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Technology 2.0

Going Electronic

By Ruth Linné Lander, FACMPE, Practice Administrator, Columbus Oncology & Hematology Associates, OH

Remember the good old days? I do, and not everything was that good. When I started post-college work, I had no calculator, no personal computer with Excel or word-processing software, no fax machine, no internet access, and no smartphone. I love technology, so I have been amazed by and embraced advances that have come along as the years have passed.

Several years ago, I heard a compelling keynote address by Newt Gingrich at the Medical Group Management Association (MGMA) national conference. He shamed us with our slow progress into the electronic medical record (EMR) arena. Using banking as an example, he reminded us how we use our credit and debit cards everywhere in this country or

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From the Editor

Where Are We Going? Does Anyone Know?

By Dawn Holcombe, MBA, FACMPE, ACHE

Oncology as a medical specialty is, and always has been, rapidly evolving. The world in which we provide care for patients is also rapidly evolving, and not always in sync with our changes. Doctors will be needed to diagnose and treat patients, but where and how that happens may look dramatically different in only 10 years. We still have the ability to shape that future, but what we do today, and every day from now on, will help to define our role. More external forces than internal forces have already shaped our evolution to 2012 from the 1970s, as described below.

Physician Offices Replaced Hospital Centers

When oncology was evolving as a medical specialty, most cancer care was delivered in hospital inpatient units. Side

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Understanding Office of Inspector General Initiatives and How to Prepare Your Practice

By Jennifer Kirschenbaum, Esq, and Erica Youngerman, Esq

Unexpected and unwanted oversight is becoming a more frequent element of practice, making it imperative that you understand current investigation and audit initiatives, and how to prepare and protect your practice.

Understanding the Office of Inspector General

The US Department of Health and Human Services (HHS) Office of Inspector General (OIG), which is tasked with protecting the integrity of the HHS programs and operations by "detecting and preventing

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fraud, waste, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; and holding accountable those who do not meet program requirements or who violate Federal laws,"[1] has taken a leading role in such investigations and audits.

OIG accomplishes its mandate by deploying its staff of approximately 1800 professionals throughout the United States to conduct audits, evaluations, and investigations, as well as coordinating and overseeing third parties conducting audit activities on OIG's behalf.[1] OIG investigates a wide variety of conduct,[2] and may seek civil monetary penalties against any person who, for example: (i) presents or causes to be presented claims to a Federal health program that the person knows or should have known is for an item or service that was not provided as claimed or is false or fraudulent[3]; (ii) violates the antikickback statute by knowingly or willfully paying or receiving remuneration for referrals of federal healthcare program beneficiaries[4]; or (iii) presents or causes to be presented a claim that person knows or should know is for a service which may not be made under the physician self-referral or Stark law.[5]

In the past several months, OIG has reported on the following activity:

1 On or around January 17, 2012, Buchanan County Health Center in Iowa agreed to pay $406,030 for allegedly employing an individual that it knew or should have known was excluded from participating in federal healthcare programs, potentially violating the Civil Monetary Penalties Law.[6]

2 On or around November 30, 2011, as a result of a self-disclosure, Evergreen Health Center, PC, in Lebanon, MO, agreed to pay $83,012.58 for allegedly submitting claims for services not provided, potentially violating the Civil Monetary Penalties Law.[6]

3 On or around October 4, 2011, as a result of a self-disclosure, County of Monterey d/b/a Natividad Medical Center of California agreed to pay $174,508.46 for allegedly entering into a professional medical services agreement with a physician group for certain call coverage and clinic services where the compensation terms offered incentives for the physician group to refer private practice patients to the Center, potentially violating the Civil Monetary Penalties Law.[7]

Available statistics show that as a result of OIG's efforts during fiscal year (FY) 2010, OIG reported recovering: (i) $3.8 billion in investigation receivables that were court ordered or agreed to be paid through civil settlements; and (ii) $1.1 billion in audit receivables as a result of OIG audit disallowance recommendations.[1] Because of the many fruits of OIG's labor, OIG has increased its efforts since FY 2010 to increase recoveries by incorporating more sophisticated reviews and expanding the scope of its investigations.

OIG Initiatives

For many practices devoting their resources and attention to patient care, minimal time is spent reviewing operations and policies in a way that protects the practice against an OIG investigation or other audit initiative, which puts such practices at a severe disadvantage that is somewhat easily preventable. Certainly, some practices that are targeted by OIG or other authorities or payers are in the category of committing egregious wrongdoing, whereas others have simply not taken the time to ensure that they are operating under the proper structure. Staying abreast of the changes to the numerous documentation requirements while also taking care of your patient population is not an easy task. There are, however, certain steps you may take to place yourself in a better position to limit exposure. Understanding the OIG *Work Plan for Fiscal Year 2012* is one such step. OIG's initiatives are not a secret; in fact, each October, OIG publishes its initiatives for the coming year. Reviewing the *Work Plan* and understanding where areas of exposure may exist in your practice is a somewhat simple first step to limiting exposure. Two examples of oncology-related initiatives are as follows:

1 Payments for off-label anticancer pharmaceuticals and biologicals: OIG states that it will focus a review on "Medicare payments for drugs and biologicals used on an off-label basis ...in anticancer chemotherapeutic regimens to determine whether patients with particular indications were prescribed anticancer drugs approved by FDA for such indications before resorting to anticancer drugs not approved for those indications."[8]

2 Medicare outpatient payments for drugs: OIG will review Medicare outpatient payments to providers for certain drugs and the administration of those drugs (eg, chemotherapy) to determine whether Medicare overpaid providers because of incorrect coding or overbilling of units.[8] OIG explains that prior reviews have identified certain drugs, particularly chemotherapy drugs, as vulnerable to incorrect coding.

OIG provides additional insight into the 2 aforementioned initiatives by stating that in calendar year 2007, Medicare payments for anticancer drugs totaled approximately $2.7 bil-

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lion, which as is readily apparent by OIG's *Work Plan*, is more money than OIG believes was proper for reimbursement. Practices billing for anticancer drugs will be targeted this year, as specified in OIG's *Work Plan*, and how those practices will be selected will likely be a result of data mining. The initiated investigations will focus on whether those targeted practices and providers accurately and completely billed for services provided, and also whether such providers have reported units of service as the number of times that a service or procedure was performed.[8] For those practices targeted for prescribing off-label drugs, OIG specified it will be looking to determine whether there were improvements in the patients' medical condition before the use of off-label drugs. The OIG *Work Plan* states that "if the beneficiaries' medical conditions improved before the use of off-label drugs, [OIG] will determine how much Medicare could have saved had the previously administered anticancer drugs continued to be used,"[8] and presumably seek to recoup such amounts from the practice. OIG states as its authority to recoup such monies that "Medicare covers FDA-approved drugs used for off-label indications in anticancer chemotherapeutic regimens when such uses are supported in authoritative compendia identified by the Secretary of HHS."[8]

Ramifications of Exposure

When appropriate, OIG has the authority to impose civil monetary penalties assessments and administrative sanctions, as well as collaborating with the Department of Justice and other government executive branch agencies capable of bringing charges.[1] OIG is authorized to seek different amounts of civil monetary penalties and assessments based on the type of violation at issue.[9] For example, in a case of false or fraudulent claims, the OIG may seek a penalty of up to $10,000 for each item or service improperly claimed, and an assessment of up to 3 times the amount improperly claimed.[10] In a kickback case, OIG may seek a penalty of up to $50,000 for each improper act and damages of up to 3 times the amount of remuneration at issue (regardless of whether some of the remuneration was for a lawful purpose).[11]

Protecting Your Practice

Protecting your practice from an OIG investigation begins with preventive compliance. This entails ensuring that your practice is properly structured to comply with numerous rules and regulations, including the self-referral laws. To place your practice in the best position possible, you should seek the advice of competent healthcare counsel to either structure your practice when it is created or to review your existing structure for compliance. In addition to proper structuring, your practice should adopt policies and procedures to govern how your practice operates, including the adoption of a compliance plan that details acceptable billing practices.

Also, as part of your practice's compliance, I strongly recommend working with an external coding and billing expert, brought in specifically to examine your practice and diagnose any areas of exposure. Although you may have a dynamic team in place handling the billing operations for your practice, having a review of your documentation and coding by an expert specializing in your practice area who has reviewed documentation and coding of many other practices and is familiar with billing requirements for your specialty will not only likely place you in a more protected position, but also potentially highlight areas where you may increase your accounts receivable.

The bottom line with investigations such as OIG's initiatives is that with electronic records and billing, oversight has dramatically changed and it is now much easier to target practices potentially overutilizing, upcoding, or abusing the reimbursement system. Those practices continuing with "business as usual," and ignoring the warning signs that it is time to adapt and modify as the oversight has, will likely have a much greater chance of being targeted. ●

References

1. US Department of Health & Human Services, Office of Inspector General Work Plan: Fiscal Year 2012. Introductory message from the Office of Inspector General. http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/WP00-Intro.pdf. Accessed March 6, 2012.
2. 42 CFR § 1003.102.
3. 42 U.S.C. § 1320a-7a(a)(1)(A) and (B).
4. 42 U.S.C. § 1320a-7b(b); 42 U.S.C. § 1320a-7a(a)(7).
5. 42 U.S.C. § 1395nn(g)(3).
6. US Department of Health & Human Services, Office of Inspector General. False and fraudulent claims. http://oig.hhs.gov/fraud/enforcement/cmp/false_claims.asp. Accessed March 6, 2012.
7. US Department of Health & Human Services, Office of Inspector General. Kickback and physician self-referral. http://oig.hhs.gov/fraud/enforcement/cmp/kickback.asp. Accessed March 6, 2012.
8. US Department of Health & Human Services, Office of Inspector General Work Plan: Fiscal Year 2012 Part I: Medicare Part A and Part B. http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/WP01-Mcare_A+B.pdf. Accessed March 6, 2012.
9. HHS OIG Work Plan | FY 2012 Introductory Message: http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/WP00-Intro.pdf.
10. 42 CFR § 1003.103.
11. 42 U.S.C. § 1320a-7a.

This article is for education and discussion purposes only and does not constitute legal advice.

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