Report on
MEDICARE COMPLIANCE

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Weekly News and Analysis on New Enforcement Initiatives and Billing/Documentation Strategies

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Go to www.AISHealth.com for summaries of the U.S. House and Senate health reform bills.

*PUBLISHER'S NOTE: **RMC** is taking a two-week holiday break and will return on Jan. 11. Seasons greetings and happy 2010.*

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CMS Fleshes Out New Billing Rules as the Sun Sets on Medicare Consultation Codes

With consultation codes on their way to Medicare oblivion, CMS is scrambling to explain the impact of this policy change on hospitals and physician practices. On Dec. 14, the agency issued a transmittal (1875) that describes how evaluation and management (E/M) codes will replace consultation codes in different scenarios, and on Dec. 17 updated an *MLN Matters* article on consultation code policy, partly to correct a coding error.

At an open-door forum Dec. 15, CMS said it will shed more light on a problem that has surfaced regarding the lowest level of consultation that can be billed under E/M codes. Meanwhile, Sen. Arlen Specter (D-Pa.) filed an amendment to the health reform bill that would delay elimination of the consultation codes for one year. Amid all the fuss, providers are struggling to minimize the reimbursement fallout and protect their coding compliance.

Last summer, CMS proposed parting ways with consultation codes in the Medicare physician fee schedule regulation *(RMC 7/20/09, p. 1)*. The regulation, which takes effect in January, was finalized in November. It means that Medicare contractors will no longer recognize CPT consultation codes for inpatient facility and office/outpatient settings (except telehealth consultation G-codes). This sounds simple enough, but there are far-reaching reimbursement and compliance implications, experts say.

Inpatient consult codes (99251 to 99255) and office/outpatient consult codes (99241 to 99245) will be Greek to Medicare. Instead, consults will be reimbursed through regular E/M codes. For example, when patients are in the hospital and physicians perform an initial evaluation, they will report initial visit codes 99221 to 99223. Physicians will use 99231 to 99233 for subsequent hospital visits.

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Hospital Settles Case Over Teaching MD's Lack of Presence, Use of Preprinted Forms

University Pediatricians, a Detroit faculty practice plan, agreed to pay $91,782 to settle civil monetary penalty (CMP) allegations stemming from claims submitted for a teaching physician who allegedly didn't show up to supervise medical fellows who were performing services, according to the settlement with the HHS Office of Inspector General. Instead, the teaching physician allegedly told the medical fellows to place preprinted, pre-signed forms in the patients' medical records, says Elizabeth Callahan-Morris, the attorney for University Pediatricians.

Medicare doesn't pay teaching physicians separately for services provided by residents they supervise unless the teaching physicians are physically present for key portions of the services. (Medical fellows and residents are virtually the same thing.) University Pediatricians was unaware that the teaching physician wasn't physically present when it billed for her services, says Callahan-Morris, with the Troy, Mich., office of Hall, Render, Killan, Heath & Lyman.

continued

After a compliance review of the use of the preprinted forms, University Pediatricians self-disclosed its overpayments to OIG. That led to the settlement, which invokes the CMP law that authorizes fines for Medicare and Medicaid false claims submissions. University Pediatricians primarily sends claims to Michigan Medicaid, which mimics Medicare's teaching physician rules, but sometimes it also bills Medicare.

The case evokes memories of the national enforcement project "Physicians at Teaching Hospitals" (PATH), during which the Department of Justice and HHS OIG conducted audits and investigations and settled with numerous hospitals over Medicare Part B claims for teaching-physician services. Though the PATH enforcement project is over, billing for teaching physicians remains a threat to compliance, says Ed Gaines, chief compliance officer for Medical Management Professionals in North Carolina, who was not involved in the University Pediatricians case.

"A lot of people think none of this matters anymore, but that's farcical given the history of success of PATH audits and the self-disclosures by many teaching hospitals," says Gaines, a lawyer and compliance veteran. Teaching-physician billing in the PATH context is on his list of top three risk areas. The reason, he says, is "there seems to be a lack of real understanding at the hospital and physician-group management level of the significance of Medicare's policy with respect to residents." Medicare is already paying hospitals and faculty-practice plans directly for the residents' education, he notes. So it's "double dipping," he says, for teaching physicians to bill Medicare again when residents perform services — unless teaching physicians are physically present at the key portion of the residents' services, document the key portions of their evaluation and management (E/M) services and link their documentation to the residents' documentation. (See Medicare transmittals 1780 and 811, and Section 100 of the Program Integrity Manual.)

And now that smaller hospitals are increasingly training residents, a new wave of compliance problems are cropping up with teaching-physician billing, Gaines says. The physicians in these hospitals may have one day's notice that family-practice residents, for example, will be cycling through the emergency department. "That small hospital never had residents before and may not be up to snuff on the documentation, coding and billing rules in this area," Gaines says.

Electronic medical records may also play a role in sabotaging compliance, he says. Some EMR systems freeze the chart after the resident documents patient care and authenticates his or her services (i.e., signs the chart electronically). When the teaching physician enters the EMR system to do the same thing (as required for Part B billing), access is blocked, Gaines says. "Both of them have to document and authenticate the medical records," Gaines notes. Setting up the EMR system this way might make sense for other reasons — to prevent altering medical records, for example — but an exception must be made for the teaching physician/resident dynamic.

Preprinted Forms Used Generic Language

University Pediatricians was able to contain the damage from the teaching physician's alleged misuse of preprinted forms because "it was reported and reviewed," Callahan-Morris says. Based on the compliance review, it appeared that the teaching physician skipped the physical presence part of patient exams, which means residents did the work, but the preprinted, signed forms made it seem like she was there, Callahan-Morris says. That allowed the faculty practice plan to submit Medicare Part B claims for

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her services in addition to the Medicare reimbursement it receives for training residents.

The preprinted form, called a "teaching physician statement," contained standard language that would normally be documented by a teaching physician in real time (e.g., "saw and evaluated the patient, discussed the patient's care with the resident or fellow, and agree with findings"), Callahan-Morris says.

She says the administration was unaware of the practice. When the preprinted forms were eventually brought to the administrator's attention, the compliance department was asked to look into the issue. Information that came back supported the need for an investigation of the teaching physician's compliance with physical presence rules, Callahan-Morris says. "That's a testament to University Pediatricians having in place a compliance program to address any concerns on documentation and billing."

Settlement Amount Is Mostly Repayment

Ultimately, University Pediatricians "concluded she billed for evaluation and management services without being physically present," Callahan-Morris says. "They didn't have confidence she was there based on the documentation." Because claims were submitted by University Pediatricians on her behalf between Jan. 1, 2003, and July 21, 2005, it was responsible for the overpayment. As part of the OIG self-disclosure protocol, Callahan-Morris says University Pediatricians audited a sample of her claims and extrapolated them to come up with a repayment of about $73,000. The other $18,000 of the settlement amount is a fine, which the lawyer characterizes as small.

There was no apparent financial motive. As an employee, the teaching physician did not personally benefit from reimbursement generated by the claims that were submitted for her services, Callahan-Morris says. As the employer, University Pediatricians collected the overpayments. Ultimately, the teaching physician resigned, she notes.

Notwithstanding the settlement, Callahan-Morris says that "preprinted forms are not prohibited." Teaching physicians who are physically present should be able to take documentation shortcuts like preprinted forms, as long as they sign the forms in real time and perform the services as noted. "But pre-signed forms and stickers can present an opportunity for them to be misused, and this can outweigh any efficiency benefits they may create."

Callahan-Morris notes that University Pediatricians is a nonprofit, and provides about $2 million in uncompensated care per year. It's affiliated with Detroit Medical Center and Wayne State University School of Medicine.

Contact Callahan-Morris at ecallahan@hallrender.com and Gaines at egaines@cbizmmp.com. ✧

DOJ-HHS Strike Force Expands to Brooklyn, Tampa and Baton Rouge

HHS and the Department of Justice announced on Dec. 15 the expansion of the successful Medicare Fraud Strike Force into three more major cities. The feds also charged 30 people for their alleged roles in schemes to submit more than $61 million in false Medicare claims.

Strike Force operations now will begin in Brooklyn, N.Y., Tampa, Fla., and Baton Rouge, La., federal officials say. The effort is a multi-agency team of federal, state and local investigators who use data analysis techniques and "an increased focus on community policing," officials said in a press release. The operation began in 2007 in south Florida, then expanded to Los Angeles in 2008, and to Detroit and Houston in May 2009.

Also in 2009, HHS and DOJ introduced the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a task force of top-level law enforcement officials and prosecutors *(RMC 5/25/09, p. 4)*, to aid the Strike Force's operations.

In the criminal cases announced simultaneously with the Strike Force expansion, 30 people are charged in five different indictments, the feds say:

◆ ***Detroit***: Defendants in two cases allegedly paid kickbacks to patients who received instructions from clinic owners and patient recruiters to feign symptoms to justify expensive testing, such as nerve conduction studies.

◆ ***Brooklyn:*** Two defendants allegedly billed for durable medical equipment, such as shoe inserts for diabetes patients, when much less expensive over-the-counter items were provided. The beneficiaries often didn't need the items, the feds add.

◆ ***Miami***: A physician and several registered nurses were among 15 people charged with allegedly defrauding Medicare of $40.8 million for home health care services. In a separate indictment, four defendants were charged for their parts in a scheme to defraud Medicare of $5.8 million of HIV infusion services.

Since its inception in 2007, the Strike Force has indicted more than 460 people and organizations that have billed Medicare for more than $1 billion, the feds say.

Fort Lauderdale, Fla., attorney Gabriel Imperato says he expects that federal officials will continue to "follow the fraud" and expand the Strike Force as needed. "I would guess that there probably are no limitations on how expanded and intensified the federal government's efforts can get," says Imperato, who is with the Broad and Cassel law firm.

Contact Imperato at gimperato@broadandcassel.com. Visit www.justice.gov. ✧

OIG: Alabama FI Should Recoup $1.5M in High-Dollar Payments

Cahaba Government Benefit Administrators, LLC, the fiscal intermediary (FI) for Alabama, will collect more than $1.5 million in overpayments resulting from high-dollar payments to providers in calendar years 2004 through 2006, says an OIG audit report (A-04-08-00039) released Dec. 14.

High-dollar payments are a hot topic right now. OIG releases audit reports about them almost daily, and they are a favorite target of recovery audit contractors *(RMC 2/9/09, p. 7)*.

In calendar years 2004 through 2006, fiscal intermediaries nationwide processed and paid nearly 41 million inpatient claims, more than 8,000 of which resulted in high-dollar payments of $200,000 or more, OIG says. During that audit period, Cahaba processed almost 1 million inpatient claims, 97 of which were high-dollar payments made to hospitals for inpatient services. Forty-nine of those payments were appropriate, but the remaining 48 included overpayments, the audit says.

Cahaba made the inappropriate payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place to detect and prevent them, OIG says. The FI also made one erroneous payment because it used an incorrect wage index in determining the payment. Cahaba told OIG this was due to a data entry error.

Here are two examples of the types of high-dollar overpayments Cahaba made:

◆ One hospital submitted a claim for 7,980 units of service for blood factor instead of 79.8 units. Its manual billing process did not divide the blood factor units by 100, as Medicare required at the time. As a result, Cahaba overpaid the hospital $511,799.

◆ Five hospitals submitted 23 claims without supporting documentation. As a result, Cahaba overpaid the hospitals $186,914.

OIG recommends that Cahaba recover the $1.5 million in overpayments, use the audit results in provider education activities, and consider implementing controls to identify and review inpatient payments greater than $200,000.

Cahaba agreed with OIG's findings and recommendations. The FI said that it would wait for direction from CMS before implementing controls to identify high-dollar overpayments.

To read the report, go to AIS's Government Resources at the Compliance Channel at www.AISHealth.com, and click on "OIG Audit Reports." ✧

Conn. MD Pays Higher Settlement Over Lack of Compliance Program

A Connecticut medical practice has agreed to pay almost $100,000, well above the amount of the damages, to resolve allegations that it violated the False Claims Act. Thomas Greco, M.D., P.C., a two-physician practice in Waterbury that specializes in rheumatology and allergies, self-disclosed to the HHS OIG that it received Medicare payments for infusion therapy services that were not rendered, the U.S. Attorney's Office for the District of Connecticut said Nov. 24.

The practice submitted Medicare claims totaling more than $66,000 between April 2006 and November 2008 for administering the drug Rituxan or intravenous immune globulin, according to the settlement. The practice did not admit liability.

The settlement amount is 1.5 times the amount of the damages.

Gregory Pepe, the attorney representing the practice, says a former employee embezzled from Greco and attempted to cover up the missing funds by replacing them with billings for services that were never performed. The settlement amount includes a penalty the feds added because of the practice's lack of a compliance program, Pepe explains.

"The resulting adverse publicity from the U.S. attorney's press release on the recovery, and the attendant media attention, coupled with the penalty being assessed, adds complexity to any practice's decision about whether to self report," he adds. The parties settled to avoid the delay, uncertainty, inconvenience and expense of protracted litigation, the settlement says.

Visit www.justice.gov/usao/ct. ✧

Improving Compliance With the Inpatient-Only Rule

These 40 changes to the 2010 Medicare inpatient-only list were identified by cross-checking Addendum B and Addendum E from the outpatient prospective payment system (OPPS) regulation (RMC 11/23/09, p. 1)*. Cheryl Rice, vice president and chief corporate responsibility officer for Catholic Healthcare Partners in Ohio, developed this method for capturing all changes. The inpatient-only list — which describes procedures covered by Medicare only when performed on an inpatient basis — is updated annually in Addendum E. But Rice has found that hospitals may overlook procedures that have been added or deleted from the inpatient-only list if they rely solely on Addendum E. This chart also reflects annual CPT coding changes and text from the OPPS rule, which takes effect Jan. 1. Contact Rice at clrice@health-partners.org.*

Delete (D) = code has been removed from the IP Only List effective 1/1/2010 and placed into clinical APCs or CPT code deleted.
Add (A) = code has been added to IP Only List in 2010 — per Addendum E and/or Addendum B (*Federal Register* 11/18/09)
HOPD = hospital outpatient department
C status = inpatient only; NI status = new code, new interim code, or code with substantial revision(s); T status = procedure has been removed from the inpatient-only list and is a significant procedure subject to reduced payments when performed with other significant procedures paid an APC under the OPPS.

	CPT/1 HCPCS/2	HOPD Status Indicator	Short Description	Replacement or Related Coding/Pair	Comments on Changes Made or Proposed Changes to Be Made
D	01632	C	Anesth, surgery of shoulder		CPT code deleted effective 1/1/2010
D	21256	T	Reconstruction of orbit		Removed from IP Only List effective 1/1/2010, now payable as a T status under APC 0256
D	23221	C	Partial removal of humerus		CPT code deleted effective 1/1/2010
D	23222	C	Partial removal of humerus		CPT code deleted effective 1/1/2010
D	27079	C	Extensive hip surgery		CPT code deleted effective 1/1/2010
D	27179	T	Revise head/neck of femur		Removed from IP Only List effective 1/1/2010, added to APC 0052 as T status
D	28805	T	Amputation thru metatarsal		Removed from IP Only List effective 1/1/2010, added to APC 0055 as T status
A	33782	C-NI	Transposition of the Great Vessels		Added in 2010 per Addendum B and E. No mention in IP Only text.
A	33783	C-NI	Transposition of the Great Vessels		Added in 2010 per Addendum B and E. No mention in IP Only text.
A	33981	C-NI	Replacement of ventricular assist device		Added in 2010 per Addendum B and E. No mention in IP Only text.
A	33982	C-NI	Replacement of ventricular assist device		Added in 2010 per Addendum B and E. No mention in IP Only text.
A	33983	C-NI	Replacement of ventricular assist device		Added in 2010 per Addendum B and E. No mention in IP Only text.
D	35641	C	Artery bypass graft		CPT code deleted effective 2008
D	37215	T	Transcatheter stent, cca w/eps	replaced 0005T-0007T; see also 0075T,0076T or 37205,37206	Removed from IP Only List effective 1/1/2010, added to APC 0229 with a T status; Added to IP Only List effective 1/1/2005 per 11/17/04 *Federal Register*, Addendum E — new 2005 CPT
A	43281	C-NI	Laparoscopic surgical hernia repair		Added to IP Only List in 2010 per Addendum B and E. Not in IP Only text.
A	43282	C-NI	Laparoscopic surgical hernia repair		Added to IP Only List in 2010 per Addendum B and E. Not in IP Only text.
A	43775	C-NI	Lap removal adjust gastric band/ port		Added to IP Only List in 2010 per Addendum B and E. Not in IP Only text.
D	43842	C	Gastroplasty for obesity		Removed from IP Only list CY 2008 — procedure is not covered.
D	44950	T	Appendectomy		Removed from IP Only List effective 1/1/2010, added to APC 0153 with a T status
D	44955	T	Appendectomy add-on		Removed from IP Only List effective 1/1/2010, added to APC 0153 with a T status
D	51060	T	Removal of ureter stone		Removed from IP Only List effective 1/1/2010, added to APC 0163 with a T status
A	61630	C	Balloon angioplasty		Added to IP Only List in 2010 per Addendum B and E. Not in IP Only text.
A	61635	C	Transcatheter placement of stent(s)		Added to IP Only List in 2010 per Addendum B and E. Not in IP Only text.

continued

Consultation Codes to Be Replaced

continued from p. 1

These codes apply to visits by both attending physicians and consulting specialists. (Codes vary for consults in different settings, such as observation and nursing facilities.)

"In all cases, physicians shall bill the available code that most appropriately describes the level of the services provided," according to the Medicare transmittal (Change Request 6740).

CMS contends that physicians who perform consultations won't take any big financial hit. "To compensate specialists for the loss of revenue through the loss of consult codes, CMS raised certain E/M payments," says Millie Johnson, institutional compliance officer for Texas Tech University Health Sciences Center. The relative value units (RVUs) for new and established patients were increased by 6%. The RVUs for hospital and nursing facility visits were raised by 0.3%.

Because numerous specialists may treat patients in hospitals and nursing facilities, CMS created a modifier to distinguish their consults from services provided by the attending or admitting physician. The "principal physician of record" is required to append modifier "AI" to the initial visit code. "The modifier will identify the physician who oversees the patient's care from all other physicians who may be furnishing specialty care," states the *MLN Matters* article (6740) on the coding changes.

Don't confuse the new AI modifier (I as in "eye") with the existing A1 modifier (1 as in "one"), which is used when providers dress one wound, says Gretchen Segado, deputy compliance officer for hospital and professional fee billing at Children's Hospital of Philadelphia.

Consultation codes remain in the CPT 2010 book, which means commercial payers may continue to pay

Improving Compliance With the Inpatient-Only Rule (continued)

	CPT/1 HCPCS/2	HOPD Status Indicator	Short Description	Replacement or Related Coding/Pair	Comments on Changes Made or Proposed Changes to Be Made
D	63076	T	Neck spine disk surgery		Removed from IP Only List effective 1/1/2010, added to APC 0208 with a T status
D	99251	C	Initial inpatient consult		While these codes have not been 'officially' deleted from CPT, Medicare will consider them invalid for payment effective 1/1/2010
D	99252	C	Initial inpatient consult		While these codes have not been 'officially' deleted from CPT, Medicare will consider them invalid for payment effective 1/1/2010
D	99253	C	Initial inpatient consult		While these codes have not been 'officially' deleted from CPT, Medicare will consider them invalid for payment effective 1/1/2010
D	99254	C	Initial inpatient consult		While these codes have not been 'officially' deleted from CPT, Medicare will consider them invalid for payment effective 1/1/2010
D	99255	C	Initial inpatient consult		While these codes have not been 'officially' deleted from CPT, Medicare will consider them invalid for payment effective 1/1/2010
D	99295	C	Neonatal critical care	use 99468	CPT code deleted effective 1/1/2010
D	99296	C	Neonatal critical care	use 99469	CPT code deleted effective 1/1/2010
D	99298	C	Neonatal critical care	use 99478	CPT code deleted effective 1/1/2010
D	99433	C	Normal newborn care/hospital	use 99462	Added to IP Only in 2005 per *Federal Register*
D	0077T	C	Cereb therm perfusion probe	use 61107, 61210	Removed from IP Only List effective 1/1/2010
A	0202T	C	Posterior vertebral joint(s) arthroplasty		New Category III code effective 7/1/2009
A	0219T	C-NI	Placement of posterior implant(s)		New Category III code effective 1/1/2010
A	0220T	C-NI	Placement of posterior implant(s)		New Category III code effective 1/1/2010
A	G0425	C-NI	Telehealth IP consult wth the patient		Added to IP Only List in 2010 per Addendum B and E. Not in IP Only text.
A	G0426	C-NI	Telehealth IP consult with the patient		Added to IP Only List in 2010 per Addendum B and E. Not in IP Only text.
A	G0427	C-NI	Telehealth IP consult with the patient		Added to IP Only List in 2010 per Addendum B and E. Not in IP Only text.

claims with consultation codes. That's a big headache for hospitals and physicians, says Holly Louie, corporate compliance officer at Practice Management, Inc., in Boise, Idaho. Some Medicare beneficiaries are still employed and have commercial insurance as their primary payer and Medicare as their secondary payer. When commercial payers stick with CPT consult codes, then specialists are in a bind. If specialists bill for consults using CPT consult codes, they can bill the private (primary) payer only for the 80% and have to abandon the 20% because Medicare will reject consult codes. But if specialists bill for consults using E/M codes, they can pick up payments from both the commercial payer and Medicare.

"Most practices will likely see little or no change in the reimbursement amount," whether they bill only the commercial payer using the consult code, or they bill both payers using the E/M service for the consultation, Johnson says.

Kick Out Secondary-Payer Claims for Review

But the scenario is still tricky for several reasons. Louie notes that many commercial payers don't implement new CPT codes — which come online every January — until April or even later.

This is an operational hassle that invites errors. Hospitals and physician practices will need edits so they can kick out claims that have consult codes for the purpose of billing commercial payers, Louie says. "If the system identifies that this is Medicare and it's coded as a consult or it is a commercial payer and not coded as a consult, the claim will kick out so the coder can manually review it," she says. Of course, it's always possible this particular problem will go away. "It's my Christmas wish that AMA will drop consult codes from CPT and all payers will be on the same page," says Segado.

Hospitals and physicians also have to figure out how to compress the original five codes for hospital consultations into the three new E/M codes for initial hospital care. "There were five consult codes to choose from and now there are only three," Louie says. That means "no one-to-one correlation," Segado notes. She and Louie see this as a compliance minefield; "CMS has not given clear guidance on how this issue should be resolved, saying only to follow the advice of your contractor medical director. Many institutions are developing crosswalks for internal use," Segado says.

Segado notes that "the burning issue is what to do for initial hospital care that doesn't meet the lowest level E/M code" but would have been considered a low-level consult before. CMS officials said at the open-door forum that they will probably provide advice on this. In the meantime, CMS officials said, providers should do as their Medicare administrative contractor or carrier sees fit. Some providers have been advised to use an unlisted E/M procedure code for consults that don't rise to the lowest-level initial hospital care visit. There are unlisted CPT codes available for items and services, such as new surgeries, that don't fit neatly into an existing code or haven't been assigned a new code yet. However, "this also creates an operational nightmare because the claim must be dropped to paper and additional information provided when billing an unlisted code," Johnson says.

Observation Consultation Coding Clarified

As the sun sets on Medicare's use of consultation codes, CMS issued a long transmittal explaining the transition to E/M codes and how it should play out.

Louie is concerned by language in the transmittal that doesn't mesh with the physician fee schedule regulation eliminating Medicare's acceptance of consultation codes. The Nov. 25 final rule states that physicians will bill for initial patient visits to hospitals and nursing facilities "in lieu of the consult code," she says. But the transmittal, which becomes official Medicare policy in the Medicare Claims Processing Manual, does not contain the phrase "in lieu of." Without that phrase, Louie says, "everyone bills initial care" for all initial visits. She thinks this is just a CMS oversight. But if not corrected, physicians could keep billing initial care codes instead of subsequent hospital codes, possibly triggering overpayments, Louie says.

The transmittal also enters some new territory. "This transmittal provides more changes that were not discussed in the final rule, specifically with respect to the use of prolonged services codes and threshold times that need to be met before prolonged services can be billed," Johnson says. The transmittal addresses prolonged services in detail, and contains a chart with threshold times for prolonged visit codes 99354 and/or 99355 billed with office/outpatient and consultation codes.

Also, the transmittal clarifies the purpose of observation services and consultations, and CMS's expectation of when relevant codes should be used. For example, Johnson says, in the case of observation patients who are not subsequently admitted to the hospital as inpatients, the physician who orders observation must use observation codes (99217-99220), while the physician who provides consultation services must use the appropriate office E/M codes for new or established patients. However, if the patient is admitted to inpatient hospital status from observation on the same date, the consultant should use the appropriate initial hospital visit code for the first visit.

"Payment for an initial observation care code is for all the care rendered by the ordering physician on the date the patient's observation services began. All other physi-

cians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes," the transmittal says. "For example, if an internist orders observation services and asks another physician to additionally evaluate the patient, only the internist may bill the initial observation care code. The other physician who evaluates the patient must bill the new or established office or other outpatient visit codes as appropriate."

Contact Louie at holly@pmiboise.com, Johnson at millie.johnson@ttuhsc.edu and Segado at segado@email.chop.edu. View the transmittal on the CMS Web site at www.cms.hhs.gov. ✧

NEWS BRIEFS

◆ **Our Lady of Lourdes Health Care Services Inc., the parent company of two New Jersey hospitals, has agreed to pay $7.95 million to resolve allegations that the hospitals defrauded Medicare,** the Department of Justice (DOJ) said Dec. 15. A whistleblower lawsuit filed in 2005 alleged that Lourdes Medical Center in Willingboro, N.J., fraudulently inflated charges to obtain outlier payments for cases that were not extraordinarily costly. Based on these allegations, DOJ conducted a separate investigation of Our Lady of Lourdes Medical Center in Camden, N.J. In a prepared statement, the company says it "emphatically asserts that the Medicare outlier payments it received were appropriate." Lourdes does not admit liability and agreed to settle to avoid protracted and costly litigation, it adds. Tony Kite, the whistleblower, was an independent hospital consultant. He will receive $365,000 as part of the settlement. Visit www.justice.gov.

◆ **More adjustments to Medicare inpatient payments will be needed to recoup overpayments caused by 2008 document and coding improvements (DCI) so that payments to providers aren't slashed in 2011,** the Medicare Payment Advisory Commission (MedPAC) said at a Dec. 10 meeting. On MedPAC's recommendation, "CMS adopted MS-DRGs in 2008 to improve severity measurement and payment accuracy," a transcript of the meeting says. The DCI shifted cases from lower severity and cost MS-DRGs to higher severity and cost groups in each base DRG. But a recalibration of 2008 payment weights failed to prevent an unwarranted increase in payments, so by law CMS can make a separate prospective adjustment to offset the expected increase, MedPAC explained. Current law would allow CMS to change the base payment rates in 2010, 2011 and 2012. But for 2010, "CMS decided not to make any adjustment to either recover the known overpayments in 2008 or to prevent further overpayments from occurring." A total adjustment in 2011 would come to 5.9%, "which is 2.6% to recover overpayments and 3.3% to prevent further overpayments," MedPAC said. To recoup accumulated overpayments and prevent them in the future, MedPAC suggests in a draft recommendation that Congress implement a 1% reduction per year to the inpatient base payment amount. To read the meeting transcript, go to www.medpac.gov, and click on "Public Meetings."

◆ **Out of 100 sampled claims from those submitted by Care Alliance of America, Inc., a comprehensive outpatient rehab facility in Florida, 97 claims did not meet Medicare reimbursement requirements,** OIG says in an audit report (A-04-05-02011) posted Dec. 11. Care Alliance received $2 million in calendar year 2003 for more than 6,000 claims for physical therapy, speech language pathology, and occupational therapy services, OIG says. The 97 sample claims included 812 services that did not meet requirements for reporting service units, 240 that did not meet documentation requirements, 104 that did not comply with the written plan of treatment, and 30 that were not medically necessary. Based on the sample results, OIG estimates that the company received more than $1.6 million in 2003 for services that did not meet Medicare's requirements. OIG recommends that Care Alliance refund the $1.6 million in claims and follow the company's own policies and procedures for reporting therapy services. Care Alliance generally disagreed with OIG's findings on many of the disallowances. OIG revised some of its findings because the company provided additional documentation, but stands by the rest of the audit. An HHS action official will make any final determinations. To read the report, go to AIS's Government Resources at the Compliance Channel at www.AISHealth.com, and click on "OIG Audit Reports."

◆ **CORRECTION:** Mary Riordan was a speaker at the Dec. 7 Web conference sponsored by the Health Care Compliance Assn. and the Society of Corporate Compliance and Ethics. An article in the Dec. 14 issue of *RMC* misspelled her name.

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