MPC, Inc.
Fall 2017

CELEBRATING 25 YEARS OF EXCELLENCE

MEDICAL PRACTICE CONSULTANTS, INC.

An Autumn of Compliance

Tips to protect your practice from employing bad actors in the healthcare industry.

- Make sure your HR Staff have been trained on all policies and procedures and any other training that may help them identify the who, what, when, where and why's when hiring a new Applicant.
- Provide your staff with the correct tools to do the verification of new hires.
- Do not over load your HR staff so that quality and efficiency can be maintained to ensure no steps are being missed during hiring.
- Understand that fraud can happen to and by nice people.
  - ⇒ Anything can happen before, during or even after the hiring process, so watch the OIG Exclusion list and verify applicant isn't on it before and after hiring.
  - ⇒ Verify all information for an applicant before hiring instead of after hiring, do not assume all is correct.
- Check references.
  - ⇒ Make sure you check all references on their application or resume to ensure there are no red flags or misrepresenting who they have worked for or what tasks they have done.

Will your EMR amendments survive a CERT or private payer review?

On April 5, 2017 CERT auditors have found numerous errors on amended records.

Here are a few rules to closely follow along with some tips for correct amending of records.

- If you must do a late entry (omitted information from time of original entry), you should add an Addenda information not available at time of original entry). You can also do corrections with an Addenda.
- Make sure, you as the provider are the only one making the original notes as well as Addenda or billing changes.
- Amendments need to be tracked. An EMR system should show you who made changes and when.
- Use the right date on amendments. The amendments should have their own date, do not use the date of the original note.
- Do not delete the original record. You want a record to show what your original notes were and what was amended.
- Providers should be allowed to use their initials. Initials can be tracked back to a provider via a EHR's tracking system or signature log. CMS allows those to be used instead of full signature.

You can find additional information on the OIG, CMS, and Medicare contractors Websites.

Get Ready to Switch to the New Advance Beneficiary Notice (ABN) form. On June 21, 2017 the New ABN should be in use.

Here are 9 rules to follow as you use the renewed ABN form.

1. Check the expiration date. After June 21,2017, the expiration date in the lower left corner should be 03/2020.
2. Only use ABNs for traditional Medicare Part A and B patients. Private payers and Medicare Advantage may have forms that are similar but they are not interchangeable.
3. Give patients an ABN when Medicare normally covers the service they will receive but you believe it will be denied, for the specific patient.
4. Use the ABN to inform patients that a

MEDICAL PRACTICE CONSULTANTS, INC.
Renee M. Brown, President
1900 NW Expressway, Suite 625
Oklahoma City, Oklahoma 73118
(405/848-8558)

service is not covered by Medicare. However, this is not mandatory.
5. Review local coverage determinations regularly to make sure you're aware of changes to frequency, covered diagnoses and other requirements that may trigger the need for an ABN.
6. Fill in parts of ABN in advance, such as the name and contact information for the practice in section A, the item or service covered by the ABN in section D and estimated cost in section F.
7. Write the patient-specific reason Medicare may not pay in section E in a way the patient can understand.
8. Provide contact information for your billing office in section H if it is different from the practice's information in section A
9. Never select an option in G or tell the patient which one to select. However, you may discuss the different options with the patient.

Resources:
Download the revised ABN: www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html

For your viewing pleasure—Examples of the Office of Inspector Self-Disclosure Settlements

07-27-2017

After it self-disclosed conduct to OIG, UMC Physicians, formerly known as UMC Physician Network Services (UMCP), Texas, agreed to pay $3,364,079 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that UMCP improperly filed claims with Federal health care programs for: (1) evaluation and management services; and (2) Doppler and Ultrasound testing services that were upcoded, not rendered, or otherwise not supported by the record.

06-23-2017

After it self-disclosed conduct to OIG, Calvert Physical Therapy and Sports Fitness Center (Calvert), Maryland, agreed to pay $368,740.59 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that: (1) Calvert submitted claims to Medicare, Medicaid and TRICARE for therapeutic services that required direct one-to-one patient contact when the physical therapist was treating more than one patient at the same time: and (2) submitted claims to Medicare for patient re-evaluations when the physical therapist was recertifying Medicare patients' existing plans of care. OIG further alleged that Calvert improperly submitted claims to Medicare, Medicaid, and TRICARE for physical therapy services that failed to meet documentation requirements for time spent with patients and modalities used to treat patients.

06-12-2017

After they self-disclosed conduct to OIG, Central Maine Medical Center and Central Maine Health Care Corporation (collectively, "CMMC"), and Comprehensive Pharmacy Services, Inc. (CPS), Maine, agreed to pay $196,929 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that CMMC, who had a contract with CPS to staff and manage its hospital pharmacies, employed an individual that CMMC and CPS knew or should have known was excluded from participation in MaineCare and that no MaineCare program payments could be made for items or services furnished by the individual.

04-28-2017

After it self-disclosed conduct to OIG, Madison Parish Hospital Service District d/b/a Madison Parish Hospital (MPH), Louisiana, agreed to pay $1,800,000 for allegedly violating the Civil Monetary Penalties Law, including provisions applicable to physician self-referrals and kickbacks. OIG alleged that MPH: (1) improperly submitted claims to Medicare related to certain inpatient admissions; (2) received remuneration in the form of inpatient Computed Tomography equipment and services provided below fair market value (FMV) from an independent diagnostic testing facility (IDTF) and paid remuneration to the IDTF in the form of below FMV medical office space and support services; and (3) improperly reported illegal remuneration from hospital vendors paid to a former CEO on MPH cost reports then used by the Medicare and Medicaid program to calculate reimbursement rates to MPH, resulting in overpayments.

If you have any questions, please call. We will be happy to help in any way we can.
Renee M. Brown, President