Avoiding Unnecessary Refunds: How to Keep Payments to Which You Are Entitled

By: David Glaser and Katie Ilten

October 10, 2018

Fredrikson & BYRON, P.A.

Agenda

- When do you need to refund?
  - Medicare.
  - Medicaid.
  - Everyone else.
- What is an overpayment?
- Analysis of the examples.

If You Do Refund, To Whom?

- Provider Self-Disclosure Protocol.
- Self-Referral Disclosure Protocol.
- US Attorney's Office.
- Medicare Administrative Contractor.
- Medicaid agency.

SSA § 1128J

GENERAL.—If a person has received an overpayment, the person shall—

(A) **report and return** the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

SSA § 1128J

An overpayment must be reported and returned under paragraph (1) by the later of—

(A) the date which is 60 days after the date on which the overpayment was identified; or

(B) the date any corresponding cost report is due, if applicable.

Important Statutory Quirk (Goof)

- The law defines “knowing” and “knowingly” as having “the meaning given those terms in Section 3729(b) of title 31 of the United States code.”
- The statute then never uses the words “knowing” or “knowingly.”
- CMS uses the definition as the basis for its “reasonable diligence” standard.

Don’t Forget

- The 60-day clock runs only when the overpayment is “identified.”
- The duty to “report and return” applies to an overpayment.

Sec. 1128B. [42 U.S.C. 1320a–7b]

Whoever has knowledge of . . . any event affecting his initial or continued right to any [benefit or payment under any federal health care program] . . . and conceals or fails to disclose such event with an intent to fraudulently secure [the] benefit or payment . . . shall be guilty of a felony, and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both.”

What About Private Payors?

- Contract.
- State law.
- HIPAA.
- A key point: don't fall victim to the "you must rebill, but bummer about the timely filing" gambit.

What Is An Overpayment?

SSA § 1128J(d)(4)

Overpayment.—The term "overpayment" means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.*

*This is important!!!.

42 CFR 401.303

"*Overpayment* means any funds that a person has received or retained under title XVIII of the Act to which the person, *after applicable reconciliation*, *is not entitled under such title.**"

*This is important!!!.

Applicable Reconciliation: Can You Offset Underpayments?

"The applicable reconciliation occurs when a cost report is filed; and …"

- 42 CFR 401.305(c)

- Page 7668 includes a convoluted assertion that reconciliation is cost-report specific. The discussion refers to Parts A and B. Part B doesn't feature cost reports.
- Offsetting underpayments seems entirely consistent with the statute, and CMS' interpretation seems baseless.

Manuals/Guidance Can't Limit Coverage

- SSA 1871/42 USC § 1395hh(a)(1)(2) says nothing other than an NCD may change benefits unless promulgated as a regulation.
- The Rachel Brand memo from January 25, 2018.

SSA 1871/ 42 USC 1395hh(a)(1)(2)

(1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title. When used in this title, the term “regulations” means, unless the context otherwise requires, regulations prescribed by the Secretary.

(2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this title shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

U. S. Department of Justice

Office of the Associate Attorney General

The Associate Attorney General

Washington, D.C. 20530

January 25, 2018

MEMORANDUM FOR: HEADS OF CIVIL LITIGATING COMPONENTS
UNITED STATES ATTORNEYS

CC: REGULATORY REFORM TASK FORCE

FROM: THE ASSOCIATE ATTORNEY GENERAL

SUBJECT: Limiting Use of Agency Guidance Documents
In Affirmative Civil Enforcement Cases

On November 16, 2017, the Attorney General issued a memorandum ("Guidance Policy") prohibiting Department components from issuing guidance documents that effectively bind the public without undergoing the notice-and-comment rulemaking process. Under the Guidance Policy, the Department may not issue guidance documents that purport to create rights or obligations binding on persons or entities outside the Executive Branch (including state, local, and tribal governments), or to create binding standards by which the Department will determine compliance with existing statutory or regulatory requirements.

The Guidance Policy also prohibits the Department from using its guidance documents to coerce regulated parties into taking any action or refraining from taking any action beyond what is required by the terms of the applicable statute or lawful regulation. And when the Department issues a guidance document setting out voluntary standards, the Guidance Policy requires a clear statement that noncompliance will not in itself result in any enforcement action.

Manuals/Guidance Can't Limit Coverage

- "Thus, if government manuals go counter to governing statutes and regulations of the highest or higher dignity, a person 'relies on them at his peril.' " Government Brief in Saint Mary's Hospital v. Leavitt.
- "[The Manual] embodies a policy that itself is not even binding in agency adjudications…. Manual provisions concerning investigational devices also 'do not have the force and effect of law and are not accorded that weight in the adjudicatory process.' " Gov't brief in Cedars-Sinai Medical Center v. Shalala.

Poll Question: How Far Back Must You Go?

- Forever.
- 10 Years.
- 6 years.
- 5 years after the year in which payment was made.
- 4 years.
- 3 years.
- 1 year.

How Far Back Must You Go?

- Two statutory provisions limit recovery of overpayments, 1870 and 1879. 1870 seems like a statute of limitation. Note neither statutes mentions “reopening.”
- 1870 focuses on “without fault” and includes a time frame, 1879 uses “did not and should not” have known, no timeframe.
- Regulations limit “reopening,” are silent on recovery.
- Manuals both limit reopening and recovery.

Social Security Act § 1870

(c) There shall be no adjustment as provided in subsection (b)(nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1814(e)) with respect to an individual who is **without fault or** where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), **if such adjustment** (or recovery) would defeat the purposes of title II or title XVIII **or would be against equity and good conscience**.

Social Security Act § 1870

Adjustment or recovery of an incorrect payment (or only such part of an incorrect payment as the Secretary determines to be inconsistent with the purposes of this title) against an individual who is without fault shall be deemed to be against equity and good conscience **if** (A) the incorrect payment was made for expenses incurred for items or services for which payment may not be made under this title by reason of the provisions of paragraph (1) or (9) section 1862(a) ***and***

Social Security Act § 1870

(B) if the Secretary's determination that such payment was incorrect was made subsequent to the third [**FIFTH**] year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-[**FIVE**] year period to not less than one year if he finds such reduction is consistent with the objectives of this title.

How Does § 1870 Work?

- Focus only on the YEAR payment is made.
- Payment made 1/4/13. Can recover 5 years after 2013, so count: 2014, 15, 16, 17, 18. Recovery possible through 12/31/18.
- Payment made 12/31/12. If new provision applies, 2013, 14, 15, 16, 17. Recovery until 12/31/17.
- Note that references to “five years” are very misleading. Simplicity trumps accuracy.

Social Security Act § 1879

(a) Where -- (1) a determination is made that, **by reason of section 1862(a)(1) or (9)** or by reason of a coverage denial described in subsection (g), payment may not be made under part A or part B of this title for any expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1842(b)(3)(B)(ii), and (2) both such individual and such provider of services or such other person, as the case may be**,** **did not know, and could not reasonably have been expected to know**, that

Social Security Act § 1879

payment would not be made for such items or services under such part A or part B, then to the extent permitted by this title, payment shall, notwithstanding such determination, be made for such items or services (and for such period of time as the Secretary finds will carry out the objectives of this title), as though section 1862(a)(1) and section 1862(a)(9) did not apply and as though the coverage denial described in subsection (g) had not occurred. … Any provider or other person furnishing items or services for which payment may not be made by

Social Security Act § 1879

reason of section 1862(a)(1) or (9) or by reason of a coverage denial described in subsection (g) shall be deemed to have knowledge that payment cannot be made for such items or services if the claim relating to such items or services involves a case, provider or other person furnishing services, procedure, or test, with respect to which such provider or other person has been notified by the Secretary (including notification by a quality improvement organization) that a pattern of inappropriate utilization has occurred in the past, and such provider or other person has been allowed a reasonable time to correct such inappropriate utilization.

Section 1879

"We believe it is inappropriate for providers or suppliers to make determinations regarding their own knowledge of non-coverage or whether they were the cause of an overpayment in lieu of reporting and returning an identified overpayment as required by this rule." – 81 FR 7666

42 C.F.R. § 405.980

(b) A contractor may reopen an initial determination or redetermination on its own motion—

(1) Within 1 year from the date of the initial determination or redetermination for any reason.

(2) Within 4 years from the date of the initial determination or redetermination for good cause as defined in § 405.986.

(3) At any time if there exists reliable evidence as defined in § 405.902 that the initial determination was procured by fraud or similar fault as defined in § 405.902.

42 C.F.R. § 405.902

"Similar fault" means "to obtain, retain, convert, seek, or receive Medicare funds to which a person knows or should reasonably be expected to know that he or she or another for whose benefit Medicare funds are obtained, retained, converted, sought, or received is not legally entitled. This includes, but is not limited to, a failure to demonstrate that he or she filed a proper claim . . ."

42 CFR § 411.21 defines a "proper claim" as a "claim that is filed timely and meets all other claim filing requirements specified by the plan, program, or Insurer."

Financial Management Manual, Ch. 3, § 70.3

Examples of § 1870 determinations:

A. Overpaid Provider or Physician Not Liable Because It Was Without Fault (§ 1870(b) of the Act.)

If a provider was without fault with respect to an overpayment it received **(or is deemed without fault, in the absence of evidence to the contrary, because the overpayment was discovered subsequent to the fifth calendar year after the year of payment)** it is not liable for the overpayment; therefore, it is not responsible for refunding the amount involved. The contractor makes these determinations.

Financial Management Manual, Ch. 3 § 170.2

The Carrier shall not attempt recovery action on individual overpayments if:

B – The Carrier Has Not Taken Action to Reopen the Payment Decision Within Four Years (48 Months) after the Date of the Initial Payment Determination

Unless Fraud or similar fault is present, a payment determination may not be reopened where the Carrier has not taken some action (which can be documented) questioning the correctness of the determination within 4 years (48 months) after the date the initial determination was approved. (See Medicare Claims Processing, Chapter 30, Correspondence and Appeals for policies governing the reopening and revision of decisions to allow or disallow a claim.)

Financial Management Manual, Ch. 3, § 90

A provider, physician, or other supplier is liable for overpayments it received unless it is found to be **without fault**. The contractor, as applicable, makes this determination.

The contractor considers a provider, physician, or other supplier **without fault**, if it exercised reasonable care in billing for, and accepting, the payment, i.e.,

- It made full disclosure of all material facts; **and**
- On the basis of the information available to it, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment; it promptly brought the question to the contractor's attention.

Normally, it will be clear from the circumstances whether the provider, physician, or other supplier was without fault in causing the overpayment. Where it is not clear, the contractor shall develop the issue.

How Far Back Must You Go?

"An overpayment must be reported and returned in accordance with this section if a person identified the overpayment, as defined in paragraph (a)(2) of this section, within 6 years of the date the overpayment was received."

- 42 CFR 401.305(f)

CMS Thinks You Must Do More Than Contractors

- "*Comment*: Commenters questioned whether they had a responsibility to go back beyond the 3 years covered in a Recovery Audit Contractor (RAC) audit that identifies overpayments.
- *Response*: Yes, as discussed previously, this final rule clarifies that when the provider or supplier receives credible information of a potential overpayment, they need to conduct reasonable diligence to determine whether they have received an overpayment.

CMS Thinks You Must Do More Than Contractors

RAC audit findings, as well as other Medicare contractor and OIG audit findings, are credible information of at least a potential overpayment. Providers and suppliers need to review the audit findings and determine whether they have received an overpayment. As part of this review, providers and suppliers need to determine whether they have received overpayments going back 6 years as stated in this rule." - *81 FR 7672*

Six Years From When?

- Remember “identify” includes quantification.
- The six years runs from the date the overpayment is quantified not from the first suspicion of an overpayment.
- Operationally, this may be challenging.

Bottom Line

- The government thinks you must go back six years from when you quantified the overpayment. (Even if the contractor doesn't go back as far!)
- We think they lack the statutory authority for this.
- You must choose the route you are comfortable with.

Case Studies

“We billed under the wrong physician.”

Reassignment

An otherwise correct Medicare payment made to an ineligible recipient under an assignment or other authorization by the provider does not constitute a program overpayment. Sanctions may be invoked against a provider (see § 30.2.15) to prevent it from executing or continuing in effect such an authorization in the future. Neither the provider nor the ineligible recipient is required to repay the Medicare payment.

Medicare Claims Processing Manual Ch. 1,30.2.3 - Effect of Payment to Ineligible Recipient

“She didn’t sign her charts before she left.”

Physician Signature

The rules will vary based on the payor, but Medicare doesn't require a signature.

"11. Is the physician's signature required on each page of the documentation?

No. The guidelines only state that the identity of the observer be legibly recorded."

Program Integrity Manual, CMS Pub 100-08 § 3.3.2.4, *Signature Requirements*

- If the signature is missing from an order, MACs and CERT shall disregard the order during the review of the claim (e.g., the reviewer will proceed as if the order was not received). *
- If the signature is missing from any other medical documentation (other than an order), MACs and CERT shall accept a signature attestation from the author of the medical record entry.

* This is wrong. See upcoming slides.

Standard Cert Request Letter

- "Request a signature log or an attestation of medical record entries if the medical record documentation is not signed or if the signature(s) are not clearly legible. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary."

“We don’t have written orders for our x-rays.”

IDTFs

Ordering of tests. All procedures performed by the IDTF must **be specifically ordered in writing** by the physician who is treating the beneficiary, that is, the physician who is furnishing a consultation or treating a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. (Non-physician practitioners may order tests as set forth in § 410.32(a)(3).) The order must specify the diagnosis or other basis for the testing.

- 42 CFR 410.33

IDTFs Are Different

"Some commenters have requested the rationale for requiring specific written orders for tests performed by IDTFs while not imposing the same requirement on testing in physician offices. The rationale for requiring testing by IDTFs to be ordered in writing by the treating physician is based in our (and, more specifically, HCFA's contractors') experience with IPLs. There have been instances in which IPLs have offered 'free' screening to Medicare beneficiaries in shopping

IDTFs Are Different

malls and senior citizen centers, which meant the IPL accepted the carrier payment for the procedure and waived billing the beneficiary for the co-insurance. . . . We believe that our experience with waste and abuse in IPL justify these requirements, including requiring the treating physician's order for a procedure."

62 Fed. Reg. 59048, 59072

Conditions of Participation

- In some settings (Hospital, ASC), signatures and orders are COP.
- Conditions of Participation are not automatically Conditions of Payment.
- See the Supreme Court case *Universal Health Services v. Escobar*.

Program Integrity Manual, Ch. 3, § 3.1 - Introduction

MAC, CERT and Recovery Auditor staff shall not expend Medicare Integrity Program (MIP)/MR resources analyzing provider compliance with Medicare rules that do not affect Medicare Payment. Examples of such rules include violations of conditions of participation (COPs), or coverage or coding errors that do not change the Medicare payment amount.

COP Violations

- Regulations and Manual provisions contemplate that providers/suppliers will be paid through (and in some cases after) the date of termination. State Operations Manual, Ch. 3, § § 3008-3008.1.
- There is no instruction for CMS to attempt to recoup payments made when a supplier was not in compliance with a condition for coverage.
- In *Escobar*, the Supreme Court said that in FCA cases, the test is materiality. Unclear how that test works in the context of an overpayment.

“Mind the setting, mind the label.”

- Are you in the office or hospital?
- “Incident to” versus “incident to.”

“Mind the setting, mind the label.”

- Office: “services and supplies furnished as incident to a physician’s professional services, of kinds which are commonly furnished in physicians’ offices . . . .”
- Outpatient hospital: “hospital services . . . incident to physicians’ services rendered to outpatients.”
- Why does it matter?
  - Office “incident to” has more bells and whistles (initiation, course of treatment, present in the office suite, etc.)

“A one day stay, pre-2 midnight.”

Short Stays: Pre 10/1/13 Guidance

Medicare Benefit Policy Manual
(CMS Pub. 100-02)
§ 10 - Covered Inpatient Hospital Services Covered Under Part A

An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

Pre 10/1/13 Guidance

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24 hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.

Pre 10/1/13 Guidance

Factors to be considered when making the decision to admit include such things as:

The severity of the signs and symptoms exhibited by the patient;

The medical predictability of something adverse happening to the patient;

The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and

The availability of diagnostic procedures at the time when and at the location where the patient presents.

Pre 10/1/13 Guidance

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital. In certain specific situations coverage of services on an inpatient or outpatient basis is determined by the following rules:

Minor Surgery or Other Treatment - When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered outpatients for coverage purposes regardless of: the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight.

“UR said it’s not medically necessary.”

Medical Necessity Denials

- Use the “treating physician rule.”
- The theory is that the patient’s physician is objective. Therefore, the physician’s opinion receives deference.
- Medicare’s legislative history supports this argument.

The "Treating Physician Rule."

"It is a well-settled rule in Social Security Disability cases that the expert medical opinion of a patient's treating physician is to be accorded deference by the secretary and is binding unless contradicted by substantial evidence… This rule may well apply with even greater force in the context of Medicare reimbursement. The legislative history of the Medicare Statute makes clear the essential role of the attending physician in the statutory scheme; 'the physician is to be the key figure in determining utilization of health services.'" Gartmann v. Secretary of the U.S. Department of HHS, 633 F.Supp. 671, 680-681(E.D. N.Y. 1986).

The "Treating Physician Rule."

A carrier is expected to place "significant reliance on the informed opinion of the treating physician" and to give "extra weight" to the treating physician's opinion. Baxter v. Sullivan, 923 F.2d 1391, 1396 (9th Cir. 1991).

The "Treating Physician Rule."

- CPM Ch. 30, § 100.2 forbids carriers from recouping an overpayment on the basis of a lack of medical necessity if a situation is ambiguous enough that the carrier requests its own physician consultant to review whether the services are covered.
- This should place the burden of proof on a carrier during an appeal.
- It provides a firm ground for challenging the carrier's arguments that office visits can be denied as not medically necessary.

CMS: “Don’t refund based on guidance. Really.”

- In guidance to the Two Midnight Rule, CMS previously said in guidance the inpatient order must be authenticated prior to patient discharge.
- Refunds and MAC audits based on this sub-regulatory requirement.

CMS: “Don’t refund based on guidance. Really.”

“It has come to our attention that some otherwise medically necessary inpatient admissions are being denied payment due to technical discrepancies with the documentation of inpatient admission orders” such as “missing practitioner admission signatures, missing co-signatures or authentication signatures, and signatures occurring after discharge. . . .

CMS: "Don't refund based on guidance. Really."

. . . We have concluded that if the hospital is operating in accordance with the hospital CoPs, medical reviews should primarily focus on whether the inpatient admission was medically reasonable and necessary rather than occasional inadvertent signature documentation issues unrelated to the medical necessity of the inpatient stay. . . .

CMS: "Don't refund based on guidance. Really."

. . . Therefore, we are proposing to revise the regulations at 42 CFR 412.3(a) to remove the language stating that a physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A."

- 83 Fed. Reg. 20448

Concurrent Surgeries

At a teaching hospital, a surgeon is working with residents on three cases. One of the cases is being opened, one is being closed, and the third is in a key portion. The teaching physician was in the third case. Someone notes the following Manual language and believes fraud has been committed.

Medicare Claims Processing Manual, Ch. 12, § 100.1.2 - Surgical Procedures

2. Two Overlapping Surgeries

In order to bill Medicare for two overlapping surgeries, the teaching surgeon must be present during the critical or key portions of both operations. Therefore, the critical or key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure. The teaching surgeon must personally document in the medical record that he/she was physically present during the critical

Medicare Claims Processing Manual, Ch. 12, § 100.1.2 - Surgical Procedures

or key portion(s) of both procedures. When a teaching physician is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, he/she must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise. **In the case of three concurrent surgical procedures, the role of the teaching surgeon (but not anesthesiologist) in each of the cases is classified as a supervisory service to the hospital rather than a physician service to an individual patient and is not payable under the physician fee schedule.**

Medicare Claims Processing Manual, Ch. 12, § 100.1.2 - Surgical Procedures

A. Surgery (Including Endoscopic Operations)

The teaching surgeon is responsible for the preoperative, operative, and postoperative care of the beneficiary. **The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be critical or key portions of the procedure. The teaching surgeon determines which postoperative visits are considered key or critical and require his or her presence**. . .

42 CFR § 415.172

(a) ***General rule*** If a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made only if a teaching physician is present during the key portion of any service or procedure for which payment is sought.

(1) In the case of surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure.

42 CFR § 415.172

(i) **In the case of surgery, the teaching physician's presence is not required during opening and closing of the surgical field.**

(ii) In the case of procedures performed through an endoscope, the teaching physician must be present during the entire viewing.

“Wrong place, wrong time . . . wrong claim?”

Wrong Date/Place of Service?

- No clear regulatory statement.
- Sometimes common sense is the way to go.

"But the LCD says we can't do it."

- An LCD is a coverage determination issued by a contractor, not promulgated by the agency, and is not even binding on an administrative law judge. See 42 C.F.R. 405.1062(a).
- Remember: Brand memo.

“But the LCD says we can’t do it.”

1871(a)(2) “No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this title shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).”

When the NCD Goes Too Far.

Where an item, service, etc. is stated to be covered, but such coverage is **explicitly limited to specified indications** or specified circumstances, all limitations on coverage of the items or services because they do not meet those specified indications or circumstances are based on § 1862(a)(1) of the Act. **Where coverage of an item or service is provided for specified indications or circumstances but is not explicitly excluded for others, or where the item or service is not mentioned at all in the CMS Manual System the Medicare contractor is to make the coverage decision, in consultation with its medical staff, and with CMS when appropriate, based on the law, regulations, rulings and general program instructions.**

- Medicare National Coverage Determination Manual, CMS Pub. 100-03, Chapter 1, Foreword, Paragraph A

"Our certification is one day late."

- Is the certification a condition of payment?
- Poll: Inpatient psych stay of 7 days. Certification comes on day 3. Do you refund:
  - Days 1-7?
  - Days 4-7?

Helpful Enforcement Position

- Critical Access Hospitals must obtain a physician certification that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission.
- Statutory requirement.

Helpful Enforcement Position

"Notice Regarding Changes to Instructions for the Review of the Critical Access Hospital (CAH) 96-Hour Certification Requirement. Based on feedback from stakeholders, CMS has reviewed the CAH 96-hour certification requirement to determine if there are ways to reduce its burden on providers.

Helpful Enforcement Position

In this final rule, CMS is reiterating the notification provided in the proposed rule that it will direct Quality Improvement Organizations (QIOs), Medicare Administrative Contractors (MACs), the Supplemental Medical Review Contractor (SMRC), and Recovery Audit Contractors (RACs) to make the CAH 96-hour certification requirement a low priority for medical record reviews conducted on or after October 1, 2017.

Helpful Enforcement Position

This means that absent concerns of probable fraud, waste, or abuse, CAHs should not expect to receive medical record requests from QIOs, MACs, RACs, or the SRMC related to the 96-hour certification requirement."

“New problem, gotta refund.”

"Course of Treatment*" MBPM Ch. 15 § 60.1.B

This does not mean, however, that to be considered incident to, each occasion of service by auxiliary personnel (or the furnishing of a supply) need also always be the occasion of the actual rendition of a personal professional service by the physician. Such a service or supply could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment*.

*What happened to diagnosis???

“Excluded employee, gotta refund.”

You hired a physician in March, after checking the exclusion list. In December, you discover that this physician was excluded from the Medicare and Medicaid programs in mid-November based on incidents that occurred prior to hiring.

Timeline

Hire the Employee	Employee Excluded	Discover Exclusion
March	November	December

“If it isn’t written, it wasn’t done.”

Challenging Documentation Denials

- “If it isn’t written, it wasn’t done,” isn’t the law.
- Medicare payment is determined by the content of the service, not the content of the medical record.
- The documentation guidelines are just that: guidelines (although the Medicare contractor won’t believe that).

Role of Documentation: The Law

"No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period."

- *Social Security Act § 1833(e)*

Role of Documentation: Guidance from CPT and CMS

- The CPT Assistant explains: “it is important to note that these are *Guidelines,* not a law or rule*.* Physicians need not modify their record keeping practices at all.”

  - CPT Assistant Vol. 5, Issue 1, Winter 1995

- Then HCFA, now CMS publicly stated that physicians are not required to use the Documentation Guidelines.

Role of Documentation: Guidance from CMS/HCFA

"Documentation Guidelines for Evaluation and Management Services Questions and Answers

These questions and answers have been jointly developed by the Health Care Financing Administration (CMS/HCFA) and the American Medical Association (AMA) March 1995.

1. Are these guidelines required?

No. Physicians are not required to use these guidelines in documenting their services.

Guidance from CMS/HCFA

However, it is important to note that all physicians are potentially subject to post payment review. **In the event of a review, Medicare carriers will be using these guidelines in helping them to determine/verify that the reported services were actually rendered.** Physicians may find the format of the new guidelines convenient to follow and consistent with their current medical record keeping. Their usage will help facilitate communication with the carrier about the services provided, if that becomes necessary. Varying formats of documentation (e.g. SOAP notes) will be accepted by the Medicare carrier, as long as the basic information is discernible."

Role Guidance from CMS/HCFA

"6. How will the guidelines be utilized if I am reviewed by the carrier?

If an evaluation and management review is indicated, Carriers will request medical records for specific patients and encounters. The documentation guidelines will be used as a template for that review. If the documentation is not sufficient to support the level of service provided, the Carrier will contact the physician for additional information."

How Do We Demonstrate a Service was Performed?

- Ask.
  - The physicians.
  - Others (nurses, receptionists).
  - Secret shopper/shadowing.
- Schedules/time based billing.
- Production data.

Questions?

David Glaser
Fredrikson & Byron, P.A.
612.492.7143
dglaser@fredlaw.com

Katie Ilten
Fredrikson & Byron, P.A.
612.492.7428
kilten@fredlaw.com