

Key Topics from the 2015 Medicare Physician Fee Schedule, OIG Work Plan and Hospital Outpatient Rule

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Agenda

- 2015 Physician Fee Schedule and OPPS highlights
- OIG Work Plan
- Questions

Misvalued Codes

- Can tie in with audits/investigations.
- Planned to look at codes with highest total expenditures.
- Received criticism because high expenditures \neq fraud.
- Concede that is true, doing it anyway just not this year.

Secondary Interpretations

- Considering paying for second interpretations.
- (Some seem to be covered now, however. Is there an exclusion for second opinions?)
- Focus on radiology, not ECGs etc.

Substitute Billing Arrangements

- Currently Q5 and Q6 for reciprocal billing arrangements and locum tenens.
- Works for up to 60 contiguous days.
- Considering changes, but none announced.

Global Surgery

- Phase out of 10 and 90 day windows.
- Seems contrary to move to bundled payment, but CMS asserts payment windows may not accurately capture costs.
- Believes fewer E&M than paid
- 10 day gone by 2017/90 by 2018.

POS 22

- Eliminating POS 22 soon.
- To be replaced with two codes to distinguish on-campus/remote or satellite locations vs off-campus and provider-based depts.
- Suggests a future change in reimbursement, once data can be collected.

Open Payments

- Deletion of Continuing Education Exclusion:
 - Before: no report required for speaker payment if speech is at accredited continuing education event.
 - Beginning 1/1/16: must report all continuing education speaker payments.

Open Payments

- Effective 1/1/16, required to report:
 - Market name of drugs, devices, biologicals, or supplies that are associated with a payment or transfer of value.
 - Distinct category of ownership interest – e.g., stock, stock option, or other.

Telehealth

- Seven new codes added to list:
 - Psychotherapy services (90845, 90846, 90847)
 - Prolonged service office (00354, 99355)
 - Annual wellness visit (G0438, G0439)
- Rural requirement still applies.

Chronic Care Management

- CPT 99490 (Effective 1/1/2015)

Chronic care management services, at least **20 minutes of clinical staff time** directed by a **physician or other qualified health care professional**, per calendar month, with the following required elements: multiple **(two or more) chronic conditions expected to last at least 12 months**, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive **care plan** established, implemented, revised, or monitored.

Chronic Care Management

- Two+ chronic conditions for 12+ months.
- Physician, APRN, PA, CNS, or CNM.
- Creation of patient-centered care plan that is shared appropriately between care team members (within and outside of practice). Must use CCM certified technology.

Chronic Care Management

- 20+ minutes, aggregated, during calendar month of clinical staff time:
 - Time spent by clinical staff counts, if furnished under the “general supervision” of a physician (or other practitioner permitted to supervise incident to services) and otherwise meets the incident to requirements.

Chronic Care Management

- Furnish CCM services using, at a minimum, an EHR edition that meets EHR Incentive Program criteria as of December 31 of previous year.
 - Electronic care plan must be accessible on a 24/7 basis to practitioners within the billing practice providing the CCM services.
 - Must be able to electronically share care plan with team members outside the practice.

Chronic Care Management

- Patient must provide written consent to services and electronic communication of medical information with other treating practitioners.
- Document that all elements of CCM services were explained and offered.
- Provide patient with written or electronic copy of care plan and document provision in medical record.

Chronic Care Management

- Inform patient of right to stop CCM services at the end of any calendar month and effect of revocation.
- Inform beneficiary that only one practitioner may furnish and be paid for services each calendar month.

Physician Certification

- Current (soon to be revised) regulation § 424.13 requires, for all inpatient services, certification (and recertification, if applicable) of
 - The reasons for inpatient treatment;
 - The estimated time of hospitalization; and
 - Plans for post-hospital care, if appropriate.
- Must be signed by the physician responsible for the case prior to discharge.
- Inpatient admission order is a part of the certification.

Physician Certification

- Effective 1/1/15, certification is required only for long-stay (20 days or longer) and outlier cases.
 - Certification for long-stay cases must be furnished no later than 20 days into the stay.

OIG Work Plan

Who's Who

- Office of Audit Services (OAS) – Reviews HHS and its contractors.
- Office of Evaluation and Inspection (OEI) – National studies to provide advice to HHS and Congress.
- Office of Investigations (OI) – Medicare police.
- Office of General Counsel to the Inspector General (OCIG) – OIG's legal counsel.

How to Use the Work Plan

- Checklist.
- List of citations.
- Horoscope.



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Dear Dr.

The Office of Inspector General of the Department of Health and Human Services is currently conducting an audit of payments for clinical laboratory services under the Medicare program. In this regard, we need your assistance to confirm that you (1) requested the services provided and billed to the Medicare program by a laboratory and (2) received and considered the test results in the treatment of your patient. Your response will be vital in assisting our efforts to ensure that Medicare dollars are appropriately spent on deserving beneficiaries.

As part of this audit, we are reviewing Medicare payments to laboratories for additional automated hemogram indices that were billed with hematology profiles (CBCs or other hematology profiles). Examples of additional automated hemogram indices include red cell distribution width (RDW), mean platelet volume (MPV), red blood cell histogram, platelet histogram and white blood cell histogram. These indices are in addition to the "standard" indices which are part of a CBC: the mean corpuscular volume (MPV), the mean corpuscular hemoglobin (MCH), and the mean corpuscular hemoglobin concentration (MCHC).

The Numbers

- 4.9 billion recovered in 2014.
 - 834.7 million in audit.
 - 4.1 billion in investigations (including 1.1 billion in state share of Medicaid restitution).
- 4,017 exclusions.
- 971 criminal actions against individuals.
- 533 civil actions for false claims/unjust enrichment.

Possible Future Work

- Integrity of the Food, Drug and Medical Device supply chain.
- Security of electronic data.
- Use and exchange of health information technology.
- Emergency preparedness and response effort.

Part A and B Plans

- Quality of care
 - Also includes access to care and the impact of competitive bidding on access.
- Appropriate payments
 - Focus on when Medicare pays different amounts for the same or similar services and payments for defective medical devices.

Defective Devices

- The DRG is reduced for certain replacement devices if the hospital gets the device for free/discount $\geq 50\%$ of the cost of the device, and when the assigned MS-DRG is noted in the IPPS rule. MCPM Ch. 3 § 100.8.
- Must use condition code 49 or 50, along with value code FD.

Defective Devices

Reminder about Charging for Recalled Devices

As a reminder, section 2202.4 of the Provider Reimbursement Manual, Part I states, "charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient." Accordingly, hospital charges with respect to medical devices must be reasonably related to the cost of the medical device. If a hospital receives a credit for a replacement medical device, the charges to Medicare should also be appropriately reduced.

MCPM Ch. 3 § 100.8.

Hospital Related Policies and Practices

Reconciliation of Outlier Payments

- Verify Medicare contractors perform final settlement of cost reports.
- Outlier payments may be adjusted to reflect the time value of under/over payments.

New Inpatient Admission Criteria

- Examine impact of new admission criteria.
- Explore variation between hospitals.

Salaries Included on Hospital Cost Reports

- Review data from cost reports and hospitals to identify salaries.
- Consider potential impact of salary caps.

Salaries Included on Hospital Cost Reports

Compensation may be included in allowable provider cost only to the extent that it represents reasonable remuneration for managerial, administrative, professional and other services related to the operation of the facility and furnished in connection with patient care... costs of activities not related to either direct or indirect patient care, *e.g.*, those primarily for purposes of managing or improving the owner's financial investment, are not recognized as an allowable cost. Compensation of a physician-owner of a facility is subject to an allocation between professional and provider components. - Provider Reimbursement Manual Ch. 9 § 902.2

Salaries Included on Hospital Cost Reports

§ 902.3 Reasonableness. Reasonableness requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions depending upon the facts and circumstances of each case. Reasonable compensation is limited to the fair market value of services rendered by the owner in connection with patient care. Fair market value is the value determined by the supply and demand factors of the open market. - Provider Reimbursement Manual Ch. 9 § 902.3

Provider-Based Status

- Examine whether provider-based facilities meet CMS's criteria.
- Compare payment for office-based physician visits to provider-based.

Provider-Based Analysis

- Pro: Better reimbursement.
- Con: 20% Co-pay.
 - Can't bill "incident to" (Shared visit ok)
 - 72-Hour rule applies.
- Anything more than 250 yards from the hospital is "off-campus," creating significant regulatory burdens.

Provider-Based Requirements

- Public awareness.
- Integrated Clinical services.
 - Privileges at both.
 - Hospital monitors as it would a department.
 - Medical director must report to hospital.
 - Hospital med staff committees/UR oversight.
 - Integrated medical record.
- Financial Integration: shared income and expenses, incorporated in providers cost report and trial balances.
- Additional rules if you are more than 250 yards from the hospital.

Provider-Based Off Campus

- 100% hospital ownership (i.e. clinic and hospital can't co-own off campus entity).
- Must be under provider control. Personnel decisions, contracts, etc., require hospital approval.
- Administrative reporting must be as frequent as in main provider.
- Billing, HR, records, purchasing, etc., must be integrated and under the main provider's direction.

Provider-Based Off Campus

- Hospital must employ (not lease) staff “directly involved in delivery of patient care” except those who “would be paid for by Medicare under a fee schedule.”
- Geographic tests (if within 35 miles, ok).

Swing Bed Services in Critical Access Hospital

- Compare reimbursement for swing bed to SNF.
- CAH receives 101% of reasonable cost for up to 25 beds.
- No LOS limit on swing bed.
- CMS suspects that case mix, adjusted per-diem PPS is cheaper.

Mechanical Ventilation

- Certain DRGs require 96 or more hours of mechanical ventilation.
- Previous OIG reviews found bills for patients with fewer hours.

Duplicate GME Payments

- Assess effectiveness of IRIS.
- For both GME and IME, no intern or resident may be counted by Medicare as more than one FTE. 42 C.F.R. § 413.78(b) and § 412.105(f)(1)(iii).

Outpatient Dental Claims

- Most dental services excluded.
- Exceptions for extraction of teeth to prepare jaw for radiation treatment.
- Reconstruction of bridge would be excluded unless related to surgical removal of a tumor.
- Wiring of teeth may be covered with reduction of a jaw fracture.
- See Medicare Benefit Policy Manual Ch. 15 § 150.

Outpatient E&M Services at New Patient Rate

- Do hospitals bill established patients as new patients?
- Hospital definition of “new patient” varies from clinic.
- New patient is anyone who was registered as an in-patient or out-patient of the hospital within three years.
- See 73 Fed. Reg. 68679 (November 18, 2008).

Cardiac Cath and Endomyocardial Biopsies

- Reviewing right heart cath and endomyocardial biopsies billed during the same operative session.
- RHC is bundled.

Patients with Kwashiorkor

- Kwashiorkor is a form of severe protein malnutrition affecting children in tropical and subtropical parts of the World during famine.
- OIG is concerned that some hospitals have coded it.

Bone Marrow or Stem Cell Transplants

- Looking for misuse.
- Covered for treatment of leukemia, leukemia in remission, aplastic anemia and severe combined immunodeficiency disease (SCID) and Wiskot-Aldrich Syndrome.
- See MCPM Ch. 3 § 90.30.

Quality Initiatives

- Reviewing quality improvement organizations (QIOs).
- Pharmaceutical compounding.
- Hospital privileging: Do hospitals assess medical staff candidates before granting privileges?
- Adverse events in IRFs (IRF care is \$7 billion / 11% of post-acute care).
- Adverse events in LTCH (11% of post-acute expenditures and \$5.4 billion. How's the OIG's math score??)

Nursing Homes

- Part A Billing - SNFs increasingly bill the highest level of therapy even with beneficiary characteristics largely unchanged. Allege 25% of 2009 claims in error.
- Questionable Part B Billing, including foot care
- State Agencies failing to verify deficiencies were corrected.
- Hospitalizations of nursing home residents for preventable conditions.

Nursing Homes: Background Checks

- § 6201 of ACA requires HHS to establish a national program of background checks.
- Must enter contracts with the state.
- Will require state and national criminal background checks and search of abuse and neglect registries of any state in which prospective employee resided.
- Fingerprint checks using integrated automated fingerprint identifications system of FBI.

Hospice

- Hospice in assisted living facilities: ALF residence have longest LOS of hospice.
- Inpatient hospice: concern about misuse. Verification that hospice is assuming all medical care for the terminal illness and related conditions.

Home Health

- Poor documentation/25% questionable billing.
- Concerned about employment of individuals with a criminal conviction.
- 42 CFR § 484.12(a) requires HHAs comply with all laws. CMS figures most states forbid employment of convicts.

Frequently Replaced Supplies

- Automatic shipment of CPAP and respiratory assistive device supplies when no physician order for refills were in effect.
- Plan says beneficiaries or care givers must specifically request refills citing MCPM, Ch. 20, § 200.
- That text allows beneficiary, physician or designated representative to request additional supplies.



ASC Payment System

Determine whether payment disparity exists between ASCs and hospital outpatient departments.

ESRD-Payment for Dialysis and Drug

- Examine bundled ESRD PPS.
- Compare actual acquisition costs to projection (previous studies suggest projections were flawed).

Ambulance Services

- Transport to dialysis that never occurred or was unnecessary.
- Use of ambulance when other methods of transportation were appropriate.

Anesthesia

- Focus on AA and QK modifiers.
- QK limits payments to 50% of allowed amount for personally performed services.
- Instructions for medical direction are unclear.

MCPM Ch. 12 § 50

“A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in

MCPM Ch. 12 § 50

directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle Scheduling matters without affecting fee schedule payment.

MCPM Ch. 12 § 50

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature. Carriers may not make payment under the fee schedule."

Diagnostic Radiology

- Review high cost diagnostic imaging for medical necessity.
- Compare reimbursement to costs.

Independent Clinical Laboratory

- OIG will study whether labs comply with “selected billing requirements.”
- We worry about lab discounts/markup.

Miscellaneous

- Ophthalmologists – Inappropriate and questionable billing.
- Physicians – POS errors, particularly ASC and HOPD.
- High utilization rate for “outpatient” PT.
- Portable x-ray
- Qualification of techs
- Multiple trips in one day

Sleep Disorder Clinics: High Volume

- Physicians, HOPD, and IDTF.
- Patient must be referred by attending physician and clinic must keep physician order.
- Need for testing must be confirmed by medical evidence like exams/tests.
- Covered for narcolepsy, sleep apnea, impotence and parasomnia.

-MBPM Ch. 15 § 70

Outpatient Drugs and Administration

- Incorrect coding.
- Overbilling units.
- Focus on chemotherapy drugs.
- On-label and off-label use.

Scrutiny of Contractors

- Executive compensation.
- Procedures for tracking and collecting ZPIC and PSC overpayments.

Medicare Advantage

- MA plans provide all Part A and Part B services and generally provide additional services not covered by Medicare.
- Focus on diagnosis coding.

Medicaid Prescription Drugs

- Reducing inappropriate dispensing of opioids.
- State collection of rebates on physician administered drugs.
- Billing for Herceptin, a breast cancer treatment.

Health Care Acquired Condition

- Scrutinize payments to states

Preventable Conditions

“Health care-acquired condition means a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary under section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis (DVT/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Preventable Conditions

Other provider-preventable condition means a condition occurring in any health care setting that meets the following criteria:

- (i) Is identified in the State plan.
- (ii) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

Health Care Acquired Condition

(iii) Has a negative consequence for the beneficiary.

(iv) Is auditable.

(v) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.”

- 42 CFR § 447.26

Medicaid Issues

- Dental services for children.
 - Concerned services are being billed improperly.
 - Concern access is insufficient.
- States improperly taxing health care providers.

42 CFR § 433.55 and § 433.6A

Scrutinizing States

- Terminating Medicaid providers terminated under Medicare or another State.
- Medicaid credit balances.
- Do States verify ownership information/enrollment?
- ND MFCU exemption.
- Payment suspension following credible allegation of fraud.



What's not there?

- Cardiac Stenting.
- Incident to.
- Stark
 - Compensation formula
 - Compensation between physicians and hospitals
- 855 forms.
- Antikickback issues.

Questions

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