Report on
Medicare Compliance

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Weekly News and Compliance Strategies on CMS/OIG Regulations, Enforcement Actions and Audits

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Face-to-Face Encounter Rule Leads to FCA Settlement; All HHAs Will Be Audited

ResCare Iowa Inc. agreed to pay $5.63 million to settle false claims allegations that it billed Medicare for home health services even though it violated the face-to-face encounter requirement and lacked other documentation. ResCare is not alone in its documentation problems, according to the government, a reality that is sparking more activity on the home health front.

All home health agencies in the nation will be audited by the supplemental medical review contractor (SMRC), one of CMS's newer program-integrity players. The audits stem from the fact that Medicare claims often are not supported by documentation that a physician or nonphysician practitioner (NPP) has certified eligibility for home health services. Medicare pays for home health when patients are homebound, require skilled services, receive services under a plan of care and have had a face-to-face encounter with a physician or NPP.

Meanwhile, CMS has developed a draft of a clinical documentation template to guide physicians in documenting the face-to-face encounter. There are both paper and electronic formats, and CMS is holding open-door forums to solicit feedback from the industry. It's a first for CMS, which has never offered the industry templates for a progress note, Melanie Combs-Dyer, director of the CMS Provider Compliance Group, explained at the first open-door forum on Feb. 11. If adopted, their use would be voluntary. The templates come in the wake of the elimination of physician narratives. As of Jan. 1, home health certifications don't require physician narratives, according to the 2015 home health prospective payment system 2015 regulation *(RMC 7/28/14, p. 1; 11/3/14, p. 7)*.

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Some Social Admissions May Be Medically Necessary Care in Disguise; Tread Lightly

Patients in the gray area of medical necessity present a regulatory, reimbursement and ethical challenge for hospitals. If patients need only custodial care, which is not covered by Medicare, hospitals are playing with fire if they submit claims for anything except ancillary services. But sometimes what seems to be a social admission is really medically necessary and it just hasn't been documented well. Or hospitals may have other reimbursement options, including the use of an advance beneficiary notice (ABN) and the hospital-issued notice of non-coverage. Whichever route they take, auditors are watching.

Medicare pays for care only when it's reasonable and necessary, and that generally doesn't include social admissions and "admissions to avoid inconvenience," which are inappropriate for Medicare payment, according to a 2013 regulation (78 *Federal Register* 160, p. 50947). Medicare also doesn't cover custodial care, which CMS defines as helping patients with activities of daily living (e.g., eating, bathing, using eye drops).

continued

But social admissions are not always black and white. "You have to do it case by case and you shouldn't have yourself held hostage to Medicare regulations," Michael Salvatore, M.D., physician adviser at Beebe Medical Center in Lewes, Del., said at a Finally Fridays webcast sponsored by the Appeal Academy on Feb. 6. The hospital has placed more utilization reviewers in its emergency room to screen incoming patients for medical necessity. "These people are very effective at getting people out of the hospital," he says. But it's not always feasible. "Most of these people require custodial care because they have a medical problem," he says. "At some point you are not obligated to participate in some kind of insanity."

For example, a 94-year-old woman with dementia was recently brought to Beebe Medical Center after she was found in bed next to her dead 90-year-old husband, who had been her caretaker. "Do we have any options? I think in good conscience you can use reducing the risk to say this person needs hospital services," Salvatore said. Until a nursing home bed opens up, keeping her safe is the treatment. These decisions are not made cavalierly. "We round every day. Probably 10 people in a room of different disciplines discuss what to do," he says. "Then we decide what we can justify in the documentation, and we stress we are trying to reduce risk." Salvatore speaks to the hospitalist about "what we can ethically say about the case" and ensure documentation doesn't sound like a patient was admitted for the purpose of satisfying Medicare's three-day qualifying stay for a skilled nursing facility admission.

But others would call that noncovered custodial care. "There is no medically necessary reason to admit her," said Ronald Hirsch, M.D., vice president of education and regulations at Accretive Physician Advisory Services. "You can't send them home in good conscience, but you can't admit them either," he said. Some or all of the services provided to these patients will not be reimbursed. How should hospitals respond? It's not that complicated, he said. "Because [many] hospitals don't pay property taxes, you have a social service obligation to the community and part of that is to take care of people like this."

Some Costs Must Be Eaten

There are practical reasons to eat some of the costs for custodial care. "This constant need to get something paid has driven us into doing things that will get us audited," said William Malm, senior manager of revenue integrity communications at Craneware. He advises case managers and compliance officers to revisit the concept of outpatient in a bed. "Outpatient in a bed is the thing we use when the physician's practice is to keep someone longer than required or for social reasons or for any reason when medically necessary services have ceased," he says. For example, the patient no longer needs observation but can't or won't go home. At this point, Medicare doesn't pay for additional charges except maybe ancillary services. Malm says, however, there are ways to capture some reimbursement. Either give patients an ABN for observation when medically necessary services are finished, which means they take financial responsibility; place patients in outpatient in a bed in the hospital's room and board module, which means the hospital stops billing hours; or bill Medicare with a GZ modifier as provider-liable hours, he says.

In terms of the ABN, Noridian Healthcare Solutions, the Medicare administrative contractor for California, "is clear on what to do with patients who completed observation and are ready to be discharged home, with or without home care, or to a long-term care facility, skilled nursing care, a nursing home or assisted living," Harriet Kinney, integrity and compliance manager for Trinity Health, a Livonia, Mich.-based health system, said in an interview. Noridian says an ABN is appropriate "if a patient is in observation and ends up staying beyond the observation due to no placement. Providers should notify the beneficiary that services are no longer medically

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necessary and an ABN should be issued to the beneficiary to remove financial liability from the provider."

But ABNs are sticky because patients will be charged the full room rate, Kinney notes. "It makes for ill will with the family and the patient, so we are careful with them," adds Mary Beth Pace, director of system case management at Trinity Health. The hospital also may want to help the patient apply to Medicaid, which pays for some basic care, she says.

They're Not Always 'Social Admissions'

Sometimes what seems like a social admission is, in fact, a medically necessary hospital stay. That can be the case with falls, which are a theme of social admissions. Whether the claim survives depends on the documentation. Pace relayed the case of a Medicare patient who broke her clavicle when she fell off a stool. The woman lived independently but relied on a walker to walk, so she lay on the floor for six hours until a neighbor discovered her. By then she was dehydrated. At the emergency room of a Trinity hospital, the patient was assessed and found unable to do activities of daily living because the fractured clavicle limited the weight she could put on her right arm. "The doctor wanted to write 'admit for SNF placement,'" Pace says. "I explained we couldn't do that" because it's against Medicare rules. However, it was possible she fell due to syncope, so the hospital did a full workup, including a carotid Doppler, and rehydrated her slowly. That triggered an inpatient admission, "but it's a different way for the physician to think and document," Pace says. If the patient goes to a SNF, it's her choice. That's what happened — she spent seven days there to regain her strength and return home to live independently using a platform walker — but it wasn't a social admission.

Other falls won't justify inpatient admission, and there may not be a reason to keep patients in the hospital for long except for pain management, Hirsch says. "Pelvic fractures are most often nonoperative," he says. Often patients can be X-rayed in the emergency room and sent home. If they stay in the hospital, he doubts they will cross two midnights. The patients should be outpatient with observation for the first midnight for pain management and physical therapy evaluation, Hirsch says. "If everything is fine, they could go home with a walker and see the orthopedist in the office. If pain is uncontrolled, give them IV analgesics and admit them as inpatient. But if pain is moderate and it's not safe to go home, you are stuck with a patient who you can't admit."

Patients in this kind of limbo may wind up in unexpected places. "Some hospitals are talking about moving the patient to a local hotel and assigning 24/7 home care," Kinney says. Some large health systems have hotels attached to them and/or discharge lounges with cots that are staffed in case a patient takes a turn for the worse, Malm says.

More conventionally, patients just stick around the hospital, and if they decline, the physician will review the case and determine whether an inpatient admission or observation placement is warranted, Kinney says. "Otherwise, the patient stays in the hospital until a bed opens up at a local nursing facility."

There's no magical answer to social admissions, Malm adds. "There is a challenge between the moral, ethical obligation to treat mankind as you would yourself and payment. So you take it one by one. I don't think you will ever avoid this and I don't think you can ever expect payment for everything you do."

Contact Kinney at kinneyh@trinity-health.org, Pace at pacem@trinity-health.org, Salvatore at msalvatore@beebehealthcare.org, Hirsch at rhirsch@accretivehealth.com and Malm at w.malm@craneware.com. Visit the Appeal Academy at www.appealacademy.com. ✧

Court: Payment for Certifying Home Health Agency Is a Kickback

A federal appeals court has upheld the kickback conviction of a Chicago area physician who accepted payments from a home health agency for certifying the need patients have for home health care.

In a Feb. 10 decision, the U.S. Court of Appeals for the Seventh Circuit rejected arguments by Kamal Patel, who was sentenced to eight months in prison after he was found guilty in June 2013.

Patel went on trial before a judge in the U.S. District Court for the Northern District of Illinois for six counts of violating the anti-kickback statute and one count of conspiring to violate it. After the government presented its evidence, Patel moved for an acquittal because he never steered patients to Grand Home Health Care. Instead, when patients chose Grand, he certified and recertified their plans of care.

The district court disagreed on the grounds that every certification and recertification amounted to a referral. Patel sought relief at the appeals court, arguing the district court made a mistake in ruling that certification and recertification (Medicare form 485) constitute referrals. Even if they do, he argued there was insufficient evidence that he was paid in return for certifications. But the appeals court ruled against him.

"The court was concerned that the possibility of financial gain could incentivize physicians to continue certifying the need for home health care even though the care was not in the patient's best interests," says Phoenix,

Ariz., attorney Ken Briggs, who is with Polsinelli. The case shows that it's possible for the government to make a kickback case even without the provider directly steering the patient to the entity that paid the kickback, he says.

According to the court decision, Patel, an internist, prescribed home health care to about 10 patients a month who used 10 to 20 different home health agencies, including Grand. At some point in 2003, Grand lost a lot of business when some of its partners left to form a competitor, and Grand allegedly sought to regain market share by paying physicians for referrals of Medicare patients, the court decision states. Before and after Grand offered Patel kickbacks, he used the same process to prescribe home health to his patients, all of whom truly needed home health care. Patients discussed the home health choices with Patel's medical assistant. Patel did not tell the medical assistant which home health agency to recommend to patients, who independently made their selections, the court decision states.

When Patel's patients chose Grand, the home health agency sent a nurse to assess the patient. Grand also filled out most of the treatment plan and Form 485, and then one of Grand's owners met with Patel. The owner paid Patel $400 for every signed Form 485 and $300 for every recertification, the court decision says. Patel was eventually indicted and put on trial.

Patel argued he couldn't be guilty of violating the anti-kickback statute because he didn't urge his patients to use Grand. The government countered that the term "refer" includes "authorization" of care by a specific provider, not just recommending the provider. In mulling it over, the appeals court decided that a broader definition of "referral" is warranted. "In passing the Anti-Kickback Statute, Congress intended to criminalize the receipt of kickbacks in return for a physician's certification or recertification, through a signed Form 485, that a patient requires Medicare-reimbursed care. The word 'referral' is commonly used — including by Congress in the Stark Act — in a way that extends to such authorizations. Moreover, a narrow definition of the term would defeat the central purposes of the Anti-Kickback Statute," the decision says.

Patel also argued that the more sweeping definition of "referral" means physicians can be prosecuted for receiving payments from entities where patients receive services even without referring them there. What if a physician is paid for a speech at a hospital and his patients are later treated there? The appeals court was dismissive, noting that payments for legitimate services can't be construed as a kickback.

Briggs, who was not involved in the case, notes that it "also goes to show that even an inept and ineffective kickback scheme can still result in significant consequences." He added that the court's definition of "referral" neutralized Patel's argument that a payment from a home health agency is allowable if the patient is able to choose from more than one provider.

Contact Briggs at kbriggs@polsinelli.com. ✧

OIG Puts ACA's More Powerful Administrative Remedies into Play

The HHS Office of Inspector General is exercising more of the muscles it got from the Affordable Care Act, including aggressive use of the Medicare exclusion authority and expanded civil monetary penalty laws.

"There are more ways for the government to punish alleged or actual misconduct than ever before. The OIG now has more administrative remedies and the capacity to go after providers," said former federal prosecutor Scott Grubman, who is now with Rogers & Hardin in Atlanta. "When the Department of Justice passes on a case because it doesn't rise to the level of a false claim or maybe it falls off the radar, the OIG can increasingly step in, armed with the ACA weapons."

Grubman, who spoke at a recent Health Care Compliance Association webinar, explained how administrative penalties were strengthened after the enactment of the Affordable Care Act. The provisions already are in effect now because they are in the health reform law, but two OIG regulations proposed in May put meat on their bones.

The Affordable Care Act radically altered the exclusion landscape. "OIG already had authority to exclude providers for a wide variety of conduct, and the ACA expanded that," Grubman said. There are two kinds of exclusions: mandatory and permissive. With mandatory exclusions, OIG is required to bar providers from Medicare and other federal health care programs for at least five years for certain offenses, such as health-care related criminal convictions. OIG, however, can use its discretion with permissive exclusions, which may be imposed for

excessive charges or unnecessary services claims; certain criminal convictions, even if they're not health care-related; kickback and Stark violations; license revocation/suspension; and failure to reveal certain information.

Now OIG's permissive exclusion authority is a lot stronger, he said. Here are some key changes from a proposed May 2014 rule (although he emphasized the Affordable Care Act provisions are self-implementing):

◆ ***OIG would be able to increase the length of a provider's exclusion if the misconduct that led to the exclusion cheated a federal health care program out of $15,000 or more.*** Instead of limiting the exclusion to three years, OIG would have leeway under the Affordable Care Act to lengthen the period because of this new "financial loss aggravating factor," Grubman said. "There's no set period," he noted, and it's easy to cross that threshold.

◆ ***Messing around with an investigation or an audit (e.g., meaningful use, zone program integrity contractor, comprehensive error rate testing program) can be cause to be excluded from Medicare.*** Before the Affordable Care Act, OIG could exclude people or entities when they were convicted of obstructing or interfering with certain criminal investigations, Grubman said.

◆ ***Providers could be excluded for knowingly making or causing a false statement, or omission or misrepresentation of a material fact in an application or contract to participate in, or enroll in, a federal health care program.*** OIG will decide whether to use this new authority in a given case based on information it gleans from CMS, Medicaid, contractors, private payers, licensing and certification authorities and law enforcement, Grubman said.

◆ ***Long after organizations settle false claims lawsuits, OIG could exclude them from federal health care programs.*** OIG would free itself from any time limit for excluding providers for violating fraud and anti-kickback laws. For example, it doesn't want to be hamstrung by any statute of limitations, such as the six years under the False Claims Act.

OIG's authority under the civil monetary penalty law was expanded by the Affordable Care Act, and it was interpreted in the May regulation, Grubman said. Here are some of the ways it will be felt:

◆ ***The sky could fall on providers when they don't grant the government timely access to records, documents and other data in any form, including electronically stored information.*** They will face civil monetary penalties (CMPs) of up to $15,000 per day and risk exclusion if they don't comply with the request to produce the material by the deadline in the absence of a compelling reason or if OIG thinks the material is about to be destroyed, Grubman said. "You have to provide records by the deadline or a compelling reason why you can't," he said. But what is a compelling reason? "It's not defined in the rule," he noted. Will it be the provider scrambling to find the time to comply? Or the fact the IT guy is on vacation? A definitive answer may come through litigation, Grubman said. Also, "OIG has the flexibility to determine the time period you must respond to the request," he said. It will consider assorted factors, "and probably will be less receptive to arguments" when larger organizations try to argue they lack the capacity or time or money to supply the requested information "although that might be true and correct."

◆ ***Providers could be assessed $50,000 for every false statement, omission or misrepresentation made knowingly in connection with enrollment applications or contracts,*** according to a new CMP and the proposed rule.

◆ ***If providers order or prescribe goods or services while excluded, they face civil monetary penalties up to $10,000 per violation if they know or should have known the claims for the goods or services will be billed to federal health care programs,*** Grubman said.

◆ ***In addition to the threat of a false claims lawsuit for failure to return a Medicare or Medicaid overpayment 60 days after identifying it, the Affordable Care Act allows OIG to impose CMPs when providers drop this ball.***

For more information, contact Grubman at sgrubman@rh-law.com. Read the proposed exclusion rule at http://go.usa.gov/83yB and the proposed CMP rule at http://go.usa.gov/8rkP. ✧

HHAs Are All Audit Targets

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But some home health agencies are stumbling over certification. The Affordable Care Act (Sec. 6407) requires physicians to certify a patient's eligibility for home health as a condition of Medicare payment. Certifications are based on a face-to-face encounter with the patient no more than 90 days before home health services start or 30 days after. The face-to-face encounter must be related to the primary reason the patient requires home health services and dated and signed by the physician. But home health agencies have expressed frustration that they face claim denials for services that must be certified by independent physicians who have no financial stake in complying with Medicare home health documentation requirements.

The kinds of documentation deficits apparently plaguing the industry were captured in the case against ResCare, which did business as ResCare Homecare Iowa. According to the settlement, between 2009 and 2014, ResCare Homecare Iowa allegedly:

◆ Lacked documentation to show compliance with the face-to-face encounter requirement,

◆ Didn't keep documentation of plans of care or orders,

◆ Billed for more visits than documented or ordered by the certifying physician, and/or

◆ Didn't have forms that patients sign agreeing to receive medical care from ResCare and allowing it to bill Medicare on their behalf.

In a statement, Nel Taylor, chief communication officer for Louisville, Ky.-based ResCare, the parent company of ResCare Iowa, said the settlement stemmed from a self-disclosure. "When the issue first arose, ResCare hired an outside firm and expert in the home health field to conduct an audit of our documentation. We brought the audit to the government agencies and disclosed the documentation errors the auditor found," she stated. "ResCare provided medically necessary, quality care to our clients. Our quality of care was never questioned." The company cooperated with the state and federal investigation, Taylor said.

The emphasis on documentation should be a wake-up call for compliance officers now that there has been a significant false claims settlement and the supplemental medical review contractor will hit every home health agency, says attorney Paula Sanders, who is with Post & Schell in Harrisburg, Pa. "I call this low-hanging fruit because it's easy for auditors to kick out claims when you're missing one of the required elements," Sanders says. "They don't even have to do a medical necessity review."

CMS Transmittals and *Federal Register* Regulations
Feb. 5 – Feb. 12

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

- CY 2015 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule (R), Trans. 3190CP, CR 8999 (Feb. 6; eff. Jan. 1; impl. Jan. 5, 2015)

Pub. 100-07, State Operations Manual

- Revisions to the State Operations Manual – Appendix PP – Guidance to Surveyors for Long-Term Care Facilities, Trans. 133SOMA (Feb. 6; eff./impl. Feb. 6, 2015)

Pub. 100-20, One-Time Notification

- Identifying "No Documentation" Medical Necessity Denials for Claims Flagged for Recovery Auditor Review, Trans. 14620TN, CR 8913 (Feb. 6; eff. July 1; impl. July 6, 2015)

Federal Register Regulations

- None published.

Concern about home health program integrity is intensifying in light of recent reports that documentation is falling far short of Medicare expectations. The HHS Agency Financial Report stated the improper payment rate for home health claims jumped to 51.4% in FY 2014 from 17.3% the year before. An April 2014 audit report from the HHS Office of Inspector General found that 32% of home health claims either had no documentation of a face-to-face encounter or the documentation was missing one of the required elements. In 10% of the 644 documents audited, there was no evidence of a face-to-face encounter. *Among the other errors:* 17% lacked the signature of the certifying physician; 4% had no date of encounter within the timeframe; 3% lacked a title; and 2% had no information on when the physician signed the document. As a result, OIG said Medicare overpaid $2 billion.

To improve compliance with Medicare regulations, CMS is acting on some suggestions in OIG's report. For one thing, the supplemental medical review contractor "will perform approximately five document-only reviews for every HHA in the country to validate that the most recent/valid face-to-face encounter is in the medical record," CMS said in its response to the report. "This will allow CMS to have better oversight of HHAs and the face-to-face requirement since one CMS contractor will be overseeing utilization." The review will take a year, and afterward, the agency will evaluate the SMRC's results and recommendations.

OIG Recommended Using a Standardized Form

OIG also recommended that CMS contemplate the use of a standardized form to ensure physicians fulfill all documentation requirements. That seems to be under way with the draft clinical documentation templates. Among other things, they would prompt physicians to document the patient's homebound status and the need for skilled care, which were the top home-health documentation deficiencies, according to the 2014 CERT report, Combs-Dyer said. "If you don't find that, you may need to ask physicians to send more documentation," she says. But it doesn't necessarily have to come from the progress note. "As long as the home health agency can find evidence the coverage criteria is met, you are good to go," Combs-Dyer said. "It doesn't matter if it's in the progress note or in the orders," as long as somewhere in the medical record the physician has documented the patient is homebound and why; the need for skilled services; and the correct dates — a face-to-face encounter 90 days before or 30 days after home health care is ordered.

In light of industry comments, CMS is weighing whether to shorten the paper template and lengthen the electronic one, Combs-Dyer said. This and home health

work flow issues around documentation will be addressed at the next open-door forum on March 11.

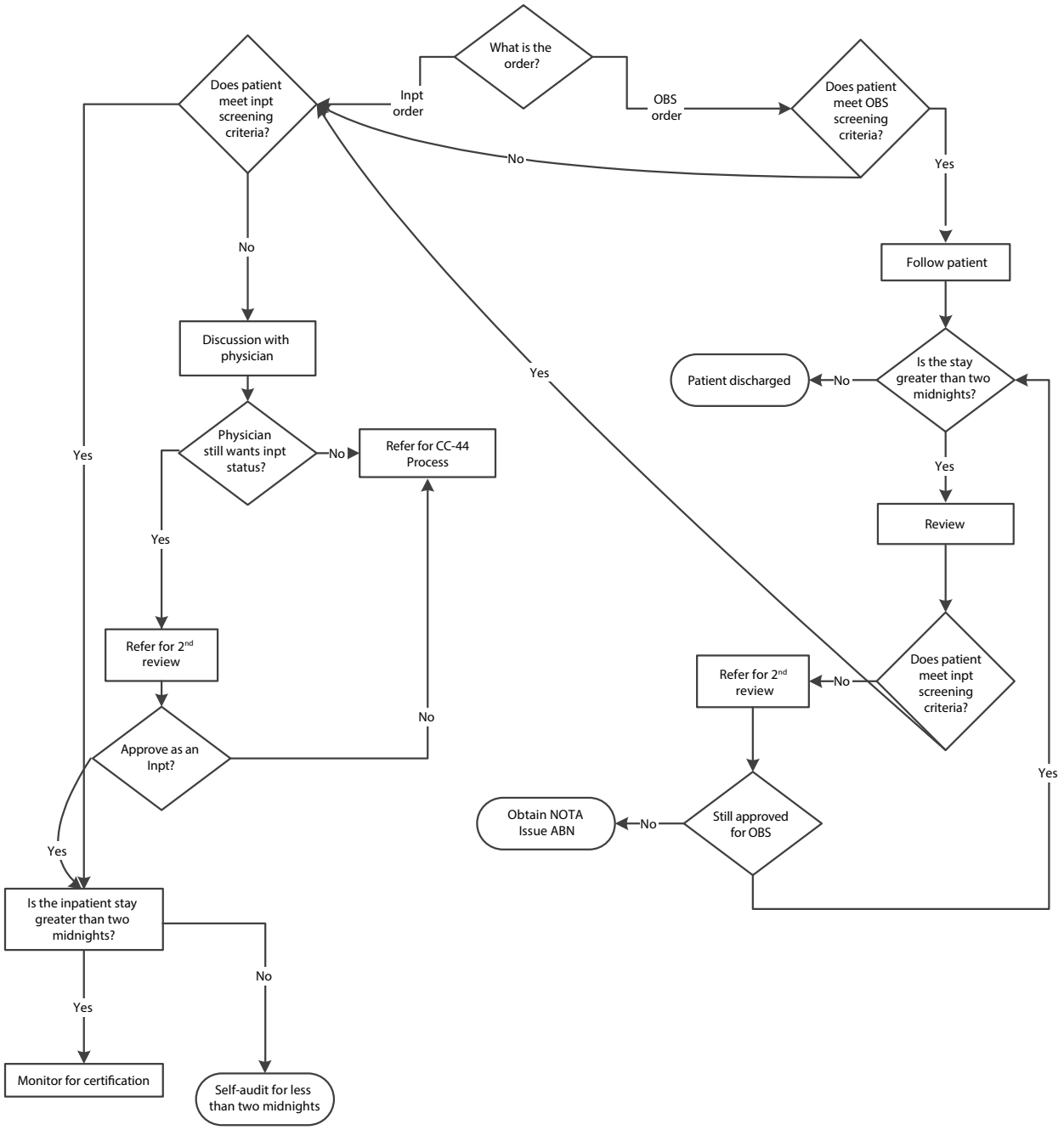
Some people have complained the voluntary templates are burdensome, Sanders says, but "if I have an error rate because I'm missing these elements, why not do it?"

For more information, contact Sanders at psanders@postschell.com.

The CMS electronic documentation template may be accessed at http://tinyurl.com/kyv9o5s and the paper template at http://tinyurl.com/pp4jugv. Read the OIG report at http://tinyurl.com/n2akx6l. ✧

Thinking Through Inpatient vs. Outpatient Level of Care

This is an algorithm used by Trinity Health, a Livonia, Mich.-based health system, to determine inpatient vs. outpatient level of care. Contact Mary Beth Pace, care management system director, at pacem@trinity-health.org.



NEWS BRIEFS

◆ **On Jan. 7, CMS announced four more Stark settlements under the self-referral disclosure protocol, but fewer details were available than usual.** A Minnesota hospital paid $231,981 to resolve an alleged violation of the physician self-referral law "because arrangements with certain physicians failed to satisfy the requirements of an applicable exception," CMS said. A physician group in North Carolina paid $180,095 after disclosing that it may have violated the Stark law. A hospital in North Carolina agreed to pay $331,429 after disclosing it may have violated Stark because "multiple arrangements with physicians and physician groups failed to satisfy the requirements of an applicable exception." A Michigan hospital settled for $59,732. Visit http://tinyurl.com/bt6sy9z.

◆ **Good Shepherd Hospice Inc., a for-profit hospice company based in Oklahoma City, agreed to pay $4 million to settle false claims allegations, the Department of Justice said Feb. 6.** Good Shepherd and its related entities allegedly billed Medicare for patients who weren't terminally ill. Medicare covers hospice care for patients with a life expectancy of six months or less. Patients waive their right to traditional inpatient services and receive palliative care instead, including pain management, nursing and dietary care and spiritual counseling. In the Good Shepherd case, the Justice Department alleged Good Shepherd "engaged in certain business practices that contributed to claims being submitted for patients who did not have a terminal prognosis of six months or less, by pressuring staff to meet admissions and census targets and paying bonuses to staff, including hospice marketers, admissions nurses and executive directors, based on the number of patients enrolled." The hospice company allegedly hired medical directors according to their ability to refer patients, with access to nursing homes being particularly appealing. The Justice Department also alleged hospice staff wasn't properly trained on hospice eligibility criteria. The case originated with two former employees who became whistleblowers. Good Shepherd provides services in Oklahoma, Missouri, Kansas and Texas. Visit http://tinyurl.com/lk9kabr.

◆ **Agape Homes, LLC, of Avondale, Ariz., agreed to pay $41,995 in a civil money penalty settlement over an excluded nurse, the HHS Office of Inspector General said.** Agape Homes provides services to disabled individuals and offers day treatment. OIG alleged it employed a nurse who was excluded from federal health care programs "and allowed that person to care for residents." Visit http://tinyurl.com/3bnymfs.

◆ **Starting July 1, CMS is instructing institutional providers to use condition code 53 on all claims for procedures involving medical devices that are provided free by the manufacturer because of a clinical trial or free sample, according to a *MLN Matters* article (MM8961).** "This new code is used to identify and track medical devices that are provided by a manufacturer at no cost or with full credit to the hospital due a clinical trial or a free sample," CMS says. Visit http://tinyurl.com/mgh7l3x.

◆ **Another "SGR fix" bill could turn into a vehicle for reforms to the Medicare appeals process and possibly another delay of full-blown audits under the two-midnight rule,** Emily Evans, a partner in Obsidian Research Group, said at a RACmonitor.com webinar on Feb. 9. Last year, Congress enacted, and President Obama signed, the Protecting Access to Medicare Act of 2014, which addressed the sustainable growth rate (SGR), the formula for physician reimbursement. Congress keeps overriding the SGR, which was designed to control Medicare spending on physician services, so now physicians face a 24% cut unless it is once again suspended by March 31. That bodes well for another SGR fix, although it isn't a permanent solution, Evans said. There is bipartisan agreement on Medicare physician payment reform but problems in agreeing on how to fund it. Meanwhile, the SGR fix could be the vehicle for extending the moratorium on many audits under the two-midnight rule, she said. Already, though, CMS said incumbent recovery audit contractors are not going to audit patient status during the limited reviews they will do through Dec. 31 *(RMC 1/12/15, p. 1)* and the HHS Office of Inspector General has suspended short-stay audits under the two-midnight rule *(RMC 1/26/15, p. 1)*. Contact Evans at Emily@obsidianresearchgroup.com.

◆ **CORRECTION:** In the Feb. 9 *RMC* story on the expansion of PEPPER reports for hospices (p. 1), one of the new risk areas was inadvertently omitted. The four new risk areas are continuous home care in an assisted living facility; routine home care in an assisted living facility; routine home care in a nursing facility; and routine home care in a skilled nursing facility.

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