



S P R I N G 2 0 0 9

Doctor Perspectives

New HIPAA Enforcement Penalties

Part of the American Recovery and Reinvestment Act of 2009 (the Recovery Act) passed in February 2009 is of significant interest to healthcare providers. Known as the Health Information Technology for Economic and Clinical Health Act (HITECH), this provision makes several changes to the Health Insurance Portability and Accountability Act (HIPAA) designed to improve its alleged lackluster enforcement.

Prior to HITECH, civil monetary penalties for violating HIPAA stipulations were \$100 per violation, with a cap of \$25,000 for all identical violations during a calendar year. These penalties did not apply if the violator did not know of the violation, or if the failure to comply was due to reasonable cause and was corrected within 30 days. (Editor's note: "Did

not know" in HIPAA regulations is always followed by "or by exercising reasonable diligence would not have known.")

HITECH eliminated these exceptions and established new minimum and maximum penalties for HIPAA violations, effective 2/17/09. Thus, the new maximum penalty is \$50,000 per violation, with an annual cap of \$1,500,000 for all identical violations.

The new minimum civil monetary penalties are tiered based upon the entity's perceived culpability for the HIPAA violation, as follows:

\$100 per violation, with an annual cap of \$25,000, for violations about which the person did not know that a violation occurred;

\$1,000 per violation, with an

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Granting Professional Courtesy: An Update

CMS has released an exception for professional courtesy services by a physician. The exception defines professional courtesy as free or discounted services rendered to a physician, his or her immediate family, or office staff. In order to meet the criteria of the new exception, the following guidelines must be observed:

The Professional Courtesy cannot violate any state or federal laws, including the anti-kickback statute.

All physicians employed by the entity or in the local community are offered the same Professional Courtesy without regards to amount of referrals given to the entity by that physician.

The entity has approved and put the Professional Courtesy policy **in writing**.

Any reductions or forgiveness of co-payments, co-insurance or deductible must be reported in writing to the insurance company of the person treated.

All health care services or items must be the type that are routinely given by the entity.

Last but not least, no Professional Courtesies can be offered to physicians, their family members, or staff who are beneficiaries of federal health plans (i.e. Medicare), unless they have shown financial need (in which case they would fall under a Financial Hardship or Charity Care policy).

If you plan on using Professional Courtesy adjustments or waivers, please be advised that in order to stay compliant, you must follow **all** of the above guidelines.

CMS “Exclusions List” - Doctors to Bear Burden

Centers for Medicare & Medicaid (CMS) issued a State Medicaid Director Letter on January 16, 2009 reminding states of their obligation to require providers to screen the employees and contractors of the provider for individuals excluded for participation in federal health care programs. On first impression this may not seem too onerous an obligation, but, because the so-called “Exclusions List” (officially titled the “List of Excluded Individuals/Entities” and generally referred to as “LEIE”) is updated frequently, to be in compliance with this directive, providers must re-screen every employee or contractor by name every month.

This is actually not a new requirement: providers of services to federal payers have always been expected to check employees and contractors against the Exclusion List, but until this CMS Letter it was deemed sufficient to do so only annually.

Screening is facilitated by a search engine at the website of the LEIE, but it must be addressed by

each individual or contractor’s name. Alternatively, providers may download the entire database and search using their own search methods.

Those who must be screened include: “...nurses, technicians, or other excluded individuals who work for a... physician practice...related to administrative duties, preparation of surgical trays, or review of treatment plans if such services are reimbursed directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid program even if the individuals do not furnish direct care to Medicaid recipients.” Further passages in the Letter specify pharmacists and any who input or file prescriptions; ambulance drivers, dispatchers, and involved with transportation; those who sell, deliver, or refill orders for DME; social workers; administrators, billing agents, accountants, claims processors, utilization reviewers; any “individual who works for an entity that has a



contractual agreement with, and is paid by, a Medicaid program.”

The CMS Letter raised numerous questions whose answers are currently unknown: Does this apply to Medicare providers, too? Will all states enact this directive? Are providers considered innocent until proven guilty of involvement with an excluded person or company, or must they demonstrate their compliance with the monthly screenings?

The one answer that seems painfully evident is that the expenses of performing the monthly screenings will be borne by the provider.

The text of the CMS Letter can be found at www.cms.hhs.gov/SMDL/downloads/SMDO11609.pdf.



Tidbits

- ◆ Don’t let the postponed “Red Flag” regulations slip up on you & your practice. These regulations govern how creditors (including medical practices which bill patients) safeguard against identity theft of those to whom credit is offered. Your practice should enact procedures to detect fraudulent patient identities before the regulations take effect August 1, 2009. Contact WUHCG for a complimentary compliance kit.
- ◆ Are you up to date on the chart audits required by your compliance plan? The OIG recommends that each practice review “five or more per Federal payer (*i.e.*, Medicare, Medicaid, TRICARE), or five to ten records per physician” at least annually. (See the last paragraph on page 5.) Call us if you need help with this.
- ◆ There are over 1000 code changes in 2009, 50 to E&M alone! Can ICD-10 be far behind?
- ◆ The Department of Health and Human Services (HHS) has announced a long-awaited proposed regulation that would replace the ICD-9-CM code sets now used to report health care diagnoses and procedures with greatly expanded ICD-10 code sets, effective October 1, 2013.

HIPAA/HITECH

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annual cap of \$100,000, for violations due to reasonable cause and not to willful neglect;

\$10,000 per violation, with an annual cap of \$250,000, for violations due to willful neglect that are corrected within 30 days of the date the person knows (or should have known) that the violation occurred; and

\$50,000 per violation, with an annual cap of \$1,500,000, for violations due to willful neglect that are not corrected within 30 days.

The Secretary of Health and Human Services bases penalty determination on the nature and extent of both the violation and the harm caused by the violation and has the discretion to impose corrective action without a penalty in cases in which the person did not know that a violation had occurred.

In light of the severity of these new penalty levels, practices should immediately review their written HIPAA policies, including annual update and staff training, to assure that they are in compliance.

Under HITECH, state attorneys general, not just the HHS Secretary, are authorized to bring civil actions against persons who violate HIPAA in some circumstances. They may also impose injunctions against further violations of HIPAA, as well as monetary damages of up to \$100 per violation, with a cap of \$25,000 for all violations of an identical standard in a calendar year. In considering the amount of damages, the court, like the Secretary, may consider the nature and extent of both the violation and the harm caused by the violation. A person found liable may also be required to pay the attorney fees and court costs incurred by the state in bringing the action.

HIPAA still provides no private right of action for individuals (i.e., the right to sue covered entities for breaching their obligations under HIPAA), but HITECH does give financial incentives to complainants. Individuals may now share in any monetary penalties or settlements collected as a result of HIPAA violations.

HIPAA under HITECH *re-*

quires the Secretary to investigate any complaint due to willful neglect and to impose civil monetary penalties for such violations. Previously, the Secretary could elect whether to do so. This provisions goes into effect on February 17, 2011; regulations will be issued by August 17, 2010.

HIPAA provides for the Secretary to turn over potential criminal violations to the United States Department of Justice for prosecution. HITECH provides, however, that if the DOJ has not prosecuted an individual for alleged criminal violations of HIPAA, the HHS Office for Civil Rights may still investigate and impose civil monetary penalties where appropriate.

The changes to HIPAA enforcement represented by HITECH make it clear that the government intends to make HIPAA enforcement a priority. If you have any questions about HITECH, or need help bringing your practice into HIPAA compliance, please contact the professionals at Watkins Uiberall Healthcare Consulting Group, 901-761-2720.



**Remember:
Effective March 31, 2009,
Medicare contractors will accept
only the revised ABN (waiver)
CMS R-131 as valid notification.**

Suspension of Minimum Distribution Requirements

As a doctor you can be both a consumer of a retirement plan and someone with responsibilities to oversee the administration of an employee pension program. A law enacted late last year may have bearing on a retirement program with which you are connected.

The Worker, Retiree, and Employer Recovery Act of 2008 (the “Act”) was signed by former President Bush on December 23, 2008. This act affects the operation of qualified retirement plans with respect to Required Minimum Distributions (RMDs).

What is the affect on RMDs for 2009? The Act suspends the minimum distribution requirements for 2009 for participants age 70 ½ and older who are generally required to take a minimum distribution from their 401(k), 403(b) or 457(b) plans or individual retirement accounts (IRAs). These RMDs are not considered eligible rollover distributions and are taxable distributions. Distributions made in 2009 that would otherwise be RMDs, but are not required to be made due to the relief, may generally be rolled over subject to the usual rules for eligible rollover distributions. This provision does not apply to minimum distributions required to be taken in 2008 (or by April 1, 2009 for participants who turn 70 ½ in 2008).

How should a qualified plan handle distributions affected by the RMD relief? While the Act suspends RMDs, it is not clear whether a plan *must* suspend distributions or may continue making the distributions. Though further guidance from the IRS is needed, there appear to be three possible approaches, 1) continue to make distributions as in prior years, 2) suspend all RMDs for 2009 or 3) let the participants decide whether or not to take the distribution. All three options have tax consequences for participants as well as notice and administrative requirements for the plan sponsor that should be considered. A review of specific plan language and current provision should also be done with your third party administration before making a decision.



Independent Member of BKR International

Watkins Uiberall’s Plan Administration & Consulting LLC (PAC) provides full service of retirement plans. For further questions about the suspension of minimum distribution requirements or information about how PAC 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.

\$\$ for E-Rx

The Centers for Medicare & Medicaid Services (CMS) recently released the e-prescribing measure specification which includes the appropriate reporting codes needed for eligible medical groups to qualify for the e-prescribing bonus. Practices that meet the e-prescribing criteria can earn a 2 percent bonus of the allowed Part B charges in 2009 and 2010, a 1 percent bonus in 2011 and 2012 and a 0.5 percent bonus in 2013. Note: that is the full allowed charge, not the payment, which is net of patient cost-sharing amounts

Medical practices not e-prescribing will face a 1 percent cut in 2012 and 2013. That cut will grow to 2 percent in 2014 and beyond. Although e-prescribing will no longer be an eligible measure under the Physician Quality Reporting Initiative (PQRI) after 2009, CMS will permit practices to receive separate bonuses from both e-prescribing program and the PQRI --- to a maximum 4 percent award.

RAC “Blackout” Until December 1, 2009

A CMS loophole governing the Tennessee Medicare Part B switchover from CIGNA to Cahaba on September 1, 2009 should delay the commencement of RAC activity in the Volunteer State beyond the scheduled August 1, 2009 start up. (Connolly Consulting Associates, Inc., the RAC agency for Tennessee, will no doubt have plenty to keep them busy with Part A providers, which have already switched to Cahaba.)

So as not to impede a Medicare Administrative Contractor (MAC) conversion, CMS provides for a “blackout” of RAC activity 90 days before and after the MAC conversion date. This would put the beginning of RAC activity in Tennessee back to December 1, 2009.

The following confirmation of this loophole was obtained by Watkins Uiberall Healthcare Consulting Group, LLC from Lisa Goldstein, legal counsel to the national MGMA:

The RAC “blackout” period is actually for three months before the cutover to the new MAC and then three months after, so 12/1/2009 should be correct if your MAC cutover is 9/1/2009, assuming that your new MAC is not your current contractor. If they are your current contractor, there will be no blackout period. For reference to the information on the three month blackout period, here is the link to a CMS document that affirmatively states this: <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Evaluation%20Report.pdf> (page 34). For reference on the lack of blackout period in the case of an incumbent contractor, see www.cms.hhs.gov/RAC and select “Frequently Asked Questions.” If you go to the second page of questions, the very last question addresses this issue.

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*** Statements contained above do not constitute legal advice and should not be considered a substitute for such advice. ***

This means that Tennessee doctors have an additional 4 months to bring their compliance plans (manual updates, chart audits, and any remedial training or re-filing needed) up to date, about the only pro-active step a provider can take in preparation for a RAC.



**There is no such thing
as inclement weather,
only inappropriate attire.
Scottish proverb**

CERT Tips Could Save Your Practice Big \$\$\$

On February 19, 2009, CIGNA Government Services issued a news article containing tips for succeeding in a Comprehensive Error Rate Testing (CERT). Its contents are so powerful & concise that, since it resides in the public domain, it is included here in its entirety.

These tips also apply to commercial carriers, even though this article is issued by & for government benefit plans.

And though CERT is a school-yard bully in analogy to RAC's hired gunslinger, this bully's findings can generate substantial charges, fines, and recoupments and is operational now.

Finally, this article is worded in the mildest terms, but it would be a serious mistake to underestimate any of these tips. Note especially the second paragraph.

"In the world of Medicare it is critical for providers to have clear, accurate, and complete medical documentation. Medicare has specific guidelines when it comes to documentation, and the CERT Contractor must follow these rules whenever they review documentation.

"Unfortunately, on many occasions, CERT finds the documentation received does not support the procedures being billed. Sometimes, it is something as simple as legibility of the writing or incomplete notes. On other occasions, the documentation issue may involve "cookie cutter" templates where the patient complaints, physician notes, documented procedures, and the medical findings are identical for the majority of beneficiaries. It is the responsibility of the provider to ensure services billed to the Medicare program are accurate and represent the individual care given to the patient.

"Medical documentation needs to be unique, specific, and should accurately reflect the services being billed. The services billed should:

Be individualized to the presenting problem(s) on the date in question

Be clearly recorded and inclusive

Be specific when it comes to the services provided.

"Example: If you gave an injection, is there a clear order for it in the record? What was the medication and how much was injected? How was the medication administered? Where was it administered? Who administered the medication?

"Remember to keep in mind:

If your notes are handwritten, make sure they are legible. If the reviewer can't decipher the documentation, the service may not be allowed.

If you perform a test, the order should be noted somewhere in the medical record.

Include patient history documents to help substantiate services.

When billing for timed codes, note the actual time in the chart and make certain your documentation clearly reflects the time you spent."

I've learned from experience that the greater part of our happiness or misery depends on our dispositions and not on our circumstances.

Martha Washington



What Month Is It?

This is not an attempt to test your time orientation, but rather a way to get your attention – each calendar month is designated to bring to your notice or to focus awareness on various issues, including many which are related to healthcare. Here are some which are coming up this quarter. Each has a website which you may access via your preferred internet search engine.

April: Alcohol Awareness; Autism Awareness; Cancer Control; Child Abuse Prevention; Caesarean Awareness; Irritable Bowel Syndrome Awareness; Occupational Therapy Awareness; STD Awareness; WalkAmerica/March for Babies/March of Dimes; World Health Day;

May: Arthritis; Better Speech & Hearing; Better Sleep; Asthma & Allergy Awareness; Digestive Diseases Awareness; Healthy Vision; Hepatitis Awareness; High Blood Pressure; Lyme Disease Awareness; Mental Health; Nurses Week; Physical Fitness & Sports Medicine; Skin Cancer Awareness; Stroke Awareness; Teen Pregnancy Prevention;

June: Hernia Awareness; Home Safety; National Safety Month; Vision Research.



Know Your QIO

Quality Improvement Organizations are funded by CMS and other sources to provide free assistance to providers in improving healthcare delivery to patients. Assistance is provided in many endeavors, including EHR installation, e-prescribing, and such PQRI measures as screening of DM patients for chronic kidney disease. There is a QIO for every state. Find your agency below or consult www.qualitynet.org.

Alabama	Alabama Quality Assurance Forum	www.aqaf.com	205-970-1600
Arkansas	Arkansas Foundation for Medical Care	www.afmc.org	501-375-5700
Florida	FMQAI	www.fmqai.com	800-564-7490
Kentucky	Health Care Excel	www.hce.org	502-454-5112
Illinois	Illinois Foundation for Quality Health Care	www.ifqhc.org	800-386-6431
Louisiana	Louisiana Health Care Review	www.lhcr.org	225-926-6353
Mississippi	Information & Quality Healthcare	www.iqh	601-957-1575
Missouri	Primaris	www.primaris.org	800-735-6776
Tennessee	QSource	www.qsource.org	800-528-2655

Be Mindful of CPT ® 99024

The CPT® manual defines 99024 as “Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure.” This code is provided specifically for documenting that the follow-up visits, which are expected after a procedure, are actually taking place. If you are not filing these no-payment

visits, you expose your practice to charges of failing to provide the full level of care bundled into the procedure. Consequently, any legitimate charges for “Unrelated procedure or service by the same physician during the postoperative period” (Modifier 70) are thereby made suspicious. Furthermore, further reckonings of how many follow-up visits to allow in a bundled procedure may be reduced by having not filed 99024s.

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Medical office practice management is a specialized field that the professionals at Watkins Uiberall have been serving with distinction for nearly 30 years. This vast reservoir of knowledge and experience allows medical professionals to focus on patients' needs, while we support them by increasing their office's efficiency and cost-effectiveness. Our areas of expertise include:

- ◆ Regulatory Issues
- ◆ Strategic Planning Consultation
- ◆ Revenue Enhancement & Cost Controls
- ◆ Office Operations Review and Consultation

Please contact William "Bill" Appling, President of Watkins Uiberall Healthcare Consulting Group LLC, for more information at bappling@wucpas.com or 901-761-2720.