

MEDICARE COMPLIANCE

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

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Provider-Based Status May Be Smart Move As DRG Window Rule Is Applied to Clinics

When the DRG window payment rule hits physician practices that are owned or operated by hospitals, a new set of billing, compliance and revenue challenges will materialize.

CMS will require hospital-owned or operated freestanding clinics to bundle diagnostic and certain nondiagnostic services into the inpatient claim when patients are admitted within three days, bringing them under the same DRG window payment umbrella as provider-based entities.

These changes will slash reimbursement for hospitals, and should open their eyes to the possibility of converting freestanding clinics to provider-based entities, since Medicare pays hospitals a higher rate for services provided there, says Boston attorney Larry Vernaglia, with Foley & Lardner LLP. But the HHS Office of Inspector General frowns on provider-based entities and patients are furious at the higher copayments. With so much at stake, hospitals have some major decisions to make.

"I think it will take time for hospitals and physician practices to implement the changes proposed by CMS," says Cheryl Storey, a health care partner in the accounting firm Moss Adams LLP.

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Failure to Follow Physician Supervision Rules Could Cost IDTF Firm \$10 Million

A recent federal court ruling backs the Department of Justice's false claims case against an imaging provider for failure to follow Medicare physician supervision rules. This development shows that the feds, as well as the courts, are serious about enforcing physician supervision rules to the letter. And if the decision against MedQuest Inc. is a sign of things to come, health care organizations could face millions of dollars in liability if they run afoul of Medicare supervision requirements.

MedQuest and three of its independent diagnostic testing facilities (IDTFs), BioImaging at Charlotte, BioImaging of Cool Springs and BioImaging at Harding, are accused of billing for certain tests when there was no direct physician supervision, which the feds say led to the submission of false Medicare claims (*RMC 6/8/09, p. 5*). The suit was filed in 2006 by the former lead technologist for the three facilities, and the U.S. Attorney's Office in the Middle District of Tennessee intervened in March 2009.

There are no allegations of patient harm or services not being delivered. But physician supervision as a billing issue apparently is starting to catch on with enforcers (see News Briefs, p. 8).

Medicare pays for diagnostic tests if they are performed by a physician in a hospital, physician's office or IDTF, which can be owned by a non-physician, but must be enrolled in Medicare and give Medicare the name of the physician who will be supervising the

tests, according to the complaint. For tests involving dye injections, a physician must be directly involved in case the patient has a reaction to the dye.

According to the complaint, technicians at the three IDTFs in question performed tests involving dye without a physician present. In some cases, local doctors allegedly were paid to supervise the tests, but were not qualified to do so (e.g., a pediatrician and two psychiatrists were listed). Additionally, the “facilities utilized a physician sign-in sheet at each facility to provide purported evidence of the necessary physician coverage,” the complaint says. However, the log sheets do not reflect coverage for certain Medicare claims, the feds point out.

Also, the government alleges that MedQuest purchased the Charlotte facility from a physician in 2004, but did not immediately enroll it as an IDTF and continued to bill as if it were a physician’s office. Had it known, Medicare would not have paid for those claims, the government says.

The whistleblower in this case is Karen Hobbs, a former lead technologist for the Nashville-area MedQuest facilities. She informed her supervisors and the company’s “higher management” that, at the Nashville IDTFs, some

of the tests using contrast were being performed without supervision by Medicare-approved physicians or, in some cases, by non-physician staff. She was fired in October 2004 for alleged “poor job performance conduct,” court documents say.

Based on physician logs from the three IDTFs, the court found that the facilities submitted 474 false claims from Jan. 15, 2004, to Sept. 12, 2006, totaling \$343,758. Also, from Jan. 15, 2004, through June 30, 2005, MedQuest used the former Charlotte owner’s billing number to submit 995 claims for which Medicare paid \$493,185. Both sides had asked the court for summary judgment on certain issues.

The U.S. District Court for the Middle District of Tennessee said this evidence was sufficient to award penalties against MedQuest under the False Claims Act. “MedQuest is an experienced provider of IDTF services with an extensively trained staff” and is the leading IDTF company in the country with facilities in 13 states, says an Aug. 23 memorandum by the court. “MedQuest had a clear alternative to submit physicians who were not radiologists, but who had the appropriate training...but elected not to do so. This supervising physician coverage for the diagnostic tests with contrast was well known to MedQuest’s upper management and managers of its Nashville area IDTFs,” the court says.

Court: Lack of Supervision Was Significant

“The proof establishes that this lack of supervising physician coverage for the diagnostic tests with contrast at MedQuest Nashville area IDTFs was so significant that MedQuest’s technical staff actually conducted the diagnostic testing without any physician supervision,” the court continued. The judge set an \$11,000 penalty for each of the 474 claims for services provided when there was no physician present, and \$5,500 for the claims submitted under the former Charlotte facility owner’s billing number.

All told, MedQuest could pay \$10,686,500 in total penalties, but the memorandum adds that an order with the final total will be entered later once the parties are able to show when the improper billings at the Charlotte facility actually started after ownership changed hands.

Britt Latham, an attorney for MedQuest, says the company is “disappointed” with the decision. “MedQuest vigorously defends its actions and the actions of the Bio-Imaging Centers as being in full compliance with applicable statutes and regulations and intends to appeal the decision to the Sixth Circuit Court of Appeals.”

What stands out about this case and the court’s decision is that “the court and the Department of Justice were very serious about enforcing physician supervision,” says San Antonio, Texas, attorney Jed Morrison, with Jackson Walker LLP. “There were no allegations that anyone was hurt or that services weren’t delivered; it’s

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purely the inability to document that they had the proper level of physician supervision by the properly qualified physicians, which is what the regulation [demands].”

“This is a wake-up call to providers,” Morrison tells RMC. Many physicians conduct imaging studies in their offices and imaging centers, and they try to have the proper level of supervision, but it can be difficult to always ensure that a qualified person is present. In MedQuest’s case, however, all of the tests at issue required direct physician supervision because they involved contrast and they didn’t have a physician onsite. “It’s not that we’re learning anything new [with this case] about supervision, but now it’s elevated to a really serious level because these became false claims and the government made an example of MedQuest. You have to take these regulations seriously and do it properly,” he says.

The U.S. attorney’s office declined to comment on the case until the judge releases the final ruling with the total amount.

Read the decision at www.tnmd.uscourts.gov/. Contact Morrison at jmorrison@jw.com. ✦

Screening Excluded Employees Is Tricky, But Fines Can Be Painful

An effective screening process for job applicants, employees and contractors who are excluded from Medicare is increasingly important at a time of almost routine civil monetary penalty (CMP) settlements with health care organizations in this area.

And now that the health reform law requires the return of overpayments within 60 days of identification, the pressure is on to prevent the hiring of excluded employees — or to locate them quickly — because Medicare will not pay for their services, directly or indirectly.

The government’s expectations in this area are clear. For example, the HHS Office of Inspector General’s 2005 compliance-program guidance for hospitals, which suggests ways to kick the tires on your compliance program, says that at least annually, they should check employees, contractors and medical and clinical staff members “against government sanctions lists, including the OIG’s List of Excluded Individuals/Entities (LEIE) and the General Services Administration’s Excluded Parties Listing System” (EPLS).

Some organizations have learned this the hard way. For example, Catholic Healthcare West in late 2010 agreed to pay \$243,819 to settle a case under the CMP for false and fraudulent claims over its employment of people excluded from Medicare after it self-disclosed the problem (RMC 11/1/10, p. 1). Almost two dozen health care organizations were in the same boat, shelling out money to the

OIG over alleged exclusion offenses. And organizations can invite false claims liability as well. The May Institute in Connecticut paid \$110,000 to settle a false claims case over services performed by two excluded individuals.

“What we saw in [the May case] is they had no program in place to exercise due diligence in screening employees,” said Will Metcalf, senior compliance analyst at University of Louisville in Kentucky. Six more CMP exclusion cases have been settled so far this year.

There are other lists to check certain employees and/or vendors against, depending on the kind of organization you work for. For example, the FDA maintains a list of disqualified and restricted clinical investigators, Metcalf said. “If you have any research, you should check it,” he said at a recent Health Care Compliance Assn. conference.

Even with the availability of the LEIE, the GSA debarment (EPLS) and other lists, sometimes it’s hard to nail down whether an employee has been excluded. It requires an organized approach. *One challenge:* the OIG downloadable Medicare exclusion database — which lists all people excluded from federal health care programs — does not include Social Security numbers out of privacy concerns, says OIG spokesman Donald White. Organizations run their employee roster against the giant list to see if names match and perhaps the address with the name. If there’s a match, organizations can plug the person’s SSN into the OIG website and it will confirm or deny that Medicare exclusion through the SSN, White says. But it’s not a random search; the health care organization already has the clues, including the SSN, and is verifying.

Document Your Exclusion Checks

Screening can get very complex at large, multifaceted organizations, according to Robin Wilcox, institutional compliance officer at the University of Louisville. “It’s almost impossible to divorce a federal dollar from someone at the University of Louisville,” he says.

For one thing, decide whether you will use a vendor to help screen employees and contractors. “It depends on the size of your institution,” Wilcox says. “Small ones may do it themselves, using LEIE and EPLS.” But talk to other departments to determine whether other kinds of screening will be required (e.g., FDA).

Decide how often to conduct exclusion checks. The federal government expects health care organizations to perform exclusion checks at least annually. Some states, pressed by CMS, want Medicaid exclusion checks done more often. “In Kentucky, we are told we should do it monthly,” Wilcox said. Former New York state Medicaid Inspector General Jim Sheehan also urged providers to check employees and vendors monthly for Medicaid exclusion screening.

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Wilcox also advises verifying the implications of potential matches. For example, “we had a nurse excluded [from Medicare] for nonpayment of student loans,” which means she could not work in federal health care programs. The nurse worked at an animal research site, and since “I don’t think you can bill Medicare for working with a cow,” it’s possible she wouldn’t have to be fired.

Organizations also must document their due diligence in screening for sanctioned employees and contractors. “Institutions that get in trouble don’t have processes in place and don’t have them documented,” Wilcox says.

Should an Outside Vendor Be Used?

University of Louisville checks all employees at the time of hire, plus all university employees annually and affiliated research employees semi-annually. Before awarding contracts, University of Louisville screens new contractors and renewals annually, as well as vendors paid more than \$1,000. Graduate students in high-risk areas (e.g., export control) are screened at the time of enrollment.

Another important decision in developing and improving your sanctions program is deciding whether to use a vendor and to what extent. Also evaluate which vendor fits your environment best, Wilcox says. “We use a hybrid process,” he says. Various University of Louisville departments submit information to the vendor, which kicks back potential matches. Right off the bat, non-matches are eliminated.

Wilcox described several caveats for organizations considering vendors in their exclusion screening. Among them:

(1) *Check the difference between annual versus per-search fees.* “There are unbelievable differences in the price,” Wilcox said.

(2) *Ask potential vendors whether they are willing to test drive their systems* (i.e., check 10 names). You already know the results, but the point is to see what the vendor’s system will kick back. “Insist on checking a live site for a couple dates in your organization so you can run names, and see what their vendor will kick back before you sign the contract,” Wilcox said.

(3) *Ensure their capability for data security and record retention.*

Screening, however, gets more complicated when there are potential matches. That’s where the rubber hits the road with any exclusion-checking program. Wilcox used the example of employee James Lee Brown. University of Louisville’s vendor ran his name and date of birth through its database of excluded and debarred individuals, which kicked out potential matches for “James B.

Brown” and “James L. Brown.” Right off the bat, Wilcox doesn’t worry about James B. Brown.

“We made a decision that a middle-name match is not a match,” Wilcox says. “You may have a different level of risk that you are willing to accept, but for us, if the middle name does not match, we move on. It’s a risk decision and a volume decision.” Anyway, he says, “we are unwilling to supply” the employee’s SSN to the vendor.

That meant Wilcox still had to nail down whether employee James Lee Brown was the same person as James L. Brown, who was excluded from Medicare. “We move forward to what we call the action date analysis,” Wilcox says. Compare the date of exclusion action against James L. Brown to the employee James Lee Brown’s resume and job history.

For example, with James L. Brown, the exclusion dates back to July 30, 1996, and relates to San Diego, Calif. But University of Louisville’s information shows James Lee Brown was hired on June 15, 1988. So next Wilcox looks back at where James Lee Brown lived at the time of exclusion. “I confirmed in our HR system that he was an employee at a [medical center] in Indianapolis from Jan. 20, 1980, to June 15, 1988,” so he was in Indianapolis right before he came to Louisville. “I think it’s reasonable enough,” Wilcox says. “That sounded good enough to me and good enough to university counsel.” The employee is not the excluded guy. At the end of the day, there is always confirmation with an SSN, date of birth and address.

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Hospitals Settle EMTALA Cases; Problems May Arise With Transfers

Judging by three recent civil monetary penalty (CMP) settlements, hospital compliance with the Emergency Medical Treatment and Labor Act (EMTALA) continues to be a challenge. Hospitals may be tripped up by transfers, although two of the three cases — in which the patients died — involved an alleged failure to give patients medical screening exams in the emergency room.

EMTALA requires hospital emergency rooms to provide a medical screening exam (MSE) to all patients and to stabilize people with emergency medical conditions regardless of their ability to pay for care. Patients can be transferred to other hospitals only if there is a medical reason for the transfer (e.g., lack of equipment or staff to treat the patient) and not because a patient lacks insurance. Hospital emergency departments (EDs) must maintain on-call panels, which are made up of specialists (e.g., orthopods, neurosurgeons) who can be summoned at any hour to treat patients for emergency medical conditions.

In the largest settlement, Parkland Health and Hospital System in Dallas agreed to pay \$50,000 to resolve its CMP liability under EMTALA, which is known as the patient dumping statute. According to OIG, a 58-year-old cardiac diabetic patient presented at Parkland's emergency room. The hospital allegedly failed to provide an appropriate medical screening examination, including an EKG or intravenous monitoring. The patient died of a heart attack.

Parkland made strides to improve its EMTALA compliance in response to the patient's death and now is implementing a comprehensive corrective action plan in response to a more recent EMTALA snafu involving a psychiatric emergency patient, a Parkland spokeswoman tells RMC.

Parkland Threatened With Termination

In September 2011, state surveyors acting on behalf of CMS cited Parkland for noncompliance with five Medicare conditions of participation and EMTALA requirements "which include deficiencies that represented immediate jeopardy to patient health and safety," according to documents posted on Parkland's website. For example, patients didn't receive an appropriate medical screening exam by a "qualified medical practitioner" to check for an emergency medical condition. And patients who were transferred to other facilities weren't stabilized or were transferred even though the hospital had the ability to treat them.

Also, CMS alleged, the hospital neglected to keep an on-call list of specialists and their alternates who are medical-staff members or who have hospital privileges for eight of eight listed specialties. Residents, who don't have privileges, were on call for five of eight specialties.

As a result, CMS threatened to yank the hospital's Medicare certification. Instead, Parkland entered into a system improvement agreement with CMS that calls for the hospital to hire an independent consultant to conduct a hospital-wide analysis of operations and recommend changes to ensure compliance with EMTALA and Medicare conditions of participation. The consulting firm will identify system failures and develop a detailed plan to get the hospital back in compliance. Parkland also will hire a compliance officer to coordinate and oversee improvements with respect to EMTALA and conditions of participation.

For now, CMS won't terminate Parkland from Medicare, but future participation will depend on its performance on the improvement and compliance plan.

Here is a summary of the other two recent EMTALA cases:

(1) Santa Clara Valley Medical Center in California agreed to pay \$48,000 to resolve its CMP case under EMTALA. According to OIG, a nearby urgent care facility

referred a patient to Santa Clara's emergency room after finding severe abnormal hemoglobin results. "It was suspected that the patient had some sort of internal bleeding," OIG stated. When the patient arrived at the ER, he showed a nurse his referral papers and complained of dizziness, blurred vision, and fatigue. "The patient was categorized as non-emergent and waited in the waiting room for seven hours," OIG alleges. No medical screening examination or stabilizing treatment was provided, according to OIG. Ultimately, the patient died in the ED. A spokeswoman for Santa Clara did not comment by press time.

(2) Jewish Hospital & St. Mary's HealthCare in Kentucky agreed to pay \$42,500 to resolve its CMP liability for alleged patient dumping. Emergency medical services (EMS) brought the patient to two different Jewish Hospital emergency rooms for a wrist laceration with arterial bleeding. One was the main emergency room and the other was a hand care center emergency room. According to OIG, "Jewish Hospital failed to provide a medical screening examination or stabilizing treatment" to the patient. Both of the emergency rooms told paramedics to transport the patient to another hospital. In a statement, Jewish Hospital & St. Mary's HealthCare says the allegations appear to stem from an isolated incident. "Nevertheless, we have taken a number of measures to prevent a recurrence. For example, the Jewish Hospital Hand Care Center emergency department has since been moved to the main Jewish Hospital emergency department. All employees and emergency room physicians have been re-trained and re-educated on the proper protocols and regulations. In addition, all continue to receive annual EMTALA educational training."

EMTALA has been around a long time and most hospitals probably have good procedures, says Schererville, Ind., attorney Bob Anderson, with Krieg Devault. EMTALA breakdowns probably relate to transfers stemming from "increasing difficulty getting specialists" to serve on call panels. "You can't get specialists to come in," Anderson says. "Maybe they're not available or maybe they want to be paid for call. That may be resulting in increasing numbers of transfers, which is where you might expect to see EMTALA complaints."

Compliance with EMTALA on-call physician panel requirements is tricky. Historically, physicians considered it part of their job to rotate call shifts. But now they are demanding payment.

"Where do you draw the line on that?" Hospitals started paying neurosurgeons and cardiovascular surgeons for being on call, "but that has the ripple effect of all specialists wanting to be paid," Anderson says. It's a financial drain for the hospital. "If you don't have a call list for neurosurgery, you have to transfer the patient. Or if you have someone on call and they are not available or

don't call in [when paged], you have to transfer them," Anderson says. CMS and OIG may consider the failure of an on-call specialist to respond to a call an EMTALA violation, Anderson says.

Sometimes transfers are acceptable when on-call specialists aren't available. Suppose there's no nephrologist on your call panel. "Maybe some of those procedures are done at your hospital but you don't have a specialist at your hospital," which means CMS doesn't require one on the call panel. "The patient will need to be transferred, but the ED physician must follow EMTALA and certify that the risks of transferring this patient outweigh the risks of keeping the patient at your hospital," Anderson says. "It may be clear in some cases and not others."

Transfers can also result from miscommunication. Specialists don't hear their beeper or think another specialist is on call. And "in the vast majority of cases, they do take the call," he says. "You don't see a lot of these cases pop up." But if they do, the results can be devastating for patients.

To avoid all kinds of EMTALA problems, hospitals must have good policies and do refresher courses for staff. "Repetition is the mother of education," Anderson says.

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Beware Extension of DRG Window

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There are all sorts of compliance complications stemming from the expansion of the DRG window payment rule, which CMS will start enforcing on Jan. 1. Hospitals have to find a way to link to services provided at their freestanding clinics, and start using new Medicare place-of-service and HCPCS codes that will trigger bundling into the inpatient claim.

Meanwhile, CMS is considering new edits to identify hospital-owned or operated physician practices. If they don't get this right, hospitals and physicians will generate overpayments.

CMS has taken a two-pronged approach to the overlay of the DRG window payment rule on hospital-owned or operated practices. The 2012 IPPS regulation states that diagnostic and "clinically associated" nondiagnostic services provided at physician practices that are "wholly owned or operated" by hospitals within three days of admission must be bundled into the inpatient bill and therefore not separately billed (*RMC 5/2/11, p. 1; 8/8/11, p. 5*). In tandem, the 2012 proposed Medicare physician fee schedule, which will be finalized in November, reduces physicians' professional fees for diagnostic and clinically associated nondiagnostic services provided at hospital-owned or

operated practices up to three days before an admission to reflect the fact that hospitals pick up the tab for office expenses, such as nurses and equipment (*RMC 7/11/11, p. 3*).

Big Changes Are Ahead on Jan. 1

The upshot: freestanding physician practices owned or operated by hospitals will be treated the same as provider-based entities for purposes of the DRG window payment rule. As a result, hospitals and physicians will take a big hit. As of Jan. 1, 2012, Medicare won't pay separately for the technical component of outpatient diagnostic or clinically associated nondiagnostic services when provided at hospital-owned or operated clinics up to three days before admission. The global fee that Medicare pays freestanding clinics will no longer include facility fees for services subject to the DRG payment window. Only physicians will get paid, although the rate will be lower.

However, Medicare is creating a new place-of-service code, modifier and condition code to keep everything straight. Physicians report the type of facility where they perform services on box 24b of their 1500 claim form, using POS code 11 (office) for freestanding clinics (which may or may not be owned by hospitals) or POS code 22 (hospital outpatient) for provider-based entities. Now CMS says it will create another POS code to indicate the freestanding clinic is wholly owned or operated by a hospital, Storey says. The agency says it also will create a new HCPCS modifier to convey to Medicare that services should be paid at the facility rate. The combination of the new POS code and modifier should make it crystal clear that Medicare should pay the physician only a portion of preadmission services because the facility portion was bundled into the inpatient claim, Storey says.

When services are not clinically associated with the admission, however, hospitals and physicians can bill Medicare separately for them. CMS created condition code 51 as a way for hospitals and physicians to signal that outpatient services provided up to three days before the admission are not clinically associated with the admission. For example, when physicians treat patients for broken fingers or arms a day or two before a procedure, they are entitled to the full payment rate. Hospitals may see a patient in the emergency room for a car accident that has nothing to do with elective surgery three days later, so reimbursement for two separate conditions is appropriate. The problem, however, is that there's no place on the 1500 form for physicians to put condition code 51, Storey says. CMS will have to fix this so physicians can report treatment that's not clinically associated with the admission.

CMS has yet to define “clinically associated,” Vernaglia says. If it offers up a definition, CMS said in the final IPPS regulation that it won’t revert to the exact-match standard. For many years, CMS required hospitals to bundle nondiagnostics into inpatient claims provided during the DRG window — but only when there was an exact, five-digit ICD-9 coding match between the outpatient and inpatient services.

CMS May Leave Hospitals to Their Own Devices

Vernaglia thinks a four-digit ICD-9 match may be a happy medium. It’s a less restrictive way to clinically associate a patient’s preadmission nondiagnostic service with the admission because only the four codes of the inpatient and outpatient diagnoses have to match. “Hospitals want something more generalizable,” he says, and “it’s auditable.” Other options are less appealing but could work, Vernaglia says, including:

(1) A physician attestation that the preadmission nondiagnostic services and admission are clinically associated, and

(2) Pre-billing chart reviews by hospital staffers to determine whether to bundle or unbundle preadmission nondiagnostics.

In conversations, CMS has indicated it will instruct hospitals to develop their own definitions of “clinically associated,” Vernaglia says. “Maybe hospitals are better off,” he says. “If CMS uses too narrow a definition, it won’t work.”

Sometimes hospitals will escape the new rule altogether. According to Vernaglia and Storey, the winners are expected to be:

(1) *Critical-access hospitals.*

(2) *Hospitals that are landlords of clinics only* (e.g., they lease physicians space in medical office buildings).

(3) *The parent company of a health care system or hospital chain when it owns the physician clinics.* If the clinics are lateral with the hospitals on the organizational chart, they’re off the DRG payment policy hook, Vernaglia and Storey say. If your company isn’t set up this way, “you could consider restructuring,” Storey says. Perhaps modify your 855 enrollment forms and rearrange the organization so the clinics are moved up to ownership by the parent company, Vernaglia adds.

(4) *Some hospitals that operate clinics under joint-venture arrangements.* If they share enough management responsibility with physicians, clinics can’t be wholly operated by the hospital anymore, they say.

But hospitals that are stuck with the DRG window payment policy expansion to freestanding clinics may have to consider another route to blunt their reimburse-

ment losses, Vernaglia and Storey say. Morphing them into provider-based entities is perhaps the only solution because Medicare pays more for the same services when they are rendered at provider-based entities than at freestanding clinics (hospital-owned or not).

Provider-based entities are not a panacea, however, so this will not be an easy decision, Vernaglia says. And hospitals have to consider the corollary that existing provider-based entities may be out of compliance.

Here are some of the complications with provider-based entities:

◆ *Patients will pay higher copays at clinics designated as provider-based,* which is likely to anger and alienate them. Already two health systems in Washington state have been sued by patients over the higher charges, generating bad publicity, and things didn’t go their way in the lawsuits. Even if there isn’t a lawsuit, hospitals may shy away from provider-based entities because of physicians’ complaints, Vernaglia says.

Miami Valley Hospital in Dayton, Ohio, for example, unraveled a provider-based cardiology practice after patients complained about higher copays, he explains.

◆ *Obstacles from regulators exist that may prevent the shift to provider-based entities,* Storey says. Suppose the hospital submits a plan to the state licensing division to convert a clinic to a provider-based entity. The state licensing division may require a construction review to determine if the clinic meets a higher level of building code (e.g., ambulatory clinic setting). Hallways may not be wide enough or doors might not be tall enough to meet building codes, and retrofitting costs may be prohibitive, Storey says.

◆ *There is skepticism from OIG, which has audits underway of provider-based entities.* For three years in a row, OIG has put aspects of this provider-based issue on the Work Plan, including inpatient and outpatient facilities. “OIG has been suspicious of this for 15 years,” Vernaglia says. For one thing, it’s “not supportive” that Medicare pays more money for the same services by virtue of their hospital ownership.

Provider-Based Compliance = Problems

If past is prologue, compliance with provider-based requirements is a problem. “The [compliance officers] I work with have had provider-based compliance on their work plans for the past several years,” Vernaglia says. Many hospitals were in good shape when they first signed self-attestations that their entities qualified for the designation years earlier, but “some have fallen off the wagon,” he says. They have stopped acting like their provider-based entities are as connected as they should be to the mothership.

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For example, Storey says, there should be signs making it clear to everyone — especially patients — that the clinic is part of the hospital. “You should have the hospital name in the name of the provider-based department so people know when they walk in the door they are going to a hospital department,” she says. If it’s a sleep disorder clinic, it should say “ABC Hospital’s Sleepytime Clinic” or “ABC Sleepytime Clinic.” It’s not good enough to name the hospital incidentally, Storey notes. “Smith Cardiology Associates at ABC Hospital” doesn’t seem to satisfy CMS.

Notwithstanding OIG scrutiny, Vernaglia notes that CMS appreciates the value of integrated hospital and provider clinical operations. “Tighter integration of physicians, hospitals and post-acute providers is the core element of most health reform initiatives in the market today, whether they are styled as accountable care organizations, bundled payments or integrated delivery systems,” he notes.

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NEWS BRIEFS

◆ **St. Mary’s of Michigan, which owns and operates the Seton Cancer Institute and other facilities, has reached a settlement agreement with the feds for \$3.49 million after self-disclosing that some of its Medicare billings for chemotherapy infusions were improper.** St. Mary’s leased space in the Huron Medical Center in Bad Axe, Mich., where it operated an oncology clinic until April 1, 2011, explains the U.S. Attorney’s Office for the Eastern District of Michigan. Chemotherapy was administered there for three or four days each week over a seven-year period without a physician present in the clinic. Providers cannot bill for chemo services performed in outpatient settings unless a physician is available in the clinic when the drugs are administered, the feds explain. St. Mary’s discovered the improper payments during a self-audit, according to the feds. Christine Bergman, a spokesperson for St. Mary’s, points out that the rules on physician supervision are complex. They differ according to where the treatment takes place, she says. “The proactive nature of our compliance program further demonstrates our commitment to honest and responsible conduct,” she says. Visit www.justice.gov/usao/mie.

◆ **A physician-owned company’s plans to provide management services to a third party got the thumbs down from the HHS Office of Inspector General in a new advisory opinion (11-15) released on Oct. 11.** OIG said the plan could generate prohibited remuneration resulting in administrative sanctions. The requestor wants to enter into a three-year management services contract with an unidentified third party (likely a pathology lab) under which the company would provide lab space, equipment, utilities, furniture, marketing and billing services. The requestor also wishes to attract new physician-investors who would have the option of referring business to the path lab, although it would not be a condition of their participation. OIG says the proposal does not satisfy any of the safe har-

bors for space rental, equipment rental or personal services and management contracts. The arrangement poses a risk of fraud and abuse because (1) the usage fees that the lab would pay the requestor would take into account the volume or value of business generated for the lab by the new investors in the form of specimen referrals directed to the lab; (2) more than 40% of the requestor’s investment interests would be held by physicians who are in a position to generate business for the lab; and (3) the requestor’s firm would be owned by physicians who lack clinical-pathology experience but have patient-referral power. “The Proposed Arrangement appears to have no business purpose other than to permit the physician investors to profit from the business they generate for the Path Lab in the form of their laboratory specimen referrals,” OIG says. Read the opinion at <http://go.usa.gov/9ju>.

◆ **Saint Francis Medical Center in Cape Girardeau, Mo., should complete its refund of more than \$267,000 for overpayments resulting from incorrect place-of-service codes,** OIG says in an audit report (A-01-11-00512) released Oct. 7. OIG found during nationwide reviews that contractors had overpaid providers that did not correctly identify the place of service on their claims. “Numerous” instances of this were identified at Saint Francis, OIG says. The hospital and two independent physicians who performed services there submitted claims resulting in overpayments of \$267,433 in 2009 and 2010, OIG contends. They used a third-party biller that incorrectly coded the claims with nonfacility place-of-service codes for services that had been performed in one of the hospital’s outpatient facilities. The hospital agreed with most of the findings, but disagreed with its outstanding overpayments for calendar year 2010 totaling \$28,264, explaining that it has resubmitted those claims. Read the report at <http://oig.hhs.gov/oas/reports/region10/11100512.pdf>.

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