

# 2018 Medicare Regulatory Update

**David Glaser**

**Catherine London**

**Pari McGarraugh**

**Marguerite Ahmann**

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**Fredrikson**  
& BYRON, P.A.

# Agenda

- News/Recent Case Highlights (David)
- Physician Fee Schedule (Marguerite)
- OPPS (Catherine)
- IPPS (Pari)
- OIG Work Plan (David)

# New Qui Tam Policy?

- Michael Granston announced that:

“Despite the significant role that qui tam cases continue to play in the Department’s False Claims Act efforts, however, it remains the case that the Department intervenes in only about 1 in 5 cases that are filed. The impact of those non-intervened matters can be significant in terms of the time the Department devotes to them – not only in investigating them initially, but also in terms of monitoring any ensuing litigation if the relator elects to proceed.”

# New Qui Tam Policy?

- While qui tam cases will always remain a significant staple of the government's False Claims Act efforts, we are mindful of the need to maximize the use of the government's limited resources. We will therefore *continue* to look critically at qui tam cases to determine whether there are matters that should be dismissed. While the qui tam provisions were designed to provide relators with a vehicle to proceed without the government's involvement, *clearly meritless* cases can serve only to increase the costs for the government and health care providers alike.

# US ex rel. Ribik v. HCR Manorcare

- Filed in 2009, Government intervenes in 2015.
- Medical necessity of therapy.
- AdvanceMed did the review.

# Note About Notes

- When asked if she had notes, Clearwater said no. She had a 133 page notebook and 5,000 pages of comments on a spreadsheet.
- She testified she had asked her supervisees to produce their notes.
- The supervisees said no one asked them about their notes.

# Who is an “expert”??

“The court finds that Rebecca Clearwater does not have the expertise to testify as to the reasonableness and necessity of the medical treatment the patients received. Her qualifications, at best, would allow her only to testify as to obvious mistakes in the billing. Furthermore, Clearwater is not a medical doctor, an occupational therapist, nor a speech language pathologist and she did not personally examine any of the ManorCare patients. The Court finds her simply not qualified.”

# PFS: Overview

- Final Rule published in the Federal Register on November 15, 2017.
- Payment rates impacts:
  - Payment rates will increase 0.41% percent for CY 2018.
  - Reflects the 0.50 percent increase per MACRA.
  - Reduced by 0.09 percent per the Achieving a Better Life Experience Act of 2014 (ABLE Act), which mandates the identification of potentially misvalued services.
  - PFS conversion factor is estimated at 35.9996, up from 35.8887 in 2017, and the anesthesia conversion factor is estimated to be 22.1887.

# Patients Over Paperwork

- Recently launched CMS initiative:
  - “A cross-cutting, collaborative process that evaluates and streamlines regulations with a goal to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience. This effort emphasizes a commitment to removing regulatory obstacles that get in the way of providers spending time with patients.”
- Impact on PFS includes:
  - Reducing reporting requirements; and
  - Removing downward payment adjustments based on performance for practices that meet minimum quality reporting requirements.

# Off-Campus Provider-Based Departments

- Certain “nonexcepted” items and services furnished by off-campus hospital outpatient PBDs covered by PFS.
- PFS payment rate for such services are subject to the “PFS Relativity Adjuster” (i.e., the percentage of the OPPS payment amount)
  - 2018 Final Rule = 40%
  - 2017 = 50%
  - Proposed = 25%
- AHA Response: “adversely impact patient access to care by reducing Medicare rates for services hospitals provide in ‘new’ off-campus hospital clinics.”

# Medicare Diabetes Prevention Program (MDPP)

- The MDPP expanded model, which will allow beneficiaries access to evidence-based diabetes prevention services, will be implemented for 2018.
- Program Basics:
  - Goal: To reduce the progression to type 2 diabetes in individuals diagnosed with pre-diabetes.
  - Practical training in long-term dietary change, increased physical activity, and behavior change strategies for weight control.
- Value-based payment structure.
- Final Rule outlines additional policies and enrollment requirements for suppliers.

# Appropriate Use Criteria (AUC) Program for Advanced Diagnostic Imaging

- Delayed until January 1, 2020 (proposed to begin January 1, 2019).
- In 2020, physicians and ordering professionals must start using the AUCs when ordering applicable imaging services and reporting consultation information on Medicare claims.
- Ordering professionals may voluntarily start reporting consultation information on claims starting mid-2018.

# PQRS

- Goodbye PQRS:
  - Last reporting period: 2016
  - Last data submission for PQRS: Q1 2018
- Hello MIPS:
  - First performance period for MIPS: 2017
- Under PQRS, there are nine measures
- Final rule reduces the reporting burden down to six measures for the 2016 reporting period.

# Medicare Shared Savings Program

- ACOs no longer need to list each physician working in FQHC or RHC on ACO participant lists.
- Other changes include:
  - Reducing burden on ACOs when submitting initial MSSP applications or applications for use of SNF 3-day rule waiver; and
  - Revisions to the definition of primary care services for ACO assignment purposes.

# PFS: Other Changes

- Misvalued code initiative
- Payment incentive for digital radiography
- MACRA patient relationship categories and codes

# Solicitation of Additional Comments Regarding...

- The initial data collection and reporting periods for the CLFS
- E/M Documentation Guidelines and Care Management Services
- Emergency Department Visits

# Telehealth Updates

- CMS continues to add new codes to the list of covered telehealth services.
- For 2018, CMS is adding the following:
  - HCPCS code G0296 (Counseling visit to discuss need for lung cancer screening using low dose CT scan);
  - CPT code 90785 (Interactive complexity);
  - CPT codes 96160 and 96161 (Administration of health risk assessment with scoring and documentation);
  - HCPCS code G0506 (Comprehensive assessment and care planning for chronic care management services); and
  - CPT codes 90839 and 90840 (Psychotherapy for crisis).

# Telehealth Updates

- Finalized proposal for separate payment for CPT 99091, describing certain remote patient monitoring.
  - Practitioners must initiate service during face-to-face visit, obtain advance patient consent and spend at least 30 minutes providing the service.
- Eliminating the requirement to report GT modifier for professional claims.

# OPPS

- Final rule published in the Federal Register on 11/1/2017.
- Some highlights:
  - 1.35% increase in OPPS payments for 2018.
  - Two-year moratorium on enforcement of direct supervision requirements for outpatient therapeutic services provided at CAHs and small rural hospitals with 100 or fewer beds.
  - Removal of total knee arthroplasty from inpatient only list for 2018.

# OPPS

- Changes to 340B Drug Pricing Program
  - CMS finalized adjustment to payment rate for drugs purchased through 340B Program.
  - Reduction in payment for separately payable, nonpass-through drugs (other than vaccines) purchased through 340B program from **average sales price (ASP) plus 6% to ASP minus 22.5%**.
  - Rural sole community hospitals, children's hospitals, and certain cancer hospitals exempted.

# OPPS

- Changes to 340B Drug Pricing Program (cont'd):
  - Drugs not purchased under 340B drug program continue to be paid rate ASP plus 6%.
  - Projected \$1.6 billion decrease in drug payments.
    - CMS offsetting decrease by redistributing an equal amount to hospitals for non-drug items and services across OPPS.
  - Hospital associations and hospitals have filed lawsuit contending CMS lacks authority to implement these changes.

# IPPS

- Final rule published in the Federal Register on 8/14/2017
- Some highlights:
  - Overall: 1.2% increase
  - 2 Midnight Rule update
  - Hospital Quality Reporting Program changes
  - Hospital Readmissions Reduction Program changes
  - DSH methodology changes

# IPPS

- 2-Midnight Rule:
  - Defines “inpatient” status
  - Came with a cut to reimbursement rates
  - Court challenges to the cut
  - Increase in rates last year to make up for the previous cuts
    - Increases will not continue in FY 2018
    - Exception for 67 hospitals that were involved in the litigation

# IPPS

- Hospital Inpatient Quality Reporting Program
  - Shift from “Pain Management” to “Communication about Pain”
  - Response to the opioid epidemic
    - “[N]ot aware of any scientific studies that support an association between” these questions and opioid prescribing practices but want to “remove any potential ambiguity”

# IPPS

- Hospital Readmissions Reduction Program
  - For FY2019, CMS will implement a socioeconomic adjustment
  - Readmissions will be adjusted to compare hospitals with similar proportions of dual eligibles (5 peer groups)

# IPPS

- DSH changes
  - ACA would reduce uninsurance and drive down DSH payments
    - ACA provided that amount of reduction is redistributed to cover “uncompensated care”
    - Historically looked at low income insured as a proxy
    - Now transitioning to using data from the S-10 (charity care and bad debt)

# OIG Work Plan

# Review of Medicare Payments for Bariatric Surgeries

- Medicare Parts A and B cover certain bariatric procedures if the beneficiary has:
  - (1) a body mass index of 35 or higher,
  - (2) at least one comorbidity related to obesity, and
  - (3) been previously unsuccessful with medical treatment for obesity.
    - CMS, Medicare National Coverage Determinations Manual, Pub. No. 100-03, chapter 1, part 2, § 100.1.
- Treatments for obesity alone are not covered.

# Review of Medicare Payments for Telehealth Services

- Telehealth covered if provided through live, interactive videoconferencing between a beneficiary located at a rural originating site and a practitioner located at a distant site.
- Originating site must be the practitioner's office or a specified medical facility, not a beneficiary's home or office.
- Will review claims at distant sites that do not have corresponding claims from originating sites.

- 42 CFR § 410.78(b).

# Comparison of Provider-and and Freestanding Clinics

- Compare payments for similar procedures in provider-based clinics and freestanding clinics.

# Payment Credits for Replaced Medical Devices That Were Implanted

- 42 CFR § § 412.89 and 419.45 require reductions in Medicare payments for the replacement of implanted devices that are due to recalls or failures.

# Skilled Nursing Facility Prospective Payment System Requirements

- For coverage, SNF stay requires at least 3 consecutive days of prior hospitalization. SNF stay must be within 30 days after discharge from the hospital or within such time as it would be medically appropriate to begin an active course of treatment.

- SSA § 1861(i).

# Home Health Compliance with Medicare Requirements

- Are patients homebound/in need of skilled services?
- For CY 2014, Medicare paid HHAs about \$18 billion for home health services.
- CERT program asserts the 2014 error rate was 51.4 percent, or about \$9.4 billion.

# Physical Therapists – High Use of Outpatient Physical Therapy Services

- Focus on independent therapists who have a high utilization rate for outpatient physical therapy services. Review of the documentation.
  - Medicare Benefit Policy Manual, Ch. 15, § 220.3.

# Accountable Care Organizations: Beneficiary Assignment and Shared Savings Payments

- Are beneficiaries properly assigned?
- Are there duplicate payments?
  - 42 CFR § 425.402 and 42 CFR § 425.114(c).

# Skilled Nursing Facilities – Unreported Incidents of Potential Abuse and Neglect

- What do you need to report?
- Must you report all crimes?

# Medicare Payments for Overlapping Part A Inpatient Claims and Part B Claims

- Inpatient at Hospital A sent to Hospital B for outpatient care: most care bundles.
  - 42 CFR § § 409.10 and 410.3; Medicare Claims Processing Manual, Ch. 3 § 10.4.
- Focus on DMEPOS, which bundles during a stay.
  - Medicare Claims Processing Manual, Ch. 20 § 01.

# Duplicate Drug Claims for Hospice Beneficiaries

- Hospice per diem covers all services necessary for the palliation and management of a beneficiary's terminal illness including prescription drugs. Is Part D paying for drugs anyway?

# Medicare Part B Payments for Ambulance Services Subject to Part A Skilled Nursing Facility Consolidated Billing Requirements

- SNF Payment is bundled. Ambulance should be billed to SNF.
  - SSA 1862(a)(18) and 1842(b)(6)(E).

# Review of Medicare Payments for Non-physician Outpatient Services Provided Under the Inpatient Prospective Payment System

- The “72 Hour Rule” bundles most diagnostic services, and some therapy, three days before a hospital admission.
- Note “non-physician” here really means diagnostic/therapeutic work, not services by NPPs.

# Medicare Payments for Unallowable Overlapping Home Health Claims and Part B Claims

- HHA care is bundled under SSA Section 1842 (b)(6)(F).
- Some bundled Part B services are improperly being billed.

# Medicare Payments for Unallowable Overlapping Hospice Claims and Part B Claims

- Hospice is responsible for all care related to the treatment of the terminal condition for which hospice care was elected, treatment of a related condition and treatment that is equivalent to hospice care except care by another hospice under arrangement or by an independent attending physician. Everyone else must bill the hospice.

- 42 CFR 418.24(d).

# Health-Care-Acquired Conditions – Prohibition on Federal Reimbursements

- No Federal Medicaid share for health-care-acquired conditions.
  - SSA § 1903 and Patient Protection and Affordable Care Act § 2702).  
(42 CFR § 447.26).

# Duplicate Payments for Beneficiaries with Multiple Medicaid Identification Numbers

- Patients assigned more than one Medicaid identification number getting multiple Medicaid payments.
- Are you on the hook?
- Do you have a duty to report patients with fake insurance?

# Medicaid Overpayment Reporting and Collections

- OIG thinks states are failing to identify overpayments.
- This includes failure to collect from primary insurers.
- They will go after the state.
- Things roll downhill.

# Hyperbaric Oxygen Therapy (HBO) Services – Provider Reimbursement in Compliance with Federal Regulations

- HBO primarily treats nonhealing wounds.
- Beneficiary must meet 1 of 15 covered conditions (see next slides). Prior OIG reviews expressed concerns that: (1) beneficiaries received treatments for non covered conditions, (2) medical documentation did not adequately support HBO treatments, and (3) beneficiaries received more treatments than were considered medically necessary. - National Coverage Determinations Manual, Ch. 20, § 20.29(A).

# Hyperbaric Oxygen Therapy (HBO) Services – Provider Reimbursement in Compliance with Federal Regulations

1. Acute carbon monoxide intoxication.
2. Decompression illness.
3. Gas embolism.
4. Gas gangrene.
5. Acute traumatic peripheral ischemia. HBO therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened.
6. Crush injuries and suturing of severed limbs. As in the previous conditions, HBO therapy would be an adjunctive treatment when loss of function, limb, or life is threatened.
7. Progressive necrotizing infections (necrotizing fasciitis).
8. Acute peripheral arterial insufficiency.

# Hyperbaric Oxygen Therapy (HBO) Services – Provider Reimbursement in Compliance with Federal Regulations

9. Preparation and preservation of compromised skin grafts (not for primary management of wounds).
10. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management.
11. Osteoradionecrosis as an adjunct to conventional treatment.
12. Soft tissue radionecrosis as an adjunct to conventional treatment.
13. Cyanide poisoning.
14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment.

# Hyperbaric Oxygen Therapy (HBO) Services – Provider Reimbursement in Compliance with Federal Regulations

15. Diabetic wounds of the lower extremities in patients who meet the following three criteria: a. Patient has type I or type II diabetes and has a lower extremity wound that is due to diabetes; b. Patient has a wound classified as Wagner grade III or higher; and c. Patient has failed an adequate course of standard wound therapy.

# Inpatient Rehabilitation Facility Payment System Requirements

- Does the record support a reasonable expectation that the patient needs multiple intensive therapies, one of which must be physical or occupational therapy; is able to actively participate and demonstrate measurable improvement; and requires supervision by a rehabilitation physician to assess and modify the course of treatment as needed to maximize the benefit from the rehabilitation process?

# Ambulatory Surgical Centers – Quality Oversight

- Are ASC surveys sufficiently frequent and detailed?
- Some were surveyed only every 5 years.

# Payments for Medicare Services, Supplies, and DMEPOS Referred or Ordered by Physicians-Compliance

- Are physicians who shouldn't be able to order certain services; supplies; and/or durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) doing so? The notice asserts physicians must be Medicare-enrolled physicians or non-physician practitioners and be legally eligible to refer and order services, supplies, and DMEPOS
  - Patient Protection and Affordable Care Act § 6405.
- Opted out physicians can order at least some services.

# Sleep Disorder Clinics – High Use of Sleep-Testing Procedures

- Requirements for coverage of sleep tests under Part B are located in Medicare Benefit Policy Manual, Ch. 15, § 70.

# Collection Status of ZPIC and PSC – Identified Medicare Overpayments

- Do audits by Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs) result in recovery of cash?

# Advanced Imaging Notice Requirement

- An element of the In-office Ancillary Exception.
- In-office exception protects ownership and compensation.
- Non-profits, rural clinics MAY not need it, BUT...
- Only the in-office ancillary exception allows you to give physicians credit for services “incident to” their work.

# Advanced Imaging Notice Requirement

- Give written notice to all MR/CT/PET pts. (E-mail is ok.)
- At time of referral (i.e. NOT registration).
- Must indicate patient can go elsewhere.
- Address/phone for at least 5 “suppliers” within 25 miles. (If fewer than five, list them. If none, no notice necessary.)
- Can say more; may wish to warn about insurance coverage.

# Questions?

David Glaser

612.492.7143

dglaser@fredlaw.com

Catherine London

612.492.7464

clondon@fredlaw.com

Pari McGarraugh

612.492.7480

pmcgarraugh@fredlaw.com

Marguerite Ahmann

612.492.7495

mahmann@fredlaw.com