THIRD-PARTY BILLING IN THE NEW YORK MEDICAID PROGRAM

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WEBINAR-1/12/11

OMIG WEBINARS-FULFILLING OMIG'S SECTION 32 DUTY-

- **Section 32 of the Public Health Law provides the duties and powers of OMIG, including the power:**
- "17. to conduct educational programs for medical assistance program providers, vendors, contractors and recipients designed to limit fraud and abuse within the medical assistance program"

- These programs will be scheduled to address significant issues identified by OMIG or by the provider community. Your feedback on this program, and suggestions for new topics are appreciated.

2011

- GOVERNOR CUOMO'S STATE OF THE STATE (January 5, 2011):
  - MEDICAID AS ONE OF THREE PRIMARY FOCUS AREAS
  - NOT BUDGET CUTTING OR TRIMMING, BUT-
  - REINVENTING, REORGANIZING, AND REDESIGNING PROGRAMS AND AGENCIES
  - MEDICAID REDESIGN TEAM STARTED WORK JANUARY 7
  - "The team must submit its first report with findings and recommendations to the Governor by March 1 for consideration in the budget process. The team shall submit quarterly reports thereafter until the end of Fiscal Year 2011-12, when it disbands."
  - REQUIRES THOROUGH REVIEW OF MEDICAID PROGRAMS AND AGENCY PRACTICES

THE GOVERNING REGULATION FOR SERVICE BUREAUS AND BILLING SERVICES; 18 NYCRR 504.9

- Regulation focus on "**persons**" "submitting claims" or "verifying eligibility" or "obtaining service authorizations"
- Service providers, not software vendors
- For software vendors, check-
  - **nyhipaadesk.com Web site (New York State Department of Health (NYSDOH), (its affiliates and agents neither endorse nor recommend any company, organization, individual, or product.)**
- Why no regulation of software vendors?-18 NYCRR 504.9 was filed in 1988 and last amended in 1993-at that time, most claims were paper, and the start of HIPAA was three years in the future.
- What about external coders who do not submit bills? False Claims Act language "cause to be submitted."

WHAT ARE "SERVICE BUREAUS," "BILLING SERVICES," AND "ELECTRONIC MEDIA BILLERS?"

- persons "submitting claims," "verifying client eligibility," "or obtaining service authorizations for or on behalf of providers" are included in the categories of service providers subject to 18 NYCRR 504.9.

HIPAA SERVICE TRANSACTIONS SUBJECTING "PERSONS" to 18 NYCRR 504.9 OBLIGATIONS

- **270/271: Eligibility Inquiry and Response (electronic eligibility)**
- **276/277: Claim Status Inquiry and Response (electronic claims status)**
- **278: Prior Authorization and Service Authorization (electronic PA/SA/UT)**
- **837P: Health Care Claim, Professional (electronic claim, fee-for-service)**
- **837I: Health Care Claim, Institutional (electronic claim, rate-based and ordered ambulatory)**
- **837D: Health Care Claim, Dental (electronic claim, dental)**
- **NCPDP: Pharmacy Transaction (multi-functional)**
  - NOTE: PAPER CLAIMS SUBMITTED ARE ALSO COVERED.

WHY DOES OMIG CARE ABOUT SERVICE BUREAUS AND THIRD-PARTY BILLERS

- ACCOUNTABILITY AT EACH STAGE OF ELIGIBILITY DETERMINATION, CLAIM SUBMISSION AND PAYMENT
  - CLAIM AND PROCESS ACCURACY-ADDITIONAL STEP BETWEEN PROVIDER AND MEDICAID WHERE INFORMATION MAY BE LOST OR CHANGED
- CONTEMPORANEOUS RECORDS SUPPORTING CLAIMS
- PROCESSING SYSTEMS AND SOFTWARE

WHY DOES OMIG CARE ABOUT SERVICE BUREAUS AND THIRD-PARTY BILLERS

- SIGNIFICANT FRAUD CASES
- COLLECTION ACTIVITIES
  - Offer "all aspects of the billing process, data entry, billing, insurance billing, collection, and follow-up"
  - "Revenue cycle management" includes
    - Tracking of third-party payers
    - Rebilling of unpaid claims
    - (illegal) balance billing of Medicaid enrollees for claims unpaid by Medicaid fee for service or managed care

WHY DOES OMIG CARE ABOUT SERVICE BUREAUS AND THIRD-PARTY BILLERS

- §6503 of ACA – Billing agents, clearinghouses, or other alternate payees that submit Medicaid claims on behalf of health care provider must register with State and Secretary in a form and manner specified by Secretary

OLDER BILLING COMPANY INVESTIGATIONS

- Handle With Care, Inc. -"lost charge" audits for nursing homes
- Gottlieb Financial Services, Inc. (GFS) provided emergency department physician billing services, allegedly used an automated coding software system that routinely upcoded emergency room visits.
- Medaphis Corporation-multiple claims for payment for the same service to the same patient on the same date of service; used incorrect or inapplicable diagnosis codes in resubmitting claims which had been denied based on the diagnosis originally stated.
- Emergency Physician Billing Services, Inc (Dr. J.D. McKean)-coders "abstracted" 40 charts per hour. No coder at EPBS ever attended training or any other informational meeting regarding emergency department coding other than in-house EPBS training, and no coder ever contacted a physician with questions regarding a chart. In a video introduced at trial, McKean said documentation of services rendered to patients for reimbursement by Medicare and other health programs was "just a red tape crap issue."

WHY DOES NEW YORK MEDICAID CARE ABOUT SERVICE BUREAUS AND THIRD-PARTY BILLERS

- HHS/OIG "Compliance Program Guidance for Third-Party Medical Billing Companies," 63 FR 70138-70152 (December 18, 1998)

"Compliance Program Guidance for Third-Party Medical Billing Companies," 63 FR 70138-70152 (December 18, 1998)

- billing for items or services not actually documented;
- unbundling and upcoding of claims;
- computer software programs that encourage billing personnel to enter data in fields indicating services were rendered though not actually performed or documented;
- knowing misuse of provider identification numbers which results in improper billing in violation of rules governing reassignment of benefits;
- billing company incentives that violate the anti-kickback statute;
- percentage billing arrangements.

HHS/OIG CONCERNS

- **Testimony of Lewis Morris, Assistant Inspector General for Legal Affairs, OIG, before the House Committee on Commerce, Subcommittee on Oversight and Investigations, regarding Medicare and Third-Party Billing Companies 4/6/2000**
- http://www.hhs.gov/oig/testimony/00406fin.htm

MEDICAID LIMITS ON PAYMENTS TO A BILLING OR COLLECTION ENTITY 42 CFR **§ 447.10**

- (f) *Business agents.* Payment may be made to a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payments in the name of the provider, if the agent's compensation for this service is—
- (1) Related to the cost of processing the billing;
- (2) Not related on a percentage or other basis to the amount that is billed or collected; and
- (3) Not dependent upon the collection of the payment.

NOT JUST THIRD-PARTY BILLING

- verifying eligibility" or "obtaining service authorizations" 18 NYCRR 504.9

H.I.S. HOLDINGS PRESIDENT DEBORAH KANTOR CONVICTED OF BRIBERY-2010

DEBORAH KANTOR OF TONAWANDA-July 2010 indictment

- From 2000-2007, Kantor and H.I.S. bribed (Niagara County employee) Albrecht more than $17,749 in checks and cash including $50 for each active Medicaid client identification number that he provided (from Medicaid Fraud Control Unit 2009 Annual Report).

DEBORAH KANTOR OF TONAWANDA-AUGUST, 2010 SENTENCING

- Kantor pleaded guilty to four felonies and was convicted of two others in a jury trial
- Sentence: five years' probation and ordered to repay the state $727,526 in three annual installments.
- County Judge Sara Sheldon Sperrazza told Kantor, "Because of the amount of restitution that is being requested in this case, this court has no intention of sending you to jail. But the court is very concerned that you pay every dime of that restitution."
- Excluded by New York OMIG September 2010
- Not yet excluded by HHS/OIG (as of 1/12/2011)

Deborah Kantor-"A FABULOUS JOB"

- "Hospital officials thought Kantor was doing a fabulous job. After all, the financially strapped institution could use all the extra cash it could find. Not one single hospital executive or board member ever questioned how Kantor was able to significantly boost Medicaid collections over a period of more than seven years." Niagara Falls Reporter, July 19, 2009

THE NEW YORK REGULATION

- 18 NYCRR 504.9
  - "persons submitting claims, verifying client eligibility, or obtaining service authorizations for or on behalf of providers, except those individuals employed by providers . . .must enroll in the medical assistance program. . ."

THE NEW YORK REGULATION

- 18 NYCRR 504.9 (b)
  - "Service bureaus must maintain a system approved by the Department for notifying providers of the claims to be submitted on their behalf. Prior to submission to the Department, claim submissions must be reviewed by the provider . . . In order that the provider may correct any inaccurate claims, delete improper claims, or otherwise revise the intended submission to ensure that only claims for services actually provided, due, and owing are submitted."

THE NEW YORK REGULATION

- 18 NYCRR 504.9 (d)
- "Service bureaus must meet the processing standards established by the department and its fiscal intermediary and satisfactorily perform claims submissions based upon a test claim provided by the department or its fiscal intermediary prior to acceptance of their enrollment applications."
- Not currently done-when we accepted tapes and diskettes, we tested sample claims to prevent data corruption

ETIN-ELECTRONIC TRANSMITTER IDENTIFICATION NUMBER

- Submitted as submitter ID on electronic files.
- If service bureau uses own ETIN number, provider has not authorized service bureau to submit, claims kick out.
- If service bureau uses provider's ETIN number, gets paid as long as valid provider ETIN number.

THE NEW YORK REGULATION

- 18 NYCRR 504.9(e)
- "Service bureaus must enter into an electronic/magnetic billing agreement with the department or its fiscal intermediary, establishing the rights and obligations of the service bureau, the provider and the department, prior to acceptance of any claims from the service bureau. Such agreements will include provisions for liability in case of errors, submission criteria, record retention requirements, data integrity, confidentiality or client data, and audit requirements."
- Magnetic media-tapes and diskettes-no longer accepted as of 2005
- Only agreements today are enrollment agreement, and ETIN agreement if service bureau uses own number.

ENROLLMENT PROCESS

- Enrollment application (a paper form sent by snail mail or hand-delivered with a "wet signature") goes to CSC
- Pre-screening checklist –signature, attachments, form completed
- Transmitted electronically to OHIP enrollment
- Address: Computer Science Corporation
  - P.O. Box 4603
  - Rennselaer, NY 12144-4603

SERVICE BUREAU APPLICANTS

You must keep this information and conditions of enrollment for your records. (from the enrollment app)

- **PROVIDING SERVICES**
- Supplier may provide claims processing and related services for one or more providers of medical care, services or supplies (customers) only pursuant to the terms and conditions of enrollment and the regulations of the Department and the written instructions or directions of its fiscal agent, Computer Sciences Corporation (CSC).
- Supplier shall process the work hereunder for timely submission to CSC in accordance with the date and claims submission deadlines of the Department's regulations.
- Systems documentation must be in place for review by the Department (i.e., available for audit by OMIG)
- EMEDNY-414601 (03/05)

SERVICE BUREAU APPLICANTS

You must keep this information and conditions of enrollment for your records (from the enrollment app)

- **ENROLLMENT OF SUPPLIER**
- By enrolling as a Medicaid supplier, supplier has agreed to fulfill those tasks and responsibilities described in both the Department's Regulations at 18 NYCRR 504.3 ("Duties of the provider") and in the Medicaid Management Information System (MMIS) Instructions.

SERVICE BUREAU APPLICANTS

You must keep this information and conditions of enrollment for your records. (from the enrollment app)

- **MAINTENANCE OF CUSTOMER RECORDS**
- Original material and data submitted by customers for claims processing by the supplier shall be kept and maintained by the supplier in readily reviewable form and format for a period of six years from the date of the claims submission in order to provide the Department, or other authorized agency, the ability to verify the accuracy and correctness of the claims submissions by the supplier. The supplier agrees not to accept from its customers for purposes of claims preparation any document required by law to be maintained by the customer such as original patient records, original prescriptions, etc.
- EMEDNY-414601 (03/05)

SERVICE BUREAU APPLICANTS

You must keep this information and conditions of enrollment for your records. (from the enrollment app)

- **PROHIBITION AGAINST ASSIGNING OR SUBLETTING CONTRACT WITHOUT CONSENT**
- Supplier shall not assign the contract or any payments due, or to become due hereunder, and shall not sublet the contract as a whole, or in part.
- EMEDNY-414601 (03/05)

FROM THE SERVICE BUREAU APPLICATION

- "Provide a copy of the fee schedule you will be using to charge for your services (i.e., claim preparation)."
- "What documentation do you provide to your customer (Medicaid provider) as verification for services billed and/or submitted."
- EMEDNY-414801 (09/09)

Ten questions for health care providers about third-party billers

- 10. Is there a non-employee or outside corporation who prepares or submits your claims to Medicaid, or checks authorization or enrollment?

Ten questions for health care providers about third-party billers

- 9. Do you know who within your organization contracts with outside persons or entities to prepare or submit claims, check enrollment, or obtain authorizations?
- Your compliance program should assure that you know whether a non-employee individual or entity prepares or submits your claims
  - Departmental or unit survey
  - Prior approval process
  - Authorization to use your ETIN (Electronic transmitter Identifier Number) by outside person or entity

Ten questions for health care providers about third-party billers

- 8. If any non-employee submits your claims, checks enrollment, or obtains authorizations, have you received a written representation that the person or entity an "enrolled service bureau" in Medicaid?
- that person or entity must be an "enrolled service bureau," that is, enrolled under 18 NYCRR 504.9

Ten questions for health care providers about third-party billers

- 7. Do you know whether **each** non-employee individual or entity which prepares or submits your Medicaid claims or checks authorization or enrollment is actually registered as a "service bureau" in New York Medicaid pursuant to 18 NYCRR 504.9?
- As of December 2010, there were fewer than 120 "service bureaus" enrolled in New York Medicaid under that regulation-OMIG has discovered in investigations many non-employee billers.
- OMIG will post on February 1, 2011 on our Web site a current list of Medicaid-enrolled service bureaus.

Ten questions for health care providers about third-party billers

- 6. Do you know whether any person or entity in your organization which prepares or submits your Medicaid claims or checks authorization or enrollment on behalf of another provider is actually registered as a "service bureau" in New York Medicaid, pursuant to 18 NYCRR 504.9? Are they following the service bureau requirements?

Ten questions for health care providers about third-party billers

- 5. If any non-employee submits your claims, checks enrollment, or obtains authorizations, have you received a written representation that the person or entity has a records preservation policy consistent with EMEDNY-414601 (i.e., six years from the date of claims submission) for material and data your organization submits?

Ten questions for health care providers about third-party billers

- 4. If any non-employee submits your claims, checks enrollment, or obtains authorizations, have you received a written representation that they are in compliance with the "prohibition against assigning or subletting their contract" set forth in EMEDNY-414601?
- Core issue-do you know who is performing the work, and are they responsible directly to you?

Ten questions for health care providers about third-party billers

- 3. If any non-employee submits your claims, checks enrollment, or obtains authorizations- What documentation do they provide to you as a Medicaid Provider as verification for services billed and/or submitted.
- EMEDNY-414801 (09/09)

Ten questions for health care providers about third-party billers

- 2. How does your third-party biller assure that they comply with OIG, CMS, and OMIG rules governing excluded persons?
- With rules governing reporting, refunding, and explaining identified overpayments? (ACA Section 6402)
- With the rules requiring certification of an effective compliance program for entities submitting over $500,000 per year in Medicaid claims? (18 NYCRR 521)

Ten questions for health care providers about third-party billers

- 1. WHO IS RESPONSIBLE FOR ACCURACY OF INFORMATION SUBMITTED BY YOUR THIRD-PARTY BILLER?

- CONTRACT LANGUAGE:
  - Client shall provide . . . All necessary practice information, including . . .diagnostic and procedure codes and charges . . .
  - Client shall provide . . .superbills for all services provided by the client . . .with correct insurance, eligibility, and complete claim information. . .

Ten questions for health care providers about third-party billers

- 1. WHO IS RESPONSIBLE FOR ACCURACY OF CLAIMS SUBMITTED BY THE THIRD-PARTY BILLER?
- Client shall bear sole responsibility for the accuracy and proper transmission of any and all information it provides . . . And for errors made by client or representative of client or errors resulting from information provided by client that results in billing errors.

Ten questions for health care providers about third-party billers

- 1. WHO IS RESPONSIBLE FOR ACCURACY OF CLAIMS SUBMITTED BY THE THIRD-PARTY BILLER?
- INDEMNIFICATION YOU PROVIDED TO YOUR THIRD-PARTY BILLER-
- INDEMNIFICATION: "Client hereby indemnifies and holds . . . and any of its constituents harmless from any liability arising from the clinical practice of the client and the accuracy or validity of any insurance billings and charges submitted by client."

THE KANTOR QUESTION

- 1. WHO IS RESPONSIBLE FOR ACCURACY OF CLAIMS SUBMITTED BY THE THIRD-PARTY BILLER?

- (ARE YOUR BILLING OR CLIENT ELIGIBILITY RESULTS TOO GOOD TO BE TRUE?)

- "Not one . . .executive questioned how Kantor was able to significantly boost Medicaid collections over a period of more than seven years."

FREE STUFF FROM OMIG

- OMIG Web site-www.OMIG.ny.gov
- Mandatory compliance program-hospitals, managed care, all providers over $500,000/year
- Over 2500 provider audit reports, detailing findings in specific industry
- 2011 work plan available on Web site
- Listserv (put your name in, get emailed updates)
- Follow us on Twitter (NYSOMIG)
- New York excluded provider list