Report on
MEDICARE COMPLIANCE

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Weekly News and Compliance Strategies on Federal Regulations, Enforcement Actions and Audits

Contents

With All the Variables, Condition Codes 42, 43 May Not Be Worth Risk Under PACT Policy

Some hospitals may decide the risks associated with condition codes 42 and 43, which bypass the post-acute care transfer (PACT) payment policy, are not worth the rewards. Between audits of the PACT payment policy by the HHS Office of Inspector General and the murkiness of when the condition codes apply clinically for patients referred to home health care, it's easier to uniformly put it out of their minds.

That's the conclusion that Partners HealthCare in Boston has come to, says Stephen Gillis, director of compliance coding, billing and audit. Condition codes are a strange area because planets have to align for them to generate reimbursement, but they may come under scrutiny. Condition code 42 was highlighted in a recent Medicare compliance review, although in a surprising way.

"At this point, we are not really appending 42 or 43," Gillis says. After becoming aware of this potential risk area, Partners investigated, evaluated the process and corrected errors, and then decided it was difficult to accurately add condition codes 42 or 43 to claims—although it still monitors for potential use of the codes "just in case," he says.

According to the PACT payment policy, hospital patients who receive post-acute care are classified as transfers, not discharges, and hospitals are paid per diems instead of MS-DRGs up to the full amount of the MS-DRG. Post-acute care is defined as home

continued on p. 7

Proposed Physician Rule Would Change Teaching Physician Documentation for E/Ms

More than 20 years after teaching hospitals started getting nailed for billing the services of teaching physicians, because they allegedly didn't adequately document their notes and physical presence when residents treated the patients, CMS may shake things up. The 2019 proposed Medicare Physician Fee Schedule regulation, which was announced July 12 *(RMC 7/16/18, p. 1)*, would let other clinicians document the teaching physician's supervision for evaluation and management (E/M) services.

If adopted, the proposal may present challenges and raise questions for compliance officers at teaching hospitals and physician practices, says Ed Gaines, chief compliance officer at Zotec Partners in Greensboro, North Carolina. Coders, billers and compliance quality assurance specialists also would face challenges in determining whether teaching physicians were, in fact, physically present when residents performed E/M services, he notes.

Currently, CMS requires both the teaching physician's performance and documentation of a "key portion note" and linkage statement to the resident's documentation, with the teaching physician determining what's key or critical, according to Medicare Transmittal 1780.

The teaching-physician provision comes five months after CMS surprised the academic medical world with a change in medical student documentation policy.

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Medicare Transmittal 3971, issued in February, said all medical-student documentation counts for E/M billing, which means teaching hospitals may charge Medicare for E/M services performed by teaching physicians when medical students they supervise document the exam, medical decision-making and other parts of the patient encounter *(RMC 2/12/18, p. 5)*.

In another dramatic event, the proposed 2019 Medicare Physician Fee Schedule regulation presents two documentation alternatives to the 1995 and 1997 Medicare documentation guidelines for office/outpatient visits: only documenting medical decision-making or time to support CPT codes. Hand-in-hand is a proposal that would, if finalized, implement a single payment rate for level two through five CPT codes.

But it's the teaching physician proposal that Gaines finds significant in light of the decades of audits and enforcement and CMS's outreach and clarity on teaching physician documentation requirements. Currently, Medicare allows teaching physicians to bill E/M services performed by the residents they supervise, even though their hospitals already receive graduate medical education (GME) payments. To receive separate E/M reimbursement, teaching physicians must personally document at least one of these: (1) "That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and (2) The participation of the teaching physician in the management of the patient," according to transmittal 1780.

It's not good enough for the teaching physician to simply write statements like "Agree with above, followed by legible countersignature or identity; Rounded, Reviewed, Agree, followed by legible countersignature or identity; or Discussed with resident. Agree, followed by legible countersignature or identity," the transmittal states.

Turning PATH on its Head

That 2002 transmittal has been dogma in the world of teaching hospitals and girded Physicians at Teaching Hospitals (PATH), a national audit and enforcement initiative by the Department of Justice and HHS Office of Inspector General. A number of teaching hospitals—kicked off by the University of Pennsylvania in 1995—settled false claims cases, because they billed Medicare Part B for services provided by residents when the teaching physicians allegedly weren't physically present to supervise (at least according to the documentation). "This has been a hot-button issue and a top-five compliance issue for physician practice compliance for 25 years," Gaines says. But it would be turned on its head by the proposed Medicare physician fee schedule, he contends. If the provision is finalized, teaching physicians wouldn't have to "document the extent of their participation in the review and direction of the services furnished to each beneficiary," the proposed rule explained. Instead, "the extent of the teaching physician's participation may be demonstrated by the notes in the medical records made by a physician, resident, or nurse."

Even the 2002 transmittal's assertion that statements like "agree with above" are inadequate seem open to interpretation. "There is at least a question under the CMS 2019 proposal whether these statements that were deemed insufficient in 2002 are now sufficient and could be documented by the resident provided the teaching physician performed the necessary required services," Gaines says.

He notes there's a distinction between performance and documentation standards, which harks back to the transmittal. Teaching physicians are required to document the "key or critical" portion of the service. Although subject to clarification in the final rule, Gaines doesn't believe the teaching physician performance standards changed in the proposed Medicare Physician Fee Schedule regulation. But there's a question about whether CMS wants to change the teaching physician documentation standards for procedures, although he

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says the focus appears to be on E/M services. "In the ED, most procedures are by definition major procedures, and it appears that the 2019 proposed regulation doesn't change the requirement that teaching physicians perform and document the key or critical portion of major procedures," Gaines says.

So while CMS seems to be keeping the performance standard for E/M services, the extent of the teaching physician's participation may be documented by the teaching physician, resident or nurse, he says.

The proposal raises additional issues, Gaines says. For one thing, he wonders whether scribes would be allowed to document teaching physicians' presence, provided they comply with the performance requirements. "The reference [in the proposed regulation] to physician, resident or nurse is specific to credentialed clinicians in the hospital, while the scribes are supposed to act as human tape recorders for the teaching physician but are not credentialed. Was the reference to clinicians meant to exclude other non-clinical personnel?" Also, electronic health records probably will be used to create a macro, which generates predetermined text, to document the teaching physician's presence. "Without substantive documentation from the teaching physician, how would a coder, compliance auditor or medical reviewer know for certain that the 'macro check box' was in fact completed by the teaching physician?"

Contact Gaines at egaines@zotecpartners.com. View the proposed regulation at https://tinyurl.com/ybd4l6tv. ✧

With Forensic Investigations, Compliance Takes a Deeper Dive Into Complaints

On the surface, there was nothing unusual about the complaint that came into Cleveland Clinic from a patient who received a bill for an emergency room visit she never had. Although Cleveland Clinic's Office of Corporate Compliance looks into these complaints because of the potential for HIPAA violations, it would have been easy to accept a surface explanation and move on because of the frequency of similar complaints and the fact that the cause is often innocuous—the result of a data entry error, for example.

"But things aren't always what they seem," said Vicki Bokar, senior director of corporate compliance at Cleveland Clinic. That's a mantra of the compliance office, which often conducts investigations with the Office of Internal Audit. When necessary, they do a "forensic reconstruction," because audit logs don't always tell the whole story. "There's a risk when you investigate cases, especially when they sound the same, that your investigators assume it's just another data entry error. You have to take each case fresh," she said at the Health Care Compliance Association's Compliance Institute in April.

That tenet was reinforced with a call to Cleveland Clinic from the woman, Jane Doe (a fictional name), who insisted she wasn't treated at the emergency room (ER) despite what the bill said, and whose account had been referred to a collection agency. The patient's contact began with a Cleveland Clinic customer service representative, who looked up her account with her Social Security number. The representative realized it was one digit off and belonged to another patient, Alice Smith (not her real name), who had, in fact, received ER services on the date in question. So Jane Doe was off the hook for the charges. But what happened? Was it data entry error or something more insidious? Finding out required an investigation, and the case was kicked to the compliance department.

Red Flags in the User Audit

The compliance investigator dug into the case, hunting for "abnormalities" in the accounts, Bokar said. There was a scanned copy of the Social Security card in Jane Doe's medical record, but Alice Smith's had no identification card. "We require by policy a photo ID, but if they come through the emergency room, we provide care and worry about it later" because of the Emergency Medical Treatment and Labor Act, Bokar said. So the investigator bookmarked this discrepancy, but alarm bells didn't go off yet. The investigator also looked at the demographic change report (DCR), a function of the Epic electronic health record system. It shows how many changes were made and who made them, Bokar said. According to the DCR, Jane Doe's account was edited by an employee named Alicia Smyth (not her real name).

Next, compliance generated a user audit of Alicia Smyth for the time she went into Jane Doe's account. The findings were unexpected: she made only one mistake with respect to Jane Doe—the wrong digit on the Social Security number—but "Alicia Smyth accessed the records of several patients who had variations on her name" (e.g., Aliah Smith, Acacia Smith, Aleeshia Smith). "At Cleveland Clinic, we have seven million patients, so this could be a coincidence. You don't want to [assume] guilt because of an unusual observation, but a good investigator tries to explain unusual findings by digging deeper," Bokar noted.

The investigator teamed with a forensics auditor from the internal audit department to follow other clues. For one thing, the patients with names like Alicia Smyth received services in different Cleveland Clinic ERs. The contact person was the same for two of the patients and so were their cell phone numbers, Bokar said. "Forensics plugged in the numbers common to the two patients to

Checklist for a HIPAA Rounding Audit

The compliance department at Northwell Health in New Hyde Park, New York, routinely conducts rounds of units and departments in its hospitals and other entities to spot check for compliance with the HIPAA privacy and security regulations by using this checklist, says Greg Radinsky, senior vice president and chief corporate compliance officer. The impetus for the rounding audits are provisions in the HIPAA privacy and security rules that require security and privacy audits, including Sec. 164.308(a)(1)(ii)(c) on information system activity reviews, Sec.164.312(1)(b) on audit controls, and Sec. 164.530(c)(2)(i)&(ii), which states "a covered entity is required under the Administrative Requirements standard to reasonably safeguard protected health information and to limit incidental uses or disclosures made pursuant to an otherwise permitted or required use or disclosure." Contact Radinsky at gradinsk@northwell.edu.

	Criteria	Potential Risk Requiring Corrective Action
1	Does the staff discuss confidential patient information among themselves in public areas?	*<FILL IN COLOR OF ASSESSMENT: Red for Requiring Action, Green for No Action Required>*
2	Does the patient receive and acknowledge receipt of the Notice of Privacy Practices as required?	
3	Is there a current version of the Notice of Privacy Practices poster posted in an appropriate area?	
4	Are computer monitors positioned away from public areas to avoid observation by unauthorized individuals?	
5	Is the screen saver activated when the computer is not in use?	
6	Are paper records stored or filed in such a way as to avoid observation by patients, visitors or unauthorized staff?	
7	Is confidential patient information left unattended in a printer, photocopier and/or fax machine and are these devices in an unsecured area?	
8	Is physical access to fax machines and printers limited to authorized staff?	
9	Are patient lists, with information beyond date/address, readily visible by visitors?	
10	Is paper PHI or any item containing PHI (e.g., IV Bags, Labels, etc.) disposed of in appropriate dedicated secure containers or shredded, where applicable?	
11	Are computer passwords visibly posted?	
12	Is staff aware it is not permissible to share their password with anyone?	
13	Are unattended computer systems (including computers on carts) appropriately logged off when not in use?	
14	Is the staff aware of whom to contact about a privacy or security complaint? (e.g., unauthorized release or access of patient information)	
15	Is the staff aware of how to encrypt an email when sending PHI?	
16	Is ePHI stored locally on unencrypted workstation hard drives? (random check of desktops)	
17	Are there unattended portable media devices (e.g., jump drives, flash drives) in unsecured areas?	
18	Is the staff observed requesting Social Security numbers in an inappropriate manner and/or making copies of any type of photo identification?	
19	Is the staff aware of the process for the release of patient information? (obtaining a HIPAA Authorization for the Release of PHI form)	
20	Is the staff aware of the HIPAA policies and procedures and do they know where to find them?	

see how many patients had the same contact number, and they came up with a whole list," she said. There was also a forensic reconstruction of the employee's actions during the emergency room visits by the supposed patients, using swipe in and swipe out times. They also looked at Alicia Smyth's prescription records.

Their conclusion: Pretending to be other people, Alicia Smyth was going from emergency room to emergency room to get painkillers.

"Who would have thought? We've had so many reports where the Social Security number was off and someone was billed for services they didn't receive and it's an interface error. But through collaboration" between the compliance and internal audit departments, which report jointly to the chief integrity officer, "we identified someone who was swiping out on her lunch break and visiting different emergency rooms and checking in as a patient with a fictitious name with different conditions that are painful," Bokar said. "She got away with this for eight or nine months." If it weren't for the fact that Jane Doe was billed for services she didn't receive and called to complain, "and the fact we had a good investigator on our team who collaborated with forensics folks, this may never have been discovered." Cleveland Clinic reported the event to law enforcement.

Forensics Prove Another Employee Snooped

In another case, a hotline caller alleged that an employee impermissibly accessed another coworker's electronic medical records and disclosed highly sensitive information to other people.

Instead of a user audit, compliance did a patient audit, which is a review of everyone who accessed the patient's medical records to identify people who don't belong there, usually because they aren't providing care, Bokar said. It turned out one employee was snooping, and the compliance department interviewed him.

The employee denied it. He insisted someone hijacked his account and that he never accessed the coworker's protected health information (PHI). A forensic audit again was indispensable. "The forensics are another resource to make sure we are conducting a clean, unbiased investigation," Bokar explained. "It's the weight of the evidence that will support the conclusion, and no one can impeach the results of your investigation."

The employee knew the patient/coworker whose records were accessed, but pointed the finger elsewhere, saying he sometimes forgets to log off, so someone else could have used his login credentials to access the coworker's medical records. He complained that the caller who reported this has a vendetta against him and a history of stirring the pot. The investigator took it all in, determined to remain objective. All that was clear at that point was the PHI of a patient/employee was accessed using the password of another employee who had no legitimate right to be there. Could the hotline caller have set up the employee knowing he didn't always log off? Could there be a love triangle? It's not unheard off. "This is why being objective and having an internal auditor's mind really helps keep us in check," she said.

This investigation was going to require more than audit logs, Bokar said. They only revealed that the patient's snapshot was viewed. "An audit trail shows someone was in the records, but it doesn't always re-create what the user saw," she explained. Forensic audits "can re-create what the user saw," so Cleveland Clinic's compliance and internal audit teams again collaborated.

That was especially important because there were doubts about the credibility of the caller who reported the impermissible access. "We wanted to focus on the facts and the data and get to the truth," Bokar said.

The forensic reconstruction turned up plenty of evidence, she said. For one thing, the employee did a specific search of the electronic medical records by the coworker's first and last name, yielding 27 results. "Even though it looked like minimum access by this employee, he added the patient name to his patient list," and after looking at the information that interested him, the employee deleted it. "It was intentional," Bokar noted. "He snooped and tried to cover his tracks by deleting it."

The employee's motive: curiosity about the coworker's excessive absence from work.

Another piece of data to confirm he wasn't framed: The investigators checked the whereabouts of the hotline caller, a nurse.

Nurse locator data (Hill-Rom) showed the nurse was responding to call lights that went off in a patient's room when the medical records were accessed inappropriately. "Pyxis and Hill-Rom data support that," she said, adding that the investigators checked to ensure the clocks were synchronized.

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SNFs, Rehab Company Settle FCA Allegations for $10M Over Therapy

To encourage therapists to provide more occupational, physical or speech therapy, a manager at Eastern Shore Rehabilitation & Health Center in Alabama allegedly gave out gift cards. The more therapy that was provided, the more money the skilled nursing facility (SNF) received from Medicare, and Eastern Shore Rehabilitation, along with eight other SNFs in Alabama and Florida that were affiliated with Southern SNF Management, Inc., were allegedly determined to max out the therapy

minutes, according to a false claims complaint. Bonuses for managers were another method allegedly used to accomplish that goal, the complaint says.

Now Southern SNF, the SNFs and Dynamic Rehab, which provided rehab at the SNFs, have agreed to pay $10 million to settle false claims allegations over medically unnecessary rehabilitation services, said the Department of Justice and the U.S. Attorney's Office for the Southern District of Alabama on July 19.

"The United States alleged that between October 2009 and December 2013, Southern SNF, Dynamic Rehab and the nine skilled nursing facilities' corporate policies and practices encouraged the provision of medically unreasonable and unnecessary therapy without regard for patients' individual clinical needs," DOJ said. There have been other DOJ settlements with SNFs and their contractors *(RMC 9/22/14, p. 1)*.

Will More Providers Go to Trial?

The defendants didn't admit liability in the settlement, and these are only allegations. A false claims lawsuit with similar allegations against another SNF company is being fought in court, says attorney Paula Sanders, with Post & Schell in Harrisburg, Pennsylvania. In that case *(U.S. ex. Rel. Raymond Dolan vs. Arlington Rehabilitation & Living Center),* the U.S. District Court for the Northern District of Illinois on July 12 threw out some of the whistleblower's expert's testimony on therapy and extrapolation.

Sanders predicts more providers will consider litigating false claims allegations in the wake of the landmark 2016 U.S. Supreme Court decision in Escobar and subsequent court rulings based on Escobar, and because "the government's theories are not as successful as I'm sure the government would like them to be." The Supreme Court ruled that Escobar allows liability to attach when the defendant submits a claim for payment that makes specific representations about the goods or services provided, but knowingly fails to disclose the defendant's noncompliance with a statutory, regulatory or contractual requirement if the falsity is "material" to the government's payment decision *(RMC 6/20/16, p. 1)*. Several courts have interpreted that to mean if Medicare continues to pay claims during the alleged fraud, it's immaterial, despite the fact that Medicare is required to pay claims within 30 days *(RMC 1/22/18, p. 1)*.

Meanwhile, CMS's proposed 2019 Medicare payment regulation for SNFs moves away from a payment model driven so heavily by therapy. For now, though, the Medicare Part A SNF benefit includes skilled nursing care, rehabilitation and other services for up to 100 days after a three-day qualifying stay in an acute-care hospital. Medicare pays SNFs under a prospective payment system based on resource utilization groups (RUGs). SNFs assign RUGs according to a beneficiary's scores on the minimum data set (MDS), which represents his or her clinical condition, functional status and use of services. But therapy minutes drive RUG assignment, and SNFs determine how much physical, occupational and speech therapy a beneficiary needs.

There are five levels of therapy RUGs, with Medicare generally paying the most for ultra-high therapy. Beneficiaries admitted to a SNF are categorized into one of these therapy levels, based primarily on the number of minutes of therapy provided during the "assessment reference period" or "look-back period." As the Office of Inspector General explained in a 2012 report on SNFs, "If the beneficiary received 45 minutes of therapy during the look-back period, he or she is categorized into a low-therapy RUG; if the beneficiary received 720 minutes, he or she is categorized into an ultra-high therapy RUG."

The settlement with Southern SNF was set in motion by three whistleblowers, who are former Eastern Shore employees: La-Wanda Davis, a speech-language therapist; Tramecier Donald, a certified occupational therapy assistant; and Megan Dinkins, an occupational therapist.

It Was Allegedly One Therapy or Another

According to their complaint, Hollywood, Florida-based Southern SNF Management, a health care management company; the affiliated SNFs; and New York-based Dynamic Rehab, which provides rehabilitation services to Southern SNF Management's SNFs, allegedly "instituted and executed a companywide policy of assigning Medicare Part A and TRICARE patients to an Ultra High level of skilled therapy regardless of whether the type, the frequency or the duration of the therapy assigned to these patients bears any relationship to the patients' individual needs or actual diagnoses."

For example, at Eastern Shore Rehabilitation & Health Center, there were "multiple ways" this was pulled off, the whistleblowers alleged. When the minutes of one type of therapy—occupational, physical or speech—decreased, the minutes of another would be increased to ensure a total of 720 minutes.

Financial incentives were also allegedly used to encourage high therapy levels. "Southern SNF facility administrators regularly received bonuses based on achieving RUG level goals as reflected in the results of their facilities' census reports," the complaint said. "These amounts were based upon both the number of Medicare Part A patients in their facility and the number of patients at the Ultra High level."

Every month, Southern SNF tracked the number of patient days at every SNF in census reports. The reports tracked the billing of RUG levels and activities of daily

living. A March 2012 report, for example, shows that most SNF patients were classified as ultra-high therapy patients. "Chain-wide, 79% – roughly 4 out of 5 patient days – had been billed at the Ultra High RUG level while virtually none had been billed at the High, Medium or Low levels," the complaint alleged.

Attorneys for Southern SNF and Dynamic Rehab did not respond to *RMC*'s request for comment by press time.

Therapy may not be the focus of enforcement down the road, because CMS has floated a plan to revamp the SNF payment model that is now all about therapy minutes. The proposed 2019 prospective payment system for SNFs has a new case-mix, patient-driven payment model (PDPM). It "would focus on clinically relevant factors, rather than volume-based service for determining Medicare payment," CMS says.

"PDPM would adjust Medicare payments based on each aspect of a resident's care, most notably for Non-Therapy Ancillaries (NTAs), which are items and services not related to the provision of therapy such as drugs and medical supplies, thereby more accurately addressing costs associated with medically complex patients. It would further adjust the SNF per diem payments to reflect varying costs throughout the stay and incorporate safeguards against potential financial incentives to ensure that beneficiaries receive care consistent with their unique needs and goals."

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Condition Codes May Not be Worth Risk

continued from p. 1

health care provided within three days of discharge, and services in skilled nursing facilities and other hospital units that are not reimbursed under the inpatient prospective payment system (e.g., psych, inpatient rehab). Hospitals are required to use discharge status codes on all Medicare claim forms, such as 06 for home health, which tells Medicare when the PACT payment policy is set in motion.

But hospitals can get out from under the PACT per diems with condition codes 42 and 43. Hospitals use condition code 42 to bypass PACT when "the care provided by the Home Care Agency is not related to the Hospital Care and therefore, will result in payment based on the MS-DRG and not a per diem payment," CMS says in MLN Matters SE1411. For example, if a patient is discharged with a home health order for physical therapy after a knee replacement but is readmitted with pneumonia, the second discharge should include condition code 42 even though the patient will receive home health care, Gillis says. The reason: The patient is resuming home health care for the knee replacement, not pneumonia, and the hospital is entitled to the full MS-DRG.

Similarly, the MLN Matters states that "[c]ondition Code 43 may be used to indicate that Home Care was started more than three days after discharge from the Hospital and therefore payment will be based on the MS-DRG and not a per diem payment."

Lack of Clarity in Decision Making

The world is messy, however. For example, maybe a home health nurse will be helping the pneumonia patient with a nebulizer even though the main reason for the home health care is physical therapy for the knee replacement. "Often the medical record documentation made it very difficult to distinguish whether the home health care was related to the reason for admission," Gillis says. "Unless you can access the home health plan of care and records, it can be very difficult to determine why the patient was getting home health care."

Also, it's not clear where the buck stops with condition code 42. The case manager? The coder? "There are too many independent decisions being made," Gillis says. "Some facilities have decided not to toy with condition code 42 or 43 because if you ask the case manager to

CMS Transmittals and *Federal Register* Regulations
July 13–19

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

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- New Physician Specialty Code for Undersea and Hyperbaric Medicine, Trans. 4087 (July 13, 2018)

Pub. 100-08, Medicare Program Integrity Manual

- Medical Review of Evaluation and Management (E/M) Documentation, Trans. 808 (July 13, 2018)

Pub. 100-06, Medicare Financial Management Manual

- New Physician Specialty Code for Undersea and Hyperbaric Medicine, Trans. 306 (July 13, 2018)

Federal Register

Proposed Regulation

- Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals With Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) and Fee Schedule Amounts, and Technical Amendments To Correct Existing Regulations Related to the CBP for Certain DMEPOS, 83 Fed. Reg. 34304 (July 19, 2018)

append it, they will say 'I don't know if they were getting home health for their knee beforehand.'" And coders are looking at the medical records but don't see anything to guide them except possibly a general order for home health. It's a dangerous place to be if they blindly add condition code 42, he says.

Hospitals can go online to the Fiscal Intermediary Standard System (FISS), which contains claims information, to track patients' post-discharge whereabouts and whether they received home health care within three days, which is essential for proper use of condition code 43. But that won't tell them anything specific about the content of home health care and whether it ties back to the admission, Gillis explains. Anyway, patients could receive home health care for multiple reasons, and if any of them relate to the admission, hospitals shouldn't use condition code 42. Sorting that out before the bill drops, however, is next to impossible.

And Gillis says there may be no reason to use condition code 42 to bypass the PACT payment policy. Sometimes reimbursement under the PACT payment policy is the MS-DRG payment. It depends on the circumstances. Here's how it's calculated, Gillis says:

If the patient is discharged to post-acute care, it only affects payment if the MS-DRG falls into one of the MS-DRGs subject to a per diem. Second, Medicare calculates the payment reduction based on the previous year's geometric mean length of stay (GMLOS) for that particular MS-DRG. The first day is counted twice because more hospital resources are used the first day. For example, if the DRG pays $10,000 and the GMLOS is five, the daily rate is $2,000 (which means the patient stayed four days). At that point, the per diem amount the hospital will receive for the patient transferred to home health is the same as the MS-DRG would have been if they were discharged home.

"You may not have reimbursement impact if you stay close to or at the geometric mean length of stay," he says.

But here's a twist: In a January 2018 Medicare compliance review of Carolinas Medical Center, OIG found the hospital billed incorrectly for 29 discharges that should have been transfers because the patients received home health care services, but on five of the claims, "the Hospital could have applied condition code 42 and still have received the full DRG Payment." Meanwhile, a new aspect of the PACT payment policy—increased payments for transfer claims with outliers—just landed on the OIG Work Plan.

Two hospitals in Connecticut have settled civil monetary penalty (CMP) cases in this area. Hartford Hospital agreed to pay $2.46 million to settle allegations it violated the CMP law on the submission of false claims, and MidState Medical Center agreed to pay $436,748 over the same allegations, according to the HHS OIG *(RMC 5/22/17, p. 1)*. The hospitals allegedly coded patients as discharges although they received home health care within three days of leaving the hospital.

To track their compliance, hospitals can run reports using condition code 42 or 43 to identify patients with PACT DRGs, and calculate the GMLOS compared to the actual length of stay plus one, and determine if they owe money.

There's always the option to "wait until the dust settles" and have patient accounts or a third-party vendor add condition code 42 or 43 later, when there's clarity, Gillis says. Hospitals can adjust claims if it's worth the money.

Contact Gillis at sjgillis@partners.org. ✧

NEWS BRIEFS

◆ **The HHS Office of Inspector General has updated its Work Plan, which is a roadmap of audits, evaluations and investigations.** It includes new items on increased payments for transfer claims with outliers and post-operative services provided in the global surgery period. Visit https://go.usa.gov/xU9Ge.

◆ **A St. Louis, Missouri, physician has pleaded guilty to obstructing an FBI investigation into his Medicare and private insurance billing, the U.S. Attorney's Office for the Eastern District of Missouri said July 13.** Vidal Sheen, 58, was under investigation for billing face-to-face office visits provided on dates he was traveling outside of Missouri, including times he was in Florida and the Dominican Republic. "For these timeframes when Dr. Sheen was out of town, he created office notes with false entries reflecting that he had seen patients in his office, using his electronic signature," the U.S. attorney's office said. He was served with a subpoena for medical records about his office visits in late 2016, and in response, on December 1, 2016, "Dr. Sheen produced medical records to the FBI in which he had made false entries about face-to-face office visits, in an effort to impede, obstruct, and influence the FBI's billing investigation." He faces a maximum of 20 years in prison and/or fines up to $250,000. Visit https://tinyurl.com/ycsyq22c.