



Don't Let Recovery Audit Contractors Push You Around!

The Recovery Audit Contractors can be daunting and may not be above trying to intimidating you, if you let them. These “bounty hunters” are paid, not by government funds, but on how much they recover from the provider. Here are some tips on survival in a RAC environment:

- * Be proactive. “The more we sweat in peace, the less we bleed in war.”
- * Update your compliance manual if it's been over a year since the last revision. Especially, get current on your audit schedule. Also, review and revise the “wolf-at-the-door” procedures prn.
- * Have an outside coding expert review a sample of your claims.
- * Look for your most common and highest dollar claim types and assure their correct coding. These

will be among the first areas of RAC examination.

- * Think about any unusual aspects of your practice (infusion therapy, sonography, etc.) and analyze any which offer exposure for heightened RAC attention to your practice.
- * Monitor the RAC's website for their hot items and scrutinize your practice for all that apply. CMS requires RACs to inform the public of the specific items under particular interest. Connolly Consulting is the RAC for most of our area. Connolly's website is www.connollyhealthcare.com/RAC.
- * Check your contact information on the CERT website (from which RAC gets their contact

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USSC Compliance Regs

Those in the healthcare industry have long been accustomed to the regulatory oversight of the Department of Health and Human Services and its subordinate agencies – CMS, OIG, and the like. Additionally, the Federal Trade Commission accedes to a more active role (or is that “rule”?) in healthcare with its Red Flag Rules becoming effective on June 1, 2010. But there's yet another agency governing healthcare providers.

The U.S. Sentencing Commission (& they don't call it that for nothing) of the Department of Justice has had a nearly silent but significant influence going back to 1984. It was established as part of an act reforming and standardizing federal prison sentences. Its intervention in healthcare

has been in the introduction of a 7-step voluntary compliance manual.

If that sounds familiar, it should: it is the USSC compliance manual on which OIG based their compliance guidance documents, after adding details & other information. Later, however, USSC amended and modified its manual, but OIG never incorporated these changes into its guidance documents.

Unfortunately, providers must conform to both plans even though they differ somewhat. Here are the 7 elements, whether from the USSC manual or the OIG guidance documents. Your compliance plan must include all of them.

1. You must have a compliance plan [USSC], and it must be written [OIG].

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The Benefits of Image Lockbox Technology for Medical Practices

Most medical practices face major challenges today when it comes to payment collections: they are overwhelmed with the massive amounts of paper linked to the collection process due to high volumes of checks, invoices, and explanation of benefits (EOBs) provided by insurance companies. In addition, they have the challenge of processing payments quickly and extracting data from EOBs while maintaining HIPPA compliance and expediting the posting of cash.

A solution to the inefficient manual processing of paper for medical practices exists in the form of a customized lockbox service, which combines the benefits of a traditional wholesale lockbox along with a full document management system. There are a variety of different customized lockbox services provided by financial institutions today, including Image Lockbox, Healthcare Lockbox, Electronic Lockbox, and Digital Lockbox, but all retain the basic functions of receiving, opening, sorting, and depositing of checks.

Due to the high volume of payment processing required by most clinics, the heaviest users of lockbox services are healthcare providers. As a result, many financial institutions have customized their lockbox services to incorporate the

conveniences that are of particular benefit to healthcare providers. A few features of the various customized lockboxes for the healthcare industry include:

•*Direct receipt of all payments/correspondence:* Not only does the bank receive checks mailed by patients/vendors, but it also receives automatic deposits (Automatic



Clearing House), credit card, and health insurer payments which can easily be downloaded to practice accounts receivable software, thus accelerating collections and minimizing risk of loss and fraud.

•*Fully HIPPA compliant:* All patient information is kept fully confidential in compliance with HIPPA and having all images available via

the Internet.

•*Daily deposit totals by customer and location:* Several banks offer browser-accessible daily deposit totals by clinic location, patient name, and even by treating physician.

•*Related correspondence digitized and up-loadable:* Banks can digitize incoming mail to include patient correspondence and EOBs, allowing the medical practice to upload the mail directly into practice management software.

The top three benefits of the Image Lockbox are increased cash flow, fraud prevention, and staff productivity. The service allows medical practices to dramatically reduce processing time and improve cash flow by having access to their lockbox contents on the same day as they were deposited in addition to viewing documents online 24 hours a day. Having images that are handled in compliance with HIPPA regulations, viewed only by requisite employees, and, in most cases, archived in secure and redundant data centers helps reduce the fraud risk associated with handling large volumes of sensitive patient information. Key statistics from a survey of Image Lockbox users in the healthcare industry conducted by Critical Technologies, Inc. re-

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Is something scary creeping up on you at the end of October?

Don't let November 1 dawn without being ready for Red Flag regulations: contact Virginia Pierce at 901-761-2720 for your complimentary Red Flag Compliance Kit.

YIKES! See page 5...



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information). You want to make sure any communications from RAC go directly to the appropriate party.

- * Assemble your audit response team, including (at least) a liaison physician, your highest-ranking administrative staff member, and management/supervision staff from billing, coding, & document maintenance. Notify your legal counsel, a de facto team member, of your preparations.
- * And, if despite all your preemptive tactics, you receive a RAC review request for records, unleash your inner bulldog. Require justification from the RAC at every step. Photocopy the credentials of any RAC personnel who request to access your premises or records, and verify their ID with the RAC office. Scrutinize their sampling method; obtain their seed number, sample size, and universe size, and verify the sample via OIG's RAT-STATS. Seek professional assistance. Keep up with appeal deadlines. Preview any records to be sent to RAC; retain a copy of all materials sent. Document every communication (phone, letter, email, voice mail, *everything*, in either direction). Ap-

peal every adverse ruling not explicitly due to practice error. (Frankly, you should be doing this now anyway on every claim denial and every partial payment).

- * Be sure to pay particular attention to E&M levels coding. Though not among RAC's hot items just now, they are complicated, controversial, and of very high volume (therefore, offering extreme exposure via extrapolation). Remember also that when E&Ms do go on the hit list (and they will), RAC can review 3 years back.

RACs can and have been successfully challenged, and repayment amounts whittled down to fractions of initial RAC assessments. The best defense is a good offense.

It has been our experience that aggressive positioning, *before* RAC interaction, and challenging every step of the RAC inquiry process will minimize RAC's financial impact on your reimbursements and keep down the not-inconsiderable administrative costs of answering a RAC investigation. Information and intervention at initial and early stages are far more effective at impacting adverse RAC allegations. Defeating these contractors early on is even more effective than confronting them at the judicial step, where most appeals are upheld.

Even if your practice doesn't have an EMR system, you may still be eligible for CMS E- Prescribing incentives. In 2010, CMS successful E-Prescribers incentive payment will be 2%. For complete details go to <http://www.cms.hhs.gov/ERXincentive/>

Billing for the Administration of the Influenza A (H1N1) Virus Vaccine

Medicare Part B provides coverage for the seasonal influenza virus vaccine and its administration as part of its preventive immunization services. The Part B deductible and coinsurance do not apply for the seasonal influenza virus vaccine and its administration. Typically, the seasonal influenza vaccine is administered once a year in the AUTUMN or winter. Additional influenza vaccines (i.e., the number of doses of a vaccine and/or the type of influenza vaccine) are covered by Medicare when deemed to be 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 Part B beneficiaries as an additional preventive immunization service. Medicare will pay for the administration of the H1N1 vaccine.



Read more at <http://www.cms.hhs.gov/MLNMArticles/downloads/SE0920.pdf>.

IRS Provides Guidance on 2009 RMD Relief



Regardless of which hat you're wearing – worker, retiree, or employer – there are some IRS changes you need to understand. Last year, Congress passed “The Worker, Retiree, and Employer Recovery Act of 2008” (WRERA) which waives **Required Minimum Distributions** (RMDs) for 2009 from certain retirement plans. However, many questions were left unanswered. The IRS has just released Notice 2009-82, which provides guidance for retirement plan administrators, plan participants and retirees regarding the recent legislation affecting RMDs. Notice 2009-82 provides relief for people who have already received a 2009 RMD this year. Individuals

generally have until the later of November 30, 2009, or 60 days after the date the distribution was received, to roll over the distribution. The Notice defines:

- **2009 RMDs.** These are Required Minimum Distributions which a plan would have been required to distribute (or IRA owner or beneficiary would have been required to take), if Congress had not adopted WRERA. It includes all RMDs for the 2009 distribution calendar year, including those which could otherwise be distributed as late as April 1, 2010.

- **Extended 2009 RMDs.** These are one or more payments in a series of substantially equal distributions (that include the 2009 RMDs) made at least annually and expected to last for the life/life expectancy of the participant and a designated beneficiary, or for a period of at least 10 years. This definition is significant because an individual cannot normally roll over one or more of a series of substantially equal distributions, as described in the previous sentence, whether or not those distributions are RMDs. For example, if a plan distributes a participant's benefit in 15 equal annual installments, the distributions are not **eligible rollover distributions** (ERDs), without regard to the RMD rules.

The Notice provides transition relief with regard to three issues:

1. Plan distributions of Extended 2009 RMDs are ERDs, notwithstanding the fact that they included 2009 RMDs and they are part of a series of substantially equal payments.
2. The 60-day rollover deadline for plan distributions of 2009 RMDs and Extended 2009 RMDs will not expire before (and is therefore extended until) November 30, 2009, if the 60-day deadline otherwise would expire before that date.
3. The IRS will not rule that a plan has an operational failure (has failed to comply with its terms) for the period from January 1, 2009 to November 30, 2009 simply because:
 - A. The plan made, or did not make, distributions of 2009 RMDs or Extended RMDs,
 - B. Participants were not given the option to receive (or not receive) distributions that include the 2009 RMDs, and
 - C. A plan offered or did not offer a direct rollover option for 2009 RMDs or Extended 2009 RMDs.

The Notice also provides two sample amendments, designed to be adopted at the individual employer level. The deadline for adoption is the last day of the 2011 plan year.

For further questions about the suspension of minimum distribution requirements or information about how Watkins Uiberall's Plan Administration & Consulting Company could help with the operation of your retirement plan, please call Scott Fletcher or Kathy Moore at 901-261-6400 or email sfletcher@planadministration.net or kmoore@planadministration.net.

The Benefits of Image Lockbox Technology for Medical Practices

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vealed the following increases in staff productivity for the average 5-to-8-physician practice after the implementation of their lockbox:

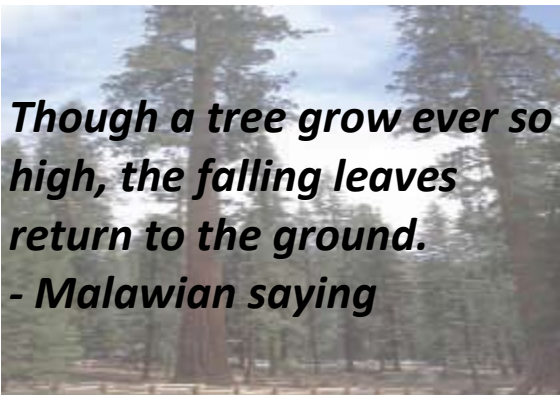
- one full-time employee equivalent saved in the first year,
- average collection cycle reduced by 5 days,
- average claim or payment research time reduced to 15 minutes or less, and
- call resolution time reduced from an average of 7 hours to 1.5 hours.

Greg Smithers, President of the Tennessee market for IBERIABANKfsb, states, "Through our partnership with Critical Technologies Inc, IBERIABANKfsb provides a feature-rich solution which can be customized to meet the specific needs of our medical clients."

The good news for physician groups is that financial institutions today are offering the latest technology-enhanced lockbox services to help medical practices streamline their receivables processing and improve information reporting. Said Philip Brooks, 1st Vice President, Treasury Management at BancorpSouth, "Many of the improvements offered to healthcare-related businesses in the lockbox environment are a result of better image-capture tools. Banks are leveraging off their investment in the check-image capture arena to apply what they've learned to non-standard paper forms like EOBs. In short, image capture technology is now cost-effective and trainable for delivering high quality medical lockbox services."

There are also lockboxes that offer a secure electronic method for submitting claims to third party payers as well as receiving payment data related to claims. Margaret McMahan, Client Advisor on the Medical Team of SunTrust's Private Wealth, stated, "These lockboxes process electronic and paper payments received from insurance payers and reconcile them to claims data. This means increased operational efficiencies and reduction in administrative overhead, while simplifying resource allocation and revenue management."

For more information on customized lockbox services, contact any of the bankers mentioned above or your own banking advisor. This article is taken in large part from one written by Michelle Blount, Senior Vice President, IBERIABANKfsb.



Though a tree grow ever so high, the falling leaves return to the ground.
- Malawian saying

Red Flags delayed...Again

In another 11th hour move, the Federal Trade Commission (FTC) is delaying enforcement of the "Red Flags" Rule until June 1, 2010. The rule requires "creditors" – which the FTC defines to include most health care providers – to establish a program to prevent identity theft in their practices.

Though delayed till 6/1/10, most Red Flag components represent good business practices, and you should seriously consider implementing them before, or even without regard to, the FTC's effective date.

Free to all inquirers, WUHCG provides a fully operational Red Flag compliance kit. Contact Virginia Pierce at vpierce@wucpas.com or 901-761-2720, x 437, for yours.

Since October 1, 2008, CMS has been authorized to collect unpaid IRS taxes by offsetting Medicare payments. Starting October 1, 2009, CMS is also authorized to collect non-tax debts owed to other Federal Agencies, i.e. educational loans, by offsetting Medicare payments. If you have questions regarding offsets due to a tax-related debt, you must contact the IRS, and for non-tax debt, you must contact the Treasury Department's Financial Management Service. For complete details go to

<http://www.cms.hhs.gov/MLNMArticles/downloads/MM6228.pdf>

Will Consult Codes Be Abolished as of 1/1/10?

If the current proposed Medicare rule goes through, as of January 1, 2010, CMS will abolish Consultation codes all together, except for the telehealth consultation “G” codes. The targeted CPT codes 99241-99245 (Office) and 99251-99255 (Hospital) which have been on the OIG “hit List” for many years, are primarily used by specialist physicians but in some cases are utilized by primary care physicians as well. CMS states that the abolishment of the Consultation codes will be done in a “budget neutral” fashion, neither decreasing or increasing total expenditures. They expect to realize this by including in the proposal an increase in the reimbursements of the New Patient and Established Patient Codes. Currently, the suggested projection is that office-based E&M codes will increase 6% and hospital E&M visits will increase 2%. We do not believe this will be enough to offset the loss of the consult codes for many specialties.



We have prepared an analysis to calculate how the loss of the Consult codes for a specialist physician might affect revenue even if additional monies are allocated to the other E&M services. For a custom analysis of the impact on your practice, please email Mary Ann Lucas, mlucas@wucpas.com, or Virginia Pierce, vpierce@wucpas.com, or call either of them at (901) 761-2720.

We are publishing this information now, before the final decision has been made, to inform you about the possible loss of the Consultation codes and to encourage you to contact your political representatives, both in government as well as at your specialty societies, medical societies, and the AMA to let them know that it is imperative that they consider this major change carefully and that they must increase the replacement codes to the correct payment level to avoid physicians losing money due to this change.

...But Wait! There's More: ZPIC Audits

Zone Program Integrity Contractors are a re-assembly of the old Program Safeguard Contractors (PSCs), awarded in 1997 after HIPAA gave CMS permission to hire outside contractors to do benefit integrity work. PSCs didn't work well: each had different type of claim (Part A, Part B DME, etc). Providers might have had to work with several PSCs at the same time. The approach of PSCs to fraud detection was fragmented; it left gaps and gave undue scrutiny to well-meaning providers while fraudulent ones evaded punishment.

The Medicare Modernization Act of 2003 provided for PSCs & Medicare Drug Integrity Contractors (MEDICs) to be re-organized together in geographical alignment with MACs (sort of). TN, MS, AR, LA, AL, GA, SC, NC, VA, & WV make up Region #5; the ZPIC contract for this region was let to Advanced Med, though currently this is under dispute by a losing bidder. (Does this sound familiar?) Region #3, including MO, KY, IL, etc., is not yet awarded.

ZPICs will cover Parts A, B, C, & D and Medicare/Medicaid data matches. ZPICs can look into provider cost reports and handle consent settlements. ZPICs can investigate soliciting/offering kickbacks and Stark violations. They can look for routine waiver of coinsurance or deductible, and for practitioners or staff on the federal ineligible list. ZPICs can conduct random checks of physician licensure and original Certificates of Medical Necessity. RACs can do none of these.

RACs may only review the CMS-approved issues reported on the RAC website. (There are currently 12 of these.) RACs may only go back 3 years. RACs have a restricted number of charts that can be requested within a certain period. ZPICs are not limited in any of these ways. ZPICs may interview beneficiaries and investigate onsite with little or no notice. ZPICs may review a provider's past audits, investigations or violations; RACs are prohibited from doing so.

ZPIC reviews may be triggered by outliers (high volumes of services or items, high cost services or items) or 3rd-party complaints. Additionally, “ZPICs are required immediately to advise the OIG of complaints by the provider's current or former employees.”

Providers may be dealing with multiple federal audits (CERT, RAC, OIG, ZPICs) simultaneously. And ZPICs may employ the potentially devastating extrapolation of recoupments, just like RACs can.

What can or should you do to deal with this latest challenge? As with all other auditors, you should have a proactive, up-to-date, and enforced 7-point compliance program. Appeal protocols are the same as with other Medicare audits.

USSC Compliance Regs

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2. You must have a representative compliance committee [OIG], and it must be overseen by the practice's governing authority and head by highest-level personnel, who additionally have a duty to foster an ethical & legal culture [USSC].
3. Staff education in amounts of 1-3 hours for non-specialties must be provided annually [OIG].
4. Open communication, especially for whistle-blowers, including protection from retaliation [USSC], specifically in the form of anonymous channels [OIG], must be maintained.
5. Practices should periodically & routinely audit and monitor providers in order to detect criminal conduct [USSC], and to evaluate aspects of the compliance program, verify conformance with it, and develop changes in either [OIG].
6. There must be incentives to act appropriately [USSC] and consistently enforced disciplinary measures [OIG].

Retention Reminder

This is the record retention schedule recommended by State Volunteer Mutual Insurance Company:

“Medical Records (Required Under Tennessee Law)

- * Retained 10 years from last contact with patient
- * Immunization records – indefinitely
- * Incompetent patients’ records – indefinitely
- * Mammography records – 20 years
- * X-rays – 4 years (if there is a separate interpretive record.)
- * Minors – 1 year after majority OR 10 years from last contact – whichever is longer
- * Under dispute – the later of after the rules above or at resolution of the dispute.”



CMS Physician Offices Scam Alert

The Centers for Medicare & Medicaid Services (CMS) has become aware of a scam wherein perpetrators are sending faxes to physician offices posing as the Medicare carrier or Medicare Administrative Contractor (MAC). The fax instructs physician staff to respond to a questionnaire to provide an account information update within 48 hours in order to prevent a gap in Medicare payments. The fax may have the CMS logo and/or the contractor logo to enhance the appearance of authenticity. Medicare FFS providers, including physicians & non-physician practitioners, should be wary of this type of request. If you receive a request for information in the manner described above, please check with your contractor before submitting any information. Medicare providers should only send information to a Medicare contractor using the address found in the download section of the CMS.gov website found at www.cms.hhs.gov/MLNGenInfo/ or www.cms.hhs.gov/MedicareProviderSupEnroll .

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& A Happy New Year*



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