Report on
MEDICARE COMPLIANCE

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

Contents

With Pay Restriction Approaching, CMS Adds Only Three HACs in IPPS; DFRR Is Finalized

CMS continued to link payment and quality in the final inpatient prospective payment system (IPPS) regulation for fiscal year 2009, although in some surprising ways. In the rule, announced July 31, only three of the nine hospital-acquired conditions it proposed in April for the second round of HACs made the final cut *(RMC 4/28/08, p. 1)*. That means a total of 11 HACs will be subject to payment restrictions when the rule takes effect Oct. 1. At the same time, CMS eliminated payment for the "N" and "U" present-on-admission (POA) indicators.

The regulation also finalized the new Disclosure of Financial Relationships Report (DFRR) with some adjustments. The DFRR is a data-gathering instrument designed to capture detailed information about hospital-physician relationships as part of CMS's enforcement of the Stark physician self-referral law *(RMC 4/21/08, p. 1)*. For the foreseeable future, CMS will limit DFRR to 500 hospitals. Among other things, CMS increased its estimate of the time and money hospitals will expend to complete the form. After seeking industry input on the proposed rule, CMS came up with 100 hours and $4,080.

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With OIG Focus on Incident-to Services, Providers Urged to Review NP, PA Billing

Medicare watchdogs have their eyes trained on services provided incident to a physician's professional services, which has appeared on all but two of the past six HHS Office of Inspector General (OIG) Work Plans. With all that external scrutiny, it's a good idea to explore the compliance challenges triggered by nurse practitioners (NPs) and physician assistants (PAs), the midlevel practitioners at the heart of incident-to billing. There are two key billing issues — incident-to billing and scope-of-practice issues.

Getting it right is essential because "Medicare contractor audits, reviews and data mining are not going away," said Cynthia Swanson, senior healthcare manager with Seim, Johnson, Sestak & Quist, LLP, a CPA and health care consulting firm in Omaha, Neb. "The government cares about the health care dollar, so they care about [the oversight] for the long term."

According to Swanson and Dawnese Kindelt, compliance officer for clinics and physicians services at Catholic Healthcare West, Medicare pays for NP and PA services if:

(1) No other entity is billing or receiving payment for that service. For example, if your NPs or PAs are seeing patients in your hospital outpatient clinic, their salaries can't be included in your facility cost report and then charged again as a professional fee on the HCFA 1500 claim form, Kindelt said. "If you bill the professional fee, take them out of the cost report so you are not reimbursed on both sides."

continued

(2) The NP or PA furnishes a covered benefit; and

(3) The NP or PA codes and documents according to American Medical Assn. and CMS documentation guidelines.

There are three options to bill NP and PA services: incident to, shared/split, or directly under the NP's or PA's name and national provider identifier (NPI) number. Here are some pitfalls associated with each:

◆ ***Incident-to billing:*** "Be sure you understand the Medicare requirements, as the rules are complex and can be confusing," Swanson said. Incident-to services must be "an integral, though incidental, part of the physician's professional services." Services by NPs and PAs must be provided under the physician's direct personal supervision. Medicare reimburses 100% of the physician fee schedule for NP and PA services provided incident to a physician's service and 85% of the Medicare physician fee schedule for direct NP and PA billing, so there's a financial incentive to master the incident-to rules when they are applicable and monitor billing accuracy to ensure compliance. This requires paying careful attention to restrictions on NP and PA billing.

For example, physicians must see patients who are new to the clinic, Swanson and Kindelt said. The role of midlevel practitioners is to treat patients according to the physician's plan of care. Similarly, if it's an established patient, and a new problem/diagnosis emerges, the physician must see the patient again. "Physicians have to see patients at the first visit and remain active throughout the course of treatment," she said. And direct physician supervision throughout is a mainstay of incident-to billing.

Incident-to Rules Do Not Apply to Consultation

Also, "incident-to rules do not apply to consultation services," said Swanson. Medicare says that consultations cannot be performed or reported as incident-to services (or as shared/split services), according to the Internet-only Manual Publication 100-02, Medicare *Benefit Policy Manual*, Chapter 15, Sec. 60. However, NPs and PAs can perform consultations and bill them directly if state licensure rules permit this, she said.

Keep in mind the importance of following other Medicare rules that are triggered by their own benefit category (e.g., diagnostic tests). "Incident to is one rule, and diagnostic test services are another," Swanson noted. How would this affect the actual practice of medicine? "State law permitting, the NP or PA may order, personally perform and interpret diagnostic test services. However, NPs and PAs are not permitted by CMS to supervise Medicare diagnostic tests," she said.

◆ ***Split/shared services:*** A split/shared visit is "a medically necessary encounter with a patient, where the physician and a qualified [midlevel practitioner] each personally perform a substantive portion of an E/M [i.e., evaluation and management] visit face-to-face with the same patient on the same date of service," according to PBSI Medicare Services, the Medicare fiscal intermediary for Louisiana (see table, p. 3).

A split/shared visit can be performed in an office/clinic setting or hospital inpatient/outpatient or emergency department setting, according to Swanson and Kindelt, who spoke on NP and PA compliance issues at the Health Care Compliance Assn. Compliance Institute in New Orleans in April. If it's in the office for an established patient service, the NP/PA must meet the incident-to rule. That's obviously not true for the hospital side, where incident-to services don't apply. Again it's important to understand the difference between incident-to services and split/shared visits.

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For split/shared services, the physician's face-to-face time must be captured in the documentation. Suppose the PA or NP has seen the patient and performed and documented the history, exam and medical decision making. If the physician then follows up with documentation that states, "seen and agreed, heart and lungs normal" and signs the medical record legibly, Medicare considers that documentation adequate, and the service may be billed under the physician name and NPI. That means reimbursement is 100% of the Medicare physician fee schedule. If the physician puts, "agree with above, lungs clear" and signs legibly, that's also acceptable. However, if the physician documents, "above noted, proceed with cardiac cath as planned," that documentation won't suffice for 100% fee-schedule reimbursement, Swanson said. *Why not?* "This documentation in and of itself doesn't establish the physician's face-to-face encounter with the patient," she said.

◆ ***NP and PA direct billing:*** Medicare reimburses 85% of the physicians' fee schedule for NP and PA services. This is the easiest method to comply with, though it obviously

Options for Billing Nonphysician Services

Cynthia Swanson, a consultant with Seim, Johnson, Sestak & Quist, LLP, says these requirements must be met to bill physician assistants (PAs) and nurse practitioners (NPs) incident to a physician's professional services. Health systems should play close attention because this area is a compliance minefield (see story, p. 1). Contact Swanson at cswanson@sjsq.com.

Nonphysician Practitioner Services: NP and PA

Three Options to Bill Medicare:

(1) Incident-to Services	(2) Split/Shared Service	(3) NP's or PA's Name and Number
◆ Must be integral, although incidental part of the physician's personal professional service ◆ NP or PA may be an employee, independent contractor or a contractor under an indirect contractual arrangement ◆ Physician must first see patient and develop the plan of care the NP or PA will carry out ◆ Physician must remain active in patient's ongoing treatment ◆ Direct physician supervision is required ◆ Bill service under physician's name and number - Medicare reimbursement 100% of Medicare Physician Fee Schedule (MPFS) amount or ◆ Bill service under NP's or PA's name and number - Medicare reimbursement 85% of MPFS amount ◆ "Incident to" not applicable to: - Consultation services - New patient office services and established patients being seen for new problem/condition (physician has not seen patient and established plan of care) ◆ "Incident to" not applicable in an institutional setting (i.e., hospital inpatient/ outpatient, emergency department, skilled nursing facility)	Applies only to selected evaluation and management visits and locations ◆ N/A to new patient visits, consultations, procedures and critical-care services ◆ N/A to services in the skilled nursing facility or nursing facility setting ◆ Both a physician and NP or PA provide services in the **office setting** for the same encounter ◆ "Incident-to" criteria must be met ◆ Bill service under physician's name and number - Medicare reimbursement 100% of MPFS amount or ◆ Bill service under NP's or PA's name and number - Medicare reimbursement 85% of MPFS amount ********** ◆ Both a physician and NP or PA provide services in the **hospital inpatient, hospital outpatient, observation or emergency department** on the same day ◆ Bill service under physician's name and number - Medicare reimbursement 100% of MPFS amount or ◆ Bill service under NP's or PA's name and number - Medicare reimbursement 85% of MPFS amount	◆ Service performed by NP or PA - Consultation services - New patient services - Established patient services - Hospital outpatient services - Hospital inpatient services - Emergency department services - Other services ◆ Bill service under NP's or PA's name and number - Medicare reimbursement 85% of MPFS amount

This information is general in scope and is intended to provide an overview of Medicare's guidelines regarding NP and PA services. For additional information, refer to your local Medicare carrier and CMS publications and websites. We encourage recipients of this information to contact legal counsel for advice and direction on specific matters of concern.

generates less reimbursement. Sometimes clinics have no choice but to bill this method because, for example, the physician is on vacation. "You can't bill incident to if a physician is not on the clinic premises," Swanson said.

Billing is not the only compliance challenge facing organizations using the services of NPs and PAs. Scope of practice is a common theme running through other compliance challenges, Swanson and Kindelt said (see table, this page):

(1) Education/experience: Ensure NPs and PAs graduate from a certified program, have experience in a clinical environment and maintain required continuing education, Swanson said. Conduct background checks on new PAs and NPs. Be wary of situations where their licenses lapse, yet billing for their services continues for a while before the lapse is detected.

(2) State laws: Get specific information on the scope of practice for your state for NPs and PAs. Swanson recommends a compendium of state laws and regulations published by the American Academy of Physician Assistants.

(3) Facility policy: Set your own internal policies governing the services that NPs and PAs will perform in accordance with the needs of your organization and your community, she said.

(4) Physician delegation: "The physician is primarily responsible for the overall direction and management of [PAs' and NPs'] professional activities and that they are medically necessary, so when it comes to the scope of practice, we want to make sure our physicians are OK with what the services are. Then physicians have to oversee and be accountable," Kindelt said.

Contact Swanson at cswanson@sjsq.com and Kindelt at dkindelt@chw.edu. For PA guidelines, visit www.aapa.org/gandp/statelaw.html and www.aapa.org/gandp/stateregguidelines.html. ✧

Compliance Checklist for Nonphysician Practitioners

This example of a checklist helps health systems determine whether they have met legal and regulatory requirements for physician assistants (PAs) and nurse practitioners (NPs) (see story, p. 1). It was developed by consultant Cynthia Swanson, who is with Seim, Johnson, Sestak & Quist, LLP. Contact her at cswanson@sjsq.com.

1. NP or PA Education and Experience	**Yes**	**No**
A. Documentation of education, training and copy of current NP's or PA's license from the state he/she is practicing is maintained.		
B. Documentation of NP's or PA's continuing medical education to maintain licensure is retained by NP or PA and/or health care organization.		
2. State Law		
A. Documentation of current NP's or PA's licensure or state certification requirements/guidelines from the applicable state, board or other organization are annually reviewed and retained.		
3. Facility Policies		
A. Facility where NP or PA practices has written protocols/standards outlining the services NPs or PAs may provide consistent with the NPs' or PAs' education, training and experience.		
B. Facility maintains records of other internal facility requirements of NPs or PAs such as: CPR training, safety/disaster training, code of conduct, confidentiality agreement, etc.		
4. Physician Delegation		
A. Supervising or collaborating physician is a fully licensed physician (M.D. or D.O.)? Documentation of this requirement is maintained.		
B. Internal policies outline the type of NP or PA supervision (personal, direct and general) and address any applicable requirements of specific payers.		
5. Other:		
A. Internal policies and procedures outline NP or PA services specific to Medicare guidelines including employment arrangements, credentialing and enrollment with Medicare and other payers, split/shared services, "incident-to" services, medical record documentation requirements and other billing requirements.		
B. Complete and up-to-date information must be maintained. The above documents are annually reviewed and updated including documentation of the review date and reviewer signature.		

Form completed by: _____ **Date:** _____

CoxHealth Case Shows How Fast Fines Pile Up; Feds Stop at $60M

Guided by an informant, federal prosecutors in Missouri spent five years investigating a multifaceted health fraud case against Cox Medical Centers (CoxHealth), and now the company will pay $60 million to settle False Claims Act allegations, the Department of Justice (DOJ) said July 22. Given the extent of alleged false claims based on Stark and kickback violations, the settlement amount should have been much higher, but if the feds kept racking up fines, CoxHealth would be history, says Joel May, health care fraud coordinator for the U.S. attorney's office for the Western District of Missouri.

This settlement is a harsh reminder of the risks inherent in noncompliant hospital-physician relationships and the importance of taking audits in this area to a new level *(RMC 6/16/08, p. 1).*

The feds allege that some financial relationships between CoxHealth and certain physicians ran afoul of the federal anti-kickback statute and the Stark physician self-

referral law. As a result, claims submitted by CoxHealth arising from these relationships are false claims, the U.S. attorney contends. The settlement also resolves alleged Medicare cost-report violations.

May tells *RMC* that CoxHealth had a compliance officer at the time of the alleged wrongdoing.

Meanwhile, she notes, "there is a criminal case still open."

Feds: Salaries Linked to Revenue Generated

CoxHealth, a nonprofit headquartered in Springfield, Mo., owned the Ferrell-Duncan Clinic, Inc. (FDCI) — but only its bricks and mortar (e.g., overhead, employing nurses). Clinic physicians were not employees and were organized into their own for-profit medical group. CoxHealth's hospital and the clinic entered into a professional services agreement to govern their relationship. That meant CoxHealth would bill for the physicians' services and pay physicians a percentage of collections. "The professional services agreement said that any compensation would be compliant with Stark," May says. But it wasn't true, she alleges.

In fact, between 1996 and 2005, salaries were allegedly calculated partly based on how much revenue each physician generated for the hospital in radiology, clinical lab work, neurodiagnostic services, durable medical equipment and supplies, and pharmaceuticals, according to the allegations in the settlement agreement. That's a Stark violation because hospitals can't bill for services ordered by physicians with whom they have a financial relationship unless an exception applies.

There were also some problematic medical-director agreements, says May. CoxHealth entered into medical directorships with certain FDCI nephrologists. "They were paid based on the number of referrals to the dialysis clinic," Ozarks Dialysis Services (ODS), she says. The fee: $1,000 per patient per year, according to May. "This is the paradigm of what not to do," she asserts. The medical-director agreements were not in writing, and even if they were, they would have spelled out tasks that the physicians were obliged to perform as part of their regular duties, she says.

"Medicare would not have paid those claims had they known the anti-kickback and Stark laws were being violated," May maintains. "Medicare wants to promote independent decision making by physicians."

CoxHealth did not return *RMC*'s calls. But in a prepared statement, President and CEO Robert Bezanson says the health care laws are "very complex and very unforgiving." He adds, "They require that the government demand repayment, which can be very large. In fact, given the size of CoxHealth and the number of patients we treat on a daily basis, one potential error in interpreting a billing regulation can affect every claim filed thereafter — in our case, tens of thousands of claims. Since damages can be assessed on a per claim basis, the repayment can quickly result in an amount that is well beyond our ability to pay."

Quality of Care Was Not Issue

He notes that quality of care was never questioned and that Medicare was never billed for services not provided, an assertion with which the prosecutor agrees. And then the CEO responded in the statement to some of the specific allegations.

In terms of physician compensation, "the government's rules regarding payments made to physicians and their practices have shifted dramatically over the last decade. CoxHealth internally discovered that under one interpretation of these rules, it may have provided improper compensation to physicians with Ferrell-Duncan Clinic, Inc.…CoxHealth determined that from 2000 to 2004, we may have paid physicians from a revenue source from which they may not have been eligible to be paid. The results of hospital administration's review were reported to the government in February 2005."

Bezanson also acknowledged that "under one interpretation," the way medical directorships were structured at ODS "may have been incorrect" between 1996 and 2004. CoxHealth came forward on its own and told the government in January 1995, according to the statement.

May says CoxHealth has maintained all along that it never intentionally violated the law. But that's irrelevant when it comes to Stark. Stark is what's known as a "strict liability" statute. If hospitals (or certain other entities) have financial relationships with physicians, hospital services provided to patients referred by those physicians violate Stark unless an exception is met — end of story. It doesn't matter what's in a provider's mind or heart. And because all the payments for services referred by the physician are invalid, the money must be repaid, plus fines — which is why, over the course of nine years, CoxHealth's liability was stratospheric, says May. The government stopped counting after a while because it was pointless, she says. After reviewing CoxHealth's financial data, DOJ auditors determined that the health system couldn't pay the fines and penalties it actually owed based on the government's allegations without going out of business. And the government is loath to put legitimate providers out of business because communities need their health care providers.

CoxHealth's settlement process took three years, so legal expenses are another factor.

Visit www.coxhealth.com/settlement. Contact May at joel.may@usdoj.gov. ✧

OIG Policy Says Copay Waivers Are OK for Retroactive Pay Increases

Copayment waivers and deductibles are usually bad news under the fraud-and-abuse laws, but OIG has opened a small window for them in light of special circumstances created by the newly enacted Medicare Improvement for Providers and Patients Act of 2008 (MIPPA). In a July 23 policy, OIG says certain providers won't face sanctions for patient cost-sharing waivers created when MIPPA reversed payment cuts that had already taken effect July 1.

MIPPA, which was enacted July 15, was retroactive to July 1. It rescinded a 10.6% Medicare payment reduction for physicians, and threw in a small payment increase. Payment cuts that took effect July 1 for other segments of the industry — durable medical equipment, prosthetics, orthotics and supplies (DMEPOS); brachytherapy sources and therapeutic radiopharmaceuticals under the outpatient prospective payment system; and the ambulance fee schedule — were similarly reversed.

These providers and suppliers were presumably thrilled about getting their reimbursement back, but it put them in a quandary: Starting July 1, they had been charging copays and deductibles consistent with the reduced payment rates as required by law, but now beneficiaries' liability for cost sharing increased retroactively, consistent with the higher payment rates, OIG says. As a result, "beneficiaries who already paid, or were billed for, cost-sharing amounts based on lower payment rates temporarily in effect since July 1, 2008, are liable for additional cost-sharing amounts under the increased MIPPA payment rates."

So OIG was asked whether providers affected by retroactive beneficiary liability have to bill beneficiaries for the higher copays and deductibles that resulted from increased MIPPA payments. The reason people were worried: Routine waivers of Medicare cost-sharing amounts potentially implicate the anti-kickback statute and the Civil Monetary Penalty Law (CMPL) forbidding inducements to beneficiaries.

Lawyer: OIG Acted Quickly

But OIG said this unusual circumstance would not trigger CMPL or anti-kickback violations. "In these limited circumstances, providers will not be subject to OIG administrative sanctions if they waive retroactive beneficiary liability," OIG states — assuming that certain conditions apply. For example, there is a narrow window — the period of time from July 1, when the payment cut took effect and then was adjusted retroactively.

Don't mistake OIG's statement as permission to routinely waive patient copays and deductibles, says Washington, D.C., attorney Heidi Sorensen, former chief of OIG's Administrative and Civil Recoveries Branch. That's taboo, as OIG has made clear in previous statements. And if providers want to go back and correct the copays and deductibles, they are free to do so.

OIG's policy statement is a relief because physicians have already collected patient copays and deductibles. If OIG hadn't issued this policy statement, the whole process would have had to be corrected for all services during the relevant time period, she says. "And it's confusing for the patient," adds Sorensen, who is now with Foley & Lardner LLP. Some elderly Medicare beneficiaries would have been baffled and annoyed by the duplicative nature of retroactive beneficiary liability, she says.

Sorensen says this new policy "steps outside OIG's normal position on copay waivers. From a policy perspective, OIG could have said it's business as usual: 'You can't waive copays and deductibles. If you want to try, get an advisory opinion.' But instead, OIG chose to get out there and say, 'Don't worry about it. We won't subject you to sanctions if you waive copays,'" she says. "It's a unique and very proactive policy. It's reflective of the kind of Inspector General Dan Levinson is — very attuned and sensitive to these kinds of issues." Sorensen said OIG did it fast: MIPPA was enacted July 15, and OIG issued the policy eight days later.

Contact Sorensen at hsorensen@foley.com. Read the policy at www.oig.hhs.gov/fraud/docs/alertsand bulletins/2008/MIPPA_Policy_Statement.PDF. ✧

OIG Advisory Opinion Says Hospital, Physicians Can Invest in ASC

A plan by a group of surgeons and a corporation that owns hospitals to invest in an ambulatory surgery center (ASC) could generate prohibited remuneration, but OIG probably wouldn't impose sanctions, according to Advisory Opinion 08-08, posted July 25.

Although physician-hospital joint ventures can be vehicles for fraud and abuse, OIG says, hospitals face "a competitive disadvantage" *vis-à-vis* ASCs owned by physicians, who control referrals. That's why OIG created an exception to the anti-kickback law (known as a safe harbor) for ASCs that meet certain conditions. Among other things, the ASCs must be jointly owned by hospitals and general surgeons or surgeons who work in the same surgical specialty.

In the arrangement at issue in this opinion, all the physicians are orthopedic surgeons, OIG explains. But the arrangement has other key mitigating factors, OIG notes:

(1) The surgeons do not hold their investment interests in the ASC either directly or through a group

practice composed of qualifying physicians. "We have previously expressed concern that intermediate investment entities could be used to redirect revenues to reward referrals or otherwise vitiate the safeguards provided by direct investment, including distributions of profits in proportion to capital investment," OIG says. But it notes that the use of a "pass-through" entity "does not substantially increase the risk of fraud or abuse," and that each surgeon's ownership in the partnership is proportional to his or her capital investment.

(2) Four of the 18 surgeons didn't meet the safe-harbor requirement that at least one-third of a physician investor's income from medical practice for the previous fiscal year be derived from ASC-qualified procedures. The protection of the safe harbor is reserved for physician-investors who use it on a regular basis, OIG explains. The requestors told OIG that the surgeons in this example practice subspecialties of orthopedic surgery that require a hospital operating room, and that they would refer patients to the ASC mostly for pain management services. They also said that no surgeon investor will refer patients to the ASC for pain management services unless the procedures will be performed personally by that surgeon.

(3) The hospital corporation is in a position to make or influence referrals to the ASC and the surgeon investors. But the arrangement requires the hospital corporation to limit its ability to influence referrals by (a) refraining from actions to require or encourage its physicians to refer patients to the ASC, (b) not tracking referrals, (c) ensuring that any compensation paid to its physicians is at fair-market value, and (d) informing its physicians about these measures annually.

(4) Services provided by the hospital corporation to the ASC must be pursuant to a contract that complies with the personal services and management contracts safe harbor. A condition of this safe harbor is that, if a service is to be provided on a part-time basis, the contract "must specify exactly the schedule of such intervals, their precise length, and the exact charge for such intervals," OIG says. The company running the ASC has an agreement with the hospital-owned physician practice to provide anesthesiology at the ASC. One of the anesthesiologists employed by the practice will serve as a part-time director of anesthesiology and medical director of the ASC. This contract does not meet the safe harbor because it "does not specify a schedule for the services to be provided by this individual," OIG explains. But it notes that all of the services are set out in the anesthesia agreement in detail, the services are reasonable and necessary for the ASC, and the payment amount is at fair-market value.

This opinion can aid providers investing in ASCs because it shines at least some light on the one-third test, says South Bend, Ind., attorney Bob Wade. "This [opinion] helps because it emphasizes the fact that [a venture] could have a few [surgeons who don't pass the one-third test] and still be an acceptable arrangement," he says. A physician either should be investing directly, or, if he/she is investing through a group, every member must meet the one-third test, Wade explains. Otherwise, "it could be used as a mechanism to compensate physicians who don't meet it. A group practice would divide out the profit to all, including those who don't qualify."

OIG has said in the past that it's fine if some investors don't pass the test, but OIG has not been more specific. In this opinion, however, OIG says the four (out of 18) surgeons "comprise a small portion of the surgeon investors," Wade notes. "There is still a struggle with how many not meeting the test would be unacceptable. Here we have 22.2% of the investors who don't meet the test," so maybe that can be used as a gauge.

Contact Wade at bob.Wade@bakerd.com. To view the advisory opinion, visit AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "OIG Advisory Opinions." ✧

CMS Adds HACs, Finalizes DFRR

continued from p. 1

According to the final rule, Medicare won't pay hospitals for additional costs stemming from treating these HACs (in addition to the eight others finalized in an earlier IPPS rule):

- ***Surgical site infections following certain elective procedures***, including certain orthopedic surgeries, and bariatric surgery for obesity.
- ***Certain manifestations of poor glycemic control.***
- ***Deep-vein thrombosis or pulmonary embolism*** following total knee- and hip-replacement procedures.

"They dropped conditions that were not preventable," says Marion Kruse, a director at FTI Consulting in Atlanta. "Clinically this was the right thing to do since there was not evidence-based medicine to prove they were preventable."

As part of its master plan to ensure Medicare doesn't pay for "never events" — which are serious, preventable errors — CMS also unveiled a process to develop National Coverage Determinations (NCDs) to address Medicare coverage of certain surgical procedures. NCDs set national policy on Medicare coverage for items and services. CMS is considering NCDs for three types of procedures: surgery on the wrong body part, surgery on the wrong patient, and the wrong surgery performed on a patient. CMS kicked off a "national coverage analysis" of these NCDs with a 30-day comment period that began July 31.

continued

Starting Oct. 1, hospitals won't get paid when codes carry "N" or "U" POA indicators. Hospitals are required to attach one of five POA indicators to all principal and secondary diagnosis codes on billing forms. This helps Medicare determine whether conditions were hospital acquired. There are five POA indicators: "Y" for yes, the condition was POA; "N" for no, the condition was not POA; "U" for unknown because documentation was insufficient to determine if the condition was POA; "W" for when the provider is unable to clinically determine whether the condition was POA; or "1" to indicate an exemption from POA reporting.

CMS says it plans to evaluate whether the POA indicators are used properly. "Medicare program integrity initiatives closely monitor for inaccurate coding and coding inconsistent with medical record documentation," the regulation states. However, CMS acknowledges that sometimes patients leave the hospital before it's possible to make "an informed determination of whether a HAC was present on admission" (e.g., transfers, leaving against medical advice, death). So CMS is weighing whether to address these situations with the use of patient discharge status codes.

Kruse says hospitals should keep a close watch on their POA indicator reporting because it could be a fruitful area for recovery audit contractors (RACs). "When considering payment for HAC conditions, concise physician documentation and coder assignment of the POA indicators is crucial. From a compliance and RAC perspective, the inappropriate use of these indicators can lead to an inappropriate payment to the hospital. I think we can count on the RACs including this area in their reviews after Oct. 1, 2008, as it is a potential area of easy money for them. Hospitals must assure that documentation supports the use of 'Y' and 'W' indicators."

Contact Kruse at marion.kruse@ftihealthcare.com. Visit AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "Inpatient Prospective Payment System." ✧

NEWS BRIEFS

◆ **In a landmark agreement, Providence Health & Services in Seattle will pay $100,000 and enter a corrective action plan to settle potential violations of the HIPAA privacy and security rules,** HHS said July 17. This is the first time HHS has required a covered entity to enter a resolution agreement, the agency says. Providence said that it lost electronic backup media and laptop computers containing individually identifiable health information on about 386,000 patients in 2005 and 2006. Under the corrective action plan, Providence must (1) revise its policies and procedures on physician and technical safeguards for off-site transporting and storage of electronic patient information, (2) train staff members on the safeguards, (3) conduct audits and site visits, and (4) submit compliance reports to HHS for three years. Providence has reinforced its security protocols and implemented new data protection measures since the incidents occurred, the health system says in a statement. Visit www.hhs.gov/ocr/privacy/enforcement.

◆ **Three former employees of Kendall Regional Medical Center in Miami pleaded guilty July 23 to conspiring to defraud the facility of $5 million,** says the U.S. Attorney's Office for the Southern District of Florida. As part of their plea, Joanna Delfel, Victor Garcia and Sylvia Oramas admitted they used the hospital's computerized supply management system so it would issue payments to two medical supply vendors for medical supplies fraudulently ordered and never delivered. They then created phony purchase orders and recorded that supplies had been delivered. Visit www.usdoj.gov/usao/fls.

◆ **Qualified Independent Contractors (QICs) did not always meet the timeliness, correspondence and data-entry requirements for Part A and Part B reconsiderations they received between May 2005 and July 2006,** OIG says in an Office of Evaluations and Inspections report (OEI-06-06-00500) posted July 18. Part A QICs met the 60-day processing deadline, but Part B contracts did not for 58% of cases, OIG found. The QICs entered inaccurate information into the Medicare appeals system for 54% of the reconsiderations, the report says. OIG says CMS should (1) add error rates to its annual reviews of QICs, (2) validate the appeals-system data and (3) monitor the length of time it takes contractors to transfer paper case files to QICs. CMS said it has taken several steps to address the issues. Visit AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "OIG's Office of Evaluations and Inspections."

◆ **CLARIFICATION:** Coding errors were a major cause of overpayments identified by recovery audit contractors (RACs). *RMC* inadvertently stated "errors" instead of "coding errors" in its July 21 article on CMS's RAC report.

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