Final OPPS Rule Ditches Formal Certs, Adds Modifier for Provider-Based Status

The formal requirement for physician certification of inpatient admissions will soon be a memory, but the substance remains the same, according to the final 2015 outpatient prospective payment system (OPPS) regulation unveiled on Oct. 31. Documentation must support the medical necessity of a two-midnight stay, and admission orders become a prerequisite for payment when the rule takes effect on Jan 1. CMS left the certification requirement in place for patients who hit the 20-day mark or are high-cost outliers.

The OPPS rule shakes up the status quo in other ways. It advances packaging of payments for outpatient services (see story, p. 3) and lays the groundwork for changes to provider-based status. Hospitals will have to start using a new modifier when billing for services rendered in provider-based departments, and physicians will use one of two new place-of-service codes that were unveiled in the 2015 Medicare physician fee schedule that was also announced on Oct. 31.

But the talk of the town was CMS’s decision to wildly scale back the physician certification requirement implemented in the 2014 inpatient prospective payment system regulation with the two-midnight rule, which is the new standard for Part A payment. Even though the elements of certification — the reason for hospitalization, the estimated time the patient will be in the hospital and the plan for post-hospital care — must still be in the documentation, the requirement boxes hospitals in and could lead to technical claim denials.

continued on p. 6

New Work Plan: OIG to Pursue Errors That Are Seen as Home Runs, ‘Niche Topics’

There’s a different flavor to the HHS Office of Inspector General’s Work Plan for 2015, and it may cause hospitals and other providers to tinker more than usual with their compliance monitoring plans. A lot of the items on the Work Plan — which is a roadmap for audits, evaluations and investigations for the fiscal year that began Oct. 1 — seem to be designed to give the OIG a bigger bang for its buck, experts say. Errors can be identified by mining data on Medicare claims, reducing the need for chart reviews.

The approach to identifying overpayments crops up again and again in the items in the hospital section of the OIG Work Plan, says Kelly Sauders, a partner with Deloitte & Touche. The auditors have selected probable home runs in terms of Medicare billing errors, with little room for hospitals to argue about interpretation of Medicare rules or medical necessity. “Most things on the Work Plan are either 100% errors or will be very close to it,” she says. “The error rate of things they are targeting will, by design, be very high.” For example, recent audit reports on hospital inpatient billing for Kwashiorkor, which is a severe form of protein malnutrition, reported errors in the entire audit.
sample, and Kwashiorkor is again on the Work Plan (see box, p. 3). This kind of audit is just a data run because hospitals probably have no or very few true cases of Kwashiorkor (ICD-9 code 260), which is very rare in the industrialized world, says Janelle Wissler, a specialist leader at Deloitte & Touche.

Similarly, OIG plans audits of outpatient evaluation and management services that are billed at the new patient rate. Until 2014, Medicare paid hospitals more for E/M visits when patients were new instead of established, which is defined as a registered hospital inpatient or outpatient within the previous three years. To identify overpayments, OIG just has to look at historical data in the common working file for claims submitted for services to the same patient in the three-year period, Saunders says. “They don’t need to review a single patient record. They know from the paid claims that the hospital made an error.” The same goes for the Work Plan item on outpatient dental claims, which are generally not covered by Medicare but have somehow become a vehicle for substantial overpayments.

Knowing the direction OIG is taking, hospitals should be using a data-driven approach to their compliance monitoring, Saunders says. “There is no excuse for any hospital to be caught on any issue in the Work Plan,” she says. “They could run these reports themselves and see where they have had an issue.”

That doesn’t mean OIG is abandoning up-close-and-personal audits. For example, OIG is relatively enthusiastic about its Medicare compliance reviews, which often involve on-site audits and intense medical-record reviews. They are yielding millions of dollars in hospital overpayments — more than ever with OIG’s increasing use of extrapolation (RMC 11/3/14, p. 8). The reviews will continue as indicated by an item called “inpatient and outpatient billing requirements.”

OIG spokesman Donald White tells RMC that the agency’s audits “are more data driven than ever.” Data helps OIG make the best use of its resources — where to look and what to look for. But data are not a replacement for on-site audits, White emphasized. “We are still very committed to a model of [sending] actual people who can understand better the problems being faced by its auditees,” he says.

There is one notable change: from now on, Work Plans will include only items that are ongoing or “that we strongly anticipate we will work on” in the next two fiscal years, White says. Items that sort of linger year after year will be dropped. Eventually, OIG will update its Work Plans periodically online, he says.

‘Niche Topics’ Are Also in the Work Plan

OIG also is going in a different direction in its reviews of other types of providers. The section on “other providers and suppliers” is full of “niche topics,” says Nina Tarnuzzer, assistant dean of physician billing compliance at the University of Florida in Gainesville. They include ambulance services (questionable billing, medical necessity and level of transport); anesthesia (payments for personally performed services); diagnostic radiology (medical necessity of high-cost tests); sleep studies; and compliance with clinical lab billing requirements.

There’s virtually nothing on the core risk areas, such as evaluation and management services, electronic health records and surgical procedures, which have captured OIG’s attention in recent years, she notes. “Obviously there is some sort of change in targeting the areas,” Tarnuzzer says. “They have a lot more data to pursue patterns.” It’s possible audits of some of the broader risks will be shifted to recovery audit contractors and Medicare administrative contractors, she says. Relying more on contractors could explain why the 2015 Work Plan is more compact than previous Work Plans, including last year’s, which was hampered by budget sequestration, the hard cap on federal budget spending.
The perceived shift in OIG’s focus doesn’t mean providers should abandon internal audits of the classic hot spots, such as evaluation and management upcoding. “Everything OIG has mentioned in the past still applies,” she cautions. “You need to continue all subjects and then also drill down to make sure you’re in compliance with these areas.” For example, concurrency testing of anesthesia services would confirm the appropriate identification of personally performed services, she says. Medicare reimbursement for personally performed services is 100% of the fee, while medical direction and medical supervision pays much less. OIG has its eye on the way modifiers are used to report the different levels of payment.

Given the nature of the 2015 Work Plan, it may be less of a factor in compliance monitoring than it has been in the past. “The Work Plan used to be a document that would create and direct effort in the forthcoming year,” says former federal prosecutor Robert Trusiak, now chief compliance officer and associate general counsel at Kaleida Health in Buffalo, N.Y. “It doesn’t create direction. It merely confirms direction. Hospitals don’t really need the Work Plan to signal the need to look at short stays or physician arrangements or meaningful use. He also was disappointed that OIG is not examining some of the biggest dangers out there, including cybersecurity and maintaining the integrity of PHI. “They aren’t reflected as an enforcement priority.”

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Outpatient Packaging to Accelerate On Jan. 1 in OPPS Transformation

In less than two months, Medicare will pay hospitals an all-inclusive fee for some of the most common tests and procedures instead of paying for the components separately, according to the final 2015 outpatient prospective payment system (OPPS) regulation, announced on Oct. 15. The payment transformation is part of CMS’s push to make hospitals and physicians more thoughtful in their health-care delivery decisions, and will be felt everywhere from compliance to purchasing to finance.

There are two major prongs in the march toward a true prospective payment system on the outpatient side: (1) packaged payments for 25 “comprehensive APCs” (C-APCs) within 12 “clinical families,” and (2) packaged payments for certain ancillary services that are integral, supportive, dependent or adjunctive to a primary service.

“Packaging encourages hospitals to establish protocols that ensure that necessary services are furnished, while scrutinizing the services ordered by practitioners to maximize the efficient use of hospital resources,” the rule states.

This writing has been on the wall for some time, but there may be a lot of frayed nerves at hospitals. “This is a little Darwinism in the OPPS — survival of the fittest,” says William Malm, senior manager of revenue integrity communications at Craneware. “No longer can you have a cardiac cath lab on every corner.” Hospitals that perform procedures cost-effectively and coax physicians to stop using the most expensive devices will weather C-APCs better, he says. The same can’t necessarily be said for hospitals that are stuck in the old way of doing things.

The C-APCs are “APCs on steroids,” Malm says. “It’s the definition of the future.” Medicare will pay a packaged payment for the C-APCs, which are mostly device-dependent procedures (in which the device

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dominates the cost of the procedure). The bundle includes all hospital services covered by Medicare Part B, including labs, radiology, an overnight stay, meals and drugs. Only items that are statutorily excluded from payment, such as self-administered drugs, are left out. The clinical families are defined as “a set of clinically related C-APCs that represent different resource levels of clinically comparable services,” CMS says (e.g., pacemaker and similar procedures, breast and skin surgery, implantable cardiac defibrillators, endovascular procedures, intraocular procedures).

CMS made some changes from the proposed OPPS rule. Originally, it packaged payment for 29 device-dependent APCs, but now there are 25. All device-dependent APCs are captured in the new payment methodology, except for APCs 0427, 0622, and 0652. CMS also added two C-APCs — 0067 and 0351 — that are not entirely device dependent. A new status indicator, J1, was created to drive all the codes on a claim to the packaging methodology, Malm says. If more than one J1 appears on the claim, Medicare will pick the highest weighted — which means highest paying — of the options, he says.

Also new are CMS’s complexity adjustments, so it can titrate payments depending on how procedures go. “These are add-on codes being done at same time that create extra intensity and they will upgrade the J1 within the same APC family,” Malm says. “But you can’t jump to a new family. You can go to the highest paid within the C-APC family.” He warns that the complexity adjustments, which appear in Addendum J of the OPPS rule, “are confusing and hard to predict in terms of financial impact.”

The other area of packaging is for more goods or services that are “integral, supportive, dependent, or adjunctive to a primary service.” These ancillary services — mostly minor diagnostic tests, but sometimes therapeutics — would be packaged into the APC for the principal procedure or service. When the ancillaries are provided in the absence of a primary service, Medicare will still pay for them separately. The same goes for preventive services, psychiatry and drug administration.

The OPPS rule would limit APC packaging to ancillary services with a geometric mean cost of less than or equal to $100. This covers a lot of ancillaries, including level I debridement and destruction, level I pulmonary treatment, level I pathology, level I and II minor procedures and level II eye tests and treatments. There are exceptions for some services under $100, including a single energy X-ray study.

Packaging is a sea change and is designed to help CMS control its costs and align with the Affordable Care Act’s emphasis on paying for value, not volume, and pushing centers of excellence, Malm says. “They are getting very clear: Unless everyone in hospitals cost effectively provide services through better negotiations with vendors or more alliances with group purchasing organizations or more efficiently, you may not be able to offer the service line,” he says.

There’s also a subtext of CMS being fed up with deference to physician preferences, Malm says. “CMS is saying, ‘if there is a lower cost device you can use and you choose to use the highest ones with bells and whistles, we won’t say you can’t, but we won’t pay for it. If you are not scrutinizing your physician practices and preferences, that is your business decision.’”

Packaging payments does not change the medical necessity requirements or billing and coding expectations, Malm says. “One of the concerns with the more comprehensive approach is that facilities may not continue to fully comply with all medical necessity and coding/billing regulations,” he says. Because C-APCs are a grouping of individual CPT/HCPCS codes representing separate tests and services, the medical necessity for each test and service must be established. There’s no cutting compliance corners because of packaging. And the advance beneficiary notice still applies if the test is not considered medically necessary in Medicare’s eyes.

Contact Malm at w.malm@craneware.com.

**Connecticut Supreme Court Allows HIPAA as the Standard of Care**

The state Supreme Court of Connecticut has ruled that a patient may sue a provider for negligence using HIPAA as the standard of care. The decision by the state’s highest court, which will be published Nov. 11, asserts that “neither HIPAA nor its implementing regulations were intended to preempt tort actions under state law arising out of the unauthorized release of a plaintiff’s medical records.”

This decision joins a line of other state decisions holding that while HIPAA may not be used to bring a private action against a provider, it may be used to establish the standard of care a provider must meet in actions alleging negligence in terms of confidentiality of medical information.

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In the Connecticut case, the lower court had dismissed the plaintiff Emily Byrne’s negligence lawsuit because HIPAA has no private right of action. The lower court rejected Byrne’s claim that she was not using HIPAA as the basis of her cause of action, but as evidence of the appropriate standard of care for claims brought under state law. The lower court said that “plaintiff has labeled her claims as negligence claims, but this does not change their essential nature. They are HIPAA claims.”

Byrne had sued Avery Center for Obstetrics and Gynecology, seeking damages for negligence and negligent infliction of emotional distress for the defendant’s alleged breach of the confidentiality of Byrne’s medical records. Byrne allegedly told Avery Center not to release her medical records to a man she had a previous relationship with, but when the man filed a paternity action against her, the Avery Center submitted her medical records to the court in 2005 without an authorization, according to the court decision. Byrne sued the Avery Center after the man reviewed the medical file, and she alleged that “she suffered harassment and extortion threats” as a result.

The state supreme court reviewed the issue of whether HIPAA preempts state law claims for negligence and negligent infliction of emotional distress against a health care provider who is alleged to have improperly breached the confidentiality of a patient’s medical records in the course of complying with a subpoena. “Assuming this state’s common law recognizes claims arising from a health care provider’s alleged breach of its duty of confidentiality in the course of complying with a subpoena,” the court said, “HIPAA and its implementing regulations do not preempt such claims, and, further, to the extent it has become common practice for this state’s health care providers to follow HIPAA procedures in rendering services to their patients, HIPAA and its implementing regulations may be utilized to inform the applicable standard of care for negligence claims such as the plaintiff’s here, as the availability of such private rights of action in state court, to the extent they exist as a matter of state law, do not preclude, conflict with or complicate health care providers’ compliance with HIPAA.” The court did not reach the issue of whether state common law recognized the negligence claim for breach of confidentiality in the course of complying with a subpoena. *Emily Byrne v. Avery Center for Obstetrics and Gynecology, P.C. (SC 18904) (Nov. 11, 2014)*

**Other State Courts Have Recognized HIPAA**

Use of HIPAA as the standard of care in state negligence cases has not become the norm, but some state court actions allowing HIPAA to serve as the standard of care have surfaced as attorneys look for ways to press claims for failure to protect an individual’s health information. In 2013, an Indiana jury levied a $1.44 million judgment against Walgreens for failing to protect one customer’s health information. According to the plaintiff’s lawyer, “the lawsuit itself was grounded in common law principles (negligence, professional malpractice, and invasion of privacy)…. I used HIPAA to establish the standard of care. Though it might seem a semantic distinction, it is actually quite important from a legal standpoint; I did not sue Walgreens for violating HIPAA; I sued Walgreens for negligence, but I used HIPAA to prove that Walgreens was negligent.”

Most of the time the issue has not arisen in a jury trial, but has been presented to the court as the standard to use to measure the defendant’s negligence. State courts of appeal in North Carolina and Utah and the state Supreme Court in West Virginia, as well as two

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**CMS Transmittals and Federal Register Regulations**

**Oct. 31 – Nov. 6**

Live links to the following documents are included on RMC’s subscriber-only Web page at www.AISHealth.com. Please click on “CMS Transmittals and Regulations” in the right column.

**Transmittals**

(R) indicates a replacement transmittal.

**Pub. 100-04, Medicare Claims Processing Manual**

- Reporting the Service Location National Provider Identifier (NPI) on Anti-Markup and Reference Laboratory Claims (R), Trans. 3103CP CR 8806 (Nov. 3; eff. Jan. 1/April 1; impl. Jan. 5/April 6, 2015)

**Pub. 100-07, State Operations Manual**


**Federal Register Regulations**

**Final Rules**

- Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Physician-Owned Hospitals: Data Sources for Expansion Exception; Physician Certification of Inpatient Hospital Services; Medicare Advantage Organizations and Part D Sponsors: CMS-Identified Overpayments Associated with Submitted Payment Data (Fed. Reg. pub. date, Nov. 10, 2014)

- Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015 (Fed. Reg. pub. date, Nov. 13, 2014)

- Home Health Prospective Payment System Rate Update, CY 2015; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies, 79 Fed. Reg. 66032 (Nov. 6, 2014)

- End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, 79 Fed. Reg. 66120 (Nov. 6, 2014)
federal district courts in Missouri, have allowed state claims for negligence to proceed using HIPAA as the standard of care.

Health care entities should review state case law and court decisions to see whether there is precedent in their jurisdiction for allowing HIPAA to be used as a standard of care in tort and negligence cases where PHI is involved. If state courts have not addressed the issue, the court may or may not allow use of HIPAA as the standard of care. Covered entities also may argue that it is the responsibility of the legislature, not the courts, to decide whether it will permit private rights of action for HIPAA-like violations.

Final OPPS Rule Shakes Things Up
continued from p. 1

“The doctors see it as administrivia even though for years they have technically done it when they write the first progress note or the history and physical,” says Harriet Kinney, integrity and compliance manager for CHE Trinity Health in Livonia, Mich. It’s a relief not to have to chase physicians down to complete another form before discharge from acute-care hospitals, although certification is a lever for improving documentation, so it has its benefits, she says.

CMS said it backed off on the certification requirement because, in general, the benefits may not outweigh the administrative burdens. “In most cases, the admission order, along with the medical record and progress notes, may also provide sufficient information to support the medical necessity of an inpatient admission without the separate requirement of an additional, formal, physician certification,” the rule states. “However, for long or very costly inpatient stays, we believe that additional review and documentation by a treating physician are necessary to help substantiate the continued medical necessity of such stays, and a physician certification provides evidence of such additional review.”

Physician orders are another thing altogether. Because orders fall under the certification requirement, CMS is making them a condition of payment under Sec. 1871 of the Social Security Act instead. Orders are a significant compliance issue and hospitals may want to turn more attention in that direction, says Steven Greenspan, vice president of regulatory affairs at Executive Health Resources in Newtown Square, Pa.

“Orders have been a big part of the probe-and-educate program,” he says. Medicare administrative contractors (MACs) are conducting probe-and-educate reviews of hospital compliance with the two-midnight rule, and a few MACs have released their findings, he says. For those MACs releasing probe-and-educate denial data, between 6.5% and 40% of claim denials are caused by invalid orders (e.g., it was missing or unsigned), Greenspan says. Denials from deficient orders trump denials from deficient certifications, which range from 4% to 29%, Greenspan says. “Orders will become more prominent in denial circles,” he says.

Clinical Evidence Must Be in the Chart

Take away the sense of drama and not much has changed, says Jeffrey Farber, M.D., vice president for hospital services utilization at the Mount Sinai Health System and associate professor at the Icahn School of Medicine at Mount Sinai in New York City. The Medicare conditions of participation always required physician orders for admission and CMS said it would accept, as a default, documentation of the certification elements throughout the medical record. “You don’t have to have a form, but the elements are the elements and they existed before and they need to be in the medical record,” he says. “CMS just wants you to think about discharge planning, which is smart medicine.”

Farber is more concerned about the claim denials that result from a lack of documentation of clinical evidence for the hospital stay, real or imagined by the auditors. Suppose a nurse practitioner with admitting privileges signs the admission order, which is then signed by the physician responsible for the patient’s treatment, because the expectation is the patient will stay two midnights. But the chart only states the patient has a GI bleed and will get a transfusion. The patient then winds up going home the next day. “There’s not enough in the medical record to support that expectation of a two-midnight stay,” he says, and the inpatient claim will be denied. If, however, the physician writes that the patient is a hypoxic 87-year-old with a tenuous fluid status, and there’s fear of an overload of fluid and he needs a unit of blood and there’s comorbid heart failure, that will support the two-midnight stay, Farber says. “If it turns out the patient can go home earlier, that’s OK. The payer may deny it and we will fight it,” he says.

Meanwhile, hospitals have to comply with the certification requirement until the OPPS rule takes effect Jan. 1. And there’s something to be said for sticking with the checklists, forms or prompts that hospitals put in place when the 2014 IPPS rule introduced certifications in connection with the two-midnight rule. “If you have a certification form, don’t get rid of it. It will work against your denials,” says William Malm, senior manager of revenue integrity communications at Craneware. “It’s a great compliance activity.” But it has to be more than a form that states “I certify the patient is expected to stay two midnights.” Malm says the form should be a checklist, so physicians can indicate they signed the admission order and completed documentation of the other elements.
Certification and orders are far from the only attitude adjustment hospitals face from the OPPS rule. They will soon have to report on their claims when services are performed in off-campus hospital-based departments. They will append a new modifier, PO, to HCPCS codes, although CMS deferred the effective date until Jan. 1, 2016. The point of the new requirement is to gather data on provider-based status, which costs Medicare more money than services provided in freestanding facilities because hospitals are paid under OPPS and then physicians receive a separate professional fee. But the new modifier foreshadows changes in provider-based status, says Boston attorney Larry Vernaglia, who is with Foley & Lardner LLP. “They are obviously trying to collect data to reduce reimbursement for it.” The modifier isn’t required for services furnished in a remote location, satellite facility, or emergency department. Hospitals are welcome to use the modifier in 2015, but it’s voluntary, he says.

To complete the provider-based picture, CMS is demanding the same kind of data from physicians. The 2015 Medicare physician fee schedule regulation eliminates the more generic point-of-service code for outpatient hospital (POS 22) and replaces it with two new codes: one for services performed in a remote location, satellite facility, or emergency department, and another for services performed in an off-campus provider-based department. The go-live date is when CMS makes the codes available, Vernaglia says, which could be earlier than the corresponding 2016 deadline for hospitals.

CMS said it will elaborate on these requirements in forthcoming administrative guidance. Provider-based status is always on some radar screen. Noncompliance with the CMS requirements recently led a hospital to settle a false claims case for $3.37 million (RMC 10/20/14, p. 1), and provider-based status is on the 2015 HHS Office of Inspector General’s Work Plan (see story, p. 1).

The final OPPS rule is slated to be published in the Nov. 10 Federal Register.

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**NEWS BRIEFS**

◆ **Oregon Health and Science University in Portland was overpaid $2.419 million for claims submitted in 2010, 2011 and 2012, according to a new Medicare compliance review.** The HHS Office of Inspector General audited 113 inpatient and outpatient claims submitted by the 572-bed hospital. While all the outpatient claims were compliant, 57 inpatient claims had errors, OIG said. There was one source of errors: inpatient admissions that should have been billed as outpatient or observation services, with 77% of the overpayment related to bone marrow and peripheral blood stem cell transplantation. The hospital said the admission errors were caused largely by staff’s reliance on screening tools that indicated stem cell transplants were proper for admission without distinguishing between a full stem cell transplant and a reduced-intensity transplant. As a result, staff thought inpatient admission was necessary. Other errors were attributed mainly to human error. The hospital also said it has taken steps to improve internal controls. View the report at http://go.usa.gov/7hQd.

◆ **If anyone has suggestions for expediting Medicare appeals and reducing the backlog, the Office of Medicare Hearings and Appeals wants to know.** In a Nov. 5 Federal Register notice, OMHA asked for input on initiatives to ease the administrative law judges’ workload (RMC 7/28/14, p. 3) and for fresh ideas. OMHA also is reaching out for recommendations on “current regulations that apply to the Administrative Law Judge level of the Medicare claim and entitlement appeals process that could be revised to streamline the adjudication process while ensuring that parties to the appeals…are afforded opportunities to participate in the process.” OMHA noted how much appeals spiked last year because of the recovery audit contractor program. “The increase in appealed claims from the RA program was particularly high in fiscal year 2013, with a 506% increase in appealed RA program claims compared to fiscal year 2012 appealed claims from the RA program, versus a 77% increase in appealed claims not related to the RA program during that same period of time,” the notice said. View the notice at http://tinyurl.com/otssho4.

◆ **CMS appears to have scaled back the scope of the third round of probe-and-educate reviews, which are designed to evaluate hospital compliance with the two-midnight rule.** In a Nov. 6 posting on its website, CMS said all Medicare administrative contractors (MACs) finished the first round of probe-and-educate reviews and were into the second round; some MACs have completed the second round. Now, CMS said, it has told the MACs that if they have time...
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before probe-and-educate ends on March 31, 2015 —
when routine auditing of inpatient admissions
presumably resumes by MACs and RACs — they should
audit hospitals that haven’t done a bang-up job on the
second round. The third round, however, will entail
a small sample size (10 or 25 claims). Earlier CMS
statements envisioned larger sample sizes (100 to 250
claims) for the third round. Visit http://tinyurl.com/
lojmp4p.

- The Eleventh Circuit Court of Appeals reversed in
part and affirmed in part a lower court’s dismissal
of plaintiff Michael Mastej’s whistleblower lawsuit
against Health Management Associates, Inc. and
Naples HMA, LLC. At issue was whether Mastej’s
allegations had stated with particularity the circum-
stances constituting fraud, which is required by Rule
9(b) of the Federal Rules of Civil Procedure. Mastej
alleged that HMA had executed contracts with six phy-
sicians for “on-call” services, which were not required
because the facility did not perform emergency ser-
vices and had taken 10 physicians on a golf outing, all
of which, he alleged, constituted financial remunera-
tion as defined by the Stark law. Because HMA had a
financial relationship with the 10 physicians who re-
ferred patients to HMA, HMA’s submission of claims
for referrals from those physicians constituted false
claims, according to Mastej’s complaint. HMA did not
challenge the allegation of the financial relationship;
instead, it challenged whether Mastej had provided
enough specific details to support the allegations.
Mastej had not identified “which patients, which
interim claims, or which payments” were involved in
the allegations. While this would seem to be the death
knell to the whistleblower case, the court explained
that “our case law has indicated that a relator with
direct, first-hand knowledge of the defendants’ sub-
mission of false claims gained through her employ-
ment as defined by the Stark law.” In this case, Mastej
had been vice president of HMA for six years until February
2007 and as CEO of another HMA facility from February
2007 until October 2007. He detailed in his complaint
the weekly and monthly meetings he attended at
which Medicare and Medicaid patients and billing
were discussed, as well as other billing and pay-
ment details to which he was privy by virtue of his
position. The court concluded, “At this preliminary
stage, Mastej has sufficiently articulated how he al-
legedly gained his direct, first-hand knowledge of the
Defendants’ submission of false interim filed in 2007
claims.” However, it only reversed and remanded
the dismissal for claims because, after that date, Mas-
* dej left HMA, and without specific details about the
patients and the claims themselves, the allegations
regarding false claims submitted in 2008 and 2009 did
not meet the Rule 9(b) specificity requirements. U.S.
ex rel. Mastej v. HMA, No. 13-11859 (11th Cir. Oct. 30,
2014).

- Yale-New Haven Hospital was overpaid $1.7
million on certain claims submitted in 2010 and
2011, according to a new Medicare compliance
review. The HHS Office of Inspector General au-
dited 192 inpatient and outpatient claims submitted
by the 1,541-bed New Haven, Conn., hospital and
concluded there were errors on 113 of them, causing
the $1.7 million overpayment. The errors included
inpatient stays that should have been billed as outpa-
tient or observation services, incorrectly billed DRG
codes, unreported manufacturer credits for replaced
medical devices, and incorrectly billed evaluation
and management services. In its response, Yale-New
Haven Hospital agreed with some of the findings,
but disagreed with others. For one thing, the hospital
said it already voluntarily refunded money stemming
from medical device credits and thinks OIG is wrong
about 56 of the short stays the Medicare auditors said
should have been outpatient services. In other areas,
the hospital “developed corrective action plans.”
View the report at http://go.usa.gov/Arum.

- CMS said on Nov. 4 it probably will not award
until late summer the next round of recovery au-
dit contractor (RAC) contracts for three regions.
Because of the challenge to CMS’s revised payment
terms of the second set of five-year contracts mounted
by an incumbent RAC, CGI Federal (RMC 9/8/14, p.
6), the new contracts will continue to be held up in
regions one, two and four. But the procurement pro-
cess is chugging along for region three and for the
new national RAC, which will audit claims for home
health, hospice and durable medical equipment, and
prosthetic and orthotic supplies. “The CMS remains
hopeful that these two new contracts will be awarded
before the end of this year,” its website says. Mean-
while, the incumbent RACs are conducting limited
reviews of certain risk areas, such as joint spinal
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