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PBN Perspectives

Protect your patients from Medicare scams with proactive education, tips

Medical practices that want to protect their patients should pay close attention to fraudsters looking to make major, illegal dollars off Medicare in 2020. Officials warn that scams tend to escalate when health care is in the news, and since 2020 is an election year, you can expect an increase in scammers seeking to raid Medicare accounts.

*(see **Fraud,** p. 3)*

Value-based care

Direct Contracting, launching soon, pushes practices to put more skin in the game

The Direct Contracting (DC) demonstration model that CMS is rolling out brings some free-market features to Medicare, letting practices negotiate with providers on how much of the capitated payments they'll receive. Experts think this represents a trend in CMS' approach to value-based care.

The Center for Medicare and Medicaid Innovation (CMMI) announced DC last April along with Primary

*(see **Value-based care,** p. 6)*

Compliance

CMS warns on sleep studies: Watch coding, certifications and diagnoses

Heads up: CMS, tipped off by OIG, is warning providers who do sleep studies to make sure they have appropriate documentation and don't botch the billing of technicians.

In a Jan. 16 MLN Connects provider guidance, CMS warned readers to "bill correctly for polysomnography services," sending them to a newly revised informational pamphlet *(see resources, below)*.

The new guidance was inspired by a June 2019 OIG report, "Medicare Payments to Providers for Polysomnography Services Did Not Always Meet Medicare Billing Requirements," based on an audit taken on claims in 2014 and 2015 involving codes **95810** (Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist) and **95811** (… ; with initiation of continuous positive airway pressure therapy [CPAP] or bilevel ventilation, attended by a technologist). Out of the 426 lines of service claimed for 200 beneficiaries under review, OIG found that 150 did not meet Medicare requirements.

These erroneous claims represent only $56,668 in overpayments but, extrapolating from that, OIG figured that $269 million out of about $800 million in Medicare polysomnography payments during the audit period were made in error.

Focus on billing basics

It's not that these services are over-prescribed. In fact, Medicare claims on them have risen only slightly on the codes over 10 years *(see benchmark, p. 5)*.

"Sleep disorders, particularly obstructive sleep apnea, the disorder for which most of the sleep studies are performed, are commonly unrecognized and vastly underdiagnosed," says Larry Epstein, M.D., president and CEO of Welltrinsic and assistant medical director of clinical sleep medicine at Brigham and Women's Hospital in Boston. "Increasing utilization of testing is appropriate, if more costly."

The OIG's findings "raise questions about the complexity of the regulatory requirements regarding ordering and performance of sleep studies and the need for better education of physicians about those regulations," Epstein says. "Typically, physicians leave billing issues to their practice or hospital billing departments. This finding argues for more direct involvement."

To avoid auditor scrutiny, it's important to get billing basics right.

#1: Document properly

Of the billing errors OIG found, the most common were "incomplete medical record documentation" and

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"documentation was missing or not provided." In the provider compliance tips to which MLN Connects recently directed readers — updated in October to reflect the OIG report findings — CMS specified elements they expected to see in such documentation:

- Relevant medical history.
- Signs of symptoms.
- Physical examination.
- Results of pertinent diagnostic tests

or procedures.

#2: Get the tech right

For some claims, OIG said that the "attending technologist did not have required credentials or training certification." Such technologists may have any of a number of certifications — for example, registered polysomnography technologist (RPSGT), registered sleep technologist (RST) or registered electroencephalographic technologist (R.EEG.T). The requirement varies among local coverage determinations (LCDs); check with your Medicare administrative contractor (MAC) to see which is required in your jurisdiction.

Watch also that your tech's credentials have not expired, and that they have been documented in your notes. And use the proper modifiers. "Providers use modifier code **-TC** or **-26**, respectively, to indicate whether the billing is for the technical or professional component," the CMS guidance states.

#3: Don't duplicate

In its recent update, CMS gave an example of "duplicative" testing that would not be covered by Medicare: When the provider re-tests a patient who is already diagnosed and receiving PAP treatment. As with the "Welcome to Medicare" and annual wellness visits, your patient may not be forthcoming as to the timing and circumstances of previous treatments that might get your claim disallowed, so press them to be specific about their sleep study history (*PBN 9/17/12*).

#4: Check diagnoses

Ensure your claims contain acceptable ICD-10-CM codes to keep in line with medical necessity. OIG refers readers to Chapter 15 of the Medicare Benefit Policy Manual, which stipulates that billing for diagnostic sleep tests is acceptable under diagnoses of narcolepsy, sleep apnea, parasomnia and impotence, but not for "chronic insomnia." — *Roy Edroso (redroso@decisionhealth.com)*

Resources:

- Medicare Benefit Policy Manual, Chapter 15: *www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf*
- CMS, provider tips for sleep studies: *www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceTipsforPolysomnography-MLN4013531.pdf*
- OIG report: *https://oig.hhs.gov/oas/reports/region4/41707069.pdf*

Fraud

(continued from p. 1)

One approach you can take to add value to your patient encounters is by serving as first-level defense, and that starts by keeping patients up to date on current scams involving health care fraud. Start with the basics: Take Medicare's cue and encourage patients to treat their Medicare cards like a credit card or Social Security card.

While CMS has removed Social Security numbers from Medicare cards and replaced them with new identifiers, that doesn't make potential fraud any less likely. On the whole, scamming incidents are on the rise: Government officials estimate that some 330,000 cases of fraud targeting patients' Medicare numbers took place last year.

Scammers also prey on potential victims following major weather catastrophes like blizzards and hurricanes. Open enrollment time, which takes place annually in the fall, also brings out those trying to run schemes. Remind your patients of important anti-fraud measures: Don't share their Medicare numbers, only give the information to doctors and health professionals and remember that Medicare doesn't offer "freebies" or "sales."

Staggering dollars lost to cons

While officials can't peg exact figures on dollar amounts lost to fraudulent schemes in Medicare, the numbers are certainly not scant. The National Health Care Anti-Fraud Association estimates that health care fraud costs the nation about $68 billion annually. Improper payments for Medicare, which involve errant and sometimes fraudulent billing practices, were estimated at about $52 billion in 2017, according to a

report from the Government Accountability Office (GAO) that year.

At a minimum, "tens of billions of dollars" are lost each year, says Joe Beemsterboer, senior deputy chief of the fraud division with the Department of Justice (DOJ).

AARP representative Kathy Stokes estimates that fraud costs Medicare around $60 billion a year. "I think that's a low-ball [figure]," Stokes says. "I think it's a lot more than that. Not only is it taking money out of the coffers of the program, but it's affecting individual beneficiaries as well."

"I would say health care and the regulatory landscape has only gotten more complicated," says Troy Barsky, a partner specializing in monitoring health care fraud and abuse at the Crowell & Moring law firm in Washington, D.C. "It gets more complicated every year. I think the vast majority of health care providers, including physicians, nurses and others, want to do the right thing."

Watch DME and testing scams

Scammers use an ever-evolving array of cons to bleed the system. Recent scams include callers identifying themselves as a government employee, insurance agent or a "health care guide" and offering pseudo-discounts for bogus insurance plans. The Federal Trade Commission (FTC) warns that medical discount plans are not health insurance. Also, "guides" will promise services via the phone, which could be fraudulent, for a fee. The FTC warns to never give personal information, such as bank account numbers and Medicare information, over the phone.

Many times, the scammers zero in on certain products. "What they traditionally will do is promise certain durable medical equipment," Beemsterboer says. "An unsuspecting elderly individual will say they do need equipment. That phone caller will then ask for their information and sell that information to a corrupt individual who may start billing for different services because they have the Medicare number."

Stokes adds that the beneficiary either receives a subpar wheelchair or no chair at all, and the problem becomes magnified when a wheelchair is needed. "Three years later when [the same] Medicare patient really needs a chair, they call Medicare and they say, 'Sorry, we already paid for one,'" Stokes says.

Consider this verbatim phone script that a potential scammer used when contacting a Medicare beneficiary. The recorded phone call uses a female voice and high-pressure language to attempt to gain personal information:

"I'm from Medicare. We're sending out the new cards, and I need to confirm your billing information to keep your coverage active. For your protection, I need the last four numbers of your Social Security Number. We need this urgently or else you'll be charged a fee."

Another popular scam involves DNA testing. "This is a big one right now, the free DNA testing; they [someone pretending to work for Medicare] may say that you have to submit to a DNA test or your benefits will be cut off," Stokes explains. "Then they take your Medicare number and send a kit."

Officials say that the patient then uses the kit and mails off the sample, after which the scammers bill Medicare in the range of $9,000 and the beneficiary never receives the DNA results. The FTC also warns that scammers are attempting to obtain Medicare numbers in order to falsely order opioid prescriptions.

Here are some examples and actions that can be taken if a Medicare beneficiary you know receives an unsolicited telephone call:

- **Example:** A caller mentions a well-known insurance provider and says they sell plans on behalf of the insurer. **Action:** Hang up and check with the named insurer.
- **Example:** A Medicare beneficiary insists on seeing, inspecting and reading a benefits fact sheet and policy from a phone solicitor. **Action:** If the person on the other end balks about literature availability, hang up and call the FTC, FBI or Medicare.
- **Example:** The caller asks to compare rates or buy "comprehensive" medical coverage at low rates. **Action:** Avoid comprehensive coverage at lower rates. It is important to remember the "too good to be true" phrase.

If your patients mention receiving unsolicited phone calls from a Medicare representative, you should remind them Medicare will not randomly call patients offering "special deals" or "discounted plans."

(continued on p. 6)

Benchmark of the week

Sleep study codes hold steady, but CPAP startup code is a denial trap

While sleep studies and continuous positive airway pressure (CPAP) devices are getting more popular, Medicare billing for them so far has held pretty steady. But as the tough denial rates for a major CPAP code show, you still have to be careful about billing them.

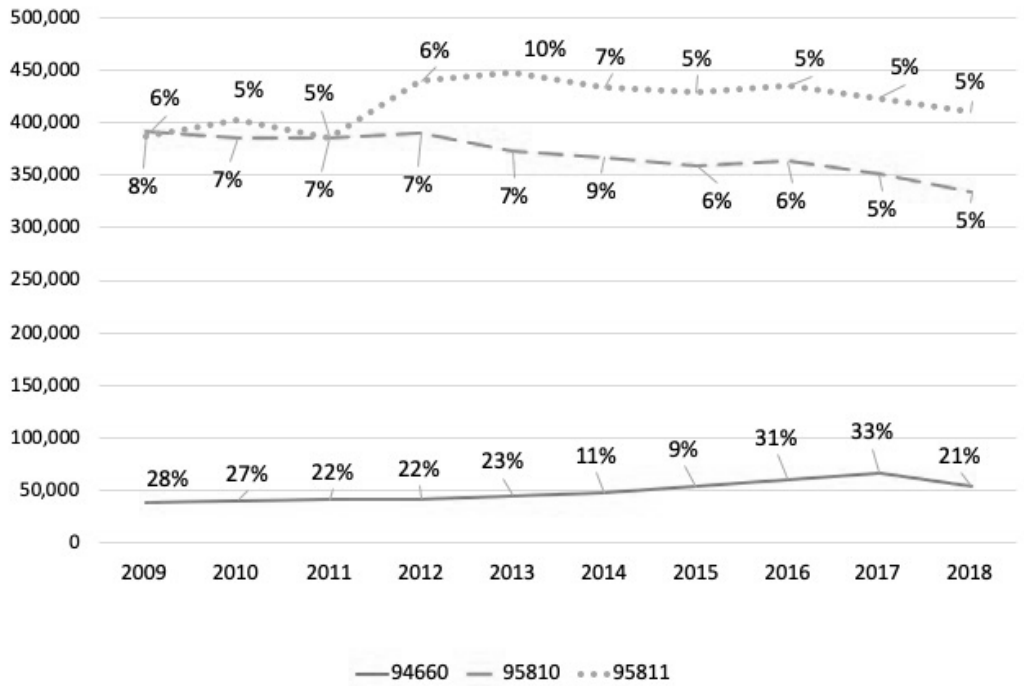
Bad sleep is big business: An IBISWorld market report puts the growth of the sleep disorder clinic market from 2013 to 2018 at 4.6%, and Grand View Research Inc. predicts that the CPAP market will reach $2.7 billion by 2025, expanding at a compound annual growth rate of 7%. It stands to reason that Medicare patients would get in on this; between 2009 and 2018, DME billing for CPAP devices, reflected in HCPCS code **E0601,** rose 62%, from 2.9 million to 4.7 million claims.

Maybe that's why OIG investigated billing for polysomnography services, aka sleep studies, in June (*see story, p. 2*). These are not cheap codes; the non-par fee for **95810** (Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist) was $621.10 in 2019. Code **95811** (... ; with initiation of continuous positive airway pressure therapy or bilevel ventilation) paid out $648.89. Note that these fees are split between the interpreting physician and the technologist with the modifiers **26** and **TC,** respectively. To get a patient started on CPAP with **94660** (CPAP, initiation and management), CMS pays $65.32.

But use of all three of these codes has not spiked. In actuality, it has been pretty steady over the past 10 years. With 95810 and 95811, the codes OIG focused on, the latter had a bit of a growth spurt at the beginning of the last decade, but since then both codes have trended down. Between 2013 and 2018, use of the two codes dropped 10.7% and 8.5%, respectively. Their denial rates are not bad, either.

But **94660,** as the chart details, has terrible denial rates aside from a brief respite in 2014 and 2015. Part of the reason may be provider ignorance; in 2018 CMS cracked down on CPAP billing, and *Part B News* reminded readers then that **94660** can't be billed with E/M codes (*PBN 3/15/18*). — *Roy Edroso (redroso@decisionhealth.com)*

Top polysomnography codes, 2009-2018, with denial rates



Source: Part B News *analysis of Medicare claims data*

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Watch insider fraud, too

Fraud cases don't occur only in the non-provider world. When you submit a claim for services provided to a Medicare beneficiary, you are filing a bill with the federal government and certifying that you earned the payment requested and complied with the billing requirements. But some billers and coders have bent the rules, and the distance between fraud and poor decision-making from a billing perspective can sometimes be a gray area.

"Medicare is a trust-based system," Beemsterboer says. "Doctors are trusted to provide medically-assisted services and doing the proper billing. Nurses to billers are also being entrusted to do the right thing. We look for different red flags throughout when we're investigating an entity or individuals."

Beemsterboer has witnessed fraudulent providers submit repeated codes on unperformed procedures and repeatedly abuse E/M codes **99415** and **99416** when consultations or procedures were completed in mere minutes.

Recent cases of abuse include billing an established patient follow-up visits using a higher-level E/M code, such as a comprehensive new patient office visit (**99201-99205**), and misuse of modifier **25.** This modifier allows additional payment for a significant, separately identifiable E/M service provided on the same day of a procedure or other service. Miscoding occurs when a provider uses modifier 25 to claim payment for a medically unnecessary E/M service.

In October 2019, a jury found a southern California doctor guilty of providing unnecessary procedures to Medicare beneficiaries, upcoding claims submitted to Medicare and re-packaging single-use catheters for reuse on patients. In January 2020, a Columbus, Ohio, physician and pain clinic owner agreed to repay $650,000 to resolve allegations of knowingly billing Medicare for unnecessary procedures involving nerve conduction studies and alcohol abuse assessments and interventions.

If you see something irregular in your office or see patients who believe they've been defrauded, call 1-877-FTC-HELP or go to ftc.gov/complaint. Your reports give the FTC the information it needs to launch investigations. — *Jim Dresbach (jdresbach@decisionhealth.com)*

Resources:

- Medicare fraud: *www.Medicare.gov/fraud*
- OIG enforcement: *https://oig.hhs.gov/fraud/enforcement/criminal/index.asp*

Value-based care

(continued from p. 1)

Care First (PCF) as the two tracks of its Direct Primary Cares initiative meant to "radically elevate the importance of primary care in the health care system" (*PBN 4/25/19*). The application period for PCF, the simpler of the tracks, closed on Jan. 22, and that model will launch in 2021 in 26 regions. Letters of Intent for DC were due Jan. 10 and its application period ends Feb. 25. For DC, an "initial implementation period" will commence this year, and a five-year performance period will begin in 2021, when DC will be accepted as an advanced alternative payment model (APM) under the Quality Payment Program (QPP).

So it's too late to get in on the first wave of DC, though CMS says it "may entertain additional application rounds for future years for all payment model options." But you should note the new features it brings to Medicare, as they may soon become more common and affect what Medicare expects from your own practice.

CMS says DC offers "private sector approaches to risk-sharing arrangements and payment" to reduce "administrative burden commensurate with the level of downside risk." On its face, "the main difference between this and traditional ACOs [accountable care organizations] is the payment is capitated," says Mollie Gelburd, associate director of government affairs for the Medical Group Management Association (MGMA) in Washington, D.C. That is, CMS will offer per-beneficiary, per-month (PBPM) payments for enrolled beneficiaries, much as Medicare Advantage plans do. These payments will be based on a benchmark CMS is developing that will take risk adjustment, regional prices and other factors into account.

"Out of Medicare's suite of ACO models — Next Generation, Shared Savings — DC is more like NextGen," Gelburd explains, referring to the most advanced of the federal ACO models (*PBN 3/25/15*). "But even within NextGen, there's a choice between

capitation and Shared Savings" — that is, between capitation, which that program called All-Inclusive Population Based Payments, and the bonus-or-penalty adjustment that providers can get with their fee for service (FFS) reimbursements in the Next Generation model, which is currently being phased out. With the DC model, one category of provider, called participant providers, is required to accept some form of capitated payment, while another, called preferred providers, can opt in.

"Direct Contracting leverages lessons learned in the NextGen ACO model, expanding on the benefit enhancements and building on the benchmarking model," observes Allen Miller, principal with COPE Health Solutions in Los Angeles. "It also has streamlined quality requirements, reducing the administrative burden on providers compared to the [Shared Savings] ACO model."

The house handles the money

If providers see less burden, the participating medical organizations, also known as the direct contracting entities, or DCEs, take on plenty — as well as more opportunity for reward. In Primary Care First, along with a flat visit fee of about $40, providers get a PBPM payment and, in year two, a performance-based payment adjustment (*PBN 12/2/19*). These are administered, like other bonuses in Medicare models, by CMS and go to the providers. But DC requires that the DCEs intermediate and adjust their providers' payments themselves, altering their share of the capitated payment based on what they negotiate with each provider.

Participant providers are required, and preferred providers are not required but may elect, to accept negotiated payment arrangements with the DCE based on the capitation payments and the fee-for-service payments to which they otherwise would be entitled. DCEs can arrange to cut a certain amount of a provider's fee-for-service payments in exchange for a certain percentage of the capitated payments paid to the DCE for care of beneficiaries who have voluntarily aligned with it. This gives the DCEs an unusual amount of control over how much of what CMS pays goes to the provider and what percentage is held by the organization.

The DCEs must also take on the risk of shared savings or shared losses based on their performance against benchmarks, though they can choose between levels of risk — the "professional" option, at 50% risk, and the "global" option, at 100% risk. So they have more at stake financially than the controlling entities in other value-based models, though they also have more control over what their providers are paid.

Generally, this looks less like traditional Medicare and more like the commercial direct primary care (DPC) model favored by some independent practices, says Kevin Kroeker, partner with Crowell & Moring in Los Angeles and a member of the law firm's Health

Care Group Steering Committee. Not coincidentally, CMS solicited advice from private payers for this program back in 2018 (*PBN 5/10/18*).

DPCs "receive capitation directly from patients instead of from an HMO for arranging primary care services," Kroeker says. "The CMS Direct Contracting model is similar in that CMS pays the provider groups directly on a capitated basis without an insurer or HMO in the middle."

Other features: Benefit add-ons and more

With at least some of its share of the CMS payments, the DCE is supposed to institute improvements that will improve patient care. Along with usual personnel and technology fixes, DCEs will be allowed to offer benefit enhancements and patient engagement incentives — for example, they may give "blood pressure monitors to patients with hypertension in order to encourage regular blood pressure monitoring," offer membership in wellness programs or provide "gift cards to eligible aligned beneficiaries, up to an annual limit of $75, for the purpose of incentivizing participation in a chronic disease management program," according to a series of DC frequently asked questions. DCEs and their beneficiaries can also take advantage of waivers currently in use by other Innovation models — for example, exemption from the SNF three-day rule (*PBN 7/24/17*).

Also, although it's under the Primary Care First umbrella, DC is not limited to covering primary care services: There is a Primary Care Capitation (PCC) option, based on defined primary care services, and a Total Care Capitation (TCC) option, based on all services, which is available to DCEs in the Global option.

Wave of the future?

Gelburd sees DC as an advance on CMS' long-promised transition to value-based care. "It's important to allow participants to have flexibility," she says. "They're changing their way of providing care and need to use tools that aren't necessarily available to other practices. It's also important, as consumers get more active and involved in their own care, to maintain patient choice and to have patient engagement incentives."

But the program's not for everyone: Given its high level of risk, "it should be attractive to, for example, NextGen ACOs facing the end of the program who want to stay in a population-based model," Gelburd says. "If they had to choose between going to Shared Savings and DC, I think they'd want to go to DC. Also, it could be attractive to groups that work with Medicare Advantage plans and risk-based contracting." Without that kind of experience, "it would be tough," she adds.

Also, keep in mind that CMS requires a heavy institutional investment in the DCEs, including an "effective governance structure plan" and a governing body with at least one beneficiary and one "consumer advocate" on board. "It isn't quite as simple as CMS allowing providers to sign up and say they want to participate for their FFS members," says Ellie Martin, senior director of provider strategies at Gorman Health Group in Ft. Lauderdale, Fla.

On the other hand, DC is a promising development for well-funded organizations who want to stretch out of the Medicare paradigm. In fact, "if a provider has enough traditional lives and capital to take the 100% risk option [in DC], they could consider becoming a provider-sponsored plan or allow for a different point of entry into the market and how it aligns with other programs they participate in," Martin suggests.

"For those practices that are interested in capitation, being able to have that cash flow, choose between the professional or global risk models and capture the first dollar savings should be attractive," Miller says. "Those who have been generating savings in other risk models should closely consider direct contracting, with the caveat that this model has strong emphasis on regional benchmarking and rate adjustments which will need to be understood in the context of each particular practice." — *Roy Edroso (redroso@decisionhealth.com)*

Resource:

- DC model overview: *https://innovation.cms.gov/initiatives/direct-contracting-model-options/*

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