BKD Health Care NEWS

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CMS publishes FY 2007 hospital inpatient PPS final rule

by Tim Wolters, twolters@bkd.com

CMS published its fiscal year (FY) 2007 inpatient PPS final rule in the August 18, 2006, **Federal Register**. The rule omitted the numerous tables that show wage index and related data for hospitals and all geographic areas of the country, which CMS finally published in the October 11, 2006, **Federal Register**. They are also posted on CMS's web site: **http://www.cms.hhs.gov/AcuteInpatientPPS/**.

The delay in publishing these tables was caused by the ongoing analysis that CMS conducted to finalize a 100% occupational mix adjustment for FY 2007. The standardized payment amounts published in the August 18 final rule were updated slightly in the October 11 notice but still reflect a 3.4% overall market basket update.

DRG weights restructured

Historically, CMS updates DRG weights each year based on the relative average charges for each DRG: the higher the average charge, the higher the DRG weight. CMS proposed the restructure of DRG weights based on hospital costs rather than charges.

The theory behind this change is that, over the years, charges have become less relevant as a measure of hospital resources as evidenced by wide variations in the relationship between costs and charges in different areas of a hospital. Hospitals tend to have higher markups in ancillary areas than in inpatient nursing units.

Because of the numerous comments it received, CMS revised the April proposed rule, but it still intends to begin using costs as a means to update DRG weights each year. The revisions CMS made to the proposed rule did reduce some of the largest affects of the restructuring. However, as there are still some fairly significant changes to DRG weights, CMS will phase in the new process over two years, with full implementation in FY 2009.

In FY 2007, one-third of each DRG weight will be computed based on costs, and two-thirds will be computed based on charges. With the restructuring of DRGs based on costs rather than charges, DRG weights tend to increase in medical DRGs (or those with a

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How OIG's 2007 Work Plan will affect your practice

by Marla Dumm, mdumm@bkd.com

An effective team approach to monitoring compliance within your medical practice should include a review of OIG's **FY 2007 Work Plan** because it contains focus areas for physician coding and billing.

Before each federal fiscal year begins, OIG issues its **Work Plan**, which outlines upcoming audit or investigative focus areas for various provider communities, including:

- Hospitals
- Physicians
- Home health and hospice
- Nursing homes and long-term care
- Mental health
- Medical equipment and supplies

Of primary interest to medical practices

The 17 items the **FY 2007 Work Plan** outlines for "Medicare Physicians and Other Health Professionals" will be of primary interest to your medical practice:

- Billing service companies
- Physician pathology services
- Cardiography and echocardiography
- Payments for the Medicare initial preventive physical examination
- Part B mental health services (provided in physician offices)
- Wound care
- Incident-to services

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Congress mandates compliance policies for providers

by Larry Fogel, lfogel@bkd.com

Regulators have traditionally allowed health care providers to voluntarily establish compliance programs; however, certain health care providers must now meet specific, newly legislated compliance requirements.

Congress recently enacted Section 6032 of the *Deficit Reduction Act of 2005* (DRA), which requires health care providers receiving at least $5 million in Medicaid reimbursement to establish detailed compliance policies for their employees, contractors and agents, *i.e.*, covered persons.

With the January 1, 2007, effective compliance deadline right around the corner, take a moment to review the requirements and how to meet them.

What Section 6032 requires

Section 6032 requirements for affected health care providers include:

- Written policies for all covered persons that provide detailed information about the *Federal False Claims Act*, state laws applicable to federal and civil false claims violations and whistleblower protection under such laws
- Detailed provisions in the provider's policies and procedures for detecting and preventing fraud and abuse
- Language in the employee handbook that addresses the foregoing laws, whistleblower protection and procedures to detect and prevent fraud and abuse

Understanding the laws: where to begin

For many providers, a good starting point is to review pertinent federal and state fraud-and-abuse laws to understand what constitutes a violation and what penalties apply.

Next, determine if your existing compliance policies and procedures contain the required verbiage by reviewing them and other compliance plans and standards of conduct.

If they fall short, revise the applicable compliance policies and procedures to comply with Section 6032, an assignment best suited to your compliance committee. If you need to create or revise your compliance policies, follow the standard protocols for submitting the revisions to the appropriate internal committees.

Though Section 6032 does not require it, we recommend you train personnel in the following:

- Applicable fraud and abuse laws
- The rights of whistleblowers to report potential violations of these laws
- Provider policies and procedures for detecting and preventing fraud and abuse

Noncompliance may be costly for providers

Providers who fail to comply with Section 6032 are subject to forfeiting their Medicaid reimbursement and could even face potential false-claims penalties. Therefore, it's imperative for providers meeting the monetary threshold to diligently comply with the requirements of Section 6032.

There are at least two unanswered questions related to the monetary threshold. The first is how the Medicaid reimbursement will be computed. For example, will it be computed based on the gross Medicaid payments, and if so, will it include or exclude special payments received under a state's provider tax program?

The second question is whether Medicaid reimbursement will be aggregated for all providers owned by a single entity. For example, will hospital and long-term care (LTC) providers owned by the same legal entity be required to aggregate their Medicaid payments? Resolve these questions as soon as possible if you are close to meeting the monetary threshold.

Section 6032 intends to foster awareness

Congress clearly believes all covered persons must be educated in the provisions of all applicable federal and state fraud and abuse laws for the following reasons:

- To recognize what constitutes a violation of the law
- To understand they can report alleged violations
- To know their rights are protected as whistleblowers

In other words, the government intends to foster greater knowledge and awareness of fraud and abuse laws to enable covered persons to report potential compliance violations that would otherwise be undetected or unreported. As a result, providers should expect more whistleblower lawsuits to potentially emerge from Section 6032 of DRA.

* * *

Closely examine your compliance programs to determine if they are adequate to detect and prevent fraud and abuse violations. Contact your BKD Health Care Group advisor for more information about Section 6032 and for help evaluating your compliance programs. ■

SNF PPS & RUG 53: how are we doing?

by Eric Doerhoff, edoerhoff@bkd.com

The question SNFs should ask themselves is "How are we doing under RUG 53, and how do we measure our success?"

Since its implementation January 1, 2006, BKD Health Care Group advisors have monitored the progress of our SNF clients under the new RUG 53 payment system. Our benchmarks will not apply equally to all, but they will help providers compare their progress under RUG 53. We analyzed approximately seven months of RUG 53 data from 72 SNFs located in multiple states. Our findings follow.

Using the nine new RUGs

For the SNFs in our data study, we analyzed the percentage of total Medicare Part A days that fell into one of the nine new payment categories, which combine rehabilitation with extensive services. We expected to find approximately 50% to 60% of a SNF's total Medicare days to be in these "Combined RUGs."

Surprisingly, just one SNF in our study achieved this benchmark. In addition, more than 14% did not report any Medicare days in the new Combined RUG categories, and more than 75% reported less than 30% utilization of the Combined RUGs.

We estimate 30% as the least amount of utilization necessary for most SNFs to maintain previous-year revenue levels, so, assuming a consistent Medicare census, it is likely these SNFs will experience a potential decrease in annual Medicare revenue from 2005 to 2006.

ADL scoring

Under SNF PPS, the ADL score is another important factor in determining a patient's RUG category. Patients must have an ADL score of 7 or more to qualify in any of the new Combined RUGs. In our sample, more than 18% of the patients would not be eligible for a Combined RUG simply because their ADL score was low, even though they may have had both clinical and rehabilitative qualifiers.

A single ADL point can make a significant difference (up to $100 per patient day) in a SNF's payment, so it's vitally important to verify ADL scoring is accurate and indicative of the actual assistance provided.

RMX & RML RUG categories

A RUG 53 system peculiarity is patients do not always fall into the anticipated RUG group. There are two different classification systems for placing patients into a specific RUG category: hierarchical and index maximizing.

The previous RUG 44 system used the hierarchical classification method, which assigned the first RUG category a patient qualified for by starting at the top of the RUG-III model and working down. The new RUG 53 system uses the index-maximizing approach.

Under the new system, a designated case-mix index (CMI)—or ranking—is assigned to each RUG category. A higher CMI assumes more resources are required to care for a patient, and a higher payment results. Index maximizing determines every RUG category a patient may qualify for, then selects the one with the highest CMI and payment rate.

For example, the CMI is 42 for RHX and 41 for RHL; however, CMIs for RMX and RML are 47 and 44, respectively. Therefore, even though a patient may have received enough minutes of therapy services to qualify for rehab high (RH) rather than rehab medium (RM), under the new index-maximizing RUG 53 system, RHX and RHL cannot be achieved because RMX and RML have higher CMIs and higher payment rates.

Though this has caused confusion among some providers, index maximizing actually results in higher reimbursement, so it is important for SNF staff to understand how this change affects SNF PPS under RUG 53.

We recommend facilities track utilization of the RMX and RML categories because, based on our benchmarking, we believe approximately 35% of a SNF's total Medicare days should qualify in these two Combined RUG categories. Still, our study group indicated less than 25% of the patients included in the analysis fell into the RMX and RML categories.

Summary: combined RUG use

We believe many SNFs still underutilize the Combined RUGs and, in turn, may leave significant Medicare Part A revenue on the table. Proper Medicare management followed by proper use of the Combined RUGs are vital for adequate and appropriate reimbursement.

As part of our analysis, we compared the participating SNFs' actual average daily reimbursement from Medicare to the daily reimbursement that could be expected if the benchmarks discussed above were achieved.

On average, we found the SNFs in our study were paid $18.61 per patient per day below what they should have received by meeting the benchmarks. For a SNF with an average daily Medicare census of 10 patients, that equates to an increase of approximately $68,000 in annual revenue. This would go directly to the SNF's bottom line, as there is no associated increase in costs.

Contact your BKD Health Care Group advisor for more information about the nine new categories and how to improve your reimbursement under RUG 53. ■

Glossary

ADL – activities of daily living

APC – ambulatory payment classification

ASC – ambulatory surgical center

CMS – Centers for Medicare & Medicaid Services

CY – current year

DRA – *Deficit Reduction Act of 2005*

DRG – diagnostic-related group

E/M – evaluation and management

FI – fiscal intermediary

HCPCS – healthcare common procedure coding system

HIPAA – *Health Insurance Portability and Accountability Act of 2002*

IT – information technology

OIG – Office of Inspector General

OPPS – outpatient prospective payment system

PFS – patient financial services

PPS – prospective payment system

RUG – resource utilization group

SNF – skilled nursing facility

CMS action on ED & HB clinic coding

by Tom Watson, twatson@bkd.com

Buried among the usual payment updates included in the 2007 Outpatient Prospective Payment System (OPPS) proposed rule were coding changes that would have affected every hospital emergency department (ED) and hospital-based (HB) clinic.

Since 2002, CMS has expressed concern over the current procedural terminology (CPT) codes hospitals currently use to bill for ED and HB clinic services. Because they were designed to measure the level of physician inputs, the codes do not necessarily measure those of hospital inputs. Therefore, CMS allowed hospitals to develop their own internal mapping methodologies for assigning patients in these areas to the various, applicable CPT codes.

CMS initially proposed to no longer use CPT for coding ED or HB clinic visits. Instead, it would have required 15 new "G codes" be used to bill the services of dedicated emergency departments (DEDs) and HB clinics. The codes would be split as follows:

- Five new G codes for HB clinics
- Five new G codes for Type A EDs
- Five new G codes for Type B EDs

In addition, CMS proposed one new G code for critical care services.

Type A vs. Type B ED

CMS has defined a Type A ED as one that is open 24 hours a day, seven days a week (24/7) and meets the definition of a DED under the *Emergency Medical Treatment and Active Labor Act of 1986* (EMTALA). A Type B ED is a department that also meets the EMTALA screening requirements but is not open 24/7. For many providers, this may encompass an urgent care or minor-emergency center not part of the main hospital campus.

Under EMTALA rules, a DED must meet one of the following criteria:

- Is licensed by the state or other applicable entity as an ER or ED
- Is promoted to the public as a location that provides urgent care for emergency medical conditions, no appointment needed
- At least one-third of all patient visits during the previous calendar year were for the treatment of urgent emergency conditions and were not previously scheduled

CMS final rule differs from initial proposal

CMS received numerous comments from providers concerned that hospitals would not have sufficient time to properly implement

In Brief

CMS issues final 2007 outpatient PPS (OPPS) rule - CMS placed its final OPPS rule on display November 1, 2006. Effective January 1, 2007, outpatient payments are scheduled to increase by 3.4%. Starting in 2009, CMS will tie payment increases to the reporting of quality measures, with a 2% reduction in the update factor for hospitals not reporting required quality measures.

CMS will continue the 7.1% add-on to the normal wage-adjusted OPPS rates for rural sole community hospitals, while other rural hospitals with 100 or fewer beds remain eligible for hold harmless payments through December 31, 2008, reduced by 10% in 2007 and 15% in 2008.

CMS is also implementing the DRA cap on ASC payment rates, with Addendum AA to the rule listing approximately 280 procedures where payment rates will be limited to the comparable OPPS payment rates. Finally, CMS notes that it intends to propose a new ASC payment methodology in the spring of 2007, for implementation in 2008.

2007 physician fee schedule reflects 5% payment reduction - CMS is tentatively finalizing plans to reduce the physician fee schedule by 5% compared to 2006 rates. Similar reductions have been proposed each year for several years, and Congress has generally intervened to prevent the reductions. It is uncertain whether Congress will act to prevent the 5% reduction from taking place in 2007.

The fee schedule final rule also implements the DRA cap on diagnostic services, limiting payment rates to the comparable OPPS payment rates. CMS estimates the cap results in a 5% negative impact on the radiology specialty, as well as a negative impact of 11% on diagnostic testing facilities. The final rule also implements a 4.3% increase in the ambulance fee schedule for 2007.

2007 home health rates finalized - CMS put final 2007 home health rates on display November 2, 2006. They generally provide for a 3.3% inflation factor, a 5% add-on for rural home health services and a 2% reduction in the payment update for providers not reporting certain quality data.

CMS proposes sprinkler system requirements - In the October 27, 2006, **Federal Register**, CMS proposes requiring all LTC facilities to install automatic sprinkler systems. While sprinkler systems are installed throughout most facilities, at least in renovated areas, CMS estimates around 2,500 facilities nationwide lack sprinkler systems that cover the entire facility.

CMS proposes the system be installed in accordance with standards last updated in 1999 and maintained in accordance with standards last updated in 1998. CMS seeks comments on a proposed phase-in period, with a range of 5 to 10 years mentioned in the proposed rule. Comments must be submitted by December 26, 2006. ■

changes

the proposed "G" codes. As a result, CMS elected to continue using CPT for billing HB clinic and Type A emergency services.

However, CMS will require Type B EDs to use G codes starting in 2007. CMS believes this is necessary because CPT does not include a class of provider that meets the definition of an ED, except for the fact it is not open 24 hours a day.

CMS also elected to delay implementation of required G codes for critical care services, so hospitals will continue to bill using CPT codes 99291 and 99292. CMS did create one new G code: G0390, which will be billed when a trauma response team is activated to assist with a critical care service.

National coding guidelines

CMS studied the proposed coding methodology developed by the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA).

In the final rule, CMS elected not to adopt the AHA/AHIMA proposals but did invite public comment on how national coding guidelines could be implemented. Until such time as national guidelines are developed, hospitals should continue to use their internal mapping methodologies.

Providers should make sure their billing systems are changed to accommodate the new G codes for Type B EDs. In addition, they should watch for further guidance from CMS about converting to G codes for HB clinics and Type A EDs, as well as changing requirements for grouping patients into the various payment levels for both clinic and ED services.

For more information on this or other changes in the OPPS 2007 final rule, contact your BKD Health Care Group advisor. ■

Infusion services: OPPS changes accepted for 2007

by Trisha Priest, ppriest@bkd.com

CMS will implement several changes in 2007, making it yet another challenging year of trying to capture drug infusion and administration charges and be paid appropriately.

In implementing these changes, hospitals are urged to reinforce clinical and coding staff training.

Coding structure revised

In FY 2006, the CPT Editorial Panel revised its coding structure for drug administration services, incorporating new concepts of initial, sequential and concurrent services.

The previous structure distinguished services based on the administration type, as well as on the first hour (and additional hours) for infusion services.

CMS has been concerned about the interface between the complex claims processing logic required for correct payments and the challenge hospitals face in coding claims correctly so accurate payments for these services are received. Initially, CMS chose not to implement the full set of CY 2006 CPT codes because of this concern.

However, in considering public comment and the APC Panel's recommendations, CMS decided in the final rule released November 1, 2006, to adopt the full set of CPT codes for CY 2007.

Therefore, all "C" codes used for CY 2006 (with the exception of C8957) will no longer be reportable after December 31, 2006 (final rule, table 31). Refer to tables 32 and 33 in the final rule for a full list of CY 2007 CPT codes and descriptors to be used for drug administration services.

CMS will assign six APC payment levels for 2007 to account for more complex and lengthy drug administration services.

APC payment levels assigned

CMS will assign six APC payment levels for 2007 to account for more complex and lengthy drug administration services. The levels will also allow for a payment for the initial hour of infusion, plus a separate payment for additional hours.

For example, CPT code 96413 (for chemotherapy infusions up to one hour) will be paid a first-hour rate; CPT code 96415 (for each additional hour of infusion) will be paid a rate for each additional hour.

Compared to CY 2006's per-day payment, the rate for the first hour of infusion is reduced in 2007 to "unpackage" and provide for payment for each hour.

For data-gathering purposes, CMS continues to encourage hospitals to report all services whether packaged into a service or not.

Increases, decreases—what's the bottom line?

There will definitely be payment rate differences in 2007. The infusion codes have been simplified to assist hospitals in possibly matching other payers' coding requirements.

Train your staff and revise charge tickets based on the final rule changes. Continue to maintain internal/external audits to validate accurate charge capture processes.

In addition, take your top HCPCS codes by volume and determine your own increases and decreases and focus on your charge capture for infusion services for 2007. ■

Writers' Bureau

Article: MDS: Are You Leaving Money on the Table?

Author: Cindy MacQuarrie

Publication: **Nursing Homes**

Date: September 2006

CMS publishes FY 2007 hospital inpatient

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heavy nursing component) and decrease in surgical DRGs (or those with a heavy ancillary component).

CMS also proposed a possible expansion of the DRG list from the current 526 DRGs to 861 consolidated, severity-adjusted DRGs. Because this change would have had a significant impact on hospital coding systems and finances, CMS had proposed to wait until FY 2008 to implement it.

In the final rule, CMS notes it may still implement a more significant expansion of the DRG system in FY 2008. However, it has implemented modest changes for FY 2007, which resulted in 20 new DRGs, eliminated eight existing DRGs and changed 32 existing DRGs.

Because of the way CMS modified its process of computing the DRG weights in the final rule, it does not expect the financial impact to be nearly as significant as originally proposed.

Nevertheless, hospitals should still review these DRG changes closely and prepare their medical staff and coding personnel and systems to implement them so proper reimbursement is received.

CMS expects the restructure to change hospital payments by less than 0.5% for any class of hospital except cardiac specialty hospitals, which are expected to see a 2.0% reduction in payments.

Because the impact varies by individual DRG and by hospital, we downloaded data from CMS's web site and created an Excel file you may find helpful: **http://www.bkd.com/docs/alerts/81806finalruleimpact.xls**.

The first tab compares (by provider) the transfer-adjusted case-mix index based on current FY 2006 DRG weights to the FY 2007 DRG weights.

The second tab compares current DRG weights effective through September 30, 2006, to the final DRG weights effective October 1, 2006.

Note: CMS used historical data to compute the impact in the first tab. To compute a more current estimated impact, hospitals should use current DRG volumes with the changes in DRG weights shown in the second tab.

Wage index, occupational mix

In compliance with a recent court order, CMS is applying a 100% occupational mix adjustment to the area wage index effective October 1, 2006.

Compared to unadjusted wage data, CMS notes 70% of rural areas and 47% of urban areas experienced an increase in their wage index as a result of the occupational mix adjustment.

To be effective October 1, 2007, hospitals had to file incomplete geographic reclassification requests with the Medicare Geographic Classification Review Board by September 1, 2006. They also were required to complete their requests by October 30, 2006, using the final wage data published October 11.

CMS made its best guess of the available geographic classification each hospital would want to maintain for FY 2007. Hospitals that disagreed with its classification decisions were required to notify CMS by October 30, 2006.

In addition, for the FY 2008 wage index development, hospitals are reminded they have until December 4, 2006, to request corrections to either the 2006 occupational mix survey data or the wage index survey from the cost reporting period beginning on or after October 1, 2003.

Changes for MDHs & SCHs

CMS finalized regulations to implement changes from the *Deficit Reduction Act of 2005* (DRA), primarily for Medicare-dependent hospitals (MDHs), and proposed various other payment policy changes.

Effective October 1, 2006, MDH regulations will:

- Extend the MDH classification for five years, through September 30, 2011
- Provide an option to use a hospital's FY 2002 cost report as a base period for computing the MDH hospital-specific rate adjustment
- Increase the amount of the hospital-specific rate adjustment to 75% of the amount by which the hospital-specific rate exceeds federal payments
- Remove the 12% cap on disproportionate share payments otherwise applicable to most rural hospitals with fewer than 500 beds that are not rural referral centers

CMS corrected the proposed regulations concerning the 2002 base period by clarifying it would be based on the cost reporting period beginning on or after October 1, 2001, and before October 1, 2002.

In compliance with a recent court order, CMS is applying a 100% occupational mix adjustment to the area wage index effective October 1, 2006.

CMS also modified the staffing data used to evaluate hospital staffing for sole community hospitals (SCHs) or MDHs requesting special payment adjustments because of decreases of 5% or more in inpatient volume.

Previously, hospitals were required to use the American Hospital Association (AHA) Monitrend staffing information, which has not been updated for many years.

Beginning with requests related to volume decreases in 2007 compared to 2006, CMS will no longer allow Monitrend staffing data to be used. Hospitals will be allowed the option of using staffing data from the occupational mix survey or the AHA annual survey.

CMS also amended the MDH and SCH regulations to require such hospitals to notify their fiscal intermediary (FI) within 30 days of any change in circumstances that would affect their MDH or SCH classification.

For example, an SCH would be required to notify its FI in the event of the following:

- A new hospital opens in its service area
- A new road opens between it and the nearest like hospital within 35 miles
- Its geographic classification is changed from rural to urban
- It increases its bed capacity to more than 50 (provided it qualifies under the special market share test for hospitals with 50 or fewer beds)
- Changes in the area's driving conditions result in a decrease in the amount of travel time between the SCH and a like hospital (provided it qualifies under the special travel time test)

PPS final rule. . .

An MDH would be required to notify its FI if it loses its rural status or increases its available beds to more than 100.

Beyond the specific examples listed above, an SCH or MDH must notify its FI if it is aware of any other change that would affect its classification. If a classification is required, it would be effective 30 days after such a determination is made by the CMS regional office.

If the hospital does not send in notification but CMS otherwise becomes aware of the change in circumstances, the change in classification would become effective on the date the hospital knew it no longer met the criteria for its classification.

CMS states that, in this situation, the change in classification would apply retroactively to any cost reporting periods within the three-year reopening period, *i.e.*, three years from the settlement date. For some SCHs and MDHs, this could result in a very large repayment if the status is lost.

Other final rule changes

CMS has expanded the quality reporting provisions as authorized by the DRA. Hospitals will be required to submit data on all 21 hospital quality measures endorsed by the Hospital Quality Alliance and National Quality Forum.

Hospitals should report third-quarter 2006 data by February 15, 2007. Hospitals not reporting quality data will be subject to a 2% reduction in their DRG payments, effective October 1, 2006.

CMS also finalized what it terms as a clarification of its medical education reimbursement regulations. CMS only counts time spent on patient care activities for indirect medical education (IME) reimbursement in the hospital complex. Likewise, in nonhospital sites, CMS only counts time spent on patient care activities for direct graduate medical education and IME purposes.

Among other issues, CMS is increasing the outlier fixed-loss cost threshold from $23,600 to $24,485 or 3.8%.

The final rule also includes revised criteria for hospitals seeking rural referral center classification, changes in capital payments, changes in the long-term care hospital PPS, *Emergency Medical Treatment and Active Labor Act of 1986* (EMTALA) requirements, grandfathering of hospitals-within-hospitals, SNF bad-debt reimbursement changes, etc.

Contact your BKD Health Care Group advisor for more information on how the final rule will affect your operations. ■

How OIG's 2007 Work Plan will affect your practice. . .

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- Reporting of eye surgeries
- Correct reporting of "site of service" of physician services
- E/M services reported during the global surgery period
- Inpatient psychiatric services
- Medicare reimbursement for polysomnography, *i.e.*, sleep studies
- Payment for Part B services ordered or billed for home health and/or skilled nursing facility beneficiaries that "normally require a face-to-face encounter" but involve beneficiaries who live "a significant distance from the physician's office," *i.e.*, long distance claims
- Medicare benefit assignment rule violations
- Advanced imaging provided in physician offices

Focus areas that directly affect occupational and physical therapy services include:

- Lack of medical necessity for occupational and physical therapy services
- Duplicate physical therapy claims
- Wound care

Medicaid's areas of interest

OIG's focus on the federal Medicaid program includes similar areas of interest, such as reimbursement for occupational and physical therapy services. It will also add items that may affect physician groups, including reimbursement of services provided in school clinics and "improper or ineligible" reimbursement for services provided by physician assistants (PAs).

Review your state's regulations for submitting PA charges, specifically whether the mid-level is required to report services under his/her own provider number or is allowed to report services provided incident-to the supervising physician.

Medicaid is also interested in laboratory services and will look at whether payments for chemistry, hematology and urinalysis tests exceed amounts recognized by Medicare for the same tests or were duplicated. It will also identify tests not grouped together (bundled into a panel or profile) for payment purposes and determine whether a physician's order properly supported the tests.

Use Work Plan to manage risk

Department managers can analyze internal charge capture and claims-processing systems to determine areas of risk. As part of an effective compliance plan, physician practice administrators should require coding and business office staff to review the annual **OIG Work Plan**.

Internal and external auditing is critical in analyzing claim information. An effective auditing process can help your practice (1) target areas of risk within the organization, (2) conduct focused compliance and reimbursement audits, (3) provide necessary education to physicians and billing staff and (4) prevent receipt of inappropriate reimbursement.

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Contact your BKD Health Care Group advisor for more information about how the **OIG 2007 Work Plan** will affect your practice office and how it could improve your coding and billing processes. ■

Paperless information systems need strong internal controls

by Derek Hunter, dhunter@bkd.com

Many organizations are moving to paperless document filing and storage systems, systems that may be closer to "less paper" than completely "paperless." Even so, the bottom line with any information system is to carefully choose the personnel allowed access to it.

As a health care provider in today's litigious society, it has become increasingly important to protect both patient and employee personal health information, especially considering the legislative and media emphasis on privacy.

Prioritize privacy, security

HIPAA imposes specific requirements and penalties for noncompliance. As a health care provider, you may encounter privacy-related lawsuits that seek financial awards, making it crucial to protect personal records and discussions by restricting access only to those who need to know.

When it comes to protecting other confidential information, your organization may have additional concerns beyond those of HIPAA.

For example, payroll information must be carefully protected, especially in organizations with wide variations in salaries and benefits. If you are located in a nonmetropolitan area where more members of the community know each other, information and data leaks can be particularly damaging to public perceptions.

Limit access

It's appropriate and important to regularly review the limits on access to information in your system. Different types of data should have different levels of access, but limiting access comes with the following trade-offs.

Just as certain members of your management team need access to highly confidential documents, so will members of your information technology (IT) personnel because of the system services they provide.

However, in many companies, IT personnel are sometimes more transient than other departmental personnel and may move from one employer to another more often. This makes the access limitation more important.

To address what could potentially threaten your system's security, regularly remind all employees—especially those with access to highly confidential documents—of their responsibility to protect private information and to not disclose it.

Though access must be limited to those who need to know, you don't want to limit access so much that a technical problem can't be fixed, and information in the system can't be accessed by those who need it.

Weigh access against risks

Virtually all organizations have certain documents that must be kept very confidential. A traditional, paper-based system can contain everything from personnel files, payroll information and medical records to management discussion memos and documents prepared in anticipation of litigation. Access is physically controlled, with documents locked safely away in file cabinets inside offices with restricted access.

Paperless, technological records storage can enhance operational access, but not without the challenge of how to limit access only to those who need to know. You must also allow your IT staff access so it can perform regular system updates and maintenance. How do you know if you're exposing your organization to inappropriate access and risk?

BKD Forensics & Dispute Consulting division can help. It offers a full range of services, including fraud prevention, investigation and on-site training. Contact your BKD Health Care Group advisor for an introduction. ■

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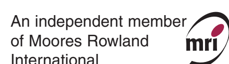

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