Compliance Quandaries

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Financial Disclosure

- Mr. Reider is a Partner in the Washington, D.C. office of Arnold & Porter LLP
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Course Objective

- Series of case studies detailing compliance quandaries
- Identify possible reimbursement issues under scrutiny
- Discuss the legal approach to cope with various compliance issues
- Develop a corrective action plan

Compliance Report

In anticipation of developing a compliance program, ABC Eyecare requested a compliance review to assess its current level of compliance with rules and regulations associated with billing practices and operational issues. This review was conducted by a billing consultant and a health care attorney. The findings reveal a series of issues to address.

1. Documentation of medical necessity
2. Premium IOL packages
3. Claim submission errors and refund process
4. Relationships with outside Optometrists
5. Leases for office space

Issue 1: Medical Necessity

- Medicare charts for physician services reviewed and findings associated with medical necessity revealed unsupported
  1. cataract surgeries
  2. diagnostic tests

Illustrative Chart Note

CC: Patient states “He said to come back today to check my cataract.” No changes in vision
Exam: 2 + NSC; BCVA 20/30 OD, 20/40 OS
Assessment: Visually significant cataracts
Plan: Phaco w/IOL, OS, followed by OD
What did I do wrong?

What do I do now?

Criteria for Cataract Surgery

- Objective evidence of a cataract
- Reduced visual acuity
- Lifestyle complaints
- Good prognosis for improvement
  - Alternate – to aid in treatment of retina
  - Patient can tolerate anesthesia
  - Patient awareness

Source: AAO Preferred Practice Pattern, Adult Cataract

Medicare Coverage Policy – Example

The patient has impairment of visual function due to cataract(s) and the following criteria are met and clearly documented:
- Decreased ability to carry out activities of daily living including (but not limited to): reading, watching television, driving, or meeting occupational or vocational expectations; and
- The patient has a best corrected visual acuity of 20/50 or worse at distant or near; or additional testing shows one of the following:
  - Consensual light testing decreases visual acuity by two lines, or
  - Glare testing decreases visual acuity by two lines

Source: NGS LCD L26853

Medicare Coverage Policy – Example

Medicare coverage for cataract extraction with Intraocular Lens implant (IOL) is based on services that are reasonable and medically necessary for the treatment of beneficiaries who have a cataract. Cataract patients must have an impairment of visual function due to cataract(s) resulting in the decreased ability to carry out activities of daily living such as reading, viewing television, driving or meeting occupational or vocational expectations, with further annotation of the following bulleted indications: The patient has been educated about the risks and benefits of cataract surgery and the alternative to surgery, and has provided informed consent.
- The patient has undergone a formal measure that documents the patient’s inability to function satisfactorily due to visual impairment while performing various Activities of Daily Living. The impairment must be documented in a printed form signed by the patient. The questionnaire must be maintained in the patient’s medical record and be available upon request.

Source: Novitas LCD L32690

Medical Necessity

- Patient survey
  - Activities of daily vision scale
  - VF–14
  - Pre-surgical questionnaire

To Refund or Not To Refund...That Is The Question

What is your obligation?
- Recent legislative amendments provide that retaining an overpayment creates liability under the False Claims Act
- Proposed regulations would provide 60 days to refund under the broad definition of an “identified” overpayment
- Recent decision to delay regulations for a year, although the statute may be considered to be self-implementing

Is this an overpayment?
- Do you know you have been overpaid?
- How much have you been overpaid?
**Illustrative Chart Note**

CC: Patient presents for pre-op services prior to cataract surgery
Tests performed: Optical coherence biometry, corneal topography, endothelial cell count, OCT
Dx: NSC – 366.16

All tests submitted and paid by Medicare

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**What did I do wrong?**

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**What do I do now?**

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**Coverage Guidelines**

“... a comprehensive eye examination ... and a single scan to determine the appropriate pseudophakic power of the IOL are sufficient. In most cases involving a simple cataract, a diagnostic ultrasound A-scan is used. For patients with a dense cataract, an ultrasound B-scan may be used.”

Source: MCM §35-44 Coverage Issues Manual (CMS-Pub 6)

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**Medicare’s Coverage Policy**

Endothelial Cell Photography

“When a pre-surgical examination for cataract surgery is performed and the conditions of this section are met, if the only visual problem is cataracts, endothelial cell photography is covered as part of the pre-surgical comprehensive eye examination or combination brief/intermediate examination provided prior to cataract surgery, and not in addition to it.”

Source: NCD §80.8

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**Issue 2: Premium IOL with Femto**

- Review revealed:
  - No financial waivers signed for premium services
  - Patient pays a flat fee for non-covered items and services that include charges for the surgeon, ASC, diagnostic tests, IOL, Femto, and comanaging provider
  - All patients referred in by ODs are comanaged
  - No signed form confirming patient choice for comanagement
  - Comanaging OD is paid 20% of the noncovered MD and ASC charges for all services including IOL and femtosecond laser
What did I do wrong?

Financial Waivers

- Voluntary ABN Uses
  - Medicare does not require ABNs for statutorily excluded care or for services Medicare never covers. However, in these situations, you may issue an ABN voluntarily.


Does the patient know what the patient is paying for?

- Concern that patient does not know what amount of the payment goes to which provider for what service
  - Each provider should bill independently, or
  - The patient should receive a line item receipt reflecting each provider, the services provided by each provider, and the amount paid to each provider

Is Comanagement a Problem?

- ASCRS/AAO Comanagement Guidance cautions that:
  - Comanagement should not be "routine"
- Documented Patient Choice
  - Is it routine when 100% of patients are comanaged?
  - What if all patients affirmatively choose to be comanaged?
  - Is that routine comanagement?
  - How do you prove patient choice?

May the Practice Pay the Optometrist for Comanagement Services?

- For covered services?
- For noncovered tests?
- For noncovered portion of IOL?
- For femtosecond laser services?
- Is the proper payment for comanaging noncovered services 20% of the charge to the patient?

What Are the Critical Elements of Comanagement?

- Documentation of patient choice
- Documentation that patient knows how much is paid to whom and for what
- For noncovered services, payment reflects the fair market value of the services provided, and is not otherwise designed to supplement the payment for covered services.
Billing staff member informs auditor that he has changed the place of service from ASC to office for intravitreal injections and for Avastin drug to facilitate payment for the drug.

What do I do now?

Surgeon overpaid for injection due to SOS differential.

ASC should purchase drug and file claim for it.

Drug may be bundled with facility reimbursement.

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If a product is compounded and a specific HCPCS code does not exist for the compounded product, the ASC should include the charge for the compounded product in the charge for the surgical procedure performed.


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Do you know you have been overpaid?

How much have you been overpaid?

Review revealed:

Practice hosts an annual continuing education weekend event for referring optometrists that takes place at a luxury resort and includes several hours of CE credit courses and 18 holes of golf at the conclusion of the sessions. A reception and dinner on Saturday night is also included. Optometrists are responsible for paying their transportation costs and hotel room costs.
What do I do now?

How Do You Spell Kickback?

- Unlike many of the questions that we normally see relating to the provision of continuing education, this is not even close
  - How much are CE credits worth? $250
  - How much is 18 holes of golf at a luxury resort? $350
  - How much is dinner at a luxury resort? $150
  - And note that this is for referring ODs only

Issue 5: Leases for office space

- Review revealed:
  - Practice leases space at OD office in neighboring town. The practice pays the OD a fixed amount per day but only for the days that they actually see patients at that location. There is no written agreement. The doctors have developed this approach based on a “handshake”.

Concerns

- What is the address on CMS 1500 for claims?
- Is the location registered with payers as an additional location for the practice?
- Is the rental fee “fair market value”?
- Can they pay on a “per use” basis?
- Are they required to have a written lease?

Conclusion

- Take compliance activities seriously
- Remember that rules and regulations are not static
- Stay informed
- Develop a formal compliance program

Thank you

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