Compliance Round-Up

Recovery Auditors, PSC Appeal, DOJ ICD Investigation, Orthofix FCA Update, HIPAA/HITECH, Meaningful Use, ICD-10, SRDP

September 11, 2012

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Continuing Goals

The goals of the Compliance Round-Up Webinars:

- Teaching/knowledge transfer
- Keep you up to date on compliance rules
- Practical points
- Assist organizations to develop in-house methods of managing
- Please share your thoughts, suggestions (and criticisms)

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Compliance Round-Up: Webinar Overview

Administrative Matters

- Monthly on the 2nd Tuesday of the month
- No charge! (feel free to spread the word….)
- Each session will be 60-75 minutes in duration
- Each session will begin at 12:00 PM CT
- If you are unable to participate in the live discussion, each session will be recorded and made available in MP3 format

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Today's Topics

1. Recovery Auditors
   A. CMS Program Instructions—Part B
   B. Connolly
   C. AHA RACTrac Survey
2. PSC Appeal
3. DOJ ICD Investigation
4. OrthoFix Settlement Update
5. HIPAA/HITECH
   A. MD Anderson
   B. Exeter Hospital
   C. Medical Identity Theft WBT
6. Meaningful Use Rules
7. ICD-10 Delayed
8. SDRP Settlements

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CMS Memorandum dated July 23, 2012 – Part B Payments

CMS Issues instructions to Fiscal Intermediaries and Carriers to Effectuate Part B Payment Pursuant to RAC ALJ Determinations Supporting Outpatient and Observation Level of Care

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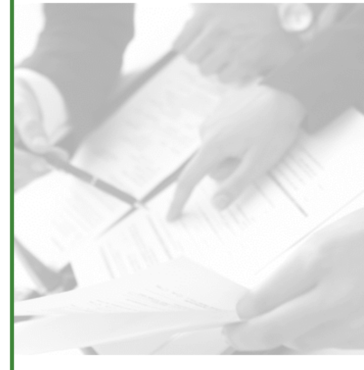
Background: ALJ/MAC Decisions Prior to July 13, 2012

Medicare Appeal Council ("MAC"). In the Case of O'Connor Hospital dated February 1, 2010, ("O'Connor")

- In O'Connor, the MAC reversed the RAC's denial of the Part B request for reimbursement.
- MAC ordered CMS' contractor to work with the provider to take whatever actions are necessary to arrange for billing under Part B, and thus, offset any Part A overpayment. The contractor shall issue a new initial determination upon effectuation.

http://www.hhs.gov/dab/divisions/medicareoperations/macdecisions/oconnorhospital.pdf.



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Background: ALJ/MAC Decisions Prior to July 13, 2012

Case of the University of Southern California Hospital Center (USCHC), ALJ Appeal Number 1-899853631 (May 3, 2012). ALJ determined:

- Part A payment was appropriately denied by RAC.
- The medical record supported that observation services were medically reasonable and necessary.
- USCHC was entitled to the hourly observation rate plus all Part B services.
- The ALJ ordered that the Medicare Contractor work with USCHC to arrange for billing for all observation services including all Part B services to offset the Part A overpayment in accordance with MFMM, Pub. 100-6, Ch 3, §170.1.

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What did the RAC, Intermediary and Carriers Do?

- Nothing until it received instructions from CMS;

- Reimbursed Part B payment improperly by using Form 12X which is used to reimburse inpatient part B claim – treated as outpatient and only ancillary services include radiology, pathology, electrocardiology, electroencephalography, physical therapy, speech pathology, renal dialysis, and medical supplies (prosthetic devices, braces, and splints) can be billed.

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What is the 13 X Bill?

The 13x bill is used to bill Part B outpatient and ancillary services such as outpatient surgeries, consultations, therapy visits or diagnostic tests rendered in the emergency or other outpatient department or clinic as a result of an encounter at the facility.

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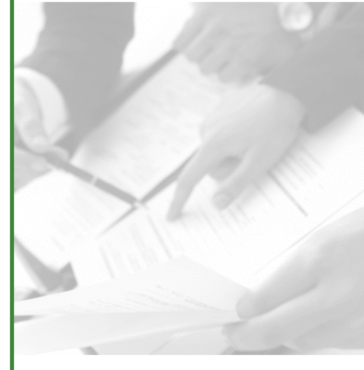
CMS Memorandum dated July 23, 2012 – Part B Payments

CMS acknowledged that there have been multiple ALJ decisions where the ALJ has upheld the contractors' denials of the inpatient services as not reasonable and necessary, but then ordered the contractor to pay the hospital full Medicare Part B outpatient reimbursement, including observation.



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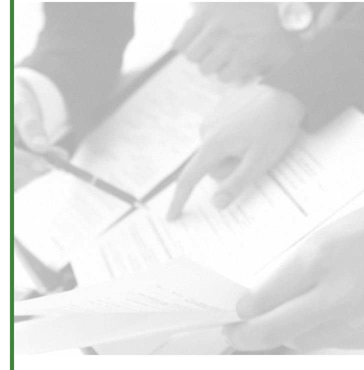
CMS Memorandum dated July 23, 2012 – Part B Payments

CMS issued mandatory instructions for claims administration contractors to follow in the event that an ALJ decision instructs CMS to make payments for Medicare Part B outpatient/observation services.



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CMS July 23, 2012 Mandatory Instructions:

- CMS acknowledges that Medicare pays for observation services under the outpatient prospective payment system (OPPS). However, observation services are generally bundled and not paid separately.

- ALJ's decision requires the claims administration contractor to pay for all services that would be separately payable under the OPPS had the hospital initially billed Medicare for outpatient services on a **13x or 85x type of claim. (Emphasis added).**

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CMS July 23, 2012 Mandatory Instructions:

Within 30 calendar days of receipt of the effectuation notice from the Administrative QIC (AdQIC):

- Contractors shall contact the provider to secure a new replacement claim with the appropriate outpatient HCPCS codes and line item charges representing rendered services, including observation, where appropriate.

- A line item charge for observation may only be included if there was an order for observation. In the absence of an order for observation, the observation charges should not be included if the ALJ only specified payment for outpatient care or services.

- If the ALJ specified "observation level of care" or "including observation care," line item charges for observation may be added if otherwise appropriate, as the ALJ is specifically substituting the order to admit for the order for observation.

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CMS July 23, 2012 Mandatory Instructions

If a contractor does not receive a replacement claim from the provider within 180 days from the date the contractor contacts the provider, it shall close the case and consider the effectuation complete.

- Cancel/delete the original inpatient claim in CWF to prevent the replacement outpatient claim from being rejected as a duplicate.
- Process the replacement outpatient claim in the Fiscal Intermediary Shared System (FISS).
- Bypass or override timely filing requirements and any other edits (including medical review), if necessary, to issue payment.

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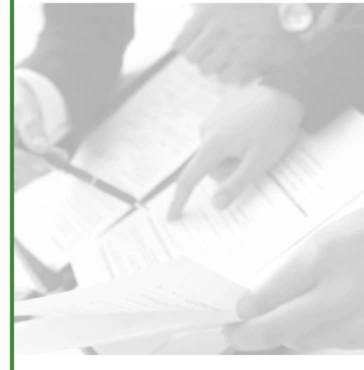
CMS Comments Reflect Unease with Mandatory Instructions:

- CMS acknowledges following conflict: The ALJ's order is in conflict with Medicare Benefit Policy Manual which specifies a limited list of medical and other health services that may be paid under Medicare Part B when an inpatient admission is "disapproved as not reasonable and necessary (and waiver of liability payment was not made)."
- Medicare Claims Processing Manual indicates that an "outpatient" means a person who has not been admitted as an inpatient but who is registered on the hospital or critical access hospital (CAH) records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH. By this definition, an inpatient stay that has been disapproved is still a stay for an admitted patient that is not transformed into an outpatient stay. Payment may only be made under the OPPS for patients that are outpatients—that is, a patient that has not been admitted as an inpatient. (*See:* Chapter 6, sections 10 and 20.6 of the Medicare Benefit Policy Manual (Publication 100-02) and Chapter 1, section 50.3 of the Medicare Claims Processing Manual (Publication 100-04). 2



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O'Connor, ALJ Decisions and CMS Transmittals Do Not Support CMS' Comments Regarding Conflicts With Policy

Also see CMS Transmittal R2386CP (January 13, 2012)

Subject: January 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Directs Medicare Contractors to use the 13X bill.

In, amending Chapter 1, Section 50.3.2 of the Medicare Claims Processing Manual, CMS issued guidance which clarified that providers could separately bill outpatient services rendered prior to a non-covered inpatient admission. CMS has stated: "In cases where a hospital determines that an inpatient admission does not meet the hospitals inpatient criteria, the hospital may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (bill type 13x or 85x).

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RAC-Connolly

- An Oklahoma Congressman (David Boren) recently wrote HHS and called for a moratorium on funds to be recouped by Connolly (Region C) and an investigation into the methods used by Connolly
- Expressed particular concern about impact on small and rural hospitals
  - "Connolly, Inc. has engaged in what can only be described as overzealous predatory tactics against Oklahoma's rural hospital community with their aggressive, overly critical approach. Connolly, Inc, and other RACs are causing significant survival choices for rural hospitals by impacting operational cash flow, cash reserves, and any other publicly approved support in the form of city or county taxes."

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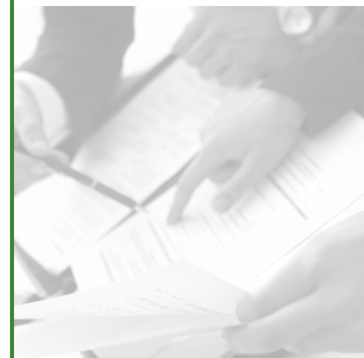
RAC Activity-RACTrac

- AHA recently released results of the RACTrac survey for Second Quarter of federal FY 2012

- Requests for medical records by RACs increased sharply from first to second quarter of federal FY 2012.

- Providers also experienced in increase in the denial of claims, both automated and complex over that same time.



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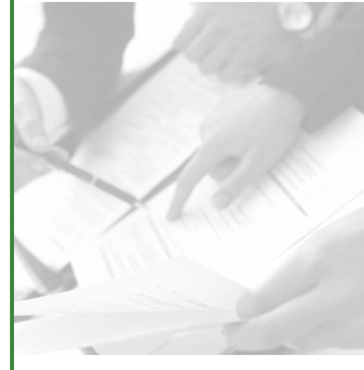
PSC—Overpayment Determination Appeal

- In an order dated August 16, the U.S. District Court for the Middle District of Florida adopted and confirmed a Report and Recommendation (Recommendation) of a Magistrate Judge dated August 1, and reversed and remanded the final decision of the Secretary of the U.S. Department of Health and Human Services (Secretary) that had upheld a Medicare overpayment of $1,614,691 assessed against Teamcare Infusion Orlando Inc. (Teamcare).

- The court concluded that the Secretary's final decision (a decision of the Medicare Appeals Council (MAC) that upheld the decision of an Administrative Law Judge (ALJ)) was not supported by substantial evidence supporting the amount of the overpayment.



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PSC—Overpayment Determination Appeal

- Teamcare is a pharmacy supplier of durable medical equipment and supplies, which was audited by TrustSolutions LLC, the Medicare Program Safeguard Contractor (PSC), for claims for items including blood glucose monitors and supplies, continuous positive airway pressure devices, nebulizers and related drugs and accessories, oxygen equipment and supplies, and parenteral nutrition.

- The record on appeal did not contain the audit performed by the PSC, any information on the "random sample" used to determine the overpayment, the total number of claims submitted by the supplier during the audit period against which the overpayment was extrapolated, the formula used by the PSC to perform the extrapolation, or even the initial determination issued by the PSC.

- It was further noted that the number of claims supposedly at issue in the sample, and in some cases the reason for denial of particular claims, varied amongst the initial determination, the redetermination, the reconsideration, the ALJ decision, and the MAC's decision.

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PSC—Overpayment Determination Appeal

- Due to the level of redaction in the record prepared by the Secretary, the Magistrate found that it could not be determined whether substantial evidence supported the findings with respect to specific beneficiaries and claims at issue.

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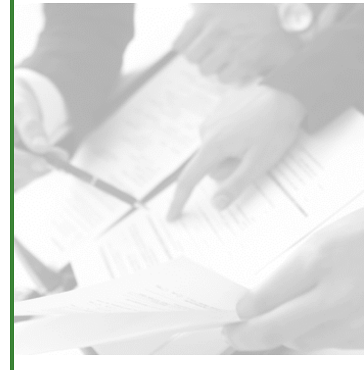
DOJ ICD Investigation

- DOJ recently emailed hospitals across the country with instructions to examine questionable implantable defibrillator surgeries on Medicare patients and estimate potential penalties under the False Claims Act.

- For more than two years, prosecutors with the Justice Department have been using data-mining technology, civil investigative demands and collaborative meetings with experts to investigate the question of whether some Medicare patients received implanted defibrillators outside of strict CMS rules on when such devices can be used.

- The DOJ's "Medical Review Guidelines/Resolution Model" instructs hospitals to self-audit and to "estimate damages, with the severity of penalties based on whether the hospital had medical reasons to violate CMS rules; if patient harm resulted; if the hospital had prior knowledge or a statistical pattern of non-guideline implants; and if a hospital compliance program was in place."



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Orthofix Settlement Update

- In July, told you about a FCA settlement with Orthofix
- U.S. District Court recently rejected agreement allowing Orthofix to plead guilty to a felony count of obstructing a government audit and pay a $7.8 million fine after concluding the deal unduly restricted his sentencing power.
- Unclear whether court's refusal to accept the plea also scuttles Orthofix's agreement to pay $34.2 million to resolve civil claims first raised in a whistle-blower's lawsuit that the company defrauded the federal Medicare program through payments to doctors who used its bone-growth stimulators

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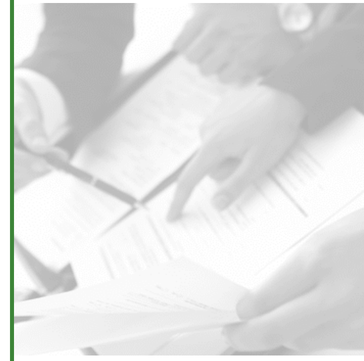
HIPAA/HITECH—Data Breach

- In a press release dated August 17, 2012, The MD Anderson Cancer Center at the University of Texas announced that it had sent letters to about 2,200 patients whose unencrypted medical records may have been compromised on a lost thumb drive.
- A trainee lost an unencrypted thumb drive on an MD Anderson employee shuttle bus. The drive contained some patient information, including patient names, dates of birth, medical record numbers and diagnoses, and treatment and research information. The USB thumb drive contained no patient Social Security numbers or other financial information.
- Third possible data breach reported this year for the center.



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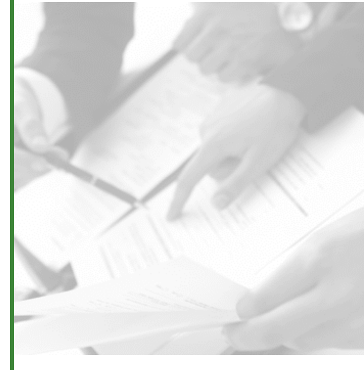
HIPAA/HITECH—Exeter Hospital

- In a press release dated August 29, 2012, Exeter Hospital (NH) announced that it was objecting to efforts by the New Hampshire Division of Public Health Services (DPHS) to gain broad access to its medical record systems.
- Request was part of an investigation to identify victims of a former employee who had exposed patients to hepatitis C
- Hospital filed an action seeking judicial guidance in New Hampshire Superior Court in Merrimack County.
- Intent is to obtain judicial guidance for both the DPHS and Exeter Hospital in “this challenging intersection between individual privacy and the DPHS’ desire to examine confidential patient medical records.”



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Medical Identity Theft

- HHS OIG recently released as WBT course designed to provide education on medical identity theft.
- It includes information on how to recognize risks and resources that Medicare and Medicaid providers can use to protect their medical identity.
- http://oig.hhs.gov/compliance/101/cme.asp

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Stage 2 Meaningful-Use Rule

- On August 23, CMS released a copy of the final rule on Stage 2 of the EHR incentive program

- CMS also released a standards and certification final rule.

- The Stage 2 meaningful-use requirements that providers must satisfy to receive payments under the program will go into effect in early 2014, according to a final rule issued by the CMS and the Office of the National Coordinator for Health Information Technology.

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Stage 2 Meaningful-Use Rule

- The final rule adds two new "core objectives" to the Stage 2 reporting requirements for physicians and hospitals. The first requirement, for physicians, is to use secure electronic messaging to communicate relevant health information with patients. The second requirement, for hospitals, is to automatically track medications from order to administration using "assistive technologies in conjunction with an electronic medication administration record (eMAR)."

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Stage 2 Meaningful-Use Rule

- Since the program began in January 2011, more than 120,000 eligible healthcare professionals and more than 3,300 hospitals have qualified to participate and receive incentive payments, according to the CMS. The rates of participation include more than half of all eligible hospitals and about 20% of eligible healthcare professionals.

- The Stage 3 phase will add another layer of health data collection and reporting requirements for the participating providers. Medicare providers that do not successfully participate by 2015 will begin to face cuts in their overall payments from the program.

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IDC-10 Formally Delayed

- The federal government finalized a one-year delay in the compliance deadline for the nationwide conversion to ICD-10 code sets.
- The delay, first proposed in April, will move the compliance deadline to Oct. 1, 2014.
- HHS said the extra time would allow healthcare organizations—small organizations in particular—adequate time to get ready for the changeover.

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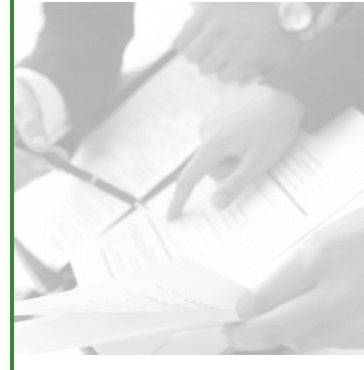
SDRP Settlements

- On August 15, CMS announced another settlement under the Voluntary Self-Referral Disclosure Protocol (SRDP).
- This settlement involved violations of the Stark Law by a Florida hospital (Hospital).
- The Hospital disclosed under the SRDP that its arrangements with three physicians for certain services may have violated the Stark Law, because those arrangements did not satisfy the requirements of the personal services exception under the Stark Law.
- The Hospital's violations were settled for $22,000.



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SDRP Settlements

- On August 22, CMS settled two more violations of the Stark Law by a hospital located in Missouri (the Hospital).
- The Hospital disclosed under the SRDP that arrangements with two physicians for the provision of dental services to certain patients may have violated the Stark Law, because those arrangements did not satisfy the requirements of the personal service arrangements exception.
- All violations disclosed were settled for $125,000.

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Next Lecture

October 9, 2012
12 pm CT/1pm ET

Questions?
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