Report on
MEDICARE COMPLIANCE

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

Contents

3 CMS Proposes Stark Exception for Gainsharing Arrangementments

4 New Code Says No More Freebies, but Many Already Abide by Rules

6 *Improvements Made to the RAC Permanent Program*

7 *Compliance Chronicle*

8 *News Briefs*

*PUBLISHER'S NOTE: **RMC** will not be published next week. The next issue will be dated Aug. 4.*

RACs Identify $1 Billion in Payment Errors; CMS Applies Lessons to National Program

Recovery audit contractors in six states identified $1 billion of improper Medicare payments during a three-year pilot program, so it doesn't seem like a stretch to imagine the dollars practically printing themselves as RAC auditors spread nationwide. While providers fear RACs will break their backs, CMS assured them that only a small fraction of their revenue was affected by RAC recoupments, and that new safeguards were implemented to prevent overzealousness, according to a July 11 CMS report. The permanent, national RAC program, in fact, will undergo some significant improvements as a result of lessons learned from the three-year pilot, the agency adds.

Between March 2005 and March 2008, RACs "succeeded in correcting over $1.03 billion of Medicare improper payments," the CMS report states. Most of it — 96% — was attributed to provider overpayments. Of that sum, $37.8 million was repaid to providers to make good on underpayments. Another $46 million stemmed from RAC overpayment determinations overturned on appeal, and $201.3 million was spent on administrative costs, including RAC contingency fees. The net result: RACs returned $693 million worth of overpayments to Medicare. They were caused mostly by errors, lack of medical necessity, insufficient documentation and lack of Medicare coverage.

continued on p. 5

Respiratory Diagnosis Coding Is a Top Error; Documentation Clarity Needed Among MDs

Respiratory system diagnoses have been a fertile area for recovery audit contractors (RACs), which pegged them as a common cause of hospital coding errors.

"Respiratory failure is one of the diagnoses that are consistently difficult," says certified coder Kathryn DeVault, a professional practice manager for the American Health Information Management Assn. (AHIMA). "RACs target respiratory failure because they know [hospitals] struggle with this diagnosis. Respiratory failure is a documentation problem for everyone."

A decade or more after DRG 79 became a universal risk area because the Department of Justice was pursuing false claims cases for pneumonia upcoding, the July 11 RAC report (see story above) listed respiratory system diagnoses as a top cause of inpatient hospital errors. In the three original RAC pilot states — New York, Florida and California — RACs collected $31.6 million in overpayments for incorrectly coded respiratory system diagnoses with ventilator support. And DeVault says respiratory failure usually pops up on the HHS Office of Inspector General Work Plan year after year.

At issue is a cluster of related respiratory DRGs. The actual DRGs are different than when the upcoding investigations were launched because Medicare-Severity DRGs (MS-DRGs) took effect last year.

The infamous DRGs 79, 89 and 90 are now MS-DRGs 179 (simple pneumonia), 178 (same, but with complications and comorbidities) and 177 (same, with major CCs). Respiratory failure is now MS-DRG 189; there is no CC or MCC. Respiratory failure with

a ventilator (fewer than 96 hours) is MS-DRG 208 and MS-DRG 207 (more than 96 hours).

DeVault says one major cause of respiratory failure claims denials is a disconnect between the treatment and the documentation. Patients arrive at the hospital's emergency department (ED) in respiratory failure. The ED physician often can reduce the danger and bring the patient under control relatively fast, and send him or her to the intensive care unit (ICU). These patients may have chronic obstructive pulmonary disease (COPD) that's exacerbated by pneumonia or by exposure to smoke or chemicals. By the time the attending physician sees the COPD patient in the ICU, "the patient doesn't appear to be in acute failure, so the [attending physician] doesn't document respiratory failure," DeVault says. Instead, the attending physician puts something in the chart like "respiratory insufficiency" or "insufficiency and acute COPD."

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So even though the principal diagnosis is respiratory failure — which means it's the condition that occasioned the admission — the attending physician believes he dealt with a case of insufficiency and won't supply adequate documentation for coders to code to respiratory failure and trigger the appropriate DRGs, says DeVault, a former hospital coder and data-quality analyst.

"When the coder sees respiratory failure documented only by the ED physician and then the attending physician documents acute respiratory insufficiency with pneumonia in the progress notes, then we have a conflict and inconsistency in the medical record," she says. "The answer should be to query the attending physician to resolve the conflict. It is the attending physicians who have the ultimate responsibility for codes we assign on that medical record, so they have to clear up those inconsistencies."

So where does the overpayment come in? Many hospitals bill Medicare for respiratory failure — which is a high-paying Medicare DRG, especially with ventilator support — but the documentation ostensibly doesn't support it because the attending physician has charted respiratory insufficiency. There's an impasse: "A clinical documentation specialist, who's an RN, can review the medical record and tell the patient was treated for respiratory failure. But we can't get the attending physician to document that because [the doctor says] 'the patient wasn't in failure when I treated him'" — even though the respiratory failure is indicated by the ED physician, nursing notes and lab tests, DeVault says.

So how can hospitals reduce claims denials for respiratory failure? Here are some of DeVault's suggestions:

◆ ***Work with physicians to document this phrase: "acute respiratory failure resolved."*** That covers all the bases.

◆ ***Educate physicians as much as possible to promote consistency in documentation.*** "I hear that more and more — consistency in documentation," DeVault says.

◆ ***Ask a pulmonologist to attend a coding meeting.*** Prepare a list of questions for him or her to answer as well as opening the floor to questions. "The nice thing about that is you will also have a relationship with that doctor from then on, and [he or she] may be less likely to ignore your query," she notes.

◆ ***Go to meetings held by different hospital departments and get on the agenda to speak about respiratory failure*** for five minutes because it's a major cause of payment errors. There is always a new angle to respiratory failure. When MS-DRGs were introduced, for example, it was important to inform physicians that more specific documentation of congestive heart failure is now required (e.g., diastolic, systolic).

Contact DeVault at Kathryn.devault@ahima.org. ✧

CMS Proposes Stark Exception For Gainsharing Arrangements

Gainsharing has gotten a big boost from CMS, which floated a detailed Stark law exception for two new types of gainsharing arrangements in the fiscal year (FY) 2009 Medicare physician fee schedule proposed June 30. CMS is seeking feedback on two types of gainsharing arrangements: incentive payments for improving quality and shared savings for reducing costs.

"This is a major step forward," says attorney Paul Danello, who is with Squire Sanders & Dempsey LLP. "It's significant in that it represents the first formal government acceptance at a policy level of gainsharing and pay-for-performance in the context of the Stark law. A great deal of the credit should go to MedPAC [the Medicare Payment Advisory Commission], which has been a strong supporter of gainsharing."

The proposed Stark gainsharing exception is a complete turnaround from the tone and character of the 1999 OIG bulletin on gainsharing, Danello says. The bulletin warned that gainsharing could violate a Civil Monetary Penalties Law (CMPL) that bans the use of physician incentives to "reduce or limit" services to Medicare beneficiaries. OIG's concerns about gainsharing arrangements include reduction in patient care, "cherry-picking" healthier patients, payments in exchange for referrals and unfair competition.

However, in a series of advisory opinions issued since 2001, OIG has repeatedly approved a certain kind of gainsharing arrangement despite its potential for violating the anti-kickback statute and a CMPL *(RMC 2/7/05, p. 1)*. The new CMS Stark exception "is a synthesis of all the advisory opinions that OIG has put forth so far on gainsharing," Danello says. "CMS has taken all the significant safeguards, limitations and conditions [described in the opinions] and transported them from the anti-kickback arena to the proposed Stark exception."

If the Stark exception is finalized, hospitals and physicians that meet its terms could engage in gainsharing, he says. However, "the proposed regulation is not the sole exclusive exception," he says. "You can use other ones like the employment exception or the fair-market value exception. So this is in addition to, not in place of, other Stark exceptions."

But the arrangements still face the anti-kickback law's prohibitions on hospital payments to physicians, so either they could take their chances or seek an advisory opinion.

In the Medicare physician fee schedule rule, CMS proposes an exception for hospital (1) incentive payments to physicians, which are designed to encourage physicians to improve quality of care (e.g., pay for performance) through changes in physician clinical or administrative practices, and (2) shared savings programs, which reward physicians for cutting costs without harming patient care.

In the regulation, CMS describes the conditions that must be met for gainsharing arrangements between hospitals and physicians on their medical staff to meet the proposed Stark exception. Here's a sampling of the criteria:

(1) The incentive payment or shared-savings program must identify concrete quality measures or cost savings. That means they must be "verifiable, are supported by credible medical evidence, and are individually tracked," using objective methodology. CMS also wants the quality measures to be relevant to the hospital's patient population and monitored through the duration of the gainsharing arrangement to guard against "inappropriate reductions or limitations in patient care services."

(2) At least five physicians must be involved per performance measure, and they would be known as the participating physician pool. Physicians can't be chosen in a way that considers volume or value of referrals or other business generated between the parties.

(3) There must be independent medical review of the incentive payment/shared-savings program's impact on quality provided at the hospital; and, if required, corrective action.

(4) For the purpose of these gainsharing programs, durable medical equipment (DME) suppliers become a designated health service. In other words, physicians can't receive incentive payments from DME companies if they have an investment or ownership interest in the DME company.

(5) Physicians participating in the incentive payment/shared-savings programs must have access to the same selection of items, supplies and devices available at the hospital before the programs began.

Danello adds that hospitals and physicians should keep in mind another Stark plan in the 2008 Medicare physician fee schedule that was proposed in July 2007. It stated that the set-in-advance requirement under Stark could be used only for personally performed physician services and had to be based on revenues directly resulting from physician services, not on other factors (e.g., the percentage of savings from the hospital department). That proposal could have doomed gainsharing, Danello says. Fortunately, the FY 2009 regulation came along with its specific plan for gainsharing arrangements, he says. Danello advises hospitals to study both regulations before embracing a gainsharing arrangement. Be prepared to revise the arrangement if CMS decides to adopt the July 2007 proposed rule, he says.

Contact Danello at pdanello@ssd.com. ✧

New Code Says No More Freebies, But Many Already Abide by Rules

Brand-name drug makers that follow their trade group's updated voluntary code for interacting with providers will no longer distribute freebies such as pens and coffee mugs. Companies also should not be buying meals for providers without offering product education at the same time, the Pharmaceutical Research and Manufacturers of America (PhRMA) says in its "PhRMA Code on Interactions with Healthcare Professionals," released July 10. While the changes should have been expected by health care entities and physicians, older doctors may have more trouble adjusting, two experts say.

"Appropriate marketing of medicines ensures that patients have access to the products they need and that the products are used correctly for maximum patient benefit," the code says. "Our relationships with health care professionals are critical to achieving these goals."

This version of the code is updated from one released in 2002 and takes effect in January 2009. PhRMA says this is an ongoing process. Companies that publicly say they will follow the code will be listed on PhRMA's Web site and will have to certify annually that they have policies and procedures in place to foster compliance with the code, the organization says.

The most visible change may be that pens with company or drug logos, seen carried by countless doctors and nurses, could disappear altogether if all companies adhere to the PhRMA code. "Providing items for healthcare professionals' use that do not advance disease or treatment education — even if they are practice-related items of minimal value (such as pens, note pads, mugs and similar 'reminder' items with company or product logos) — may foster misperceptions that company interactions with health care professionals are not based on informing them about medical and scientific issues," the organization says. But educational items, such as anatomical models for exam rooms, are still OK a long as they cost less than $100, according to the code.

PhRMA says companies can still buy meals for providers, but they must be "modest," "occasional" and must take place in the office or hospital setting and should accompany an informational presentation. Entertainment tickets are out now too.

PhRMA also says arrangements under which health care professionals work as consultants should be handled with care. "It is appropriate for consultants who provide advisory services to be offered reasonable compensation for those services and reimbursement for reasonable travel, lodging, and meal expenses incurred as part of providing those services. Any compensation or reimbursement made in conjunction with a consulting arrangement should be reasonable and based on fair-market value," the code says.

"With some exceptions, revisions to the PhRMA Code reflect many of the policy changes already implemented by health care providers in response to OIG focus on industry relations," says Nickie Braxton, corporate compliance officer at Hartford Hospital/Hartford Health Care Corporation in Connecticut. The prohibition of pens, pads, etc. "will have little impact on providers who have increasingly prohibited acceptance of these marketing materials already," along with free meals inside or outside the workplace. "Many health care providers, including Hartford Hospital, prohibit these meals altogether. Industry representatives must make appointments to meet with our hospital representatives and may not bring snacks or meals with them," she says.

Can Bagels and Danishes Influence Docs?

"Physicians accustomed to bagels and Danishes, meals, golf resorts,…entertainment at industry-sponsored events, etc., will probably be less than enthusiastic about these changes, although most have surely been hearing about these compliance concerns for some time," Braxton continues. Many physicians "are offended by the notion that they may be influenced by these minor offerings, and they're indignant at the notion that they would prescribe a drug simply because someone brought them a bagel. But these [drug] companies are made [up] of very bright, creative, industrious individuals. Why would they spend millions of dollars on bagels and Danishes each year if this strategy had no impact?" she asks.

Braxton says that physicians are being pursued by pharmaceutical and durable medical equipment manufacturers for many different business relationships, including consulting and investments. They should enter these arrangements with eyes wide open, she says, because even deals that seem "reasonable and transparent" may "raise questions of conflicts of interest and kickback activity to the federal government," Braxton says.

Lee Tumminello, an attorney with Baker & Daniels LLP, agrees that the updated code may be a bigger change for the older generation of physicians, but that young doctors have been urged by groups such as No Free Lunch to refuse gifts and meals from companies.

Pharmaceutical manufacturers also have been instituting many of the policies on their own over the years because of government enforcement actions based on the anti-kickback statute and other laws, Tumminello says. "For the goals of the code to be achieved, everyone in this industry has to participate in this and should educate themselves on what these guidelines are. This is what the government has been looking to when it enforces the anti-kickback statute," she says.

Read the code at www.phrma.org/files/PhRMA%20Marketing%20Code%202008.pdf. Contact Tumminello at lee.tumminello@bakerd.com and Braxton at Nbraxton@harthosp.org. ✧

CMS Learns From RAC Pilot

continued from p. 1

It's a watershed moment because the numbers give Congress proof that RACs bring home the bacon at a time of tremendous pressure on the Medicare budget. RACs are paid only for identifying overpayments and, to a lesser extent, underpayments. The pilot, mandated by Congress, was carried out by private contractors in New York, California and Florida. During the last year, Massachusetts, Arizona and South Carolina were added, but the reviews were limited. RACs went national starting this summer, but so far in a limited number of states. CMS promises "aggressive outreach to providers in every state before overpayment notices and medical record requests are issued."

According to the report, during the RAC pilot $828 million was improperly paid to inpatient hospitals. Of that amount, about 36% was caused by incorrect coding and 41% was attributed to inappropriate admissions. The worst offenders for hospitals: surgical procedures performed in the wrong setting (i.e., the admission was medically unnecessary); incorrectly coded excisional debridement; cardiac defibrillator implant in the wrong setting; treatment for heart failure and shock in the wrong setting; and incorrectly coded respiratory system diagnoses with ventilator support (see story, p. 1).

Despite the huge recovery numbers, CMS maintains the RACs had "limited financial impact on most providers." For example, more than 84% of hospitals audited by two of the RACs had their Medicare revenue affected by less than 2.5%, and the same went for 95% of hospitals audited by the third RAC.

Providers' Costs Go Beyond Repayments

But Boston attorney Larry Vernaglia says repayments are just one aspect of the RACs' cost for providers. CMS did not take into account collateral damage. "Costs to providers of preparing for and responding to RACs have been very large," says Vernaglia, who is with the law firm Foley & Lardner. "Many hospitals have seen costs in the six-figure range" — from staff time, consulting, computer systems and responding to RAC medical record requests.

During the three years of the pilot, providers appealed 14% of the RACs' overpayment determinations, and 4.6% of the determinations were overturned. CMS added that as of May 1, 2008, an additional 3,009 claims are pending at the second and third level of appeals. And providers still have the right to appeal another roughly $255 million worth of overpayment determinations.

Some experts take issue with key findings in the RAC report. Michael Taylor, M.D., senior director of governmental retrospective appeals for Executive Health Resources (EHR), a consulting firm in Pennsylvania, says RACs have affected some providers disproportionately. For example, in Florida in fiscal year 2008, "while 67.1% of providers had no offset, 12.6% of providers had an offset of 5% or more," Taylor says.

The reasons why some hospitals are hit harder than others by RACs is unclear, but Taylor says it's possibly related to the strength of a hospital's compliance program and "the propensity of the RACs to target high-dollar areas." For example, hospitals that performed a large volume of implantable cardiac defibrillator procedures may have experienced more high-dollar overpayment determinations because the RACs targeted those procedures in two of the initial demonstration states, he notes. Vernaglia adds that rehab hospitals in California were hit hard by the RAC there *(RMC 10/22/07, p. 1)*, which prompted CMS to order the RAC to review its overpayment determinations. And CMS had to tell the RAC in Florida to shut down inappropriate reviews of two different procedures and return money to specialists *(RMC 3/3/08, p. 1)*.

Appeals Numbers May Be Incomplete

Taylor and Robert Corrato, M.D., CEO of EHR, also say the appeals numbers are premature. "Since so many RAC overpayment determinations were issued in the final quarter of the demonstration project, a significant number of appeals might have been filed which are not yet represented in the report's statistics," Taylor says.

Many hospitals, for instance, have RAC overpayment determination appeals in the pipeline, and they are increasingly successful *(RMC 6/23/08, p. 1)*. "The [RAC appeals] numbers are not complete, and that is the bottom line," he says. "As more data roll in over the next two or three quarters, the percentages will change dramatically." And, Corrato adds, the updated numbers should embolden providers to appeal more often when they think the RAC has wrongly declared an overpayment determination. Taylor adds that so far, 33.3% of appealed RAC overpayment determinations have been decided in favor of the provider.

The fundamental myth of the appeals process, adds Vernaglia, is that it's a great equalizer. The truth is, even when providers believe the RAC is wrong, they often lack the money and time to appeal the overpayment determination, he says. "RACs know this, and so they still have motivation to be overaggressive on overpayment determinations." This may be true especially in cases where the cost of appealing is greater than the money

involved in the disputed claim; winning would be a Pyrrhic victory.

The report describes some experiences CMS had with the RACs during the pilot, and how that led to changes in the administration of the permanent, national program (see table, below). For one thing, providers in all three pilot states worried that RACs were misinterpreting Medicare coverage or payment policies when auditing claims.

So in August 2007, CMS hired AdvanceMed to be the RAC validation contractor. Since then, RACs have to run every new avenue of overpayment review past CMS. The RAC must submit to CMS the provider type, error type, policy violated and potential improper payment amount per claim. CMS decides whether to green-light the RAC or submit it to the validation contractor for further review. If the latter course is chosen, the validation contractor audits a sample of claims and then gives CMS its recommendation (yea or nay to full-scale RAC review). "Thus, a RAC cannot perform any automated or complex reviews in excess of 10 medical records without CMS approval," the report notes.

Another change: CMS said some providers worried that there was no way to ascertain whether RACs' findings were accurate (especially when providers didn't appeal). To address this concern, CMS requires validation contractors to review a random sample of overpayment claims from every RAC. The accuracy scores of every RAC will be made public.

Vernaglia praised CMS's application of the lessons learned. He thinks one of the most beneficial changes for providers is CMS's termination of RAC contingency fees when overpayment determinations are overturned on appeal. Under the pilot, RACs got paid for claims denials

Improvements Made to the RAC Permanent Program

The July 11 CMS recovery audit contractor report describes differences between the RAC pilot and the permanent, national RAC program, which CMS is rolling out (see story, p. 1). Go to www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

Issue	Demonstration RACs	Permanent RACs
RAC medical director	Not required	Mandatory
Coding experts	Optional	Mandatory
Credentials of reviewers provided upon request	Not required	Mandatory
Discussion with CMD* regarding claim denials if requested	Not required	Mandatory
Minimum claim amount	$10.00 aggregate claims	$10.00 minimal claims
AC* validation process	Optional	Limited
External validation process	Not required	Mandatory
RAC must pay back the contingency fee if the claim is overturned on appeal	Only required to pay back if claim is overturned on the first level of appeals	Required to pay back if claim is overturned at all levels of appeals
Vulnerability reporting	Limited	Frequent and mandatory
Standardized base notification of overpayment letters to providers	Not required	Mandatory
Look-back period (from claim payment date — date of medical record request)	4 years	3 years
Maximum look-back date	None	10/1/2007
Allowed to review claims in current fiscal year?	No	Yes
Limits on number of medical records requested	Optional. Each RAC set own limit	Mandatory. CMS will establish uniform limits
Time frame for paying hospital medical record photocopying vouchers	None	Within 45 days of receipt of medical record
MSP* included	Yes	No
Quality assurance/Internal control audit	No	Mandatory
Remote call monitoring	Yes	Yes
Reason for review listed on request-for-records letters and overpayment letters	Not required	Mandatory
RAC claim status Web page	Not required	By January 2010
Public disclosure of RAC contingency fees	No	Yes

* CMD = contractor medical director, AC = affiliated contractor, MSP = Medicare secondary payer.

even when their findings were rejected on appeal — a big incentive to find all kinds of errors that didn't exist, Vernaglia says. Now RACs lose their money if the provider succeeds at any level of appeal, from rehearing to the administrative law judge. While that's a big improvement, Vernaglia says the only way to guarantee a lack of audit bias is to penalize unjustified claims determinations.

Contact Vernaglia at lvernaglia@foley.com and Corrato at rcorrato@ehrdocs.com. Read the RAC report at www.cms.gov/RAC. ✧

COMPLIANCE CHRONICLE

Following are highlights of proposed rules, notices, transmittals, audit reports, advisory opinions and Office of Evaluation and Inspections reports released by CMS between June 2 and July 11. For more information on these, visit AIS's Government Resources at the Compliance Channel at www.AISHealth.com.

Rules:

◆ **36443–36448 [E8–13520],** posted June 27, "Medicare Program; Use of Repayment Plans."

◆ **36448–36463 [E8–14440],** posted June 27, "CMS Appeals or CMS Contractor Determinations When Provider or Supplier Fails to Meet Medicare Billing Requirements."

◆ **36469–36471 [E8–13279],** posted June 27, "Medicare and Medicaid Programs: Hospital Conditions of Participation; Laboratory Services."

Proposed Rule:

◆ **38502–38881 [E8–14949],** posted July 7, "Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B (CY 2009)." *(RMC 7/14/08, p. 8)*

Transmittals:

◆ **Trans. 87 (CR 6137),** posted July 11, "Percutaneous Transluminal Angioplasty (PTA) With Stenting."

◆ **Trans. 52 (CR 6102),** posted July 11, "Change to CR Implementation Report Due Dates."

◆ **Trans. 139 (CR 6089),** posted July 11, "Interaction with Recovery Audit Contractors (RACs)."

◆ **Trans. 1548 (CR 5993),** posted July 9, "Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)."

◆ **Trans. 1547 (CR 6114),** posted July 3, "Update-Long Term Care Hospital (LTCH) Prospective Payment System (PPS) Rate Year 2009."

◆ **Trans. 1546 (CR 5889),** posted July 1, "Modification to existing Medicare Summary Notice (MSN) Procedures regarding the MSN Customer Service Information Box, Beneficiary Estate Information and the Appeals Address."

◆ **Trans. 262 (CR 5644),** posted July 1, "Flagging Health Insurance Claim Numbers (HICN) in the Medicare Carrier System (MCS) for Pre-Payment Review/Audit."

◆ **Trans. 1545 (CR 5792),** posted June 27, "Payment for Inpatient Hospital Visits (Codes 99221 - 99239)."

◆ **Trans. 85 (CR 6098),** posted June 27, "Cardiac Computed Tomographic Angiography (CTA)."

◆ **Trans. 58 (CR 6001),** posted June 27, "Medicare Acute Care Episode Demonstration - Rescinds and fully replaces CR 5767."

◆ **Trans. 1543 (CR 6077),** posted June 27, "Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Rate Year 2009."

◆ **Trans. 84 (CR 6099),** posted June 27, "Private Contracting/Opting out of Medicare."

◆ **Trans. 92 (CR 6081),** posted June 27, "Private Contracting/Opting out of Medicare."

◆ **Trans. 261 (CR 6078),** posted June 27, "Update to Section 12 of Chapter 10 of the Program Integrity Manual."

◆ **Trans. 1540 (CR 6095),** posted June 20, "July 2008 Update to the ASC Payment System; Summary of Payment Policy Changes."

◆ **Trans. 260 (CR 6065),** posted June 20, "Clarification of Chapter 10."

◆ **Trans. 91 (CR 5988),** posted June 20, "Self-Administered Drug Exclusion Lists."

◆ **Trans. 1541 (CR 6085),** posted June 20, "Screening Pelvic Examinations."

◆ **Trans. 1539 (CR 5988),** posted June 20, "Self-Administered Drug Exclusion Lists."

◆ **Trans. 1538 (CR 6060),** posted June 20, "New Waived Tests."

◆ **Trans. 1536 (CR 6094),** posted June 19, "July 2008 Update of the Hospital Outpatient Prospective Payment System (OPPS)." *(RMC 6/23/08, p. 1)*

◆ **Trans. 354 (CR 6086),** posted June 13, "Hospitals Exempt from Present on Admission (POA) Reporting (i.e., non Inpatient Prospective Payment System or IPPS Hospitals) and the Effects on Grouper."

◆ **Trans. 438 (CR N/A),** posted June 13, "Determinations and Appeals Procedures Mailing/Web Site Update."

◆ **Trans. 351 (CR 6073),** posted June 13, "508 Compliancy for Medicare Remit Easy Print (MREP) Software."

◆ **Trans. 347 (CR 6066),** posted June 6, "Analysis and Design Only -- Systems Improvements to Streamline Updates to the Place of Service (POS) Code Set."

OIG Advisory Opinion:

◆ **08-07,** posted July 7, "concerning a proposal for a health care system to provide $10 gift cards to patients whose service expectations were not met." *(RMC 7/14/08, p. 5)*

NEWS BRIEFS

◆ **CMS should consider other management practices of imaging services, which are taking place more often in physicians' offices and have seen "rapid spending growth,"** the Government Accountability Office (GAO) says in a report (GAO-08-452) posted July 14. Medicare spending for imaging services paid for under the physician fee schedule more than doubled between 2000 and 2006, the report says. "The proportion of Medicare spending on imaging services performed in-office rose from 58% to 64%. Physicians also obtained an increasing share of their Medicare revenue from imaging services. In addition, in-office imaging spending per beneficiary varied substantially across geographic regions of the country, suggesting that not all utilization was necessary or appropriate," the report says. GAO interviewed private health plans and found that insurers have practices in place to manage spending growth in this area. For example, they rely on prior authorization (PA), which requires doctors to get the plan's approval before a service can be ordered. In response to the report, CMS says it will examine the use of PA for Medicare payments for imaging services. Read the report at www.gao.gov/cgi-bin/getrpt?GAO-08-452.

◆ **An administrative law judge (ALJ) upheld OIG's administrative sanctions on a durable medical equipment (DME) supplier and its owner in a June decision,** the office said July 16. OIG imposed a $100,000 civil monetary penalty and a $42,000 assessment, and it also excluded Florida-based Kast Orthotics and Prosthetics Inc. and owner Cary Frounfelter from Medicare for seven years. OIG says they "falsely claimed they provided the devices after the beneficiaries had been discharged from HealthSouth, or within a 48-hour window prior to discharge," and then improperly billed Medicare. The ALJ called the relationship with HealthSouth Inc. a "corrupt bargain." A spokesperson for Kast could not be reached for comment. Visit http://oig.hhs.gov and click "What's New."

◆ **On July 15, both houses of Congress overrode President Bush's veto of the Medicare Improvements for Patients and Providers Act (H.R. 6331), which will delay CMS's DME competitive bidding program, among other things.** The DME competitive bidding process was mandated by the 2003 Medicare reform law. CMS officials have said that the program will save Medicare about $1 billion *(RMC 1/14/08, p. 5)*. Suppliers who were awarded contracts were scheduled to begin doing business under the program July 1, but this and other aspects made it controversial. Under the program, beneficiaries would get items through only those suppliers that submitted bids and won contracts with the government. CMS signed up 325 suppliers out of nearly 1,000 bidders to serve in the initial 10 communities. Many suppliers complained about the qualifications for the bidding process and about not getting a contract with CMS. H.R. 6331 will throw out the contracts awarded during the first round of the program, which took place in 10 metropolitan areas, and restart the bidding and contracting process in 2009. The second round affecting 70 more regions will start in 2011 — nearly two years later than what was originally required. Also, CMS is now required to notify bidders about any paperwork discrepancies and give them an opportunity to correct documentation. Visit http://thomas.loc.gov and search for H.R. 6331.

◆ **Hospitals got a break with the passage of the Medicare Improvements for Patients and Providers Act (H.R. 6331), which includes another moratorium on separate billing for independent pathology lab services,** CMS explains in a July 16 statement. In 1999, CMS said it would "implement a policy to pay only the hospital for the technical component (TC) of physician pathology services furnished to hospital patients." That payment will be included in the DRG and APCs, and hospitals without their own pathology labs will have to pay independent labs directly. But the policy never took effect because of delays and moratoriums granted to the industry. The latest moratorium was set to expire on June 30, and CMS had already issued a transmittal 357 preparing Medicare contractors to stop paying labs separately for the pathology technical component. But Congress has again come to the rescue, and CMS has canceled the transmittal.

◆ **The False Claims Act Correction Act of 2007 (H.R. 4854) was marked up by the House Judiciary Committee on July 16** and reported out to the full House, according to Taxpayers Against Fraud (TAF). There is not yet a date scheduled for a House vote on the bill. Visit www.taf.org.

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