

HEALTH CARE bulletin

News & Resources on Health Care Law

FALL 2009

also in this issue:

page 3

New BCBS Payment Methodology

Recent Fraud Prevention and Detection by the OIG

page 5

Helpful Hints

page 6

In the News

page 7

Health Care Practice Group News



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IS YOUR ORGANIZATION RAC READY?

If you are feeling a bit overwhelmed by the Medicare Recovery Audit Contractor ("RAC") program, you are not alone. Just getting your hands around the RAC "who, what, when, where and why" can be a daunting task. Below are some practical suggestions for preparing your organization for a RAC audit.

1. Appoint a RAC Committee. To steer your RAC audit activities and efforts, consider appointing a RAC committee made up of individuals in senior leadership positions and key areas of your organization (e.g., claims/billing, medical records, corporate compliance, information technology). You may also want to designate a "RAC Coordinator" to lead the committee and serve as the point person for coordinating and responding to RAC requests, reviews and appeals.

2. Provide RAC Education and Training. Individuals leading your RAC efforts need to know and understand the difference between automated and complex reviews, how RAC audits will be conducted, procedures for communicating with the RAC, and appeal timelines and requirements. Accordingly, you should provide training and educational opportunities to personnel involved in your RAC efforts. You may also want to consider developing policies and procedures on how RAC audits will be handled by your organization—so as to ensure that there are clear and uniform guidelines for addressing RAC requests and submissions.

3. Get to Know Your Assigned RAC.

Connolly Healthcare ("Connolly") has been appointed to serve as the RAC for Alabama. Accordingly, if you have not done so already, bookmark Connolly's RAC website (www.connollyhealthcare.com/RAC) and add the names and telephone numbers of Connolly representatives to your RAC contacts list. You should also take some time to review Connolly's medical record submission requirements (there are specific guidelines for submitting paper records and records on CD), as well as Connolly's instructions for appointing an organizational "point of contact" for RAC correspondence.



4. Conduct a RAC Risk Assessment.

As part of its RAC duties, Connolly is required to post a list of CMS approved audit issues on its website. To date, the following issues have been "approved" for Alabama: wheelchair bundling, urological bundling, blood transfusions, untimed codes, IV hydration therapy,

(continued)

Is Your Organization RAC Ready?

continued from page 1

bronchoscopy services, and pediatric codes exceeding age parameters. Accordingly, consider conducting a pre-RAC audit of your Medicare claims to look for these and other “risk” areas, such as billing or coding inaccuracies, lack of supporting documentation, duplicate claims, etc. (Keep in mind that RACs are limited to a 3-year “look back” period.) You may also want to review categories of services that were identified during the RAC demonstration project as having the highest overpayment assessments. (CMS has posted information about its RAC demonstration project on its website at: www.cms.hhs.gov/RAC.)

Given that your organization could be targeted for multiple complex reviews, you should familiarize yourself with the RAC record request process and timelines for responding.

5. Develop a Tracking System for Records Requests.

In conducting complex reviews, RACs are limited to a certain number of medical records that they can request from health care providers. For example, RACs are generally permitted to request 10 medical records every 45 days from a solo practitioner and up to 50 medical records every 45 days from a large physician group practice (defined as having 16+ members). For hospitals, the record requests may vary depending on the average monthly Medicare claims submitted under the hospital’s NPI, with a maximum of 200 medical records every 45 days. (CMS has posted guidance on record limits and the use of NPIs for Part A and Part B provider requests on its website at: www.cms.hhs.gov/RAC.) Given that your organization could be targeted for multiple complex reviews, you should familiarize yourself with the RAC record request process and timelines for responding. You will also want to implement procedures for carefully maintaining and documenting all RAC correspondence—such as the dates when record requests are received, dates/times of conversations with RAC representatives, and



copies of any correspondence, medical records and documentation that your organization submits to the RAC (including shipping receipts showing proof of delivery).

6. Know the RAC Appeal Levels and

Timelines. If an automated or complex review results in an overpayment determination, the RAC will notify you of its findings and your rights to either refund or appeal the overpayment. You should not, however, rely on the RAC to provide you with a crash course on all the various intricacies of the appeals process. Instead, it is critical that you understand the RAC rules, five-stage appeals process, deadlines, and submission requirements *before* you receive an overpayment demand letter. You should also know the specific timeframes for stopping recoupment of overpayments (which are significantly shorter than the appeal deadlines). An internal system for managing and tracking deadlines, RAC communications, and appeal submissions will greatly assist your organization with effectively defending the merits of denied claims and protecting its legal rights and interests.

7. Seek Outside Assistance. Finally, consult with outside experts for assistance in responding to RAC audits. For example, a Medicare claims/coding expert may help your organization to challenge medical necessity denials by identifying Medicare guidelines, policies, etc., which support the manner in which the services were performed, documented and/or submitted to Medicare for payment.

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If you would like more information on preparing for RAC audits, please contact Jennifer Griffin in our Birmingham office. Jennifer can be reached by telephone at (205) 458-5338 or by E-mail at jgriffin@burr.com.

NEW BCBS PAYMENT METHODOLOGY

Blue Cross Blue Shield of Alabama (“BCBS”) recently announced a change in its payment methodology for preferred medical doctors by transitioning to the Resource Based Relative Value Scale (“RBRVS”) payment methodology. The RBRVS is a nationally recognized payment methodology that is currently used by over 70% of the nation’s commercial payors. By focusing on value based payment, the new methodology will emphasize the cost of care and the quality of medical services provided, recognizing those providers who are providing high quality services at lower costs. The RBRVS assigns a value to each CPT code. The fee schedule is calculated by applying certain conversion factors to the value unit. BCBS will initially apply different conversion factors for each CPT code, but intends to incorporate fewer conversion factors as the RBRVS is transitioned in.

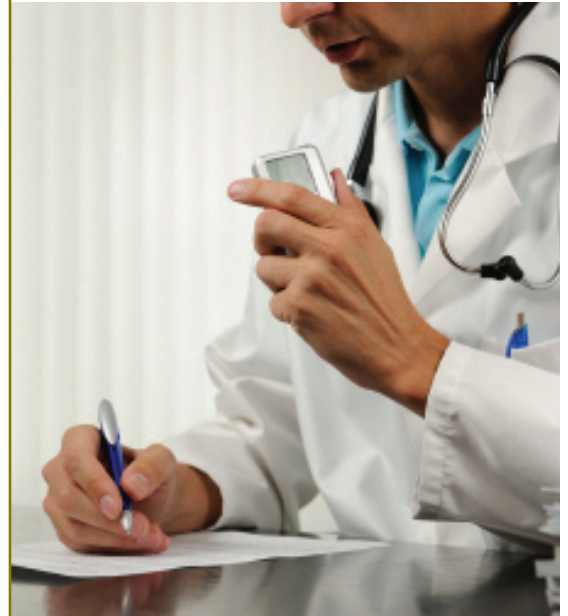
The transition to RBRVS is expected to last a couple of years. Under the new payment methodology, the payments for some CPT codes will increase, while others will decrease. Depending on which specialty a provider practices and which CPT codes he/she bills most often, this methodology change could significantly impact a provider’s practice. BCBS estimates that about 60% of physicians will receive an increase in reimbursement, while 40% will experience some level of decrease. For some specialties, the decrease in reimbursement may be as much as 20%.

BCBS estimates that about 60% of physicians will receive an increase in reimbursement, while 40% will experience some level of decrease.

The transition to RBRVS was originally set to begin on December 1, 2009. However, due to a related dispute and ongoing conversations with specialty societies, BCBS has delayed the effective date. At this time, BCBS has stated that the anticipated effective date will be no later than July 1, 2010.

Additional information on the payment methodology changes can be found by visiting the following website, <https://www.bcbsal.org/providers/newPaymentMethodology/index.cfm>.

If you would like more information on the new BCBS payment methodology, please contact Kelli Fleming in our Birmingham office. Kelli can be reached by telephone at (205) 458-5429 or by E-mail at kfleming@burr.com.



RECENT FRAUD PREVENTION AND DETECTION BY THE OIG

The Office of Inspector General (“OIG”) of the Department of Health & Human Services (“HHS”) handles fraud prevention and detection. In that regard, the OIG issues compliance guidance in many forms, such as advisory opinions, fraud alerts, fraud bulletins, open letters, etc. Each issue, this newsletter will summarize some of the recent guidance issued by the OIG.

Advisory Opinions

Advisory Opinions are issued to the requestor of the opinion and are binding only on HHS. While such guidance has no applicability to arrangements other than those described in the opinion, they are often helpful in determining how the OIG will interpret similar actions by other parties.

(continued)

Recent Fraud Prevention and Detection by the OIG

continued from page 3

No. 09-01:

A non-profit skilled nursing facility proposed to offer complimentary local transportation to friends and families of residents using a company-owned van. The nursing facility is not easily accessible by public transportation and, for some visitors, requires crossing a toll bridge. The transportation would only be provided to and from the facility, would not include transportation for residents of the facility, would be minimally advertised, and would not include costs reimbursable by a federal healthcare program. The OIG concluded that while the arrangement could potentially violate the Anti-kickback Statute and the civil monetary penalties provision, it would not impose administrative sanctions.

To access the complete Advisory Opinion on free transportation, visit: <http://oig.hhs.gov/fraud/docs/advisoryopinions/2009/AdvOpn09-01.pdf>.

A non-profit hospital with a shortage of on-call specialists proposed to compensate medical staff physicians for call services provided to patients without insurance coverage.

No. 09-05:

A non-profit hospital with a shortage of on-call specialists proposed to compensate medical staff physicians for call services provided to patients without insurance coverage. The payments to the physicians would only be for services rendered while on call and would be in accordance with a set fee schedule. All physicians on the hospital staff would be allowed to participate in the program. The OIG concluded that while the arrangement could potentially violate the Anti-kickback Statute, it would not impose administrative sanctions. The OIG did caution that call coverage arrangements should be closely scrutinized.

To access the complete Advisory Opinion on paying for call coverage, visit: <http://oig.hhs.gov/fraud/docs/advisoryopinions/2009/AdvOpn09-05.pdf>.



[hhs.gov/fraud/docs/advisoryopinions/2009/AdvOpn09-05.pdf](http://oig.hhs.gov/fraud/docs/advisoryopinions/2009/AdvOpn09-05.pdf).

No. 09-07:

An operator of a dialysis facility proposed to provide eligible dialysis patients with free nutritional supplements. The supplements would only be provided if the patient's treating physician determined they were medically necessary. The supplements would be administered at the facility when the patient received dialysis treatment and would cease once they were no longer needed by the patient. The program would not be advertised and the supplements are not items generally reimbursable by federal healthcare programs. The OIG concluded that while the arrangement could potentially violate the Anti-kickback Statute and the civil monetary penalties provision, it would not impose administrative sanctions.

To access the complete Advisory Opinion on free nutritional supplements, visit: <http://oig.hhs.gov/fraud/docs/advisoryopinions/2009/AdvOpn09-07.pdf>.

No. 09-11:

A hospital proposed to offer free blood pressure screenings to walk-in visitors. The screenings would not be advertised, would not be conditioned on the visitor obtaining any other goods or services, and visitors would not receive a discount for follow-up services. If the screening shows an abnormal result, the visitor would be directed to either his/her own physician or the emergency room, if circumstances warrant. The screenings would not be billed to any third-party payor. The OIG

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Recent Fraud Prevention and Detection by the OIG

continued from page 4

concluded that while the arrangement could potentially violate the Anti-kickback Statute and the civil monetary penalties provision, it would not impose administrative sanctions.

To access the complete Advisory Opinion on free blood screenings, visit: <http://oig.hhs.gov/fraud/docs/advisoryopinions/2009/AdvOpn09-11.pdf>.

No. 09-16:

A non-profit corporation proposed to advertise chiropractic services and provide referrals for such services. The corporation does not provide any items or services payable by a federal health care program. If a patient requests a chiropractor referral, the corporation would provide the name of a participating chiropractor in the relevant zip code. The names are provided on a rotating basis. In order to participate, a chiropractor must pay the corporation a flat fee, which is reduced if the chiropractor is a member of the state chiropractic association. The association would advertise and promote the referral services to its members at a fee to the corporation. The OIG concluded that while the arrangement could potentially violate the Anti-kickback Statute, it would not impose administrative sanctions.

To access the complete Advisory Opinion on advertising and referral services, visit: <http://oig.hhs.gov/fraud/docs/advisoryopinions/2009/AdvOpn09-16.pdf>.

Additional Guidance

Periodically, the OIG will publish additional guidance on various fraud and abuse topics.

the Self-Disclosure Protocol (“SDP”). The letter stated that the OIG would no longer accept into the SDP issues only involving liability under the Stark Law in absence of an Anti-kickback Statute violation. The letter further stated that for kickback-related submissions through the SDP, there will be a minimum \$50,000.00 settlement amount. However, the OIG will continue to analyze the facts and circumstances of each disclosure to determine the appropriate settlement amount.

To access the open letter on SDP, visit: <http://oig.hhs.gov/fraud/docs/openletters/OpenLetter3-24-09.pdf>.



If you would like more information on recent fraud prevention and detection by the OIG, please contact Kelli Fleming in our Birmingham office. Kelli can be reached by telephone at (205) 458-5429 or by E-mail at kfleming@burr.com.

The OIG recently issued an open letter to health care providers clarifying issues surrounding the Self-Disclosure Protocol (“SDP”).

3-24-2008:

The OIG recently issued an open letter to health care providers clarifying issues surrounding

HELPFUL HINTS

DATA BANK NEWSLETTER

The National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank (collectively, the “Data Bank”) publishes a quarterly newsletter which provides Data Bank users with information on upcoming system improvements and helpful hints regarding Data Bank policies and procedures. For example, in its October 2009 issue, the Data Bank announced that practitioners will be able to receive self-query results electronically rather

(continued)

Helpful Hints

continued from page 5

than by mail. The October issue also contained a section providing answers to common Data Bank questions—such as “What is the deadline for submitting a Medical Malpractice Payment Report?” To sign-up and receive a copy of the Data Bank’s quarterly newsletter, visit the Data Bank website: <http://www.npdb-hipdb.hrsa.gov/>.



ABME OPINIONS AND DECLARATORY RULINGS

On its website, the Alabama Board of Medical Examiners (“Board”) posts opinions and declaratory rulings on a variety of important medical practice issues. Topics include:

- What constitutes the practice of medicine in Alabama;
- Health care referrals and fees;
- Professional corporations, limited liability companies and partnerships;
- Dispensing and prescribing drugs;
- Optometrist/ophthalmologist relationships; and
- Physician extenders and assistive personnel.

To locate specific opinions or rulings, visit the Board website at: <http://www.albme.org/> and search under the heading “Board Opinions”.

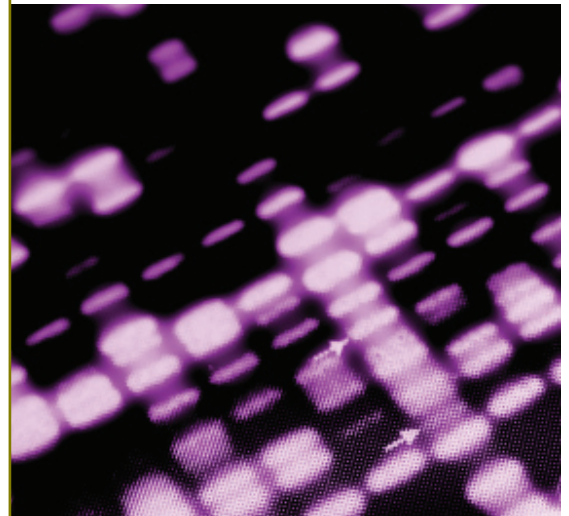
IN THE NEWS

HHS STRENGTHENS HIPAA ENFORCEMENT

On October 30, 2009, the Department of Health & Human Services (“HHS”) published

The HITECH Act revisions significantly increase the penalty amounts which may be imposed for HIPAA violations, and become effective November 30, 2009.

an interim final rule amending the HIPAA civil money penalties and related enforcement provisions, enacted as part of the Health Information Technology for Economic and Clinical Health (“HITECH”) Act, which is part of the American Recovery and Reinvestment Act of 2009. The HITECH Act revisions significantly increase the penalty amounts which may be imposed for HIPAA violations, and become effective November 30, 2009. To learn more about these HIPAA changes, go to the HHS press release at: <http://www.hhs.gov/news/press/2009pres/10/20091030a.html>, or access a copy of the interim final rule at: <http://edocket.access.gpo.gov/2009/pdf/E9-26203.pdf>.



HHS GINA PROPOSED REGULATIONS

On October 7, 2009, HHS issued proposed regulations addressing Section 105 of the Genetic Information Nondiscrimination Act of 2008 (“GINA”) and its impact on HIPAA covered entities and their Privacy Rule obligations. The proposed regulations modify the HIPAA Privacy Rule to clarify that genetic information is health information and prohibit the use and disclosure of genetic information by health plans for eligibility determinations, premium computations, applications of any pre-existing condition exclusions, and any other activities related to the creation, renewal or replacement of a contract of health insurance or health benefits. To learn more about these and other GINA-HIPAA changes, go to the HHS press release at: <http://www.hhs.gov/news/press/2009pres/10/20091001b.html>, or access a copy of the regulations at: <http://edocket.access.gpo.gov/2009/pdf/E9-22504.pdf>.



(continued)

In The News

continued from page 6

OIG RELEASES WORK PLAN FOR FY 2010

On October 1, 2009, the HHS Office of Inspector General (“HHS-OIG”) released its Work Plan for the 2010 Fiscal Year. The Work Plan highlights areas which the HHS-OIG intends to focus on for FY 2010 including, but not limited to: same-day hospital readmissions, hospital admissions with “present on admission” conditions, observation services during outpatient stays, provider-based status for inpatient and outpatient facilities, Medicare Secondary Payer issues, hospice utilization, Medicare incentive payments for e-prescribing, Medicare payments for imaging services, enrollment standards for IDTFs, and payments for services ordered or referred by excluded providers. To access a copy of the FY 2010 Work Plan, go to the HHS-OIG website at: <http://oig.hhs.gov/>.



NEW HITECH ACT BREACH NOTIFICATION RESOURCE

On September 23, 2009, HHS announced a new webpage with information and guidance regarding the HITECH Act breach notification interim final rule. Located at: <http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/index.html>, the webpage contains information on the rule's history, definition of what constitutes a “breach” for notification purposes, and a detailed discussion of the notification requirements. Users of the webpage can also access a copy of the interim final rule (“Breach Notification for Unsecured Protected Health Information”), published in the *Federal Register* on August 24, 2009.

HEALTH CARE PRACTICE GROUP NEWS

The Health Care Bulletin is an effort on the part of the Burr & Forman Health Care practice group to keep our clients informed of legal issues which may impact their health care practices and business. If you have any questions about this

issue and/or would like to see a particular topic covered in future issues, please contact Kelli Fleming by telephone at (205) 458-5429 or by E-mail at kfleming@burr.com.



Congratulations to **Howard Bogard, Jim Hoover,** and **Jack Mooresmith** who were recently recognized as Best Lawyers in America for 2010 in the field of health care law.



Burr & Forman LLP will be sponsoring a free educational session on “Organizing an Effective Response Process for the RAC Audits” for the Alabama Hospital Association. The seminar will be held on December 2, 2009 at 10:00 a.m. at the Hospital Association's main office in Montgomery.



Alabama Association of Health Information Management (“AAHIM”) Seminar:

On January 29, 2010, Jim Hoover and Jennifer Griffin will present an all-day seminar for AAHIM members on medical record compliance issues and Alabama law. The program will begin around 8:30 a.m. and will be held at Burr & Forman's Birmingham office. For more information, please contact Jennifer Griffin by telephone at (205) 458-5338 or by E-mail at jgriffin@burr.com.



Red Flags Rule Compliance Guide: Burr & Forman has developed a compliance guide on the Red Flags Rule containing information about the applicable regulations, as well as necessary policy and form templates and implementation tools which can be used to address specific compliance needs. For more information, including an order form, please visit <http://www.burr.com/forms/redflagsguide.aspx>.



RAC Seminar: Burr & Forman hosted a seminar on the new Medicare Recovery Audit Contractor (“RAC”) Program. To access the recorded oral presentations, PowerPoint presentations, and handouts from the RAC seminar, please visit <http://www.burr.com/seminar/racwebinar2009.aspx>.



Birmingham Medical News: Each month a Burr & Forman health care attorney writes an editorial for the Birmingham Medical News. A

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copy of these articles can be found on the Burr website at <http://www.burr.com/resources/topic/health+care.aspx>.



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In addition, the Rules of Professional Conduct in the various states in which our offices are located require the following language:

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