

MEDICARE COMPLIANCE

Weekly News and Compliance Strategies on CMS/OIG Regulations, Enforcement Actions and Audits

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OIG Work Plan: Post-Acute Care Looms Large; Compliance Reviews Continue

Post-acute providers, which sometimes draw the short compliance straw, are all over the HHS Office of Inspector General's (OIG) 2017 Work Plan, which was released Nov. 10. There are also a few new hospital targets, but the Work Plan has a range of post-acute care items at a time when hospitals are expanding their PAC services.

"There is something for everyone," says Janelle Wissler, a specialist leader with Deloitte & Touche in Tampa, Fla. "They have encompassed all the PAC providers and other provider types — home health, inpatient rehabilitation, skilled nursing facilities [SNFs], inpatient psychiatric facilities, hospices, durable medical equipment, wound care centers and outpatient physical therapy — that hospitals are adding to their systems."

Some post-acute provider types will be examined from multiple angles, Wissler notes. For example, in the SNF arena, the Work Plan has items on reimbursement, the adverse event screening tool, unreported incidents of abuse and neglect, complaint investigations and compliance with the three-day qualifying acute-care hospital stay before SNF admission.

continued on p. 8

Amid Trump Administration Unknowns, Enforcement, Compliance May Be Stable

A slew of program-integrity measures, including the Medicare-Medicaid 60-day overpayment refund rule, could disappear if President-elect Donald Trump and the Republican-controlled Congress repeal and replace the Affordable Care Act, as they have pledged to do. But there is speculation they are more likely to gut the parts of the law on spending (e.g., the individual and employer mandates, subsidies and the medical-device tax), which will leave intact the compliance and enforcement provisions of the Affordable Care Act, among other things, experts say.

Although it's early and the implications of the Trump victory on all corners of the health care industry are sketchy, experts expect compliance programs and enforcement to hold steady. "Those are pretty bipartisan areas of agreement," says Allison Kassir, a government relations adviser with King & Spalding in Washington, D.C. "I don't see a lot changing in enforcement and compliance."

Patrick Burns, executive director of Taxpayers Against Fraud in Washington, D.C., has the same impression. Although Republicans retained their control of the House and Senate, they lost seats to Democrats in both chambers, and are facing tense negotiations on immigration, trade, replacing Obamacare and drug pricing, he says. "There's no opposition to fighting fraud," Burns says.

The commitment to enforcement and compliance has not wavered much in the past when there has been a change in administration political parties, says attorney Gabriel

Imperato, with Broad and Cassel in Fort Lauderdale, Fla. “Consequently, I do not anticipate a lot of groundswell for radically transforming the commitment to organizational compliance,” he said. “I certainly do not expect a change in the commitment by Congress and the administration to False Claims Act enforcement, and this phenomenon largely drives criminal and civil health care fraud enforcement.”

But more subtle shifts may occur, he says. “I would keep my eye on the continuing viability of the Individuality Accountability Policy,” also known as the Yates memo, which is the Department of Justice (DOJ) blueprint for nailing culpable individuals when settling corporate fraud cases (*RMC 12/14/15, p. 1; RMC 9/14/15, p. 1*). “I would also probably have my eye on how DOJ will deploy and utilize the recently created position of corporate compliance counsel,” he says. The Health Care Fraud Prevention and Enforcement Action Team (HEAT) also may be reviewed, although it has been considered successful and may not change significantly. “It is viewed by many to be enforcement against true crime and everybody is for enforcement against true crime,” Imperato says.

It’s conceivable a Trump administration with a Republican-controlled Congress could be a more favorable environment for eviscerating the whistleblower provision of the False Claims Act, says Mark Pastin, president of the Health Ethics Trust in Alexandria, Va. “For decades, corporate America has been trying to get rid of the False Claims Act, but they haven’t had much luck. It’s been protected by Sen. [Charles] Grassley and the court system,” he says. “I could see a concerted effort with presidential backing to gut” the whistleblower part of the False Claims Act, which would weaken the reporting and non-retaliation aspects of compliance programs.

Burns, however, says he doesn’t think things will play out this way. “President Trump is going to need Grassley,” a Republican from Iowa who is chairman of the Whistleblower Protection Caucus and co-author of the 1986 amendments to the False Claims Act, which increased whistleblowers’ rewards and fortified their protection. “Not just for the Supreme Court nomination but for a lot of things,” Burns says. Grassley is chairman of the Senate Judiciary Committee and serves on the Finance Committee, and “he is respected by Democrats and Republicans.”

Some Rules May Be Put on Hold

The industry has to prepare for the possibility that Trump “will bring everything to a screeching halt until they figure out what they will do in health care,” says Jennifer Walsh, director of public affairs for Foley & Lardner LLP in Washington, D.C. “It’s hard to stop the compliance side of things, but some of the regulations and policies that have come out” may be put on hold. Walsh doesn’t think, however, that the new administration will reverse Sec. 603 of the Bipartisan Budget Act of 2015, which said goodbye to outpatient prospective payment system billing by off-campus provider-based space that’s established after Nov. 2, 2015, and is subject to various convolutions through rulemaking (*RMC 11/7/16, p. 1; 11/2/15, p. 1*). “Sec. 603 is a big saver for the government and has bipartisan support,” Walsh says.

Trump said during the campaign that if elected, he would put a moratorium on new regulations until they were reviewed, but Kassir doesn’t think that would apply to Medicare payment regulations. “You have the Affordable Care Act hot-button issues and regulations coming from that vs. the mechanics of government and how Medicare sets rates,” she says. “I don’t see them undoing routine payment rules.”

Walsh advises providers to move ahead with implementation of the regulations that take effect Jan. 1 unless they hear otherwise.

How things will unfold on other fronts is unclear. “Nothing would surprise me at this point,” Walsh says.

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“He is going to have a lot of power.” Providers should brace for wholesale Medicare reform — House Speaker Paul Ryan favors moving to a premium-support system — and for continued payment reform. “Everyone agrees the fee-for-service system is broken,” she says. “There will be changes, but we will see an even more rapid move away from fee-for-service Medicare. That’s something the Republicans wanted. They’ll have to go down this road anyway. It just might be bumpier.”

But in a Trump administration, bundled payments, such as the Comprehensive Care for Joint Replacement model, and other pay-for-performance programs may not come out of the Center for Medicare and Medicaid Innovation (CMMI), Kassir says. It’s possible CMMI, which has been a Republican whipping boy, will go away, she says. “Republicans may root that out and say ‘this is null,’ but in the meantime they could administratively reverse the course of everything CMMI has done so far,” Kassir says. Then again, “maybe they won’t — it’s a neat administrative tool that’s not bound by a lot of regulations. They can test it now that they are running the show.”

With almost 20 million Americans insured because of Obamacare, repealing before replacing will be tough, Walsh says. One blueprint for replacing it is “A Better Way,” which was developed in June by House Republicans, Kassir says.

“There are a lot of ways they can get things done,” Kassir says. “It may be done in component parts.”

Contact Kassir at AKassir@KSLAW.com, Walsh at JWalsh@foley.com, Imperato at gimperato@broadandcasel.com, Pastin at mpastin@corporateethics.com and Burns at pburns@taf.org. ✧

In Clinical Validation Appeals, Push Evidence That Auditors Overlook

If they put documentation supporting the physician’s diagnosis in neon lights and use evidence-based guidelines to back it up, hospitals have a good chance of winning appeals of claims that were denied in clinical validation reviews. Sometimes hospitals can use the clinical criteria cited in the audit to their own advantage.

Appeals of clinical validation reviews may come into play more with recovery audit contractors (RACs) coming back online (*RMC 11/7/16, p. 4*) because they no longer perform routine patient status reviews under the two-midnight rule. Clinical validation, not to be confused with DRG validation, is the province of clinicians, not coders, a fact that was reinforced by the 2017 ICD-10-CM Official Guidelines for Coding and Reporting, said Denise Wilson, vice president of clinical audit and appeal services at AppealMasters in Lutherville, Md.

Certain conditions — including sepsis, acute kidney injury, congestive heart failure and pneumonia — are vulnerable to clinical validation reviews, Wilson said at a Nov. 2 webinar sponsored by Intersect Healthcare and AppealMasters. Medicare auditors also perform clinical validation on cases with a single complication and comorbidity or major CC, but only if removing the CC or MCC affects reimbursement. Auditors may dispute a diagnosis based on the criteria used by the physician, and that’s ripe for an appeal because “there isn’t one acceptable set of criteria to diagnose sepsis or malnutrition or acute kidney injury,” Wilson said. “It’s up to the physician to diagnose, and not based just on a checklist.” She has seen sepsis denials for discharges the day after new criteria took effect Feb. 23, before physicians had a chance to absorb them. They are mostly on the commercial side, and are being appealed.

Clinical validation — also known as diagnosis validation — is “a clinical review to see whether the patient possesses the conditions that are documented,” Wilson said. Medicare auditors and commercial payers challenge the diagnoses that the physician documented in the medical record and coders put on the claim. If DRGs are downcoded or CCs or MCCs are dropped because auditors conclude there isn’t adequate clinical support for them in the documentation, hospitals lose money. That’s different than DRG validation audits, which is a more black and white determination of whether the correct codes were assigned and principal and secondary diagnoses were correctly sequenced.

The distinction was driven home in the 2017 update to the ICD-10-CM Official Guidelines for Coding and Reporting. They stated that “The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.” The guidelines caused a commotion in the coding world because they seemed to say that coders can take what physicians write at face value and code their diagnoses without having to scour the medical records for supporting information (*RMC 8/15/16, p. 4*). In response, *Coding Clinic*, AHA’s quarterly newsletter, explained that “If the physician documents sepsis and the coder assigns the code for sepsis, and a clinical validation reviewer later disagrees with

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the physician’s diagnosis, that is a clinical issue, but it is not a coding error” (fourth quarter 2016 issue).

In other words, it’s out of the coder’s hands, Wilson says. “There was a lot of confusion with clinical validation audits. If it’s a clinical issue, then it’s a problem with how the physician is coming up with that diagnosis, and you should look at it with your clinical hats. It’s not a coder error.”

Clinical validation denials often can be successfully appealed, Wilson said. She has won 90% of appeals of RAC claim denials — often at the first level of appeal — and 50% on the commercial payer side. The strategy depends on combing through medical records, finding the clinical documentation for the diagnoses and evidence-based guidelines supporting them and then organizing them for appeals tribunals.

Here are two examples:

(1) *The hospital showed that the medical literature used by the RAC actually contradicted it.* The RAC declared there was not enough clinical evidence to support a hospital’s secondary diagnosis of pneumonia for a 55-year-old woman with acute on chronic systolic heart failure who had an aortic valve and mitral valve replace-

ment. As a result, the MS-DRG was changed from 216 (cardiac valve and other major cardiothoracic procedures with cardiac catheterization with MCC) to MS-DRG 217 (cardiac valve and other major cardiothoracic procedures with cardiac catheterization with CC), which reduced the hospital’s reimbursement by \$27,000. In the review results letter, the RAC said “The chest X-ray revealed no acute pulmonary process and the CT scan showed ‘No evidence of pneumonia.’ She remained afebrile with clear lung sounds. She was found to have a urinary tract infection and was treated with intravenous antibiotics.”

The letter also stated that the respiratory assessment should reveal bronchial breath sounds, rales, or inspiratory crackles; parenchymal infiltrates or consolidation on chest radiograph are usually present with pneumonia; and lab findings typically show leukocytosis, and cited the pulmonary diseases chapter written by Chestnut and Prendergast in a widely used reference book, *Current Medical Diagnosis and Treatment*.

That raised the question of whether the RAC used the clinical indicators from the book correctly or “tweaked the words” to justify its denial, Wilson said. “It’s always a stronger argument if you can use the same

Appealing Clinical Validation Denials

Here’s an example of the material presented to successfully appeal the downcoding of a case in a clinical validation audit. It was developed by Denise Wilson, vice president of clinical audit and appeal services at AppealMasters. This case of acute respiratory failure was downcoded to asthma by a commercial payer until it was overturned (see story, p. 3). Contact Wilson at dwilson@intersecthealthcare.com.

Physician Progress Notes:		
Document Source & Date	Pertinent Information	Page(s)
Consult 2/2/16	Pulmonary Consult: Monitor closely in MICU due to high risk of Respiratory Failure	7
H & P 2/2/16	CC: SOB However, symptoms progressed, and she was brought to the emergency department for further evaluation. In the emergency department, patient was found to be hypoxic with a PO2 of 65. The patient will require greater than 2 midnight stay given her significant shortness of breath with hypoxic respiratory insufficiency. She is at great risk for respiratory failure, requiring intubation this hospitalization. Assessment: Hypoxic Respiratory insufficiency with impending failure PMH: Asthma Wheezing bilaterally with Inspiratory and expiratory effort, Accessory muscle use with breathing Patient chest discomfort most likely secondary to her increased accessory muscle use.	26,27,28
Consult 2/2/16	She was short of breath at rest yesterday; she also started having substernal heaviness which is not typical for her asthma. When she saw her pulmonologist, she was advised to go to the emergency room for further treatment	22,24
Progress Notes 2/3/16 – 2/5/16	Problem/plan Summary: Acute Hypoxemic Respiratory Failure Hypoxic Respiratory Failure - Improved	20, 32
Discharge Notes 2/5/16	At the emergency room, she was noted to be hypoxic on room air and was wheezing at rest. Workup showed a clear hyper inflated chest x-ray. ABG showed an increased A-a gradient with out hypercarbia. Because of her increased oxygen requirements, she was admitted to the MICU and placed on Vapotherm 50% FiO2. Discharge Diagnosis: Acute Hypoxemic Respiratory Failure	13,15,16

reference to appeal that was used to deny, and show in your argument how the auditor misused or misquoted the reference," she noted. In this case, the RAC said that the "chest X-ray revealed no acute pulmonary process and the CT scan showed 'no evidence of pneumonia,'" but the Chestnut and Prendergast chapter states that "parenchymal infiltrates or consolidation on chest radiograph are usually present with pneumonia." That means the RAC didn't use the clinical indicators appropriately, Wilson said. "The RAC denied the case based on the absence of pneumonia in the chest X-ray when the chest X-ray doesn't always have to show abnormalities indicative of pneumonia, as stated by the reference they cited."

There are other clinical indicators of pneumonia, and the patient had them, as Wilson set forth in a chart for the appeal. For example, the patient's white blood count climbed during her hospital stay, and the physician had documented a progression from rule out pneumonia to possible pneumonia to pneumonia. The discharge note described leukocytosis, and the CT scan showed the left lower lobe was infected with atelectasis pneumonia.

The Medicare administrative contractor agreed. At the first level of appeal, the hospital won and got its money back.

(2) *A commercial payer rejected a principal diagnosis code of J96.01 (acute respiratory failure) for a 65-year-old patient.* It was replaced with J45.21 (mild asthma with exacerbation), which downcoded the MS-DRG from 189 (pulmonary edema and respiratory failure) to 203 (bronchitis and asthma without CC/MCC) — a reimbursement loss for the hospital of \$2,644. The reason for the change: the patient's arterial blood gas reading for oxygen in the blood wasn't low enough to qualify for hypoxic respiratory failure, and the documentation mentioned exacerbation of asthma. Wilson found this inexplicable because the history and physical stated the patient was at high risk for hypoxia, which is an oxygen deficiency, and noted "she is at great risk for respiratory failure." Her discharge diagnosis was acute hypoxemic respiratory failure.

In the appeal, Wilson put in a chart the clinical support for the diagnosis and the practice guidelines on acute respiratory failure (see box, p. 4). The appeal was successful.

Contact Wilson at dwilson@intersecthealthcare.com. View the reference book at <http://jnm.snmjournals.org/content/50/1/165.full.pdf>. Review the new sepsis criteria at <http://jama.jamanetwork.com/article.aspx?articleID=2492881>. ♦

Appealing Clinical Validation Denials (continued)

Laboratory:				
Test	Date(s)	Result	Reference Range	Page
Pulse Oximeter	2/2/16	87%	O2 Sat 95-100%	26
ABGs	2/3/16	pH 7.43 PCO2 – 27(L) PO2 – 89 HCO3 – 18(L) O2 97% with 50% O2	7.350-7.450 35.0-45.0 MMHG 80.0-100.0 MMHG 22.0-26.0 MMOL/L 95-100%	74
Source/Reference	Kaynar, A. M., Sharma, S. (2012). Respiratory Failure. Medscape Reference. As Found On: http://emedicine.medscape.com/article/167981-overview			
Evidence Based Guideline/ Practice Guideline Recommendation	<p>Hypoxemia is a major immediate threat to organ function. In respiratory failure the respiratory system fails in one or both of its gas exchange functions: oxygenation and/or carbon dioxide elimination.</p> <p>There are 2 types of failure, classified as follows:</p> <ul style="list-style-type: none"> • Hypoxemic respiratory failure (type I) - characterized by an arterial oxygen tension (Pa O2) lower than 60 mm Hg with a normal or low arterial carbon dioxide tension (Pa CO2). Common etiologies include: cardiogenic or noncardiogenic pulmonary edema, pneumonia, and pulmonary hemorrhage. • Hypercapnic respiratory failure (type II) - characterized by a PaCO2 higher than 50 mm Hg. Hypoxemia is common in patients with hypercapnic respiratory failure who are breathing room air. The pH depends on the level of bicarbonate, which, in turn, is dependent on the duration of hypercapnia. Common etiologies include: drug overdose, neuromuscular disease, chest wall abnormalities, and severe airway disorders (eg, asthma and chronic obstructive pulmonary disease [COPD]). <p>Acute respiratory failure is characterized by life-threatening derangements in arterial blood gases and acid-base status.</p> <ul style="list-style-type: none"> • Acute hypercapnic respiratory failure develops over minutes to hours, with a pH less than 7.3. • The distinction between acute and chronic hypoxemic respiratory failure cannot readily be made on the basis of arterial blood gases. <p>After the patient's hypoxemia is corrected and the ventilatory and hemodynamic status has stabilized, every attempt should be made to identify and correct the underlying pathophysiologic process resulting in respiratory failure.</p>			

Physician Rule Pays for More Telehealth, With a New Modifier

Medicare will pay for more telehealth services next year, but there are strings attached to this new reimbursement opportunity, according to the 2017 Medicare physician fee schedule regulation, which was released Nov. 2. The new telehealth-eligible services are critical care consultations, end-stage renal disease services and advanced care planning services. Aside from telehealth, doors were opened to payment for other services in the final regulation, including non-face-to-face prolonged evaluation and management services and behavioral health care management.

CMS is embracing telehealth, if incrementally. “Every year, they’re adding new services and new codes that can be provided by telehealth,” says attorney Richelle Marting, with the Forbes Law Group in Overland Park, Kan.

Medicare covers certain telehealth services provided in rural areas, which include counties outside of Metro-

politan Statistical Areas (MSAs) or in health professional shortage areas either outside of an MSA or in a rural census tract (*RMC 6/20/16, p. 3*). Telehealth services have to be delivered in an “originating site,” such as hospitals, physician practices and other approved locations. Providers must use face-to-face, interactive audio and video telecommunications systems that enable real-time communication between the distant-site provider and the patient at the originating site.

With revenue comes responsibility, and starting Jan. 1, distant sites have to put a new place-of-service code — POS 02 — on their claims when telehealth services are delivered in their facility. “CMS will use it to adjust relative value units to the facility practice expense for the service,” Marting says.

Until Jan. 1, providers report the POS code for the location where the patient would have been seen if the service were delivered in person. That muddied the waters of reporting telehealth places of service. Should providers located in an urban hospital report a hospital place of service where they are located, or use the physi-

CMS Transmittals and Federal Register Regulations

Nov. 4 – Nov. 10

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

- Implementation of Changes in the End-Stage Renal Disease Prospective Payment System and Payment for Dialysis Furnished for Acute Kidney Injury in ESRD Facilities for Calendar Year 2017, Trans. 229BP, CR 9807 (Nov. 4; eff. Jan. 1; impl. Jan. 3, 2017)

Pub. 100-04, Medicare Claims Processing Manual

- Updates to Chapters 8, 13 and 14 to Correct Remittance Advice Messages, Trans. 3650CP, CR 9841 (Nov. 10; eff./impl. Feb. 2, 2017)
- Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment, Trans. 3649CP, CR 9848 (Nov. 10; eff. April 1; impl. April 3, 2017)
- FISS Implementation of the Restructured Clinical Lab Fee Schedule, Trans. 3653CP, CR 9837 (Nov. 10; eff. Jan. 1, 2018; impl. April 3/July 3, 2017)
- Quarterly Update to the Correct Coding Initiative Edits, Version 23.0, Effective January 1, 2017, Trans. 3646CP, CR 9847 (Nov. 4; eff. Jan. 1; impl. Jan. 3, 2017)
- Therapy Cap Values for Calendar Year 2017, Trans. 3644CP, CR 9865 (Nov. 4; eff. Jan. 1; impl. Jan. 3, 2017)

Pub. 100-16, Medicare Managed Care Manual

- Update of Chapter 1 of the Managed Care Manual, Trans. 124MCM, CR 3892 (Nov. 10; eff./impl. Nov. 10, 2016)

Pub. 100-19, Demonstrations

- Oncology Care Model Monthly Enhanced Oncology Services Payment Rate for Certain Non-Physician Practitioners, Trans. 162DEMO, CR 9812 (Nov. 4; eff. April 1; impl. April 3, 2017)

Pub. 100-20, One-Time Notification

- Adding a Foreign Language Tagline Sheet to Medicare Summary Notices, Trans. 17480TN, CR 9617 (Nov. 8; eff./impl. Oct. 28, 2016)
- Issuing Compliance Letters to Specific Providers and Suppliers Regarding Inappropriate Billing of Qualified Medicare Beneficiaries for Medicare Cost-Sharing, Trans. 17470TN, CR 9817 (Nov. 4; eff. Dec. 6, 2016; impl. March 8, 2017)

Federal Register Regulations

Proposed Regulations

- Fire Safety Requirements for Certain Dialysis Facilities, 81 Fed. Reg. 76899 (Nov. 4, 2016)

Final Regulations

- Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record Incentive Programs; Payment to Nonexcepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing Program; Establishment of Payment Rates under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital (Fed. Reg. pub. date, Nov. 14, 2016)
- Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Medicare Shared Savings Program Requirements (Fed. Reg. pub. date, Nov. 15, 2016)

cian office place of service where the patient in a rural area is located? “This implicates whether the facility or non-facility practice expenses RVU is used for payment,” she says.

POS 02 solves the problem, Marting says. Distant site providers that report the new POS code will receive the facility physician expenses RVU, which is lower than the practice physician expenses RVU, she says. The POS code doesn’t apply to originating sites that are billing the facility fee. They continue to use the code that reflects the type of facility where the patient is located, Marting says.

Providers will continue to report the GT and GQ modifiers, which inform Medicare they provided services by telehealth. “However, CMS may eliminate those modifiers in the 2018 fee schedule if you report POS 02 and meet all other telehealth requirements,” she says.

Here are the telehealth services added to Medicare’s orbit in the 2017 physician fee schedule rule:

◆ **Critical care consultations:** CMS created new HCPCS codes (G0508 and G0509) to pay for critical care consults delivered by telehealth. “This new coding would provide a mechanism to report an intensive telehealth consultation service, initial or subsequent, for the critically ill patient, such as a stroke patient, under the circumstance when a qualified health care professional has in-person responsibility for the patient but the patient benefits from additional services from a distant-site consultant specially trained in providing critical care services,” according to the regulation. CMS limits this to one consult per day per patient.

◆ **Advanced care planning services:** CPT codes 99497 and 99498. “That’s a good code for providers to consider if they are discussing advanced care planning because it can be reported in addition to basic office visit or hospital visit codes,” Marting says.

◆ **End-stage renal disease services:** CPT codes 90967, 90968, 90969 and 90970.

There are other reimbursement opportunities in the Medicare physician fee schedule regulation. For one thing, Medicare will pay for non-face-to-face prolonged evaluation and management services (CPT 99358 and 99359) starting Jan 1. That includes the time providers spend poring over medical records before a visit with a complicated patient, Marting says. “Medicare has paid face-to-face prolonged service times for a while but now they are paying non face to face” — the time providers spend working on a patient’s case outside the visit, she says. But it must be time personally spent by the billing provider, and therefore doesn’t include nurse or administrative time or the pre- and post-service time already included in E/M visits. “From a compliance perspective, when you say you spend an hour in prolonged time, it

needs to be above and beyond the total valued service time of the related E/M service,” Marting says.

CMS will also pay physician practices separately for managing patients with behavioral health conditions. There are three models that involve care coordination between a psychiatric consultant or behavioral health specialist, behavioral health care manager, and the primary care clinician and are shown to improve outcomes. One of them is “psychiatric collaborative care,” which has three new codes: G0502, G0503 and G0504. The treating physician manages the patient in the practice and then employs or contracts with a behavioral health manager, who oversees the patient’s psychiatric condition and consults with a psychiatric consultant to review medications.

The patient must receive 70 minutes of services the first month and 30 minutes per month in subsequent months. The behavioral health manager’s time must be carefully documented because his or her time is counted toward the code at the end of the month, Marting says.

“There are a lot of definitions of the codes that providers have to keep in mind,” she notes. For example, there is incident-to billing. Time reported for some codes is for services provided by clinical staff, such as nurses trained in behavioral health activities, and it will have to be counted as nursing services provided incident to the treating physician. But CMS lightened the supervision load, changing it from direct to general supervision so the treating physician doesn’t have to be onsite, she says.

Three Compliance Tips

Because new services can introduce risk, Marting offers the following compliance suggestions:

◆ **Distinguish time.** “Many of the new codes can be reported in addition to other services provided during the same day or time period. The time used to count towards each service must be distinct and separate, and documentation should reflect that distinction,” she says.

◆ **Describe collaboration.** “When clinical staff or qualified behavioral health manager time is being reported, especially if they’re contract staff and not employees, documentation should show that there is collaboration and integration,” Marting says.

◆ **Describe work.** In addition to recording the duration, the activities should be described. “Specifically, providers should ensure they have a mechanism to document each of the required service elements within a service period before codes are reported,” she says.

The regulation will be published in the Nov. 15 *Federal Register*.

Contact Marting at rmarting@forbeslawgroup.com. View the rule at <http://tinyurl.com/gwdq5al>. ↵

OIG Releases Work Plan

continued from p. 1

The Work Plan, which is OIG's annual roadmap of audits and investigations, helps health care organizations develop their internal risk assessments. Sometimes, however, "when we see a lot of hospital work plans, they are still focused on covering areas based on the skill sets of the compliance department," says Kelly Sauders, a partner with Deloitte & Touche in New York City. For example, if compliance officers are unfamiliar with the post-acute space, they may be reluctant to do reviews there, she says. "But they should because they're on the OIG Work Plan," Sauders says. "As a compliance officer, you need to look across all risk areas that might exist in your organization."

At two health systems that own SNFs, compliance officers were providing very little oversight, says Wissler, who has been working with them. "None of their processes had been looked at" for years, she says.

The OIG Work Plan also has new hospital items besides PAC. They include hyperbaric oxygen therapy and incorrect medical assistance days. OIG will continue to perform Medicare compliance reviews and is still auditing compliance with the two-midnight rule and other risks, including the reporting of manufacturer credits for

replaced medical devices and overlapping Part A and Part B claims.

"There are still a lot of the oldies but goodies on the Work Plan, but it is much broader," Sauders says.

OIG moved surprisingly fast with a new item on chronic care management. Medicare only started paying physicians separately for chronic care management in 2015. In the past, Sauders says, there was a longer lag time between Medicare coverage of new services and their appearance on the Work Plan, but OIG's use of data analytics may expedite the identification of risk areas. She has seen firsthand that some providers don't understand all of the requirements for billing chronic care management. For example, Medicare doesn't allow billing during the same service period for both chronic care management and transitional care management, which also is on the Work Plan. For both items, OIG will audit whether providers billed simultaneously for these services and other mutually exclusive services.

Sauders suggests that compliance officers with oversight of physician groups focus on the use of chronic care and transitional care management codes. "Look at how they are used in combination with other services," she says. "That's a good example of how you could use data analysis."

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NEWS BRIEFS

◆ **Albert Einstein Healthcare Network and the Einstein Practice Plan agreed to pay \$968,418 to settle false claims allegations**, the U.S. Attorney's Office for the Eastern District of Pennsylvania said Oct. 28. They allegedly improperly billed on behalf of a cardiologist who no longer works there. The settlement stemmed from Albert Einstein's self-disclosure to the U.S. attorney's office. "According to the self-disclosure and the investigation that followed, between October 15, 2010 and January 9, 2012, bills were submitted to Medicare for services performed by the cardiologist which the United States alleges were not medically necessary or lacked sufficient documentation, resulting in overpayments to Einstein," the U.S. attorney's office said. Visit <http://tinyurl.com/h55ke6o>.

◆ **Medicare administrative contractors (MACs) will send letters to providers who may have overcharged patients enrolled in the qualified Medicare beneficiary (QMB) program for co-pays and deductibles**, according to *MLN Matters*

MM9817. Federal law bars providers from charging QMB enrollees coinsurance. "Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions," CMS says. "MACs will also send a copy of the compliance letter to the named beneficiary, with a cover letter advising the beneficiary to show the mailing to the named provider and verify that the provider corrected the billing problem." Visit <http://tinyurl.com/zb15lwf>.

◆ **A Springfield, Ill., psychiatrist will pay \$908,000, to settle allegations of false billing**, the U.S. Attorney's Office for the Central District of Illinois said Nov. 8. Duttala Obul Reddy allegedly billed Medicare and Medicaid for evaluation and management services provided at long-term care facilities when either the services were not provided or they weren't provided to the extent claimed, the U.S. attorney's office said. He was excluded from Medicare for 10 years. In the settlement, Reddy denied the allegations. Visit <http://tinyurl.com/zk8tvb6>.

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