Report on
# Medicare Compliance

Volume 26, Number 11 • March 27, 2017

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

Contents



## Hospital Settles Stark CMP Case for $2.3M; Doctors Allegedly Were Paid Above FMV

Metro Health Hospital in Michigan agreed to pay $2.3 million to settle allegations that its payments to several physicians were more than fair market value (FMV) in violation of civil monetary penalty laws. The hospital allegedly went over an annual payment cap for one physician and above sliding-scale compensation with another and overpaid a physician practice for wound care services provided by its nurse practitioners, according to the settlement with the HHS Office of Inspector General. The settlement stemmed from the hospital's self-disclosure to OIG.

"The settlement continues the emphasis on ensuring that compensation paid meets the standards of fair market value and commercial reasonableness," says attorney Bob Wade, with Barnes & Thornburg in South Bend, Ind. However, he says there's some flexibility in these areas under the Stark law. Certain compensation arrangements, such as soft payment caps, will fly in employment agreements but not in independent contractor agreements, while other compensation arrangements pass muster with independent-contractor agreements, but not employment agreements. Knowing the differences may keep whistleblowers and enforcers at bay, Wade says.

The settlement centered on professional services agreements that Metro Health entered into with two physician groups. One was for neurosurgery and the other for

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## New RACs Eye Cataract Surgery, Some MACs Have Found Errors; Records May Be Scattered

Recovery audit contractors (RACs) are back in business, and they have their sights set on improper payments for cataract surgery, which already has been under the microscope of medical reviewers at some Medicare administrative contractors (MACs). Hospitals may be vulnerable if some of the documentation supporting the medical necessity of the procedure is located outside the hospital or ambulatory surgery center—for example, at a doctor's office—and suddenly the RACs and MACs want to get their hands on it.

"Lack of information equates to a denial," says Maria Johar, M.D., system physician adviser for Promedica Health System in Toledo, Ohio.

Hospitals in Ohio and Kentucky, for example, were shell shocked when most of the cataract surgery claims reviewed by their MAC in a probe audit were denied. "They came at it with guns blazing," Johar says. At least it was mostly because the documentation was missing, a problem that's easier to fix than a substantive lack of medical necessity for the procedure.

The MAC, CGS Administrators, requested documentation to support the medical necessity for cataract removal (CPT codes 66984, 66983 and 66982). The MAC reviewed 108 claims for cataract removal in Ohio and denied 97. That's an 88.7% denial rate for a total reimbursement loss of $315,453. In Kentucky, CGS reviewed 91 claims and denied 76 of them, which was an 85.6% denial rate and a reimbursement

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loss of $326,896. The claims were partially or fully denied because documentation didn't support medical necessity.

When Johar looked to see what really went wrong at her hospital, it usually wasn't a lack of medical necessity for the procedure. The physicians generally were following the MAC's local coverage determination, Johar says. The components of the documentation that support the medical necessity, however, were scattered in different places and not always in the patient chart. The reason the documentation wasn't complete in the chart is because cataract surgery is performed in a Promedica ambulatory surgery center (ASC) while the ophthalmologists who perform the procedure first see patients in their offices, which are not at the surgery site, she says. They may perform tests in their offices, and the results don't migrate to the patient charts at the ASC. As a result, when the MAC sent an additional documentation request (ADR) to the hospital, the health information management department sent what was in the chart, but it wasn't adequate to support medical necessity.

### No Surgery Until Chart is Complete

To turn that around, Promedica now requires the ASC to have all required documentation in the patient chart before scheduling cataract removal surgery, Johar says. "We make sure we have everything now," she says. "When we send in an additional documentation request, we have a complete record." Promedica developed a checklist to help ensure it has locked down all the documentation required to support the cataract surgery's medical necessity (see box, p. 3).

Cataract removal is considered medically necessary and, therefore, covered by Medicare when one or more of these conditions or circumstances are present and documented, according to various LCDs:

(1) "Cataract causing symptomatic (i.e., causing the patient to seek medical attention) impairment of visual function not correctable with a tolerable change in glasses or contact lenses, lighting, or non-operative means resulting in specific activity limitations and/or participation restrictions including, but not limited to reading, viewing television, driving, or meeting vocational or recreational needs.

(2) Concomitant intraocular disease (e.g., diabetic retinopathy, or intraocular tumor) requiring monitoring or treatment that is prevented by the presence of cataract.

(3) Lens-induced disease threatening vision or ocular health (including, but not limited to, phacomorphic or phacolytic glaucoma).

(4) High probability of accelerating cataract development as a result of a concomitant or subsequent procedure (e.g., pars plana vitrectomy, iridocyclectomy, procedure for ocular trauma) and treatments such as external beam irradiation.

(5) Cataract interfering with the performance of vitreoretinal surgery.

(6) Intolerable anisometropia or aniseikonia uncorrectable with glasses or contact lenses exists as a result of lens extraction in the first eye (despite satisfactorily corrected monocular visual acuity)."

Sometimes it wasn't just about the "helter skelter" documentation. Occasionally physicians did not demonstrate medical necessity for cataract surgery as required by the LCD, she says. For example, they may have neglected to show how the patient's cataracts affected their activities of daily living. But mostly denials stem from "scattered pieces of documentation."

### Translation Services May Help

Reaching out to physician practices with translation services also helped Promedica improve its compliance. It turned out physician practices sometimes waived some policies because patients spoke a particular language that the practices couldn't translate. Promedica offered the physicians its translation services, which helps them satisfy Medicare documentation requirements and improves patient satisfaction. That, in turn, is necessary for Promedica's compliance because the physicians are performing the surgeries at the ASC. "We have a lot of resources available to us," Johar says.

Hospitals, meanwhile, should be aware they may be receiving ADRs from RACs on cataract surgery. It's on the list of CMS-approved audits of at least two of the RACs in the second five-year round of the program: Cotiviti and Performant. Cotiviti plans to conduct complex reviews of cataract surgery at ASCs and at hospital outpatient hospital departments. According to its website, "Documentation will be reviewed to determine if Cataract Surgery meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary." Performant will do an automated review of ASC and hospital outpatient claims for "once in a lifetime" cataract surgery and a complex review of cataract removal.

Findings by the comprehensive error rate testing (CERT) contractor "also highlight the areas of missing documentation," Johar says.

Contact Johar at maria.johar@promedica.org.✧

## Checklist for Cataract Surgery Medical Necessity

Promedica Health System in Toledo, Ohio, developed this checklist to ensure it has all the documentation to support the medical necessity of cataract surgery before it's scheduled. Contact Maria Johar, system physician adviser, at maria.johar@promedica.org.

### Comprehensive Cataract Removal

#### Medical Necessity Checklist {LCD 33954}

**CPT 66830 CPT 66840 CPT 66850 CPT 66852 CPT 66930 CPT 66940 CPT 66982 CPT 66983 CPT 66984**

**Patient Name ---------- DOB ---/----/------**

Medicare coverage for cataract extraction and cataract extraction with intraocular lens implant is based on services that are reasonable and medically necessary for the treatment of beneficiaries who have a cataract, and who meet all of the following criteria:

**History:**

**Biometric Results:** **RIGHT** **LEFT**

**Date:**

**Visual Acuity Exams:**

**Date:**

**Limitation of activities of daily living (ADLs)**

**Decreased ability to carry out activities of daily living including (but not limited to):**

- ❒ Reading or
- ❒ Watching Television or
- ❒ Driving or
- ❒ Meeting Occupational Or Vocational Expectations;

And

- ❒ The patient has a best corrected visual acuity of 20/50 or worse at distant or near;

OR

- ❒ Additional testing shows one of the following:
  - o Consensual light testing decreases visual acuity by two lines, or
  - o Glare testing decreases visual acuity by two lines
- ❒ The patient is no longer able to function adequately with the current visual function; and
- ❒ Other eye disease(s) including macular degeneration and/or diabetic retinopathy have been ruled out as the primary cause of decreased visual function; and
- ❒ Significant improvement in visual function can be expected as a result of cataract extraction; and
- ❒ The patient has been educated about the risks and benefits of cataract surgery and the alternative(s) to surgery (e.g., avoidance of glare, optimal eyeglass prescription, etc.); and
- ❒ The patient has undergone an appropriate preoperative ophthalmologic evaluation that generally includes a comprehensive ophthalmologic exam and ophthalmic biometry.

For patients with a best corrected **visual acuity of 20/40** or better, cataract extraction will be considered if all other criteria have been met and there is **substantial documentation of the medical necessity** of the procedure for that patient. If the decision to perform **cataract extraction in both eyes is made prior to the first cataract extraction**, the documentation must support the medical necessity for each procedure to be performed. Bilateral cataract extraction performed on both eyes, on the **same date of service** is termed **immediate sequential bilateral cataract surgery (ISBCS)**. ISBCS as an approach to bilateral cataract extraction may afford certain clinical benefits but carries with it the possibility of bilateral visual loss. The decision to perform ISBCS should be an individual decision, made jointly by the patient and physician.

***The medical record must document the rationale for ISBCS and that the patient has been apprised of the risks and benefits of both this approach and of the available alternatives.***

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## Shape of Bundled Payments Is in Doubt; For Now, CJR Moves Forward

Hospitals don't have to read tea leaves to see that mandatory bundled payment programs, including cardiac payment bundles and the Comprehensive Joint Replacement (CJR) model, probably won't stay in their current form, and they may soon become voluntary and possibly disappear. Already CMS, on March 21, delayed the expansion of the CJR model and the effective date of the newest kid on the block, the cardiac bundled payment program, until Oct. 1 (*82 Fed. Reg. 14464*). Both these bundled payment programs are mandatory for certain hospitals, but HHS Secretary Tom Price has long indicated his preference for voluntary participation.

"Prior statements by Secretary Price call into question whether the programs will go forward as mandatory programs," says Robert Jagielski, compliance director for clinical integration at MedProVidex, a subsidiary of Dignity Health, a California-based health system.

However, the delay doesn't affect hospitals already deep into the CJR program that went live April 1, says Washington, D.C., attorney Daniel Hettich, with King & Spalding. That program applies to hip and knee replacements at 800 hospitals in 35 states. Only the expansion of the CJR program to femur fractures and other hip surgeries, which was announced in a Dec. 20, 2016, regulation, is on hold, he says. The CJR expansion was unveiled with the mandatory cardiac bundled payment program.

Compliance in this area will be in suspended animation until it's clear what CMS will do with mandatory bundled payment programs now that there is new leadership, Jagielski says. "Hospitals are set up to meet the requirements of the program—to report on measures and produce results and documentation. You are working closely with operations so you can document and audit them," he says. "If the programs are going to

## Checklist for Cataract Surgery Medical Necessity (continued)

### Complex Cataract Surgery (CPT code 66982)

A **miotic pupil** which will not dilate sufficiently to allow adequate visualization of the lens in the posterior chamber of the eye and which requires the insertion of four (4) iris retractors through four (4) additional incisions, Beechler or similar expansion device, a sector iridectomy with subsequent suture repair of iris sphincter, synechialysis utilizing papillary stretch maneuvers or sphincterotomies created with scissors.

- CPT 66830 REMOVAL OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE AND/OR ANTERIOR HYALOID) WITH CORNEO-SCLERAL SECTION, WITH OR WITHOUT IRIDECTOMY (IRIDOCAPSULOTOMY, IRIDOCAPSULECTOMY)
- CPT 66840 REMOVAL OF LENS MATERIAL; ASPIRATION TECHNIQUE, 1 OR MORE STAGES
- CPT 66850 REMOVAL OF LENS MATERIAL; PHACOFRAGMENTATION TECHNIQUE (MECHANICAL OR ULTRASONIC) (EG, PHACOEMULSIFICATION), WITH ASPIRATION
- CPT 66852 REMOVAL OF LENS MATERIAL; PARS PLANA APPROACH, WITH OR WITHOUT VITRECTOMY CPT 66920 REMOVAL OF LENS MATERIAL; INTRACAPSULAR
- CPT 66930 REMOVAL OF LENS MATERIAL; INTRACAPSULAR, FOR DISLOCATED LENS
- CPT 66940 REMOVAL OF LENS MATERIAL; EXTRACAPSULAR (OTHER THAN 66840, 66850, 66852)
- CPT 66982 EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (1-STAGE PROCEDURE), MANUAL OR MECHANICAL TECHNIQUE (EG, IRRIGATION AND ASPIRATION OR PHACOEMULSIFICATION)
- CPT 66983 INTRACAPSULAR CATARACT EXTRACTION WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (1 STAGE PROCEDURE)
- CPT 66984 EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (1 STAGE PROCEDURE), MANUAL OR MECHANICAL TECHNIQUE (EG, IRRIGATION AND ASPIRATION OR PHACOEMULSIFICATION)

**Office staff MUST send (All pertinent documents must be attached)**

**INSURANCE ……..……/ Medicare / Medicaid**

**ALL COMMERCIAL PTS MUST HAVE AN AUTH #……..……..**

**Sent by OFFICE…….**

**Anticipated date of surgery ……..……..**

**Preadmission Precheck…… Date……..……..**

change, everything goes on hold. You will wait and see. We can't move forward until we know the rules we are playing under."

### Waivers Still Apply

However, because the original CJR program continues for the time being, its fraud and abuse waivers still apply, Hettich says. The waivers allow hospitals to distribute gainsharing payments to physicians and post-acute providers without violating the anti-kickback or Stark laws, as long as hospitals satisfy the criteria set forth by CMS and the HHS Office of Inspector General. There's also a waiver from the civil monetary penalty (CMP) law that bars beneficiary inducements (*RMC 12/7/15, p. 1*).

Meanwhile, the implementation dates of the newer bundled payment programs may be put off even more. The March 21 CMS notice in the *Federal Register* asked for industry feedback on a delay until Jan. 3, 2018—and there are indications the programs will be revamped.

The delay was a result of the 60-day freeze on new regulations ordered by the Trump administration in January, Jagielski says. "I would not draw any inference, positive or negative, from the fact that the regulation was delayed other than the reason stated in the preamble to the delayed rule, which is to avoid unnecessary administrative costs and burdens in the event that changes come," he says.

The bundled-payment models hold hospitals financially accountable through application of rewards or penalties based on how Medicare's actual 90-day spending for the hospital patients compares to a "target price" set by CMS. In the five-year CJR model, for example, the clock starts with admission for MS-DRG 469 (major joint replacement or reattachment of lower extremity with major complications or comorbidities) or 470 (major joint replacement or reattachment of lower extremity without major complications or comorbidities) and ends 90 days after discharge from the hospital.

Medicare pays hospitals and their "collaborators"—physicians, physician practice groups and various post-acute care (PAC) providers (e.g., skilled nursing facilities and home health agencies)—on a fee-for-service basis. In addition, hospitals that hit a "target" price set by CMS and meet quality, efficiency and patient satisfaction goals get a bonus. If they charge Medicare more than the target price, they have to fork over some money. Notably, Hettich points out, the "target price" includes a built-in discount or savings to Medicare of up to 3%. CMS and the HHS Office of Inspector General also jointly published fraud and abuse waivers to clear the way for hospitals to share with physicians the rewards they may reap if they reduce costs and improve quality and to give patients incentives to promote engagement with their care.

In the Dec. 20 regulation, CMS announced bundled payments for cardiac episodes of care. They are mandatory for inpatient care and up to 90 days after for heart attack and bypass surgery patients at hospitals in 98 metropolitan areas. There's also a mandatory payment bundle for cardiac rehab. They were supposed to start in July.

"It's not a surprise the regulations were delayed because Tom Price, before he was secretary, was extremely critical of mandatory bundled payment programs," Hettich says. Price, a physician, was one of 179 House members who signed a September letter to Andy Slavitt, then-acting administrator of CMS, and Patrick Conway, M.D., then chief medical officer and director of the Center for Medicare and Medicaid Innovation. "Until recently, the tests and models developed by CMMI were implemented, as intended, on a voluntary, limited-scale basis where no state, healthcare provider, or health insurer had any obligation to participate," the letter stated. But CMS crossed the line with mandatory bundled payments, they said. "These mandatory models overhaul major payment systems, commandeer clinical decision-making, and dramatically alter the delivery of care." The House members asked CMS to immediately quit implementing the mandatory models.

Now that Price is in charge, odds are he will make his wish come true, Hettich says.

**Report on Medicare Compliance** (ISSN: 1094-3307) is published 45 times a year by the Health Care Compliance Association, 6500 Barrie Road, Suite 250, Minneapolis, MN 55435. 888.580.8373, www.hcca-info.org.



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Whether bundled payment programs are mandatory or voluntary, Jagielski notes that "hospitals have already invested resources in care coordination teams and open communication with post-acute care providers in teaming up. If the programs continue as voluntary, hospitals that put all those steps in place and can come in under target price can do it on a voluntary basis." And it's always possible they will disappear, Hettich says, although there's bipartisan support for moving to value-based purchasing.

"You still want to engage your providers to continue to be ready to participate in the models when the final regulations come out because Tom Price still sees there is value in them," he says. "Everyone should be working toward value-based programs and getting ready for the transition regardless of the form it takes, whether it's through ACOs or other initiatives.

A lot of compliance in these programs is aimed at ensuring they meet Medicare conditions of participation and are able to report on quality measures and fulfill documentation requirements (*RMC 12/19/16, p. 1*), Jagielski says. "We can't move forward until we know what the rules are," he says. "Operations are impacted by the fact this program could be restructured with different requirements and that has an impact. You take a breather and wait until guidance comes up."

Contact Hettich at dhettich@kslaw.com and Jagielski at Robert.jagielski@dignityhealth.org. View the regulation delaying the bundled payment programs at http://tinyurl.com/laf24tu.✧

## Trump Includes $70M More to Fight Fraud, Prevent Overpayments

President Trump's budget blueprint calls for spending more money to fight health care fraud and to ramp up the prevention of overpayments so auditors and enforcers spend less time chasing ill-gotten Medicare dollars after they've gone out the door. CMS has been moving away from "pay and chase" for years, and the Trump administration said it would push that approach. In addition, the budget blueprint calls for an additional $70 million in "discretionary funding" for the Health Care Fraud and Abuse Control program in fiscal year 2018.

"On its face, it looks like they're going in the right direction," says Peter Budetti, a physician-lawyer who is the former deputy CMS administrator for program integrity. But he'd like to see more emphasis on audits and investigations of fraud in Medicare Advantage (Part C) and the prescription-drug program (Part D) and an expansion of the Medicare rewards program for beneficiary whistleblowers.

"Everything we've talked about so far only speaks to fighting fee-for-service fraud. More attention needs to be paid to fraud in Medicare Advantage and Part D," Budetti tells *RMC*. "That has lagged way behind."

In a proposed 2013 enrollment rule, CMS included new requirements for the Medicare Incentive Reward Program. It markedly increased rewards for beneficiaries and others who have direct information, such as their own claims, about providers and suppliers who game Medicare. The reward would have risen from a maximum of $1,000 to 15% of the final amount collected applied to the first $66,000,000, which is almost $10 million, but CMS never finalized the changes to the 20-year-old rewards program. The CMS whistleblowers are different from whistleblowers through the *qui tam* provisions of the False Claims Act because it's an administrative program. Patients don't have to mount a lawsuit, survive legal challenges and then wait years for the disposition of the case. The reward program is for patients who suspect their providers are up to no good, and they don't need an attorney.

In terms of controlling fraud, Budetti says the "biggest breakthrough" in recent years has been the CMS Fraud Prevention System, which was implemented in 2011. The Fraud Prevention System screens all Medicare Part A and B claims before payment, running every claim against multiple models that address different types of vulnerabilities and schemes. It taps into the Integrated Data Repository, which includes claims, beneficiary data and Part D drug information, and uses other resources, including compromised beneficiary Medicare identification numbers. He says it has a return on investment of 11 to one, and the Fraud Prevention System 2.0 is about to be implemented.

A $70 million increase "would be very useful if spent the right way," says Budetti, now with Phillips & Cohen, a law firm representing whistleblowers.

Contact Budetti at (202) 833-4567. ✧

## Hospital Settles Stark Case for $2.3M

*continued from p. 1*

general surgery services. OIG alleged that some of the independent-contractor physicians were paid above FMV in four ways:

(1) The hospital's compensation arrangement with two physicians included one component that exceeded fair market value from Jan. 1, 2011 to March 31, 2015. The agreement with one of the physicians was signed more than 30 days after it went into effect.

(2) The hospital's payments to one physician "exceeded an established annual cap for physician services" between Oct. 1, 2013 and Sept. 30, 2014.

(3) The hospital's payment to one physician "exceeded an established sliding scale conversion factor for physician services" from May 1, 2012, through Sept. 30, 2013.

(4) The hospital's payment to a physician for wound care services performed by nurse practitioners exceeded FMV from April 1, 2011, to July 30, 2012. The agreement for the services was signed more than 30 days after the effective date.

Metro Health applied to OIG's Self-Disclosure Protocol, which offers providers reduced penalties if they voluntarily report potential violations. The hospital was accepted into the protocol in February 2015. It did not admit liability in the settlement and declined to comment on the allegations.

Caps and conversion factors are familiar challenges in the FMV arena of physician compensation. In terms of caps, "a financial arrangement with a referring physician has a maximum compensation in a written agreement, and it's important to ensure that the compensation does not exceed the max," Wade says.

That's definitely the case with independent contractors. Their agreements with hospitals have to fall within Stark exceptions for personal services arrangements or independent contractor arrangements. For example, if a medical director agreement with an independent contractor calls for $100 an hour with a max of 100 hours a year, "you have to live and die by the terms of that written agreement," Wade says.

Employment agreements are a different animal. "You can exceed the maximum compensation stated in an employment agreement," he says. This tends to come up in productivity-based compensation arrangements, where hospitals reward physicians partly according to their work relative value units (work RVUs). The harder physicians work and the more patients they treat, the more work RVUs they generate. If the physician has reached the work RVU cap set forth in the employment contract on Nov. 1 and the contract doesn't expire until Dec. 31, "either he takes a two-month vacation—why work for no pay?—or you go beyond the cap because he generates another 2,000 work RVUs," Wade says. "That is 100% compliant under Stark," he says. But hospitals must ensure they validate that the physician's hyperproductivity is a reflection of reasonable and necessary services.

With sliding-scale conversion compensation, hospitals should make sure they apply the conversion factors consistent with the contractual requirements, Wade says. "For employment arrangements, it's important to apply the conversion factor only with respect to personally performed services and not apply them for services referred or performed by nonphysician practitioners," he says.

There are two ways to do sliding scale conversions. Under the incremental method, hospitals pay progressively more per work RVUs as they pile up. For example, a hospital may pay physicians $30 per work RVU for the first 2000 work RVUs, $35 per work RVU between 2,000 and 4,000, $40 per work RVU for 4,000 to 6,000, and $45 per work RVU beyond that, up to 8,000.

Then there's the single-tiered model. The hospital pays, for example, $45 per work RVU—but only if the physicians reach 8,000 work RVUs. If they don't hit the magic number, physicians are paid at a lower rate, like $35 per work RVU.

After hospitals apply sliding-scale conversion models, Wade says they have to test them. Evaluate whether the aggregate compensation divided by the hours worked is FMV. Can you defend the higher compensation at 100%? Even though the per-hour compensation will be lower with the incremental model, its FMV has to be validated. "Both models may work, but you have to test them," he says.

FMV also may become a landmine when hospitals contract with physician groups for services provided by their employed nonphysician practitioners (NPPs). The physician group pays a FMV salary to the NPP, but may try to add on the NPP's benefits, malpractice, bonus

## CMS Transmittals and *Federal Register* Regulations March 17-23

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**

- FISS Implementation of the Restructured Clinical Lab Fee Schedule, Trans. 3740 (March 23, 2017)
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for July 2017, Trans. 3738 (March 17, 2017)
- Billing for Advance Care Planning (ACP) Claims, Trans. 3739 (March 17, 2017)

### *Federal Register*

**Final Regulations**

- Medicare Program; 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; Corrections, 82 Fed. Reg. 14639 (March 22, 2017)
- Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model; Delay of Effective Date, 82 Fed. Reg. 14464 (March 21, 2017)

and possibly an administrative fee in its charges to the hospital because it's an independent-contractor arrangement, Wade says. Because the physician group absorbs all these costs for the NPP, building them into the fee charged to the hospital is appropriate, but it must be FMV, Wade says. "I have five files on my desk right now with this scenario," he says. In one of them, the compensation the hospital paid to the group for the NPP's salary is way above FMV, but if the analysis considers the other expenses (e.g., benefits, malpractice, administrative costs), "that's acceptable in an independent-contractor arrangement" with the hospital.

### Stacking is a Risk

With Stark, the whole can become greater than the sum of its parts in employment agreements. "You have to make sure the hospital doesn't layer on a number of additional responsibilities so when you get to the totality of the compensation package, it's no longer fair market value," says Carol Carden, a principal in Pershing Yoakley & Associates in Knoxville. Sometimes, in employment agreements with physicians, in addition to a base salary plus work RVUs if the physician hits productivity levels, the hospital will have agreements with the same physician for additional payments for supervision, medical director duties and taking excess calls. "At some point, you have to add it all together," Carden says. Even if each agreement is FMV, "you may get to the point where the totality of the compensation is no longer defensible."

As fee-for-service reimbursement gives way to fee-for-value and the Merit-based Incentive Payment System (MIPs) moves forward (*RMC 12/19/16, p. 1*), hospitals are playing a new ballgame with FMV compensation, Carden says. More physician compensation will be at risk (i.e., linked to patient outcomes), she says. Hospitals will increasingly be under pressure to push the boundaries and prove their quality measures are not duplicative and influence patient outcomes. There will be pressure to prove hospitals are not paying quality-based compensation for services that should be considered standard of care (e.g., the number of chest-pain patients given aspirin in the emergency room), she says.

Hospitals should avoid the temptation to set quality metrics based on things they are currently measuring because it's administratively easy. But figuring out how much additional compensation hospitals can put on the table to reward physicians for meaningful patient outcomes in this context is still more an art than a science, Carden says. There are some broad parameters published in compensation surveys that give general guidance on what percentage of compensation is being put at risk related to quality outcomes, and hospitals can also look at how governmental payers are treating quality based compensation parameters.

Contact Carden at ccarden@pyapc.com and Wade at bob.wade@bt.com.✧

## *NEWS BRIEFS*

◆ **Obstructing a Medicare audit got the owner of two Alabama pharmacies a year of probation, including home confinement for six months,** the U.S. Attorney's Office for the Northern District of Alabama said March 23. Pharmacist Rodney Dalton Logan, owner of Sheffield Pharmacy and Homecare in Sheffield and Russellville Pharmacy in Russellville, pleaded guilty in August 2016 to obstructing a 2012 federal audit of Medicare claims submitted by the Sheffield pharmacy. Logan also was ordered to pay a $2.5 million fine and barred from working in a pharmacy during his probation. Logan's pharmacies were both retail and compounding pharmacies. Part D doesn't reimburse pharmacies for drugs compounded with bulk pharmaceutical powders, but "Russellville and Sheffield nonetheless sought Part D reimbursement after February 2009 for compounded medications, primarily topical pain creams, made from bulk powders," the U.S. attorney's office alleged. They billed using the code for the tablet or capsule version of the ingredient. Visit http://tinyurl.com/ltcwzvx.

◆ **Because Nantucket Cottage Hospital in Massachusetts overstated its 2011 Medicare wage data, it was overpaid $156,000 two years ago, and there was a ripple effect, with Medicare overpaying 55 hospitals in the state $133.6 million,** the HHS Office of Inspector General contends. The hospital didn't always comply with Medicare rules for reporting wage data and wage-related costs on its 2011 cost report, OIG contends. CMS uses hospitals' self-reported wage data, including wages, contract labor, hours and fringe benefits, to calculate the wage index. 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. The wage index has been under the microscope of OIG and CMS (*RMC 3/14/16, p. 1*). Already Medicare administrative contractors audit every hospital's wage data annually. In its written response, the hospital disagreed with some of the findings. Visit https://go.usa.gov/xXre5.