

Weekly News and Analysis on New Enforcement Initiatives and Billing/Documentation Strategies

Contents

- 3** Elements of a Discharge Summary
- 4** Complex Requirements For Imaging Challenge Compliance Efforts
- 6** CMS Transmittals And Regulations
- 8** News Briefs

There's no need to wait for your next issue to stay on top of the latest industry news! The "From the Editor" postings at your subscriber-only Web page will keep you updated all week long. Log in at www.AISHealth.com/newsletters/reportonmedicarecompliance.

Managing Editor

Nina Youngstrom
nyoungstrom@aishealth.com

Contributing Editor

Francie Fernald

Executive Editor

Jill Brown

When MDs Can't Bill, Medicare Won't Pay Hospitals, but Screening Isn't Available

Hospitals may be blindsided by revocations of physicians' Medicare billing privileges, which means the services that these physicians perform, order and refer are not billable to Medicare. Physicians who fail to report certain events — mundane or serious — to Medicare may have their billing privileges taken away, but there is no routine way for hospitals to find out when that happens.

It may come as a surprise to some hospitals that physicians sacrifice their billing privileges and enrollment for failing to notify Medicare within 30 days of "adverse" actions, including license suspensions, as well as changes in practice locations, says San Francisco attorney Judy Waltz, with Foley & Lardner LLP. Physicians themselves may not be forthcoming, because they didn't realize their reporting obligations or didn't honor them. Whatever the reason, hospitals are at risk of losing Medicare revenue if services were ordered, referred or performed by physicians in provider-based clinics or hospital services were ordered or performed by independent physicians — and any one of them had privileges yanked.

"There are serious economic and professional consequences for revocation of billing privileges and it's almost impossible to find out who lost privileges," says Jim Sheehan, former federal prosecutor and New York state Medicaid Inspector General. CMS has new methods to sniff out physicians who lose their Medicare billing privileges, but there's no database that hospitals can use to check for billing revocations like the HHS Office of Inspector General's List of Excluded Individuals and Entities. "This should be available to everyone," says Sheehan, now executive deputy commissioner of the New York City Human Resources Administration.

continued on p. 6

Discharge Summaries Take Center Stage; Risks Grow with Electronic Health Records

Discharge summaries are getting more attention, as the final link in the chain of evidence that may protect claims from auditors and as a tool to prevent readmissions, improve continuity of care and comply with meaningful use and core measure requirements. But discharge summaries have evolved with the adoption of electronic health records and the spread of hospitalists, and their quality and integrity could use a fresh look, experts say.

"The time of discharge is a big compliance risk. It can set off an adverse chain of events, including readmissions," said Sandra Routhier, senior healthcare consultant with Panacea Healthcare Solutions, at a Feb. 14 webinar sponsored by RACMonitor.com.

Because discharge summaries are a prime piece of documentation in terms of substantiating the medical necessity of admission and coding diagnoses and procedures, they have to stand up to auditor scrutiny. "The discharge summary is my favorite document in the inpatient record," Routhier said. "It's where the doctor summarizes the

whole encounter" (see box, p. 3). Auditors should be able to tell from discharge summaries exactly what they will find in the rest of the medical record — what the patients presented with, what was suspected on admission, what clinicians did for them during the stay and what the plan for discharge is. But electronic health records have brought significant changes to discharge-summary formats, and some of the required elements normally found in a discharge summary dictated by physicians may be missing, Routhier said.

Discharge summaries also are "the handoff document from hospital to home or the outpatient environment," George Alex, senior managing consultant at the Berkeley Research Group in Baltimore, said at the webinar. "The post-discharge provider may not have access to all the information so the discharge summary must stand on its own." Studies show that making discharge summaries available to primary care physicians reduces readmissions, Alex said.

The elements of discharge summaries are set forth by CMS and accreditation bodies and incorporated in hospital bylaws. Under the Medicare conditions of participation (Sec. 482.24(b) and (c)), discharge summaries

must include the outcome of the hospitalization, the disposition of care, medications, adverse reactions, complications, health care-associated infections, provisions for follow-up and a final diagnosis documented within 30 days — although hospitals are starting to demand it sooner, Routhier and Alex said. The Joint Commission echoes many of these requirements.

Discharge Summaries Are Key to Coding

A lot is riding on discharge summaries in terms of coding and billing. They communicate the clinical information needed to select principal and secondary diagnoses, which drive the MS-DRG. Physicians can elaborate on diagnoses — which conditions were confirmed and which were ruled out, Routhier said. Suppose urinary tract infection is documented as a differential diagnosis in the history and physical, but cultures were negative and antibiotics discontinued on the third day. Did the patient have a UTI or not? "If it's something that impacts the stay and qualifies as a principal or secondary diagnosis, it is relevant to mention it in the discharge summary," she said.

But be wary of "surprise diagnoses" in discharge summaries, Routhier said. "Sometimes you see a diagnosis show up in the discharge summary that's not supported in the body of the medical record or clinical evidence. It's suspicious when acute respiratory failure is documented in the discharge summary out of the blue." Conversely, auditors say sometimes there's nothing about the principal or secondary diagnosis in the discharge summary. "If it's so significant, why isn't it in the discharge summary?" Auditors are very skeptical of these claims, although this isn't necessarily a deal-breaker. "If it isn't included in the discharge summary, it better be overwhelmingly supported throughout the medical records," Routhier said. Both problems may be a side effect of electronic health records; physicians could have copied and pasted conditions from a previous admission or pulled in diagnoses from a problem list that hasn't been properly maintained.

Hospitals should also think twice about discharge summaries that are created by dictation services or providers who did not participate in the care of the patient and then co-signed by attending physicians. "I have encountered facilities that outsource the creation of discharge summaries to qualified individuals who review the medical records and then they're co-signed by the attending. I don't find those documents are that valuable from a coding or abstracting perspective," she said. The discharge summary is supposed to finalize the medical record for the inpatient encounter, but that's not possible unless the attending physician completes it.

Report on Medicare Compliance (ISSN: 1094-3307) is published 45 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

Copyright © 2013 by Atlantic Information Services, Inc. All rights reserved. On an occasional basis, it is okay to copy, fax or email an article or two from *RMC*. But unless you have AIS's permission, it violates federal law to make copies of, fax or email an entire issue, share your AISHealth.com subscriber password, or post newsletter content on any website or network. To obtain our quick permission to transmit or make a few copies, or post a few stories of *RMC* at no charge, please contact Eric Reckner (800-521-4323, ext. 3042, or ereckner@aishealth.com). Contact Bailey Sterrett (800-521-4323, ext. 3034, or bsterrett@aishealth.com) if you'd like to review our very reasonable rates for bulk or site licenses that will permit weekly redistributions of entire issues.

Report on Medicare Compliance is published with the understanding that the publisher is not engaged in rendering legal, accounting or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought.

Managing Editor, Nina Youngstrom; Contributing Editor, Francie Fernald; Executive Editor, Jill Brown; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Tracey Filar Atwood; Production Director, Andrea Gudeon.

Subscriptions to *RMC* include free electronic delivery in addition to the print copy, e-Alerts when timely news breaks, and extensive subscriber-only services at www.AISHealth.com that include a searchable database of *RMC* content and archives of past issues.

To order an annual subscription to **Report on Medicare Compliance** (\$528 bill me; \$498 prepaid), call 800-521-4323 (major credit cards accepted) or order online at www.AISHealth.com.

Subscribers to RMC can receive 12 Continuing Education Credits per year, toward certification by the Compliance Certification Board. Contact CCB at 888-580-8373.

A related problem crops up with the growing use of hospitalists, Routhier said. More inpatients are treated by various hospitalists during their stay. While they all contribute to the medical record, there can be problems completing a comprehensive discharge summary because there have been so many fingers in the documentation pie, she said.

In terms of the continuum of care, discharge summaries are the first and maybe the only communication between the hospital and post-discharge provider (e.g., the primary care physician), Alex said. They are essential to continuity of care, medication reconciliation and preventing readmissions and their associated penalties. But hospitals must have a process for identifying post-acute providers and relaying discharge summaries to them, he said. It's easier when physicians are part of the same electronic health records system. For example, a 21-point electronic template was found in one study to reduce

readmissions, identify the primary care physician and improve the quality of the discharge summary, Alex said.

EHRs have changed the discharge summary landscape, for better and worse. One benefit is that discharge summaries can be completed much faster. "Often hospitals have gone from 30 days to seven days to three days to a 24-hour commitment," Alex said. Some hospitalist contracts have bonuses or penalties linked to timeliness of discharge summary completion. EHRs pave the way because some sections of the discharge summary, such as medication reconciliation, can autopopulate over the course of the hospital stay. "What you will find at discharge is the amount of work is less substantial," he said.

Physicians also use voice recognition or EHRs to create discharge summaries in real time. That's a far cry from the discharge summaries of the past, which were dictated for later transcription, Routhier said. The speed dovetails nicely with meaningful use requirements. To

Elements of a Discharge Summary

Sandra Routhier, senior health care consultant with Panacea Healthcare Solutions, lists the recommended elements of a hospital discharge summary. Contact Routhier at srouthier@panaceahealthsolutions.com.

- ◆ **Patient Identification and demographics**
- ◆ **Principal Diagnosis** (The condition after study that was determined to have led to the admission)
- ◆ **Additional Diagnoses** (other comorbid conditions and/or complications that impacted resources consumed during hospitalization; include confirmed diagnoses and those still suspected at the time of discharge)
- ◆ **Surgical or Other Significant Procedures**
- ◆ **History of Present Illness** (Significant H&P findings, events that resulted in inpatient hospitalization, condition that occasioned the admission)
- ◆ **Hospital Course** (summarize the events of the hospitalization — doesn't need to be a day-by-day, play-by-play. Recommend problem-based vs. chronological. What were the significant events? Tell the story of the hospitalization for each significant medical problem — the beginning, middle and end.)
 - **Patient's condition/diagnoses** (address severity of illness, response to treatment, address any differential diagnoses that were confirmed, ruled out or still uncertain at time of discharge)
 - **Findings and Diagnostics** (Summary of significant diagnostic tests and their findings)
 - **Treatment and Procedures** (Summary of significant treatments and procedures including medication changes)
 - **Consultations**
 - **Complications**
- ◆ **Condition on Discharge** (Exam on discharge)
- ◆ **Discharge Plan and Instructions**
 - **Disposition** (Place to which patient was discharged, such as home with home health services or skilled nursing facility)
 - **Instructions/Education** (Disease and/or surgery-specific discharge instructions and patient education such as diet, activity, wound care, etc.)
 - **Medications** (all medications prescribed at time of discharge; Medication reconciliation)
 - **Orders for post-discharge diagnostic tests**
 - **Referrals/Appointments** (provisions for follow-up care)
- ◆ **Physician Signature(s) with date and time** (author and any required co-signatures)
- ◆ **Document creation date and time**

SOURCE: Sandra Routhier, Panacea Healthcare Solutions

qualify for incentives under stage I, hospitals must make a copy of discharge instructions at time of discharge in paper format, or, if requested by the patient, in electronic format, Alex said. Stage II meaningful use requires hospitals to “generate and transmit summary of care documents at transition of care and referrals,” the CMS website says.

With EHRs, hospitals can effectively capture e-prescribing and post-discharge orders (e.g., labs, follow-up X-ray) depending on the functionality provided in their EHR system. “It can be prepopulated into the discharge summary without creating a lot of rework for the physician,” Routhier said. And canned text can be dropped into the document when the same type of information needs to be communicated in the discharge summary, such as disease-specific discharge instructions. “But you don’t want a lot of cutting and pasting. We are seeing problem lists pulled in that are not being managed effectively,” she said.

It’s important to ensure electronic discharge summary templates are well crafted or they may backfire. If physicians find them confusing or they lack prompts for all the required elements, they will hunt for “work-arounds” and perhaps undermine the quality of the discharge summary, Alex said.

There’s a monitoring benefit to EHRs, Alex said. How quickly are discharge summaries completed? How often are certain parts completed or neglected? “It gives you information about how to tackle problems,” he said. If certain fields are missed by all physicians, group training is a better approach. But if only a handful of physicians always drop the ball, then one-on-one discussions are preferable.

Discharge summaries also figure into core measures, which are CMS quality ratings posted on the Hospital Compare website. CMS tracks hospital compliance with

standards of care for certain conditions, such as acute myocardial infarction. If the core-measure requirements have been met — for example, the physician identified a contraindication for prescribing a beta blocker or statin at the time of discharge — but this was not documented in the medical record, there’s always the chance to add it to the discharge summary, Routhier said.

Alex cautioned that there is another core measures angle. Coding every complication and comorbidity documented in the discharge summary, as coders are trained to do, may not turn out well from a core measures perspective. “You may identify diagnoses that drive up the DRG payment but have unintended consequences on core measures [case selection and reporting],” he said. “That information will be included on the Hospital Compare website so you want to come up with a balanced approach.”

Contact Routhier at srouthier@panaceahealthsolutions.com and Alex at galex@brg-expert.com. ♦

Complex Requirements for Imaging Challenge Compliance Efforts

There are almost endless ways to run afoul of Medicare laws and regulations on imaging, whether it’s provided through a physician practice, hospital or joint venture. Both longstanding and new rules continue to challenge provider efforts to comply, including supervision requirements and the Stark law.

“Imaging may be the most heavily regulated service offered by clinics and hospitals. I believe there may be more ways to violate a law or regulation with imaging than with any other service,” says Minneapolis attorney David Glaser, with Fredrikson & Byron. “No mortal can keep all of the rules straight.”

At the same time, revenue is under increasing pressure because the volume of diagnostic tests has grown exponentially. “Payers, both governmental and [private], have been squeezing it for years and they will keep squeezing,” Glaser says.

Medicare’s imaging rules vary according to the setting where they are provided and the nature of the arrangement under which they are provided.

In the office setting, Medicare requires treating physicians to write an order for imaging (except for diagnostic mammograms based on screening mammograms). “A scan not ordered by the treating physician in the office is not considered medically necessary,” says attorney Katie Ilten, also with Fredrikson & Byron. “It’s a condition of payment.” For this purpose, treating physicians include physician extenders, such as physician assistants and nurse practitioners.

Example of a Bad Discharge Summary

“Hospital Course: Pt was seen and evaluated, treatment and work up was initiated, course of action was taken and orders were given as the result of work up became available, pt was kept comfortable, with symptomatic relieve therapy, as well as specific treatment for the clinical condition, pt improved And the condition was stable for discharge to continue treatment as out pt”

SOURCE: Sandra Routhier, Panacea Healthcare Solutions

Supervision requirements in the office can trip up physicians. Only physicians (not physician extenders) can supervise diagnostic tests, and the Medicare physician fee schedule sets three supervision levels for imaging performed in the office: direct, personal and general.

Consider the '30-Second' Test

When direct supervision is required in the office setting, the physician must be present in the office suite and immediately available to render assistance and direction throughout the performance of the procedure. "This is a tricky one," Ilten says. "We know you don't have to be in the room" but the other two criteria aren't absolutely clear. Office suites have different configurations, and "immediately available" means different things to different people, Ilten says. For example, an office suite may be contiguous rooms or several floors of a townhouse. Are physicians meeting the direct supervision criteria if the scan is performed on the first floor while the supervising physician is on the third floor? "CMS says this is a question for local carriers, so we have them interpreting this in different ways," Ilten says.

Glaser thinks the "immediately available" test is satisfied when physicians meet the 30-second test. "CMS doesn't like different buildings but if you are in the same building and can get there in 30 seconds, you have a pretty good argument that you are immediately available."

If personal supervision is required, the physician must be in the room during the whole procedure. General supervision means the imaging is provided under the overall direction and control of the physician but the physician's presence is not required during the performance of the procedure, Ilten says. "Supervising physicians are responsible for technicians doing scans and for the equipment. Only physicians can supervise technicians," she says, which obviously means physician extenders cannot supervise imaging. That may get confusing because Medicare allows physician extenders to order imaging and to provide direct supervision for most outpatient therapeutic services. But they can't supervise imaging because it's not considered a physician's service, Glaser says.

CMS added a new wrinkle to imaging compliance effective January 1, 2012. Medicare now pays only for the technical component of "advanced diagnostic imaging services" (e.g., nuclear medicine, diagnostic MRIs) to accredited suppliers. CMS has named three organizations — the American College of Radiology, the Intersocietal Accreditation Commission, and The Joint Commission — to perform accreditation services, CMS says on its website.

In another new rule, CMS recently revised its policy on place-of-service codes, which affects billing for imag-

ing (*RMC 2/20/12, p. 4*). The POS codes indicate where services are performed, including POS 11 (office), POS 21 (inpatient hospital) and POS 22 (outpatient hospital). But how physicians report them to Medicare changed on April 1, 2012. POS codes must now correspond to where the beneficiary received the technical component of the service (e.g., the MRI), not where the physician interpreted the test, Ilten says. In other words, the face-to-face encounter with the patient dictates the POS code.

Shifting to hospitals, imaging can be ordered by any physicians and other clinicians with privileges, such as NPPs. The rule limiting treating physicians to the order do not apply, Glaser says. If the patients walk into a clinic and there is an order by the treating physician for a chest X-ray but the radiologist thinks an X-ray of the abdomen is also needed, he can't just add it; the referring physician must do this. Yet in a hospital, the additional X-ray can be added. "The inconsistency under the Medicare rules is some really crazy stuff," Glaser says. "That one is not intuitive."

Only physicians are allowed to supervise outpatient diagnostic tests performed in the hospital, Ilten says. The same supervision definitions apply from the Medicare physician fee schedule. It's pretty easy to comply with. "When directly supervising tests, you must be immediately available," Ilten says. That means no farther than 250 yards away from the hospital. Suppose the hospital buys an orthopedic group and it has an MRI machine. There has to be a physician onsite whenever MRIs with contrast are performed if the hospital is outside the 250-yard mark, he notes. This Medicare rule is designed to protect patient safety, although he has doubts that a technical problem with the machine could be remedied by a physician.

Health Reform Complicates Imaging Compliance

The Affordable Care Act made some changes that complicate matters for imaging compliance. For example, it ended Stark's exception for physician-owned hospitals. Although the health reform law grandfathered in the physician-owned hospitals that already were in business, "going forward you can't add beds or upgrade the hospital much at all," says Steve Beck, also an attorney with Fredrikson & Byron. More importantly, imaging joint ventures protected by Stark's rural exception can run afoul of the new provision. "You can blow out the exception," Beck says. When a hospital and physicians do a joint venture to operate a scanner and set it up to be hospital-based, it can be deemed as physicians having an ownership interest in the hospital, which is prohibited by the new law.

In terms of leases, Glaser wants to disabuse providers of the notion that you need a block lease for a con-

tiguous period of time to qualify for the Stark exception for leases. Informal statements from CMS have indicated the lease must be established in blocks of time and three hours is thrown around by lawyers as the required increment of time. "I say, 'baloney.' Yes, it has to be exclusive, with only one physician leasing at a time. But it can be for any period of time as long as it really is exclusive. The requirement is exclusivity, not blocks of time."

Equipment joint ventures are a particularly risky area, Beck says. Often the rate of return is above fair-market value, which triggers the Stark tripwire. "If the rate of return is high, if [doctors] earn good money, they should be really careful," he says. The most common examples are hospitals joint venturing with a group of physicians, typically radiologists, orthopedists or cardiologists. The doctors pay for the equipment and lease it to the hospital. The doctors benefit from both professional fees for interpreting scans and from the return on investment in the joint venture, while the hospital bills for the technical fees from all the patients referred by the physicians.

CMS has made this harder by implementing the stand-in-the-shoes rule, which judges financial relationships between hospitals and physicians more directly,

even if there is a group practice in the middle. As a result, joint ventures have to meet a Stark exception for direct compensation arrangements. In addition, because of the revised definition in Stark of the "entity" furnishing the service, these joint ventures may need to meet an ownership exception instead of a compensation exception, and that's difficult. Beck says it's still possible to do the deals. However, under the lease, the joint venture can no longer charge the hospital a per-unit (e.g., per hour) fee for time spent on the MRI or other imaging machine.

Sometimes providers try to argue that fair-market value means a fair-market return on their investment (e.g., 10%). "That will be a position that is hard to support with a regulator," Beck says. "A better position is 'I might get a return that is 10% or a loss of 10% — these are equal probabilities. I expect this [joint venture] to involve real risk.'"

Contact Glaser at dglaser@fredlaw.com, Ilten at kiltlen@fredlaw.com and Beck at sbeck@fredlaw.com. ♦

Billing Revocations Pose Risk

continued from p. 1

CMS's view is that physicians whose billing privileges have been revoked are not authorized to order or refer patients for Medicare items or services, such as diagnostic tests, Waltz says. "It's pretty scary what CMS can do under these authorities to oust providers and suppliers from Medicare participation," she says. "Probably the only place that hospitals can get this information is from physicians themselves. Hospitals may need to take actions that will put doctors on notice that they expect reports on events which may impact Medicare and Medicaid billing privileges, and require physicians to regularly confirm their 'good-standing' status in government programs — in the bylaws and in policies and procedures requiring such reports."

Even physicians who aren't Medicare participating providers are affected. The Affordable Care Act required them to enroll in Medicare "for the sole purpose of ordering/ referring items or services for Medicare beneficiaries" using the 855o form, according to CMS.

Recently, one hospital was surprised to find that a physician had lost his license months earlier but didn't tell Medicare, according to the compliance officer, who asked not to be identified. "The 855i enrollment form requires that a provider needs to notify Medicare within 30 days of any adverse legal action including licensure suspension," the compliance officer says. "If a hospital has an employed physician, it has liability."

Even though suspension of a medical license itself is grounds for termination of Medicare billing privileges, failure to report extends the time of disenrollment. If

CMS Transmittals and Federal Register Regulations Feb. 15 — Feb. 21

Live links to the following documents are included on RMC's subscriber-only Web page at www.AISHealth.com. Please click on "CMS Transmittals and Regulations" in the right column.

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- Healthcare Provider Taxonomy Codes Update, April 2013, Trans. 2660, CR 8211 (Feb. 15; eff. April 1; impl. no later than July 1, 2013)

Pub. 100-08, Medicare Program Integrity Manual

- Update to Chapter 15 of the Program Integrity Manual, Trans. 450, CR 8155 (Feb. 15; eff./impl. March 18, 2013)

Pub. 100-20, One-Time Notification

- The Inclusion of Veterans Administration Skilled Nursing Facility Claims to the VA Medicare Remittance Advice Process — Implementation, Trans. 1192, CR 8089 (Feb. 15; eff./impl. July 1, 2013)
- Recovery of Annual Wellness Visit Overpayment, Trans. 1190, CR 8153 (Feb. 15; eff./impl. July 1, 2013)
- Bundled Payment for Care Improvement Model 4 — HI and SMI Payment Attribution and Outlier Payments, Trans. 1189, CR 8196 (Feb. 15; eff./impl. July 1, 2013)
- CD-10 CR — Updates to National Coverage Determination/ Local Coverage Determination Processing in the VMS Shared System, Trans. 1191, CR 8207 (Feb. 15; eff. July 1; impl. Oct. 7, 2013)

Regulations

- None published.

physicians lose their license for a few months and are forthcoming with Medicare, they can reapply and may resume billing quickly when their license is reinstated. But failing to report almost guarantees a one-to-three year revocation plus a re-enrollment waiting period. And if all physicians have to disclose is a change of address, there are no consequences when the required information is updated on time — except the dire ones associated with failing to report it, which can include a retrospective disenrollment and resulting overpayment, Waltz says.

Revocations Are a Sleeper Risk

All of this goes to show that revocations are a sleeper risk of provider enrollment, which is already a hotbed of Medicare program integrity activity. And they can be the domino that leads to a provider's downfall.

"For failure to report, the Medicare billing privileges can be lost. For revocation of the billing privileges, the chance to order or refer was lost, as well as participation in Medicaid in that state. For loss of Medicaid enrollment in one state, there is supposed to be reciprocal loss of Medicaid enrollment in all other states. And ultimately, a career can be lost," Waltz says.

CMS now requires most health care organizations to re-enroll in Medicare every five years. That means filling out the 855 form, and thanks to a 2011 regulation spelling out a provision from the health reform law, coughing up more information about owners, managers and board members (*RMC 11/7/11, p. 1*).

When information changes, providers must promptly update their 855 forms. Mistakes or intentional omissions may be penalized with revocation of Medicare billing privileges and loss of enrollment status. For example, physicians, nonphysician practitioners and nonphysician practitioner organizations have 30 days to inform their Medicare administrative contractor of (1) a change of ownership; (2) an adverse legal action (e.g., licensure suspensions or revocations); or (3) a change in practice location.

There's a good chance that CMS will know quickly when providers should have reported something to their Medicare contractors. "The government has reported it is doing data mining on a weekly basis," Waltz says. As part of its national Fraud Prevention System (FPS), which uses predictive modeling to identify improper payments in fee-for-service Medicare, CMS has tasked zone program integrity contractors (ZPICs), its fraud and abuse hunters, with more administrative actions, such as revocations of Medicare billing privileges. "As directed by CMS, ZPICs previously focused their investigative efforts on gathering evidence to verify overpayments and developing criminal and civil cases for law enforcement agencies — a lengthy process that often involved many

investigative steps," the Government Accountability Office said in an October 2012 report (GAO 12-351). "According to CMS program integrity officials, the information provided by FPS is well-matched with the evidence necessary for ZPICs to recommend revocations against providers without having to conduct extensive investigations. These [CMS] officials also told us that they have directed the ZPICs to focus on pursuing revocations because revocations prohibit providers suspected of fraud from billing Medicare.

CMS also has deployed an automated provider screening contractor to screen enrollees for licensure revocations, exclusions and other black marks, and report its findings to MACs and the National Supplier Clearinghouse, according to the GAO report.

That's good for CMS but it still doesn't help health care organizations and private payers, Sheehan says. "There are states and managed care plans looking for this information and hospitals and clinics make credentialing decisions every day. If CMS made the right decision, [revocation information] should be available to everyone."

Recent HHS Decisions Clarify the Rules

Recent HHS Department Appeals Board decisions have made it clear that billing revocations will probably stick when based on the failure to notify Medicare of adverse events. In a July 18, 2011, decision, the administrative law judge (ALJ) ruled against physician John Crews, who was licensed to practice medicine and surgery in Virginia and Pennsylvania. The Virginia Board of Medicine in 2009 suspended his medical license over "nine separate violations related to inadequate patient care," but he kept practicing in Pennsylvania. The following year, the MAC for Virginia revoked Crews' Medicare billing privileges, and shared that information with Highmark Medicare Services, the MAC for Pennsylvania. Because Crews had failed to report the billing revocation to Highmark, it revoked his billing privileges for a year, a move that he appealed.

In the decision (CR2399), the ALJ stated Crews signed an enrollment application agreeing to tell the Medicare contractor of any final adverse action within 30 days, including license suspension. Crews said he believed that his attorney had told Highmark about the Virginia license suspension, but the ALJ said he presented no evidence to support this.

Contact Waltz at jwaltz@foley.com. For a list of all physicians enrolled in Medicare through the Internet-based Provider Enrollment, Chain and Ownership System (which Waltz warns may not always be accurate), visit www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html. ✧

NEWS BRIEFS

◆ **The retrial of the federal government's landmark Stark and false claims case against Tuomey Healthcare System, which had been scheduled for late January in Columbia, S.C., has been postponed until April 15,** according to the U.S. District Court for South Carolina. In 2010, a jury found Tuomey liable for Stark violations, but not false claims (*RMC 4/12/10, p. 3*). The U.S. district court judge who oversaw the trial allowed the government to recover \$45 million from Tuomey because of the Stark violations and gave the government a second chance to prove false-claims violations because of a trial error (*RMC 6/14/10, p. 1*). However, the U.S. Court of Appeals for the Fourth Circuit subsequently threw out the entire case, ruling that Tuomey's seventh amendment right to a jury trial was violated because of the judge's ruling (*RMC 4/16/12, p. 1*).

◆ **In a letter to the American Hospital Association, the contractor responsible for the Medicare medically unlikely edits (MUE) explained that some of the edits are being modified to address program vulnerabilities.** The edits, which were introduced in January 2007, limit the units of service a provider can report for a specific HCPCS/CPT code under most circumstances for a single beneficiary on a single date of service (DOS) (e.g., a heart transplant code's MUE value is 1). Because the MUE claim adjudication rules apply the MUE value to the unit of service reported on each line of a claim rather than based on the DOS, there have been overpayments to providers who report the same code on more than one claim line rather than representing on one line the total units of service associated with the code during the patient visit. CMS will change some of the MUEs to DOS MUEs but will not identify which edits are affected. However, the letter emphasizes, by addressing one common coding error, providers can reduce the number of denials due to DOS MUEs. Providers, except ASCs, should report a bilateral surgical procedure on one claim line with modifier 50 and one unit of service. (ASCs cannot use modifier 50.) The letter also asks national health care organizations to remind their providers to use the anatomic modifiers and report procedures with different modifiers on separate lines when appropriate. The DOS MUEs will debut in the April 1 version of the edits. For a copy of the letter, visit <http://tinyurl.com/a86su36>.

◆ **The theft of a Tennessee physician's Medicare provider number, the stolen identity of several Florida Medicare beneficiaries and an old barn and unfinished house were all Yennier Capote Gonzalez needed to launch his alleged scheme to defraud the Medicare program,** according to a press release from the U.S. Attorney for the Middle District of Tennessee. Gonzalez, of Miami, had incorporated Gainesboro Ultimate Med Service in rural Gainesboro, Tenn., in 2010 and subsequently falsely billed the Medicare Advantage program for \$232,000, the feds said. His scheme was exposed when he tried to wire himself \$17,000 from a new company bank account, which had received a \$38,000 payment from Medicare, and the HHS Office of Inspector General was notified. A visit to the business address by investigators revealed only an old barn; an unfinished house on another tract of land was used as the address for the beneficiaries. On Aug. 25, 2010, while making a second effort to wire the money, Gonzalez was arrested fewer than 48 hours from the time the OIG received the complaint. He was convicted of five counts of health care fraud, two counts of aggravated identity theft, and one count of money laundering, and on Feb. 15, Chief U.S. District Judge William J. Haynes, Jr., sentenced Gonzalez to 67 months in prison and ordered him to pay restitution of \$19,296. Visit www.justice.gov/usao/tnm/pressReleases/2013/2-19-13.html.

◆ **A tenth person has pleaded guilty in connection with an alleged scheme to pay cash for referrals to an Orange, N.J., diagnostic facility.** Cardiologist Shashi Agarwal pleaded guilty on Feb. 14 to receiving more than \$100,000 in kickbacks from Orange Community MRI, LLC, for his MRI and CAT scan referrals to the facility, according to the U.S. Attorney for the District of New Jersey. Agarwal has agreed to return the cash and will be sentenced for violating the anti-kickback statute on June 6, according to a press release. Visit www.justice.gov/usao/nj/news.html.

◆ **The latest round of the Program for Evaluating Payment Patterns Electronic Reports (PEPPERS) for acute-care hospitals has been completed and was distributed in mid-February,** according to a press release from the TMF Health Quality Institute. TMF prepares these reports under contract with CMS. Visit www.pepperresources.com.

**IF YOU DON'T ALREADY SUBSCRIBE TO THE NEWSLETTER,
HERE ARE THREE EASY WAYS TO SIGN UP:**

1. Return to any Web page that linked you to this issue
2. Go to the MarketPlace at **www.AISHealth.com** and click on “Newsletters.”
3. Call Customer Service at 800-521-4323

**If you are a subscriber and want to provide regular access to
the newsletter — and other subscriber-only resources
at AISHealth.com — to others in your organization:**

Call Customer Service at **800-521-4323** to discuss AIS's very reasonable rates for your on-site distribution of each issue. (Please don't forward these PDF editions without prior authorization from AIS, since strict copyright restrictions apply.)