Report on
Medicare Compliance

Volume 29, Number 29 • August 17, 2020

Weekly News and Compliance Strategies on Federal Regulations, Enforcement Actions and Audits

Contents

Follow us on Twitter
@ HCCAPublication

Managing Editor
Nina Youngstrom
nina.youngstrom@hcca-info.org

Copy Editor
Bill Anholzer
bill.anholzer@hcca-info.org

CMS Plans to End IPO List, Increase Prior Auth; Buck Would Stop with Two-Midnight Rule

In an unexpected confluence of events, CMS is planning to terminate the inpatient-only (IPO) list, which guarantees Medicare payment for procedures only when they're performed on inpatients, while expanding prior authorization for outpatient procedures, according to the proposed 2021 outpatient prospective payment system (OPPS) regulation[1] that was published in the Aug. 12 *Federal Register*. If finalized, the changes will underscore CMS's emphasis on medical necessity and the primacy of the two-midnight rule, experts say. But they also are sparking concern that coverage decisions and payment are becoming indistinguishable. Hospitals should prepare to staff up utilization management, because checking the compliance boxes for IPO procedures is far less labor intensive than evaluating whether surgeries should be performed on inpatients versus outpatients.

The IPO procedure list, with 1,740 services, will be phased out in three years, starting with 266 musculoskeletal services next year. CMS test drove the idea when it recently moved total knee arthroplasty (TKA) and total hip arthroplasty (THA) off the IPO list and into the realm of the two-midnight rule. The proposed OPPS rule includes a table with the musculoskeletal codes and the comprehensive ambulatory surgical classifications (C-APCs) they will fall into if the procedure is performed on an outpatient.[2]

continued on p. 6

In Proposed Physician Rule, Telehealth Expands and Contracts, Limited by Statute, PHE

Telephone-only evaluation and management (E/M) services as a type of telehealth will disappear next year or whenever the COVID-19 public health emergency (PHE) ends, according to the 2021 proposed Medicare Physician Fee Schedule (MPFS) regulation,[1] which is scheduled to be published in the Aug. 17 *Federal Register*. And CMS plans to add and remove telehealth services in different ways, across three categories, partly by making some PHE telehealth services permanent. The glitch, however, is Medicare coverage again will be limited to originating sites—essentially rural areas—and audiovisual technology after the PHE. CMS's hands are tied, because a permanent telehealth expansion to all corners of the country and to telephone calls requires a change in the Social Security Act, which only Congress can make, attorneys said. For the same reason, a patient's home won't be a telehealth originating site when the regulation takes effect Jan. 1 if the PHE expires by then. In fact, a number of Medicare payment proposals are contingent on which comes first: the end of the PHE or 2021—a testament to the turbulence of the times.

"We are starting to see a little bit of the unwinding plan and what can remain permanent versus what is likely to get reeled back and returned to pre-COVID rules," said Richelle Marting, an attorney in Overland Park, Kansas. CMS also is asking for an unusual amount of feedback as it figures out how to proceed, said attorney David Glaser, with Fredrikson & Byron in Minneapolis. "They are soliciting comment

continued

more actively than they ever have before, so there is an opportunity for people to chime in."

The proposed MPFS has changes all over the map. Two are on the supervision front, and both were seen as positive. One is a telehealth addition that, if finalized, would allow physicians to provide direct supervision virtually, using real-time, interactive audiovisual technology, said attorney Thomas Ferrante, with Foley & Lardner in Tampa, Florida. That's a game changer for billing incident to the physician's services, he said. Physicians wouldn't have to be physically present to provide direct supervision for incident-to billing or other services. Virtual supervision would be allowed, if finalized, until Dec. 31, 2021, or the end of the PHE, whichever is later, Ferrante said.

The other supervision proposal, which would be permanent, is unrelated to telehealth. Glaser said CMS would permanently change supervision requirements to allow nonphysician practitioners (NPPs) to supervise diagnostic tests. "That would be a great thing," he said. "This is long overdue. NPPs can do the tests, but they can't supervise them." According to the proposed regulation, NPPs (e.g., nurse practitioners, certified nurse midwives) who are authorized to perform the tests under their scope of practice would also be authorized to supervise the tests.

Meanwhile, CMS didn't deviate from its plans to move ahead with radical changes to coding and documenting office/outpatient visits. Starting in 2021, physicians and other clinicians will base their office visit E/M levels of service on the documentation of time or medical decision-making only, with new definitions of both, so they don't have to factor in the history and exam, although they still must be medically appropriate.[2] New American Medical Association guidelines for medical decision-making will rule the day. The changes affect nine CPT codes: four for new patients (CPT 99202-99205)—99201 will be deleted—and five for established patients (99211-99215).

Some providers may be tempted to hold bills from a compliance perspective until robust auditing clears them to bill, but that's probably unnecessary, said Valerie Rock, a principal with PYA in Atlanta, Georgia. Although providers have to make some adjustments, the new documentation guidelines probably won't skew their E/M levels of service to the point it affects cash flow, she said. But providers should start training and auditing, Rock said. "There will be some providers who will be impacted more than others."

CMS Sets Out Three Categories for Telehealth

Parts are moving with Medicare coverage of telehealth, between the uncertain PHE end date, how that fits with the proposed MPFS rule, and eight or nine bills pending in Congress to eliminate the originating-site requirement. "There's a lot of good stuff in here, but I don't want this to give people a false sense of achievement," Ferrante said. "There's work to get done."

For example, CMS currently limits the provision of subsequent nursing facility visits to once every 30 days. In the MPFS rule, CMS is proposing to revise this frequency limitation to once every three days. That's far more generous, Ferrante said, but again, this won't benefit Medicare beneficiaries who want to receive health care from their home.

As explained in the proposed MPFS rule, there have traditionally been two categories for additions to telehealth coverage, and this year CMS added a third and then grouped telehealth services into three lists:

1. Nine codes that will become permanent.
2. Seventy-four codes that will be removed when the PHE expires.
3. Thirteen codes (dubbed category 3 codes) that will be added on a temporary basis.

According to the MPFS, category 1 services "are similar to professional consultations, office visits, and office psychiatry services that are currently on [the] Medicare telehealth services list." CMS is proposing to cover as category 1 services the telehealth services that were added in the March 31 interim final rule for the COVID-19 PHE. On top of that, CMS added nine new

Report on Medicare Compliance (ISSN: 1094-3307) is published 45 times a year by the Health Care Compliance Association, 6500 Barrie Road, Suite 250, Minneapolis, MN 55435. 888.580.8373, hcca-info.org.

Copyright © 2020 by the Health Care Compliance Association (HCCA). All rights reserved. On an occasional basis, it is okay to copy, fax or email an article from *RMC*. Unless you have HCCA's permission, it violates federal law to make copies of, fax or email an entire issue; share your subscriber password; or post newsletter content on any website or network. To obtain permission to transmit, make copies or post stories from *RMC* at no charge, please contact customer service at 888.580.8373 or service@hcca-info.org. Contact Aaron Black at aaron.black@hcca-info.org or 952.567.6219 if you'd like to review our 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.

Subscriptions to *RMC* include free electronic delivery in addition to the print copy, as well as a searchable database of *RMC* content and archives of past issues at compliancecosmos.org.

To order an annual subscription to **Report on Medicare Compliance** ($665 for HCCA members; $765 for nonmembers), call 888.580.8373 (major credit cards accepted) or order online at hcca-info.org.

Subscribers to this newsletter can receive 20 non-live Continuing Education Units (CEUs) per year toward certification by the Compliance Certification Board (CCB)®. Contact CCB at 888.580.8373.

EDITORIAL ADVISORY BOARD: ***JULIE E. CHICOINE, JD, RN, CPC,*** General Counsel, Texas Hospital Association; ***JEFFREY FITZGERALD,*** Polsinelli PC; ***EDWARD GAINES, Esq.,*** Zotec-MMP; ***DEBI HINSON,*** Compliance Content Developer, Healthstream; ***RICHARD KUSSEROW,*** President, Strategic Management Systems; ***MARK PASTIN, PhD,*** Council of Ethical Organizations; ***ANDREW RUSKIN, Esq.,*** K&L Gates; ***WENDY TROUT, CPA, CHC, CCS-P,*** Director, Corporate Compliance, WellSpan Health; ***LARRY VERNAGLIA,*** Foley & Lardner LLP; ***BOB WADE, Esq.,*** Barnes & Thornburg

category 1 codes, including GPC1X (complexity inherent to the visit) and 96121 (neurobehavioral status exam). These services will be added permanently, assuming they're finalized, when the rule takes effect Jan. 1.

Next up are category 2 codes, which are for "services that are not similar to those on the current Medicare telehealth services list." CMS is proposing to remove 74 codes when the PHE ends, because it believes these services are unlikely to satisfy category 2 criteria to justify continuing forever, Ferrante said. They include initial and subsequent observation and observation discharge day management (CPT codes 99217-99220, 99224-99226, and 99234-99236); initial hospital care and hospital discharge day management (CPT codes 99221-99223 and 99238-99239); and radiation treatment management services (CPT code 77427), among others.

Some New Telehealth Codes Are Temporary

Then there's category 3, which are telehealth services CMS would add temporarily—either through the end of the PHE or the end of 2021, whichever is later. For example, if the PHE expires in February 2021, these codes will be covered through the end of 2021, Ferrante said. So unlike the 74 codes in category 2, which will be dropped when the PHE ends, CMS is giving category 3 codes until at least the end of 2021. CMS explained that it's trying to collect information on telehealth delivery of these services for possible future coverage. They are:

- 99336 and 99337 (domiciliary, rest home, or custodial care services for established patients).
- 99349 and 99350 (home visits for established patients).
- 99281-99283 (emergency department visits).
- 99315-99316 (nursing facility discharge day management).
- 96130-96133 (psychological and neuropsychological testing).

There's a potential snafu, however, Marting said. If the PHE expires in October without another extension, there will be a gap in telehealth coverage because the 2021 MPFS doesn't take effect until Jan. 1, which CMS acknowledged in the proposed rule, she said. "In an election year, it's difficult to predict how the administration will handle the extension of the PHE in October," Marting noted. In July, HHS Sec. Alex Azar waited until the day before the PHE expired to extend it for another 90 days.

CMS Proposes Big Shift in Payment Rates

The proposed regulation includes a big bump in pay for office/outpatient E/M services (CPT 99202 to 99215), with a corresponding drop for other types of services, such as surgery. Medicare pays for physician services based on relative value units (RVUs), which are a combination of work, practice expenses and malpractice RVUs. CMS comes up with payment for a CPT code by multiplying the total RVUs by a conversion factor. CMS proposed to reduce the conversion factor by about 11% next year, from $36.09 to $32.36, Rock said.

An 'Olive Branch' for Primary Care Physicians

"CMS is trying to give an olive branch to primary care physicians, but now is not the right time to have a negative impact on surgical specialties," she said. The proposed rule plans a big hike for rheumatology (up 16%), family practice (up 13%) and endocrinology (up 17%). Physicians who don't bill E/M services primarily will take a hit, including surgeons, at a time they already have lost revenue from the reduction in elective surgeries because of the pandemic, Rock said. Other specialties facing a drop in their Medicare payments include infectious disease (down 4%) and emergency medicine (down 6%).

In keeping with this tilt toward primary care and chronic care management, CMS added GPC1X, a complexity code, for orchestrating the patient's care across the continuum. "It's distinct from the chronic care management or preventive care codes. You can still bill all of those services, but this is giving you additional revenue for managing all the patient's care," Rock explained. Physicians are permitted to bill this code even if patients only have one complex chronic condition. That's different from chronic care management, which is reimbursable only if patients have two or more chronic conditions. "CMS is saying the code would be added every time you bill an E/M service. The issue is that a lot of different physicians may feel like they are the center point. Should everyone bill it? Or should one person bill it? I think it adds to the complexity of the billing process unnecessarily, especially when the point is burden reduction," Rock said.

Contact Marting at richelle.marting@outlook.com, Rock at vrock@pyapc.com, Glaser at dglaser@fredlaw.com and Ferrante at tferrante@foley.com. ✧

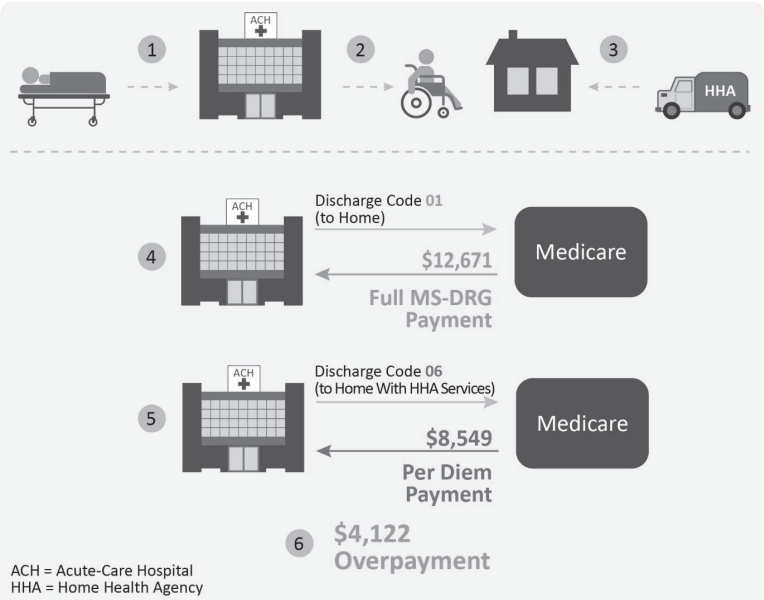
Endnotes

1. CMS, "Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy," proposed rule, RIN 0938-AU10, last accessed August 13, 2020, https://bit.ly/2XWlWAZ.
2. Nina Youngstrom, "New E/M Documentation Guidelines, Table Take Effect Soon; 'There Is a Different Mindset,'" *Report on Medicare Compliance* 29, no. 19 (May 18, 2020), https://bit.ly/2BIbF3C.

Chart: Coding Errors, Lack of CMS Edits Contributed to PACT Overpayments

In a new report[1] on Medicare overpayments to hospitals for patients who receive home health care within three days of discharge, the HHS Office of Inspector General contends that both hospitals and CMS contribute to errors under the post-acute care transfer (PACT) payment policy (see story, p. 5).[2] When hospitals don't report the home health discharge disposition code or bypass the policy with condition codes 42 or 43, they receive the full MS-DRG payment instead of per diem payments. The Common Working File (CWF) has edits to detect home health claims associated with hospital discharges, but there are flaws. CWF edits weren't designed to prevent MS-DRG payments when home health care was provided to a patient within three days of discharge for a readmission "because the CWF edits would look only at the first line of the home health claim" for the first admission, OIG said. Overpayments may be on their way down, however, because CMS explained in the OIG report that it improved edits in April.

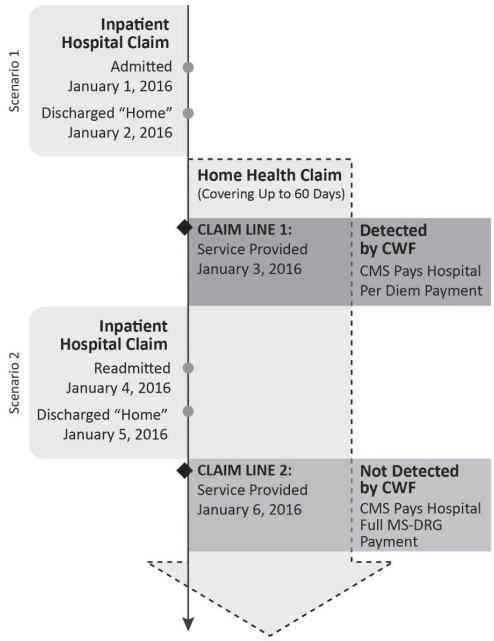
Figure 1: Example of an Overpayment to an Acute-Care Hospital for an Inpatient Claim Subject to the Post-Acute-Care Transfer Policy



ACH = Acute-Care Hospital
HHA = Home Health Agency

1. An ACH admitted a beneficiary for inpatient services because of complications from heart disease.
2. After stabilizing the patient, the ACH discharged the patient on the third day.
3. Within 3 days of discharge, the beneficiary received home health services related to his inpatient stay (complications from heart disease). Therefore, the ACH should be paid the lower per diem payment based on the post-acute-care-transfer policy.
4. In this example, the ACH billed Medicare for the Medicare Part A inpatient services with the patient discharge status code indicating a discharge to home (i.e., code 01). In return, the ACH received a payment of $12,671, the full MS-DRG payment, for the inpatient services.
5. If the ACH had billed Medicare for the Part A inpatient services with a discharge status code indicating a discharge to home with home health services (i.e., code 06), the ACH would have received a payment of only $8,549 for the inpatient services. (This payment represents the amount that would have been paid by applying the per diem rate for the inpatient stay in the ACH.)
6. Because the hospital used the patient discharge status code indicating a discharge to home (i.e., code 01), Medicare overpaid the ACH $4,122 ($12,671 – $8,549).

Figure 2: Inadequacy of CMS CWF Edits



Endnotes

1. Office of Inspector General, *Inadequate Edits and Oversight Caused Medicare to Overpay More Than $267 Million for Hospital Inpatient Claims With Post-Acute-Care Transfers to Home Health Services*, HHS, August 2020, https://go.usa.gov/xfwKT.
2. Nina Youngstrom, "More Recoupment for PACT Errors Is Coming; CMS Has Added Edits," *Report on Medicare Compliance* 29, no. 29 (August 17, 2020).

Subscribers to RMC are eligible to receive up to 20 non-live CEUs per year, which count toward certification by the CCB. For more information, contact the CCB at 888.580.8373.

More Recoupment for PACT Errors Is Coming; CMS Has Added Edits

Medicare administrative contractors (MACs) will again be recouping millions of dollars from hospitals for noncompliance with the post-acute care transfer (PACT) payment policy, this time in connection with patient discharges to home health care and the related use of condition codes 42 and 43, according to a new report[1] from the HHS Office of Inspector General (OIG). This stubborn compliance problem may finally start to recede, however, because CMS said it added edits to the Common Working File (CWF) in April to prevent full MS-DRG payments when patients receive home health care within three days of discharge.

According to the PACT payment policy, acute-care hospital patients who get post-acute care are classified as transfers, not discharges, and hospitals are paid per diems instead of MS-DRGs up to the full amount of the MS-DRG. Post-acute care is defined as home health care provided within three days of discharge for a related diagnosis or condition, same-day admission to skilled nursing facilities and other hospital units that are not reimbursed under the inpatient prospective payment system (e.g., psych, inpatient rehab), and same-day hospice admissions. Hospitals are required to use discharge status codes on all Medicare claim forms, such as 06 for home health, which tells Medicare the PACT payment policy is in play. When hospitals find out later that a patient was discharged to post-acute care rather than home, they are supposed to submit an adjusted bill to Medicare. The CWF has prepayment and postpayment edits that should prevent Medicare overpayments under the PACT policy, although they don't always do the trick.

In the home health arena, hospitals are allowed to bypass the PACT policy and collect the full MS-DRG payment with condition codes 42 and 43. They use condition code 42 when the care provided by the home health agency is unrelated to the hospital care and condition code 43 when home health care starts more than three days after the patient's discharge from the hospital. Hospitals may not always apply the codes appropriately, however, partly because the Social Security Act requires a "complex clinical judgment" to determine whether home health services are related to the condition or diagnosis that caused the patient's inpatient hospital care, which may hamper compliance.

According to the report, posted Aug. 7, OIG audited a stratified random sample of 150 inpatient claims submitted in 2016 and 2017 and concluded that Medicare paid only three correctly. The rest of the claims should have been reimbursed at the graduated per diem rate instead of full MS-DRG payments, but hospitals failed to report the home health discharge disposition code or apply condition code 42 or 43 (see box, p. 4).[2]

OIG: Hospitals Were Overpaid $267 Million

That caused $722,288 in overpayments, which OIG extrapolated to about $267 million for hospital services. Of the extrapolated overpayments, OIG said nearly $219 million was attributable to "Medicare's inadequate CWF edits, which looked only at the first line of the home health claim and ignored the other dates of service on the home health claim." Almost $41 million was caused by "Medicare's inadequate provider education, oversight, and controls related to the use of condition code 42," and about $7.3 million stemmed from the lack of CWF edits for condition code 43.

OIG recommended CMS direct the MACs to recover the part of the $722,288 in overpayments and $218.5 million in extrapolated overpayments that are within the reopening period, and reprocess claims with condition code 43 and recoup the part of the $7.207 million in overpayments within the reopening period. OIG also suggested new edits to prevent overpayments. CMS agreed for the most part, noting it had implemented an edit to "use the home health services on each line with a home health claim rather than only the first line to allow the edits to capture home health claims that overlap a hospital stay." There is also a new edit to prevent the use of condition code 43 when patients got home health care within three days of hospital discharge.

But CMS didn't bite at another OIG recommendation: to reduce the need for clinical judgment that's inherent in condition code 42, which requires a statutory change.

These findings came on the heels of a broader November 2019 OIG report[3] about Medicare overpayments caused by noncompliance with the PACT transfer policy. OIG said that Medicare improperly paid almost $54.4 million to acute-care hospitals for inpatient claims under the PACT transfer policy and suggested that CMS recover the money. CMS directed MACs to get that money back and pursue overpayments hospitals received after the audit period.

PACT Errors Don't Always Cause Overpayments

OIG has done a series of audits of Medicare payments under the PACT policy over the years, which is how it landed on the internal work plan of MultiCare Health System in Tacoma, Washington, said Samantha Karpenko, director of corporate compliance. An auditor on her team pulled a judgmental sample—hospital claims most likely to need a home health discharge disposition code because they overlapped with an initial home health visit during a 12-month period—and audited 40 of them. At first blush, the results of the audit were alarming, with a 40% error

rate, partly because condition codes 42 and 43 weren't applied consistently, Karpenko said.

But it turned out the potential overpayment is likely insignificant and possibly not an overpayment at all. That was "an unexpected result," she said. "My head was reeling on what our potential overpayment could have been if all DRGs were impacted by the reduction."

Overpayments are not inevitable, because the PACT payment policy doesn't apply to all MS-DRGs, she noted. Also, sometimes the graduated per diem equals the MS-DRG payment. For the most part, there will only be an effect on payment if the length of stay is less than the geometric mean length of stay, Karpenko said.

"This is definitely a complicated area of reimbursement," she said. It requires scrutiny, especially when hospitals outsource claims management, Karpenko said. "They are not your employees" and may not be as invested in compliance.

Contact Karpenko at karpesa@multicare.org. ✧

Endnotes

1. Office of Inspector General, *Inadequate Edits and Oversight Caused Medicare to Overpay More Than $267 Million for Hospital Inpatient Claims With Post-Acute-Care Transfers to Home Health Services*, HHS, August 2020, https://go.usa.gov/xfwKT.
2. Nina Youngstrom, "Chart: Coding Errors, Lack of CMS Edits Contributed to PACT Overpayments," *Report on Medicare Compliance* 29, no. 29 (August 17, 2020).
3. Nina Youngstrom, "CMS Will Recover PACT Policy Overpayments After OIG Audit," *Report on Medicare Compliance* 28, no. 40 (November 11, 2019), http://bit.ly/319ese7.

CMS Plans to End IPO List

continued from page 1

"All bets are off now, and there's no guaranteed status on any [surgical] cases," said Alvin Gore, M.D., physician advisor and director of utilization management at St. Joseph Health System in Santa Rosa, California. Once again, compliance officers and physician advisors will have to ask physicians to do a 180 for reimbursement purposes. "It will be on the physicians' shoulders to put in the documentation" why they admitted the patients. It's a departure from IPO claims, which "are very fast because they are a shoo-in. Finance likes them because they are quick and foolproof. Now they will be removed and will have to be relied on for the two-midnight obligation, so it's a subjective opinion," Gore said. The question is, how much more work will that be? That analysis is already underway at St. Joseph's.

Looking at the big picture, phasing out the IPO list is consistent with "the holistic process of lowering the cost of health care," he said. It represents CMS "finally realizing the only difference between inpatient and outpatient surgery is payment, and it makes no sense to deny payment because the doctor forgot to write an order" for an inpatient-only procedure, said Ronald Hirsch, M.D., vice president of R1 RCM.

But in one fell swoop, hospitals and physicians will face far more decision-making about which patients are expected to stay two midnights and who qualifies for a case-by-case exception to the two-midnight rule that, after a two-year moratorium, may be second-guessed by auditors, he said. And hospitals will take a financial hit. Some procedures that always generated MS-DRG payments will convert to C-APCs, which are usually a lower amount.

CMS 'Is Conflating Payment and Coverage'

Meanwhile, CMS proposed to add cervical fusion with disc removal and implanted spinal neurostimulators to the five surgeries that have required prior authorization since the new process started July 1. The existing procedures are more cosmetic than the two being added, effective July 1, 2021.

"The global message is that medical necessity for procedures is being scrutinized much more than ever before," Hirsch said. His advice: Hospitals shouldn't schedule any procedures unless confident they meet medical necessity guidelines—a national coverage determination, local coverage determination or specialty society guidelines.

The juxtaposition of these developments is troublesome, said attorney Andy Ruskin, with K&L Gates in Washington, D.C. "On the one hand, CMS is saying, 'We're not going to babysit you any longer,' with respect to inpatient-only procedures, but on the other hand, they are putting in new prior authorization requirements for the two procedures," he said. The rationale CMS gives for killing the IPO list is that physicians should be allowed to use their own judgment. "But then why add these procedures to the prior authorization list? It seems completely inconsistent not to trust their judgment here but to entirely rely on their judgment regarding IPO-list procedures," Ruskin said.

He sees this expansion of prior authorization requirements as proof of CMS "conflating payment and coverage, and that's just wrong." CMS could have just as easily issued a national coverage determination for hospitals to follow, which is how it traditionally guides providers on medical necessity. Hospitals should expect more of this because of the July 17 decision[3] from the U.S. Court of Appeals for the District of Columbia upholding CMS's site-neutral payment policy. "CMS likely now believes that it has unlimited adjustment authority," Ruskin said.

He also sees the elimination of the IPO list as a step toward CMS expanding Medicare coverage of procedures at ambulatory surgery centers, which will result in lower reimbursement for these procedures and more competition for hospitals. In fact, the proposed rule adds 11 procedures, including THA, to the list that Medicare will pay for at ambulatory surgery centers in 2021.

Crystal Ball: More Utilization Reviews

In the proposed OPPS rule, CMS acknowledged the concerns for patient safety with phasing out the IPO list. But it contends that "the evolving nature of the practice of medicine, which has allowed more procedures to be performed on an outpatient basis with a shorter recovery time, in addition to physician judgment, state and local licensure requirements, accreditation requirements, hospital conditions of participation (CoPs), medical malpractice laws, and CMS quality and monitoring initiatives and programs will continue to ensure the safety of beneficiaries in both the inpatient and outpatient settings, even in the absence of the IPO list."

The IPO list would be history by Jan. 1, 2024. CMS asked for comments on whether three years is an appropriate amount of time for the transition, whether to include other services in 2021, and what "clinical families" should be removed next.

As soon as the OPPS rule was proposed, Gore started pondering how the elimination of the IPO list would affect staffing and workflow. "The IPO list is about five minutes' work," he said. "You just need to verify a few things." For example, has the physician placed an inpatient order? In the case of an orthopedic procedure, has the surgeon exhausted conservative strategies (e.g., physical therapy) before resorting to a joint replacement? Does presurgical documentation conform to medical necessity? If all is right with the world, claims are released from billing without additional review, Gore said.

That won't be the case in a few months, if CMS sticks to its plan. With 1,740 additional services eventually falling under the two-midnight rule, hospitals are looking at more internal and external reviews. Gore is trimming the IPO list to the procedures most frequently performed at St. Joseph to get a better feel for the impact of moving them all off the list, starting with musculoskeletal procedures. "Our UR [utilization review] manager told me off the cuff about a 30% increase in staff is needed, but it's just a guestimate," he said. "If it all goes through the two-midnight rule, there will be an initial screening that's evidence based, and the ones that don't pass through the first level will have to go through a second review."

Gore anticipates some documentation challenges. For example, even though CMS left total joint revisions

CMS Transmittals and *Federal Register* Regulations, July 31-Aug. 13

Transmittals

Pub. 100-04, Medicare Claims Processing Manual

- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment, Trans. 10265 (Aug. 7, 2020)
- Billing for Home Infusion Therapy Services On or After January 1, 2021, Trans. 10269 (Aug. 7, 2020)
- Update to Osteoporosis Drug Codes Billable on Home Health Claims, Trans. 10274 (Aug. 7, 2020)
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October 2020 Update, Trans. 10288 (Aug. 7, 2020)
- Influenza Vaccine Payment Allowances - Annual Update for 2020-2021 Season, Trans. 10263 (July 31, 2020)
- Penalty for Delayed Request for Anticipated Payment (RAP) Submission – Implementation, Trans. 10254 (July 31, 2020)

Pub. 100-20, One-Time Notification

- Correction to Editing Update for Vaccine Services, Trans. 10275 (Aug. 7, 2020)
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)–January 2021 Update, Trans. 10261 (July 31, 2020)

Pub. 100-19, Demonstrations

- Telehealth Expansion Benefit Enhancement under the Pennsylvania Rural Health Model (PARHM) – Implementation, Trans. 10282 (Aug. 7, 2020)

Pub. 100-02, Medicare Benefit Policy Manual

- Billing for Home Infusion Therapy Services On or After January 1, 2021, Trans. 10269 (Aug. 7, 2020)

Federal Register

Proposed Regulations

- Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; and Physician-Owned Hospitals, 85 Fed. Reg. 48772 (Aug. 12, 2020)
- Medicare Program: Electronic Prescribing of Controlled Substances; Request for Information (RFI), 85 Fed. Reg. 47151 (August 4, 2020)
- Medicare Program; Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage, 85 Fed. Reg. 47723 (August 6, 2020)

Final Regulations

- Medicare Program; FY 2021 Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) and Special Requirements for Psychiatric Hospitals for Fiscal Year Beginning October 1, 2020 (FY 2021), 85 Fed. Reg. 47042 (August 4, 2020)
- Medicare Program; FY 2021 Hospice Wage Index and Payment Rate Update, 85 Fed. Reg. 47070 (August 4, 2020)
- Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Value-Based Purchasing Program for Federal Fiscal Year 2021, 85 Fed. Reg. 47594 (August 5, 2020)
- Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2021, 85 Fed. Reg. 48424 (August 10, 2020)

Notice

- Medicare and Medicaid Programs; Quarterly Listing of Program Issuances-April Through June 2020, 85 Fed. Reg. 48691 (August 12, 2020)

Final Methodology

- Basic Health Program; Federal Funding Methodology for Program Year 2021, 85 Fed. Reg. 49264 (August 13, 2020)

Contact Aaron Black at aaron.black@hcca-info.org or 952.567.6219
to find out about our reasonable rates for individual and bulk subscriptions.

on the IPO list when TKA was moved off it, "now they have to be justified." As with all documentation, the magic word is "because," as in, "because of intra-operative difficulties with intubation, patient would require additional respiratory support that would extend the care beyond 2 midnights."

Initially, hospitals will be spared external audits. In the proposed OPPS rule, CMS said for the two years after procedures are taken off the IPO list, they will be exempt from claim denials under the two-midnight rule, as was the case with TKA and THA. But claims would still be denied if the quality improvement organization determines the procedures weren't medically necessary, and they may be audited for patient status for education purposes.

Contact Hirsch at rhirsch@r1rcm.com, Gore at alvin.gore@stjoe.org and Ruskin at andrew.ruskin@klgates.com. ✧

Endnotes

1. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; and Physician-Owned Hospitals, 85 Fed. Reg. 48,772 (August 12, 2020), https://bit.ly/33Wywnu.
2. Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 85 Fed. Reg. 48,772, 48,912 (August 12, 2020).
3. Nina Youngstrom, "Court Restores Site-Neutral Payments; Lawyer: More Trouble May Be Ahead," *Report on Medicare Compliance* 29, no. 27 (July 27, 2020), https://bit.ly/2XW1VdP.

NEWS BRIEFS

◆ **CMS has awarded the contract for reviews of short hospital stays and higher-weighted DRGs, but it's on hold for now.** CMS "continues to temporarily pause the performance of both Short Stay reviews and Higher Weighted Diagnosis-Related Group (HWDRG) reviews by the Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs)," a spokesperson told *RMC*. "A bid protest was received in response to the recent contract award for this work. CMS anticipates that the BFCC-QIO claims review operations will resume after the protest is resolved." Information on the bid protest is available on the Government Accountability Office website.[1]

◆ **The HHS Office of Inspector General (OIG) has posted its annual *Top Unimplemented Recommendations: Solutions To Reduce Fraud, Waste, and Abuse in HHS Programs*.**[2] Recommendations for CMS to consider with respect to Medicare Parts A and B include re-evaluating the inpatient rehabilitation facility payment system, seeking "legislative authority to comprehensively reform the hospital wage index system," and analyzing the potential effects of counting time spent as an outpatient toward the three-night requirement for skilled nursing facility services.

◆ **The former vice president of market development for Proove Biosciences Inc. has pleaded guilty to conspiring to pay doctors kickbacks to order genetic tests for Medicare patients in violation of the Anti-Kickback Statute**, the U.S. Attorney's Office for the Southern District of California said Aug. 4.[3] According to the plea agreement with Donald Joseph Matthews, Proove paid $3.5 million to physicians "to induce them to order Proove's DNA tests—which the company claimed could determine a patient's risk of abusing certain prescription narcotics. Proove billed approximately $45 million to the Medicare program for the tests, in violation of Medicare's prohibition against kickbacks, and Proove received approximately $21 million in unlawful payments," the U.S. attorney's office said.

◆ **In a new Medicare home health provider compliance audit,[4] the HHS OIG said Condado Home Care Program Inc., in San Juan, Puerto Rico, was overpaid $13,771 during a two-year audit period**, which OIG extrapolated to $97,210. OIG contends the home health agency billed Medicare for services provided to beneficiaries who weren't homebound or didn't require skilled services, reported the wrong Health Insurance Prospective Payment System codes, and provided services under a plan of care that didn't satisfy Medicare requirements. In a written response, Condado's administrator, María de L. De León Rosa, explained the safeguards the health agency already has in place and the improvements it has underway.

Endnotes

1. "GAO Bid Protest Docket," Government Accountability Office, accessed August 14, 2020, https://bit.ly/3artuR3.
2. Office of Inspector General, *Top Unimplemented Recommendations: Solutions To Reduce Fraud, Waste, and Abuse in HHS Programs,* August 2020, https://bit.ly/342OMDw.
3. Department of Justice, U.S. Attorney's Office for the Southern District of California, "VP of Genetics Company Pleads Guilty to Paying Physicians Sham Clinical Research Fees as Part of $21 Million Medicare Fraud Scheme," news release, August 4, 2020, https://bit.ly/3gXqwGp.
4. Office of Inspector General, "Medicare Home Health Agency Provider Compliance Audit: Condado Home Care Program, Inc.," August 2020, https://go.usa.gov/xfsKT.