Medicare Regulatory Payment Issues Update

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Medicare Topics

• Provider-Based Scrutiny
  – OIG, CMS, and Mixed Use
• Supervision of Outpatient Services
• 2-Midnight Rule
  – Status and 68% Settlement Offer
Medicare: “Complex regulatory structure.”

"Truth and enlightenment are on another peak. I do medicare explanations."
Provider-Based: Basics

• Not a special designation or payment type.
  – "Provider based clinics."
  – "Provider based billing."

• THIS IS JUST HOSPITAL BILLING.
  – Facility fee on a UB-04.
  – Professional on 1500 with POS 21, 22 (unless CAH elects all-inclusive).
  – Just like traditional hospital-based doctors in ER, radiology, anesthesiology, etc...
  – Provider based status is NOT a special payment status - except for certain RHCs.
  – Hospital CoPs and payment rules apply (ex. supervision).
Provider-Based: Basics

• Regulation 42 C.F.R. § 413.65 defines what operations are part of a Medicare certified provider (vs. supplier).
• It determines what services can be billed under the Medicare provider number.
• Provider = hospital, CAH, SNF, HHA, Hospice, CORFs, RHC, FQHC, CMHC.
• Originally § 413.65 applied to ALL providers, but was amended in 2002 to effectively limit to hospitals/CAHs.
Provider-Based: Exclusions

• § 413.65 Not applicable to provider based status of:
  – ASCs, CORFs, HHAs, SNFs, Hospices
  – Inpatient rehab units
  – IDTF’s and clinical labs paid only on fee schedule
  – PT/OT/ST unless at a CAH or caps suspended*
  – ESRD - see § 413.174
  – Ambulance
  – Non-revenue producing departments

• With exclusions, § 413.65 effectively only applies to hospital outpatient departments and RHCs.

*PT/OT/ST cap currently applies to hospitals
Provider-Based: Definitions

- **Main provider** - provider that creates or acquires another entity to deliver additional services in its name, etc.
- **Campus** - physical area of main buildings and others within 250 yards.
- **Department of a provider** - facility or organization that is created or acquired by main provider to provide services in its name, etc.
Provider-Based: Definitions

- **Provider based entity** - separately certified provider owned by main provider (traditional “hospital based” concept) SNF, RHC, etc.
- **Remote location of a hospital** - another site that furnishes inpatient services.
- **Freestanding facility** - entity that is not provider-based.
Provider-Based: Requirements

- **Universal** requirements - all facilities or organizations:
  - **Common licensure** - if allowed by state law.
  - **Financial Integration** – must be included in hospital trial balance and allowable cost centers on cost report, same as any other hospital department.
  - **Clinical Integration** –
    - Same clinical oversight as any hospital department: Medical director, QA, UR, etc.
    - Medical records – unified retrieval system or cross reference.
    - Medical staff of site/facility have clinical privileges at hospital.
  - **Public Awareness** – patients must be aware when they enter facility that they are being treated as hospital patients.
    - signage, registration forms, phone listings, internet, marketing materials, etc must all use hospital name.
Provider-Based: Requirements

• **OFF-CAMPUS** sites must also meet:
  – *Common ownership* - same legal entity & governing body.
  – *Administration and supervision* -
    • same supervision as any other provider department.
    • HR, billing, payroll, benefits, records, purchasing, salary structure done by same employees.
  – *Location* - within 35 miles of main provider or meet market share test.
• Management contract rules apply.
• Joint venture prohibited.
Provider-Based: Requirements

• Required management contract terms – OFF-CAMPUS SITES:
  – provider’s control is clear.
  – provider employs all non-management employees providing patient care (excluding those that can separately bill – physicians, mid-level practitioners).
  – management personnel must follow provider policies.
  – manager’s policies must be approved by provider.
  – periodic written reports required.
  – on-site personnel subject to provider’s approval.
Provider-Based: Hospital Department Obligations

- Site of service indicator- professional component must be billed at facility payment rate (POS 22).
- All terms of provider agreement - deficiencies at any site jeopardize entire hospital provider status.
- Non-discrimination provisions applicable to physicians.
- EMTALA obligations:
  - On-campus – apply as part of hospital.
  - Off-campus – apply only if is a dedicated ED.
Provider-Based: Hospital Department Obligations

• Treat all Medicare patients as hospital outpatients (facility fee billed on UB-04).
• DRG 3-day payment window applies.
• Off-campus sites must provide notice of dual coinsurance (facility/technical & professional components) to each Medicare patient before services provided (unless emergent).
• Meet all applicable Medicare hospital conditions of participation.
  – includes hospital building code!
Provider-Based: Requirements

• A facility or organization cannot be provider based if all patient care services are furnished under arrangement.
  – “Facility” and “organization” not defined - used in definition of department.
  – UA defined elsewhere as any contract that prohibits “vendor” from billing Medicare directly.
  – Lithotripsy example.
Provider-Based: Requirements

- Joint Venture Rules.
  - **ON-CAMPUS** provider-based joint venture allowed if:
    - On campus of provider/owner
    - Can be PB to that owner only
    - No minimum ownership % required
    - Meets universal requirements and obligations (when applicable)
  - Complicated conundrum...
    - Bill by hospital on UB-04, but belongs to JV.
    - Requires UA type contract terms.
  - **OFF-CAMPUS** site cannot be provider-based if operated by a joint venture.
Provider-Based: Attestations

- Application to and/or pre-approval by CMS NOT REQUIRED.
  - Eliminated by 8/1/02 PPS regulations for FFY 2003.
- § 413.65 now says may submit “attestation:”
  - Notify CMS of provider-based locations.
  - State that applicable requirements met.
  - Attest to meeting obligations.
- May notify CMS of material changes.
- Voluntary - self monitoring process.
- Benefit of attestation is reduced look-back period.
Provider-Based: Attestations

• No official form published.
  – Use MAC sample format if it has one.
  – Send to MAC and copy to Regional Office.
    • On-campus – supporting documentation not required (recommend sending anyway).
    • Off-campus – required.
  – MAC may make determination.
  – RO should either approve or disapprove.
Provider-Based: Attestations

• Benefits of Attestation:
  – CMS only recoups excess payment back to date of attestation.
  – Triggers self-review of criteria.
  – Supports compliance process.
  – Educates staff on requirements.
  – § 413.65 says - not provider based because believed to be!!!!
  – TO FILE OR NOT TO FILE.
    • Consider possible grandfather protection.
  – BUT BE PATIENT – MAC/RO may be slow.
    • We have had non-responses and lost attestations.
Provider-Based: Financial Impact

- Amount of, or even any, increased revenue is **not automatic**, varies by:
  - specialty
  - payor mix
  - volume
  - rural vs. urban
- Must do case specific analysis.
  - Compare current physician payment to:
  - Hospital based payment:
    - Cost for technical component
    - Physician professional component only
    - “Facility” RVUs
Provider-Based: Public Awareness

• Public Awareness – Naming/Branding/Signage.
  – The Hospital name is required – a must!
  – Multiple tag lines are fine
    • Community Hospital
    • Mayberry Clinic
    • Spectacular Medical Group
    • Spectacular Health System
  – Hospital does not "need" to be first or biggest.
  – But, avoid fine print "Community Hospital"
  – Not just signage: marketing materials, registration, phone listings, websites....... (CMS does check!)
Provider-Based: Public Awareness

• Public Awareness – Naming/Branding/Signage.
  – Multi-hospital example:
    • 4 system hospitals in region – flagship & 3 outlying CAHs.
    • 200+ employed docs @ 15 clinic locations.
      – All locations provider based to 1 of 4 hospitals.
      – Some on-campus, some off-campus.
    • System going through corporate branding and wanted all 4 hospitals to have the same name.
  – We asked CMS regional office.
    • No prohibition on hospitals having same name, but....
    • Won't work here: patients at off-campus provider-based clinics won't know which hospital the site is based to.....
    • Patient needs to know which hospital.
Provider-Based – Recent OIG Focus

- OIG’s 2013 Work Plan.
  - Hospital-owned physician practices using provider-based status (new).
  - “We will determine the impact of hospital-owned physician practices billing Medicare as provider-based physician practices. We all also determine the extent to which practices using the provider-based status met CMS billing requirements.”
  - “In 2011, the [MedPAC] expressed concerns about the financial incentives presented by provider-based status and stated Medicare should seek to pay similar amounts for similar services.”
Provider-Based – Recent OIG Focus

- 2013 OIG Survey regarding provider-based services.
  - OIG sent information requests to hospitals regarding ownership and operations of provider-based facilities.
  - Hospitals selected at random based on Certification and Survey Provider Enhanced Reports data.
  - Stated purpose was “to determine the number of hospitals that own provider-based facilities.”
  - But, collected information could potentially result in additional OIG or CMS enforcement contacts with specific hospitals.
Provider-Based – Recent OIG Focus

• OIG’s 2014 Work Plan.
  – Impact of provider-based status on Medicare billing.
    • “We will determine the impact of subordinate facilities in hospitals billing Medicare as being hospital based (provider based) and the extent to which such facilities meet CMS’s criteria.”
  – Comparison of provider-based and free-standing clinics (new).
    • “We will review and compare Medicare payments for physician office visits in provider-based clinics and free-standing clinics to determine the difference in payments made to the clinics for similar procedures and assess the potential impact on the Medicare program of hospitals’ claiming provider-based status for such facilities.”
Provider-Based – Mixed Use

• CMS’ Position on Mixed-Use Locations.
  – CMS has become increasingly restrictive in its review and approval of mixed-use sites especially those where the provider-based and non-provider-based locations share the same suite.
  – Generally, the direction CMS seems to be headed is to require more separation of the freestanding vs. provider-based space.
Provider-Based – Mixed Use

• When reviewing these mixed-use locations, CMS:
  – Expects to see separate and distinct space for the provider-based services – including separate and distinct waiting rooms, entrances, signage, etc.
  – Focuses on the public awareness, life safety code and separate and distinct space.
  – Have seen denials based on mixed-use alone.
Provider-Based – Mixed Use

- Although may be technically possible to set up mixed-use site.
  - It would likely be complex and have higher risk of compliance issues, especially in light of CMS’ current position on the issue.
  - Would be difficult to satisfy the public awareness and clinical integration requirements, as well as the obligation for billing all Medicare patients in the “department” as hospital patients.
  - Possible and practical for off-campus provider-based clinics to be mixed use on a “suite by suite” basis.
Provider-Based – OPPS 2014

• Payment change for hospital outpatient departments for CY 2014.
• CMS collapsed the 5 levels of visit codes for both new and established patients into 1 code for facility payment (G0463).
• Single level of payment for all outpatient clinic visits except for emergency room visits.
• MedPAC strikes again: recent proposal to reduce payment for services in 66 APCs to more closely mirror payment under the MPFS.
Provider-Based – OPPS 2015

• CMS proposes to begin collecting data on services furnished in off-campus, provider-based departments beginning January 1, 2015.
• CMS will require hospitals and physicians to report a modifier for services furnished in an off-campus, provider-based department on both hospital and physician claims.
• Final Rule expected in November.
Outpatient Supervision

• Condition of Medicare payment for outpatient services.

• Direct supervision for “therapeutic” services.
  – “Immediately available” standard regardless of on-campus or off-campus location.
  – Can be a “clinically appropriate” mid-level provider.

• General, direct, or personal physician supervision for diagnostic services.
  – Level of supervision is determined by CMS.
    • MPFS look up for level assignment.
  – Condition of payment under OPPS; CAHs are not paid under OPPS.
Outpatient Supervision

• Applies to all hospitals and CAHs.
• Non-enforcement policy for CAHs and small rural hospitals (less than 100 beds).
  – September 9, 2014: H.R. 4067, introduced by Rep. Lynn Jenkins (R-KS), requires the Secretary of HHS to halt the enforcement of these supervision requirements for the remainder of calendar year 2014.
  – House passed the legislation by a voice vote; Senate received bill on September 14th.
Outpatient Supervision

• Exceptions to direct supervision requirement in 42 CFR § 410.27 (therapeutic services):
  – PR/CR/ICR: Separate conditions specified in regulations; only a physician can supervise.
  – Non-surgical extended duration therapeutic services (NSEDTS).
  – Advisory Panel on Hospital Outpatient Payment (The Panel) selected services.
  – CMS supervision file (June 2014):
    http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/OPPS-General-Supervision.pdf
2 Midnight Rule - Inpatients

• Before October 1, 2013, I/P admission was appropriate when a patient is generally expected to remain at least overnight.
  – Physicians instructed to use a 24-hour period as a benchmark.
  – CMS described the decision to admit as an inpatient as a “complex medical judgment, which can only be made after the physician has considered a number of factors.”

• Revised rules because of:
  – Concern about extended observations stays.
  – Medical necessity denials based on patient status.
2 Midnight Rule - Inpatients

- Effective October 1, 2013, I/P admission is generally appropriate when the physician expects the patient to require a stay that will span at least two midnights.
  - Applies to all hospital types including CAHs (except for inpatient rehab facilities).
  - The expectation of the physician must be documented in the medical record and should be based on such complex medical factors as:
    - patient history and comorbidities
    - severity of signs and symptoms
    - current medical needs
    - risk of adverse events
2 Midnight Rule - Inpatients

- Exception for unforeseen circumstances.
  - Death
  - Transfer
  - Other??
    - Unexpected improvement
    - Mechanical ventilation
2 Midnight - Inpatients

- In the 2014 IPPS Final Rule, CMS finalized the “2-midnight rule” which includes:
  - 2-midnight benchmark: Inpatient admission is generally appropriate if the physician admits a Medicare beneficiary with the expectation that the beneficiary will require care that “crosses 2 midnights.”
  - CMS stated that the admitting physician can consider all time spent at the hospital, including time spent receiving initial outpatient services, when estimating the beneficiary’s total expected length of stay.
  - 2-midnight presumption: States that claims for I/P services with lengths of stay greater than 2 midnights after admission order will generally be presumed to be appropriate.
Enforcement Delay in 2-Midnight Rule

• CMS delayed enforcement of the 2-midnight rule
  – Hospitals and practitioners are required to follow the 2-midnight rule for inpatient admissions beginning on October 1, 2013.
  – Regulation itself in effect (definition of inpatient admission).
  – Delay applies to Medicare Administrative Contractor (“MAC”) and Recovery Audit Contractor (“RAC”) reviews of inpatient admissions.
  – Delay period extended from 90 days to 180 days to 1 year + (March 15, 2015).
Enforcement Delay in 2-Midnight Rule

• Summary of delay:
  – Generally, RACs and other Medicare review contractors will not conduct post-payment patient status reviews of inpatient hospital claims with dates of admission on or after October 1, 2013 through March 31, 2015.
  – MACs and RACs NOT to review claims spanning greater than 2 midnights after admission, for a determination of whether the inpatient patient status was appropriate.
  – CMS will NOT permit RACs to review inpatient admissions of one midnight or less.
  – MACs and RACs will NOT review any claims related to critical access hospitals.
Enforcement Delay in 2-Midnight Rule

• Summary of delay (*cont.*)
  – However, if CMS finds evidence of “systematic gaming, abuse or delays in the provision of care in an attempt to surpass the 2-midnight presumption,” this could trigger further review.
  – During the delay period, MACs and RACs can continue reviews for other purposes, e.g., medical necessity of an underlying surgery.
  – Series of Open Door Forum calls to provide guidance and answer questions.
Enforcement Delay in 2-Midnight Rule

• During the delay period, MACs will conduct a probe review and education process for inpatient admissions
  – Will give non-punitive feedback on whether they are applying the 2-midnight benchmark correctly.
  – MACs will review a sample of 10 to 25 inpatient hospital claims spanning less than 2 midnights after admission.
  – This “probe sample” review will apply to prepayment records so if the MAC determines that the inpatient admission was not medically necessary, the hospital can rebill the claim under Medicare inpatient Part B.
Enforcement Delay in 2-Midnight Rule

- During the delay period, MACs will conduct a probe review and education process for inpatient admissions
  - If a MAC finds no issues, it will not conduct any further reviews for that hospital, unless there are “significant changes in billing patterns for admission.”
  - If a MAC identifies issues, the MAC will conduct education for that hospital and then conduct further follow-up reviews, as needed.
- Corrective action plans on provider specific basis.
- Provider concern levels categorized as minor, moderate, or major concerns.
Physician Certification/Order

• A physician order for an inpatient admission.
  – Previously was included in the conditions of participation.
  – Effective October 1, 2013 became a condition of payment.
• As a condition of payment for hospital inpatient services:
  – Physician must certify the medical necessity that the services be provided on an inpatient basis.
  – Certification includes an order to admit; order is a “critical element” of the physician certification.
Physician Certification

- Certification must include the following:
  - Authentication of the order.
    - The physician certifies that the inpatient services were ordered consistent with Medicare regulations governing the order.
    - Include certification that hospital inpatient services are reasonable and necessary.
    - For cases not on the “inpatient-only list” are appropriately provided as inpatient services consistent with the 2-midnight benchmark.
  - The reason for inpatient services.
    - Hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study; or
    - Special or unusual services for cost outlier cases under the IPPS.
  - The estimated/actual time the patient requires/required in the hospital.
  - Plans for post-hospital care, if appropriate.
  - For inpatient CAH services.
    - Physicians must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to CAH.
Physician Certification

• Timing:
  – Certification must be completed, signed, dated and documented prior to discharge;
  – CAHs: Certification must be completed prior to discharge.
Physician Certification

- Authorized to sign the certification:
  - Must be one of the following types of practitioners:
    - A doctor of medicine or osteopathy; or
    - A dentist or doctor of podiatric medicine in certain circumstances.
  - Must be signed by the practitioner responsible for the case, or another practitioner who has knowledge of the case and who is authorized to do so by the responsible practitioner or by the hospital’s medical staff.
  - Includes the:
    - admitting physician of record or a physician on call for him or her;
    - surgeon responsible for a major surgical procedure or a surgeon on call for him or her.
Physician Certification

• Authorized to sign the certification:
  – A practitioner who has admitting privileges at the hospital as permitted by State Law; and who is knowledgeable about:
    • The patient’s hospital course;
    • The medical plan of care; and
    • The patient’s current condition
  – Does not have to be the same person as the practitioner who signed the admitting order.
Physician Certification

• No specific format or procedures are required.
  – But information needs to be able to be verified.

• Absent a specific form, CMS will look for the following:
  – Physician signature or countersignature on the inpatient admission order.
  – Medical necessity of the inpatient services: Either the diagnosis and plan documented in the inpatient admission assessment or the inpatient admitting diagnosis and orders.
  – Time requirements: inpatient admission order that complies with 2-midnight benchmark, physician notes and discharge planning instructions.
  – Post hospital care plan: physician notes or discharge planning instructions.
  – CAH 96 hour expectation: either physician notes or by actual discharge within 96 hours.
Physician Order

- The order should be specific regarding “admit to inpatient.”
  - Orders such as “Admit to Medicine” or “Admit to Dr. Smith” may be considered an inpatient order if:
    - the interpretation is consistent with the remainder of the medical record.
    - but, physician should clarify any ambiguous orders before billed to Medicare.

- The practitioner order must be furnished at or before the time of the inpatient admission.
Physician Order

• The practitioner order must be furnished at or before the time of the inpatient admission.
• The order must be furnished by a physician or other practitioner who is:
  – licensed by the state to admit inpatients.
  – granted privileges by the hospital to admit inpatients.
  – knowledgeable about the patient’s hospital course, plan of care, and current condition of time of admission.
• Ordering practitioner determines medical necessity and renders the admission decision.
Physician Order

• The ordering practitioner is not required to write the order but must sign the order.
• May be, but is not required to be, the physician who signs the certification.
• Admission decision may not be delegated to another individual who is not authorized by state/hospital to admit.
  – Others may act as a proxy (resident, MLP or other NPP).
  – Ordering practitioner must counter-sign the order prior to discharge.
  – Applies to ED docs and “bridge” orders.
Physician Order and Certification


• “As a condition of payment for hospital inpatient services under Medicare Part A, section 1814(a) of the Social Security Act requires physician certification of the medical necessity that such services be provided on an inpatient basis. The order to admit as an inpatient (“practitioner order”) is a critical element of the physician certification, and is therefore also required for hospital inpatient coverage and payment under Part A. The physician certification, which includes the practitioner order, is considered along with other documentation in the medical record as evidence that hospital inpatient service(s) were reasonable and necessary. When a physician signs the certification, they are certifying that inpatient hospital services were reasonable and necessary.”
Physician Order and Certification

- Change proposed in CY 2015 rule:
  - CMS is proposing to rescind the requirement that a physician certify all hospital inpatient admissions.
  - CMS currently requires a physician certification, including an admission order, for all inpatient admissions. CMS is backtracking on the physician certification requirement for shorter patient stays and non-outlier stays, and appears to be taking the position that the admission order is a sufficient safeguard from both a Medicare beneficiary and trust fund protection standpoint.
  - Therefore, an admission order would continue to be required for all inpatient admissions, but the physician certification would only be required for outlier cases and long-stay cases of 20 days or more.
2 Midnight Rule in Practice

- Work with case managers and physicians to understand the “2-midnight benchmark” for appropriateness of admission.
- Medically necessary hospital stay = screening tools can still be helpful but inpatient criteria not determinative.
- Documentation is critical: reason for hospital care, expectation of stay beyond 2 midnights, formal inpatient admission order, required elements of physician certification.
- Order/certification is a condition of payment.*
- Order only valid if practitioners have admitting privileges (authenticate verbal and “bridge” orders).
- Timing issues: certification must be completed prior to patient discharge.*
- Consider impact of MAC response during probe and educate process to paid claims.

* May be impacted by CY 2015 proposals related to certification.
68% Settlement Offer

- CMS believes that the changes in Final Rule 1599-F (published in August 2013) will not only reduce improper payments under Part A, but will also reduce the administrative costs of appeals for both hospitals and the Medicare program.

- To more quickly reduce the volume of inpatient status claims currently pending in the appeals process, CMS is now offering an administrative agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment (68% of the net allowable amount).

- CMS encourages hospitals with inpatient status claims currently in the appeals process or within the timeframe to request an appeal to make use of this administrative agreement mechanism to alleviate the administrative burden of current appeals on both the hospital and Medicare system.
68% Settlement Offer

- Hospitals should send their request by October 31, 2014. Providers who aren’t able to meet this timeframe should request an extension from CMS.
- **Note:** Effective 10/15/2014, if a hospital is unable to produce a list of all eligible claims in a timely manner, the hospital may submit a request for a “Potentials List.” CMS will respond within 2 business days with a list of POTENTIALLY eligible claims at Level 2 and above.
- Email to: [MedicareAppealsSettlement@cms.hhs.gov](mailto:MedicareAppealsSettlement@cms.hhs.gov)
68% Settlement Offer

• “All or nothing” process.

• AHA letter to CMS in September questioned RAC fees:
  – “Hospitals have informed us that they consider the decision on RAC fees to be one of fundamental fairness that will impact their evaluation of the terms of CMS’s offer. . . . [b]ecause hospitals have been asked to accept partial payment in order to alleviate the significant strain on the appeals system, we expect that CMS has required a corresponding financial sacrifice from the RACs.”

• Letter from Chairman of the Ways and Means Committee Kevin Brady (R-TX) to HSS Secretary Sylvia Burwell challenging the authority of CMS to continue with the settlements.
  – Criticizes HHS for its quiet handling of the manner; urges HHS to provide an explanation for its authority to engage in an “all or nothing” settlement process to wipe out some of the agency’s backlog of administrative appeals at a set 68 percent reimbursement rate.
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