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Consider the Submission of 'Imperfect' Medicare Claims on a Case-by-Case Basis

When services don't meet all technical Medicare requirements, hospitals may be conflicted over whether to bill for them.

Do you sacrifice all the reimbursement, knowing there is a chink in your compliance armor, even if it's small? Or can some claims be submitted if the flaw is minor? Suppose an inpatient rehabilitation facility (IRF) patient received 178 minutes of therapy one of the days when he should have received 180 minutes. Is the entire stay null and void? Or maybe the physician reviewed and concurred with the admission of the patient, but didn't enter or sign an order in the computer in time. Does that ruin the IRF's entire Medicare claim? What if the physician's compliance mishap was caused by an EHR software glitch and he had to give up after several tries? Does that make the claims submission OK?

Hospitals have to decide on a case-by-case basis, attorneys say. "It will depend largely on the facts and what 'technical requirement' has not been met," says San Francisco attorney Judy Waltz, with Foley & Lardner LLP. "If CMS has taken the position that something specific is required to support billing a code or service and that amount of service wasn't provided, then it shouldn't be billed."

The answer turns partly on the payment methodology. Services paid under prospective payment systems will fare better when providers or suppliers mess up a technical requirement for a specific service as long as they generally comply with Medicare expectations for the patient's episode of care, she says. "You have to figure out what is being billed for and how it is being paid and work backwards to determine whether the deficiency relates to a condition of participation or a condition of payment," Waltz says. For example, IRFs are PPS facilities, which means all the services provided are paid as a package deal. "The concept of a stay in an IRF is rehab for that patient's condition but if you are two minutes short on a therapy session, it's not going to be as big a compliance deal because Medicare is paying for the bundle of services relating to that admission and the goal is for the patient to get better," she says. CMS expects the IRF to satisfy the conditions of participation, which means certain requirements are met (e.g., developing a plan of care and providing services consistent with it), and to provide X number of services, but CMS probably would address a deficiency, such as a late plan of care, as a survey/certification issue, not as a payment denial, Waltz says.

In contrast, independent physical therapists can't bill a CPT code if they provided something less than the service described by the code because providing services consistent with the code is viewed as a condition of payment, Waltz says. In that case, CMS is paying for a specific service, not a bundle that includes the service. The same goes for a coverage determination, she says. If a national or local coverage determination stipulates that certain services must be performed for coverage purposes, then doing anything less undermines the integrity of the claim. But that's different from falling outside the requirements for a package of services provided under the bundled payments of a PPS at a hospital or IRF governed by conditions of participation, Waltz says. However, because Medicare compliance is never easy, there can also be conditions of payment that relate to bundled services, Waltz notes.

As hard as the Department of Justice and whistleblowers have tried, they have mostly been unable to successfully make a case that violating the conditions of participation is tantamount to submitting a false claim, says Denver attorney Jeff Fitzgerald, with Polsinelli Shughart. Violating the conditions of payment may be a false claim. However, when the conditions of participation are violated, hospitals get cited for deficiencies and could lose their Medicare provider status, Waltz says. And that's not to say DOJ won't succeed eventually in basing false claims cases on conditions-of-participation failures, since the department has connected the dots between substandard care and false claims.

A 'Litigation Lens' Brings Clarity

As claims come under more internal and external scrutiny, providers can ask themselves whether they have substantially complied with the regulatory obligation, Fitzgerald says. If they submit the claim and it's denied, would it be upheld on appeal? "Looking through the litigation lens helps clarify," he says. "Some requirements you can cure or you might have substantially met the spirit of the rule." For example, it might not be fatal to the payment of a claim if a physician

missed a deadline because of a frozen computer. But some things are beyond the pale. Fitzgerald recently reviewed the billing at an anesthesia practice at the request of the anesthesiologists, who were troubled by one physician's habit of rounding the time he spent providing services. Since Medicare pays for anesthesia based on time, every minute counts, and this anesthesiologist rounded in whatever direction benefited his wallet. It wasn't too subtle; documentation showed him ending at 12:05 p.m. in operating room one and starting at noon in operating room two. "When you are paid every 60 seconds, there is no provision for rounding. There's no Medicare provision for giving yourself an extra five minutes," Fitzgerald says. The rounding netted the anesthesiologist an extra $20,000 a year, and over four years he took in $80,000 in overpayments. The practice repaid Medicare, but it was a lot of risk for a relatively small amount of money.

Keith Wolf, general counsel for St. Barnabas Hospital in the Bronx, N.Y., says as a general rule hospitals must meet technical requirements. "Otherwise, it is not a claim that should or can be paid," he says. "From a compliance perspective, our view of the world is that bills go out clean and if for some reason a technical violation comes in through an audit, we are not fighting unless it exceeds a dollar value and we want to take a stand on an issue," Wolf says. A missing signature in the official medical record can sometimes be remedied during a field audit through the use of other documentation. For example, there may be a form attached to a lab sample so the lab can process the specimen. "If the physician signed that form, the argument goes that the signed form is a physician order, even though that form was not in the official medical record — it's a lab form. Clearly you prefer that the physician order be in the official medical record, but this is a way that one can make a productive argument in support of payment on a technical issue to an auditor."

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