MPC, Inc.
August 2017

BE AWARE OF THE CHANGES TO COME

CELEBRATING 25 YEARS OF EXCELLENCE

MEDICAL PRACTICE CONSULTANTS, INC.

New Medicare Cards

Medicare is taking steps to remove Social Security numbers from Medicare cards. Through this initiative the Centers for Medicare & Medicaid Services (CMS) will prevent fraud, fight identity theft and protect essential program funding and the private healthcare and financial information of our Medicare beneficiaries.

The new Medicare cards issued by CMS will have a unique, randomly-assigned number called a Medicare beneficiary Identifier (MBI). This will replace Social Security numbers on cards and in various CMS systems. Patient's will begin to receive new cards in April 2018 with all cards replaced by April 2019. **Your systems will need to be able to accept the new MBI format by April 2018** but you can continue to bill the old numbers until the 21- month transition period is over.

Department of Health & Human Services Office of Inspector General

The Office of Inspector General released a report June 2017, entitled (Medicare Paid Hundreds of Millions in Electronic Health Record Incentive Payments That Did Not Comply With Federal Requirements). In Summary:

- Between May 2011 and June 2014, the Centers for Medicare & Medicaid Services (CMS) under the Electronic Health Record Incentive Programs improperly paid over $729 million to providers that did not comply with federal requirements.
- CMS offered significant incentives to health care providers to encourage adoption of EHR systems that satisfied "meaningful use" requirements.
  - Providers required to self-attest to federal program requirements.
  - Retain all documentation supporting their attestation for a period of six years.
  - CMS was required to conduct risk-based audits of inaccuracies in eligibility, reporting, and payment.
- OIG selected a random sample of 100 eligible professionals.
  - Out of the sample of 100 eligible professionals, the OIG identified 14 eligible professionals. Findings:
  - Meaningful use requirements not meet "because of insufficient attestation support, inappropriately reported meaningful use periods or insufficiently used certified EHR technology."
  - Overpayments totaling $291,222 to the 14 eligible professionals reviewed in the sample. Extrapolating based on this sample, the OIG estimates that

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CMS inappropriately paid $729,424,395 in incentive payments to providers who did not satisfy the meaningful use requirements.

- CMS also made EHR incentive payments in error when EPs (Eligible Patients) switched between Medicare and Medicaid incentive programs. In Summary:
  - 471 EHR incentive payments
  - Amount involved $2,344,680
  - Payments were for the wrong payment year

THE OFFICE OF INSPECTOR'S 2017 WORK PLAN HAS STATED "AUDITS OF VARIOUS COVERED ENTITIES RECEIVING EHR INCENTIVE PAYMENTS FROM CMS" WILL BE PERFORMED.

ACA Risk Adjustment Program Audit

- CMS to conduct Initial Validation Audit (IVA) audit. In summary:
  - Validate the data used when assessing the payment transfers for the Affordable Care Act's (ACA) Risk Adjustment (RA) program.
  - Provider's role is essential to the success of the IVA.
  - Blue Cross and Blue Shield is asking for the cooperation of the providers.
  - As BCBS providers, you may be asked to provide medical records.
  - The records will be used to validate all the diagnosis codes used in the ACA RA risk score calculation.

CMS Global Surgery Data Collection

Practitioners will be required to identify post-operative vis its.

In Summary:

- Practitioners in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island.
- Report on claims data on post-operative visits furnished during the global period of specified procedures using CPT code 99024, **beginning July 1, 2017.**
- Practitioners who only practice in practices with fewer than 10 practitioners are exempted from required reporting, but are encouraged to report if feasible.
- Although reporting is required for global procedures furnished on or after July 1, 2017, CMS encourages all practitioners to begin reporting as soon as possible.
- Codes for Which Reporting on Post-Operative Visits is Required have either 10-or 90-day global periods

As CMS steps up audits, Novitas has published some very sound advise. *Documentation Requests – Are You Prepared?* These are some of the actual responses Novitas and the CERT contractor received when documentation was requested for billed services.

- "We have no records at this office."
- "We are not the billing agency for your client's physician."
- "Beneficiary is not a patient of our office."
- "No visit in hospital for this date of service."
- "Contact Medical Records."
- "We are unable to comply with request. We show no treatment at this facility for the dates of service you requested."
- "Patient never seen at this practice."

Unfortunately, the result was claims denials and providers returning money to Medicare.

It's not a question of "if" you will be asked for documentation to support your services, but "when" you will get an additional documentation request letter. Preparation before receiving a request will help you support the services you bill. Preparing for documentation requests saves time and money, due to reduced administrative costs associated with claim denials, refunds, and appeals."

So—Enjoy the Dog Days of Summer! Winter Comes Soon Enough!