Report on
MEDICARE COMPLIANCE

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

Contents

RAC Fears May Spur 'Defensive Coding,' Creating Payment, Compliance Risks

Hospitals should nip in the bud any changes in coder behavior that may emerge because of anxiety about recovery audit contractor (RAC) audits. During the RAC pilot, some coders engaged in "defensive coding" — refusing to code certain conditions in the medical record unless they were documented with textbook-like perfection — in the hope of avoiding a RAC challenge, says consultant Marion Kruse, a former hospital documentation compliance specialist and now a director at FTI Consulting. "Some coders are running scared," she tells *RMC*. This change in coder activity could spread to hospitals nationally as the permanent RAC program unfolds, Kruse says. And that endangers reimbursement and creates compliance risks, she says.

"The intent and spirit of the coding guidelines may be lost as some coders over-analyze them," Kruse observes. "Where is it written that coders can't code [a condition] because the physician only mentioned it once or twice in the progress notes and then in the body of the discharge summary, but not in the diagnosis section of the discharge summary? This could end up making coding more unpredictable," she contends.

At the same time, coders are posing more frequent questions to *AHA Coding Clinic* that are outside the scope of coding, says Nelly Leon-Chisen, editor of the publication, which is published by the American Hospital Assn. (AHA). Apparently

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Hospitals Face Lab Audits Triggered by CERT Contractor Despite Signed MD Orders

In the latest drama surrounding physician orders for outpatient diagnostic testing, one hospital's payments for certain lab tests have been suspended during an audit despite its possession of signed physician orders. And another hospital was told it had a high error rate for outpatient diagnostic tests because of a lack of signed physician orders. CMS in two recent transmittals has stated that hospitals can proceed with lab tests based on orders from physicians that lack their signatures as long as the physician's medical records document "his or her intent that the test be performed" *(RMC 3/16/09, p. 1).*

The first hospital, 125-bed Olympic Medical Center in rural Port Angeles, Wash., is being audited by its fiscal intermediary (FI), Noridian Administrative Services, says Compliance Officer Mic Sager. He was told by a Noridian nurse reviewer that despite signed physician orders for the lab tests, the hospital has to produce additional proof the tests were ordered and necessary (e.g., progress notes).

"Even though the requisition was signed, the FI wants to see the office notes. It's crazy," Sager says. "Do they really expect us to review doctors' office notes to

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determine the medical necessity of a lab that the doctor orders when he gave us the diagnosis and signature?"

The impetus for the audit of Olympic by the FI is the high volume of lab tests performed by the hospital. A letter from Noridian, a copy of which was obtained by *RMC*, includes a bar graph comparing the units billed to Medicare for CPT 85025 by Olympic versus other hospitals of a similar size during the same time period (March 1, 2008, to Aug. 31, 2008). Sager says it makes perfect sense that Olympic provides far more lab tests than comparable hospitals. Olympic serves as a reference lab for its service area because there are no commercial labs operating in its county. As a result, the number of lab tests performed by Olympic is higher than the number performed by peer hospitals, Sager says.

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The billing data were supplied to Noridian by the Comprehensive Error Rate Testing (CERT) contractor, a major CMS program-integrity player.

These two cases reflect the ongoing doubt and mixed messages about Medicare rules governing physician signatures on orders for outpatient diagnostic tests. Hospitals say they are unclear about what's allowed because CMS said in a March 2008 transmittal on signature stamps that physician orders must be signed. But CMS has also put out transmittals saying signatures are unnessary.

The Noridian letter to Olympic says that Noridian's medical review unit is auditing 40 claims for lab tests including CPT 85025 (complete blood count, automated and automated differential white blood cell count). It says that Olympic may be asked to send Noridian copies of physician orders, lab reports, physician clinic/progress notes and itemization of services. After he received the letter, Sager called Noridian to discuss the medical-records request, assuming that the FI wanted only back-up documentation (e.g., progress notes) when orders lacked physician signatures. But he was surprised to hear that the FI wanted the mother lode no matter what.

FI Wants Copies of Physicians' Notes

Even if the lab order was signed by the ordering physician, Noridian wants copies of notes from the physician's office to confirm the physician's intent to order the lab test and to verify that the diagnosis the hospital entered on the claim form is documented in the physician's medical record, Sager tells *RMC*. "I told the nurse reviewer that if the physician signs an order with an ICD-9-CM code, that should meet any requirement for physician documentation of the diagnosis as well as intent to order," he says. "She disagreed, stating, 'How do we know the physician wrote the codes on the requisition?'" That's very frustrating, he says. "To punish us for documentation not being in the medical record when we have the signature is totally inappropriate," he argues.

RMC was not able to obtain a response from Noridian by press time.

Sager told the nurse reviewer that the hospital will appeal any denials that stem from signed orders. He reasons that there is no regulatory authority the FI can cite to justify claims denials when orders are signed by the physician. He points out that orders are governed by a 2001 CMS program memorandum (AB-01-144) stating that "referring physicians are required to provide diagnostic information to the testing entity at the time the test is ordered." The memorandum defines an order as "a written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed

to the testing facility; a telephone call by the treating physician/practitioner or his/her office to the testing facility; and an electronic mail by the treating physician/practitioner or his/her office to the testing facility." (CMS notes that physicians and testing facilities, such as hospitals, must document phone orders in their respective copies of the beneficiary's chart.)

Noridian's audit findings are due to the hospital this month. Sager remains hopeful that his hospital's audit results will be supported by the regulations and that a signed order will suffice.

However, San Francisco attorney Judy Waltz says that CMS and its contractors have long maintained that labs must be able to establish medical necessity for the tests they are paid for. "An order alone is not sufficient to establish medical necessity. The physician could order 20 of the same tests every day (or on a single day), sign all the orders, and most likely the lab could not establish medical necessity for all those tests," says Waltz, with the law firm Foley & Lardner LLP.

Also, she says, the requirement to provide diagnostic information is a different requirement than discussing medical necessity. "Diagnostic information is a kind of first step to proving medical necessity," Waltz contends. "The diagnostic code gets the claim through the computer edits — there are coverage determinations that limit coverage to certain diagnoses, and this is how the computer knows the claim is *prima facie* payable."

Is CERT Reform Needed?

Some legal experts agree that these kinds of incidents show the need for CERT reform. "This hospital never should have been put on prepayment review," says Washington, D.C., attorney Andy Ruskin, with the law firm Morgan, Lewis & Bockius LLP. He believes it's unfair to require the hospital to furnish documentation that only the ordering physician maintains and to which the hospital, serving as a reference lab, has no right. The FI seems to be confusing the role of a hospital serving as a reference lab with the role a hospital would serve when treating its own outpatients, he says.

"When serving as a reference lab, the hospital should be treated no differently from entities such as Quest" and other entities that serve an ancillary role to the ordering physician's treatment, Ruskin tells *RMC*. He maintains that, under the circumstances, it is likely that the hospital would win in any appeal of a claims denial, as long as it has the minimal documentation required to meet applicable *Medicare Claims Processing Manual* instructions.

Regarding the fairness of prepayment review, Waltz agrees it's no picnic for the hospital. But she notes that CMS "has to follow the money it paid on the claim, and it doesn't have any way to 'punish' the doctor whose records are inadequate to support the claim. So it will require the lab to prove up front that the claim is payable upon request."

In the other case, the compliance officer, who asked not to be identified, tells *RMC* that the FI called to give the hospital a heads up that it was identified by the CERT contractor as having a high error rate for outpatient diagnostic and lab tests because of unsigned physician orders. However, the FI didn't say an audit was planned.

In fact, the compliance officer says, the FI seems more concerned about the overall validity of the order form used by the hospital. The hospital developed a form for its community physicians that lets them quickly check off their name and the tests they want to order. In response to the call, the compliance officer plans to meet soon with the FI "to make sure we are on the same page." But so far, no money has been recouped related to the high error rate cited by the CERT contractor, the compliance officer says.

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MDs Face Coding, Medical-Necessity Risks With Observation Services

In addition to the intense spotlight shining on hospital observation and its interplay with inpatient admissions, observation services are a risk area on the physician side because physicians and coders may get tripped up by coverage and coding rules. "In chart reviews, some questions have arisen on how physicians interpret or report observation," says Cynthia Swanson, senior healthcare manager with Seim, Johnson, Sestak & Quist, LLP in Omaha, Neb. "And there are problems with coders understanding the rules. They're still confusing people." She recommends spot checks of observation billing in physician practices to identify any Medicare problems with coding and reporting it (see chart, p. 4).

Observation is an outpatient service that allows patients to be monitored so physicians can determine if they require admission as inpatients or can be discharged home. "Generally, a physician anticipates that the patient's condition can be evaluated/treated within 24 hours, and/or rapid improvement of the patient's condition can be anticipated within 24 hours," Swanson says. But Medicare won't pay for something

that's not medically necessary, so "you need a clear written order to say it is a placement in observation," she notes. "Make it specific."

CMS provides specific guidelines for reporting initial hospital observation services (CPT codes 99218 through 99220) and observation care discharge services (99217). Local Medicare contractors also have published information on observation care services, she points out.

A physician's/practitioner's order(s) for observation care services must be medically necessary for an observation stay based on the patients' illness or medical condition. For Medicare beneficiaries, physician services and observation care are Part B benefits, and therefore any outpatient deductibles and copayments/coinsurance apply.

Swanson describes key concepts for physicians to remember about observation services:

◆ ***Initial observation services are provided per calendar date,*** not per 24-hour period.

◆ ***When the phrase "observation status" is initiated in the course of an encounter in another site of service,*** all evaluation and management (E/M) services are considered part of the initial observation care when performed on the same date. For example, if the physician initially treats the patient in his or her office or emergency department (ED) but then refers the patient to observation, the physician bills all services provided to the patient for that episode of care as part of the observation. "The physician does not bill for the office or ED visit," Swanson says. "All the E/M services provided by the physician are rolled into the initial observation care. You just bill the observation admit code."

◆ ***Observation care discharge is used to report all services provided to the patient on discharge from observation status*** if the discharge is on a different day than the initial date of observation, Swanson says. She explains that physicians should bill for two different codes when patients are admitted to observation and discharged on different dates. "Sometimes I see that physicians or coders miss the second code," she says.

◆ ***A clearly written physician/practitioner order is required for admission to the observation,*** Swanson says. The order should state the status that's being ordered (e.g., "Place in observation"). The order must be written before initiating observation services. (A written order of "Admit" or "Admit to floor" is interpreted as an order for inpatient care.)

◆ ***Physician's/practitioner's order(s)*** for initial observation care must be dated, timed and signed, as should also be the physician's/practitioner's discharge order from observation status.

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Overview of Medicare Billing Guidelines for Physician Observation Services

Omaha, Neb., consultant Cynthia Swanson describes the core billing rules and codes for observation services (see story, p. 3). Contact Swanson at cswanson@SeimJohnson.com.

Patient is admitted to observation care for less than eight hours on the same calendar date.	Report 99218, 99219 or 99220.
Patient is admitted (minimum of eight hours, but less than 24 hours) and discharged from observation status on the same calendar date.	Report using code 99234, 99235 or 99236.
Patient is admitted to observation and discharged on a different calendar date.	Report using code from 99218-99220 and 99217.
Patient is admitted to the hospital from observation status on the same calendar date.	Report only the applicable initial hospital care code (99221-99223).
Second day of observation. (In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.)	If patient remains in observation status a second day and is not admitted to the hospital or discharged that day, report using outpatient visit code 99211-99215.
Another physician sees the patient during his/her observation stay.	Other physicians who provide services to a patient during his/her observation stay should report an outpatient visit code 99201-99215 or an outpatient consultation code 99241-99245, as applicable.

Internal policies and procedures for the reporting of observation care services should be established and annually reviewed and updated. Conducting internal reviews and spot checking the billing of observation care services from time to time can assist with your ongoing health care compliance efforts.

References:
- Medicare Transmittal 1465, February 22, 2008, Change Request 5973
- *Medicare Claims Processing Manual*, Chapter 4, Part B Hospital, 290.1
- *Medicare Claims Processing Manual*, Chapter 12-Physicians/Nonphysician Practitioners, Section 30.6.8

Updating Templates Helped Hospital Improve Its Admission Decisions

With auditors cracking down on inpatient admissions when observation services are an alternative, hospitals are auditing observation and looking for ways to improve the decision-making process in terms of admission versus observation placement.

For example, West Penn Allegheny Health System in Pittsburgh performed an internal audit at one of its six hospitals and found an opportunity to clarify admission and observation criteria for physicians, especially in the cardiology arena, Compliance Officer Robert Michalski tells *RMC*.

The audit was conducted because the medical necessity of inpatient admissions — particularly short stays — is a main target of recovery audit contractors and OIG. Short stays are a sign that patients potentially could have been managed in observation.

At one hospital, "we ran data populations of inpatient DRGs and stratified it by looking at DRGs where we would expect a longer length of stay, yet we were coming up with a shorter length of stay," Michalski says. Some of the cases that stood out were for chest pain and Acute Coronary Syndrome, he says.

Patients who come in through the emergency department (ED) can wind up inappropriately admitted as inpatients when they could have been placed in observation or vice versa, he says. *The reason:* "Some physician order sets and protocols might not thoroughly prompt physicians to consider all relevant criteria when making the admission versus observation decision," Michalski says. And some templates and guidelines (for distinguishing observation from inpatient admission) "might not be updated to the current standards either," he says. For example, the protocols should reflect the latest InterQual criteria for making admission decisions. With rapid medical and technology advances, staying current is essential to compliance with inpatient versus outpatient admission decision making, he maintains.

If cardiology-related admissions need further scrutiny, consider these DRGs, he says:

- ***014*** (intracranial hemorrhage or cerebral infarction),
- ***079*** (respiratory infections and inflammations age > 17 with complication or comorbidity),
- ***127*** (heart failure and shock),
- ***143*** (chest pain),
- ***182*** (esophagitis, gastroenteritis, and miscellaneous digestive disorders age > 17 with complication or comorbidity),
- ***183*** (esophagitis, gastroenteritis, and miscellaneous digestive disorders age > 17 without complication or comorbidity),
- ***296*** (nutritional and miscellaneous metabolic disorders age > 17 with complication or comorbidity), and
- ***297*** (nutritional and miscellaneous metabolic disorders age > 17 without complication or comorbidity).

Some improvement in practice patterns were observed as soon as the hospital updated its templates and guidelines and provided education to the physicians, Michalski says. To confirm the solution has taken hold, the hospital plans a further auditing.

Other solutions are being employed at West Penn Allegheny to reduce inappropriate inpatient admissions. Some of the hospitals in the health system have assigned case managers to the ED because those staffers understand InterQual admission criteria very well, Michalski says. "These are resources for the physicians," he says. "Ideally, the physician would [work] proactively with the case manager" on admission decisions.

For example, if a patient comes to the ED with chest pains and the physician wants to rule out a heart attack and other conditions, the case manager can discuss with the physician whether to admit the patient or hold him or her in observation as more information comes in and his or her condition unfolds.

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FY 2010 Budget Increases Funds For Fraud Fighting by $300 Million

President Obama's fiscal year (FY) 2010 budget increases funds for fighting health care fraud by more than $300 million in 2010, with allocations totaling more than $1.7 billion from 2010 to 2014.

Funds for the Health Care Fraud and Abuse Control Program (HCFAC) got a boost of $311 million for FY 2010 on top of the mandatory $1.1 billion, according to the budget, released Feb. 26. The increases will continue steadily through 2014, it indicates. The extra money sends a signal that fraud and abuse is a major priority for the government, one expert says.

Congress created HCFAC when it strengthened the government's war on health fraud in 1996 with HIPAA. The law required the Department of Justice and OIG to coordinate local, state and federal agencies engaged in fraud fighting and to recycle fines and penalties obtained from the resulting cases back into Medicare.

The HHS section of the budget says the increased funds will be used to target improving oversight and program integrity activities for the Medicare Prescription Drug Program, Medicare Advantage and Medicaid.

continued

"These resources will enable [CMS] to more rapidly respond to emerging program integrity vulnerabilities, identify excessive payments, and establish new processes for correcting problems," the document says.

The budget does not specify how much funding each program will receive or what portion will go to the Justice Department.

"If the president of the U.S. announces in an address to the nation that fraud and abuse is important and then he puts it into the budget, that is a clear sign to the bureaucracy of what he wants," says Brian Flood, managing director at consulting firm KPMG, LLP.

Read the entire budget at www.whitehouse.gov/omb. ✧

RACs May Spur Defensive Coding

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because of RAC-induced insecurity, coders are asking more often about matters that are clinical in nature or related to licensure, as if trying to cover every base, she tells *RMC*.

For example, "coders see something documented by the doctor, and it may be reviewed for medical necessity or justifiable diagnosis," says Leon-Chisen, who is also director of coding and classification at AHA. "Instead of asking the physician, they ask *Coding Clinic* for guidance."

Or coders reviewing documentation of body mass index for obesity will seek guidance from *Coding Clinic* on the scope of the dietician's licensure. "We can't get into licensure and scope of practice," Leon-Chisen says. "That's determined by each facility or state." However, coders "are afraid when they get audited by RACs, it can only be documented by this type of professional or that the documentation doesn't say enough," she says.

Three Examples of Coder Behavior Change

So what's going on? Kruse says the fact that RACs may be able to exploit gray areas of the official coding guidelines has unnerved some coders. This is starting to affect the way they translate physician documentation into codes.

Here are three examples from Kruse:

(1) A Medicare patient may have multiple problems, including leukoencephalopathy. This disorder is progressive and causes a deterioration of myelin in the brain, and it can be confirmed by a CT scan or MRI. The presence of this condition in many cases means the patient's other health issues must be managed more aggressively. But leukoencephalopathy itself is not treatable and is generally not the principal diagnosis. However, it's a major complication/comorbidity (MCC) under the Medicare severity DRGs, which means it increases reimbursement for the principal diagnosis/DRG. For both clinical reasons and to ensure appropriate communication to others who may eventually take care of the patient, it is important to code the condition, says Kruse, a former nurse.

But Kruse says she noticed during the RAC pilot that some coders stopped coding leukoencephalopathy because they decided the lack of treatment meant it wasn't clinically significant. Physicians will put it twice in the progress notes and note it on the discharge summary, but some coders still won't code it. Kruse thinks this is wrong. Hospitals should be on solid ground if they code leukoencephalopathy. Even if the RAC denies the additional payment generated by the MCC, she says more reasonable minds will prevail on appeal.

"Do you really think an administrative law judge" or other HHS or civil court judge "will tell the hospital they shouldn't have coded a documented case of leukoencephalopathy that is confirmed via testing?" she asks.

(2) Kruse says she observed coders in pilot states refuse to code acute exacerbation of congestive heart failure (CHF) because physicians didn't document the word "acute." Instead, the physicians wrote "exacerbation of combined CHF." Kruse says the code for that diagnosis is listed as "acute exacerbation of combined CHF." Although the words "acute" and "exacerbation" are synonymous in medical parlance, coders would refuse to code the acute CHF, which is an MCC. *Coding Clinic* eventually clarified this issue, citing a medical dictionary's definition. These coders so feared they would be blamed for RAC repayments that they started arbitrarily rejecting documentation, she says.

(3) Some coders won't separately code acute blood-loss anemia that stems from post-operative loss of blood, Kruse says. Coders have decided it's integral to the procedure even though the physician ordered a blood transfusion. There are two codes for post-op anemia: one for complications (e.g., the surgeon nicks a vessel resulting in a major hemorrhage) and one for acute blood-loss anemia. In an effort to indicate the anemia was due to blood loss (but not a complication), many surgeons will document "expected acute blood loss anemia." The physician's use of the word "expected" prompts some coders to treat the blood-loss anemia as integral to the procedure, which can't be separately coded, Kruse says. This means the claim shows a transfusion without a diagnosis that supports the medical necessity of the service. In many cases, it also means the case is assigned to a non-CC DRG even though the resources were expended to treat the condition, she contends.

AHIMA: Coders React to Myriad Auditors

Kathryn DeVault, a manager of professional practice resources for the American Health Information Management Assn. (AHIMA), agrees that coders are getting more defensive in their coding because of RACs and other auditors from, for example, CMS and the HHS Office of Inspector General (OIG). "It's hard when someone comes to us and says, 'You were too aggressive when you coded this chart, and therefore it's a RAC denial,' and they are taking back all this money," she says. "It's our personality. We like to get it right the first time."

Excisional debridement is a good example, DeVault says. Before the RACs came in, coders would code excisional debridement if physicians charted that they removed dead tissue. Now coders won't code excisional debridement unless they see some version of the word "excise."

Leon-Chisen said excisional debridement was also the source of more coder questions to *Coding Clinic* because it was a RAC target. But coders focused on clinical aspects, which again is not *Coding Clinic's* specialty. For example, coders wanted to know what types of instruments surgeons should use to cut away dead tissue, and how many millimeters of clean wound around the margin should be left to qualify for this procedure. "That is a specificity they need to get from physicians rather than us, because we don't have the authority to promulgate clinical parameters," Leon-Chisen says. Instead, the kind of guidance *Coding Clinic* would provide would be something like this: If it's excisional debridement, this is the code that should be used.

However, as always, "we normally try to be as specific as we can," Leon-Chisen says. "We realize people rely on our advice, and there can be different interpretations."

Executives Should Empower Coders

Kruse advises hospital officials to try to prevent any erosion of coding conventions as the national RAC rollout progresses. Reassure coders that they won't be blamed for unreasonable RAC claims denials. "Put together a very strong RAC committee, and at least for the short term, the whole C-suite should be there," including the CEO and CFO, she says. "Empower the coders to not feel like it will all come back to them" when RACs declare overpayments. The message should be one of solidarity and the need to defend arbitrary decisions by the RAC. "Coders need to understand the RAC will exploit gray areas, and they need to work with their hospitals to fight unreasonable determinations…not avoid them through defensive coding practices based on unwritten rules," she contends.

DeVault echoes that coders must feel supported by their hospital administrators. It has to be clear that if a claim is denied, it will be treated as a learning opportunity. "Coders have to have confidence…that their organizations won't throw them under the bus," she says. Coders should code based on documentation and clarify with physicians if there are inconsistencies in documentation, but they should not refrain from coding just because they are afraid of repercussions, DeVault says.

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NEWS BRIEFS

◆ **CORRECTIONS:** In general, the primary code for joint injections should be billed only once, with the modifier appended when administering a bilateral injection. Two recent *RMC* stories *(RMC 2/16/09, p. 6* and *RMC 1/19/09, p. 5)* incorrectly stated that for bilateral facet joint injections, bill the primary code twice, and the second time, use modifier 50. Given the confusion in the area, CMS says it plans to put out guidance on the issue this spring….The ARRA provision on restrictions on disclosures will take effect Feb. 17, 2010. A table in the March 16 issue of *RMC* incorrectly stated that it would take effect Feb. 18, 2009.

◆ **San Mateo County in California will pay the federal government $6.8 million to resolve allegations that San Mateo Medical Center (SMMC) submitted false Medicare and Medicaid claims,** the Department of Justice (DOJ) said March 12. The feds allege that SMMC falsely inflated its bed count to receive higher disproportionate share hospital (DSH) payments from Medicare. The facility also improperly billed for federal Medicaid payments for certain mental patients, the feds allege. The county was supposed to report the patients to the state Department of Mental Health to ensure that no federal funds are used to pay for them, DOJ explains. The case was originally filed by Ronald Davis, a former county employee. He will receive more than $1 million as part of the settlement. A county spokesperson could not be reached for comment. Visit www.usdoj.gov.

◆ **Victory Memorial Hospital in Brooklyn, N.Y., agreed to pay between $2.3 million and $2.8 million to resolve claims that it submitted cost reports in 1996 and 1997 with high cost-to-charge ratios,** the U.S. Attorney's Office for the Eastern District of New York said March 6. The settlement amount will depend on whether underpayments also exist in the hospital's cost reports for 2007 and 2008, the feds explain. The case stems from a whistleblower complaint filed by Joseph Lee, a former manager of reimbursement and budget at Victory. Lee reported to Victory officials that they were submitting inflated cost-to-charge ratios, but the hospital did not correct the submissions, the feds allege. Lee's share of the settlement depends on the final amount. An attorney for Victory could not be reached for comment. Visit www.usdoj.gov/usao/nye.

◆ **"Inadequate administration" leaves the Medicare home health benefit vulnerable to upcoding, kickbacks and billing for services not rendered,** the Government Accountability Office (GAO) says in a report (GAO-09-185) released March 13. CMS contractors screen applications from prospective home health agencies, but are not required to check the criminal history of persons named on the HHA application. Also, CMS does not allow the physicians who authorize home health care to see information that would let them determine whether an HHA is billing improperly, GAO says. And CMS regulations state that HHAs can be kicked out of Medicare only for billing for services that could not have been rendered, but they exclude removing HHAs engaging in other types of abusive or improper billing, the report says. GAO says CMS should (1) consider checking the criminal history of officials named on HHA enrollment forms, (2) let physicians whose Medicare numbers were used on claims cross-check the services, (3) direct CMS contractors to do postpayment reviews on claims submitted by HHAs that have high rates of improper billing identified through prepayment reviews, and (4) expand the types of improper billing practices that are grounds for revocation of billing privileges. CMS said it would consider letting physicians cross-check some claims and amending the regulations. CMS commented on — but did not agree or disagree with — the other two recommendations. Read the report at www.gao.gov.

◆ **TrailBlazer Health Enterprises, the Medicare carrier for Virginia, made more than $150,000 in high-dollar payments to hospitals that included overpayments,** OIG says in an audit report (A-03-07-00020) posted March 11. Between calendar years 2003 and 2005, TrailBlazer processed more than 45 million claims as the Part B carrier. More than 300 of those were high-dollar payments of $10,000 or more, and 73 of those were appropriate, OIG says. Of 15 high-dollar payments that were incorrect, three providers refunded a total of $60,000 before OIG's audit. Five other providers had not yet refunded overpayments of $94,000, but that total includes one claim of more than $38,000 that may have been refunded. OIG says the overpayments were the result of providers incorrectly claiming excessive units of service and because CMS did not have sufficient edits to detect the payments at that time. OIG says TrailBlazer should (1) recover the remaining overpayments, and (2) verify that the $38,000 claim has been refunded, among other things. TrailBlazer said it has initiated recovery of the overpayments. Visit AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "OIG Audit Reports."

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