO organizations might need to be rewritten to replace percentage based compensation.

To avoid these complications while still maintaining the public policy spirit of the law, the state legislature recently made changes to the Medical Practice Act. The changes can be summarized as:

(1). A practice may pay fair market value fees to any person or entity conducting billing, administrative preparations or collection services based upon: (A). a percentage of fees billed or collected, (B). a flat fee, or (C). any other arrangement that directly or indirectly divides these under the following conditions:

(i). a practice controls the amount of the fee charged and collected; and

(ii). all charges collected are paid to the practice, deposited directly into an account under the sole control of the practice or deposited in a trust account by a licensed collection agency.

(2). A practice may grant a security interest in accounts receivable for bona fide advances made to the practice provided a practice must remain in control and responsible for collection of their Accounts Receivable.

(3). The following types of services may NOT be compensated on a percentage or division of fees:

- (i). payments for marketing or management of a practice
- (ii) allowing the practice to participate in a provider network
- (iii) the negotiation of fees or charges on behalf of a practice
- (iv) where the practice is in a program where beneficiaries are encouraged to use the services of the practice

Discounting Dilemmas

Tips on Avoiding Violations of Federal Statutes

By Amy K. Fehn and Andrew B. Wachler

In most industries, professionals do not think twice about extending courtesies to colleagues, referral sources, or needy clients. For healthcare providers, however, these types of seemingly innocent and even generous practices can create civil and criminal liability.

Professional Courtesy

The term “professional courtesy” can have many meanings, but most often refers to the provision of free or discounted services to professional colleagues. Sometimes professional courtesy will also be extended to a colleague’s family member or office staff. Professional courtesy may include waiving the entire cost of services or waiving cost-sharing amounts, such as co-payments or deductibles.

When professional courtesy is extended to a physician or the family of a physician who is or may become a referral source, this conduct can violate the federal anti-kickback statute, which generally prohibits paying or receiving any remuneration for patient referrals payable by the Medicare program or other federal health programs. The anti-kickback statute is intent-based and is implicated if even one purpose of an arrangement is for the purpose of inducing referrals. Violation of the anti-kickback statute is a criminal offense and can lead to imprisonment of up to five years, fines of up to \$25,000, and mandatory exclusion from the Medicare program. Most states have equivalent statutes that extend this prohibition to referrals for services covered by private insurance.

The Office of the Inspector General (OIG) addressed the issue of professional courtesy when it published the *OIG Compliance Program Guidance for Individual and Small Group Physician Practices*. Specifically, the OIG discussed the fact that the extension of professional courtesy would implicate the anti-kickback statute if the beneficiaries were selected in a manner that takes into account the volume or value of past referrals or the ability to generate future referrals.

Triggering the Stark Law

Professional courtesy, when extended to a physician or entity who refers “designated health services” can also implicate the Stark law. The Stark law is a strict liability statute and the penalties for violating the statute can include denial of payment, refund demands, civil monetary penalties, and exclusion from the Medicare program.

The Stark ban on physician self-referral generally makes it unlawful for a physician to refer Medicare or Medicaid patients for radiology tests, clinical laboratory tests, physical or occupational therapy, home health care, or other such “designated health services” to an entity with which the physician has a “financial relationship.” A financial relationship can be an ownership or a compensation arrangement with an entity. A compensation arrangement is defined to include any arrangement involving any remuneration between a physician and an entity, including remuneration that is “in cash or kind.” The provision of free or discounted services to a provider of “designated health services” or the provider’s family would be such prohibited remuneration.

There is, however, an exception to the Stark regulations to allow for certain extensions of professional courtesy. In order to fall within the Stark exception, all of the following elements must be met: (1) the professional

courtesy must be extended to all members of the entity's medical staff in the case of a hospital, or all members of the local community or service area, in the case of a physician practice; (2) the health care items and services are of a type routinely provided by the entity or practice; (3) the professional courtesy policy must be set forth in writing and approved in advance by the entity's governing boards; (4) the professional courtesy must not be extended to Medicare or other federal health program beneficiaries unless there is a showing of financial need; and (5) the arrangement cannot violate the anti-kickback statute or any state law.

Waiver of Co-Payments

Professional courtesy or other practices that involve waiving co-payments or other cost-sharing amounts raise additional concerns. Where the recipients of such waivers are Medicare beneficiaries, the waiver of co-payments and deductibles can be viewed as a violation of the Federal False Claims Act. This is because Medicare regulations require providers to bill Medicare no more than the "actual charge" for the service rendered. When a provider waives the Medicare copayment, he or she is actually providing the service for a lower cost than what is being reported to Medicare. For example, if the actual charge of the service is reported as \$100 and the co-payment is \$20, then waiving the co-payment will result in an actual charge of only \$80. A provider who misrepresents the actual charge as \$100 could be charged with violating the False Claims Act.

Because the Health Insurance Portability and Accountability Act (HIPAA) extends the reach of the Federal False Claims Act to claims submitted to all payors, the practice of waiving co-payments could also result in violations for non-Medicare patients where a private health plan places the same type of "actual charge" limitation on payment. State laws and private insurance contracts may also prohibit waiver of co-payments for private pay patients.

In addition, waiver of co-payments, especially to the extent it is advertised to beneficiaries, potentially violates the prohibition on providing inducements to a patient to generate business payable by a federal health care program and can subject a provider to civil monetary penalties.

Usual and Customary Charges

Providers can be excluded from the Medicare program for submitting claims for services that are "substantially in excess" of the entity's "usual charges." Routinely waiving co-payments and providing other forms of discounts can decrease a provider's "usual charges" to the point where the Medicare fee schedule is

“substantially in excess” of these usual charges. Similarly, many private payors require providers to limit charges to those that are “usual customary and reasonable.” Routine waivers and discounts could impact this value as well.

Financially Needy Patients

The OIG has recognized exceptions to the prohibition on waiving co-payments where patients have demonstrated financial need. In a 2004 letter to hospital providers, the OIG stated that waiver of fees for financially needy patients would not be considered when calculating the providers’ usual charges and would not be considered to be a violation of the anti-kickback statute. Although the guidance was directed specifically to hospital providers, the OIG’s advisory opinions have increasingly been favorable toward the waiver of cost-sharing amounts for patients with demonstrated financial need. Providers who waive patient obligations based on financial need should only do so when the patient has produced documented evidence of financial need.

Compliance

As part of their billing and regulatory compliance plan, providers should have policies in place addressing the waiver of co-payments and the extension of professional courtesy. According to a recent report from the AMA, there have been no reported instances of prosecution by the OIG or the Department of Justice (DOJ) for fraud and abuse related to the extension of professional courtesy. However, providers should not take this as a pass to ignore the law, as violations can also be used against a provider in audits and other investigations to increase the government’s bargaining position.

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E-prescribe Systems

Incentive Program

Alison A. Spooner

Medicare has created incentives for physicians to implement e-prescribe systems.

CMS has reported that it is going to decrease the minimum reporting requirements for providers to earn an e-prescribing bonus in 2010. Going forward for 2010, e-prescribing incentive amounts will be 2% of a providers' total estimated allowed charges for covered professional services during the reporting period (one calendar year). The incentive amount will be reduced to 1 percent in 2011 and 2012 and reduced again to 0.5 percent in 2013. CMS also reports that under current law, you will be penalized beginning in 2011 for failure to e-prescribe. Instead of reporting a percentage, work towards reporting the minimum number of "successful" reporting instances, this will lessen the likelihood that your practice would face a payment penalty beginning that year. It is important to note that in order to qualify for e-prescribing, a minimum of 10% of your allowed charges must come from professional services that are eligible for the e-prescribing process, a minimum which has not changed from 2008.

CMS Electronic Prescribing Incentive Program

Calendar Year	Amount of Incentive	Amount of Penalty
2009	2.0%	-
2010	2.0%	-
2011	1.0%	-
2012	1.0%	-1.0%
2013	.05%	-1.0%
2014	-	-2.0%

Reporting E-prescribing Measure - Denominator codes

To become a "*successful e-prescriber*" and allow your practice to become eligible in receiving an incentive payment, you must meet the requirements of reporting at least 50% of the Medicare Part B (FFS) applicable cases for the reporting year.

Denominator Codes

90801	90808	96150	99204	99215	G0101
90802	90809	96151	99205	99241	G0108
90804	92002	96152	99211	99242	G0109
90805	92004	99201	99212	99243	
90806	92012	99202	99213	99244	
90807	92014	99203	99214	99245	

Reporting E-prescribing Measure - Numerator codes

When reporting an applicable case you should report one of these G-codes (also known as numerator codes) on the claim you're submitting.

- If ALL of the patient's prescriptions have been generated during this visit you would report: G8443
- If NO prescriptions were generated during this visit report: G8445
- If SOME or ALL of the prescriptions generated for for the patient during this visit were phoned in to the pharmacy or printed due to state/federal law or regulations, requested by the patient, or due to other reasons a pharmacy would be unable to receive an electronic transmission; or because the prescriptions were for narcotics or other controlled substances report: G8446

For more information on E-prescribing you may refer to the following sites

- For a Medicare CMS E-Prescribing Incentive Fact Sheet go to:

<http://www.cms.hhs.gov/pqri/downloads/pqriesprescribingfactsheet.pdf>

- Medicare's Practical Guide to the E-prescribing Incentive Program:

<http://cms.hhs.gov/partnerships/downloads/11399.pdf>

- A Clinician's Guide to Electronic Prescribing:

http://www.hrsonline.org/Policy/ICDRegistry/upload/e-Prescribing_Clinicians_Guide_Final.pdf

Swine Flu

Facts about H1N1

Alison A. Spooner

CMS has reported in a previously published "MLN Matters" article that typically, the seasonal influenza virus vaccine is administered once a year in the fall or winter. Additional influenza vaccines (i.e., the number of doses of a vaccine and/or type of influenza vaccine) are covered by Medicare when deemed a medical necessity. The Influenza A (H1N1) virus has been identified as an additional type of influenza. The H1N1 virus vaccine will be provided to Medicare beneficiaries as an additional preventative immunization service. Medicare will only pay for the administration of the H1N1 vaccine.

HCPCS codes for H1N1 - effective for dates of service on or after September 1st, 2009.

G9141 - Influenza A (H1N1) immunization administration, (includes the physician counseling the patient/family).

G9142 - Influenza A (H1N1) vaccine, any route of administration.

Payment for G9141 (Influenza A H1N1) immunization administration, will be paid at the same rate established for G0008 (Administration of influenza virus vaccine). H1N1 administration claims will be processed using the diagnosis V04.81 (influenza), and, depending on the provider type, using revenue code 771.

Since the H1N1 vaccine will be made available at no cost to providers, Medicare will not reimburse providers for the vaccine. Providers do not need to place the G9142 (H1N1 vaccine code) on the claim.

Payments will not be made to providers for office visits when the only purpose of the visit is to administer either the seasonal and/or the H1N1 vaccine(s).

Finally, Medicare will pay for seasonal flu vaccinations even if the vaccinations are rendered earlier in the year than normal. It is understood that such preparations are critical for the upcoming flu season, especially in planning for influenza A (H1N1) vaccine.

Medicare Reimbursement Rates for Vaccines

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for seasonal flu vaccines and their administration. However, some reimbursement rates have changed and those are listed for you below.

CPT	Description	Reimbursement	Effective Date
90658	Flu Vaccine	\$11.36	09/01/09
G0008	Flu Admin.	\$22.57	09/01/09
G9142	H1N1 Vaccin	N/A	09/01/09
G9141	H1N1 Admin.	\$22.57	09/01/09
90732	Pneumo Vaccine	\$37.60	10/01/09
	Pneumo Admin.	\$22.57	10/01/09
90746	Hepatitis B Vaccine	\$59.70	10/01/09
G0010	Hepatitis B Admin.	\$22.57	10/01/09