CMS Proposal to Drop ‘Narratives’ Is a Mixed Bag for Home Health and Physicians

CMS plans to ditch a home health documentation requirement that plays a role in Medicare payment denials, according to the proposed home health payment system regulation published in the Federal Register on July 7. Under the proposal, physicians wouldn’t have to include narratives in their certifications of patient eligibility for home health, a move designed to ease the regulatory burden on home health agencies and physicians alike.

But there’s a downside for home health agencies because narratives connect the medical necessity dots; and a downside for physicians who would lose payment for certifications if home health claims are denied after a medical review, one expert says.

“The narrative can be so effective in preventing claim denials,” says Jane S necinski, president of Post Acute Advisers in Atlanta. “The proposed rule takes out the requirement for a physician narrative, but the intent is still there that physicians have to certify medical necessity.” For that reason, home health agencies may want to ask for narratives even if the provision is finalized. “It makes physicians think, ‘what is my clinical thinking that makes home health care necessary for this patient?’”

The Affordable Care Act (Sec. 6407) requires physicians to certify a patient’s eligibility for home health as a condition of Medicare payment. Certifications are based on a face-to-face encounter with the patient no more than 90 days before home health services start or 30 days after. The face-to-face encounter must be related to the primary reason the patient requires home health services and must be dated and signed by the

continued on p. 7

Alabama Providers Settle Stark Case for $24.5M; Feds Say Exceptions Didn’t Apply

Sometimes the words in hospital-physician contracts don’t match what actually transpires. That was the crux of the Department of Justice’s case against an Alabama health system, two clinics and a physician group, which agreed to pay $24.5 million to settle false claims allegations that physicians were compensated in ways that violated the Stark and anti-kickback laws.

Infirmary Health System, two subsidiary clinics and Diagnostic Physicians Group (DPG) had compensation relationships that allegedly amounted to payments for referrals of lab and radiology tests, DOJ alleged. The lawsuit was originally filed by whistle-blower Christian Heesch, a former DPG physician, and was later taken over by the U.S. Attorney for the Southern District of Alabama.

Mobile-based Infirmary Health System owns IMC Diagnostic and Medical Clinic (IMC-DMC) in Mobile and IMC Northside Clinic in Saraland. The government alleges that IMC compensated DPG physicians partly based on their referrals for designated health services. The providers did not admit liability in the settlement.

continued
The case is an object lesson in the fine line that providers walk as they navigate the Stark law, says Denver attorney Jeffrey Fitzgerald, who is with the firm of Polinselli. The health system’s compensation relationships conceivably could have passed muster if they had been slightly different, he says. “It sounds like they were trying to use a corporate structure that essentially replicated what you are allowed to do under the Stark law using the group practice and in-office ancillary services exceptions, but they didn’t follow the detailed requirements according to DOJ,” Fitzgerald says. “Close enough often doesn’t count in Starkland.”

The Stark law prohibits Medicare payments to entities for designated health services (e.g., hospital inpatient and outpatient services) if they were ordered by physicians who have a financial relationship with the entities, unless an exception applies. An interlocking exception exists for in-office ancillary services provided by group practices. Stark regulations allow physicians to bill Medicare for designated health services provided in their offices if the in-office ancillary services exception is met. The exception is limited to a “group practice,” which Stark defines as a “single legal entity” that provides at least 75% of patient services through the group and bills under its provider number, and doesn’t tie compensation to the volume or value of the physician’s referrals except for his or her personally performed services and incident-to services, among other criteria.

According to the government’s complaint-in-intervention, IMC-DMC entered into a “physician services agreement” with Diagnostic Physicians Group in 1988 and updated it after the Stark law was enacted in 1991 and expanded in 1993. It stated they would abide by the in-office ancillary services and group practice exceptions. But the new contract gave lip service to Stark, with compensation designed to cement the relationship with the independent-contractor physicians and reward them for referring designated health services through 2011, the complaint alleged.

In its 1997 physician services agreement, IMC-DMC handed over physician services to Diagnostic Physicians Group, while overhead, non-physician staff, equipment and billing remained the responsibility of the clinic. The physicians were paid a percentage of collections for EKGs, nuclear imaging and other tests, and agreed to comply with all laws and regulations.

Physicians Were Allegedly Rewarded

Despite the promises made on paper, IMC-DMC found a way to reward physicians for joining the team, the complaint alleged. IMC-DMC billed Medicare under each physician’s tax ID number and used it to track his or her DHS orders, sharing a monthly “Stark report” with DPG. “This information was ultimately used to compensate the DPG physician for his or her DHS referrals,” the complaint alleged.

For its part, DPG distributed Stark and non-Stark collections differently, the complaint alleged. Non-Stark collections were given to physicians based on their productivity share of IMC-DMC’s overall collections, while Stark collections were handed out using a “preset Stark bonus.” Although the contract stipulated the preset Stark bonus had nothing to do with the volume or value of a physician’s referrals, the complaint alleged it “correlated to the collections from his or her referrals of DHS to IMC-DMC, as evidenced by the information in DPG’s bonus spreadsheets.”

Relationships got tangled in the process of allegedly rewarding DPG physicians for services they did not personally perform, according to the complaint. For example, starting April 1, 2008, DPG physicians referred patients for nuclear cardiology imaging tests to IMC-DMC, where they were administered by clinic employees on equipment owned by the clinic. But Medicare was billed for the facility fee by IMC-Northside, which ulti-
mately paid the ordering DPG physician for the referral, the complaint alleged.

At some point, the hospital, the clinics and the physician group allegedly knew they were in a Stark quagmire, the government alleges. At a June 2010 meeting, a hospital executive told them that, in the opinion of an attorney, “CMS would likely rule that because 2 entities exist we do not meet the strict definition of a ‘Group Practice’ and the IOAS exception was not available.” But allegedly nothing changed before the contract expired, the complaint says.

Because Medicare claims for the radiology services stemmed from compensation arrangements that allegedly violated the Stark and anti-kickback laws, they are false claims, the complaint alleged. But it didn’t have to be this way, says Fitzgerald, who is not involved in the case. Hospitals can closely align with physicians and reward them for revenue from designated health services without setting off Stark alarms.

**Two Paths to Hospital-Physician Alignment**

Two popular ways for hospitals to align with physicians are employment or establishing a “captive medical group” that is a separate legal entity essentially controlled by the hospital, Fitzgerald says. "When you do that, the group practice can furnish DHS and keep DHS revenue the same way as if it were owned by the doctors as long as it meets the group practice and in-office ancillary services exceptions," he says. “But you need to go through a process to structure it that way.”

That’s part of the lesson from this case, as well as the $85 million Halifax Health Stark settlement (RMC 3/10/14, p. 1), the Tuomey Healthcare jury verdict (RMC 10/7/13, p. 1) and others. “The government will pick apart compensation plans if they weren’t perfectly done,” Fitzgerald says. “Stark is a persnickety law and if you don’t do it right, the consequences can be huge.”

In fact, attorney Lisa Noller, who represents Infirmary Health System and IMC, says “it was our position the contracts with DPG met the elements of the personal services exception and fair-market value exception” to the Stark law, which meant they were in compliance. “The law does not require you to meet particular exceptions,” says Noller, who is with Foley & Lardner in Chicago. Stark exceptions and anti-kickback safe harbors aren’t an albatross, she says. “I encourage defense counsel to do an early analysis of whether arrangements meet other exceptions. Too often they don’t do that because they believe they are constrained by the contract.”

Noller emphasizes that in April the U.S. District Court for the Southern District of Alabama dismissed the case against Infirmary Health System without prejudice, but it settled anyway to put an end to the tug of war with the Department of Justice. “We were buying finality,” she says.

This settlement also is remarkable because it’s at least the third time the government has held physicians accountable for alleged Stark and/or kickback violations after many years of just nailing the hospital, says attorney Bob Wade, who is with Krieg DeVault in Mishawaka, Ind. In April, Devender Batra, M.D., and Belmont Cardiology, Inc., in Ohio agreed to pay $1 million to the Department of Justice in connection with their allegedly improper compensation relationships with East Ohio Regional Hospital and Ohio Valley Medical Center (RMC 4/28/14, p. 1). The hospitals self-disclosed the compensation relationships to the U.S. Attorney for the Northern District of West Virginia and agreed to pay $3.8 million in 2011. “This is starting to gain momentum that when there are Stark violations, the government will go after both,” he says. “Physicians can’t hide under a rock and say ‘this is a hospital responsibility.’ The settlements are indicating they are all culpable.”

The defendants entered into a five-year corporate integrity agreement with the HHS Office of Inspector General.

Contact Fitzgerald at jfitzgerald@polsinelli.com and Wade at rwade@kdlegal.com. ♦

**More ALJs, Pilots May Cut Appeal Backlog; Fate of Rebilling Is Unclear**

With HHS administrative law judges receiving 13,000 new appeals of Medicare claim denials per week, Chief ALJ Nancy Griswold encouraged providers to consider new ways to put their appeals to rest.

The Office of Medicare Hearings and Appeals introduced two pilot programs designed to resolve exponentially more cases and reduce the enormous backlog caused largely by the recovery audit contractor program. But one pilot is designed for Part B claims only and it’s unclear how the other pilot will affect the ability of hospitals to rebill Part A claim denials to Part B. It’s a troublesome issue because denials of claims for hospital admissions are the highest-value item in the audit and appeals process. This raises the question of how much the pilots can chip away at the appeals backlog unless both are open to admission claim denials without sabotaging Part B rebilling, one attorney says.

The number of appeals pouring in are “more than the 65 ALJs can handle,” Griswold said July 21 at a RACmonitor.com webinar. That means providers may wait as long as two years for a hearing. There are rays of hope, however, in the form of both pilot programs and the addition of ALJs, among other initiatives, she said. Seven
new ALJ teams will report to the OMHA Cleveland office and to a new office in Kansas City on Aug. 25, she said.

**Two Pilots Were Announced Last Month**

The two pilots — statistical sampling and settlement conference facilitation — that were unveiled on June 30 (RMC 7/14/14, p. 8) could expedite appeals. The statistical sampling pilot is open to Part A and B claim denials. It’s focused on “providing appellants with the option of addressing large volumes of claim disputes at the ALJ level,” Griswold said. If they participate, providers will submit a minimum of 250 claims to OMHA, which will consult with a statistician to construct a sampling methodology. The statistician will select a random sample of as few as 30 claims for the ALJ to review at a hearing “with an outcome that would be nearly the same as if 250 claims were individually adjudicated,” she said. The results would be projected to the entire universe of 250 claims. Griswold said the statistical sampling pilot is limited to provider and supplier appeals of qualified independent contractor (QIC) decisions — the second level of appeals — that are assigned to an ALJ or are in the process of being assigned, which means they were filed between April 1 and June 30, 2013. Only CMS can decide whether the statistical sampling pilot will allow Part B rebilling of Part A inpatient denials, Griswold said.

“That’s the elephant in the room,” says attorney Jessica Gustafson, who is with The Health Law Partners in Southfield, Mich. Until there is some clarification from CMS on its position related to whether and how Part B will roll it out with Part A claims,” she says. Otherwise, “I don’t know it will do a lot to alleviate the backlog.”

Of the two pilots, Gustafson thinks the settlement conference facilitation has more merit. “It is lower risk to the appellant,” she says. This is standard operating procedure with commercial audits and it’s heartening to see Medicare give it a shot. “They are piloting it with Part B claims and if they see it as successful, my hope is they will roll it out with Part A claims,” she says. Otherwise, “I don’t know it will do a lot to alleviate the backlog.”

Contact Gustafson at jgustafson@thehlp.com. For more details on the statistical sampling pilot, visit http://tinyurl.com/nqkd3g5; for the settlement conference pilot, visit http://tinyurl.com/k7klm6z.

**Hospital Uses Best-Practice List to Evaluate Its Compliance Program**

When employees leave their jobs at Greater Hudson Valley Health System in Middletown, N.Y., the health system taps them on the shoulder for some feedback. Former employees receive a letter from the compliance department asking whether they had any compliance concerns or experienced anything unsettling. A subset — terminated employees — are invited for an exit interview. A subset — terminated employees — are invited for an exit interview. The reason: all of the Part A inpatient hospital claims (that were denied based on patient status) that are eligible for inclusion in the statistical sampling pilot are also eligible for Part B rebilling if the Part A claim is denied pursuant to an ALJ hearing. If CMS does not confirm that Part A inpatient claims eligible for and included in the statistical sampling pilot will remain eligible for Part B rebilling, “it’s tough to recommend that hospitals participate and potentially give up their rights for rebilling,” Gustafson says. Even if Part B rebilling is allowed in the statistical sampling pilot, it’s unclear how this could be carried out.

The second pilot, which is for settlement conference facilitation, also known as alternative dispute resolution, is open only to appeals of Part B denials filed in 2013, Griswold said. ALJs would essentially stay out of the negotiation between CMS and the provider. “OMHA provides a facilitator, but it is a traditional alternative dispute resolution concept in which the parties are in control,” she said. And that means CMS, not the Medicare administrative contractor. Providers may request settlement conference facilitation if at least 20 claims are disputed, or $10,000 is in controversy. When providers or suppliers request facilitation for a certain type of claim denial, all appeals in that category must be included (e.g., power wheelchairs).

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New York State Office of Medicaid Inspector General’s (OMIG) Bureau of Compliance.

Because compliance programs are mandatory in New York state for providers that bill Medicaid, they must certify in writing they have an effective compliance program. OMIG conducts onsite compliance-efficacy reviews at health care organizations, evaluating each of the eight compliance-program elements, and has published the three categories — best practices, opportunities for improvement and insufficiencies — to make its expectations more concrete (see box, p. 6).

Health System Did Comprehensive Assessment

Trish Manna, director of audit, compliance and HIPAA privacy at Greater Hudson Valley, merged the three lists in an Excel spreadsheet. “We did a full-blown assessment to see how we comply with each of the elements,” she says. “It provided an opportunity for a tune up.” No deficiencies were identified, but Manna and Sugrue found areas to upgrade, including:

✦ Training and education: One of OMIG’s suggestions for compliance effectiveness is analyzing and tracking results of online compliance education quiz scores to identify gaps in compliance education and adapt training to them. Manna thought this through and realized that while Greater Hudson Valley employees must complete a quiz after compliance training, “we don’t educate people who did poorly on quizzes. This is an opportunity for improvement.” She is considering a different strategy for getting through to these employees or may supplement their training. Also, the health system’s organizational development and learning department has online software that can extract incorrect answers to compliance quizzes and correlate them to subjects or departments that need follow-up.

✦ Refunding overpayments: An OMIG best practice for compliance program effectiveness is documentation of steps that providers take to refund Medicaid overpayments, and having no system to refund overpayments made the list of insufficiencies. The stakes are higher now that the Affordable Care Act requires providers to return Medicare and Medicaid overpayments within 60 days of identifying them at the risk of violating the False Claims Act (RMC 7/21/14, p. 1). To improve its tracking in this area, Greater Hudson Valley decided to develop a compliance committee dashboard. “Refunds occur in the normal course of business, but unless they’re part of self-disclosure, this often falls outside of the purview of the compliance officer,” Sugrue says. “Reporting metrics to our management and board compliance committees would be a good way to show how our revenue cycle department is aligned with compliance. By looking at the type, frequency and categories of overpayment refunds, it can further help us to calibrate any needed approach toward billing accuracy.”

✦ A system for routine identification of compliance risk areas: One of OMIG’s best practices is implementation of a review process before Medicaid claim submission to address billing and coding errors and weaknesses. Sugrue and Manna identified this as an area that could use some beefing up. Since Manna oversees compliance data analytics, she will add data on trends in billing and coding errors to compliance dashboards that are submitted to the compliance committee and board. “OMIG is saying, ‘why don’t you take a closer look at this? Maybe there are trends.’ What if we are making overpayments in a certain area or certain type of claim or there are commonalities?” Sugrue says. By amalgamating the data into its existing dashboard, the health system is more likely to find and fix problems.

“Best practices go stale quickly as other organizations advance and figure out ways of doing things better, smarter and more efficiently in the compliance area,” Sugrue says. “We fulfill the regulatory obligations, but can we do it better? That’s what we like to ask ourselves.”

Contact Sugrue at ssugrue@ormc.org and Manna at tmanna@ormc.org. ♦

CMS: Coding Assignment Errors Led to Overpayments for DRG 857

Some hospitals are billing incorrectly for MS-DRG 857 (post-operative or post-traumatic infections with operating room procedure and complications and comorbidities), according to the July edition of the Medicare Quarterly Provider Compliance Newsletter. The problem may stem from coders not coding specifically enough and favoring encoder software over good old-fashioned coding books, one expert says.

RACs have found “improper diagnosis code assignment, which affected DRG reimbursement,” CMS said in the newsletter. It used two cases to explain the problem. One involves an 83-year-old man with a history of right degenerative joint disease. He had a right total knee replacement and was later admitted as an inpatient with an infected knee hematoma. To drain the hematoma, the patient underwent arthrotomy with drainage of the hematoma.

The medical record attributed the infection to an internal prosthetic device, total knee prosthesis, so the auditor removed the principal diagnosis code of ICD-9 998.59 (other operative infection) and replaced it with 996.66 (infection and inflammatory reaction due to internal prosthetic device implant and graft), and noted the hematoma was a complication of the device. The auditor
also replaced the secondary diagnosis code 998.12 (hemorrhage or hematoma complicating a procedure) with 997.77 (other complication due to internal joint prostheses), CMS said.

As a result, the hospital’s MS-DRG morphed from 857 to 487 (knee procedures with principal diagnosis of infection without CC/MCC).

In the second case, an 85-year-old man was admitted for evaluation and management of a presumed pacemaker pocket infection. He had a procedure to treat a pocket infection that led to explantation of the dual-chamber pacemaker. The hospital coded other postoperative infection (998.59) as the principal diagnosis, but should have reported 996.61 (infection and inflammatory reaction due to cardiac device, implant and graft). That changed the DRG from 857 to 261 (cardiac pacemaker revision except cardiac replacement with CC).

These coding errors happen partly because coders are not reaching out for the specific diagnosis codes available in the ICD-9-CM coding book, says Janelle Wissler, a specialist manager at Deloitte & Touche. “Complications should be coded out of the book,” she says. While encoder software is very useful, it shouldn’t replace coding books. ICD code 998.59, for example, is a nonspecific code, and it’s unlikely to get the coder to the right MS-DRG, she says. “If you wind up with nonspecific codes, revert to the book.” Wissler also worries that coders haven’t internalized the nuances of MS-DRGs. If they truly understand them, there will be red flags when a principal diagnosis is assigned to an MS-DRG that doesn’t seem to jibe with the patient’s surgery in such a way that a specific body-system MS-DRG results.

Contact Wissler at jwissler@deloitte.com. Read the Medicare quarterly newsletter at http://tinyurl.com/kkva7ga.

Using Government Tools in Compliance Self-Audits

When the New York State Office of Medicaid Inspector General’s Bureau of Compliance posted best practices for compliance programs as well as opportunities for improvement and insufficiencies, Greater Hudson Valley Health System in Middletown, N.Y., made a master list of all 197 items and evaluated how it stacked up against each one. Then it color coded them accordingly — green for “fully compliant,” yellow for “can be enhanced to best practice” and red for “action needed.” Below is an excerpt from the health system’s internal effectiveness review, with light grey standing in for yellow and dark grey standing in for green. (See the full list on the “From the Editor” section of RMC’s subscriber-only page at AISHealth.com.) Contact Steve Sugrue, vice president of compliance, real estate and audit, at ssugrue@ormc.org.

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<tr>
<th>Element (1) Written policies and procedures</th>
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<tr>
<td>1. Publication of code of conduct and/or compliance plan document on the provider’s intranet and/or public website.</td>
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<td>2. Language in the compliance plan document outlines the benefits of a corporate compliance program as a way to obtain buy-in from the provider’s constituency.</td>
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<th>Element (2) Designate an employee vested with responsibility</th>
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<td>1. The compliance officer reports directly to the governing board, with dotted line responsibility to a member of senior management.</td>
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<td>2. The chief executive officer receives regular reports from the compliance officer if the compliance officer does not report directly to the CEO.</td>
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<th>Element (3) Training and education</th>
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<td>1. Use of an electronic training and education system that tracks mandatory compliance education of employees via an electronic system which:</td>
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<td>a. is customized to the organization;</td>
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<td>b. sends an individualized e-mail to employees to announce upcoming required and elective training; and</td>
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<td>c. tracks each employee’s required compliance training and educational needs.</td>
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<td>2. Results of online compliance education quiz scores are analyzed and tracked to identify areas of weakness for both the education program and for those being trained. Additional training and education is provided based on this analysis. Results of the online post-test quizzes are utilized to identify risk areas and assess the need for internal monitoring and auditing.</td>
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<td>3. The compliance training and educational materials are tailored to the needs of differing organizational levels as well as the educational backgrounds of all employees.</td>
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<td>4. Issuance of a brochure to consumers, partners, and vendors that highlights the provider’s quality initiatives and commitment to performance and quality improvement. The brochure includes a “CONTACT US” section, which identifies contact names and numbers of the compliance staff.</td>
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<tr>
<td>5. The compliance manual/code of conduct is distributed annually and upon hire.</td>
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physician. The heart of the certification is the physician’s narrative of the clinical findings that support the need for home health care, which is covered only if the patient is homebound and in need of skilled nursing or physical/speech therapy. The purpose of the face-to-face encounter is to discourage physician certification of home health eligibility based solely on information from the home health agencies when the Medicare improper payment rate for home health in fiscal year 2013 was 17.3% vs. 10.1% for other fee-for-service claims, CMS says. The majority of improper payments stem from insufficient documentation.

There was a hue and cry from home health agencies about the face-to-face encounter requirement, partly because their Medicare claims were at the mercy of certifying physicians who had no skin in the game. If the home health payment was denied because of an inadequate narrative, the physician wasn’t affected. Anyway, home health agencies argued, the information in the narrative was available elsewhere in the medical record.

Narratives Help to Justify Home Health

In response, CMS floated a number of changes to the face-to-face encounter requirement, according to the proposed home health rule. First it would oust the narrative. “In determining whether the patient is or was eligible to receive services under the Medicare home health benefit at the start of care, we would review only the medical record for the patient from the certifying physician or the acute/post-acute care facility (if the patient in that setting was directly admitted to home health) used to support the physician’s certification of patient eligibility,” CMS says. If medical reviewers were unconvinced, the Medicare check wouldn’t be in the mail.

Sceciniski has doubts about the wisdom of eliminating narratives because they help justify home health services. Physicians may not write what seems obvious to them or there’s conflicting information in the medical record, which could trigger a claim denial, she says. Suppose the surgeon documents that the patient can’t drive post-op and the primary care physician orders home health. “There’s nothing to tie the two together,” Sceciniski says. “Maybe the patient can’t use his legs and that makes him homebound, but without that narrative, you will continue to get denials for home health care.”

In fact, physicians tend to fall back on canned statements, she says. “They say, ‘home health is medically necessary’ or ‘inpatient care is medically necessary,’ but that doesn’t mean a hill of beans in CMS’s eyes. They will deny it.” Generally, she says, physicians do all this great clinical and critical thinking to determine level of care — outpatient, home health, inpatient rehab, skilled nursing, etc. — “but they don’t do a good job of documenting it.”

Although physicians may be thrilled to escape the narrative requirement, they may pay for this freedom in their pocketbooks because of another change in the proposed rule. CMS says physician claims for certification or re-certification of home health services won’t be paid by Medicare if the home health care itself is not covered “because the certification/re-certification of eligibility was not complete or because there was insufficient documentation to support that the patient was eligible for the Medicare home health benefit,” the proposal states. CMS apparently is harking back to a program-integrity vision it laid out in Medicare Transmittal 505, which said Medicare auditors may deny a physician’s claim as “not reasonable and necessary,” without an audit, when the

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**CMS Transmittals and Federal Register Regulations**

**July 18 – July 24**

Live links to the following documents are included on RMC’s subscriber-only Web page at www.AISHealth.com. Please click on “CMS Transmittals and Regulations” in the right column.

**Transmittals**

(R) indicates a replacement transmittal.

**Pub. 100-02, Medicare Benefit Policy Manual**

- Cardiac Rehabilitation Programs for Chronic Heart Failure, Trans. 191BP; CR 8758 (July 18; eff. Feb. 18; impl. Aug. 18, 2014)

**Pub. 100-03, National Coverage Determinations**

- Cardiac Rehabilitation Programs for Chronic Heart Failure, Trans. 171NCD; CR 8758 (July 18; eff. Feb. 18; impl. Aug. 18, 2014)

**Pub. 100-04, Medicare Claims Processing Manual**

- Cardiac Rehabilitation Programs for Chronic Heart Failure, Trans. 2989CP; CR 8758 (July 18; eff. Feb. 18; impl. Aug. 18, 2014)
- New Waived Tests, Trans. 2988CP; CR 8805 (July 18; eff. Oct. 1; impl. Oct. 6, 2014)
- October 2014 Quarterly Average Sales Price Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files, Trans. 2990CP; CR 8836 (July 18; eff. Oct. 1; impl. Oct. 6, 2014)
- October Quarterly Update to 2014 Annual Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement, Trans. 2991CP; CR 8829 (July 18; eff. Oct. 1; impl. Oct. 6, 2014)

**Pub. 100-08, Medicare Program Integrity Manual**

- Cardiac Rehabilitation Programs for Chronic Heart Failure, Trans. 530P1; CR 8758 (July 18; impl. Aug. 18, 2014)

**Pub. 100-20, One-Time Notification**

- Implementation of a Prospective Payment System for Federally Qualified Health Centers (R), Trans. 1395OFTN; CR 8743 (July 16; eff. Oct. 1; impl. Oct. 6, 2014)

**Federal Register Regulations**

- None published.
All home health agencies in five to eight states would be home health that ties reimbursement to quality of care. CMS later rescinded the transmittal, but said it would formalize the connection between denying claims for physician certifications and denying claims for home health “in future sub-regulatory guidance,” not a regulation.

CMS also says payment would be denied for home health services if the patient’s medical record isn’t adequate to prove the patient was eligible for the benefit.

In another section of the proposed regulation, CMS set in motion a value-based purchasing program for home health that ties reimbursement to quality of care. All home health agencies in five to eight states would be required to participate in 2016. The financial impact is eye-opening: a 5% to 8% payment increase or decrease depending on the home health agency’s performance, says Emily Evans, a partner in Obsidian Research Group in Nashville.

CMS already has a hospital value-based purchasing (VBP) program, which ties 1.25% of payments to quality. Acute care and home health are a natural fit for value-based purchasing, because hospitals are also penalized for readmissions, which are more likely to occur if patients receive substandard home health care, Evans says. “CMS wants to stop paying for care that isn’t done well.”

Contact Evans at emily@obsidianresearchgroup.com and Snecinski at jane.snecinski@postacuteadvisors.com. View the proposed home health rule at http://tinyurl.com/p83ta4r.

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**NEWS BRIEFS**

♦ Despite perceptions to the contrary, the new national coverage determination for cardiac permanent implantable single and dual chamber cardiac pacemakers took effect Aug. 13, 2013, a CMS official confirmed July 21. In an email to Ronald Hirsch, vice president of regulations and education for Accretive Physician Advisory Services, Jamie Hermansen of the CMS Coverage and Analysis Group at the Center for Clinical Standards and Quality said that “providers and our Medicare contractors should now be following the revised NCD policy. We have delayed the implementation of the automated claims systems changes and the related policy manualization so that we can review and address the inquiries we received from multiple stakeholders, including yourself, about coding of the pacemaker decision. We are carefully considering them and working to address them as appropriate. Additional information will be forthcoming.” Many providers were under the impression the NCD was delayed because CMS pretty much said so (RMC 7/14/14, p. 8). Documentation under the new NCD (20.8.3) is simpler than under the previous NCD, Hirsch says. Physicians document three things: “that the patient has bradycardia due to sinus node dysfunction or second- or third-degree heart block; that the patient had symptoms associated with the bradycardia, such as lightheadedness, fatigue, or syncope; and that the bradycardia is not reversible, such as due to the use of medications that slow the heart rate or cause heart block,” he says. Then the physician is free to choose whether the patient benefits most from a single- or dual-chamber pacemaker. Contact Hirsch at rhirsch@accretivehealth.com.

♦ American International Biotechnology, LLC, agreed to pay $343,739 to settle false claims allegations, the U.S. Attorney for the Western District of Pennsylvania said on July 11. The settlement resolves allegations that American International Biotechnology obtained improper referrals for genetic tests billed to the Medicare program. The company, using a contract sales agent, “falsely marketed its genetic tests to a Pennsylvania medical practice as part of a free clinical research study for which patients and insurers would not be billed, and later billed those tests to Medicare,” the U.S. attorney alleges. The contract sales agent allegedly offered payments to an employee of the medical practice in exchange for referrals of genetic tests in violation of the anti-kickback statute. The company did not admit liability in the settlement. Visit http://go.usa.gov/9SrT.

♦ The owner of Polaris Allergy Labs in East Point, Ga., pleaded guilty to one count of health care fraud for faking the results of allergy tests referred by physicians, the U.S. Attorney for the Northern District of Georgia said on July 22. Doctors would send patients’ blood samples to the lab to be tested for food and environmental allergies, and from September 2012 to February 2014, owner Rahsaan Jackson Garth allegedly told lab technicians not to test some of them in order to save money, the feds say. Instead, he dummed reports and billed insurers. Visit www.justice.gov/usao/gan.
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