KOHLER
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Putting the pieces together

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Welcome to our newest edition of Kohler HealthCare Consulting's "*Pieces for Success*". *We hope you find this periodic newsletter to be informative and of assistance. If you know others who may find this information useful, please feel free to share our newsletter with them or with their permission, forward their email address to us for inclusion in our distribution list.*

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ADDITIONAL INFORMATION 10

TIDBITS, ANNOUNCEMENTS AND EDUCATIONAL/SPEAKING ENGAGEMENTS

Free Kohler Connection Webinars [check our website frequently for any changes]. Contact Noel Asen (nasen@kohlerhc.com) for webinar information. Existing webinars are also available and we can hold one just for your organization! See our website for listings. Again, if interested, please contact us at 410-461-5116.

Kohler Connection Webinars, Speaking Engagements and News:

KHC NEWS

Need Help With Your Charge Description Master (CDM)? KHC has recently expanded our list of services to best serve our clients. Our approach is crafted to fit our need. Many of our options are very budget-friendly and we would love to work with your team. For more information, please visit www.kohlerhealthcareconsulting.com or contact Lauren Rose at lrose@kohlerhc.com or 443-421-1930.

- **The Insurance Companies Have Been Keeping the Discounts.** Maybe you didn't think about the discounts from drug makers on medications. But now the Wall Street Journal (March 27, 2018) reports that Aetna Inc. said it would pass on the discounts to the members who are using these drugs. Earlier this month United Health Group Inc. made a similar announcement. So now the discounts that have been negotiated will be applied to the commercially fully insured plan members at the time of the sale starting in 2019. Not quite time to celebrate yet, or ever.

- **Good Nursing Homes.** From the AARP Bulletin - They have used the CMS rankings to present the rating of facilities in each state. The best? Washington State and Maine at 56%, followed by Utah, DC, Minnesota and Vermont at 55%. The other states that are considered to be good [at least 50%] are Oregon, California, North Dakota, Idaho, Arizona, Wisconsin, New Hampshire, Rhode Island, New Jersey, Delaware, Florida, and Alabama. The worst at 26%, 27%, and 28%, are West Virginia, Louisiana and North Carolina, respectively.

- **Laboratory Date of Service Rule Implementation.** Per Change Request 10419, issued March 16, 2018, even though the change for laboratory date of service and billing entity for certain molecular pathology and advanced diagnostic laboratory tests referenced in last month's newsletter is effective January 1, 2018, the implementation date is not until July 2, 2018. What does that mean? Hospitals CAN change their systems now to have the performing laboratory bill for these services with the date of service as the date performed; however, they are NOT REQUIRED to be in compliance until July 2, 2018.

  - **Maryland and the New 2018 Medicare Laboratory Date of Service and Billing Regulations** – KHC has heard from the Health Services Cost Review Commission that Maryland is not exempt from these new regulations. Essentially, in Medicare's eyes, these are no longer considered hospital services and as such, would not be subject to HSCRC guidelines. We would love to hear your thoughts on these new

regulations. Feel free to email Lauren Rose at lrose@kohlerhc.com with any feedback.

- **2018 Lab Fee Schedule.** Some of our clients have been reaching out because the fee schedule for Lab looks very different this year. Keep in mind that as of January 1, 2018, there are no longer separate laboratory fees for each state. There are now universal payment rates. For more information, please review this fact sheet:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Clinical-Laboratory-Fee-Schedule-Fact-Sheet-ICN006818.pdf

- Please follow KHC on Linked In: https://www.linkedin.com/company/kohler-healthcare-consulting-inc.

- **HCPro Books Authored by KHC Staff:**

Long Term Care From A to Z, Written by KHC Staff— published in December 2016. The book is now available for sale thru: https://hcmarketplace.com/long-term-care-billing. See website for more details.

Hospital Billing From A to Z, written by KHC staff is a reference guide that covers Medicare requirements with ease of use for those involved in hospital billing. The book is available thru:

http://hcmarketplace.com/hospital-billing-from-a-to-z?code=EB313813&utm_source=HCPro&utm_medium=email&utm_campaign=HBFAZ

Physician Practice Billing From A to Z is a comprehensive, user-friendly guide to billing requirements, with particular emphasis on Medicare. This resource will help physician practice billers understand the relevant regulations, code sets, compliance issues, and a myriad of other factors that affect the billing process. To learn more about the book or to order go to HCPro: http://hcmarketplace.com/physician-practice-billing-from-a-to-z?code=PPI&utm_source=edit&utm_medium=enl&utm_campaign=ENL_PPI_063015

CMS, OIG AND MEDICARE UPDATES

MOON: CMS-10611 – Robin Stover

The Federal Notice of Observation Treatment and Implication for Care Eligibility Act requires all hospitals and critical access hospitals to provide written and oral notification to Medicare patients who are placed in observation status. All Medicare patients who receive observation care in the hospital for more than 24 hours must receive a Medicare Outpatient Observation Notice (MOON). Patients must receive this notice no later than 36 hours after the start of observation services. The form must be acknowledged with signature and date by the patient or representative and a hardcopy must be given to the patient. This is the only CMS notice of coverage that defines the coverage as non-appealable.

The purpose of this form is to inform patients up-front about potential out-of-pocket expenses. The MOON informs patients that:

- Part A does not cover outpatient services
- Part B requires a copayment for certain services
- There will most likely be extra charges for self-administered drugs used for chronic conditions.
- Observation services do not count toward the 3-day inpatient stay required for Part A Skilled Nursing facilities that may be required after discharge.

The MOON is a standard CMS form that requires the following information to be completed for each patient.

- Patient name and number
- Attending physician name
- Date and time observation services initiated
- Description of why patient is placed in observation status

- Additional patient information as necessary

The signed form should be filed in the medical record and should be included for any record request by payer. It is important to determine who in your organization will be responsible for sharing this information with the patient. HIM staff should be educated to look for the timely completion of this form in the record prior to coding.

To access the necessary forms (CMS 10611-MOON), or for questions regarding the MOON, go to www.cms.gov/Medicare-General-Information/BNI or call 1-800-MEDICARE.

APPROPRIATE USE CRITERIA FOR ADVANCED DIAGNOSTIC IMAGING UPDATES – Julie Leonard

The implementation date has been delayed until 2020 for mandatory use; however, the beginning of the voluntary reporting period is slated for July of this year for Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging (ADI). The providers affected by the AUC reporting are both the ordering and rendering providers of ADI services. CMS has allowed for an introductory period beginning in 2020 where claims will not be denied for lack of claim information that supports the AUC consultation. The services rendered from 01/01/2020 through 12/31/2020 will be considered for training and education.

CMS has been reviewing the increased use in the utilization of high cost tests for medical necessity and has included this as part of the Office of Inspector General's (OIG) work plan in years 2012 through 2015. The use of AUC for ADI was included in the final rule in 2016 (https://www.gpo.gov/fdsys/pkg/fr-2015-11-16/pdf/2015-28005.pdg) and subsequent years.

The AUC is based on a "consultation" with a Clinical Decision Support Mechanism (CDSM). CMS has a list of qualified CDSM at https://www.com.gov/Medicare/Quality-Initiatives-patient-assesment-instruments/appropriate-use-criteria-program/cdsm.html

The ordering provider will provide clinical information to the CDSM, including but not limited to diagnosis, signs and symptoms, pertinent clinical history and the ADI planned for the patient. The CDSM with then provide the "consultation" results in real time to the ordering provider. The results with provide feedback as to the appropriateness of the planned ADI service and may indicate different service or a result of not-applicable could be returned. The ordering provider will include the results on the order to the rendering provider who then includes the information on the claim form submitted to Medicare for reimbursement.

The areas of review for use of AUC are listed in Priority Clinical Areas (PCA):

- Coronary artery disease (suspected or diagnosed)
- Suspected pulmonary embolism
- Headache (traumatic or non-traumatic)
- Hip pain
- Low back pain
- Shoulder pain (to include rotator cuff injury)
- Cancer of the lung (primary or metastatic, suspected or diagnosed)
- Cervical or neck pain

The services to be reviewed, at present time, include:

- Diagnostic magnetic resonance imaging
- Computer tomography
- Nuclear medicine (including positron emission tomography)
- *excludes x-ray, ultrasound and fluoroscopy services.

The setting for reporting the AUC is outpatient

- Physician's office
- Hospital outpatient departments (including ER unless the situation is emergent)
- Ambulatory Surgical Centers
- Any other provider led outpatient setting.
- *Inpatient services are not included in the AUC reporting at this time nor are professional services billed to Medicare resulting from the inpatient stay.

What is still unresolved is the mechanism in which the results of the CDSM consultation will be reported i.e., G-code or other HCPCS code, which is not under consideration at this point, or a modifier to be reported as the AUC consultation identifier. The modifier appears to be a more simplistic approach to reporting the consultation results from the CDSM.

All providers both ordering and rendering need to pay attention to the CMS website and publications for the AUC for ADI consultation progress. The rendering providers can deny the service order if CDSM consultation results are not included in an effort to reduce any reimbursement penalties the rendering provider may be subject to after 01/01/2021.

Additional information can be found at the CMS home page for the AUC:

https://www.com.gov/medicare/quailty-initatives-patient-assesment-instruments/appropiate-use-criteria/index.html

OIG FINDS MOST TELEHEALTH CLAIMS DO NOT MEET MEDICARE REQUIREMENTS, RESULTING IN $3.7M IN IMPROPER PAYMENTS – Josh Leventhal

Many organizations provide telehealth services in order to ensure that all patients receive the care they deserve. A recent OIG report published on April 13, 2018 found $3.7M in overpayments for claims between 2014 and 2015.

The OIG reviewed more than 190,000 claims totaling $13.8M in payments. Over one-third of the 100 claims sampled by the OIG failed to meet Medicare telehealth reimbursement requirements. Telehealth claims submitted by providers through Medicare Part B must meet certain conditions, including that the originating site must be a practitioner's office or a medical facility, not a patient's home, and the beneficiary must be in a qualified area. Twenty-nine (29) of the claims sampled failed this requirement.

CMS provided comments in response to the OIG that were supportive of recommendations to conduct periodic post-payment reviews and to offer more education and training to practitioners on Medicare telehealth requirements.

The full report can be found on the OIG's website: https://oig.hhs.gov/oas/reports/region5/51600058.pdf

Organizations that provide telehealth are encouraged to review CMS' booklet on requirements available on CMS' website: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf as well as utilize the Medicare Telehealth Payment Eligibility Analyzer https://datawarehouse.hrsa.gov/tools/analyzers/geo/Telehealth.aspx.

Organizations should also set up their own audits to identify potential overpayments, as well as implement controls prospectively to ensure that claims are submitted appropriately. See Kohler HealthCare's previous newsletter for details on self-disclosure should an overpayment be identified, or give us a call if you need help or a referral to an attorney.

SPOTLIGHT ON MARYLAND

RATE UPDATES FOR GLOBAL BUDGETS – Lauren Rose

One of the most critical questions for hospitals in Maryland is "What percentage increase in rates (revenues) will I receive this year?" In anticipation of the July 1, 2018 rate orders that will be issued to hospitals, Jerry Schmith shared a high level walk-through of this calculation during the April 11th Health Services Cost Review Commission (HSCRC) meeting. This walk-through did not include actual values and was more of an educational presentation to ensure both the commissioners and audience members have an understanding of the various components of a rate update.

Factors included in the initial rate update calculation include:

- Inflation (using Global Insights Market Basket) – *this includes a gross adjustment as well as a specific adjustment for pharmaceuticals;*
- Care Coordination – *this allocation is to allow for hospital investments in Population Health*
- Market/Volume – *this update adjusts for changes in hospital demographics ("aging of population), transfers, drug population/utilization, and other categorical updates specific to the hospital*
- Savings – *this rewards hospitals where the hospital has improved (i.e. reduced) potentially avoidable utilization*

- Quality – *this rewards or penalizes hospitals for quality based reimbursement, hospital acquired conditions, and readmissions*

The HSCRC also "reserves" money for specific requests that might arise from hospitals during the year and planned adjustments that occur during the second half of the year as data and associated calculations are finalized. The HSCRC also makes global adjustments for uncompensated care and the deficit for Maryland Medicaid. There may also need to be adjustments as the HSCRC factors in the statewide "guardrails" including the maximum increase in hospital spending per capita of 3.58%, the Medicare Savings Test of $330 million over 5 years, and the Medicare Total Cost of Care (TCOC) limit of 1% growth from year-to-year (and the TCOC update for Maryland cannot be above the nation two consecutive years).

Watch for more details from the HSCRC as we move closer to July 1st.

PHYSICIAN PRACTICES

YOUR PRACTICE IS ONLY AS GOOD AS YOUR SUPPORT STAFF – Sara Rivenburgh

Never underestimate the advantages of a top notch front office staff. It is an all too common misconception that anyone can answer the phones and check in a patient correctly. Not only is the receptionist the first person your patient meets in the office, he/she can be the key to optimizing reimbursement-- in other words, the lifeblood of your business.

Patient satisfaction is very important to the success of any practice. Contrary to what you might think; there are other very qualified specialists out there who can serve the patient's needs. If patients receive a warm welcome and friendly assistance when checking in, they'll be less likely to complain when you're running behind schedule. Even more important than friendly service, the receptionist (and all your front desk staff) is the one responsible for correctly entering the patient's information into the computer system - demographics and insurance information. If not done correctly and completely with the appropriate authorization for your services, you will not get paid or it may take additional staff hours to research and correct to get payment. Recently, when analyzing the revenue cycle flaws of a local surgical practice, Kohler HealthCare Consulting discovered that 25% of their claim denials were due to front end practice errors. These errors were as "minor" as ID numbers transposed in data entry and as major as no authorization obtained for services rendered. Unfortunately, the results are the same: claim denied…no payment. Often times, these errors are not corrected within timely filing limits and the entire claim has to be written off.

The medical office receptionist, as well as other front desk staff, is likely the position with the lowest wage in the office. This makes sense as the job does not require special certification or training, It's important that the Practice train these staff completely. However, a well-run practice values the entire staff and rewards performance. My dentist has the nicest, most efficient office staff I have ever encountered. He treats his entire staff to a week-long cruise every year. It is as important to reward good performance as it is to hold staff accountable for poor performance. When everyone on the team feels valued, it is reflected in their performance and the practice thrives. In general, a happy staff leads to better performance and, in turn, higher reimbursement.

SEPARATING THE ZEBRAS FROM THE HORSES: ACQUIRED MEDICAL PRACTICES CANNOT BE MANAGED THE SAME WAY AS A HOSPITAL DEPARTMENT – Charlotte Kohler

Zebras and horses both have four legs and look very similar. Ten medical practices may generate the same amount of income as your radiology department, but the approach in the management is far different. This may be one of many reasons why it is so difficult to create a culture that encourages the once independent physicians to become team leaders, and team leaders are needed to develop higher quality, standardized care, at a reasonable price. How do we move from the physician's management style that they practiced while independent and continue to motivate into an environment that is heavily divisionalized and fraught with competing agendas. Whereas the initial physician acquisitions brought together physicians who needed capital and some stability in the healthcare environment, it is now no longer the only option they may have. Consequently, management style and effectiveness is key to outcome and keeping your employed physicians.

There are "consolidators" of single specialty medical practices that perform much like a Management Services Organization with the medical practices having the clinical ownership. As discussed in the MGMA Connections (April 2018) private equity companies have been very involved with the consolidation efforts. With our own experience in

performing due diligence for these acquisitions we have seen a lot of activity in Dental, Gastro, Ortho, DME, Physical Therapy, and Dermatology. One of the first leading consolidations in our area has been in Urology in 2006. *The Baltimore Sun* (April 7, 2018) reported that Chesapeake Urology would be joining forces with Tennessee Urology Associates in the formation of the "MSO" to share management consultancy and back office functions such as billing and call center. This will combine 87 positions at Chesapeake with 18 urologists from Tennessee.

These specialty groups are seeking a way to improve operations and diminish their overhead costs, while continuing ownership by the physicians in the clinical aspects and the MSO. However on the hospital side the challenges are different. Ownership by the physicians is not part of this equation.

Not only does the hospital have the substantial investment to purchase the medical practices but then there is significant additional infrastructure needed including the health information technology. The goal from the patient care delivery perspective is to integrate all levels of patient care including the physician level practices, ambulatory services, the hospital itself, and post-acute settings. Regardless of the salaries and bonuses paid to the physicians, they have far less "skin in the game", and this changes the total dynamic from what is seen in the consolidation by specialty practices compared to employment by the hospital. The challenge that hospital leadership faces is to leave the "hospital approach" behind and implement effective approaches with their employed physicians and the staff---reducing the fragmentation and components, and the various reporting divisions, to create an environment much like what the physicians had in their own practice— each person is responsible for results and if results are not obtained, then changes must be made more immediately (sooner) than later.

FINANCIAL MANAGEMENT AND STATISTICAL SAMPLING

WHY CONFIDENCE IS SO IMPORTANT – THE PERILS OF AN AUDIT EXTRAPOLATION – Scott Wilson AND Dr. Frank Alt

We have recently seen a trend of payers sending demand letters to providers for substantial amounts which are largely attributed to an extrapolated amount. An extrapolation is essentially projecting an error rate found in a sample to an ENTIRE population. With the operating margins for so many providers under immense pressure from so many external forces ranging from regulatory burdens to financial tightening, an audit finding of a 10% (or more) error rate in a sample to an entire population can translate into an overpayment demand in the hundreds of thousands of dollars (or more, much more).

While there are no generally accepted statistical principles that govern extrapolation per se, statistical sampling has been used by the Medicare program since the early 1970s as an effective and acceptable methodology of estimating the amount of overpayments in a population. By using samples and extrapolations, regulatory auditors can avoid the costly and prohibitive alternative of examining every item in the population. Chapter 8 of the Medicare Program Integrity Manual (MPIM) includes guidelines for data analysis, statistical sampling, extrapolation and estimating overpayments which are widely used and adhered to within the healthcare industry.
So what does all this mean? Simply put, it means, as a provider of healthcare services, if you are faced with an overpayment demand letter from an insurance company (or another party representing one) based on an extrapolation of an audit sample error rate, there are ways to challenge and overcome the extrapolation and the alleged overpayment.

Some of the areas in an extrapolation that lend themselves to challenge are as follows:

- Precision and confidence – this relates to the level of uncertainty surrounding the point estimate of the extrapolation. The MPIM has clear guidance concerning this. We have used this as a strategy for challenging the extrapolation.
- Sample size – if the sample size if too small, the sample value could have too much sampling error resulting in a sample value inappropriate for extrapolation. This is another area that we have used to challenge the extrapolation.
- Random and representative – in order for a sample result to be valid, there must not be selection bias in the sample selection such that the sample is representative of the entire population.

The preceding list is not all-inclusive. The most important thing to keep in mind if you find yourself facing an extrapolation is to consult an expert who is knowledgeable regarding the nuances of statistical science. If you are

currently facing an overpayment demand as a result of an audit sample extrapolation or are interested in obtaining more information, contact Scott Wilson, MBA, CPA, CFE, at swilson@kohlerhc.com or call him directly 410-599-2971.

OTHER ARTICLES OF INTEREST

E-DISCOVERY AND THE ROLE OF HEALTH INFORMATION MANAGEMENT – Diane Jordan

Any litigation support or effort to mitigate or reduce demands for repayment by a payer, starts with *information.*

With the emergence of electronic health records (EHR), healthcare organizations are facing an increasing challenge to identify and produce information stored electronically for litigation purposes. To manage e-Discovery, the operational issues must be understood, which includes where information exists, in what format, how it is created, stored, updated, and used. Electronic data of any kind can serve as evidence. This may include data on devices, including text, images, voice, spreadsheets, databases, legacy systems, tape, smartphones, instant messages, email, calendar files, and more.

e-Discovery is the initial phase of litigation used to describe the method by which parties will obtain and review electronically stored information (ESI). Amendments to the Federal Rules of Civil Procedure (FRCP) in December 2006 placed electronically stored information on an equal level with paper documentation in the court and the 2013 FRCP amendments, specifically rule 37e, address preservation. e-Discovery is not "release of information (ROI)" because it relates to litigation for parties in a dispute and focuses on relevance and includes information that is located in the EHR and anything that is relevant to the litigation. Technically, there isn't really "e-Discovery" since the 2006 FRCP amendments. It is all "Discovery" since paper documents are also part of the discovery process.

Health Information Management (HIM) departments play a key role in ROI as the official custodian of the patient's medical records and should provide authoritative and technical knowledge about the management of both paper and electronic health information within the organization.

In most healthcare organizations, the HIM department accepts and processes subpoenas for patient medical records. HIM should work closely with legal counsel in the identification, preservation, and production of all information (electronic and paper) relevant to litigation.

ESI creates four levels of custodianship. These levels depend on a person or entity's relationship to the data and the data system and proximity to the case in litigation. HIM should remain the official custodian of the patient's record.

The four levels of custodianship are:

- **Primary of Direct Custodians** – those persons who work with the data directly or have direct involvement or knowledge of the events of the case. Primary custodians may be deposed or required to testify because of their direct involvement or knowledge of the case.
- **Data Owners or Stewards** – persons with responsibility to oversee business process areas. They are knowledgeable regarding the procedures used to create, manage, and preserve specific records, i.e. finance, radiology, lab.
- **Business Associates and Third Parties** – contractors and others who serve a variety of functions associated with a party's information but who are not parties to the litigation, i.e. a claims clearinghouse.
- **Official Record and System Custodians** – the HIM department is usually designated as the official custodian of the overall medical record. Responsibility should include content and compliance associated with management of electronic information.

The e-Discovery process is the preservation, collection, processing, review, and analysis of information. It is looking at the record, but for relevant information in any format. If information was relied on to make a decision, it may have relevance, and is subject to discovery.

The e-Discovery process includes:

- Creating and retaining ESI in accordance with information governance program and records retention policies.
- Identify and preserve relevant ESI and ensure it cannot be altered or destroyed. Collect and review all ESI.
- Process and filter ESI to remove excess and duplicates.

- Review and analyze the filtered ESI for privilege.
- Produce the remaining ESI, after filtering out what's irrelevant, duplicated, or privileged.
- Get back ESI inadvertently disclosed to the opposing party that should have been filtered out.

It is vital that HIM has a key role in the Discovery process of ESI. HIM is knowledgeable and can help the attorneys understand the flow of data, locating data, and appreciating how systems are used and their weaknesses. HIM can also ensure the implementation of information governance policies and adherence to state and federal laws.

References

Baldwin-Stried Reich, Kimberly, A. e-Discovery and Electronic Records. (2012) American Health Information Management

AHIMA e-Discovery Task Force, "Litigation Response Planning and Policies for E-Discovery" Journal of AHIMA 79.

THE OPIOID PROBLEM IN AMERICA - Susan Santoro

In the United States, on a daily basis, more than 115 people die after overdosing on opioids (prescription pain relievers, heroin and synthetic opioids such as fentanyl). Opioid abuse has become a serious national public health issue.

The genesis of the problem dates to the late 1990s, with the assurances of the pharmaceutical companies that opioid pain medication would not become addictive to patients. This resulted in higher prescribing rates and subsequently the onset of the misuse of these medications. Opioid overdose rates began to increase and, in 2015, more than 33,000 Americans died as a result of an opioid overdose.

Our factual knowledge about this problem is alarming with nearly 21% - 29% of patients who are prescribed opioids; misuse the drugs and a 4% - 6% subset of these patients transition to heroin use. Nationally, opioid overdoses have increased 30% (July 2016 – September 2017) in 45 states.

States and multiple federal agencies (NIH, HHS, and CDC) are implementing strategies to deal with this problem. At the April 4, 2018 National Rx Drug Abuse and Heroin Summit, National Institutes of Health Director Francis S. Collins, M.D., Ph.D., introduced HEAL (Helping to End Addiction Long-term) Initiative, a trans-agency effort to develop best practices to effectively treat patients with pain while preventing addiction based on scientific evidence.

Interesting information recently released by CMS in its Comparative Billing Report (CBR201801), which based on Part D Medicare Claims, presents key metrics for per beneficiary related to provider prescribing patterns including average number of days of opioids prescribed and average charges.

Increased scrutiny into opioid prescribing patterns will occur as the newly established Prescription Interdiction and Litigation ("PIL") task force under the Department of Justice ("DOJ") integrates all of its anti-opioid efforts.

The PIL Task Force will fight the opioid crisis employing the following strategies:

At the manufacturer level, the PIL Task Force will hold opioid manufacturers accountable for unlawful practices through the use of all criminal and civil options.

Build upon and strengthen existing DOJ initiatives to ensure that opioid manufacturers are marketing their products not only truthfully but also and in accordance with Food and Drug Administration rules.

Under the Controlled Substances Act, use criminal and civil avenues against doctors, pharmacies and others that are not in compliance with the law.

Build upon and expand the efforts of the existing Opioid Fraud and Abuse Detection Unit to identify and prosecute individuals who are contributing to the opioid epidemic such as pill-mill schemes and pharmacies that unlawfully divert or dispense prescription opioids for illegitimate purposes.

In a speech on the subject by the Deputy Associate Attorney General Stephen Cox commented the following relating to opioids: "The False Claims Act provides the government with a powerful tool to pursue all of those in the opioid distribution chain that are responsible for the improper marketing, distribution, prescription and diversion of opioids – from pharmaceutical manufacturers to physicians, and everyone in between… The False Claims Act is a tool we are increasingly using to address the opioid crisis."

It is only through the combined efforts of all of the federal, state and local initiatives that there will be a reversal of this national public health crisis – the opioid problem in America.

References:

1. National Institute of Health, National Institute on Drug Abuse.

2. National Institute of Health, Press Release "NIH launches HEAL Initiative, doubles funding to accelerate scientific solutions to stem national opioid epidemic".
3. CMS, CBR201801.
4. Part B News, April 16, 2018.
5. Department of Justice, Office of Public Affairs News, "Attorney General Sessions Announces New Prescription Interdiction & Litigation Task Force", Tuesday, February 27, 2018.
6. Department of Justice, Office of Public Affairs News, " Deputy Associate Attorney General Stephen Cox Delivers Remarks at the Federal Bar Association Qui Tam Conference" , Washington, DC, Wednesday, February 28, 2018.

KEEPING THE PATIENT PAYING AND HAPPY – Dawn Homer

With the trend of high deductible health plans (HDHPs) on the rise, it's important to get patients to pay their bills in a timely manner.

It's important not to hassle or alienate the patient but train your staff on how to properly ask for the payment and deal with the patients appropriately.

The larger the patient responsibility portion the more difficult it can be to collect. Arming your staff with the tools and training will aid in debt collection.

As HDHPs become the new insurance normal, many suggest looking at improved ways to motivate patients to pay.

- **Make Expectation Clear**
  - Do insurance verifications 24-48 hrs. prior to patient appointment; this will give your staff time to handle any unexpected issues
  - Clearly state in signage and forms regarding payment (i.e., "Copayments due at time of service.")
- **Prep/Train Staff**
  - Train front end staff with scenarios and role play exercises to arm them with the ability to handle all types of patients.
    - The patient that doesn't know they owe.
    - The angry patient that wants to argue (never battle with patient at front desk).
  - Ensure staff can show the patient what and why they owe.
- **Make Staff Accountable**
  - Keep staff up to date on problem accounts.
  - Ensure front end staff has the tools needed to do their job as well as the open communications with back end staff so the team can work together to collect the monies due.

Lastly, do not "muscle" the patient – be aware of the "Fair Debt Collections Act" and any state laws regarding collections. Best practice is to either have a collection agency (if you choose to hire one) or staff that is trained to build a relationship with the patient, either by agreeing to a payment plan or asking for another option like a credit card.

Ideal result is to keep the patient and keep their account current.

ADDITIONAL INFORMATION

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