

# Medicare Myths

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# Important Notes

- ◆ The quotes at the top of slides are myths.
- ◆ It is easy to talk about Medicare and Medicaid. State law can throw a wrench into plans.
- ◆ Stark is complicated enough that many people take the easy route and “just say no.”

# The Well-Intentioned Whoops

- ◆ You hear something today and think “my doctors better hear this.”
- ◆ The meeting minutes state “at the seminar, we learned that we have been doing this improperly.”

# Separating Fact From Fiction

- ◆ McCarthyism is alive and well, and living in the health care industry.
- ◆ Carriers, consultants, clients and counselors are often guilty of mistakenly believing some policy or conventional wisdom is based in law.
- ◆ Sometimes, they'll use interesting techniques to change behavior.

# Question Authority

- ◆ Is it a requirement or a guideline?
- ◆ Medicare -- ask if it is in the statute, regulations or Medicare Claims Processing or Beneficiary Carriers Manuals.
- ◆ Get a copy of the rule in writing.
- ◆ Determine if the rule was properly promulgated.
- ◆ Ask your lawyer/consultant to explain all arguments supporting and refuting their position.
- ◆ Just because they sound smart doesn't mean they're right.

# Example 1

- ◆ A physician saw 1700 patients; you have charts for 1200. The physician has some “seat of the pants” notes for some of the remaining patients scribbled on the backs of scratch paper.

# Audit Results

	Under-coded	Correctly-coded	Over-coded
Dr. A	13%	76%	11%
Dr. B	50	30	20
Dr. C	15	50	35
Dr. D	0	19	81
Dr. E	33	33	33

**“If it isn’t written, it wasn’t done.”**

- ◆ Good advice, but not the law.
- ◆ Medicare payment is determined by the content of the service, not the content of the medical record.
- ◆ The documentation guidelines are just that: guidelines (although the carrier won’t believe that).

# Role of Documentation: The Law

“No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.”

*Social Security Act §1833(e)*

# Role of Documentation: The Cases

- ◆ Carriers also often cite Anesthesiologists Affiliated v. Sullivan, 941 F.2d 678 (8th Cir. 1991).
- ◆ In that case, the court rejected the defendant's argument that even if the clinic made billing errors they were "merely a matter of unartful description of the services it provided."

# Role of Documentation: The Cases

- ◆ This situation is distinguishable from E&M cases because the anesthesiologists' defense was even if they did not provide services as claimed, they provided other reimbursable services.
- ◆ In short, that is a case where the bill does not accurately describe the work done.
- ◆ In most E&M cases, the bill describes the work done, there is simply a lack of documentation.

# Role of Documentation: Guidance from CMS/HCFA

- ◆ The CPT Assistant explains: “it is important to note that these are *Guidelines*, not a law or rule. Physicians need not modify their record keeping practices at all.”

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- ◆ CMS has publicly stated that physicians are not required to use the Documentation Guidelines.

# Role of Documentation: Guidance from CMS/HCFA

## **“Documentation Guidelines for Evaluation and Management Services Questions and Answers**

These questions and answers have been jointly developed by the Health Care Financing Administration (CMS/HCFA) and the American Medical Association (AMA) March 1995.

1. Are these guidelines required?

No. Physicians are not required to use these guidelines in documenting their services.

## Guidance from CMS/HCFA

However, it is important to note that all physicians are potentially subject to post payment review. In the event of a review, Medicare carriers will be using these guidelines in helping them to determine/verify that the reported services were actually rendered. Physicians may find the format of the new guidelines convenient to follow and consistent with their current medical record keeping. Their usage will help facilitate communication with the carrier about the services provided, if that becomes necessary. Varying formats of documentation (e.g. SOAP notes) will be accepted by the Medicare carrier, as long as the basic information is discernible.”

# Guidance from CMS/HCFA

“6. How will the guidelines be utilized if I am reviewed by the carrier?”

If an evaluation and management review is indicated, Carriers will request medical records for specific patients and encounters. The documentation guidelines will be used as a template for that review. If the documentation is not sufficient to support the level of service provided, the Carrier will contact the physician for additional information.”

# Role of Documentation: Guidance from CMS/HCFA

“7. What are my chances of being reviewed?

Review of evaluation and management services will only occur if evidence of significant aberrant reporting patterns is detected (i.e., based on national, carrier or specialty profiles). Our reviews are conducted on a ‘focused’ basis--there is no random review.”

- ◆ **Documentation is relevant only if there is doubt that the services were truly rendered.**

# Audit Results

	Under-coded	Correctly-coded	Over-coded
Dr. A	13%	76%	11%
Dr. B	50	30	20
Dr. C	15	50	35
Dr. D	0	19	81
Dr. E	33	33	33

# ~~Audit~~ Review Results - What Do They Mean?

	Documentation Exceeds Code <del>Under-coded</del>	Documentation Supports Code <del>Correctly-coded</del>	Documentation Does Not Support Code <del>Over-coded</del>
Dr. A	13%	76%	11%
Dr. B	50	30	20
Dr. C	15	50	35
Dr. D	0	19	81
Dr. E	33	33	33

# Retrospective vs. Concurrent Reviews

- ◆ Consultants/Lawyers argue duty to refund supports doing concurrent reviews.
- ◆ This logic seems flawed. In either event, you are equally “on notice” of any problem. The question is whether you have a duty to refund.
- ◆ Anecdotal evidence suggests concurrent reviews are more effective.

# Should We Quantify Exposure?

- ◆ The government may use it against you.
- ◆ It is an effective method of convincing skeptics.

# Should We Quantify Exposure?

If you do it, include a disclaimer like “our chart reviews are not audits designed to determine whether we have been overpaid or underpaid. First, they are not a statistically valid sample. Moreover, they only review the documentation, without attempting to determine the amount of work you actually performed. Therefore, these figures are far from scientific.

# Should We Quantify Exposure?

However, since a Medicare review would base the initial overpayment determination solely on the documentation, these figures give you some idea of how your charts would fare in the first phase of a Medicare review.”

# Should I Try To Preserve The Confidentiality of Reviews?

- ◆ Reasons for confidentiality:
  - Distribution may waive any privilege.
  - Every recipient is a potential *qui tam* plaintiff.
- ◆ Reasons for dissemination:
  - Secrecy builds fear; disclosure builds trust.
  - Sunshine is a great disinfectant.

## Example 2

- ◆ One day, a patient who was treated by the very productive president of your group calls and complains she was billed for a complete physical, but she never removed any clothes.
- ◆ What do you do?

## Example 2

A review of that physician's appointment book reveals that the physician worked from 9-3, took lunch, and saw 67 patients; 6 of the visits were billed as 99215/99205. The documentation supports all but 5 of the visits. (There is a comprehensive physical documented for the woman who called.)

# Stark

- ◆ A physician may not make a referral to an entity for the furnishing of designated health services if the physician (or an immediate family member) has a financial relationship with the entity.
- ◆ An entity may not bill for designated health services furnished under a prohibited referral.
- ◆ The penalties only apply when a bill is submitted, but beware of licensing boards.

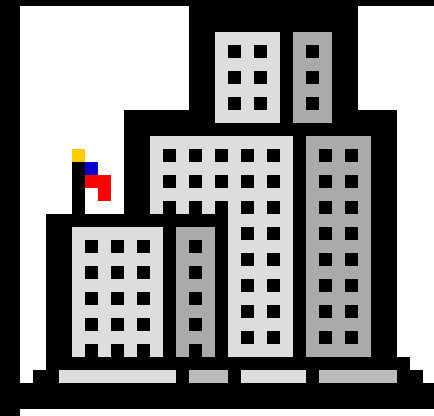


physician

Order for DHS



like lab, x-ray, therapy,  
hospital services



\$/services like a



lease, salary  
ownership, goods, service

Entity, such as  
clinic, hospital,  
etc.

# Designated Health Services

- ◆ **Clinical laboratory**
- ◆ **Physical therapy**
- ◆ **Occupational therapy**
- ◆ **Radiology services**
- ◆ **Radiation therapy services and supplies**
- ◆ **Durable medical equipment and supplies**
- ◆ **Parenteral and enteral nutrition**
- ◆ **Prosthetics and orthotics**
- ◆ **Home health services**
- ◆ **Outpatient prescription drugs**
- ◆ **Inpatient and outpatient hospital services**

# “Physicians may not get revenue from designated health services”

- ◆ Very misleading. Distinguish between **revenue** and **credit**.
- ◆ Physicians can not be credited for simply ordering a scan/DHS covered by Medicare/Medicaid.
- ◆ You can credit physicians for ordering scans (and other DHS) for non-governmental patients.
- ◆ You can divide ancillary revenue on factors other than who ordered them.

# “Physicians may not get revenue from designated health services”

- ◆ Physicians can get credit for DHS personally performed or those “incident to” their work.
  - This is a BIG exception. Chemo, PT and a host of other services may qualify.
- ◆ You can divide profits among subgroups of 5 or more physicians.
- ◆ Beware of the DME problem: You can’t own DME in an urban area.
  - Know the difference between DME and prosthetics and orthotics.

# Practical Points

- ◆ Can always distribute DHS money on any basis other than referrals, i.e. equally, RVUs, seniority.
- ◆ Understand the pros and cons of incident to.

# “Incident To” Billing

- ◆ Clinic can bill for “incident to” services only if:
  - Clinic pays for the expenses of the ancillary person.
  - Clinic is the sole provider of medical direction.
  - The first visit for the illness/injury in question is with a physician (later visits may be with the non-physician provider).

# “Incident To” Billing

- The service is something typically done in an office.
- **The service is not in a hospital or nursing home.**
- A clinic physician is “in the office suite.”
- As of 1/1/02, the service must be billed under the supervising physician’s name. (But this may be changing, someday).

# Pros and Cons of “Incident to”

## ◆ Pros:

- Better reimbursement (but not for PT).
- Supervising physician can get production credit.

## ◆ Cons

- Can't take referrals from the outside without seeing the patient.
- Must bill under a physician who is present.
- Can't do it in the hospital.

## Example 3

- ◆ Orthopedic group contracts with radiology group to place an MRI on site, and lease techs to operate the equipment. Ortho group pays a “per click” payment to the radiology group, and bills payors for the service.

# “You can’t profit from an outsourced service”

- ◆ The real questions are whether the payments reflect fair market value and whether there is a legitimate business purpose for the transaction.
- ◆ Courts have ruled that if “one purpose” of a venture is to pay for referrals, you are guilty of a felony. Be honest with yourself about your rationale.

# “You can’t profit from an outsourced service”

- ◆ In a “per click” transaction, there are generally two different areas where you need to worry about FMV.
  - The “per click” price.
  - The total profit.
- ◆ Both must be reasonable.

## Example 4

An internal medicine practice leases techs and equipment from a cardiology clinic and bills for the services. The carrier says that the IM group can't bill for the leased techs, and that you must have a physician present at all times when the diagnostic tests are performed, because diagnostic tests are covered as being "incident to" the physician's services. They also seek an overpayment because they find a lack of written orders for some scans.

# Are they right?

- ◆ Do you need to have a physician present?
- ◆ Can you bill for services by a leased tech?
- ◆ Do you need a written order?

# “Diagnostic Tests Are Billed Incident to a Physician’s Service”

- ◆ Diagnostic tests are covered under §1861(s)(3). By contrast, incident to services are covered under §1862(s)(2).
- ◆ Must have an order from treating Dr. It need not be written.
- ◆ Final supervision rules published in 1997 finally took effect in April 2001.
- ◆ Each service requires either general, direct or personal supervision by a physician.

# “A clinic can’t lease techs to perform a test”

- ◆ CMS Guidance last October established supervision as the key test for who can bill a diagnostic test.
- ◆ You can employ or lease techs and equipment, but to bill Medicare you must supervise. (Note: the proposed 2008 fee schedule would change this!)

# Diagnostic Tests

- ◆ In October 2002, CMS radically changed their policy on diagnostic test billing.
- ◆ Underlined text is new, *pink/italics* type was deleted. The remaining text was unchanged.

## CPM Ch. 13, § 20.2.4

- ◆ B. Payment.-- If a test is personally performed by a physician or is supervised by a physician, such physician may bill under the normal physician fee schedule rules. This includes situations in which the test is performed or supervised by another physician with whom the billing physician shares a practice.

## CPM Ch. 13, § 20.2.4

- ◆ *<For this purpose, services under a physician's supervision has the same meaning as is required for services to be considered incident to a physician's service (see §2050), i.e., direct supervision of the physician's own employees or of his or her medical group which constitutes a physician directed clinic under §2050.4>*

## CPM Ch. 13, § 20.2.4

- ◆ Section 2070 sets forth the various levels of physician supervision required for diagnostic tests. The supervision requirement for physician billing is not met when the test is administered by supplier personnel regardless of whether the test is performed at the physician's office or at another location.

## CPM Ch. 13, § 20.2.4

- ◆ *<In addition, for the supervision requirement to be met, the personnel must be employed by the physician or by his or her medical group in his, her, or its medical practice. The fact that a physician may have an ownership interest in the outside supplier is not material to this determination, and employees of such supplier are not considered the physician's employees for purposes of this provision.>*

## CPM Ch. 13, § 20.2.4

- ◆ D. Questionable Business Arrangements.--Section 15048.B imposes no special charge or payment constraints on tests performed by a physician or a *<physician's employees under his or her supervision.>* technician under the physician's supervision. There are two requirements for all diagnostic tests under §1861(s)(3) of the Act, as implemented by 42 CFR §410.32 and §§15021 and 2070. Namely, the test must be ordered by the treating practitioner, and the test must be supervised by a physician.

## CPM Ch. 13, § 20.2.4

- ◆ However, attempts may be made by the medical diagnostic community to adjust or establish arrangements which continue to allow physicians to profit from other's work or by creating the appearance that the physician has performed or supervised his/her *<employees' performance of the service>* technicians who are employed, contracted, or leased.

## CPM Ch. 13, § 20.2.4

- ◆ Some of these arrangements may involve cardiac scanning services and mobile ultrasound companies leasing their equipment to physicians for the day the equipment is used, and hiring out their staff to the physicians to meet the supervision requirement. The bonafides of *<these arrangements are extremely suspect. HCFA views this arrangement as a transparent>* **such arrangements may be suspect and could be an** attempt to circumvent the prohibition against the mark-up on purchased diagnostic tests.

## CPM Ch. 13, § 20.2.4

- ◆ If you have any doubt that a particular arrangement is a valid *<employer-employee relationship and/or believe that a physician is billing for a purchased diagnostic test in excess of the amount permitted, refer the case to the>* relationship where the physician is performing or supervising the services, this should be investigated.

# “You need a written order for all diagnostic tests.”

- ◆ An IDTF must have a written order.
- ◆ When explaining why IDTFs need a written order, CMS explicitly stated that a written order for a diagnostic test is not necessary in a physician clinic.
- ◆ Note the difference between “you need an order” and “you need a written order.”

# Billing for Reads

- ◆ Medicare policy permits you to bill for reads done offsite if:
  - Contract permits Medicare to collect overpayment from either party.
  - The person doing the service has unrestricted access to claims you submit.
- ◆ Medicaid still varies by state.

# The Stark Trap

- ◆ Listservs say Stark prohibits off-site reads.
- ◆ The theory is based on the definition of a “physician in the group practice.”
- ◆ Question: can an IK offsite be considered a physician in the group practice?

# The Stark Trap

- ◆ “an independent contractor physician during the time the independent contractor is furnishing patient care services (as defined in this section) for the group practice under a contractual arrangement with the group practice to **provide services to the group practice’s patients in the group practice’s facilities.**”

**“The carrier has total authority to determine medical necessity.”**

- ◆ While carriers like to believe this, many courts have adopted the “treating physician rule.”
- ◆ The theory is that the patient’s physician is objective. Therefore, the physician’s opinion receives deference.
- ◆ Medicare’s legislative history supports this argument.

**“The carrier has total authority to determine medical necessity.”**

“It is a well-settled rule in Social Security Disability cases that the expert medical opinion of a patient’s treating physician is to be accorded deference by the secretary and is binding unless contradicted by substantial evidence... This rule may well apply with even greater force in the context of Medicare reimbursement. The legislative history of the Medicare Statute makes clear the essential role of the attending physician in the statutory scheme; ‘the physician is to be the key figure in determining utilization of health services.’” Gartmann v. Secretary of the U.S. Department of HHS, 633 F.Supp. 671, 680-681 (E.D. N.Y. 1986).

**“The carrier has total authority to determine medical necessity.”**

A carrier is expected to place “significant reliance on the informed opinion of the treating physician” and to give “extra weight” to the treating physician’s opinion. Baxter v. Sullivan, 923 F.2d 1391, 1396 (9th Cir. 1991).

# “The carrier has total authority to determine medical necessity.”

- ◆ CPM Ch. 30, § 100.2 forbids carriers from recouping an overpayment on the basis of a lack of medical necessity if a situation is ambiguous enough that the carrier requests its own physician consultant to review whether the services are covered.
- ◆ This should place the burden of proof on a carrier during an appeal.
- ◆ It provides a firm ground for challenging the carrier’s arguments that office visits can be denied as not medically necessary.

## Example 5

An oncologist documents a consult as “Ms. Patient was referred to me by Dr. Smith to manage her colon cancer pain.” At the initial visit, the physician begins a course of treatment. The physician mails a copy of the chart notes back to Dr. Smith with a brief cover letter thanking Dr. Smith for the referral.

# New Consult Guidance

- ◆ New policy says a consult does not occur when there is a “transfer of care.”
- ◆ Seems to revert to pre-1998 language.

# New Consult Guidance

- ◆ “An internist sees a patient that he has followed for 20 years for mild hypertension and diabetes mellitus. He identifies a questionable skin lesion and asks a dermatologist to evaluate the lesion. The dermatologist examines the patient and decides the lesion is probably malignant and needs to be removed. He removes the lesion which is determined to be an early melanoma. The dermatologist dictates and forwards a report

# New Consult Guidance

to the internist regarding his evaluation and treatment of the patient. Modifier -25 shall be used with the consultation service code in addition to the procedure code. Modifier -25 is required to identify the consultation service as a significant, separately identifiable E/M service in addition to the procedure code reported for the incision/removal of lesion. The internist resumes care of the patient and continues surveillance of the skin on the advice of the dermatologist.”

**“If the chart says referral, it can’t be a consult.”**

- ◆ The use of the word “referral” should be discouraged because it is misleading, but its presence does not change a consult into a visit.
- ◆ Determine whether a physician is seeking an opinion or advice regarding a specific problem.

## Is It a Consult or Visit?

- ◆ “A request for a consultation . . . and the need for consultation must be documented in the patient’s medical record.” CPM Ch. 12 § 30.6.10.
- ◆ A written report must be provided to the referring physician. This can be a letter or communication via the chart. (What about a carbon copy?)

# Is It a Consult or Visit?

- ◆ Any subsequent visit (i.e., not something to complete the initial consultation) is an established patient or SH visit.
- ◆ Can have a consultation within a group if the consultant is in a separate specialty.
- ◆ These rules only apply to Medicare. For all other payors, rely on the CPT definition.

## Example 6

You have a OB/GYN NP who sees patients referred from Internal Medicine physicians. She has been billing the visits as consultations.

# “NPs and PAs cannot bill for a consultation.”

- ◆ Historically, CMS spokespeople, and most carriers, have said that nurse practitioners and physician assistants cannot bill for a consultation.
- ◆ CMS now concedes they can bill consults.
- ◆ This disregards SSA § 1861(s)(2)(K) that says a NP can do anything a physician can do if it is in the scope of the NP’s practice.
- ◆ CPM 12 § 30.6.4 suggests that PAs, NPs, CNSs and midwives can perform any service in CPT codes 99201-99499 when performed incident to a physician’s services.

# “All clinic notes must be signed.”

- ◆ Carriers/consultants often claim that signatures are required.
- ◆ There is no rule requiring signatures for clinic services.
- ◆ Conditions of participation for hospitals/other facilities may require signatures in the chart; COPs are different from reimbursement rules.

## Example 7

Your group hired a physician in March. In December, you discover that this physician was excluded from the Medicare and Medicaid programs in mid-November based on incidents that occurred prior to being hired by your group.

# Timeline

Hire the  
Employee  

---

March

Employee  
Excluded  

---

November

Discover  
Exclusion  

---

December

# “Every rule violation is an overpayment.”

- ◆ The law requires the government to waive overpayments when the provider/supplier is “without fault” and recovery violates equity and good conscience.
- ◆ After a certain period of time, there is a presumption that the physician/supplier is without fault.

## Example 8

Mrs. Jones, who has high blood pressure, diabetes, and a host of other conditions she loves to mention, calls and schedules an “annual physical.”

# Preventive Medicine

- ◆ This is one of the most confusing coding issues.
- ◆ Split billing is the answer.
- ◆ The covered visit is provided in lieu of part of the preventive medicine's service of equal value to the visit. The physician may charge the beneficiary the difference between the physician's current established charge for the preventive medicine service and the established charge for the covered visit. CPM Ch 12 § 30.6.2.

# Pricing

- ◆ House Energy & Commerce Committee Investigated 20 Hospital Systems.
- ◆ “Whether the uninsured are expected to pay substantially higher amounts for medical services than insured patients.”
- ◆ Believes charges vastly exceed cost, and only the uninsured pay “full sticker price.”

# The Investigation

- ◆ Claim in California, urban hospitals average 304.8% of mark-up over actual costs.
- ◆ Letter cites a CA hospital where the uninsured were 2% of patients, but 35% of total profits.
- ◆ Committee's belief seems questionable.
- ◆ Letter suggests harsh treatment of the uninsured, not pricing in general, is the focus of the investigation.

# The Investigation

- ◆ That said, many questions deal with chargemaster issues and cost to charge ratios.
- ◆ While the investigation is of hospital billing, clinics face identical issues.
- ◆ What industry has pricing most similar to the medical industry?

# Some Questions

- ◆ Are clinics required to charge everyone the same price?
- ◆ Is it a kickback to offer the uninsured a discount off of your billed charges?
- ◆ Do you have to put patients into collection?

# “You must bill everyone the same charges.”

- ◆ You can have different prices for identical **services** to different payors.
- ◆ Medicare will pay no more than your median (50<sup>th</sup> percentile) charge.
- ◆ Having different prices can create issues, but they are no different than the issues created by accepting less than your billed charges as payment in full.

# “You need to bill everyone the same charges.”

- ◆ Medicare recognizes that you will offer discounts to insurers. This is permitted. Why would discounts to the uninsured be worse?
- ◆ What industry has pricing most similar to the health care industry?
- ◆ Understand the concept of implied contracts, and how they relate to hamburger.

# “Kindness to the Uninsured is Illegal”

- ◆ The Medicare/Medicaid antikickback statute only applies to patient’s with governmental insurance.
- ◆ Many folks focus on the rules governing bad debt coverage, which require “reasonable collection efforts” from the non-indigent.
- ◆ You can define indigent.
- ◆ Consistency should be enough.

# Discounts

- ◆ Recognize the differences between free care, a discount, and insurance only.
- ◆ For poor patients, it is hard to imagine anyone complaining about any of the 3.
- ◆ For referring physicians, beware of both Stark and the Antikickback law.

# Discounts to Referring Physicians

- ◆ Stark would allow professional courtesy with some conditions, including notification of the insurer for “insurance only” situations.
- ◆ Antikickback is a problem only if the courtesy is targeted to help referring physicians.

# Insurance Only

- ◆ If the insurer objects, they have a potent arsenal available.
- ◆ They can argue that you have misrepresented your charge, this would lower your reimbursement.
- ◆ They can argue that you have eliminated the patient's duty to pay, also eliminating any duty of the insurer to cover the care.

# “You can’t charge for free stuff.”

- ◆ This sounds very authoritative, but what is the source?
- ◆ There is a rule prohibiting mark-up of purchased diagnostic tests, and charging for drug samples, but these appear to be unique.
- ◆ MCM 2050 says incident to services must represent a “cost” to the physician, but doesn’t elaborate.
- ◆ If you can’t bill for free stuff, is there a limit on marking up the price? Does paying one cent allow limitless mark-up?

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