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USC Office of Compliance

## HEALTHCARE COMPLIANCE NEWSLETTER

Issue 8, Winter 2015

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*This newsletter is prepared by the Office of Compliance and is intended to provide you with current information about healthcare compliance and HIPAA privacy issues. For additional information,*

### Spotlight on the USC Help & Hotline

The Help & Hotline is a number that all USC faculty, staff, and students can use to report suspected violations of law confidentially and without fear of retribution. Anyone who has knowledge or a good faith belief that an applicable law, regulation or university policy has been violated should report such information to the Help and Hotline.

The Help & Hotline also can be used to ask questions about applicable laws, regulations and university policies that may impact your job duties.

The Help and Hotline is available staffed 24 hours a day, 365 days a year at **(213) 740-2500**.

For more information, please visit: <http://ooc.usc.edu/how-use-it>

### Better, Smarter, Healthier: HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements from Volume to Value

On January 26, 2015, in a meeting with nearly two dozen leaders representing consumers, insurers, providers, and business leaders, Health and Human Services Secretary Sylvia M. Burwell announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity, of care they give patients. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

Many health care providers receive a payment for each individual service, such as a physician visit, surgery, or blood test, and it does not matter whether these services help - or harm - the patient. In other words, providers are paid based on the volume of care, rather than the value of care, provided to patients. The January announcement continues the shift toward paying providers for what works - whether it is something as complex as preventing or treating disease, or something as straightforward as making sure a patient has time to ask questions.

For the full press release, visit: <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>

To read more about why this matters: <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact->

*to view past newsletters, or to provide comments about this or any future issues of this newsletter, please contact the Office of Compliance at (213) 740-8258 or at [complan@usc.edu](mailto:complan@usc.edu).*

[sheets/2015-Fact-sheets-items/2015-01-26-2.html](http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-2.html)

To learn more about Better Care, Smarter Spending, and Healthier People: <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26.html>

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## **Medical College of Wisconsin Inc. Pays \$840,000 to Settle Alleged False Claims for Neurosurgeries**

United States Attorney James L. Santelle of the Eastern District of Wisconsin announced on January 9, 2015 that the Medical College of Wisconsin, Inc. (MCW) has paid the federal government \$840,000 to resolve allegations that it violated the False Claims Act. MCW is alleged to have knowingly billed federal healthcare programs for neurosurgeries involving residents who did not receive the required level of supervision from teaching physicians.

If a resident helps perform a surgery, Medicare will pay for a teaching physician's services only if he was present for the surgery's key parts and either remained immediately available throughout the surgery or else arranged for a back-up surgeon to be available. MCW allegedly billed for teaching physicians' services even though they were responsible for multiple overlapping surgeries and did not satisfy those supervision requirements.

"The settlement we are announcing...reflects the focused, sustained, and purposeful efforts of the Justice Department, together with our partnered federal agencies, to investigate and redress fraud in our health care system," said Mr. Santelle. "Under the authority of the False Claims Act, we are aggressive yet even-handed in pursuing health care fraud to ensure that taxpayer dollars are spent lawfully and that federal monies that should not have been paid are returned with an appropriate penalty."

The full press release is [here](#).

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## **Second Year of Open Payments Data Submission Begins**

Beginning February 2, 2015, applicable manufacturers and applicable group purchasing organizations (GPOs) are able to register or recertify their registration in the Open Payments system and begin data submission for any payments or transfers of value that occurred in the 2014 calendar year.

All applicable manufacturers and GPOs must register or recertify their registration. Applicable manufacturers and GPOs can now submit corrected 2013 data (if needed) and submit their 2014 data to the Open Payments system. March 31, 2015 is the deadline for all submissions.

Physicians and teaching hospitals may also now register in the system so they can be prepared to review any data that may be submitted about them.

The review and dispute period for physicians and teaching hospitals is anticipated to start in April.

CMS released the first year of Open Payments data on September 30, 2014, to help consumers understand the financial relationships between the healthcare industry, and physicians and teaching hospitals. This release was part of the Open Payments program, created by the Affordable Care Act, and lists consulting fees, research grants, travel reimbursements, and other gifts to the healthcare industry - such as medical device manufacturers and pharmaceutical companies - provided to physicians and teaching hospitals during the last five months of calendar year 2013. The

2013 data contained 4.45 million payments valued at nearly \$3.7 billion.

CMS plans to publish the 2014 payment data and make any applicable updates to the 2013 data in June 2015. More information about the Open Payments program is available at <http://www.cms.gov/openpayments/>.

## **Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010**

Evaluation and management (E/M) services are visits performed by physicians and nonphysician practitioners to assess and manage a beneficiary's health. Medicare paid \$32.3 billion for E/M services in 2010, representing nearly 30% of Part B payments that year. In 2012, OIG reported that physicians increased their billing of higher level codes, which yield higher payment amounts, for E/M services in all visit types from 2001 to 2010.

The Office of Evaluation and Inspections (OEI) conducted a medical record review of a random sample of Part B claims for E/M services from 2010, stratifying claims from physicians who consistently billed higher level codes for E/M services (i.e., "high-coding" physicians) and claims from other physicians.

In total, Medicare inappropriately paid \$6.7 billion for claims for E/M services in 2010 that were incorrectly coded and/or lacking documentation, representing 21 percent of Medicare payments for E/M services that year.

The OEI found that 42% of claims for E/M services in 2010 were incorrectly coded, which included both upcoding and downcoding (i.e., billing at levels higher and lower than warranted, respectively), and 19 percent were lacking documentation.

The OEI recommended that CMS (1) educate physicians on coding and documentation requirements for E/M services, (2) continue to encourage contractors to review E/M services billed for by high-coding physicians, and (3) follow up on claims for E/M services that were paid for in error. CMS concurred with the first recommendation, did not concur with the second, and partially concurred with the third recommendation.

The complete report can be found here: <http://oig.hhs.gov/oei/reports/oei-04-10-00181.asp>.

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