Report on
MEDICARE COMPLIANCE

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

Contents

CMS Focuses On Correct Dates of Service; They May Not Always Fit With Charge Process

In new guidance, CMS cautions providers to put the correct date of service on their claims, with an emphasis on when the service is completed as opposed to when it begins. There's concern this could disrupt charging systems, which generally are set up to expect some action when services are provided, and could open the door to claim denials if the documentation that providers turn over to auditors doesn't cover all the dates of service, a compliance officer says.

In a Sept. 19 *MLN Matters* (SE17023), CMS tells providers to "determine the Medicare rules and regulations concerning the date of service and submit claims appropriately" and ensure their "billing and coding staffs are aware of this information." The guidance, which is aimed at providers who bill Part B, covers a wide range of services: radiology, pathology, surgery, home health, diagnostic and neuropsychological tests, maternity benefits, end-stage renal disease, cardiovascular monitoring, labwork, care plan oversight, transitional care management and prothrombin time (PTT) monitoring.

There's a theme to the MLN, says Stephen Gillis, director of compliance coding, billing and audit at Partners HealthCare in Boston. If the services start and end on different dates, "CMS is saying you bill at the completion date," he says.

continued on p. 7

IRF Claim Denials Are Mounting; Auditors Use Coverage Guidelines, Eye Physician Notes

After reviewing a sample of inpatient rehabilitation claims from Hackensack Meridian Health Network, the Medicare administrative contractor (MAC) for New Jersey denied most of them, an outcome familiar to inpatient rehabilitation facilities (IRFs) across the country. It was a wake-up call for the health system, which has a 30-bed inpatient rehab unit. Medicare pays for medical and therapy services provided at IRFs, and with compliance and revenue at stake, Hackensack Meridian Health Network made immediate moves to improve compliance with the exacting coverage guidelines.

"It will put your service line in serious jeopardy if you don't put in a corrective action ASAP," says Peter Hughes, director of corporate compliance at Hackensack Meridian Health Network. The IRF's case manager now reviews the documentation in every chart every day to ensure it meets the coverage requirements, and its rehab physicians have received intensive training.

IRFs are feeling the heat from auditors of all stripes, including the supplemental medical review contractors (SMRCs), MACs and recovery audit contractors (RACs). "And there are isolated audits from the HHS Office of Inspector General and zone program integrity auditors," says Jane Snecinski, president of Post Acute Advisors in Atlanta. "IRFs are getting hit on all sides," she says. "Many providers audited by the SMRCs had 100% denials."

They are audited against a series of answers to frequently asked questions posted on the CMS website in 2009, says Catherine Gill, director of clinical and rehabilitation

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services at LW Consulting in Harrisburg, Pa. The FAQs address the 2010 Medicare coverage guidelines for the IRFs. "Make sure your documentation meets these expectations—that's my number-one recommendation. They should be required reading for everyone," she says.

A more recent emphasis of audits is whether physicians demonstrate medical necessity for admission, Gill says. "They may be in compliance with the technical coverage requirements, but do the rehab physicians in their documentation make a good case that patients need a rehab level of care and couldn't be cared for in a skilled nursing facility?" Gill says. "That's a more subjective piece and harder to argue. It relies on clear physician documentation."

Improving compliance is a matter of urgency because auditors continue to find high levels of errors, Snecinski says. For example, Wisconsin Physician Services (WPS), a MAC, posted the results of a recent audit of inpatient rehabilitation facility Part A stays billed with case mix group 07XX or 08XX. WPS audited 271 claims between April 1, 2017, and June 30, 2017, and declared a 79% error rate. The claims were denied because documentation didn't support the patient's need for intensive rehab, documentation didn't show that the patient's medical management and rehab needs called for an inpatient stay and close physician involvement, and/or documentation wasn't adequate to meet Medicare technical requirements and medical necessity guidelines.

Claim denials are particularly hard to swallow with IRFs. Denial rates of 80%—which is what happened in New Jersey, where Novitas Solutions, the MAC, denied 16 out of 20 claims reviewed—cost the Hackensack Meridian Health Network IRF $350,000 to $400,000, Hughes says. "The results were consistent across a lot of providers," he says.

Audits Follow Six Coverage Guidelines

Everything comes back to the coverage guidelines. "They've been in place for seven years," Snecinski notes. "IRF providers have had enough time to get them right." The coverage guidelines are:

(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.

(2) Post-admission physician evaluation (PAPE): 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.

(3) Individualized plan of care (IPOC): The physiatrist has four days to synthesize a plan of care in collaboration with the interdisciplinary team. The plan of care establishes the length of stay, defines the medical prognosis, and identifies the patient's discharge destination and goals for recovery and should address both medical and rehab issues.

(4) Medical supervision: The physiatrist must have three face-to-face visits with patients every week. The content of the note should reflect medical status, functional status and progress made as a result of participation in the program.

(5) Intensity of therapy: Patients must receive three hours of medically necessary therapy five days a week, and they have to truly participate in the therapy and benefit from it. Medicare also accepts 900 minutes of therapy averaged over seven days if identified by the rehab physician.

(6) Team conference: The interdisciplinary team (doctor, nurses, case manager/social worker, therapists) has to meet weekly during the patient's stay.

The coverage requirements were the focus of compliance reforms at Hackensack Meridian Health Network. Its IRF did "extensive training with the physicians," Hughes says. There's no way to get the documentation done in time without the physiatrists' cooperation, and because they're not employed, "they don't dance to our drum all the time," he notes. "You have to impress upon

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them that without documenting what's required, you end up with technical denials. You have to convince them to be team players." The vice president of clinical effectiveness, who is a physician, meets with the physiatrists one-on-one, and the IRF has a medical director to continue the documentation education. That works with 90% of physicians, but some resent Medicare rules and rebel, Hughes says.

IRF Does Daily Document Reviews

The IRF also added a daily review of all documentation (e.g., PAPE, IPOC) to ensure it's in the chart before patients are discharged, Hughes says. "We struggled to find a person to do this because it's extremely time consuming," he says. It's a team effort, and "everyone recognizes this. Otherwise the claims will be denied." The daily review was assigned to a case manager, using a checklist for consistency (see box, p. 4). For example, if a patient is going to fall short of the physical, speech or occupational therapy minutes required by the coverage guidelines—three hours a day, five days a week, or 900 minutes spread over seven days—the case manager will ask the therapist to document an explanation for the shortfall (e.g., the patient was unable to complete the session), Hughes says.

The IRF also holds patient records after discharge until there's certainty all the documentation is where it should be, excluding the discharge summary, until the unit auditor gives it one last look. Holding charts affects coding and billing, and the IRF is doing it less now that it reviews documentation daily. "It's an additional incentive to get the job done right because discharged not final billed is a big stat in hospitals," he says.

Therapy documentation has been another challenge. It turned out the electronic health records (EHRs) weren't retaining all the therapy notes, "so we didn't have primary source documentation," Hughes says. "We had to work with the whole team—the physician, case manager and therapists—to understand CMS's expectations with splitting minutes so the IPOC could be designed accordingly."

This area lacks clarity, Gill says. Medicare pays for individual, concurrent and group therapy, but in the expensive IRF setting, CMS has conveyed that the "preponderance" of therapy should be individual. However, CMS never defined what constitutes preponderance, and MACS are denying claims if IRFs don't clearly determine how much time was spent in concurrent therapy (two patients working on different goals but treated simultaneously) or group therapy (patients working on the same goal) as opposed to individual therapy, she says. "It's something new we are seeing from the MACs: denials simply because the documentation is unclear in defining how much time was spent 1:1 versus in group sessions," Gill contends.

IRFs will continue to be hammered by audits unless their documentation shows compliance with the coverage guidelines, Gill and Snecinski say. "The requirements are the requirements. They are going to make sure every single element is met," Gill says. If not, payment for the entire admission is out the window.

Despite the risk to payment, spotty documentation continues. Partly it's because clinicians "want to take care of patients, and they know what they've done and that it's appropriate." But if they stick to the basics, it's not that hard to meet the Medicare documentation requirements, she says. "Get rid of the garbage and just say how this intervention was done to address this deficit and that it helped me address this goal or how you adjusted your treatment plan because you saw this was happening. Just a sentence or two," she says. "It doesn't have to be a long narrative."

Physicians also don't do IRFs or themselves any favors with documentation shortcuts in the electronic health records (EHRs). Many physicians copy and paste or copy forward earlier notes into subsequent notes, leaving out their medical and functional updates from face-to-face visits, Snecinski. "This results in denials because there's no demonstration of medical necessity that supports the need for an IRF bed, she says. And physicians may put their own reimbursement at risk. "I can't imagine CMS is willing to pay for a note that reflects no new information," she says.

CMS Transmittals
Sept. 15 - 21

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

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) — January 2018, Trans. 3861 (Sept. 15, 2017)
- Annual Clotting Factor Furnishing Fee Update 2018, Trans. 3862 (Sept. 15, 2017)
- Updated Editing of Always Therapy Services — MCS, Trans. 3863 (Sept. 15, 2017)
- October 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS), Trans. 3864 (Sept. 15, 2017)

Pub. 100-20, One-Time Notification

- Targeted Probe and Educate, Trans. 1919 (Sept. 15, 2017)

Checklist for Reviewing Compliance with the IRF Coverage Guidelines

This is a basic version of a checklist used by Hackensack Meridian Health Network in New Jersey to ensure its inpatient rehabilitation facility (IRF) meets all of Medicare's exacting coverage requirements, says Peter Hughes, director of corporate compliance. The documentation is reviewed daily in the patient's chart by the IRF case manager, he says. Of the 1,100 IRFs in the country, 834 are distinct part units in short-term acute-care hospitals, and they are vulnerable to audits. Contact Hughes at peter.hughes@hackensackmeridian.org.

Inpatient Rehabilitation Facility (IRF) CMS Audit Tool

[Pick the date]

Patient Label	H&P – 24 Hr.	Post-Admission Physician Evaluation (PAPE) – 24 Hr.	Individualized Plan of Care (IPOC) – 48 Hr.	Pre-Admission Screening Form 48 Hr. Prior to Admission	Physician Admission Orders Signed by Day 5	Signed IRF –PAI Consent	Weekly Team Rounds Forms & Signatures	Therapy (PT, OT or ST) Initiated Within 36 Hours	900 Minute Compliance	Reason 900 Minutes Not Met	Individual Therapy Minutes ≤75%	Therapy Type Documented
												PT OT ST
												PT OT ST
												PT OT ST
												PT OT ST
												PT OT ST

Here are other tips for IRFs to reduce claim denials:

◆ Consider an internal concurrent case management system, Snecinski says. "It's almost a necessity to help physicians meet the coverage guidelines," she says. "You don't let the EHR run your physician documentation. Make it individualized and unique for at least three days on the face-to-face visit required for coverage guidelines." Teaching hospitals have to be alert to residents and interns completing the PAPE, progress notes and the IPOC because "that's not OK with CMS."

◆ Review the chart before responding to additional documentation requests. Make it easy for auditors to find notes that fulfill the coverage requirements and don't confuse them by changing terminology. If the IPOC is called the initial team conference in your EHRs when you print it out, rename it the IPOC when you submit the medical records, Snecinski says. It may seem like components are missing if auditors can't readily identify them by the title.

Contact Hughes at peter.hughes@hackensackmeridian.org, Gill at cgill@lw-consult.com and Snecinski at jane.snecinski@postacuteadvisors.com. View the FAQs and other IRF information at http://tinyurl.com/ycyaa6mz. ✧

IPPS Rule Clears Another Path for Perks of Rural Reclassification

Urban hospitals now have the formal go-ahead from CMS to become rural hospitals on paper without losing wage-index advantages, which is a good deal for many hospitals. The final 2017 inpatient prospective payment system (IPPS) regulation loosened the requirements for rural reclassification after CMS lost two court cases over simultaneous rural and wage-index reclassifications, and the 2018 IPPS regulation liberalized an important deadline that paves the way for reclassification. It's an open road now to rural classification, and often the pros outweigh the cons, an attorney says.

"For some hospitals, it's a no brainer. They get all the benefits of being rural and never have to touch the rural wage index," says Washington, D.C., attorney Daniel Hettich, with King & Spalding. "Rural hospitals are a favored creature in Medicare. They get all sorts of benefits because they are vulnerable." For example, rural reclassification confers benefits in the comprehensive care for joint replacement model. While rural hospitals are eligible for the 20% bonus, their penalty is capped at 5%, he says.

"People were worried this is too good to be true and it would be frowned on if hospitals took advantage of this new opportunity," he says. "But CMS put out the 2018 rule, making the process easier, and I think hospitals are getting more comfortable as other hospitals are coming on board."

Hospitals have always been free to reclassify as rural if they have 275 beds and are eligible to be a rural referral center (RRC) because the relevant statute, including 42 USC 1395ww(d)(8)(E)(ii)(111), says hospitals can reclassify as rural if they'd qualify to become a rural referral center (RRC) if they were rural. "Since a rural hospital with 275 beds qualifies to become a rural referral center, an urban hospital with 275 beds will qualify for referral reclassification," Hettich says. But the matter of wage-index reclassification got in their way. The wage index is a measure of the geographically adjusted labor costs, and it figures into DRGs, APCs and other Medicare prospective payments because paying people is the lion's share of most hospital budgets.

Hospitals Won Anti-Stacking Battle

When hospitals are treated as if they're in a rural area, they assume the rural wage index. Hospitals had another idea in mind. They wanted to continue to align their wage index with the most favorable urban area, Hettich says. But CMS has long maintained that hospitals could only have one reclassification in place at a time, saying both reclassifications violate its so-called anti-stacking rule (42 C.F.R. § 412.230(a)(5)(iii)(2000)). CMS's position took the wind out of the sails of rural reclassification because the rural wage index tends to be lower than the urban wage index, he says. If hospitals were going to lose millions of dollars from the wage index, rural reclassification became a lot less appealing, despite all the other benefits, which include more lenient criteria for the 340B drug-discount program, he says.

Hospitals that were stuck with either/or reclassification appealed CMS's anti-stacking rule in federal court, and won. In two cases—Geisinger Community Medical Center v. Secretary United States Department of Health & Human Services (U.S. Court of Appeals for the Third Circuit) in 2015 and Lawrence + Memorial Hospital v. Burwell (U.S. Court of Appeals for the Second Circuit) in 2016—judges nullified the anti-stacking rule.

So CMS let it go, Hettich says. "After CMS lost twice, they specifically addressed it and made it easier for hospitals to stack rural reclassification and wage-index reclassification," he says.

'CMS Is Not Overtly Hostile to These Arrangements'

The end of the anti-stacking rule came in an interim final regulation in 2016, which said urban hospitals that reclassify as rural can also seek reclassification for wage-index purposes. "Even better, CMS said if you become a rural hospital, any existing urban wage-index reclassification stays in place, Hettich says. This was finalized in the 2017 IPPS. In the 2018 IPPS regulation, CMS clarified that hospitals could submit proof of RRC status to the Medicare Geographic Classification Reclassification Board (MGCRB) after their application had been submitted but before a decision was reached, he says. Also, CMS amended its policy so a hospital's RRC status only had to be approved at the time of the MGCRB's review, even if the effective date for the RRC status was some time later. "That's a nice benefit, but perhaps more importantly, it's an indication that CMS is not overtly hostile to these arrangements," he notes.

For many hospitals, there are clear financial advantages to reclassifying as an RRC. For one thing, it's easier for rural hospitals to qualify for 340B drug discounts. Their disproportionate share payment (DSH) threshold, which is intended to approximate the proportion of a hospital's patients who are indigent and is required for 340B eligibility, is 8.25% for rural hospitals but 11.75% for urban hospitals.

Rural hospitals also enjoy more generous reimbursement for indirect graduate medical education (IME) reimbursement. They get a 30% upward adjustment to the cap on the number of residents (technically, full-time equivalents) established in 1996 on full-time residents. Rural hospitals also can expand on the FTE caps by starting new programs, he says. "The adjustments become permanent after maintaining rural status for 10 years," Hettich says.

There are a few disadvantages to being rural. "If you don't already have a wage index reclassification in place, you may have to endure the rural wage index for one year," he says. "You also lose capital DSH payments, but that tends to be pretty small potatoes." Finally, rural hospitals with fewer than 500 beds are capped at 12% for the purposes of DSH payments, unless they elect to become RRCs, he explained. And not everyone benefits. Some hospitals are happy with their wage index, already get the maximum benefit from 340B, and aren't teaching hospitals, so rural reclassification holds no appeal.

Contact Hettich at dhettich@kslaw.com. ✧

OIG Finds 100% Errors in Outpatient Billing for Inpatients Elsewhere

Medicare overpaid $51.6 million for outpatient services performed at acute-care hospitals when other types of hospitals should have picked up the tab, the HHS Office of Inspector General says in a report posted Sept. 21. In the process, beneficiaries paid $14.4 million in deductibles and coinsurance they didn't owe. OIG recommended that CMS recover the money and that hospitals pay back their patients.

The report has broad implications for credit balances and shows that hospitals don't have a good method to identify when patients are coming from other facilities, experts say.

OIG conducted a review of claims paid to hospitals between Jan. 1, 2013, and Aug. 31, 2016, for outpatient services provided to inpatients at other facilities—inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs) and critical access hospitals (CAHs). The patients were brought to the hospitals for various services, including surgery, CT scans, X-rays and other radiology services, labwork, emergency department visits, drug injections, EKGs, infusion services and ambulance services.

The findings: Not a single dollar was paid correctly, OIG said. "None of the $51,640,727 we reviewed, representing 129,792 claims, should have been paid because the inpatient facilities were responsible for payment. In addition, beneficiaries were held responsible for unnecessary deductibles and coinsurance of $14,365,590 paid to the acute-care hospitals for those outpatient services," OIG concluded.

There Are Credit-Balance Implications

When patients receive outpatient services while inpatients elsewhere, the hospitals are not supposed to bill Medicare directly for the outpatient services. They should charge the IRF, CAH, LTCH or IPF for the outpatient services, and it's up to IRF, CAH, LTCH or IPF to get paid by Medicare. "As stated in Federal requirements, all items and nonphysician services provided during a Medicare Part A inpatient stay must be provided directly by the inpatient hospital or under arrangements with the inpatient hospital and another provider. The inpatient facilities in our review should have included those services on their inpatient claims to Medicare, and the acute-care hospitals could then have looked to the inpatient facilities for payment for the outpatient services provided," OIG stated.

Bruce Truitt, a faculty member of the Medicaid Integrity Institute and Government Audit Training Institute in Washington, D.C., says the audit findings have far-reaching implications. Hospitals presumably will get paid one way or another for outpatient services, and it's just a question of billing the other facility instead of Medicare. But they are faced with refunding deductible and coinsurance payments, he says. "Even more broadly, since patient account balances affect both individual credit balances and, thereby, hospital-level accounts payable and receivable, hospital (and related entity) financial statements may also be materially misstated," Truitt says. Incorrect credit balances also create legal risk, he says. Credit balances are "unclaimed property," which is governed by state laws and regulations and timelines for notifying and returning property to consumers. "We see once again that audits of credit balances are absolutely critically needed in health care," he says.

Apparently hospitals are having a hard time figuring out the status of a patient sent from another facility and billing accordingly, says Ronald Hirsch, M.D., vice president of R1 Physician Advisory Services. "Perhaps these recoupments will be a wake-up call to figure it out."

OIG attributed the overpayments to common working file (CWF) edits that didn't pick up on the overpayments. "In 94% of cases, the Medicare contractor processed for payment the acute-care hospital's outpatient claim before the inpatient facility's inpatient claim. The postpayment edit generated an alert to notify the Medicare contractor to recover the improper payment for the outpatient service, but the contractor did not act to recover it," OIG said. More or less the reverse happened with the rest of the cases, but with prepayment edits.

In addition to recouping overpayments, OIG suggested that CMS fix the CWF edits.

Hospitals are supposed to ask inpatients where they are coming from (e.g., another hospital, long-term care facility) and mark down the admission source code as part of compliance with prevention quality indicators. The error rate on internal reviews is in the 8% to 12% range *(RMC 9/11/17, p. 4)*. The outpatient side is another story.

Contact Truitt at brucetruitt@gmail.com and Hirsch at rhirsch@r1rcm.com. View the report at https://go.usa.gov/xRJ3X. ✧

Example of Outpatient Service Billed Improperly to Medicare

This example is from the HHS Office of Inspector General's audit report on Medicare overpayments to acute-care hospitals for outpatient services provided to patients who were inpatients of other facilities (see story, p. 6).

"An LTCH admitted a Medicare beneficiary on April 19, 2014, for cholecystitis (inflammation of the gallbladder) and encephalopathy (a disease of the brain that alters brain function or structure). During the beneficiary's inpatient stay, it was determined that the beneficiary needed surgery to insert a pulse generator and needed an electrocardiogram. On May 13, 2014, the beneficiary was transported to an acute-care hospital to receive those services on an outpatient basis. After the services were performed, the beneficiary returned to the LTCH on May 14, 2014, to receive additional inpatient services related to his condition. The LTCH discharged the beneficiary on June 13, 2014.

The acute-care hospital submitted a Part B claim to Medicare for the outpatient services before the LTCH discharged the beneficiary. The Medicare contractor processed the outpatient claim on June 10, 2014, and paid the acute-care hospital $30,734. After discharging the beneficiary, the LTCH submitted a Part A claim to Medicare for the beneficiary's inpatient stay. The Medicare contractor processed the inpatient claim on June 25, 2014, and paid the LTCH $61,522. Because the CWF's postpayment edit generated an alert to the Medicare contractor that a previously paid outpatient claim overlapped with a paid inpatient claim, the Medicare contractor should have recovered the outpatient payment to the acute-care hospital but did not do so."

CMS Focuses On Dates of Service

continued from p. 1

"There's a challenge in being able to hold onto an encounter and not close it until the service is completed. In some ways, it contradicts the conventional charge capture processes."

The MLN section on diagnostic psychological and neuropsychological tests states that "in some cases, for various reasons, psychological and neuropsychological tests (96101/96127) are completed in multiple sessions that occur on different days. In these situations, the date of service that should be reported on the claim is the date of service on which the service (based on CPT code description) concluded. Documentation should reflect that the service began on one day and concluded on another day (the date of service reported on the claim). If documentation is requested, medical records for both days should be submitted. Psychiatric Testing when provided over multiple days based on the patient being able to provide information is billed based on the time involved as described by CPT and the last date of the test."

Suppose the psychologist meets with the patient for three hours of testing on Jan. 7 and again on Jan. 14 for the same reason, and then writes a report on the test results for two hours on Jan. 28. CMS is saying the psychologist shouldn't bill until the evaluation is done—Jan. 28—and then the claim would be cumulative, for eight units of testing. "That's not consistent with current charging processes," Gillis says. "My billing systems want me to charge for Jan. 7, 14 and 28."

On top of that, if the Jan. 28 claim were audited—which now would include the Jan. 7 and 14 visits—Gillis wonders whether the health information management department would realize it has to pull records from all three sessions. "How do you get your clinical documentation to jibe with billing? I hope it all jibes and supports billing for eight hours. This creates opportunities for errors."

Practices May Have to Hold Claims

The MLN section on cardiovascular monitoring states that "There are many different procedure codes that represent the cardiovascular monitoring services. These can be identified as professional components, technical components, or a combination of the two. Some of these monitoring services may take place at a single point in time, others may take place over 24 or 48 hours, or over a 30-day period. The determination of the date of service is based on the description of the procedure code and the time listed. When the service includes a physician review and/or interpretation and report, the date of service is the date the physician completes that activity. If the service is a technical service, the date of service is the date the monitoring concludes based on the description of the service. For example, if the description of the procedure code includes 30 days of monitoring and a physician interpretation and report, then the date of service will be no earlier than the 30th day of monitoring and

will be the date the physician completed the professional component of the service."

Gillis says providers are set up to bill for the encounter—when they give patients the device—not when patients return it. "It creates logistical challenges," he says.

CMS also reminds providers that the professional and technical components of radiology may have different billing dates. "The technical component is billed on the date the patient had the test performed. The professional component is billed on the date the physician provided the interpretation and report of the radiology service," CMS says. "If these are furnished on different dates, they must be billed on different dates using the TC Modifier for the technical component and the 26 Modifier for the professional component."

Gillis suggests compliance officers meet with their chargemaster teams (also known as revenue integrity teams) to talk about modifying the billing system in response to CMS's instructions. That means holding onto claims after encounters instead of billing them. The question is, can you modify your charging process to be compliant with date-of-service reporting? Normally, encounters need to be closed for charges to be dropped and billed, but now a lot of encounters will have to remain open longer than expected, he says.

Contact Gillis at sjgillis@partners.org. Read the MLN at http://tinyurl.com/yalvwemd. ✧

NEWS BRIEFS

◆ **CMS spelled out the details of its new audit strategy, "Targeted Probe and Educate" (TPE), in Medicare Transmittal 1919, released Sept. 15.** Under TPE, Medicare administrative contractors (MACs) will concentrate on providers and suppliers with the highest error rates or billing practices that differ substantially from their peers *(RMC 8/21/17, p. 1)*. CMS said MACs will do up to three rounds of prepayment and postpayment TPE audits. Providers will be educated one-on-one after each audit, and there will be "45 to 56 days between each educational intervention and the next round for the provider/supplier to improve," according to the transmittal. "The MAC shall discontinue the process if/when the provider/supplier becomes compliant." Attached to the transmittal is a sample letter for MACs to send providers. The letter tells providers they have 45 days to respond to additional documentation requests. "If the requested documentation is not returned within 45 days, the claim will be denied due to lack of documentation, which will contribute to your error rate," the sample letter states. Visit http://tinyurl.com/y8ore78n.

◆ **OSF St. Francis Hospital & Medical Group in Michigan has agreed to pay $1.143 million to settle a civil money penalty (CMP) case.** The HHS Office of Inspector General alleged that OSF St. Francis Hospital & Medical Group billed Medicare, Medicaid, TRICARE and Veterans Affairs for physical therapy services "provided by personnel who were not eligible to bill federal health care programs for those services" from Nov. 21, 2010, to Sept. 30, 2015, according to the settlement. OSF St. Francis Hospital & Medical Group self-disclosed conduct to OIG and entered its Self-Disclosure Protocol in December 2016. An attorney representing the provider declined to comment. Visit http://tinyurl.com/y7tzu4f8.

◆ **The HHS Office of Inspector General has released its monthly update to the 2017 Work Plan.** Visit https://go.usa.gov/xRtpd.

◆ **Attorney General Jeff Sessions said Sept. 22 that the Department of Justice is awarding almost $20 million "to help law enforcement and public health agencies address prescription drug and opioid abuse."** In a speech in Harrisburg, Pa., Sessions said "Based on preliminary data, approximately 64,000 Americans lost their lives to drug overdoses last year"—worse than the previous year, when 52,000 Americans died. One of the major reasons is opioid prescriptions, which almost tripled between 1991 and 2011, he said. While Sessions said treatment is important, "it cannot be our only policy." Prevention "is the best long-term solution…law enforcement is prevention," he said. In this arena, DOJ has a new resource, a data analytics program, "to help us find the tell-tale signs of opioid-related health care fraud by identifying statistical outliers," he said. There's also the Opioid Fraud and Abuse Detection Unit, he said *(RMC 8/7/17, p. 8)*. Twelve assistant U.S. attorneys focus exclusively on investigating and prosecuting opioid-related health care fraud cases. The enforcement focus on providers who prescribe high-dose opioids has spooked some providers. Their policies, procedures and other documentation will be indispensable in the event of audits and investigations *(RMC 7/31/17, p. 1)*.