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SPECIAL POINTS OF INTEREST:

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If Your Business Accepts Credit Cards, You Need to Read This!

On December 4, 2003, Congress enacted the Fair and Accurate Credit Transactions Act ("FACTA"). Laudably, Congress sought to address rampant and costly identity theft and credit card fraud. The good news is that, because of FACTA, consumers are now entitled to a free credit report each year. The bad news (for all but plaintiffs' lawyers) is that FACTA has spawned more than 250 federal class-action lawsuits, ensnaring companies such as Wendy's, Victoria's Secret, Bath & Body Works, Costco, FedEx Kinko's, Avis Rent A Car, Toys "R" Us, IKEA, and Rite Aid.

FACTA added sections to the Fair Credit Reporting Act ("FCRA," 15 U.S.C. §§ 1681 *et seq.*), including three particular rights or obligations: (1) FACTA, as mentioned above, gave consumers the right to a free credit report each year; (2) FACTA created an obligation for businesses to protect customer and employee "consumer information," which is defined as information about consumers or employees, including consumer reports or information derived from a consumer report; and (3) ***FACTA mandated that retailers truncate the credit card information reflected on a transaction receipt***. It is largely because of FACTA that retailers no longer print out receipts containing all 16 digits of your credit card number, but rather truncate the number to a maximum of five digits and remove the credit card expiration date. It is this third aspect which has caught the eye of class-action plaintiffs' counsel and which is the focus of this *Commentary*.

Con't on p. 4

Trailblazer Has Left the Building...

There seems to have been some confusion among practices regarding the recent CMS Medicare Administrator Contractor awards. Virginia is a slightly complicated state in that for the purposes of Medicare Administrative Contractor awards, it is split into two areas:

- MAC Jurisdiction 12 — Fairfax County, Arlington County and the City of Alexandria are bundled into the DC/Metro area which is covered by Jurisdiction 12.
- MAC Jurisdiction 11 — all of Virginia ***other than*** Fairfax County, Arlington County and the City of Alexandria are covered by Jurisdiction 11.

Historically Trailblazer Health Enterprises had been the MAC for both Jurisdictions 11 and 12. However, when requests for proposals were reviewed, Highmark was awarded the contract for Jurisdiction 12 in October 2007. The transition from Trailblazer to Highmark (for providers located in Fairfax and Arlington County and the City of Alexandria) was completed in 2008. This contract award is still in effect, and has not been affected by any other MAC awards.

On January 7, 2009, CMS announced that it has awarded the MAC contract for Jurisdiction 11 (i.e., the rest of Virginia) to Palmetto GBA. So now, throughout 2009, providers located in all of Virginia ***other than*** Fairfax & Arlington Counties or the City of Alexandria will be transitioning from Trailblazer to their new MAC, Palmetto GBA.

Again, this will not impact those providers who transitioned to Highmark in 2008!

CMS's New National Coverage Decisions Swipe Payment From 'Never Events'

It's not just the inpatient providers under the gun… As of January 15, 2009, "never events" may never be paid!

The Centers for Medicare and Medicaid Services announced Jan. 15, 2009, three national coverage determinations to prevent Medicare from paying for certain serious, preventable errors in medical care.

The errors covered in these NCDs — known as "never events" — are identified in the National Quality Forum's list of Serious Reportable Events:

- Wrong surgical or other invasive procedures performed on a patient;
- Surgical or other invasive procedures performed on the wrong body part; and
- Surgical or other invasive procedures performed on the wrong patient.

These NCDs are effective immediately, although CMS will post implementation instructions for processing the claims at a later date. To view the NCDs, visit:

- Wrong body part: www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=222
- Wrong patient: www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=221
- Wrong surgery performed on a patient: www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=223.

As is consistent with current policy, Medicare does not cover any services related to these non-covered services. "The national coverage policies for certain types of surgical errors are important steps for Medicare in working to reduce or eliminate their occurrence and their associated payments," said CMS Acting Administrator Kerry Weems. "These policies have the potential to reduce causes of serious illness or deaths to beneficiaries and reduce unnecessary costs to Medicare."

While the rationale behind non-coverage of such "never events" is sensible in that they are the result of avoidable and potentially serious clinical errors, the release of the NCDs has the potential to create some unintended consequences for coders and billers. For example, simple claims submission errors (like mistakenly appending the -RT modifier instead of the -LT modifier for a unilateral procedure) might now be denied and flagged as a "never event." There is some speculation that unlike regular claims denials, there will be no appeals process for disputing denials for "never events," so these simple coding and/or documentation errors could potentially preclude the practice from receiving legitimate reimbursement without recourse. Furthermore, unlike Medicare's Hospital Acquired Conditions (HAC) non- coverage rules, the "never events" NCDs apply to all settings (including the office) and all procedures (no matter how simple), rather than just the management of complex diagnoses in inpatient settings.

While more information is sure to come on this issue, it behooves all medical practice staff and billing associates to be extraordinarily diligent when documenting and filing claims related to such procedures (such as documenting the –LT or –RT modifier for a unilateral procedure) to avoid any potential "never event" pitfalls!

Identity Theft Is Closer To Home Than We'd Like To Admit

In the last few issues of The M.E.D.I.C., Inc. Quarterly, the issue of the "red flag rules" has been addressed. How apropos that shortly after our last publication, this press release was issued relating to a case involving, yes, HIPAA, identity theft and red-flag issues.

I publish it for your review and information — these issues are clearly being reviewed and investigated by governmental entitles — it is our collective responsibility to be sure that we in the medical community are addressing any potential concerns at our offices. Please feel free to contact M.E.D.I.C,. Inc. Should you have any questions or concerns regarding your office practices.

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January 9, 2009
FOR IMMEDIATE RELEASE
http://www.usdoj.gov/usao/md

MEDICAL WORKER SENTENCED TO PRISON IN IDENTITY THEFT SCHEME

Used Stolen Identities of at least 49 Individuals to Buy a Luxury Car and other Merchandise

Greenbelt, Maryland - U.S. District Judge Deborah K. Chasanow sentenced Christel Ebony Norwood, age 32, of Ft. Washington, Maryland today to 30 months in prison followed by five years of supervised release for bank fraud and aggravated identity theft, announced United States Attorney for the District of Maryland Rod J. Rosenstein. Judge Chasanow also ordered Norwood to pay restitution of $27,433.68.

According to her guilty plea, Norwood used her temporary employment at two medical facilities to steal the names, dates of birth, social security numbers and other identifying information of at least 49 individuals. She and her co-conspirators used the stolen identities to purchase goods at retail stores and a Maryland car dealership, where some of her co-conspirators worked. The co-conspirators were paid for allowing Norwood to purchase items at these stores.

For example, in June 2007, Norwood used stolen identity information of a victim to forward the victim's mail to a mail box that Norwood controlled. Norwood also used the victim's stolen identity to obtain $35,560.20 from a bank to finance her purchase of a 2002 Mercedes-Benz coupe.

In September 2007, law enforcement officers observed Norwood driving the Mercedes-Benz at a mall in Springfield, Virginia and arrested her. The officers found a counterfeit Washington, D.C. driver's license and three credit cards in the name of another victim in her purse, along with items purchased at a retail store using the second victim's identity. Norwood admitted to fraudulently using the credit cards and driver's license, which she claimed were obtained through a third party. A search of Norwood's home revealed the stolen identity information of at least 49 individuals. Officers also discovered that Norwood, using at least four of the stolen identities, had accumulated at least $15,225 in fraudulent charges at three retail stores.

United States Attorney Rod J. Rosenstein thanked the U.S. Postal Inspection Service for its investigative work and commended Assistant United States Attorney Jonathan Su, who prosecuted the case.

How FACTA Affects Your Medical Practice, Con't.

Con't. from p. 1

FACTA's Truncation Requirement. Section 1681c(g)(1) of the FCRA, part of the FACTA enactment, provides that "no person that accepts credit cards or debit cards for the transaction of business shall print more than the last 5 digits of the card number or the expiration date upon any receipt provided to the cardholder at the point of the sale or transaction." This aspect of FACTA was phased in over time to allow large and small businesses to conform to the requirements and update the cash registers in service. The requirement was fully phased in as of December 4, 2006. Since then, the class-action lawsuits have come fast and furious.

With the law fully enacted and phased in, if a violation existed—say, for example, a retailer printed out the customer's receipt with the last seven digits or with the credit card's expiration date—plaintiffs' lawyers could either bring a negligence claim under section 1681o of the FCRA seeking "actual damages" or bring suit under section 1681n for a "willful violation" of 1681c(g) and seek between $100 and $1,000 per violation.

Because proving "actual damage" would prove elusive, if not impossible, virtually every class action brought under FACTA has alleged a willful violation and a right to statutory damages. Pause for a moment and contemplate the large retail entities that have been sued and the number of transactions they engage in during a single day. Now, multiply that by between $100 and $1,000. The numbers quickly run into the millions. Furthermore, there is no cap to the amount of total damages that can be sought, only a cap of $1,000 per violation. Simply put, hundreds of millions of dollars are at issue in these lawsuits. Considering that federal law caps consumers' loss for credit card theft at $50, these statutory damages simply create a windfall for plaintiffs at the expense of the other customers, who ultimately pay for that windfall through higher prices.

What Is a Willful Violation? With such a large amount hanging in the balance, the definition of a "willful" violation became a pivotal question. More to the point, for a violation to be willful, must the retailer "knowingly" violate FACTA, or merely have a "reckless disregard" for it? In June, the United States Supreme Court answered this question through its unanimous decision in *Safeco Insurance Co. of America v. Burr*, 551 U.S. ___, 127 S. Ct. 2201 (2007). Unfortunately for retailers, the Supreme Court chose the lower standard of reckless disregard.

The Supreme Court held "that where willfulness is a statutory condition of civil liability, we have generally taken it to cover not only knowing violations of a standard, but reckless ones as well." Consequently, a plaintiff class need only show that the retailer was reckless in failing to truncate its credit card receipts to unlock the vault of statutory damages.

On a brighter note, however, the Court did clarify that "a company subject to FCRA does not act in reckless disregard of it unless the action is not only a violation under a reasonable reading of the statute's terms, but shows that the company ran a risk of violating the law substantially greater than the risk associated with a reading that was merely careless." A company's reading of the statute will be found to be objectively reasonable if the statute is less than clear and there is a "dearth of guidance." In that situation, an unknowing violation "falls well short of raising the 'unjustifiably high risk' of violating the statute necessary for reckless liability."

With the standard for seeking statutory damages resolved, the next issue for retailers to closely monitor is how courts deal with the factual determination of what constitutes a reckless disregard for FACTA. Thus far, plaintiffs have argued, *ipso facto*, that a FACTA violation should be deemed reckless in all instances because the law has been in effect since 2003, and it has been phased in over the past four years. In other words, they would argue that a retailer has had plenty of time and opportunity to comply with FACTA; thus, any failure to

Con't. on p. 7

Don't Forget To Use The New ABN!!!

The Advance Beneficiary Notice ("ABN") is a notice that must be given to Medicare beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case (i.e, Medicare payment is expected to be denied), and that in such event, the beneficiary will be responsible for payment for such services. The ABN must be used on a visit-by-visit basis, and may NOT be used for multiple visits (even if addressing the same procedures). The notifying providers must complete the ABN as described below, and deliver the notice to affected beneficiaries or their representative ***before providing the items or services that are the subject of the notice***.

Effective March 1, 2009, the ABN-G and ABN-L were deemed invalid; rather, notifying providers were to begin using the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). This new ABN form can be accessed at: http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp. From that website, click on the link "Revised ABN CMS-R-131 Form and Instructions," which will take you to a folder with several zip files, one of which is the "Final Revised ABN" — the form CMS-R-131 which must now be utilized.

Some salient points regarding use and presentation of the ABN:

- The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before the beneficiary signs the ABN.
- The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice.
- Employees or subcontractors of the provider may deliver the ABN (i.e., the provider need not be the person discussing the ABN with the patient).
- ABNs are never required in emergency or urgent care situations.
- Once the ABN has been completed and signed, a copy must be given to the beneficiary or representative, and the provider must retain the original notice on file.

On Monday, March 3, 2008, CMS implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN) (CMS-R-131). After the year-long transition period, in which both the new and old ABN forms have been accepted, this form will completely replace the General Use ABN (CMS-R-131-G), and the Lab ABN (CMS-R-131-L) for physician-ordered laboratory tests, as of March 1, 2009. The form (English and Spanish versions) and notice instructions have been posted by CMS on their Beneficiary Notice Initiative web page (www.cms.hhs.gov/BNI/02_ABNGABNL.asp#TopOfPage)). Some key features of the new form are that it:

• Has a new official title, the "Advance Beneficiary Notice of Noncoverage (ABN)", in order to more clearly convey the purpose of the notice;
• Replaces the ABN-G and ABN-L;
• May also be used for voluntary notifications, in place of the Notice of Exclusion from Medicare Benefits (NEMB) (CMS Form 20007);
• Has a mandatory field for cost estimates of the items/services at issue; and
• Includes a new beneficiary option, under which an individual may choose to receive an item/service, and pay for it out-of-pocket, rather than have a claim submitted to Medicare.

Again, please be advised that the ABN-G and ABN-L will no longer be valid as of March 1, 2009. For additional information, please see http://www.cms.hhs.gov/BNI/Downloads/ABNAnnouncementFAQs.pdf.

It's Coming.... The RAC Program Takes Over the Nation

In the Spring 2007 issue of the *M.E.D.I.C. News Quarterly*, you were first introduced to the concept of the Medicare Recovery Audit Contractor ("RAC"). To briefly recap, the Medicare Modernization Act of 2003 provided for the establishment of these RACs, whose function would be to review randomly providers' claims and coding to ensure that claims were being filed (and thus paid) appropriately. The RACs are compensated based on a percentage of the funds that they recapture, so it is to their clear benefit to ferret out these Medicare overpayments.

Initially, the program was implemented in California, Florida and New York, and was then expanded to include Massachusetts, South Carolina and Arizona. Since its inception, the RAC program has collected over $900 million in overpayments from providers (and returned $38 million in underpayments). Clearly, this program is here to stay!

On October 6, 2008, CMS announced the first phase of the national expansion of the RAC program and the winning contracts:

- **Region A — Diversified Collection Services, Inc. of Livermore, California,** initially working in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island & New York (to eventually include Connecticut, New Jersey, Delaware, Pennsylvania, ***Maryland & DC***), can be reached at 1-866-201-0580;
- **Region B — CGI Technologies and Solutions, Inc. of Fairfax, Virginia**, initially working in Michigan, Indiana & Minnesota (to eventually include Wisconsin, Ohio, Illinois, & Kentucky), can be reached at 1-877-316-7222, or via e-mail at racb@cgi.com;
- **Region C — Connolly Consulting Associates, Inc.** of Wilton, Connecticut , initially working in South Carolina, Florida, Colorado & New Mexico (to eventually include ***Virginia, West Virginia***, Tennessee, North Carolina, Georgia, Alabama, Mississippi, Arkansas, Louisiana, Texas & Oklahoma), can be reached at 1-866-360-2507; and
- **Region D — HealthDataInsights, Inc. of Las Vegas, Nevada,** initially working in Montana, Wyoming, North Dakota, South Dakota, Utah & Arizona (to eventually include Washington, Oregon, Idaho, Nebraska, Iowa, Kansas, Missouri, California, Nevada, Hawaii, Alaska), can be reached at 866-590-5598 (Part A), 866-376-2319 (Part B), or via e-mail at racinfo@emailhdi.com.

After this announcement, the selection process for these contracts was contested by the unsuccessful candidates, thereby placing the entire RAC program on hold pending resolution. On February 4th, the parties protesting the contract awards settled their dispute, and the stop work order which had been in effect was lifted, thereby allowing CMS to continue with the implementation of the national RAC program.

Going forward, the four selected RACs will contract with subcontractors to supplement their efforts:

- PRG-Schultz, Inc. will serve as a subcontractor to HDI, DCS and CGI in regions A, B and D.
- Viant Payment Systems, Inc. will serve as a subcontractor to Connolly Consulting in region C.

Each subcontractor has negotiated different responsibilities in each region, including some claim review.

According to the RAC expansion plan, Virginia, West Virginia & Maryland will be phased in on or after August 1, 2009. In any event, pursuant to the Section 302 of the Tax Relief and Health Care Act of 2006 the RAC Program must be permanent and fully expanded to encompass all 50 states by no later than 2010.

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How FACTA Affects Your Medical Practice, Con't.

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do so by now must be deemed reckless. The error with this approach is that it ignores reality-based defenses (*e.g.*, absent all 16 digits and the CVC code, the card number is likely of little value) in favor of strict liability.

Are There Any Defenses? Assuming that the receipt fails to comply with FACTA, three basic defenses exist. The first defense focuses on the statutory text regarding whether the receipt in question falls within FACTA's purview. For example, FACTA applies to receipts received at the point of sale. Does "point of sale" mean a purchase at a store, or does it also apply to online transactions? This is likely an issue that will be addressed at the onset of a case. If successful, it would result in dismissal of the case.

The second defense requires proving that the alleged actions do not constitute a willful violation. If successful, this defense would require the plaintiff to prove actual damages, which would be almost impossible. If a business can show that its actions were reasonable based upon the law, even if later found to violate the law, then that action is likely not a willful violation. Furthermore, if a business can show that its actions were negligent rather than reckless—for example, the business changed its registers, but missed a few machines in the process—it is possible that the court may find that action to fall below the threshold required for a willful violation.

The final defense centers on disqualifying the plaintiff class, and it has gained some support. At least two federal district court judges have denied class certification for these types of cases. When comparing the plaintiffs' failure to show any actual harm against the potential harm to the defendants in the tens of millions to hundreds of millions of dollars, the court determined that class actions were not the best method to adjudicate these claims. Both judges determined that individual claims provided a better mechanism of enforcing FACTA's truncation provisions:

If Plaintiff is able to prove that Defendant committed a "willful" violation of FACTA, each class member would be eligible to receive between $100 and $1,000 in statutory damages. If the class is certified, Defendant faces statutory damages alone of between approximately $4.8 million and $48 million. (Def. Motion at 1). Given the disproportionate consequences to Defendant's business and the lack of any actual harm suffered by members of the potential class, the Court finds that Plaintiff fails to meet the superiority requirements.

That both defendants immediately corrected their error upon filing of the complaints served as a major consideration behind these decisions: "By immediately remedying their misconduct upon receiving Plaintiff's Complaint, Defendants demonstrated good faith and nullified any deterrence benefit that might have been derived from a class action." Ideally, this trend will continue and other trial courts will also deny class certification as long as the defendants immediately remedy any potential violation.

What Should My Business Do Now? If your company has not been sued for a FACTA violation, you still need to act. Conduct an audit of the receipts issued to customers to ensure that all stores comply with FACTA. If any potential violation is noted, correct it immediately. Also, to avoid future unknown liability, monitor the decisions related to FACTA to determine whether there are any changes regarding the statute's interpretation. With that, your company will be able to immediately correct any "new" violations found to exist under the law.

If your company has been sued, act immediately to come into compliance with FACTA. Simultaneously, obtain legal counsel to help you explore the various defenses available to minimize the potential exposure your company may face. Otherwise, a simple receipt error could lead to enormous expense.

This article has been reprinted with permission of its authors, Shawn J. Organ and Kasey T. Ingram. Mr. Organ is a partner at the Columbus, OH office of Jones Day. Mr. Ingram is an associate at the same law firm. They can be reached for further questions or comments at 1.614.281.3961/sjorgan@jonesday.com or 1.614.281.3922/ktingram@jonesday.com respectively.

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TO:

Top 10 Targets of RAC & OIG, per AAPC

10. Debridement Coding. Errors in coding surgical debridement vs. active wound care management
9. Duplicate Billing. Filing claims mire than once for the same service.
8. Stark Violations. Physicians referring patients to services in which the y have a financial interest, or in which a family member has a financial interest.
7. Pharmaceutical Coding in Physician Offices. Incorrect use of codes or units in billing of injections.
6. Social Worker Services in Facilities. Some clinical social worker services provided to inpatients in hospitals or skilled nursing facilities cannot be billed under Part B.
5. Psychiatric Services. Overutilization of psychiatric services provided in outpatient settings.
4. Medical Necessity. Documentation not supporting the level of service provided to the patient.
3. E/M Billing During Global Periods. Use of modifier 24 in billing services that should have been included in the global surgical package.
2. Place of Service Errors. Physicians performing services in ASCs or outpatient facilities but billing applying a place of service code indicating the service was performed in the physician office.
1. Incident-to Errors. Physician assistants and nurse practitioners performing services for a physician not following billing specific guidelines related to the physician's relationship to the patient and the physician's presence in the office.

Patti & Larissa will be attending a Medical Society of Virginia seminar addressing the Recovery Audit Contractor program… stay tuned for additional information!

Monthly Reports From M.E.D.I.C., Inc.

Just a quick blurb to alert all M.E.D.I.C., Inc. clients that as of 4/1/09 (April 1st), your monthly reporting package will include two Accounts Receivables reports: one comprising the entirety of a practice's Accounts Receivable and another which will specifically exclude from the report all balances which have been sent to a collection agency for formal collection activity, so as to provide you with a more accurate and specific picture of the status of your practice's Accounts Receivable. Please contact us should you have any questions!

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