

MEDICARE COMPLIANCE

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

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OPPS Rule: Provider-Based Space May Bill For New Services; CMS Offers New Method

CMS loosened its grip on off-campus provider-based space in the final 2017 outpatient prospective payment system (OPPS) regulation, which was released Nov. 1. Never mind the scare from the proposed rule, because provider-based departments that survived the 2015 congressional crackdown will be able to bill the OPPS for new services, and provider-based departments that didn't make the cut or relocated will use an unconventional payment method for all services and a new modifier introduced in an interim final rule with comments (IFC) tucked inside the final rule.

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Hospitals Must Now Tell Joint Commission About Changes in Advance, Align With 855

In a new development, health care organizations are now required to inform The Joint Commission of changes they "contemplate" making — the same kinds of changes they must reveal to CMS after the fact on updates to the 855 enrollment form.

Effective Oct. 1, The Joint Commission revised its policy on notifications about certain changes, including a change in ownership (CHOW) or location, the addition of a new type of service, "the acquisition of a new component" and a substantial increase or decrease in the volume of services or people served. Health care organizations still have to notify The Joint Commission 30 days after executing changes, but now they must also share the information beforehand — "when the change is initially contemplated," according to its updated policy.

"It's a game-changer," says Cheryl Rice, vice president and chief corporate responsibility officer for Mercy Health, an Ohio-based system. "If you fail to do this, your accreditation may be in jeopardy."

The Joint Commission, which accredits 21,000 hospitals and other health care organizations, defines "contemplated" as "when leadership within the organization has approved moving forward with the proposed change and identified a time frame

CMS: Next Hospital Settlement Process Starts Dec. 1, at 66%

Starting Dec. 1, hospitals again will have a way to get partial payment for their disputed patient-status cases instead of waiting months or years for a decision on their appeals (*RMC 10/3/16, p. 7*). CMS is carrying out another round of the settlement process for inpatient vs. observation claims, but said on Nov. 3 that this time hospitals will get 66% of the net allowable amount instead of 68% if they agree to withdraw pending appeals. CMS will elaborate in a Nov. 16 call. Visit <http://tinyurl.com/zmo9u5f>.

for implementing that change.” The Joint Commission wants advance notice to determine whether the change warrants an onsite survey.

“It’s a new layer of Joint Commission reporting,” Rice notes. “I believe the intent of advance notice is to help facilitate transparency of changes that impact operations covered under the conditions of participation as well as expediting accreditation reviews, particularly for CHOW, moved locations and expanding services that are most at risk for being noncompliant with conditions of participation at the start of business.”

The Joint Commission’s advance-notice requirement shouldn’t be addressed in isolation because health care organizations must report many of the same changes on Medicare 855 enrollment form updates — and now they must attest to their compliance with anti-discrimination laws because Medicare enrollment has been linked to compliance with Section 1557 of the Affordable Care Act.

“Operational leaders have to understand the multiple sets of standards. You have Medicare conditions of participation standards that The Joint Commission will hold you to for accreditation purposes, as well as the enrollment standards of CMS for provider status and

payment purposes,” she says. “It’s both and that’s the challenge.”

CMS in 2006 implemented specific timeframes for all providers submitting enrollment applications and informing CMS of important changes at their facilities. Reporting timeframes vary — they’re usually within 30 to 90 days — based on what’s being changed, Rice says. Providers are required to tell Medicare of changes in: (1) legal business name/tax identification number; (2) “doing business as” (DBA) name; (3) practice location; (4) ownership; (5) authorized/delegated officials (e.g., board members, senior executives); and (6) payment information (e.g., electronic funds transfer information). They’re also required to report adverse legal actions, including felony convictions, license suspensions and debarments and exclusions. Since 2008, independent diagnostic testing laboratories and durable medical equipment, prosthetics and orthotics suppliers have been required to report changes in 30 days instead of 90.

“What should match is what you report on the 855, what you report to the Joint Commission and what you put on the cost report,” Rice says. “You shouldn’t have a variance.”

Anti-Discrimination Is Part of Puzzle

Boston attorney Alan Einhorn finds The Joint Commission’s new language “troubling.” Hospitals and other providers are accustomed to providing prior notifications about changes in ownership, mergers and other significant events in states with certificate of need laws and for licensing, so that’s not the problem. “It’s more a concern of vagueness regarding when an organization must provide the notice,” says Einhorn, with Foley & Lardner LLP. Without a firm deadline for reporting before the fact, there’s “an element of uncertainty,” he says. “In addition, this particular advance notice requirement could end up impacting the timing for deal closings, or even the deals themselves.” Some hospitals would prefer to stick with after-the-fact reporting, when deals “are less likely to be undone,” he says.

Layered on the Joint Commission and 855 reporting obligations (see box, p. 3) is the new anti-discrimination attestation. Health care organizations must certify that they comply with non-discrimination provisions, including new requirements set forth in Sec. 1557, Rice says. Providers who are applying for Medicare enrollment or undergoing a CHOW must submit forms to the HHS Office for Civil Rights confirming their compliance with non-discrimination provisions. The HHS “Assurance of Compliance” form requires providers to attest to their adherence to five civil rights laws: Sec. 1557, which prohibits discrimination based on race, color, national origin, sex, age or disability; Title VI of the Civil Rights Act of

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1964; Section 504 of the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972; and The Age Discrimination Act of 1975.

It can be challenging to communicate operational changes, especially the Joint Commission and 855 timelines, she says. “You have to have a good process — someone dedicated to 855 maintenance on what key changes trigger reporting,” Rice says. “Operational leaders need to be aware that conditions of participation set the baseline for operational compliance as a provider under CMS but that The Joint Commission, as well as other accrediting bodies, can add on to standards for areas of frequent standard deficiencies.” It’s important for operational leadership to understand the risk of an entity

losing accreditation if it doesn’t satisfy the conditions of participation and The Joint Commission standards in a timely manner and before the start of business.

“They need plenty of lead time to be fully compliant with business operational requirements,” she says. That’s not the way it is with CMS, which has given health care organizations time to report the changes after the fact. “That’s significant.”

Contact Rice at clrice@mercy.com and Einhorn at aeinhorn@foley.com. View The Joint Commission document at <http://tinyurl.com/hxt4yfp> and the HHS Assurance of Compliance at <https://www.hhs.gov/sites/default/files/hhs-690.pdf>. ✦

Ensuring Compliance With the Medicare Enrollment Change Schedule

Here are the general time frames for reporting changes to CMS based on instructions in the Medicare 855 enrollment form and communications in the Program Integrity Manual, according to Cheryl Rice, vice president and chief corporate responsibility officer for Mercy Health, an Ohio-based health system. She says some 855 forms have not been revised since July 2011. The regulatory cites for the time frames and reporting changes appear at the bottom of the chart. Contact Rice at clrice@mercy.com.

Provider Action	Time Frame for Action	Impact of Delinquent Reporting / Action
<ul style="list-style-type: none"> • Required for all types of Providers and Suppliers including Institutions and Individuals - Additions, Deletions, Changes • New instructions, definitions, regulatory references, web links and required supporting documentation • New specialties, service and supply categories, certification designations • Revised timeframes for reporting and monitoring of changes in enrollment application information • Revised information to support Supplier standards and Conditions of Participation for DMERC, IDTF, Advanced Imaging • Enhanced Certification and Attestation sections that require original signature by individual (Medicare revised the Enrollment 855 Application Formats about five years ago. The revisions had to be implemented by October 1, 2011.)		
National Provider Identifier (NPI) for mandatory claims submission rules	Mandatory as of May 27, 2007 for all providers and suppliers prior to submission of 855 Enrollment; Submission within 30 days of any changes to NPI info	Any claim submitted with an inactive billing number is incomplete and unprocessable. Sanctions may be imposed under section 1848 (g) (4) of the Social Security Act for failure to file a claim required
Missing Information on new first time application to Medicare	Submission within 30 days for new enrollees	Application rejected without appeal if no communication with CMS. If good-faith effort to resolve timeframe may be extended
Routine Revalidation of existing Medicare provider (3-5 year cycle)	Submission within 60 days for revalidation of existing enrollees	Onsite review and possible deactivation or revocation of provider's billing privileges and collection overpayments
Change in Owners, Ownership or Control (i.e. financial, control, legal interest)	Submission within 30 days including review, update, and submission of any changes and supporting documentation	Onsite review and possible deactivation or revocation of provider's or supplier's Medicare billing privileges and collection of overpayments
Change in Officials, Directors, Authorized Official, Delegated Official or Managing Employee	Submission within 30 days including review, update, and submission of any changes and supporting documentation	Onsite review and possible deactivation or revocation of provider's or supplier's Medicare billing privileges and collection of overpayments
Change in Billing Services	Submission within 90 days including update, and submission of changes and supporting documentation; * Exception: DMEPOS must report within 30 days	Onsite review and possible deactivation or revocation of provider's or supplier's Medicare billing privileges and collection of overpayments
Change in Practice Location	Submission within 30 days including update, and submission of changes and supporting documentation;	Onsite review and possible deactivation or revocation of provider's or supplier's Medicare billing privileges and collection of overpayments
Change in Licensure, Accreditation, Certification	Submission within 90 days including update, and submission of changes and supporting documentation; * Exception: DMEPOS must report within 30 days	Onsite review and possible deactivation or revocation of provider's or supplier's Medicare billing privileges and collection of overpayments

CMS Picks New RACs, but Protests May Briefly Delay Audits Again

Recovery audit contractors (RACs) will soon be back in business now that CMS has chosen vendors for the second round of the program. But audits may not start for a few months because the vendors that are on the cutting room floor probably will challenge the contract awards.

That could slow things down for up to 100 days, says Emily Evans, managing director of health policy for Hedgeye Risk Management in Washington, D.C.

CMS chose:

◆ Performant Recovery for region one,

- ◆ Cotiviti (the successor organization to Connelly Consulting) for regions two and three,
- ◆ HMS Federal Solutions for region four, and
- ◆ Performant Recovery for region five, which is a new, national contract for reviews of home health, hospice and durable medical equipment claims.

Hospitals should brace for a somewhat different kind of RAC experience. “The program will be greatly constrained as compared to the program that ran from 2010 to 2014” and was extended on a smaller scale until spring 2016, Evans says. There have been changes made to the RAC modus operandi that are designed to quiet some of the criticism leveled at the contingency-fee audi-

Ensuring Compliance With the Medicare Enrollment Change Schedule (continued)

Provider Action	Time Frame for Action	Impact of Delinquent Reporting / Action
Change in Equipment (IDTF)	Submission within 90 days including update of model and serial #, and submission of changes and supporting documentation;	Onsite review and possible deactivation or revocation of provider's or supplier's Medicare billing privileges and collection of overpayments
Change in CPT-HCPC Procedures (IDTF)	Submission within 90 days including update of model and serial #, and submission of changes and supporting documentation;	Onsite review and possible deactivation or revocation of provider's or supplier's Medicare billing privileges and collection of overpayments
Change in Supervision of Diagnostic Testing or Diagnostic Tests Performed	Submission within 30 days including update, and submission of changes and supporting documentation;	Onsite review and possible deactivation or revocation of provider's or supplier's Medicare billing privileges and collection of overpayments
Change in Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS)	Submission within 30 days including supply category, submission of supporting documentation for accredited versus non-accredited supplier	Onsite review and possible deactivation or revocation of provider's or supplier's Medicare billing privileges and collection of overpayments
Change in Surety Bond or Comprehensive Liability Insurance (DMEPOS)	Submission within 30 days including update, and submission of changes and supporting documentation;	Onsite review and possible deactivation or revocation of provider's or supplier's Medicare billing privileges and collection of overpayments
No submission of claims under existing Provider number	Consecutive 12-month period without submitted claims; beginning with first day of the first month through last day of 12th consecutive month	Deactivation of provider number
Adverse activity and subsequent CMS action against an Individual or Organization	Submission within 30 days from official notice or CMS initial revocation	If a provider's billing privileges revoked, CMS will review all other related Medicare enrollment files and associated providers and may result in revocation of other associated Medicare provider.
Change in any Other 855 fields	Submission within 90 days including update, and submission of changes and supporting documentation; * Exception: DMEPOS must report within 30 days	Onsite review and possible deactivation or revocation of provider's or supplier's Medicare billing privileges and collection of overpayments

Regulatory Sources for Timeframes:

- 42 CFR 410.33 (2) (g) (2);(4) (iii) and (10) - IDTF Independent Diagnostic Testing Facility
- 42 CFR 424.516 (d) and (e) - Additional Provider and Supplier Requirements for Enrolling/ Maintain Enrollment Status
- 42 CFR 424.57(c) (2) and (25) - Special Payment Rules for Items Furnished by DMEPOS Suppliers and Billing Privileges
- CMS Medicare Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Supplier Standards
- CMS Program Integrity Manual Pub 100-07 Chapter 10-Medicare Provider/ Supplier Enrollment Section 7.1 General
 - General Procedures Section 7.1 (all other providers and suppliers)
 - Physicians & Non-Physician Practitioners Section 7.1 (A)
 - IDTF Section 4.19.1 A (2)
 - Definitions of Owners, Managers, Officers and Directors Section 4.5, 4.7 and 4.16
 - IDTF Section 4.19.1 A (2)
 - CHOW- Change of Hospital Ownership Section 5.5.2.3 B
- CMS Program Integrity Manual Pub 100-07 Chapter 15-Medicare Provider/ Supplier Enrollment Section 15.1.1 Definitions

tors. “CMS clearly got the message from the provider community that it was an overly burdensome program that may be targeted to one type of provider — inpatient hospitals — and somewhat unfairly,” she says. “So they put in place a number of provisions that will keep the program from running wide open like it did.”

For example, on its website CMS said that effective Jan. 1, 2016, it revised the limit on the number of additional documentation requests (ADRs) that a facility can receive from a RAC. “The limits are diversified across all claim types of a facility (e.g., inpatient, outpatient),” CMS said. “This ensures that a provider with multiple claim types is not disproportionately impacted by a Recovery Auditor’s review in one claim type (e.g., all of a provider’s inpatient rehabilitation claims reviewed or all inpatient hospital claims reviewed).”

Routine hospital short-stay audits are off the table now that CMS shifted them to quality improvement organizations (QIOs), with RACs on tap to audit repeat offenders under the two-midnight rule (*RMC 10/31/16, p. 5; 9/19/16, p. 4*). Instead, expect a lot of action in the area of home health and hospice, Evans says. Hospices in particular will garner attention on the heels of enforcement actions, HHS Office of Inspector General reports (*RMC 9/26/16, p. 6; 9/19/16, p. 8; 4/11/16, p. 8*), and the recent release of Medicare utilization data.

Protests Are a Wild Card

The start date of RAC audits is a little unclear because post-award protests are expected from vendors that didn’t win the RAC contracts, Evans says. For example, if CGI, which had a RAC contract for the first five years of the program, submitted a proposal for the second round, she assumes it will file a post-award protest. After all, CGI mounted a vigorous pre-award appeal, starting in 2014 with a protest filed with the Government Accountability Office. CGI objected to the method of procurement — specifically CMS’s plan to change the way it paid RACs. During the first round of contracts, CMS paid RACs their contingency fees after the overpayment determination. In the second round of contracts, CMS planned to pay RACs after the second level of appeal if the provider lost.

GAO turned down CGI’s protest. The RAC appealed to the U.S. Court of Federal Claims, and lost again. But CGI was persistent, taking its case to the U.S. Court of Appeals for the Federal Circuit, where it prevailed. The court said CMS’s new payment terms violated federal contracting law (*RMC 3/16/15, p. 1*).

That left CMS with two options, Evans says. It could “change the method of procurement from the task order system to a full request for proposal process or change the payment terms,” she says. CMS went with the first

choice, which slowed down the awarding of the contracts, but allows it to change the timing of RAC payments. The CMS website says that RACs won’t receive their contingency fees until after the second level of appeal is exhausted.

If CGI files a post-award protest, RAC audits won’t get underway until at least January. “It takes 100 days maximum to resolve those,” Evans says. However long it takes, RACs apparently are here to stay. Their use is required by law — the 2006 Tax Relief and Health Care Act turned the RAC demonstration program into a nationwide improper payment recovery mission — and RACs have generated billions in recoveries, although they also are driving the volume of appeals that has bedeviled the Office of Medicare Hearings and Appeals.

Contact Evans at eevans@hedgeye.com. View CMS’s RAC contract awards at <http://tinyurl.com/zzgqwh4> and its description of “enhancements” to the RAC program at <http://tinyurl.com/zy6pozv>. ✦

OPPS: Provider-Based Gets Space

continued from p. 1

Notwithstanding CMS’s invitation for feedback from hospitals on the IFC, the changes in the final rule will take effect Jan. 1.

There is still more to the provider-based story in the OPPS regulation. CMS promised subregulatory guidance in three areas — the new modifier, PN; a new exception to the ban on relocating provider-based space; and cost reporting — and reminded hospitals that it is a compliance risk area.

“CMS came up with some useful shortcuts,” says Boston attorney Larry Vernaglia, with Foley & Lardner LLP. “You can add new services — that’s a big change from the proposed rule. It would have been a real challenge to keep an eye on what services you had in the past and never do it differently, and irrational for a health care delivery system that it couldn’t have had facilities grow and change with population needs.”

But the jury is out on how hospitals will fare under the final rule and its new 50% payment, notes Washington, D.C., attorney Andy Ruskin, with Morgan Lewis. “People have to dig into the details and figure out if they will be paid fairly and whether the billing mechanisms CMS established will be workable.”

The final regulation interprets Sec. 603 of the Bipartisan Budget Act of 2015, which said goodbye to OPPS billing in new off-campus provider-based space after Nov. 2, 2015, with some exceptions (*RMC 11/23/15, p. 1; 11/2/15, p. 1*). Provider-based departments that were billing the OPPS up to that date are grandfathered in, so they’re safe to bill the OPPS. But if they opened for business

after that, provider-based departments have to shop for a new payment system, such as the Medicare physician fee schedule. Exceptions include emergency departments and remote locations. The driver behind Sec. 603 is the fact that Medicare pays more for the same services when they're performed in provider-based space — a facility fee and a physician fee — compared to freestanding clinics.

The proposed OPSS rule was a shock to the hospital system (*RMC 7/18/16, p. 1*). Even off-campus provider-based departments that were grandfathered, which CMS now calls "excepted," were hit hard. They were not going to be able to add services, expand or relocate while continuing to bill the OPSS. In the final rule, CMS eased off some of the more Draconian aspects of the proposed rule, while injecting uncertainty in other ways.

CMS replaced the method it proposed for services that provider-based departments add after Nov. 2, 2015.

Before, they could bill the OPSS only for the items and services they billed when the clock struck midnight on Nov. 2, 2015, but new or expanded services from 19 clinical families were off limits. They were dubbed "non-excepted services," which meant they could be billed only by physicians under the Medicare physician fee schedule (at the higher facility rate). That left hospitals to enter contracts with physicians to ensure hospitals got their fair share, which lawyers said put them at risk of Stark and anti-kickback violations.

In response, CMS killed the clinical families idea. Coming up with a new plan probably wasn't easy because no version could include billing the OPSS, according to Sec. 603. The result: "CMS gave the industry half a loaf," Vernaglia says.

The final rule sets forth new rates for nonexcepted items and services under the Medicare physician fee schedule and it's half the OPSS amount, but hospitals

CMS Transmittals and Federal Register Regulations

Oct. 28 - Nov. 3

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Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- Instructions to Process Services Not Authorized by the Veterans Administration in a Non-VA Facility Reported With Value Code 42, Trans. 3635CP, CR 9818 (Oct. 28; eff. Oct. 1, 2013; impl. April 3, 2017)
- Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program – January 2017, Trans. 3636CP, CR 9792 (Oct. 28; eff. Jan. 1; impl. Jan. 3, 2017)
- January 2017 Quarterly Average Sales Price Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files, Trans. 3640CP, CR 9843 (Oct. 28; eff. Jan. 1; impl. Jan. 3, 2017)
- Correcting Editing for Condition Code 54 and Updating Remittance Advice Messages on Home Health Claims, Trans. 3630CP, CR 9826 (Oct. 27; eff. April 1; impl. April 3, 2017)
- New Physician Specialty Code for Hospitalist, Trans. 3637CP, CR 9716 (Oct. 28; eff. April 1; impl. April 3, 2017)

Pub. 100-06, Medicare Financial Management

- New Physician Specialty Code for Hospitalist, Trans. 274FM, CR 9716 (Oct. 28; eff. April 1; impl. April 3, 2017)

Pub. 100-19, Demonstrations

- IVIG Demonstration: Payment Update for 2017, Trans. 159DEMO, CR 9746 (Oct. 28; eff. Jan. 1; impl. Jan. 3, 2017)

Pub. 100-20, One-Time Notification

- Modifications to the National Coordination of Benefits Agreement Crossover Process, Trans. 17330TN, CR 9681 (Oct. 27; eff. April 1; impl. April 3, 2017)
- Network Fee Reduction for Acute Kidney Injury services submitted on Type of Bill 72x, Trans. 17380TN, CR 9814 (Oct. 27; eff. Jan. 1; eff. April 1; impl. April 3, 2017)

Federal Register Regulations

Final Rules

- *Correction*: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; Technical Changes Relating to Costs to Organizations and Medicare Cost Reports; Finalization of Interim Final Rules With Comment Period on LTCH PPS Payments for Severe Wounds, Modifications of Limitations on Redesignation by the Medicare Geographic Classification Review Board, and Extensions of Payments to MDHs and Low-Volume Hospitals, 81 Fed. Reg. 75328 (Oct. 31, 2016)
- CY 2017 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements, 81 Fed. Reg. 76702 (Nov. 3, 2016)
- Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record Incentive Programs; Payment to Nonexcepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing Program; Establishment of Payment Rates under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital (Fed. Reg. pub. date, Nov. 14, 2016)
- Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Medicare Shared Savings Program Requirements (Fed. Reg. pub. date, Nov. 15, 2016)

with provider-based departments will be able to stick with their UB-04 claim forms, which also allows costs and charges to flow through their cost reports and be reported on Medicare provider statistical and reimbursement reports. “We are using a rate that is 50 percent of the OPSS rate for each nonexcepted item or service, with some exceptions,” the final rule states. CMS will apply OPSS payment rules, including packaging logic, with some exceptions. For example, Medicare will pay separately for therapy, preventive services and drugs that are separately payable under OPSS, the rule states.

Hospitals can breathe a sigh of relief that CMS got rid of APC clinical families for excepted items and services. “That’s wonderful because hospitals won’t have claims where some of the services will be billed as OPSS and others will be billed as freestanding, which would have been a monumental task, and they won’t have to figure out how physicians will bill,” Ruskin says. “CMS is trying its best to make sure they don’t put hospitals into that jam.”

Vernaglia also thinks it’s “an extremely positive development for the hospital industry.” He was alarmed at the prospect of hospitals having to contract with thousands of physicians to share revenue from reimbursement as the 2017 proposed rule contemplated. “This would have created a blizzard of contracting and years of compliance clean-up,” Vernaglia says.

PN ‘Stands for Pain in the Neck’

When it reports items and services, provider-based departments must append the PN modifier to HCPCS codes for nonexcepted items and services. That makes it the second modifier required for provider-based billing, says Valerie Rinkle, president of Valorize Consulting. Starting Jan. 1, 2016, all hospitals had to report the PO modifier on line items for services delivered in off-campus provider-based departments. “Medicare will have both pieces of data, which will enable them by provider number to track if there’s a change in the mix and type of services provided,” she says. Presumably that will play into CMS’s decision on how to proceed after 2018, because the final rule said the 50% payment method may not be permanent.

“The PN modifier stands for pain in the neck,” Vernaglia jokes. However, the 50% payment rate allows hospitals to “model whether they could survive on 50% from Medicare.” Maybe not having grandfathered provider-based space isn’t the end of the world if hospitals can change their case mix or shift costs to commercial payers, Vernaglia says. No matter how you slice it, though, there are now the “haves and have nots of provider-based space: those that will be able to receive full OPSS reimbursement and those that will only get half.”

The hybrid of a new Medicare physician fee schedule payment and OPSS packaging seemed a little nonsensical to Rinkle and Ruskin. “What’s concerning is they are keeping packaging in the hospital but also allow separate payment for most individual services in freestanding clinics,” Rinkle says. “It seems to benefit freestanding clinics because they are paid for every drug and line-item service they perform, whereas CMS is retaining OPSS packaging concepts under this new form of the Medicare physician fee schedule applicable to non-excepted off-campus provider-based departments.” CMS is trying to accommodate clinicians, whose cooperation is needed for the exacting provisions of the Medicare Access and CHIP Reauthorization Act (MACRA), Rinkle notes.

Payment is not the only contentious area addressed in the final rule. Whether excepted provider-based departments can relocate without losing their status also took center stage. In the proposed rule, CMS said “no” — if provider-based departments leave their physical address, they no longer can bill the OPSS — although CMS dangled the possibility of an exception, such as natural disasters. Commenters hoped for more leeway, but that wasn’t in the cards. “Allowing unlimited relocation of an off-campus [provider-based department] would potentially result in relocation to larger facilities, with different equipment and staff and unbridled expansion of service lines,” the rule stated.

However, CMS adopted an exceptions process that’s limited to “extraordinary circumstances outside a hospital’s control.” Provider-based space stays that way despite relocation if it’s caused by “natural disasters, significant seismic building code requirements, or significant public health and public safety issues.” Exactly what does that mean? The answers will come in forthcoming subregulatory guidance on how hospitals request a relocation exception, which will be decided on a case-by-case basis by CMS regional offices.

“Relocation is a huge deal,” Ruskin says. “It’s very disconcerting they said this.” He’s concerned exceptions will be granted haphazardly; “some regional offices will say never and others will approve a lot.” CMS could

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have defined relocations by square footage, for example, or applied some other metric. “They gave short shrift to what a lot of commenters had to say,” probably because they used most of their bandwidth on the new payment methodology, Ruskin says. “CMS certainly has the authority to relax the relocation policy.” What happens if a provider-based space is bursting at the seams? And there’s merit to relocating to consolidate multiple service lines so patients don’t have to visit various outpatient locations to receive the services they need, he says.

Vernaglia also is disappointed in the “limited utility” of the relocation exception. Apparently CMS doesn’t have certain scenarios in mind. Suppose the landlord kicks out the provider-based department because he wants to rent it to Starbucks, he says. “What if the landlord realizes he has the hospital by the short hairs and raises rent from \$1,000 to \$10,000 a month or evicts? That is an extraordinary circumstance,” he says. But will CMS think so? Anyway, it’s unfortunate “they are kicking the can on permitting relocation, leaving it to CMS regional offices,” Vernaglia says.

There’s a clear program integrity bent to the rule, with CMS warning it will be watching hospitals to ensure they don’t play fast and loose with provider-based space. As the final rule states, “from a monitoring and enforcement perspective, we intend to follow traditional

practices, including prepayment and postpayment reviews to the extent applicable to ensure that hospitals are correctly identifying nonexcepted items and services. We expect that existing protocols used by program integrity entities will continue to be used to monitor and enforce appropriate billing of nonexcepted items and services. Hospitals will be expected to maintain documentation sufficient to prove that an off-campus PBD is an excepted off-campus PBD.”

CMS is guided in the regulation by its desire to curb hospital acquisitions of physician practices in keeping with Sec. 603. Medicare paid more for services at practices that were converted to provider-based space than it paid before the acquisition. And it’s not small potatoes, the final rule noted; according to a September 2016 study by the Physicians Advocacy Institute and Avalere Health, “hospital ownership of physician practices has increased by 86 percent and the percent of hospital-employed physicians increased by almost 50 percent from July 2012 to July 2015.”

The final 2017 OPPS rule will be published in the Nov. 14 *Federal Register*.

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NEWS BRIEFS

◆ **CMS said it has created a new physician specialty code for hospitalists**, according to *MLN Matters* 9716. The code, C6, takes effect April 1, 2017. “Make sure your billing staffs are aware of this physician specialty code,” CMS said. Visit <http://tinyurl.com/jxm6246>.

◆ **CMS eliminated separate hospital payments for “clinically unrelated” lab tests and killed the L1 modifier, which is used to identify unrelated lab tests on claims**, according to the final outpatient prospective payment system (OPPS) regulation, which was announced Nov. 1 (see story, p. 1). Lab tests are considered clinically unrelated when they are ordered by a different physician for a different diagnosis. CMS made the distinction between clinically related and unrelated lab tests in the 2014 OPSS regulation, when it packaged most lab tests into other services (*RMC 10/6/14, p. 1*). Hospitals have been permitted to bill Medicare separately for clinically unrelated lab tests using the L1 modifier. But the fledgling billing policy hasn’t exactly been a success, CMS says, so it will package unrelated lab tests

and forget about the modifier. Visit <http://tinyurl.com/h2ra7fd>.

◆ **A Medigap insurer’s proposed arrangement with a preferred hospital organization to discount Medicare inpatient deductibles and give \$100 credits to policyholders who use network hospitals for inpatient stays got a green light from the HHS Office of Inspector General (OIG)**. Even though the arrangement possibly could generate prohibited remuneration under the kickback law if there were the intent to induce referrals, OIG won’t impose sanctions, according to a new advisory opinion (16-11). The requestor asked if this arrangement would run afoul of the civil monetary penalty laws prohibiting kickbacks and beneficiary inducements or trigger exclusion. OIG concluded the proposed arrangement poses little risk. Among the reasons: The discounts and premium credits wouldn’t raise or affect per-service Medicare payments, and “the proposed arrangement would be unlikely to increase utilization,” according to the opinion. Visit <http://go.usa.gov/xkeuB>.

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