Gearing up for future challenges
an interview with Tom Twinem
Director, Corporate Compliance / Privacy Officer
Children's Hospital of Wisconsin
See page 16

25
Medical directorship arrangements: Increased government enforcement and best practices for compliance
Wade Miller and Kimyatta McClary

31
Establishing a baseline compliance pulse for hospital and physician groups: Evaluations by outside counsel
Ann Bittinger, William J. Holahan, and Caroline Kubovy

43
Advanced practice providers: Top three compliance problems
Carolyn Buppert

49
OIG 2014 Work Plan explores new compliance projects
Nathaniel Lacktman

This article, published in Compliance Today, appears here with permission from the Health Care Compliance Association. Call HCCA at 888-580-8373 with reprint requests.
On December 10, 2013, the Federal Register published the Center for Medicare & Medicaid Services’ (CMS) final rule amending the Medicare conditions of payment for “Incident To” therapeutic outpatient hospital services, which includes critical access hospitals (CAH). The new condition of payment requires services and supplies to be furnished in accordance with state law. Previously, CMS had deferred to hospitals to ensure that state laws were followed, but did not explicitly make compliance with state law a condition of payment. The new amendment allows CMS to deny and recoup payments for Incident To therapeutic outpatient hospital services that were performed or administered by personnel who were not properly licensed or qualified to render those services under state law.

Therapeutic services and supplies that hospitals and CAHs provide on an outpatient basis are those services and supplies (including the use of hospital facilities) that are incident to the services of physicians in the treatment of patients. Specifically, all non-diagnostic hospital and CAH outpatient services are services that aid the physician or practitioner in the treatment of the patient (and thus, they are considered Incident To). Such Incident To therapeutic services include clinic services, emergency room services, and observation services.

**Increased scrutiny**

This change is merely an added layer to CMS’s increased scrutiny of Incident To outpatient services. Indeed, CMS recently clarified its belief that direct supervision is necessary for most of these outpatient therapeutic services, unless personal supervision or personal performance of these services by the physician or non-physician practitioner is more appropriate. CMS stated that the motivation for the regulation change stems from situations in which Medicare was billed for Incident To services that were performed by an individual who did not meet the state standards for those services in the state in which the services were performed. But because compliance with state law was not a condition of payment, Medicare had little recourse. The rule change allows the federal government to recover funds paid where services and supplies are not furnished in accordance with state law. Thus, going...
forward, individuals who furnish hospital outpatient therapeutic services must not only be supervised properly according to Medicare payment rules, they must also be licensed and qualified to do so under state law.

**Tips for compliance**

The best way to help your organization avoid potential Medicare overpayment liability under this rule change is to educate the affected individuals in your organization. Hopefully your organization is already rendering services in compliance with state law, but it may be prudent to explain that this new rule raises the stakes for non-compliance.

Start by verifying that the clinical staff understands the state’s scope of practice laws and the requirement that those personnel may not render services to patients that they are not qualified to provide. If you lack confidence that the clinical staff understands their scope of practice, it may be helpful to research the parameters and educate your clinical staff and supervisors on the different rules in your state. A baseline audit may be necessary to assess your organization’s current level of compliance.

In addition, check in with the person or department responsible for confirming that clinical personnel are properly licensed and otherwise qualified by the state to perform their clinical duties. In most organizations, this will be Human Resources or Credentialing. Verify that there are internal controls in place for (1) screening clinical candidates to ensure they are properly licensed and qualified for their position, and (2) monitoring the clinical staff’s licenses to confirm they are current and not expired.

In the event you discover that a practitioner has provided services outside the scope of his/her practice according to state law, or that an individual’s state-mandated licenses have lapsed (or that the individual was not properly licensed to begin with), you should conduct an audit to determine if any of the services provided by that practitioner were billed to Medicare as Incident To hospital outpatient therapeutic services. If so, you may be liable to return payments associated with those services to Medicare.

1. Centers for Medicare & Medicaid Services: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Final Rule, 2013. Available at http://go.cms.gov/1i6ChqJ