Report on
MEDICARE COMPLIANCE

Volume 17, Number 32 • September 15, 2008

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

Contents

Stakes Raised for Compliance Auditing as CMS Deploys Advanced Data-Analysis Tools

Several changes in the regulatory and compliance world — including the loss of free government audit data, the mandatory assignment of present-on-admission (POA) indicators and CMS's deployment of sophisticated data analytics to detect payment errors — are raising the stakes for hospitals to develop their own data capabilities.

In January 2009 hospitals face the end of the Program to Evaluate Payment Patterns Electronic Report (PEPPER). Through the Hospital Payment Monitoring Program (HPMP), CMS's vehicle to reduce inpatient payment errors, CMS distributed PEPPER data to all hospitals for 13 risk areas. PEPPER informed hospitals when they were below the 10th percentile or above the 75th percentile in billing for each risk area compared to all other hospitals in that state. This allowed hospitals to expend audit resources on obvious hot spots. Though HPMP ended in July, PEPPER data will be available until Jan. 31, 2009.

So hospitals are out one big source of free data at the same time as other pressures are mounting. Medicare and Medicaid program-integrity contractors are intensifying audits, with CMS rolling out the national version of the recovery audit contractors (contract awards are slated to begin at the end of September) and the first set of Medicaid integrity contractors. CMS also is developing the "One Program Integrity System Integrator," known as "One PI." CMS's One PI contractors provide data-analysis tools and use data-analysis methods for Medicare and Medicaid fraud-and-abuse detection.

continued on p. 5

ICD-10 Codes Will Be New World for Data Reporting; Compliance Requires Planning

In a challenge reminiscent of Y2K compliance, hospitals will soon tackle the adoption of ICD-10 diagnosis codes and the HIPAA transaction standards needed to use them. Given the breadth of the changes, experts advise hospitals to start preparing now for the new coding systems. A lot of pre-implementation work will be necessary, as will post-implementation validation of the codes (see checklist, p. 3).

HHS on Aug. 15 proposed two interdependent regulations that are critical to the operations of the health care system. One rule would replace the outdated ICD-9-CM code sets with ICD-10 code sets for diagnoses and certain procedures on Oct. 1, 2011. The second rule, which takes effect April 1, 2010, would update the "X12" standard used for HIPAA electronic transactions. The latter update is necessary to accommodate the former.

continued

Published by Atlantic Information Services, Inc., Washington, DC • 800-521-4323 • www.AISHealth.com
An independent publication not affiliated with hospitals, government agencies, consultants or associations

"Compliance, quality, utilization review and reimbursement are migrating to a similar point because of technology, and this is one of the things facilitating that trend," asserts Julie Chicoine, compliance director for Ohio State University Medical Center.

It's almost impossible to overstate the importance of this development and its transformative nature. "This is not just an update. This is a complete change from one coding system to a new one that is structured in a completely different way," Chicoine says. "This is an enormous change for the better. It is key to health care quality and payment on so many levels."

ICD-9 codes are three to five digits long and are organized around body systems (e.g., digestive, musculoskeletal). There are 16,000 ICD-9 codes. In contrast, ICD-10 codes are three to seven alphanumeric characters. The characters capture digits according to an axis of classification based on etiology, anatomy or severity. Anatomy is the primary axis. There are 68,000 diagnosis codes and 87,000 inpatient hospital procedure codes, so the level of specificity that can be captured by an ICD-10 code is an entirely different order of magnitude, says Chicoine.

The regulation couldn't come soon enough, she maintains. ICD-9 is running out of codes, and the codes are not descriptive enough to capture necessary details of a patient's situation. ICD-9, developed in 1979, is somewhat archaic considering the advances in knowledge of disease states and treatment since then, Chicoine says. "ICD-10 will make the description of diagnoses and procedures much more accurate — not just for payment, but for health care data monitoring, cost containment and quality measurement and patient safety," she says.

For example, while ICD-9 had just one code for a routine well-child visit, there are ICD-10 codes for a well-child visit without abnormal findings, a well-child visit with abnormal findings and for the abnormal findings, Chicoine says.

HIPAA Update Has Room for POAs

Without updating the uniform electronic standards for HIPAA transaction and code sets, HHS couldn't implement ICD-10. So it has proposed the transition from the 4010A version to the 5010 version. This is an update for the electronic transactions that are now required by Medicare for eight essential standard transactions, including claims submission, payment, remittance advices, coordination of benefits and health care claim status.

"5010 sets the framework for ICD-10," says Chicoine. "4010A is not big enough for ICD-10. 5010 was written with ICD-10 in mind."

The 5010 update is critical also because it creates space for present-on-admission (POA) indicators, which must be assigned to all principal and secondary diagnoses (see story, p. 1).

According to Chicoine, compliance officers should understand the basics of ICD-10 because they affect every aspect of health care, including registration, billing and electronic health records, and quality reporting. Hospitals must establish a multidisciplinary ICD-10/HIPAA 5010 task force. Start examining the differences between ICD-9 and ICD-10. "It's a good time to contact your vendor and find out what upgrades they have in place," she contends.

Contact Chicoine at julie.chicoine@osumc.edu. Fact sheets describing the proposed rules will be forthcoming at www.cms.hhs.gov/apps/media/fact_sheets.asp. ✧

Report on Medicare Compliance (ISSN: 1089-6872) is published 45 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

Managing Editor, Nina Youngstrom; Associate Editor, Eve Collins; Editor, Angela Maas; Executive Editor, James Gutman; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Gwen Arnold; Production Coordinator, Darren Jensen.

Call Nina Youngstrom at 800-521-4323 with story ideas for future issues.

Subscriptions to *RMC* include free e-mail delivery in addition to the print copy. To sign up, call AIS at 800-521-4323. E-mail recipients should whitelist **aisalert@aispub.com** to ensure delivery.

To order **Report on Medicare Compliance:**

(1) Call 1-800-521-4323 (major credit cards accepted), or

(2) Order online at www.AISHealth.com, or

(3) Staple your business card to this form and mail it to:
AIS, 1100 17th St., NW, Suite 300, Wash., DC 20036.

Payment Enclosed* ❑ $618

Bill Me ❑ $648

*Make checks payable to Atlantic Information Services, Inc.
D.C. residents add 5.75% sales tax.

Subscribers to *RMC* are eligible to receive up to 12 Continuing Education Credits per year, which count toward certification by the Compliance Certification Board. For more information, contact CCB at 888-580-8373.

Call 800-521-4323 (or visit the Marketplace at www.AISHealth.com) to order ***Report on Medicare Compliance on CD***, a searchable CD with all issues of the newsletter published from January 2006 through June 2008. ($89 for subscribers; $389 for non-subscribers.)

Hospital Preparation Checklist for ICD-10 and HIPAA 5010

Julie Chicoine, compliance director for Ohio State University Medical Center, outlined some steps to help hospitals start the process of preparing for the transition to the next generation of diagnosis codes (ICD-10) and HIPAA transaction and code sets (see story, p. 1). Contact Chicoine at julie.chicoine@osumc.edu.

CMS acknowledges that the transition to the new Version 5101 and adoption of ICD-10 will be significant. While these changes can seem daunting, health care providers, vendors and insurers can take steps now to ensure timely implementation and compliance with these changes. This checklist should facilitate organizational readiness for this pending change:

Evaluate and Assess: Convene a task force to assess the organization's current situation and determine what business processes will be affected by these changes. Task force objectives should include:

◆ ***Analyze the differences between 4010A1 and Version 5010 with emphasis on organization-specific business operations,*** including billing systems, patient records systems, reporting systems and associated system interfaces.

◆ ***Initiate and/or complete a gap analysis for purposes of implementing system changes.*** System modifications may include payment modifications, upgrades to software applications and training.

◆ ***Evaluate the degree of system integration, need for outside technical assistance, and number of systems and system interfaces*** that must be upgraded to incorporate version 5010 changes.

◆ ***Review current vendor contracts regarding upgrade services.*** Some software maintenance contracts offer free or low-cost upgrades to accommodate regulatory changes.

◆ ***For ICD-10, special attention should be given to DRG software and other systems*** that will need to be updated to recognize and accept the new codes.

◆ ***Work with business partners to test operability of software and/or applications*** that demonstrate the ability to create, send and receive Version 5010 transactions.

Planning and Budget: For each business operation that may be affected by these changes, organizations should begin project planning and budgeting for implementation of Version 5010 and adoption of ICD-10. Planning and budgeting should include:

◆ ***Potential risk for disruption of business transactions/productivity losses and the financial impact that these disruptions could have on the organization.*** Also consider costs for additional claims processing resulting from errors and delays in implementing the system changes.

◆ ***Evaluate the need for acquiring new technology to facilitate implementation and transition to Version 5010 and ICD-10.*** Potential costs can include analysis of business flow changes, software procurement, or customized software development; integration of new software into existing provider/vendor systems; staff training; collection of new data; and the testing and transition process.

◆ ***Address issues with business partners who will also be getting into compliance with Version 5010 and ICD-10.***

Monitor: Organizations should monitor the federal Web sites including CMS and/or the *Federal Register* for any publications and/or definitive guidance on achieving compliance with Version 5010 and adoption of ICD-10.

◆ ***Publications should be referred to the organization's legal counsel*** for assistance with drafting and submitting comments within the rule-making period.

◆ ***Watch for CMS FAQs, fact sheets, and other supporting education and outreach materials*** regarding adoption and implementation of these proposed rules.

Action Plan: Identify key individuals within the organization to evaluate implementation strategies, educational needs and processes, including training, testing and changes to existing electronic systems, as well as appropriate communication strategies to individuals who will play a role in implementation of Version 5010 and adoption of ICD-10. Keep in mind:

◆ ***Adoption of the new Version 5101 and the ICD-10 codes will affect nearly every provider*** who submits diagnostic codes and every payer that processes health care claims.

◆ ***Training and education will be necessary not only for coding staff but also to code users,*** including quality management, utilization review, providers, researchers, data analysis, business office and others involved in health care operations.

◆ ***Organizations will also need to make necessary updates and changes*** to existing institutional policies governing health care transactions and similar operations affected by these changes.

Man Who Fled After 1998 Fraud Conviction Gets 51-Month Sentence

A man who lived as a fugitive for a decade after his health fraud and kickback conviction was sentenced Sept. 2 to 51 months in prison, according to the U.S. Attorney's Office for the Eastern District of Michigan. Richard Montgomery, the former co-owner of a company that provided neurodiagnostic testing services, escaped detection for so long by stealing a dead person's identity. Meanwhile, his daughter, who was the other co-owner of the company, served time in jail for conspiracy.

Montgomery's company marketed the services to chiropractors in 20 states and allegedly paid more than $459,000 in kickbacks or referral fees to providers to induce them to refer patients for testing, federal officials say. The tests usually generated a $2,400 insurance claim. Blue Cross Blue Shield of Michigan paid about $750,000 in claims, the feds say.

Montgomery also was ordered to pay $780,000 in restitution to the insurer as part of his sentencing. The feds were seeking 87 months to 108 months in prison, a sentencing memorandum shows. "There is nothing trivial about a massive, four-year scheme to pay kickbacks to 53 chiropractors for needless medical examinations, costing patients and Blue Cross/Blue Shield more than $1,000,000. And there is nothing inconsequential about Montgomery's flight from justice and remaining a fugitive for more than nine years," the memorandum says.

Some of the patients had Medicare coverage, which is why Montgomery was also charged with violating the federal anti-kickback law, says a Department of Justice official who asked not to be identified. The anti-kickback law applies only to payments for referrals for goods or services reimbursed by federal health care programs. Some chiropractors were given lease agreements based upon how many tests they conducted, the official says.

Daughter Served 15 Months in Prison

Montgomery's daughter pleaded guilty to a conspiracy charge in 1998 and served 15 months in prison. Seven chiropractors and one owner of a clinic also were convicted for their parts in the scheme, but the government says a total of 53 chiropractors were involved. And the feds contend that Montgomery was the leader of the conspiracy, according to court documents.

A jury convicted Montgomery in 1998, but he failed to appear for his sentencing in 1999, the feds explain. He was found in May 2008 living under a deceased person's identity in Pennsylvania, say the feds, who note that he faced three years in prison or less at the time of his trial.

His attorney says they have filed an appeal but declines to comment further on the case. In a sentencing memorandum, Montgomery argues that he is being punished by the government because he exercised his right to a jury trial when others involved in the scheme pleaded guilty. He also contends that he had very little to do with the scheme.

Visit www.usdoj.gov/usao/mie. ✧

CMS Pours Energy Into Data Analysis, Has Big Plans for 2010

CMS is using data in new ways to narrow down both billing and geographic areas prone to fraud, waste or abuse and to identify payment policies that invite overpayments. The data are being shared with program-integrity and law-enforcement partners.

"This is the future," said attorney Larry Vernaglia, with Foley and Lardner LLP. "Compliance officers need to be more savvy than ever before in understanding how Medicare and Medicaid use this data."

CMS has a "vulnerability surveillance team" (VST) that uses data to track payment errors and obtain corrective action plans, according to Lameka Davison, a CMS health insurance specialist. The team serves as a "focal point for identifying and tracking fraud, waste and abuse," particularly in Medicare Parts A and B, she said.

"We detect provider and supplier behavior patterns through data mining," she said. Some of the categories reviewed by the VST are inappropriate billing, outlier payments, identity theft, compromised use of National Provider Identifiers (NPIs) and weak operational policies that "on their face create risk" of overpayments, Davison said at a Health Care Compliance Assn. audioconference earlier this year.

The VST responds to data-driven analysis requests from CMS field offices (e.g., in Miami), regional offices and law enforcement. Data are provided to government agencies and contractors, including recovery audit contractors, that share the same program-integrity goals. Potential fraud-and-abuse referrals come to the VST from a multitude of sources, including Medicare administrative and program-integrity contractors. They are prioritized according to eight factors, including the financial impact of the possible fraud or abuse, severity and scope, and resolution probability. Decisions on what suspicious activity to focus on are made with the VST steering committee.

Once the VST and its steering committee have agreed on a target, CMS data-analysis teams step in. CMS pulls program-integrity data for analysis from its National Claims History Warehouse. "We use several different databases to pull it out," said Jennifer Smith, also a CMS insurance specialist. CMS also uses the Provider Enroll-

ment Chain and Ownership System (PECOS), which is the enrollment database for demographic data, as well as geographic information system mapping to identify trends in specific geographic areas. CMS draws on other products as well, most of them custom built.

Data analysis is a multistep process. When a referral about potential fraud, waste or abuse comes in, first the data must be validated. Were the codes reported correctly? Are the dollar amounts accurate?

Once there is confidence that the data are valid, Smith pins down the disparity between the improper activity and its compliant version (e.g., policies, procedure codes, payment process, bill types). A quality-control review is then conducted to ensure the process used to analyze the data was accurate.

Data analysis uncovers all sorts of billing anomalies. Smith gave a snapshot of a CMS review of home health agencies (HHAs) in Los Angeles, Miami and Harris County, Texas, between 2003 and 2006. Here are a few findings: In Los Angeles County, the number of HHAs doubled, and the dollars they billed increased by 60%. In Harris County, the number of HHAs grew by 150%, and in Miami the volume increased 300%. "We looked to see if the beneficiary populations were growing in those areas," she said, and while there was some growth, "it was not enough to support the extreme growth of the HHAs."

Mapping Tool Pointed to HHA Clusters

The mapping tool revealed where there were clusters of HHAs. For example, on Wilshire Boulevard in Los Angeles, there were four HHAs in one building, three across the street and another in a building next door. That alone doesn't prove there's monkey business afoot, but it lets CMS narrow its target list.

"Wherever we looked, we found a different problem," Smith said. Some HHAs used stolen provider numbers. Some HHA offices were shell companies with no desks or people there. Miami had high outlier payments. For example, the number of insulin shots HHAs administered — 60 shots per 120 visits — was way out of proportion with the national average — 30 shots per 120 visits.

Smith described CMS's vision for the data-analysis group for 2010. Among the goals: "Identify and resolve potential vulnerabilities early in the life cycle — prior to public disclosure"; establish a central repository "to collect and synthesize all Medicare program vulnerability data to promote comprehensive and cohesive identification of risks"; and put more emphasis on developing and evaluating leads.

While CMS doesn't share its data warehouse or tools with providers, it does provide free data. Smith suggested providers click on "research, statistics data and systems" on the CMS Web site, www.CMS.gov. There is a multitude of links under this topic. Most of the data in the CMS Web site are national but some are at the state level, she said.

Quality Data Are Another Source

Meanwhile, Medicare contractors are busy sorting through CMS data to identify patterns of fraud and abuse. For example, CMS instructed program safeguard contractors, or PSCs (who are morphing into zone program integrity contractors, or ZPICs), to look through claims data for 15 high-risk areas that could lead to fraud and abuse by claim type (e.g., billing spikes). "Then the PSCs are supposed to develop and implement an action plan," Janice Anderson, an attorney with Foley & Lardner LLP, said at the audioconference.

Data analysis takes many forms in the compliance-and-enforcement world. Quality reporting is one of them. Under CMS's hospital quality initiative, Hospital Compare, hospitals must report on 27 measures of care in the areas of heart attack, heart failure, pneumonia and the prevention of surgical infections — or face a small loss in DRG payments. "The quality data is very important in this era because of changes occurring in reimbursement policy," Anderson said. "These are uncharted waters for both CMS and providers, where payment and enforcement will be based on quality, and the whole quality program will be integrated with compliance."

Hospitals also should keep an eye on state adverse-event reporting. "Many states have adverse-event reporting statutes," said Anderson. They are used to identify patterns of bad medical outcomes. For example, one hospital in California recently had to pay a large fine based on its adverse-event history, she said. The New York state Office of Medicaid Inspector General also is integrating adverse-event reporting into Medicaid oversight on the premise that hospitals with weaknesses in one area (e.g., quality) may have weaknesses in others (e.g., billing) because there may be general systemic and/or management failures.

Contact Anderson at janderson@foley.com. ✧

Hospitals Must Develop Data Skills

continued from p. 1

And that's just for starters. CMS in July announced that fiscal intermediaries and Medicare administrative contractors were taking over medical reviews from the quality improvement organizations *(RMC 7/14/08, p. 1*). There are also seven zone program integrity contractors, which will investigate overpayments and fraud in all parts of the Medicare program for their region.

What do all these players have in common? They perform data mining, which enables contractors to sort through huge amounts of data to identify improper claims. "This is a new era of using data in the health care marketplace," says Larry Vernaglia, an attorney with Foley & Lardner LLP. "CMS has always had access to tons of data, but now they have new ways to slice and exploit this data both internally and through Medicare contractors" (see story, p. 4).

Some compliance experts think hospitals should be matching computer wits with the government. "There is a simple way of doing auditing, but it's the equivalent of walking around the edge of the lake. You have to data mine if you want to dive into the lake," contends Harriet Kinney, organizational integrity manager for Trinity Health, a large Michigan-based nonprofit integrated delivery system. "You need to do this kind of analysis to have a robust compliance program. You have to be able to look at your data and analyze it and let it help you focus your audit work."

Trinity has a data warehouse containing Medicare revenue data, clinical data and claims data, among other things. Everyone in the organization can tap into it. Kinney says you don't have to be an IT expert to use these kinds of tools. Just figure out what information you want, and let the tech people manipulate the data to extract it.

For example, "knowing PEPPER was going away, we wanted to continue the success we had with that data and share it across the system. So we wanted to recreate it internally or create a better and more comprehensive set of tools for ourselves," says Kinney. She says the tools also are important for conveying salient compliance information to senior executives.

But she emphasizes that you cannot make a value judgment based on the data alone. It requires medical-record review to determine an error. It's dangerous to infer errors solely from the data, Kinney says.

Using Data to Audit MS-DRGs

Here's an example of how hospitals can use data in their compliance auditing. Pneumonia Medicare-severity DRGs (MS-DRGs) are always ripe for scrutiny. Kinney says hospitals may want to pull data for a six-month period for what used to be DRGs 79 and 89. DRG 89 is now MS-DRGs 193 (Simple Pneumonia & Pleurisy with major complications and comorbidities), 194 (Simple Pneumonia & Pleurisy with CCs) and 195 (Simple Pneumonia & Pleurisy without CC/MCC). DRG 79, also known as "complex pneumonia," is now MS-DRG 177 (Respiratory Infections & Inflammations with MCC), 178 (Respiratory Infections & Inflammations with CC), and 179 (Respiratory Infections & Inflammations without CC/MCC) (see tables, p. 7).

Hospitals could start by looking at how many discharges they had per month for each set of DRGs. Were there spikes in the admissions from year to year? That would be something to look into, trending from year to year.

After this initial analysis, data would need to be parsed into more detail, focusing on the principal diagnosis code, the length of stay and the discharge status-code assignment for the complex pneumonia discharges.

For example, what do your data say about pneumonia due to Gram-negative bacteria (482.83)? It's a fairly generic diagnosis unless the strain of bacterium is specifically identified. Right off the bat, hospitals should question one-day stays for medical necessity, especially if the patient is receiving only oral antibiotics.

But compliance gets trickier. Physicians generally try to nail down the type of Gram-negative bac-

teria by ordering a two-part lab test. The first part, a sputum test, takes three days. The second part, a Gram stain culture, takes five to seven days. If the data reveal that the hospital has billed for a type of Gram-negative pneumonia, such as Klebsiella or Staphylococcus aureus pneumonia, after a one-, two- or three-day stay, then there is the possibility of inappropriate principal diagnosis coding, such as coding from lab results without appropriate physician documentation. This could result in a payment error. So a fact pattern like this would trigger an account review on the grounds that there could be potential coding errors.

Analyzing the data from this viewpoint may also reveal there is a sudden higher incidence in the reporting of one ICD-9 code over another. Lastly, data may reveal that there is a higher incidence of patients being discharged home after one to two days. Only with chart review would an auditor be able to determine if there was a payment error caused by inappropriate coding or issues of medical necessity, she says.

The bottom line: Hospitals are at risk for billing either too-short stays, which may signal a lack of a medically necessary admission, or stays that are longer but not long enough to justify the assignment of a specific type of bacterial pneumonia as principal diagnosis.

Kinney also runs data reports to evaluate POA indicator compliance. CMS requires hospitals to attach one of five POA indicators to all principal and secondary diagnoses, and Kinney recommends checking on compliance frequently. Quality and finances are implicated with POA compliance.

Start by running a coder-specific POA report for one day. Depending on the findings, these mini-audits may be a useful daily audit tool.

The findings can be presented in a simple box. The left and middle columns list, respectively, the POA indicators and what they stand for. These indicators are "Y" for yes (the condition was POA), "N" for no (the condition was not POA), "U" for unknown (the documentation is insufficient to determine if the condition was POA), "W" for clinically undetermined (the provider is unable to clinically determine whether the condition was POA), and "1" (exempt from reporting).

Also, leave a blank to account for charts lacking a POA indicator, which could be a simple coder error of forgetting to enter a POA indicator or a "hiccup in the computer system," Kinney says. CMS says it will return claims to providers unpaid if they lack POA indicators, and the claims then have to be resubmitted.

The right column of the box should report the principal diagnosis count for that particular day's audit run. There should be a high number in the "Y" column and a low number in the "N" column.

If there are more than a handful of "U"s, Kinney suggests that hospitals track down the particulars. Is there one attending physician responsible for most of them? If so, focus education on him or her that stresses the need for clear, consistent documentation. "This is something you can tackle and improve. If you set it up correctly, you can do this audit every day," she says. She also advises running the report for each coder separately. That helps pin down when errors stem from just one coder's misconceptions.

The timing is perfect since CMS stops paying for 11 hospital-acquired conditions that weren't POA on Oct. 1. Daily audits will help hospitals fix errors before dropping claims.

Contact Kinney at kinneyh@trinity-health.org. ✧

Slicing and Dicing Data for Audits

Analyzing data around high-risk Medicare-severity DRGs (MS-DRGs) is one way compliance officers are improving the quality of audits (see story, p. 1). Here is an example of the first run of data for pneumonia. Contact Harriet Kinney, organizational integrity manager for Trinity Health, at kinneyh@trinity-health.org.

Month	Number of Simple Pneumonia Discharges	Number of Complex Pneumonia Discharges
1	3	3
2	3	2
3	5	6
4	5	17
5	5	5
6	1	5

Data Analysis: Drilling Down Further

This chart is an example of additional information on two pneumonia diagnoses. These data point compliance auditors toward accounts that need more review (see story, p. 1). Contact Harriet Kinney, organizational integrity manager for Trinity Health, at kinneyh@trinity-health.org.

Month	Number of Discharges	Length of Stay < 5 Days	Principal Diagnosis 507.0, Aspiration Pneumonia	Principal Diagnosis 482.83, Pneumonia Due to Gram-Negative Bacteria
1	3	1	3	0
2	2	2	2	0
3	6	4	2	4
4	17	10	8	9
5	5	4	3	2
6	5	5	1	4

NEWS BRIEFS

◆ **A nonprofit organization's modifications to its program that provides grants to needy patients who have chronic conditions could generate prohibited remuneration under the anti-kickback statute, but the HHS Office of Inspector General (OIG) will not impose sanctions,** it says in a "Notice of Modification of OIG Advisory Opinion No. 04-15," posted Sept. 4. The program does not constitute grounds for impositions of civil monetary penalties, OIG adds. The requestor wants to change the program to (1) provide donors with monthly data about the aggregate number of applicants and qualifying applicants, (2) allow donors to change or discontinue their contributions with 120 days notice, and (3) expand assistance to patients suffering from other chronic or life-threatening diseases. OIG says the changes do not affect the conclusion it reached in Advisory Opinion 04-15, which was released on Nov. 5, 2004. Visit AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "OIG Advisory Opinions."

◆ **Henry Ford Hospital in Detroit should submit a revised Medicare cost report for fiscal year (FY) 2005 to correct wage data overstatements of more than $27 million,** OIG says in an audit report (A-05-07-00063) posted Sept. 4. The facility is one of 15 in a Michigan core-based statistical area and reported wage data of $493.8 million and 15.3 million hours in its FY 2005 cost report. Its hourly wage index was calculated as $32.36, which CMS would have used for the FY 2009 wage indexes, OIG explains. Henry Ford reported inaccurate data that affected the calculation, the audit found. OIG says the facility should submit a revised report for FY 2005 and implement review procedures to ensure that future wage data are accurate. Henry Ford agreed with the findings. Visit AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "OIG Audit Reports."

◆ **Dilcia Marinez pleaded guilty to conspiracy to commit health care fraud and conspiracy to commit money laundering for her role in a scheme that defrauded millions from Medicare,** the U.S. Attorney's Office for the Southern District of Florida said Sept. 9. Marinez was president of an HIV infusion clinic in Miami. She admitted that the clinic submitted about $14 million in Medicare claims for HIV infusion services that were never provided or were not medically necessary, the feds say. She also admitted to laundering about $4 million for other conspirators. This case is related to one that defrauded Medicare of $110 million and involved 11 clinics in south Florida, the feds add. Visit www.usdoj.gov/usao/fls.

◆ **In the wake of the news that CMS's durable medical equipment (DME) error rate for FY 2006 was "significantly understated," Sen. Charles Grassley (R-Iowa) has requested that claims from home health agencies (HHAs) also be reviewed,** according to a just-released July 24 letter he sent to OIG. "[Past] OIG work identified a significant improper payment rate for HHA services," but CMS reported that the FY 2007 error rate for HHAs was 1.4%, Grassley says. "One of the allegations pertaining to the DME error rate was that it was 'unrealistically low.' It seems to me that the HHA error rate may also be 'unrealistically low,'" he says. OIG released an audit on Aug. 25 that claimed CMS told its Comprehensive Error Rate Testing (CERT) contractor to take shortcuts and ignore some Medicare procedures *(RMC 9/1/08, p. 2)*. Grassley also requests in an Aug. 25 letter that CMS examine the method to determine the FY 2007 error rate and investigate who directed the contractor to deviate from the established policies. Visit http://finance.senate.gov.

◆ **CMS is giving skilled nursing facilities (SNFs) rate increases worth $1.5 billion for FY 2009 even though "there is no reason to believe this windfall will help improve the quality of care or quality of life for nursing home residents,"** says the Center for Medicare Advocacy, a nonprofit education and advocacy group. The organization says the rate increase will come in two parts: (1) an "inaccurate calibration" of payment rates, which CMS promised to recalculate prospectively, but backed away from; and (2) a marketbasket increase of 3.1% for FY 2009, despite a suggestion from the Medicare Payment Advisory Commission that SNFs receive no increase. Read more at www.medicareadvocacy.org.

◆ **Juan Carlos Castaneda pleaded guilty Aug. 29 to conspiracy to commit money laundering in a Medicare fraud scheme,** according to the Department of Justice. Castaneda admitted that he laundered more than $3 million for Miami-area HIV infusion clinics, which billed Medicare for services that were medically unnecessary or never provided. He also pleaded guilty in July 2007 to all counts in a separate indictment that charged him with paying kickbacks to 72 owners of durable medical equipment companies. He is now serving 63 months in prison for that case, which also is part of the larger scheme to defraud Medicare of $110 million (see above brief), the feds say. Visit www.usdoj.gov.

If You Don't Already Subscribe to the Newsletter, Here Are Three Easy Ways to Sign Up:

(1) Call us at **800-521-4323**

(2) Fax the order form on page 2 to **202-331-9542**

(3) Visit the MarketPlace at **www.AISHealth.com**

If You Are a Subscriber And Want to Routinely Forward this E-mail Edition to Others in Your Organization:

Call Customer Service at **800-521-4323** to discuss AIS's very reasonable rates for your on-site distribution of each issue. (Please don't forward these e-mail editions without prior authorization from AIS, since strict copyright restrictions apply.)