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Managing Your Practice vs Your Practice Managing You!

Revalidation-Audits-Practice Divorces



CPM Provider Newsletter Digest



October 2011

Volume 7, Issue 10

The Great National Medicare Provider Revalidation



Roughly 750,000 providers in the Medicare program soon will be asked to revalidate their individual enrollment records during a massive anti-fraud effort required by the health system reform law. The Centers for Medicare & Medicaid Services (CMS) hopes to weed out only the people who shouldn't have billing privileges, but providers are concerned that legitimate health professionals could get caught up in the enrollment sweep by mistake.

CMS gradually will send revalidation requests by mail to more than 1.4 million health professionals -- more than half

of whom are doctors -- between now and March 23, 2013, the agency announced on Aug. 10. Providers who have enrolled since March 25, 2011, will not be required to revalidate, because their applications were scrutinized under new screening criteria, CMS said. Those receiving a request would have 60 days to recertify their enrollment information, which for some doctors will be similar to the process they first used to sign up with the program.

"Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges," CMS stated in the notice. Previous revalidation efforts have targeted much smaller segments of providers, such as those who had not updated

(Cont'd on pg 3)

5 Ways to Manage Your

Online Reputation

In the days of social media, negative online content could have far-reaching legs and a devastating impact on a provider unless it's managed efficiently.

Even if some providers themselves are not online, their names, comments on their style of practice, and complaints or compliments about them probably are. All of the online content devoted to a particular provider could negatively impact his or her reputation, and subsequently his or her business, if steps aren't taken to manage that content and -- when necessary -- defend it. This is often referred to as online reputation management.

(Continued on pg 6)

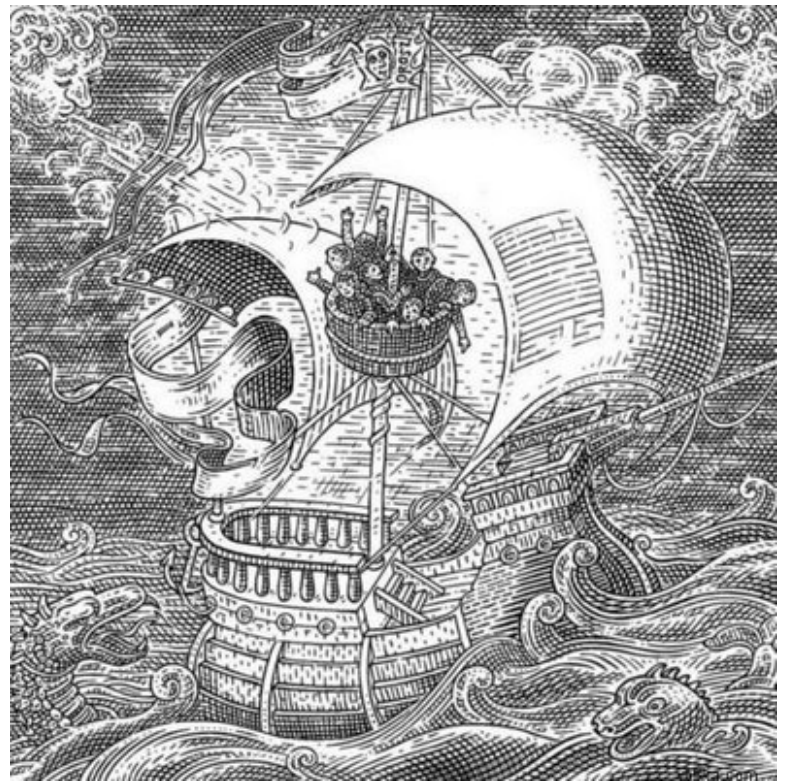
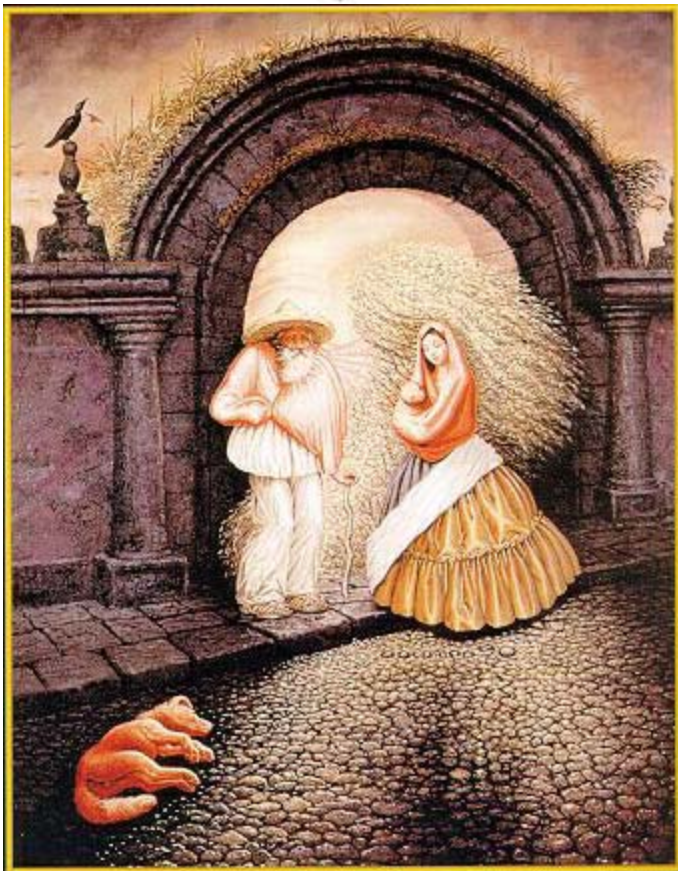


Ramblings From the Editor

L. A. Seidelman, Editor

Optical Illusions...

In the spirit of Halloween, here are some interesting and fun optical illusions for you to discern...what do you see?



See more optical illusions in the "Avoiding the Medicare Audit" article on page 13

Linda Seidelman

The Great National Medicare Provider Revalidation

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their enrollment within the past five years or medical suppliers in areas known to be at high risk for fraud. Medicare administrative contractors across the country process about 27,000 new enrollments and more than 30,000 reassignments, or changes to billing and payment information, each month. Doctors have described Medicare enrollment as tedious and confusing at times. Attempts to

strengthen safeguards in the process have created problems for those caring for Medicare patients in recent years. In March, CMS implemented additional program integrity defenses mandated by the health reform law to prevent fraud. Provider practices have reported long wait times for new applications to be approved since then.

"We have very significant concerns with this revalidation effort in light of the problems Providers have had with

enrollment and revalidation efforts in the past," said American Medical Association President Peter W. Carmel, MD. "The AMA is making this a priority and urging CMS to reconsider this action." Provider practice administrators are being told to watch for the letters requesting revalidation, said Allison Brown, a senior advocacy adviser with the Medical Group Management Assn. in Washington. Practices are urged to begin revalidation as soon as they receive a request, she said. Providers can revalidate using paper applications or by using CMS' online enrollment system, called PECOS, the Provider Enrollment, Chain and Ownership System, which CMS says is the most efficient way to submit necessary information. But even if every practice complies with the letters as soon as they receive them, the plans to revalidate all health professionals who enrolled before March 25 would require contractors to process thousands of additional applications a day on top of the ones they already receive. Practices also must wait until their Medicare contractor sends them a

request before they can revalidate. "We may end up with enrollment backlogs just given the scope of the revalidation effort," Brown said.

Bureaucratic brick walls

The Neurology Medical Group of Diablo Valley in Pleasant Hill, Calif., saw the hassles of the

T ***he next day I received an email that said the application was rejected***

Medicare enrollment process when it attempted to change the practice address for a neurologist who was starting at the medical group in September 2009.

The initial enrollment application sent in August 2009 went missing. A second application was denied on a technicality, and a third application was approved in February 2010. But the Medicare contractor would backdate the provider's enrollment status only to late November 2009. The contractor has denied the practice \$30,000 in Medicare charges billed by the neurologist between September and November of 2009.

"It was insufferably delayed, so we could not serve Medicare patients," said Steven Holtz, MD, a neurologist at the group. The practice recently hired another neurologist, who will start on Sept. 1. The practice sent the provider's Medicare enrollment

Continued...

| Health professional type | Enrollments | % of total |
|-------------------------------------|------------------|-------------|
| Physicians | 750,836 | 52% |
| Nonphysicians | 300,362 | 21% |
| Clinics, group practices and others | 241,441 | 17% |
| Equipment suppliers | 102,104 | 7% |
| Institutional professionals | 49,926 | 3% |
| Total (as of March 2) | 1,444,669 | 100% |

The Great National Medicare Provider Revalidation

(from pg 3)



application in July, but the contractor returned the application and noted that it was sent too early, said Nadia George, the practice administrator. Resending it on Aug. 1 resulted in an approval two weeks later, but that was short-lived. "The next day I received an email that said [the application] was rejected,"

She followed up with a phone call

to the contractor's enrollment department and was told the application appeared to be approved. George is planning to have the new hire treat one Medicare patient before Sept. 1 and have him submit a claim to ensure that the provider is in the Medicare system.

Such an experience is not unique. Providers tend to find enrolling in the Medicare program an unnecessarily long, complicated and bureaucratic process, said Donald Waters, executive director of the

Alameda-Contra Costa (Calif.) Medical Assn. It's a task often left to professional credentialing staff and practice administrators. But even the most experienced staffers encounter problems with confusing language on enrollment forms and vague instructions that cost provider practices time and money, Waters said.

The MGMA's Brown said CMS has planned improvements to the enrollment website. Changes would allow providers to sign online applications electronically, instead of having to print a certification statement for the application and mail it to a contractor. The improvements could be implemented by January 2012, she said.

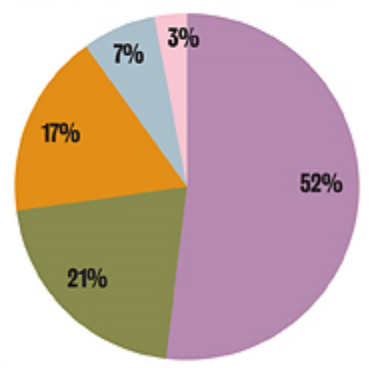
A massive re-enrollment effort

Medicare plans to revalidate the enrollments of more than 1.4 million individuals and facilities by March 23, 2013. Providers account for more than half the list.

Physical Therapists considered moderate risk

Health professionals are subject to different screening criteria during the Medicare enrollment process. Providers and non-provider practitioners fall in the limited-risk category; physical therapy, x-ray suppliers and currently enrolled home health agencies are in the moderate risk category; and new home health agencies and new equipment suppliers are in the high-risk category. ☒

PERCENTAGE OF TOTAL ENROLLMENT



| Type of screening | Limited | Moderate | High |
|--|---------|----------|------|
| Verification requirements set by Medicare | Yes | Yes | Yes |
| License verifications | Yes | Yes | Yes |
| Verification of Social Security numbers, taxpayer ID numbers, etc. | Yes | Yes | Yes |
| Unscheduled site visits | No | Yes | Yes |
| Fingerprint-based background checks | No | No | Yes |

Medicare Revalidation Assistance



Did You Know That Medicare Now Requires All Healthcare Providers Who Enrolled in Medicare Prior to March 25th, 2011 to Revalidate Their Medicare Billing Privileges?



Avoid PTAN Inactivation! Have Your Provider Revalidation or Enrollment Submitted Correctly the First Time!

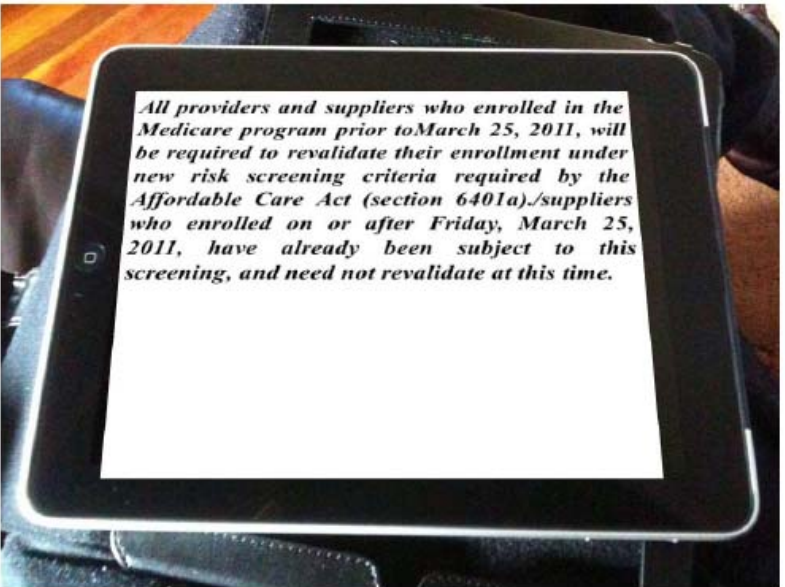
Dear Healthcare Provider: It is time to Revalidate Your Medicare Billing Enrollment...

When the Medicare Enrollment Revalidation letter comes in the mail, it can be an overwhelming prospect. The 855B (the what?!?) is 49 pages alone (paper)!

Most times, CMS will require an 855I, 855R, and a CMS588 also.

There is also a definite deadline in which all enrollment applications and supporting documentation must be received by your Medicare carrier—that's right, not postmarked, received.

If these deadlines are not met, Provider's PTAN will become deactivated until such time that enrollment compliance is achieved. It can be a pretty stressful prospect, not to mention the interruption in reimbursements.



That's where Clinical Practice Management comes in!

We have been 100% successful in assisting Providers through the mandatory revalidation process. We are well-versed on both the CMS PECOS enrollment system and paper enrollments. We also have a 100% success rate in initial Provider enrollments as well.

So whether you're revalidating your Medicare privilege, or applying to become a Medicare Provider for the very first time—CPM can navigate the process for you! Contact us for fee amounts! 714-450-4999

Phone: 714-450-4999

FAX: 714-974-0055

email: kimberly@cpm4results.com
or
lseidelman@cpm4results.com

5 Ways to Manage Your

Online Reputation



From page 1

Online reputation management has become big business, as evidenced by the number of radio and online ads offering to help providers. But providers can manage their own reputations, help build positive ones, and prevent negative content from turning into a crisis that needs to be dealt with professionally.

As quickly as online content can spread, especially in the age of social media, experts say online reputation management should be a key component to any business plan.

"The best defense in these cases is good offense," said Scott Sobel, president of Media and Communications Strategy, a Washington-based public relations firm specializing in crisis management.

Christian Olsen, vice president of Levick Strategic Communication's digital and social media practice, said social media has changed the dynamics of reputation management, because in addition to providers communicating with their patients, their patients are now communicating with one another on social media websites.

For most providers, there are five simple steps they can take to manage and maintain a good reputation online. For others, managing their online reputations may require more time and expertise than they have available.

Step One: Google yourself

Olsen said many make the mistake of thinking that because they don't have a website or are not involved in social media they are not online. "It just means your voice is not being heard in a conversation about you," he said.

The first step in managing a reputation is knowing what there is to manage. Reputation management experts recommend that providers conduct Google searches on

themselves at least once a month, preferably more often.

Things can spread quickly online, so seeing what content is there on a regular basis will help doctors stay ahead of a potential crisis.

It's also a good way to see what positive things are being said about you, which you may be able to build on.

Steven Wyer, managing director of Reputation Advocate Inc. and author of the book *Violated Online*, said providers should set up alerts on Google and Yahoo. These alerts

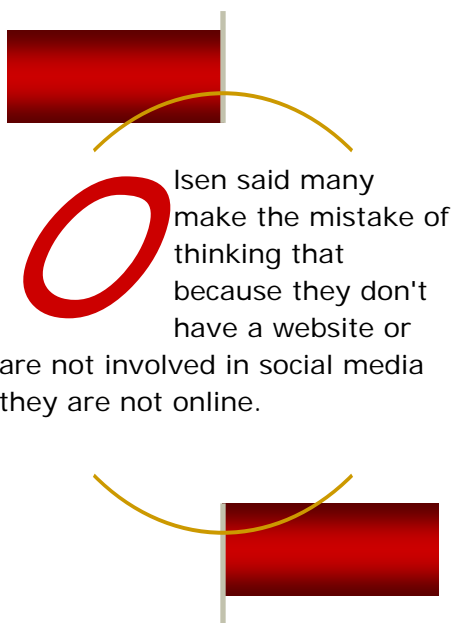
work by registering keywords, such as a name, that the search engines will use to comb the Internet looking for any new mention of those keywords on blogs, websites, online forums and other sites. When it finds a new mention, it will send an email detailing where the keywords were mentioned, what was said and a link to the website.

The mistake many providers make, however, is to not include all reasonable variations of their name in an alert, Wyer said. For example, John Smith, MD, could have several variations, including Dr. John Smith, Dr. John C. Smith, Dr. John Smith, MD, etc. Alerts for a handful of those variations should be set up.

Step Two: Correct mistakes and false information

The easiest places to start are websites that show up high in Google searches. Those sites are likely to be provider finder or rating sites or health plan provider finders. The sites often

Continued...



Olsen said many make the mistake of thinking that because they don't have a website or are not involved in social media they are not online.

5 Ways to Manage Your Online Reputation



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include wrong or outdated contact information and incomplete biographical and educational history.

Many of these sites give providers the opportunity to edit their own profiles, which they should do by bolstering the information that is presented and highlighting positive aspects. Experts say providers should complete their CVs by adding professional achievements such as awards and published articles. They also can use the forum to talk about their style of practice and what patients can expect from them.

Dealing with false or inflammatory content can be trickier, Olsen said. How providers handle false or misleading information on a site could make a situation worse, depending on how it's handled. They should do what they can to correct the information without being too aggressive, he said. One suggestion is to acknowledge the problem and then ask the

author of the content to take things offline to find a resolution.

"Respond in public, but ... definitely don't play it out in the open," Olsen said.

Wyer said most websites have posted terms and conditions. If content on the site clearly violates those terms, a request can be made to the website's site administrator to have the information removed. The same request can be made of content that violates privacy laws or *Health Insurance Portability and Accountability Act (HIPAA)* regulations. Insults are generally not violations, but Web posts that contain personal identifiable information would be considered violations.

Step Three: Create your own content

The best way providers can steer conversations in the direction they want, or help hide the conversation they hope no one sees, is to start the conversation themselves. Experts say providers can do this on many online venues: personal blogs, websites and personal social media pages, which all tend to rank high in

search engine results. If you already have done a search on yourself, you would know which sites are ranked high and need to stay high, and which sites you may want to push down in the results. Posting information on sites that generally rank high in Google searches, such as provider finder sites and LinkedIn profiles, will help push other content down in the search results. The farther down the better, as 90% of people won't go past the first page of search results and 99% won't go past page 2, said Noah Lang, director of business development for Reputation.com.

Wyer said it's important for providers to own their own name online, starting with claiming their profiles on finder and review sites. On most provider profile sites, a link asks if you are the doctor being profiled. If you are, you can register with the site to take ownership of that listing and edit it as you see fit.

Owning your name could include buying website domains under the provider or practice name, creating social media pages and

creating blogs in your name.

A misconception, Wyer said, is that all of these sites must be managed daily. If a provider wants to establish him or herself as a blogger, the goals and strategies are different. But simply populating the sites with basic information such as the doctor's bio, contact information and a link to a website, combined with the appropriate keywords and elements to ensure good placement in Google searches, doesn't require daily or even weekly maintenance.

Step Four: Embrace constructive criticism

Studies have found that an overwhelming majority of online reviews of physicians are positive. But even if a doctor does not achieve unanimous positive reviews, that's all right, experts said.

Sobel says having only simple and positive reviews will raise red flags. "You want to look for good

Continued...

5 Ways to Manage Your Online Reputation



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but balanced comments. There will always be someone unhappy," he said. But it's important for patients to use reputable sites that rate doctors fairly.

Physicians should find a handful of rating sites they trust and direct patients to them. They can do so by having staff verbally tell patients about the sites, hang signs in the waiting room that list the Web addresses, and hand out fliers at the check-out desk.

Step Five: Address actionable items

Sobel said many of the things patients complain about online are things physicians can work to change immediately and publicize online. Knowing what the "hot button issues" are among patients -- long waits, lack of response or slow responses, and leaving a message for the doctor and having someone else call them back -- and addressing those things in

the practice and online will go a long way toward improving your reputation. Part of managing your online reputation is managing how you come across online addressing those issues.

Lang said physicians should broadcast online when changes have been made due to complaints.

Sobel said a physician's website not only can be a source of the positive information they want patients to find but also can serve as a way to respond to negativity in a positive way.

When a physician's reputation has taken a beating, Sobel said, ignoring it and hoping it goes away is not a sound option. Besides their knowledge of medicine, physicians' reputations are their highest commodity, he said.

Think twice before taking legal action for something online

Things read online might be blatantly false and even harmful to a physician's reputation. But in most cases, taking legal action may make the situation worse.

When opinions and reviews include false information that would constitute libel or defamation, legal action might be warranted, said Craig Newman, a New York-based attorney. But he warns clients to think long and hard before filing a lawsuit or drafting a cease-and-desist letter.

Because of the many exceptions, libel and defamation are very hard to prove in a court of law. Therefore, physicians take a risk when filing a suit, bringing more attention to the matter, and not being able to prove their case.

Noah Lang, senior director of business development at Reputation.com, said it's generally better just to let things live and die. A physician could send a cease-and-desist letter, but then a blogger could post that online, only exacerbating the issue.

However, experts said legal action might be warranted -- including a call to law enforcement -- if a physician sees something threatening to family or staff members as well as the physician.

Here's what to look for in a reputation management firm

Not all reputation management firms are created equal. If a reputation management company doesn't handle things correctly, a bad situation could be made worse.

First, experts say, a good reputation management firm will have a good understanding of the physician's business. If it specializes in services for physicians specifically, the better.

A good firm will have a relationship with a reputable lawyer or law firm and have some knowledge of public relations. The firm also should be familiar with First Amendment and copyright laws.

While a good firm should never talk about specifics of a prior case, it should be able to talk in general terms about the techniques it will use, such as search engine optimization. ☞



Pain management for practice breakups

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Splitting up a practice partnership is nearly always emotional and painful, but experts say there are ways to minimize the drama.

Attorney John Fanburg likes to say that medical partnerships are "marriages without love." He should know, as part of what keeps him busy is helping medical practices divorce as peacefully as possible.

There may not be love, but there is plenty of emotion embedded in a medical practice partnership, whether the practice is made up of two or two dozen doctors.

When the partnership fails, there is much at stake: Professional

Professional reputations, health insurance contracts, vendor relationships, employees' livelihoods -- and, most important, patients' health and happiness -- are at risk. Even a relatively amicable split can be emotionally and professionally draining.

Elizabeth Twardon, MD, is a family physician who practices at Family Care of Fairview in Asheville, N.C. This summer she left her employed, part-time position at another practice in town when the partners in the group split up, with some starting their own group and another leaving family practice.

She has had to deal with practical considerations, such as learning a new electronic medical record system, making sure she has copies of her paper records from the old practice and ensuring that her patients know how to find the new office.

But the biggest hardship was on the patients, especially those who had to find a new physician after decades of care from the same one, she said.

Though she felt lucky to find

another place to practice where there was room for her and the patients who followed her, she said the transition has been a struggle for everyone involved. "It was sad to see it go," she said.

Fanburg, who works out of the New Jersey office of the Brach Eichler law firm, is not the first to compare a medical practice breakup to the dissolution of a marriage. Experts say the keys to surviving a practice split are the same as those for surviving a divorce:

- Prepare for the possibility of a breakup even if everyone in the partnership thinks it never will happen.
- Be reasonable.
- Communicate.
- Ask for help from a professional if things get out of hand.
- Choose partners the next time who share the practice's values and vision, and resolve not to let the next partnership suffer from neglect.

Why it's so hard to stay together

Many factors threaten medical partnerships. The combination of increasing demands on physicians' time and declining compensation for care can prove poisonous.

"When people are dividing the pie, and the pie shrinks, their table manners get worse," Fanburg said, quoting a favorite aphorism.

Many common reasons for breakups come down to a generational divide, said Jim Farrell and Timothy Monaghan,

West Palm Beach, Fla., attorneys with the law firm Shutts & Bowen. The two attorneys spend much of their time guiding practices that are splitting.

They and Fanburg said resentment among older and younger partners over work distribution, on-call requirements,

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Pain management for practice breakups

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The medical partnership preup

The right preparation and thoughtful approach to establishing a practice can keep a practice split, however unexpected, from being more painful than necessary, experts said.

States have varied requirements about what legal documents are needed to establish a medical practice. Other decisions to make are whether partners are forming a corporation, limited liability corporation or another entity. What's essential in any case -- even if it's merely an agreement to share an office or equipment -- is completing that paperwork and keeping it current.

In about half the breakups Fanburg manages, the group's paperwork is nonexistent, flawed or out-of-date. If that's the case, splitting partners probably will need an attorney or at least a mediator to ensure that the breakup unfolds fairly.

"Every physician should have a shareholder employment contract, different than the ones from nonowner employees, and documents called bylaws that set forth how the corporation is run and

partnership buy-ins, profit sharing and delayed retirements are commonplace.

The newest common reason for medical practice divorce is disagreement about whether to sell the practice to a hospital system or merge with a larger medical group.

Sometimes even absent a generational disconnect or choice about whether to sell the practice, the rapid pace of change in health care and the stress of keeping up with those changes can lead to feuding.

"Whether it's a marital partnership or a business partnership, often external frustrations get expressed to the people nearest to you," said Charles Bond, an attorney and health policy analyst with the Berkeley, Calif., firm of Physicians' Advocates. He represents physicians exclusively and has done work for the American Medical Association.

managed, who the president is and how that person is elected," he said.

Experts recommend reviewing -- and, if necessary, revising -- shareholder agreements or other practice documents annually at best, but at least every five years.

Establishing ground rules when a practice first sets up shop is not enough, either. Debra Phairas, practice management consultant and owner of Practice & Liability Consultants in San Francisco, said physicians should revisit their bylaws often and make sure they still make sense. Looking at those rules during an annual strategic meeting gives the group a chance to talk about values and goals on a regular basis before

disagreements push the partners apart, she said.

Consider this

Whether partners are contemplating a split or have agreed to part, it's important to be realistic about the risks and to try to address every contingency. Here are some questions to discuss with practice partners:

- Will one or more partners remain and take over managed care contracts in the practice's name? Be sure that payers don't require new contracts.
- Are electronic patient records protected? Monaghan and Farrell said downloading an entire set of patient records can violate the Health Insurance Portability and Accountability Act and is unethical, but too often that



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- The departing physician may become excluded from an insurer's panel after leaving. Sometimes, Monaghan said, insurers will limit a physician panel in a certain area. If a practice splits, insurers will exclude physicians who worked for an in-network group.
- If a practice divorce becomes too contentious, Monaghan warned, it could get back to payers, and "they could use it as an excuse to dump the whole group."
- If the entire group dissolves, noncompete clauses don't apply, so physicians should prepare for competition from former partners.

Patients come first

There are many decisions partners must make on how to divide up equitably when a practice dissolves, but patients and their records are not among them, Bond said.

AMA policy calls for physicians to give patients adequate notice that a practice is closing or a partner is leaving and to forward medical records, if necessary, to wherever the patient wants to transfer.

- doesn't stop departing physicians from trying it. Talk to the practice's EMR vendor about how to handle licenses for the physicians who still need access to the records.
- How will patients be notified? What will the letter say? Will it go to anyone who has ever been there, or just in the last few years?
- If just one physician is leaving a large group, how will the practice identify his or her patients to notify them?
- How will physicians split equipment like exercise machines and exam tables?

There also are some realities in a practice breakup that partners might not be aware of:

It is unethical, according to AMA policy, not to disclose where a physician has moved if a patient asks.

Phairas and Bond said physicians sometimes forget this, but it's the best policy, because it leaves the decision to the patient.

If the practice shuts down entirely, physicians still must maintain patient records. The requirements for storage vary by state, so it's important to find out what the law is and make sure patients have access to those records.

Monaghan said doctors risk losing their business if they ignore patients or expose them to

breakup drama.

It's also important to protect patients from solicitations from departing doctors, Farrell said. Surreptitious downloads of patient files might lead departing partners to contacting patients who may not even have seen them.

"All of a sudden there's been a mass mailing based on that database, and the front desk gets a phone call from a patient who says, 'I've always been with Dr. Smith. Why am I getting solicited by Dr. Jones?'"

Next time

If the dissolution of one partnership gives rise to another shared practice, experts say the ground rules for strong marriages will help avoid conflict.

"I say my most successful partnerships have four C's: courage to communicate, confront and compromise," Phairas said.

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Pain management for practice breakups

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That type of commitment has kept clients who were in at least one case literally fist-fighting from splitting up, he said.

"It's like they say -- the biggest step is recognizing you have a problem and acknowledging that," he said. "If we get a commitment and we all agree that it makes sense to stay together to try to work this out, that goes a long way."

Legal considerations

Experts say many of the headaches associated with the dissolution of a practice can be prevented or mitigated by ensuring that partners put their expectations and agreements in writing.

Start off on the right foot. Be sure that when a practice is formed, all partners sign the appropriate shareholders' agreement and employment agreements. The agreements should include a contingency plan for a practice split, and for one or more partners' death or disability.

Keep practice documents updated by revisiting them on a regular basis -- annually if possible, but at least

That's one reason she recommends that practice partners meet often. Failure to talk and listen can be fatal to the partnership.

"It's almost like in marriage. There's this expectation, 'They should know how I'm feeling, or figure out what's going on,' " Phairas said. "But nobody can read your mind. You have to communicate -- before it blows up, before seething resentment starts building."

As in any relationship, sometimes the saving grace for a medical partnership is recognizing what would be lost with a breakup.

Doug Griest, PhD, is a psychologist with Atlanta firm Management Psychology Group, and works often with medical groups facing organizational crises. They come to see him, he said, because they want to stay together but need help working as a team.

every five years.

Make sure that when new partners join the practice, they have signed the appropriate agreements.

Agree upon a time frame for a partner to give notice before leaving or retiring.

Agree upon how to assign patients to a primary physician, so that if one partner leaves, it is clear which patients need to be notified.

Make sure buy-in requirements are in writing and regularly updated to reflect the reality of the marketplace and the practice.

Make sure requirements for on-call time are in writing.

What to tell patients

Whether a partner leaves and the practice stays open, or the practice is closing, patients want to know what's going on and need to be told. But how do physicians break the news?

Send a letter to patients and answer questions about the changes to your practice by phone or in person. Be prepared for the

additional call volume when patients receive the letter. Instruct staff how to handle calls about the practice changes.

If one or more partners is leaving but the practice is not closing, tell patients, "We're sorry to see them leave. We're still available to take care of all of your needs."

Tell patients where a departing partner will be practicing. Provide an address, phone number and instructions on how to get a copy of medical records. Patients have a right to follow their physicians and to receive copies of their medical records. ☑





Know Medicare's rules ahead of time, and steer clear of trouble

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consequences if the auditor finds problems with our practice?"

You can put your mind at ease by understanding what triggers the audit process, and what can be done to avoid it. As with any process, it's fundamental to understand the ground rules.

By completing Medicare's enrollment forms, you've legally bound yourself to these ground rules.

Under Section 15, "Certification Statement" of the 855i form, the physical therapist "[a]gree[s] to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in Section 4A of this application."

Subsequently, with each CMS 1500 claim form submitted, you're attesting to the following: "I certify that the services shown on this [CMS 1500] form were medically indicated and necessary."

Additionally, understanding the penalties can provide the necessary incentives to ensure compliance with all of Medicare's rules and regulations. Audits are designed to detect fraud and abuse.

Medicare audit. They may be the two words a physical therapy practice fears the most. When the audit notice arrives in the mail, the chaos begins.

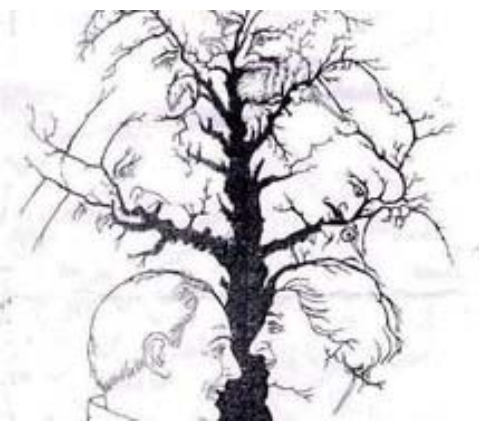
The audit process is cumbersome. You have to identify patient records, locate and retrieve them, copy them and then mail them to the auditors. Then, the waiting and worrying begins.

The questions start to bounce around in your head: "Why are we being audited? Did we do everything correctly? Were our treatments medically necessary?" And finally, one of the most critical questions arises. "What are the

Fraud vs. Abuse

Medicare defines abuse as "practices that, either directly or indirectly, result in unnecessary costs to the Medicare program. Many times abuse appears quite similar to fraud; however, abusive acts are not committed knowingly, willfully and intentionally."

In judging abusive billing practices, CMS uses three standards: whether the billing



- 1) was reasonable and necessary;
- 2) conformed to professionally recognized standards; and 3) reflected a fair price.

Medicare provides several examples of abuse, which are not limited to the following:

- Providing medically unnecessary services; billing Medicare patients higher fees than non-Medicare patients;
- Billing Medicare for services that are the responsibility of other insurers under the Medicare secondary payer regulation;
- Violating the participating provider agreement.

There's a fine line between fraud and abuse. A violation may be initially categorized as abuse, but may be subsequently reclassified as fraud if CMS determines that the violation was performed knowingly and willfully.

Fraud, on the other hand, is defined as "making false statements or representations of material facts in order to obtain some benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person's own benefit or for the benefit of some other party."

Continued...



Avoid the Medicare Audit

Know Medicare's rules ahead of time, and steer clear of trouble

To prove fraud, it must be proven that the violations were performed knowingly, willfully and intentionally. Examples of fraud include, but are not limited to: billing Medicare for services that were not provided; engaging in bribes, kickbacks or rebates to obtain referrals of patients; and describing a non-covered service in a misleading way, such that the billing reflects that a covered service was actually performed.

Regardless of the distinction between the two, suspicion or evidence of either fraud or abuse can trigger an audit. The distinction between the two determines the difference in the

in the repercussions.

Medicare Enforcement

Medicare contracts with fiscal intermediaries for benefit coverage and payment determinations. One responsibility of the intermediary is to carry out the functions of the Medicare Integrity Program. The functions of the Medicare Integrity Program are "review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made. including skilled nursing facilities and home health agencies, including medical and utilization review and fraud review."

Under the Medicare Improvements and Extension Act of 2006, the Medicare Integrity Program is required to engage recovery audit contractors (RACs) to identify and recoup overpayments made by the Medicare program. RACs are incentivized to uncover fraud and abuse; their payment for doing so is made on a contingent basis.

CMS places several reporting requirements on the audit contractor. The RAC is required to

report performance statistics pertaining to the number and amount of overpayments that are recovered, the number of fraud referrals, and the return on investment of such activities by the contractor. Physical therapists must also consider Medicaid in their compliance efforts as well, because the Patient Protection and Affordable Care Act expanded the RAC program to Medicaid.



In essence, RACs analyze compliance with Medicare's coverage rules and take the appropriate corrective actions with non-compliant providers. Evidence of provider fraud is referred to the Program Safety Coordinator for further development, which ultimately may lead to civil or criminal prosecutions.

The audit contractor's work responsibilities are not the only origination source of an audit. The Office of the Inspector General, as

well as the respective State Medicaid Fraud Control Units, maintain hotlines on which suspected instances of fraud can be reported.

Additionally, the Federal False Claims Act has a whistleblower provision, whereby a person who reports the defrauding of a government program (e.g., Medicare) can share in the penalty assessed against the person or entity committing fraud. Fraud Alerts, Government Accounting Office reports and bulletins may also trigger an audit.

Following the audit, the contractor will provide the findings. As such, the provider is entitled to a full review and explanation of the audit findings, and the audit must be understandable to the provider such that it permits the provider to develop an appropriate corrective action plan. Further, the audit must inform the provider of appeal rights, as well as consent settlement options, and allow an opportunity for the provider to provide additional

Continued...



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information to the auditor.

The auditor must consider the additional information if offered by the provider on a timely basis.

However, no explanation is necessary when reporting the findings would compromise pending law enforcement investigations or reveal the findings of law enforcement-related audits.

How Do I Avoid This?

The risk of an audit may be driven by the effectiveness of your clinic's management. In

particular, it is management's responsibility to ensure that the clinicians, the front desk and the billing departments are educated about the rules and regulations governing Medicare participation.

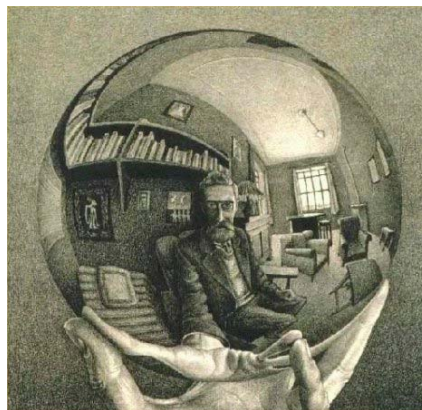
All these areas play a role. The front desk may be responsible for verifying benefits and selecting the proper payer to bill.

The billing department may be responsible for placing billing modifiers on the claim and entering charges. With respect to billing, you should be aware of the Medicare 8-minute rule as well as the distinctions among the descriptions of various CPT codes. In avoiding an audit, much of the focus should be directed to clinical documentation and billing. Documentation must support medical necessity and substantiate the billing.

One helpful resource is the compliance guidance program guidelines offered by the Office of the Inspector General. Recommendations include implementing internal monitoring and auditing through the performance of periodic audits, implementation of compliance and

practice standards through the development of written standards and procedures, designation of a compliance officer or contact to monitor compliance efforts and enforce practice standards, and conducting appropriate training and education on practice standards and procedures.

A Medicare audit can drain a practice's already limited resources. It can be time consuming and cumbersome. A



proactive approach through internal controls and staff education may reduce the risk of an audit.

It's important that all clinic employees understand the rules governing Medicare and Medicaid

participation. Intent and willfulness are keys to determining distinctions between fraud and abuse, though repeated instances of abuse may rise to the level of fraud. The penalties for fraud are far more significant than those for abuse.

Implementing a compliance program may involve some time and effort, but lowering your risk will provide peace of mind, making it well worth the effort.



What do you see? A lady looking in a dressing table mirror, or a man looking at a skull? Throughout this article are other optical illusions, can you discern them all?

Citation Page

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The 4-1-1 On Us!

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L to R; John O'Connor, Kimberly Saalfeld,
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