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

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In Appeals, QIC Links Coding to Medical Necessity, Seems to Sideline CMS Transmittal

Some providers are finding that the protection they thought they had from their appeals of claim denials changing midstream isn't there after all. In a number of decisions, a qualified independent contractor has shifted its reason for denying appeals—from lack of medical necessity to coding errors—and linked the downcoding to medical necessity, an attorney says.

"They're trying to merge coding and medical necessity into the same concept, and they're not," says Richelle Marting, with the Forbes Law Group in Overland Park, Kan.

This subverts CMS's directions to Medicare administrative contractors (MACs), which decide the first level of appeals (redeterminations), and QICs, which decide the second level of appeals (reconsiderations), she contends. In a 2015 Medicare transmittal, CMS told MACs and QICs to quit messing with the rationale for appeals of claims denied after postpayment reviews (*RMC 8/24/15, p. 6*). It had been maddening for hospitals and physicians to defend against a coding denial, only to watch it turn into a medical-necessity denial at redetermination or reconsideration (and vice versa). Then last year, MACs and QICs were instructed not to pull a bait and switch on appeals of claim denials from prepayment reviews, according to a follow-up transmittal (*RMC 5/16/16, p. 4*).

But that's exactly what's happening, only with a twist, Marting says. At least one QIC is changing the appeals from medical necessity to coding, but then saying it's not really a big change because the downcoding is a matter of medical necessity.

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M.D.s are 'Spooked' by Scrutiny of Opioid Prescribing; Documentation Is Best Defense

It raised some eyebrows when Attorney General Jeff Sessions implied in a July 12 speech that the weight of the government will come down on physicians who write too many prescriptions for opioids.

"In Nevada, doctors are writing 94 prescriptions for painkillers per 100 residents. Unbelievable," he told an audience of state, local and federal law enforcers in Las Vegas. "You are all on the front lines of this fight."

With state and federal regulators and law enforcers taking a closer look at the prescribers of high-dose opioids, and in some cases starting to tighten the purse strings, providers and compliance officers may want to add reviews of opioid dispensing practices, oversight and documentation to their work plans, says Colorado attorney Jeff Fitzgerald, with Polsinelli.

"There is a real uptick of government enforcement related to potential diversion of prescription opioids," he says. Many people think of diversion as facility-based nurses stealing patients' drugs for their own use, but another version of diversion is high on the enforcement agenda: doctors writing opioid prescriptions at high doses or

continued

for patients who sell their pain medications. Because of this focus on prescriptions, "a lot of doctors are spooked right now," Fitzgerald says. "Providers need to implement compliance measures to protect their prescribers from enforcement activity because, despite the DOJ's rhetoric, prescription opioids are often clinically appropriate for chronic pain management."

The crackdown was loud and clear in the July 13 national "takedown" by the Department of Justice-HHS Medicare strike forces, the largest ever for health care fraud. The government was allegedly defrauded of $1.3 billion, and 120 of the 412 people charged with crimes are facing accusations in connection with prescribing and distributing opioids and other narcotics.

Meanwhile, the Food and Drug Administration on July 11 announced "a comprehensive action plan" to address the "growing epidemic of opioid abuse, dependence and overdose." Among other things, the FDA will change labels on immediate-release opioids and expand access to abuse-deterrent formulations.

There's action on the state level too. In Colorado, for example, on July 10, the Medicaid agency put very narrow curbs on the amount of opioid prescriptions it will pay for, Fitzgerald says. The first prescription is limited to seven days. After that, patients may receive two more seven-day refills. "A fourth refill request will require providers to obtain prior authorization from the Department" and possibly a consultation with a pain management specialist, according to a statement from the Colorado Department of Health Care Policy and Finance. Until this change, patients could receive a 30-day supply of opioids and additional refills as ordered by their physicians. Colorado Medicaid also implemented a cap on "morphine milligram equivalents" (MME). Starting Oct. 1, the daily max will drop from 300 MME to 250 MME.

On the clinical side, there may be a change in thinking about the use of opioids to manage chronic pain. In the July 18 *Annals of Internal Medicine*, researchers reported on a synthesis of 67 studies of strategies designed to reduce or end the use of long-term opioids for chronic pain. They found that "pain, function and quality of life may improve with opioid dose reduction," but noted the conclusions were limited by "poor quality studies with uncontrolled designs."

That could pose problems for providers if their prescribing practices are taken out of context, Fitzgerald says. "As a compliance lawyer, that concerns me because the government has a tendency to take current thinking and apply it retroactively," he says. "I worry an aggressive government lawyer might say, 'Doctor, when you prescribed a high-dosage opioid three years ago, that was wrong, even though the prescription was within the standard of care at the time.'"

As the scrutiny intensifies, Fitzgerald recommends physician practices and hospitals apply "classic compliance principles" to opioid usage. "Make sure your policies and procedures related to opioid prescriptions and drug diversion are up-to-date, he says (*RMC 12/21/15, p. 4; 9/22/14, p. 1*).

Tools for Managing Your Risk

Documentation also will be indispensable in the event of audits and investigations (see box, p. 3). "The higher the dose, the more you need to control your risks," Fitzgerald says.

Here are tools for physician practices to manage their risks when writing opioid prescriptions:

◆ The Prescription Drug Monitoring Program (PDMP): Every state has a database that physicians and pharmacies can use to check if controlled substances have previously been prescribed to a patient. This helps identify patients who are seeing multiple physicians for the same types of drugs. "It's a good process for providers to make sure the PDMP is reviewed appropriately, and a best practice is to review it every time a controlled-substance prescription is written," he says.

◆ Drug urinalysis: Patients' urine is tested for the presence of both the drugs they are supposed to be taking

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and illicit drugs. Physicians should test for both because the absence of the prescribed opioid may indicate the patient is selling rather than taking his or her medication and the presence of illicit drugs could put the patient at risk of harm (e.g., overdose).

◆ Treatment plans: Every chart should have a treatment plan that explains the patient's issues, especially with pain management and chronic pain. "In an ideal world, the treatment plan would include consideration of non-opioid pain-management methods, such as physical

Protecting MDs Who Prescribe High-Dose Opioids to Chronic-Pain Patients

With a nationwide opioid crisis and law enforcement pursuing physicians who are perceived as over-prescribing narcotic drugs, physician practices and their hospital employers may want to ensure their documentation is rock solid, says Denver attorney Jeff Fitzgerald, with Polsinelli. Before patients are given an opioid prescription, a nurse or medical assistant should run through the documentation in the chart. "Doctors understand if they write high levels of opioids, there is some risk to that, but if you document all the items in this checklist, you have controlled your risk," he says. "It would be hard for law enforcement to say the prescriptions were inappropriate." Physicians also may want to develop a separate process to document their reviews of opiate prescriptions for new patients and new injuries/pain. Contact Fitzgerald at jfitzgerald@polsinelli.com.

Existing Chronic Pain Patient Checklist

Separate process should be developed for new patients, new injuries/pain

Right Checks	Right Chart Note	Right Prescription
Patient chart reviewed and contains:	Note from today's encounter contains:	Today's prescription reviewed:
❑ Current PDMP confirming no unknown prescriptions or other physician prescribing opioids ❑ Urinalysis dated within __ days confirming presence of prescribed opioids and lack of others or illicit drugs ❑ Treatment plan and informed consent	❑ Current 5As of pain management ❑ Risk of abuse, addiction or referral for substance abuse treatment ❑ Statement addressing risk of diversion ❑ Statement addressing titration or discontinuation of opioid ❑ Statement addressing need for or compliance with pain contract	❑ Today's prescription is no more morphine equivalents than prior prescription ❑ Prescription for no more than __ day period ❑ No prescription for benzodiazepines or carisporodol

A separate policy should address:
❑ Process for lost prescriptions ❑ Process for referral to pain specialist ❑ Process for referral substance abuse treatment ❑ Process for titration or determination to not titrate ❑ Process for termination for noncompliance ❑ Clinical issues or standards potentially including o Max morphine equivalents o Combination of drugs o Short acting v. long acting o Marijuana and illicit drug use o Evidence of injury and pain

therapy and exercise, as well as consideration of a titration timeline," he says.

◆ Pain-management contracts with high dose or potentially noncompliant patients: These contracts make the patient specifically agree to comply with certain conditions (e.g., following the care plan, taking medications on time, refraining from using alcohol, not sharing pills with others, not seeking pain medications from other providers) in return for continuing to receive prescriptions.

◆ Caps on refills: While there is significant potential for physicians to disagree about the clinical standards, some providers are placing a hard cap on the amount of morphine equivalents that may be prescribed, he says. Other providers are implementing peer review type processes for patients who are being treated with high dose opioids, Fitzgerald says.

◆ Other policies around practical aspects of long-term chronic pain management: They include when patients should be referred to pain specialists, weaned from opioids and terminated from the practice for noncompliance with medication use.

Contact Fitzgerald at jfitzgerald@polsinelli.com. View Jeff Sessions' speech at http://tinyurl.com/y8r-mz9hq and the *Annals of Internal Medicine* article at http://tinyurl.com/y7aeugqo.✧

M.D. Settles FCA Case for $4M Over Modifier 57, Patient Charges

A Florida physician agreed to pay $4 million to settle false claims allegations over the misuse of modifier 57 and billing for medically unnecessary assistants at surgery, the U.S. Attorney's Office for the Middle District of Florida said July 24. James Norman, M.D., owner of Norman Parathyroid Center in Wesley Chapel, also allegedly charged Medicare patients directly for an initial phone consultation and data entry.

The case was set in motion by two whistleblowers: former patient Myra Gross, a Medicare beneficiary, and her husband, David, a retired podiatrist. The whistleblowers alleged that Norman engaged in misconduct in connection with his performance of parathyroid surgery from April 2008 to December 2016.

According to the complaint, Myra Gross was waiting to have surgery when another surgeon from the practice stopped by for a brief visit. It was billed as CPT code 99204—new patient office visit or other outpatient visit, typically 45 minutes long—with modifier 57, the complaint says. The charge for CPT code 99204-57 and similar charges for other patients allegedly were false because there was no office or outpatient visit. There was only a quick pre-surgical "meet and greet," which didn't rise to a level four evaluation and management (E/M) service, partly because the surgeon didn't examine the patient. And the requirements for modifier 57 weren't met.

Norman Parathyroid Center also allegedly billed for the services of an assistant surgeon, which must be medically necessary. But that wasn't the case, the complaint alleged; "The surgery only took 18 minutes, and the incision is only approximately 14 minutes long."

Medicare patients who lived outside the Tampa Bay area were required to pay, out of pocket, fees of $750 to $1,750 for "the assimilation and organization of their medical chart" into the Norman Parathyroid Center database, chart review by one of its physicians and a phone consultation, the complaint alleged.

Mistakes Around Modifier 57

Modifier 57 is appended to an E/M service provided on the day before or the same day of a procedure when a decision is made to perform a major procedure, says George Blake, a specialist master with Deloitte & Touche in Philadelphia. The modifier bypasses edits that prevent separate payments for pre and post op visits that are bundled into the procedure during the 90-day global period.

"The use of modifier 57 means the initial decision for surgery was made during that visit, and documentation better support it. So if the procedure was scheduled before the visit, by definition it doesn't meet the definition of the modifier," says Laura Siniscalchi, a specialist leader with Deloitte & Touche in Boston.

In other words, a last-minute check to make sure the patient is still in good health and appropriate for surgery is part of the global surgery payment, notes Christine Anusbigian, a specialist leader with Deloitte & Touche in Detroit.

Modifier 57 is "sometimes misunderstood," Blake says. It may be inappropriately attached when the surgery isn't performed for a week or two or it's used by a physician who doesn't perform the surgery. "It should only be used by the surgeon rather than someone who will recommend the surgery," he cautions. "You shouldn't see a high volume of it. That would be a red flag."

Also, if patients see their physicians a few days before surgery for other reasons, the physicians would get paid and don't need a modifier, Siniscalchi says. But if the documentation states that the visit is to get cleared for surgery, "the medical necessity of that is in question because it's part of the global surgery."

Norman's alleged patient charges also appear to violate the Medicare participation agreement, says

Ed Gaines, chief compliance officer of the emergency department division of Zotec Partners in Greensboro, N.C. Physicians who accept Medicare assignment can't charge patients directly for administrative services, such as chart review, or to recover the difference between their charges and Medicare reimbursement, which is known as balance billing, he says.

There's Little Room for Patient Charges

As the Medicare participation agreement states, "For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the MAC/carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more agreement becomes effective."

Participating clinicians must bill the Part B Medicare administrative contractor (MAC) for covered services, the MAC adjudicates the claim and issues the explanation of benefits and then the clinicians can bill the beneficiaries for their co-insurance or charges if the Part B deductible is not met, Gaines says. "So direct billing of Medicare patients is very limited," Gaines says.

The U.S. attorney's office did not respond to a request for comment on how charging patients extra would defraud the government or why the patient's husband has standing to be a whistleblower.

Norman didn't admit liability in the settlement.

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With EMTALA and Behavioral Health, 'Stabilizing' Patients Can Go Awry

When suicidal, homicidal or psychotic patients show up in the emergency room, they must be stabilized in compliance with the Emergency Medical Treatment and Labor Act (EMTALA), which can be a far different experience than with pneumonia or heart attacks. Determining when psychiatric patients are stable for discharge or transfer to a psychiatric facility is not always clear-cut, but pressure is mounting on hospitals and physicians to improve their policies and procedures. One out of every eight emergency department (ED) visits is for mental health or substance abuse disorders, the fines for EMTALA violations recently doubled and civil monetary penalty settlements have focused on psychiatric cases.

EMTALA requires hospitals to give "medical screening exams" to all patients presenting to the emergency room, regardless of ability to pay, and to stabilize them if they have "emergency medical conditions" (EMCs). To "stabilize" an emergency medical condition means "to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility…"

But that regulatory language provides little practical guidance for hospitals when it comes to patients with mental health conditions that can't be quickly stabilized, said Austin, Tex., attorney Catherine Greaves, with King & Spalding. "If patients have a serious mental illness, you are not going to cure it in the ED in the same way you might cure an infection with antibiotics. It is one of the risks hospitals face dealing with the mental health population." A strict reading of EMTALA obligations of screening and stabilizing patients under EMTALA only gets you so far, she noted. "That is not CMS's interpretation" in the behavioral health context, she said. For example, a patient may be stabilized with chemical or physical restraints for a period of time to be transported to another facility, "but be aware the underlying condition may not be fully stabilized and CMS requires this to be taken into consideration," Greaves said.

CMS Transmittals and *Federal Register* Regulations
July 21 - 27

Live links to the following documents are included on *RMC*'s subscriber-only webpage at www.hcca-info.org. Please click on "CMS Transmittals and Regulations."

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS), Trans. 3811 (July 25, 2017)
- October 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files, Trans. 3809 (July 21, 2017)

Pub. 100-03, Medicare National Coverage Determinations

- Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS), Trans. 200 (July 25, 2017)

Federal Register

Proposed Regulation

- Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program, 82 Fed. Reg. 33950 (July 21, 2017)

Hospitals should brace for more challenges with behavioral health patients and EMTALA, Greaves said at a Health Care Compliance Association webinar on July 25. "We have 10% of the state inpatient psychiatric beds available that we had in the 1970s"—14 beds per 100,000 patients, compared to England's 54 beds per 100,000 patients. "There often aren't places to send people," she said. "Their families are turning to the ED as a way to obtain care for their loved ones."

Some hospitals are running afoul of EMTALA with respect to psychiatric EMCs. In June, AnMed Health in South Carolina agreed to pay $1.295 million—the largest civil monetary penalty settlement ever in an EMTALA case—over allegations its hospitals kept some psychiatric patients in their emergency rooms for days or weeks at a time, even though they had on-call psychiatrists and inpatient mental health units (*RMC 7/24/17, p. 1*).

How Stable Is Stable?

People with psychiatric EMCs may be a danger to themselves or others, have a lack of orientation that interferes with their ability to meet basic needs (e.g., nutrition, safety) or have an underlying mental illness. For example, patients may be suicidal or homicidal, assaultive or combative, or delusional.

The medical screening exam for psychiatric patients typically has two steps: (1) an initial exam to rule out organic causes of the mental disorder and (2) a psychiatric review. "It's important for physicians not to ignore medical screenings with psychiatric patients or just do cursory screenings. Greaves said. "Just because they're in a psychiatric crisis doesn't mean they're not having issues with diabetes or hypertension that's out of control, which puts them at risk of a stroke," for example, she said. Not all behavioral health patients will require exhaustive lab work (e.g., a healthy patient who presents with a panic attack). It depends, which is why hospitals should have policies and procedures clinically on how to assess behavioral health patients, Greaves said.

MSEs should not be confused with triage, said Houston attorney Kristin Roshelli, with King & Spalding. "The medical screening exam is not the same as triage," she said. "It determines whether an emergency medical condition exists, not the order to be seen."

In the ED, hospitals may be able to remove the imminent danger—preventing patients from harming themselves or others—but if their underlying emergency medical condition is still there, then what? How stable is stable? "One of the key things in deciding how stable the patient is will be communication within the ED," Greaves said. The physician may say the patient is not suicidal anymore, while the nurse or other staff member speaking to the family learns that the patient was still talking about killing himself on the way to the hospital. "There needs to be a way to pass that information to the physician, who can use it in making the determination about whether the patient is stable enough to transfer or discharge" or should be admitted, Greaves said.

Patients may be transferred when hospitals lack the capacity to treat them, and receiving hospitals must accept transfers if they have the capability to treat the patients, according to EMTALA. Hospitals may consider the use of chemical or physical restraints long enough to stabilize the patient for transfer to an inpatient psychiatric hospital or unit of another hospital, but again, that doesn't address the underlying psychiatric emergency medical condition, which CMS says must also be considered.

Some Unstable Patients May Be Transferred

The challenge with transfers of psychiatric patients is they may take hours, especially in rural areas, and medications administered to stabilize patients could wear off. There are counties in Texas, for example, that have no hospital, and it could take hours to get the patient to a hospital with an inpatient psych unit that can accept the transfer, Greaves observed. What kinds of medicines will last long enough to make the transfer? Does the hospital have teams on hand that are capable of stabilizing the patient? Is appropriate transportation equipment available? "Physicians have to take this into consideration when determining whether patients are stable enough to transfer," she said.

Sometimes psych patients can't be stabilized. Then physicians admit them, or they transfer them anyway. "If you can't stabilize the patients, the facility may keep them in the ED long enough with the belief they can be stabilized for transfer," she said. Transferring an unstable patient under EMTALA may sound risky, but it's allowable if the benefits outweigh the risks, Greaves said. It's a five-step process:

(1) Provide medical treatment to minimize risks to the patient.

(2) Arrange for the receiving hospital to accept the transfer.

(3) The physician certifies in writing the transfer outweighs the risk to the patient.

(4) The transfer is accomplished with qualified personnel, transportation and equipment.

(5) Copies of the patient's medical records are sent to the receiving facility.

All of this has to be amply documented to prevent EMTALA violations, she emphasized. Transferring unstable psych patients "will be extremely difficult to

explain" if the hospital has an inpatient psych unit, Greaves noted. "There have to be specific reasons why the patient was transferred" (e.g., the patient requests to be transferred to a different facility in writing after being informed of the risk and has the mental capability to make the request).

No Type of Vehicle Is Foolproof

The process of transferring behavioral health patients invites more risk. Things have gone awry in transfers, and there have been EMTALA cases as a result. For example, Research Medical Center in Kansas City, Mo., agreed to pay $360,000 in a CMP settlement over alleged EMTALA violations after an investigation revealed that a patient was hit by a vehicle during a transfer to another hospital—and 17 more violations were found, OIG said (*RMC 1/30/17, p. 1*).

Sometimes patients are "boarded" in the ED while awaiting transfers to psychiatric facilities. "If you're going to transfer a patient after they've waited hours or days in the ED, they have to be re-evaluated," Roshelli said. The physician should confirm the patient is stable for transfer and record the time, and vital signs should be taken again. "If they were determined to be stable the day before and have been waiting for a bed in another hospital, 24 hours later is not good enough," Roshelli said. "CMS wants to know they were stable at the time of transfer, because patients could have had medical or psych issues intervene in the meantime."

For behavioral health patients, the stakes are higher with the types of vehicles used for transfers. "Not a single vehicle is foolproof," Roshelli said. Vehicles should be safe, but preserve the patient's "humanity and dignity." Ambulances are full of objects that can be used to harm themselves or others and there's no barrier to protect the driver from an aggressive patient. The police can be called to transport a psych patient, but that can be stigmatizing and traumatic for patients, and "there may be no established protocol for the safe transport of behavioral health patients," Greaves said. Police may be required to put psych patients in handcuffs even though they're not criminals, she said. And private vehicles are asking for trouble under EMTALA, she noted. They're not out of the question if the patient is voluntarily seeking treatment, but it probably will be hard to show the arrangement meets the requirement for "appropriate personnel and transportation equipment."

It's something to keep in mind now that the fines for EMTALA violation increased in December 2016. For example, for hospitals with more than 100 beds, they doubled from $50,000 per violation to $103,139.

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Appeals Link Coding, Medical Necessity

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"Unless further CMS direction on this issue is provided, I believe that CMS's instruction is essentially meaningless," Marting says. "A contractor can always find a way to tie medical necessity into their denial decision."

This development may force a change in appeal strategy, Marting says. Providers may have to cover all coding and medical necessity arguments as they begin the appeal journey instead of rebutting the specific reason for the claim denial. Otherwise, they may not be able to provide additional evidence in support of their appeals if the QIC shifts from medical necessity to coding since they can't add evidence to the case file after reconsideration without just cause, she explains. But there's some risk here because "maybe you're tipping the reviewers to things they wouldn't have considered," she says. "It's kind of a strategy decision."

From No Payment to Some Payment

In a number of cases, the MAC, in its role as claims processor, denied claims for evaluation and management services as medically unnecessary, and then the MAC, at redetermination, upheld that decision. On appeal, the QIC was convinced otherwise—the services were appropriate, but the E/M services should have been billed at a lower level because they weren't medically necessary at the higher level.

The apparent contradiction has played out in letters that one medical group received from the QIC. Several years ago, the medical group, which treats patients in skilled nursing facilities, started receiving 100 to 150 prepayment requests for medical records every month from Wisconsin Physician Services (WPS), its MAC. WPS ultimately denied most of the claims for lack of medical necessity, which meant no payment would be forthcoming.

At reconsideration, the QIC, C2C Solutions, agreed the physicians in the medical group should be paid something for more than half the claims—in other words, the patients needed to be seen—but not at the level of service they billed for. In a letter to the physicians that confounds Marting because it seems to state the QIC won't mix and match coding and medical necessity, the QIC wrote that, "When the medical record supports a higher or lower level code, the Medicare contractors shall not deny the entire claim but instead shall adjust the code and adjust the payment. Medicare contractors shall upcode or downcode when it is possible to pay for the item or service actually provided without making a reasonable and necessary determination…"

But the QIC also linked the two concepts, noting that, "It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted."

To the physicians, it's a victory to get some of their money back after facing wholesale denials, but it's an alarming development overall. "The decision says that level of service and medical necessity are the same reason for denial," Marting says, and that's contrary to Sec. 1861 of the Social Security Act and the Medicare Program Integrity Manual (100-08). As the Program Integrity Manual notes, in different sections, clinical reviewers should make medical necessity determinations (Chapter 3, Sec. 3.3.1.1.A) and certified coders should perform coding determinations (Chapter 3, Sec. 3.6.2.4).

'It Will Come Up in Every Audit I'm Appealing'

Marting asked the QIC's legal division to review the decision in light of Medicare's transmittals. She prefers a complete reversal of the claim denials—and full payment—because she believes the medical group's services are medically necessary and even the QIC acknowledged the MAC made a mistake in declaring them not reasonable or necessary outright. After spending three months thinking it over, the QIC declined on the grounds that "reviewing the level of service is part of medical necessity," she says.

It's unfortunate because the physicians treat patients who are in skilled nursing facilities after discharge from the hospital for rehab from strokes and other acute conditions, she says. "They aren't stable nursing-home patients," she notes. "They are patients who days or weeks prior were often in serious medical condition in the hospital." The physicians have provided services designed to prevent complications and readmissions, Marting contends. "The medical group is happy that Medicare recognized the difference between patients in nursing homes and patients who are post-acute and need a lot of medical attention." But the physicians are still pursuing full payment before an administrative law judge. Until the matter of conflating medical necessity and coding is resolved and the QIC glossing over the transmittal is addressed, "it will come up in every audit I am appealing," Marting says.

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NEWS BRIEFS

◆ **Pain Management Group P.C., (PMG) in Antioch, Tenn., agreed to pay $312,000 to settle false claims allegations over medically unnecessary urine drug tests and non-FDA approved pharmaceuticals,** the U.S. Attorney for the Middle District of Tennessee said July 24. PMG allegedly submitted false claims to Medicare and TennCare, the Medicaid program, for Botox, Supartz, and Eufflexa that it bought from foreign suppliers and administered to Medicare and TennCare patients during 2014 to 2015, the U.S. attorney's office said. The government started investigating PMG "after extensive data analysis identified PMG as a potential outlier in the provision of urine drug testing to Medicare patients," the U.S. attorney's office said. "Once informed of the investigation, PMG cooperated and instituted remedial measures to address the United States' allegations." Visit http://tinyurl.com/ybptuty2.

◆ **CMS on July 25 issued the 2018 proposed payment regulations for home health agencies and floated a redesign of the payment system for 2019.** The rule has proposals to refine the home health prospective payment system case-mix adjustment methodology, "including a change in the unit of payment from 60-day episodes of care to 30-day periods of care, to be implemented for periods of care beginning on or after January 1, 2019. Additionally, the proposed rule includes proposals for the Home Health Value-Based Purchasing Model and the Home Health Quality Reporting Program." View a fact sheet at http://tinyurl.com/y878zrah.

◆ **A Houston physician was convicted for his role in a $1.5 million health fraud scheme involving home health care and medical testing,** the U.S. Attorney's Office for the Southern District of Texas said July 21. A federal jury convicted Ronald F. Kahn, M.D., of one count of conspiracy to commit health care fraud and one count of conspiracy to pay and receive illegal kickbacks. The U.S. attorney's office said that from about 2006 to 2013, Kahn and others submitted fraudulent claims for home health care services in connection with Allied Covenant Home Health, Inc., in Houston. Kahn admitted patients to Allied even when they didn't qualify for home health services. "To make it appear that these patients did qualify, Kahn falsified medical records and signed false documents purporting to show that patients admitted to Allied's home health program satisfied Medicare's requirements for admission, the evidence showed," according to the U.S. attorney's office. Visit http://tinyurl.com/y8r5w4lu.