Settlements Over Excluded Employees Pile Up; Screening Snags Bedevil Compliance

A wave of settlements with the HHS Office of Inspector General (OIG) over excluded employees is a cautionary tale for health care organizations, even as they face stumbling blocks in their exclusion screening. In the last four months of 2015, 21 health care organizations resolved civil monetary penalty (CMP) cases for employing people who had been thrown out of federal health care programs, with settlement amounts ranging from $24,128 to $21 million (see box, p. 3). OIG has intensified its enforcement of CMP and exclusion cases with its “litigation team” (RMC 7/27/15, p. 1), and state Medicaid agencies are cracking down on exclusions. But there are still imperfections in the screening process that are exacerbated by the fact that sometimes employees are oblivious to their exclusions or try to pull the wool over their employers’ eyes, lawyers say.

Exclusion screening “is the painful cost of doing business, but it’s important that you do it and not take shortcuts,” said attorney Mary Malone, with Hancock, Daniel, Johnson & Nagle, at a Jan. 25 webinar sponsored by the Health Care Compliance Association.

The implications of billing for services provided by excluded employees and contractors were set out by OIG in its 2013 bulletin on exclusions (RMC 5/13/13, p. 1). According to OIG, no federal health care program payment will be made for goods or services provided by an excluded person or entity or at the medical direction or on the prescription of an excluded person, regardless of payment methodology (e.g., DRGs, cost reports, fee schedules, bundled payments, capitation). This includes direct care,
such as physicians’ services, and indirect care, such as preparing surgical trays and reviewing treatment plans. Excluded persons also are forbidden to furnish “administrative and management services that are payable by the Federal health care programs,” the bulletin says. That means excluded people can’t serve in executive or leadership roles, such as CEO, CFO, general counsel, director of health information management or physician practice office manager.

Ensuring excluded people and vendors are kept at bay can be harder than it sounds, Malone said. Sometimes it’s because the employees didn’t know they were excluded. OIG is required by law to notify people and entities they have been excluded by sending letters to their last known address, but OIG is not obligated to confirm they were received, said attorney W. Clay Landa, who also spoke at the webinar. What an excluded person doesn’t know can hurt future employers, he said.

For example, Malone represented a hospital that settled a CMP case over a certified coder who worked there for nearly a dozen years before her exclusion came to OIG’s attention. Neither the hospital nor the coder was aware of it. The exclusion was unrelated to the employee’s work as a coder, but resulted from a plea deal the coder entered into at the urging of her attorney when she was working in a clinical position in another facility years earlier. The coder was unaware the plea would affect her license or cause Medicare exclusion. The coder lived with her parents at the time, and they all said they never got an exclusion letter. After “reinventing herself” as a coder, she got married and took a job in the hospital’s billing office, Malone said. Years after the criminal case, the hospital was surprised to learn she was persona non grata with Medicare, although OIG wouldn’t reveal how it found out, Malone said. Even though the hospital has a screening program, it didn’t detect the coder’s exclusion. “She was screened every month for 11 years, and it never came up because” she was excluded under her maiden name and screened with her married name. To arrive at a CMP settlement amount, OIG had the hospital look at payer mix and determine how much time the coder spent working on federal health care payer claims. The hospital then paid the corresponding amount of her compensation multiplied by 11-plus years.

Try Searching LEIE With Three Letters

The hospital’s missing the exclusion because of a name change underscores the importance of looking more than skin deep at OIG’s exclusion database, the List of Excluded Individuals and Entities (LEIE). There are two ways for health care organizations to search the LEIE, Landa said. One option: Download the entire database every month, merge it with your employee and vendor list and see what pops out. “The downloadable files don’t have Social Security numbers or employee identification numbers, but they have dates of birth,” Malone said. “Any potential matches have to be verified.”

The second option: Health care organizations enter employee and vendor names on the OIG website, five at a time, to see if any match, although this approach “is not operationally possible” for larger organizations, according to Malone and Landa. They tend to hire screening vendors, Landa said. “It’s helpful but won’t protect providers from liability if the vendor makes mistakes and doesn’t identify an excluded employee working within the health system,” Malone noted.

Whichever route health care organizations take, they can’t assume they’re home free with searches based on one version of the name. Malone advised running variations of the name — maiden, married and hyphenated — through the LEIE. Keep in mind that employees who know they are excluded may try to evade detection. “Consider entering only a few letters of the [last] name to get an accurate result,” such as “Smi” instead of “Smith,” Landa said. When you have a possible match, use the Social Security number to nail it down.
The LEIE is not foolproof. One Virginia nursing home client got an OIG repayment demand because it had an employed nurse on the exclusion list. Although the nurse was, in fact, on the LEIE, she shouldn’t have been. While working in New York state, the nurse had a board of nursing hearing, but it went well, and her license was intact, Malone said. Loss of license is a driving force behind exclusions, but in this case the exclusion was a mistake, and Malone said it all ended well. The experience was a wake-up call for the nursing home to screen employees for exclusions, she noted.

Sometimes health care organizations are duped by employees who know they’re excluded. That was the case with a certified coder who was brought into a hospital billing department through a staffing company that was responsible for exclusion screening, Malone said. As it turns out, she was a paroled felon. The coder was good at her job, but she was perceived as a troublemaker, clashing with her supervisor, who felt the coder insinuated the supervisor had compliance problems. The charade ended when someone who knew the coder called the hospital and spilled the beans about the coder’s stint in prison for fraudulent billing in a previous job and her subsequent exclusion. She managed to conceal it from the hospital in terms of tax forms and the background check by changing one digit of her Social Security number, but it’s inexplicable why the billing company didn’t detect the exclusion, Malone said. “This woman was a professional criminal,” she noted. “She knew how to work the system and how to avoid detection.”

Hospitals have more than OIG to worry about when it comes to exclusions. Many states require providers to screen for Medicaid exclusions, and 39 states have their own lists to check for excluded employees/vendors, Landa said. “Providers may just be checking the LEIE, but states can have exclusions, and OIG is not required to exclude a person from Medicare based on a state exclusion,” Landa said. However, under the Affordable Care Act, it’s all for one and one for all in terms of Medicaid: When one state excludes, they all must exclude, if providers are “excluded for cause,” he said. What “cause” means is a little fuzzy, although CMS has indicated that “cause” includes adverse licensure actions, fraud, billing for services that were not furnished or medically necessary, misusing a billing number and falsifying information on applications or medical records, Landa said.

CMS told states in 2009 to require Medicaid providers to screen for exclusions monthly, and the majority of states followed suit, Malone said. “But there is still confusion and a lack of consistency in the frequency,” she noted. “Our suggestion is, whether the state requires it or not, screen every 30 days to ensure you are catching

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### Civil Money Penalty Settlements for Excluded Employees: Last Third, ’15

- Quality Medical Imaging, Nevada: $34,187.34
- Windsor Health Care Golden Palms, California: $214,303.69
- S&F Market Street Healthcare, LLC, California: $207,427.34
- Windsor Oakridge Healthcare Center, L.P., California: $34,943.48
- Quest Diagnostics Inc. (Quest), Summit Health, Inc. (Michigan location) and Unilab Corporation (California location): $126,599.25
- Advocate Health and Hospitals Corporation, Illinois: $317,660.89
- Huntington Healthcare & Rehabilitation Center, Ltd., Texas: $214,016.48
- South Kansas Independent Living Resource Center, Inc.: $47,520.18
- Webster Manor Long Term Care Facility, Inc., Massachusetts: $92,881.76
- Kroger Co., Ohio: $21,523,047
- Northampton Manor, Inc., Maryland: $183,450.97
- Van Rue, Inc., Ohio: $35,117.64
- Cardiology Associates of Fredericksburg, Ltd., Virginia: $49,578.63
- Baptist Hospitals of Southeast Texas: $116,946.72
- East Tennessee Children’s Hospital Association, Inc.: $221,920.61
- COMHAR, Inc., Pennsylvania: $24,128.07
- Community Hospice, LLC, Mississippi: $87,792.87
- Brier Creek Integrated Pain & Spine, PLLC, North Carolina: $222,348.81
- Spectrum Health Primary Care Partners, Michigan: $292,225.64
- Sanderling Renal Services-USA, LLC and SRS Ely, LLC, Tennessee: $39,337.50
- Humphreys Community Care Center, LLC, Mississippi: $541,136.77


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updates.” That’s consistent with the recommendation in OIG’s 2013 exclusion guidance.

When health care organizations identify an excluded employee or vendor, they don’t necessarily have to spill their guts to OIG, Landa contended. “There is no affirmative obligation to report an excluded provider” under the CMP law. They are obliged, however, to return overpayments stemming from exclusions within 60 days of identification, according to the 60-day Medicare overpayment refund rule, he noted. Some health care organizations take that route. “We know facilities that adjust their cost report and state, ‘we are removing the salary associated with the excluded provider,’” Landa explained. Of course, if OIG finds out about exclusion, it may levy a CMP, with the health care organization losing the benefits of self-disclosure.

According to the Self-Disclosure Protocol (SDP), which OIG updated in 2013 (RMC 4/22/13, p. 1), health care organizations that come clean about potential misconduct probably avoid corporate integrity agreements and settle CMP cases for reduced amounts — generally a 1.5 multiplier on damages. If it’s an exclusion matter, Landa said, submissions to the SDP should:

♦ Explain how the exclusion was discovered by the health care organization and why it was overlooked initially.

♦ Describe the screening program. “Don’t fall into the category where OIG thinks you stuck your head in the sand,” he advised.

♦ Show how the employment of an excluded person was an anomaly.

♦ Update policies and procedures to ensure exclusions are identified.

Contact Malone at mmalone@hdjn.com and Landa at clanda@hdjn.com.

Hospitals Try New Ways to Track Device Credits; 53 Is in Effect

The only upside to the replacement of a device related to the recall of certain cardiac leads — which obviously is awful for patients — is that it can be easier for hospitals to comply with Medicare rules for passing on manufacturer credits for replaced implantable medical devices. That’s one of the recent developments in the uphill battle to comply with this requirement, which is under constant scrutiny by the HHS Office of Inspector General (OIG).

“The reporting process is easier with recalls” versus devices under warranty, says Stephen Gillis, director of compliance coding, billing and audit at Partners HealthCare in Boston. And while device-credit reporting remains a compliance headache, some hospitals are making headway.

When patients need their medical devices replaced because they malfunctioned or the devices are recalled, manufacturers will refund all or some of the cost of the replacement device, depending on its age (and whether warranties apply). Hospitals are required to pass on credits to Medicare, which foots the bill for surgeries to implant replacement devices. Medicare uses credit information included on claims to reduce payments for inpatient and outpatient procedures performed to replace or fix faltering devices, such as pacemakers and defibrillators. Under the “prudent buyer” standard, hospitals owe Medicare the credits even if they don’t collect them from the manufacturer, according to OIG. The failure to pass on device credits to Medicare has been cited as an overpayment in virtually all Medicare compliance reviews, and there are also two device-reporting items on the 2016 OIG Work Plan. Meanwhile, as of July 1, 2015, CMS requires hospitals to use a new condition code, 53, when implantaing devices under certain circumstances.

Transmittal 1494 Explains It All

Hospitals may make mistakes when reporting device credits because it can be complicated, although CMS made it easier in 2014 (RMC 3/8/15, p. 1), said Michael Calahan, vice president of hospital and physician compliance at HealthCare Consulting Solutions, at a Jan. 27 webinar sponsored by RACMonitor.com. For medical devices replaced during inpatient procedures, hospitals have to report credits only if they are worth 50% or more of the price the hospital paid for the device, which is represented by value code FD on the UB-04 claim form. Hospitals also put down the amount of the credit, which is used to reduce the MS-DRG payment for the corresponding procedure dollar-for-dollar, Calahan said. Condition codes 49 (product replacement within product lifecycle) or 50 (product replacement for known recall of a product) must still be reported to reflect the reason for the replacement device credit, but modifiers -FB and -FC are history. On top of that, CMS confirmed device-credit reporting for procedures performed in hospital outpatient departments and ambulatory surgery centers to the Inpatient Prospective Payment System method, with the same value code required to trigger a dollar-for-dollar reduction in the Medicare payment, he explained. Medicare Transmittal 1494 is a revelation in terms of sorting all this out, Calahan said.

But compliance with the device reporting requirement still doesn’t come naturally in the context of hospital operations because “it takes a village” to identify, track and report credits, Calahan contended. Coordinating that many departments — including materials management, revenue cycle, accounts payable, compli-
ance, data management and clinical departments — isn’t usually a recipe for success. Some compliance officers, however, are learning more about what helps and what hinders compliance.

One realization: Hospitals can streamline reporting when patients undergo procedures for recalled devices, Gillis says. “There has been an uptick in recall-related replacements for device leads, and it’s different than being under warranty because the manufacturer is advising you to replace the device,” he says. “You may not have the credit in hand, but it is more likely that if you knew what you were doing ahead of time, you would be putting in the condition code and value code on the bill going out the door the first time.” In other words, instead of the method they use with warranties — billing Medicare for the procedure to explant the device, sending the explanted device to the manufacturer, waiting for the manufacturer to decide whether the warranty is in effect and, if so, to cut a check, and then reprocessing the Medicare claim — hospitals know up front they will get 100% of the cost of the recalled device and can bill accordingly.

Partners also abandoned its earlier approach to improving compliance with the device-credit reporting requirement, which put accounts payable at the center. “There were too many transactions in the accounts payable department, and it was too difficult to identify device credits,” Gillis says.

**Reaching Out to Manufacturers**

Instead, Partners is working directly with device manufacturers. “They are more responsive now to individual requests,” Gillis says. There is still a challenge, however, in getting timely notification on warranty credits even though you may get it faster than before. Suppose in January the hospital buys 30 devices from the manufacturer and explants 10 of them, immediately returning them for a credit. The manufacturer gets paid by the hospital but takes 60 to 90 days to issue credits, if any. “Someone has to track it to completion,” he says.

To abandon monitoring your accounts payable transactions for device credits, it sometimes requires a hospital employee to contact the manufacturer to get device-credit information, Gillis explains. “You have to reach out to them. It’s worth the effort to do it monthly, bi-monthly or quarterly.” He suggests connecting with someone in the manufacturer’s warranty department and staying on top of him or her, or getting the manufacturer to send routine reports that identify device-credit determinations. But the most critical first step is to get the explanted devices back to the manufacturers with any requested data, Gillis says. They will require details, so Partners developed a form that contains key information, including the name and serial numbers of the implanted and explanted devices, the dates of the original and replacement surgeries and a physician signature. “Sometimes you need to send in the operative report,” he notes. That’s the best you can do, and with these recalcitrant manufacturers, “either you will get the credit or you won’t.” Generally, the manufacturers are usually right in their credit determinations as long as they get what they need from hospitals, Gillis says.

While OIG continues to monitor device-credit reporting, it also seems to be watching the bigger picture of costs associated with replacing devices, he says. One of the new Work Plan items notes that OIG “will review Medicare claims to identify the impact on beneficiary safety and quality of care, as well as the costs to Medicare, resulting from additional use of medical services associated with defective medical devices.”

Another new angle similar to credits for replacement devices is condition code 53, which CMS debuted last year. Hospitals should report 53 for only the initial placement of a medical device they receive free from manufacturers as part of a clinical trial or when it’s a free sample, Calahan said (see MLN Matters 8961, released Jan. 30, 2015). “You need to work it into your policies and procedures and your work-flow protocols because it’s something you have to pick up,” he advised. Remember, he said, condition code 53 only applies to freebies in outpatient procedures. And don’t also report condition codes 49 and 50 because they are only for replacement devices, Calahan noted.

Contact Gillis at sjgillis@partners.org and Calahan at mcalahan@hcsglobal.net. ᵇ

**More Audits Coming to IRFs**

*continued from p. 1*

president of Post Acute Advisers in Atlanta. “I always say to inpatient rehab providers, ‘you have to be so fastidious with coverage criteria. Don’t give auditors low-hanging fruit so they can deny entire reimbursement for the whole stay.’”

For example, every IRF/inpatient rehabilitation unit (IRU) in Washington state watched as an average of half their records requested for review for the past year and a half resulted in reimbursement denials by Noridian Healthcare Solutions, the MAC, Snecinski says. Then in November, Noridian announced plans to do IRF prepay-
ment reviews in Oregon, at CMS's direction, “to ensure payment is made only for those medical services that are reasonable and necessary,” according to its website. All IRFs/IRUs in the state are facing a probe review of 100 claims that have edit number 50235 billed after Nov. 23, 2015, and have type of bill 111-115 because “data analysis has identified a potentially high use of IRF claims billed with TOB 111-115.” Condition codes 04 and 69 will be excluded.

Sneckinski also expects recovery audit contractors to look at inpatient rehab on a wide scale when they are back in full swing, probably later this year.

With denials a serious risk, it behooves IRFs to improve their compliance with the coverage guidelines on the front end, says Snecinski. However, since the coverage guidelines are technical, there is hope that IRFs will prevail when they appeal claim denials that are based on medical necessity, she says. “I wish we had a crystal ball and could look ahead [to] when administrative law judges start reviewing cases and see where common sense will prevail,” she says. “When they get to the ALJ level, I believe a significant number of denials will be overturned, but who knows when that will be? Two to three years down the road, cash flow will be dead in the water.”

There are 1,186 IRFs in the nation, and 931 are hospital-based. They treat beneficiaries with serious diagnoses who need both medical and functional treatment and 60% of whom meet specific diagnostic categories (e.g., stroke, brain injury and major multiple trauma). Also, IRFs must comply with CMS’s six coverage guidelines, which took effect in January 2010, to prove medical necessity. In Medicare’s eye, patients who don’t meet the coverage guidelines, at least as documented by the IRFs, could be treated in a less-intensive setting, such as a skilled nursing facility. IRFs have been under scrutiny by Medicare watchdogs in recent years (RMC 12/23/13, p. 1), and CMS now provides IRFs with Program for Evaluating Payment Patterns Electronic Reports (PEPPERS) so they can improve their compliance monitoring (RMC 9/5/11, p. 1).

Here are the six coverage guidelines and some of the problems, according to Snecinski:

(1) **Preadmission screen:** A licensed clinician must complete a preadmission screening of patients within 48 hours of admission. The data gathered during the preadmission screening will be used by the rehab physician (i.e., physiatrist) to confirm the admission is appropriate. “Theoretically, the physician doesn’t have to see the patient before that, but he must review and approve the admission prior to admission,” Snecinski says.

(2) **Post-admission physician evaluation:** The physician has to perform a post-admission evaluation within 24 hours of the patient’s IRF admission. The physician compares the patient’s status at admission to the information in the preadmission screen. “CMS has a laundry

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**CMS Transmittals and Federal Register Regulations**

Jan. 29 – Feb. 4

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**Transmittals**

(R) indicates a replacement transmittal.

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

- Off-Cycle Update to the Long Term Care Hospital Prospective Payment System Fiscal Year 2016 Pricer, Trans. 3445CP, CR 9527 (Jan. 29; eff. Jan. 1; impl. April 4, 2016)
- Manual Update to Pub. 100-04, Chapter 20, to Include Used Rental Equipment, Trans. 3443CR CR 9488 (Jan. 29; eff. July 1; impl. July 5, 2016)
- Payment for Purchased DMEPOS Furnished to Medicare Beneficiaries Residing Outside the U.S. — Expatriate Beneficiaries, Trans. 3444CP, CR 9468 (Jan. 29; eff. July 1; impl. July 5, 2016)

**Pub. 100-06, Medicare Financial Management**

- Monitoring Accounts Receivable that are in a Redetermination or Reconsideration Status, Trans. 261FM, CR 9470 (Jan. 29; eff./impl. March 1, 2016)

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

- Payment Clarification for the Purchase of Used Inexpensive and Routinely Purchased Durable Medical Equipment When Previously Rented, Trans. 1601OTN, CR 9491 (Jan. 29; eff. July 1; impl. July 5, 2016)
- Award of Medicare Administrative Contractor Contract for Jurisdiction 15, Trans. 1600OTN, CR 9456 (Jan. 29; eff. Sept. 17, 2015; impl. March 1, 2016)
- Required Billing Updates for Rural Health Clinics (R), Trans. 1596OTN, CR 9269 (Jan. 26; eff. April 1; impl. April 4, 2016)

**Federal Register Regulations**

**Proposed Rules**

- Expanding Uses of Medicare Data by Qualified Entities, 81 Fed. Reg. 5397 (Feb. 2, 2016)

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list of what should be included in the evaluation. The physician should state, 'based on my expertise, this person should be admitted because...','"" Snecinski says.

(3) Plan of care: The physiatrist has four days “in which he or she synthesizes a plan of care in collaboration with the interdisciplinary team,” she says. The plan of care establishes the length of stay and goals for the patient’s recovery and should address both medical and rehab issues. This is critical to demonstrating medical necessity “because inpatient rehab beds are licensed as acute care beds and certified as rehab beds, so there should be an acute medical reason for the admission,” Snecinski explains. Alarm bells should ring when it comes to total joint replacement. There’s no question patients require rehab, but if there is no medical reason for concurrent hospital care, such as previous stroke with residual effects, uncontrolled diabetes or uncontrolled hypertension, the IRF admission may be denied, she cautions. “That’s how CMS views inpatient rehab — it’s an intense level of care.” In fact, Snecinski rues how documentation seems to be getting increasingly vanilla. “A doctor said to me, ‘anyone with two cents of common sense will be able to read the medical record and know what I am treating.’ I said, ‘you need to say, ‘I am admitting this patient for treatment of cardiac arrhythmia, stroke, uncontrolled diabetes,’’ and they are hesitant,” she says. “In their assessment and plan, instead of saying the patient has diabetes, we will work on establishing insulin scale and medication calibration so we can get it under control, and it is necessary to do it as an inpatient, they say, ‘the patient has diabetes.’ If they would do a better job of documenting the medical necessity of the admission in the plan, the rate of denials would be significantly lower — and in most cases, it’s just a change in dictation.”

(4) Medical supervision: The physiatrist must have three face-to-face visits with patients every week. “That’s a real biggie and something case managers should concurrently audit,” Snecinski says. The physician’s notes on the face-to-face visit have to reflect the coordination of the medical care and rehab care and whether progress is being made. “Rehab physicians have historically visited the patient every day, but often I will be a monkey’s uncle to understand the medical necessity of even one visit because the notes are so thin,” she says. “This is one of the most significant barriers to establishing medical necessity and compliance with coverage guidelines for inpatient rehab.”

(5) Intensity of therapy: Patients must receive three hours of medically necessary therapy five days a week that they can truly benefit from and participate in. Medicare also accepts 15 hours of therapy a week averaged over seven days. This was added to the coverage guidelines because medically complex patients can’t always endure three hours of therapy a day, Snecinski says. “CMS acknowledged that, but you need to put that in the plan of care,” she cautions.

continued

### Coverage Guidelines for Inpatient Rehab

<table>
<thead>
<tr>
<th>Coverage Guidelines</th>
<th>Requirements Specified in Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-admission Screening Process</td>
<td>Completed within 48 hours of admission by a licensed clinician; Content specified; Admission confirmed by the Rehab Physician between the time the screen is complete and admission</td>
</tr>
<tr>
<td>Post Admission Physician Evaluation</td>
<td>Completed within 24 hours of admission; confirming/discussing changes between the patient assessment and the Pre-admission screen; content specified</td>
</tr>
<tr>
<td>Plan Of Care</td>
<td>Completed within 4 days of admission, synthesized by the rehab physician with input from the Interdisciplinary Team; required elements identified</td>
</tr>
<tr>
<td>(Interdisciplinary) Team Conference</td>
<td>Held weekly with the rehab physician, treating members of the interdisciplinary team including an RN (with rehab experience) and SW</td>
</tr>
<tr>
<td>Close Medical Supervision</td>
<td>Minimum of 3 F-2-F visits by the rehab physician; documentation reflects medical issues, rehab issues and progress toward goals</td>
</tr>
<tr>
<td>Intensity of Therapy Services</td>
<td>Initiated within 36 hrs/admission; Minimum of 3 hours of therapy/5 days a week or an average of 15 hours over 7 days as specific in the Plan of Care; group therapy counted if included in the Plan of Care</td>
</tr>
</tbody>
</table>

SW = social worker, F-2-F = face to face

SOURCE: Post Acute Advisors

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www.twitter.com/AISHealth • www.facebook.com/AISHealth • www.linkedin.com/company/atlantic-information-services
(6) **Team conference:** The interdisciplinary team (doctor, nurses, social worker, therapists) has to meet weekly during the patient’s stay.

It’s clear from MAC audits that noncompliance with one coverage guideline can lead to wholesale denials of the IRF stay, Snecinski says. “When the coverage guidelines came out, CMS said if all the technicalities of the coverage guidelines are not met, we will not deny the entire payment. But that information didn’t get down to the MACs because they are denying based on minutes,” she says.

Werner advises IRFs to concurrently audit their records to ensure they are on top of deadlines (e.g., pre-admission and post-admission screening). “The overall plan of care must be completed by the end of the fourth rehab day, but it’s the single most missed deadline I see when I do compliance auditing,” she says. “They don’t do it until day five or day seven.”

Hospitals sometimes figure they can get by on almost perfect, Snecinski says. But the audits are making it clear they can’t, even though 100% compliance isn’t always within their control (e.g., a patient has trouble completing a therapy session). “The warnings were out there,” she says. “MACs say if you miss three minutes, you didn’t comply with the regulation.” But sometimes the auditors make mistakes.

This may be a neglected area because often post-acute services don’t get the same attention as other inpatient areas. But the impact can be significant. One 257-bed acute care hospital experienced $750,000 in claim denials stemming from its 10-bed inpatient rehab unit, Snecinski says.

For more information, contact Snecinski at jane.snecinski@postacuteadvisors.com and Werner at lwerner@flemingaod.com. 🔼

**NEWS BRIEFS**

♦ In a Medicare compliance review of University of Minnesota Medical Center (A-05-14-00050), the HHS Office of Inspector General (OIG) found $565,000 of overpayments on 130 claims submitted in 2012 and 2013 — and then estimated the hospital received overpayments of $3.26 million for the audit period. OIG contends it found errors on 29 inpatient claims and 101 outpatient claims when it audited the 885-bed acute care Minneapolis hospital. In a rare finding in Medicare compliance reviews, a significant amount of the overpayment — $148,376 — stemmed from inpatient rehabilitation facility (IRF) services (see story, p. 1). Twelve of 75 claims submitted for IRF stays “did not meet Medicare criteria for acute inpatient rehabilitation,” OIG said. In terms of other inpatient errors, the hospital billed Medicare for inpatient stays that could have been outpatient or observation services. In its written response, the hospital “respectfully disagreed” with OIG’s findings on the medical necessity of the IRF and inpatient admissions. Visit http://go.usa.gov/cmKGA.

♦ An HHS administrative law judge (ALJ) ruled on Feb. 3 in favor of the Office for Civil Rights (OCR) and upheld the $239,800 civil money penalty (CMP) imposed on Lincare, Inc., for violating the HIPAA privacy rule. OCR says it has sought CMPs for HIPAA violations only twice, and both times they were upheld. Lincare furnishes respiratory care, infusion therapy and medical equipment to in-home patients and has more than 850 locations in 48 states, OCR says. Its investigation got underway after someone complained that a Lincare employee left documents with protected health information (PHI) of 278 patients in an old residence after moving, according to OCR. “Over the course of the investigation, OCR found that Lincare had inadequate policies and procedures in place to safeguard patient information that was taken offsite, although employees, who provide health care services in patients’ homes, regularly removed material from the business premises,” OCR says. Lincare contended it didn’t violate HIPAA because the PHI was stolen, OCR says. The company sought to have the case dismissed on summary judgment, but the judge declined. Visit http://tinyurl.com/j86ena5.

♦ The former owner and operator of National Care EMS, a now-defunct Houston-area ambulance provider, agreed to resolve allegations that he and the company paid kickbacks to nursing facilities and hospitals in return for access to their more lucrative Medicare and Medicaid transport referrals, the U.S. Attorney’s Office for the Southern District of Texas said Jan. 27. Former owner Mohammed Elsaleh will pay $125,000 to settle the “swapping” allegations leveled against him and the company. His brother, Husam Alsaleh, the owner of a successor company that is also named National Care EMS, has agreed to fork over $120,000 to further the settlement. Visit http://tinyurl.com/z3ytpnz.
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