Report on
Medicare Compliance

Volume 21, Number 3 • January 23, 2012

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

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As Infusion Grows More Complex, Hospitals Trigger Overpayments, Revenue Losses

With advances in cancer treatment, hospital outpatient departments are administering more complex chemotherapy regimens and, in the process, opening themselves up to billing errors.

Because nurses typically give a patient several chemotherapy and nonchemotherapy drugs during an encounter, they may make mistakes on the forms used to charge Medicare and other payers. That results in overpayments *and* lost revenue for hospitals for drug administration. Hospitals also may be cheating themselves out of reimbursement for the more intense patient education required in this environment, experts say.

"Sicker patients can now be safely treated in the outpatient setting and you will see them getting three or four chemo agents plus three or four premeds [i.e., anti-nausea drugs] plus hydration. Keeping track of the charge capture process is challenging," says Stephen Gillis, director of billing compliance for Massachusetts General Hospital in Boston.

Elaborate billing rules tend to mask certain mistakes, and as a result, neither Medicare nor hospital billing systems can detect certain errors by checking drug-administration codes against the drugs themselves.

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'Evergreen' Contracts Can Help Avoid Stark Law Violations, but They Aren't a Cure-All

After renting space to a physician group in its brand-new office building, a hospital found itself between a Stark rock and a hard place.

The hospital calculated the lease rate based on the capitalized cost of constructing a new facility so it could make reasonable returns on the new structure. The lease called for automatic renewals triggered by the physician-tenants, with rent increases tied to the consumer price index (CPI). That had its advantages — the hospital never committed the common Stark sin of unwritten or expired contracts — and the lease kept chugging along. But 15 years later, with no fair-market valuation and no policies guiding its Stark behavior, the hospital was in trouble. Other tenants were grumbling because they paid more than the first tenants. Clearly it was time to update the lease. But how could the hospital resolve the Stark problem when it was at the mercy of the physicians, who had all the leverage?

"Is it commercially reasonable for a landlord to lock itself into a lease that can end up running for decades at the unilateral option of the tenant with no contractual out clause or other mechanism to re-set rates if they get out of whack?" asks Milwaukee attorney David Edquist, who helped the hospital out of its mess. The answer is that the government might say "no" if it were to investigate the arrangement.

continued

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Managing Editor
Nina Youngstrom
nyoungstrom@aishealth.com

Associate Editor
BJ Taylor

Executive Editor
Jill Brown

This hospital's experience is an argument for policies and procedures governing financial relationships. It sounds like a no-brainer, but compliance officers would be surprised at the number of hospitals that lack policies, says Edquist, with the law firm von Briesen & Roper. "Sometimes it's because responsibility is diffused," he says. "Multiple people are approving arrangements so no one [person] is putting it together." But policies are critical for compliance and can soften the blow if a violation occurs. "If you get into trouble, policies help when the government may exercise discretion about whether to prosecute and whatever sentencing recommendation to give," says Edquist, who spoke at a Jan. 11 webinar sponsored by the Health Care Compliance Assn.

The Stark law bars Medicare payment for designated health services (e.g., inpatient and outpatient services) referred by physicians who have a financial relationship with the DHS entity, unless an exception applies (see box, p. 3).

Edquist says DHS entities should *have* policies on:

- Fair-market value and commercial reasonableness,
- Leases, and
- Personal services/medical direction.

He says DHS entities should also *consider* policies on:

- Physician recruitment,
- Non-monetary compensation,
- Marketing,
- Physician practice acquisitions,
- Joint ventures,
- On-call services,
- Gainsharing, and
- Loans and guarantees.

Fair-market value is at the heart of Stark compliance. Or, as the U.S. District Court for the District of Columbia Circuit said in the American Lithotripsy Society 2002 decision, "payment exceeding fair market value is in effect deemed payment for referrals."

Transactions Must Be Fair-Market Value

Edquist says that all transactions with referral sources must be fair-market value. "That's plain and simple," he says, but it doesn't mean appraisals will be plain and simple. Appraisers in other industries can take into consideration factors that don't fly in health care. For example, when considering physician compensation, obviously the value of their referrals is not part of the equation. An appraiser's inclusion of an aspect of physician referrals is partly what got Bradford Regional Medical Center in Pennsylvania into Stark trouble *(RMC 3/21/11, p. 1)*.

DHS entities must have a credible process for determining fair-market value. They should consider the use of fair-market value methodology. For example, did they hire an outside appraiser to assess fair-market value? Did they use regional or national survey information (e.g., Medical Group Management Assn. data)? If it's a lease, did a broker provide information? "You can't just rely on what the hospital next door paid for a physician practice," Edquist says. Is there documentation to establish that arrangements are negotiated at arm's length? It should be clear the hospital could not have obtained the same item or service elsewhere, for less money.

The files of DHS entities should include documentation for all of these things, as well as the fully executed, current copy of the contracts. "We have run into situations where we have a current copy, but there were side deals clients entered into and they don't wind up in the files," Edquist says. For example, the parties might agree to add services or reduce space, and adjust payments accordingly, but then fail to document this in a written amendment. "Everyone needs to be singing off the same sheet of music."

He says DHS entities may want to consider describing fair-market value in different contexts, with separate poli-

Report on Medicare Compliance (ISSN: 1094-3307) is published 45 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

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cies for each (e.g., physician-practice acquisitions, leases, employment). "Specify how you get to fair-market value," he says. For example, include when it is appropriate to pay higher rent (e.g., to reflect recent renovations).

Edquist relayed the following example of a fair-market value policy, which comes from a regional hospital in Texas: "The hospital will ensure that all physicians and other potential referral sources have written leases, the rent payable under the leases is consistent with fair market value (without taking into account the volume or value of any referrals or other business generated between the parties), all leases would be commercially reasonable even if no referrals were made between the parties, and all rental payments are either current or appropriate collection proceedings are being pursued." This policy applies to its office space and equipment leases with physicians and other potential referral sources, Edquist says.

Although fair-market value grabs all the attention, don't forget commercial reasonableness, another core element of Stark compliance. It can be addressed in fair-market value policies, Edquist says. It's possible for

Applying the Stark Law to Your Arrangements

Health care organizations can use these flowcharts to help them determine whether the Stark law applies to their financial relationships, and gain insight about what exceptions might be available. Contact attorneys David Edquist and Michele Bergholz Frazier of the law firm von Briesen and Roper at dedquist@vonbriesen.com and mfrazier@vonbriesen.com.

Does Stark Apply?

Does physician refer patient(s) for designated health services that are covered by Medicare to a health care entity with which it has a financial relationship?

Yes → What type of financial relationship?

No → Stark law not implicated

Direct

Does Hospital Meet Any Direct Compensation Exceptions? (42 CFR § 411.357)

(a) Rental of Office Space
(b) Rental of Equipment
(c) Bona fide employment relationship
(d) Personal Services Agreement
(e) Physician recruitment
(f) Isolated transactions
(g) Certain arrangements with hospital
(h) Group practice arrangements with hospital
(i) Payments by a physician
(j) Charitable donations by a physician
(k) Non-monentary compensation (<300)
(l) Fair Market Value compensation
(m) Medical staff incidental benefits
(n) Risk-sharing arrangements
(o) Compliance training
(q) Referral services
(r) Obstetrical malpractice insurance subsidies
(s) Professional courtesy
(t) Retention payments in underserved areas
(u) Community-wide health information system
(v) Electronic prescribing items and services
(w) Electronic health records items and services

Indirect

Does Hospital Meet Indirect Compensation Exception? (42 CFR § 411.357(p))

(1) Fair market value and does not take into account volume or value of referrals or other business generated by the referring physician for the entity furnishing designated health services
(2) If compensation is based on a lease arrangement, rental fees may not be based on a (a) percentage of revenues generated through use of the space or equipment, or (b) per-unit-of-service charges reflecting services to patients referred between the parties.
(3) In writing, signed by parties and sets out items or services covered by the arrangement
(4) In compliance with anti-kickback statute

Direct Compensation

- FMV for services and items actually provided
- No consideration of volume or value of referrals or other business generated by the referring physicians for the DHS entity
- Terms are in writing (few exceptions)
- Agreement is signed by both parties
- Services/items are specified
- Don't involve counseling or promotion of an activity that violates the law
- Must be comercially reasonable
- Must be one year (few exceptions)
- Compensation terms are set in advance (few exceptions)

Indirect Compensation

- FMV for services and items actually provided
- No consideration of volume or value of referrals or other business generated by the the referring physicians for the DHS entity
- Terms are in writing (except employment)
- Agreement is signed by both parties
- Services/items are specified
- No violation of the anti-kickback statute or any federal or state law governing billing or claims

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an arrangement to be fair-market value but not commercially reasonable. For example, it's not commercially reasonable to pay multiple physicians to serve as the medical director for the same department when you only need the services of one, even if they are all being paid a fair market value rate.

DHS entities may have tracking systems and/or assign contract officers to keep tabs on contracts, and both are effective tools to prevent Stark violations from, for example, expirations. However, they can be expensive. Another option is "evergreen contracts." Considering the number of Stark violations involving expired contracts, it's handy to have contracts that roll over year after year. Evergreen contracts automatically renew, with both parties reserving the right to terminate on 30, 60 or 90 days of notice, without cause, Edquist says. "There's no termination date so you avoid the risk of expiration," he says. The down side, however, is they "pose the risk of staleness and encourage laziness." DHS entities that choose this route should build in reminders to review the contracts periodically to ensure compensation is still fair-market value and the other terms are commercially reasonable.

Edquist also says "cheat sheets" help speed the process of reviewing physician contracts at renewal time, which should improve Stark compliance (see box below). Instead of hunting and pecking through a long contract for relevant terms that may need updating, the cheat sheets run down the key elements — a relief for DHS entities that may have dozens or even hundreds of contracts.

In addition to Stark policies, DHS entities need to demonstrate they have processes for complying with the law. For example, Edquist says, "if an organization adopts a process for confirming the fair market value of compensation that complies with IRS guidelines, that process gives you a double benefit: it helps the organization from a Stark/fraud and abuse compliance perspective, and also helps to protect the organization's 501(c)(3) status by qualifying for a rebuttable presumption that the compensation was reasonable for IRS purposes."

Sample Part-time Lease: Terms and Cheat Sheet

Hospitals and other health care organizations that are under Stark's spell must have written contracts with physicians that are commercially reasonable and call for fair-market compensation. If they expire, hospitals must return all Medicare reimbursement stemming from services referred by physicians who are paying a hospital (e.g., for office space) or receiving money from a hospital (e.g., for administrative services). But renewals are often overlooked by busy hospitals and physicians. To simplify and expedite the contract-renewal process, hospitals may want to use cheat sheets that just require them to review the key terms, such as compensation, says Milwaukee attorney David Edquist, with von Briesen and Roper. "You can revise this rather than revising the entire agreement," he says.

Part-Time Lease — Sample Terms

Part-Time/Reserved Block Leases

Space Description. Landlord leases Tenant {one room per time block} [1] {within the space identified on Exhibit A (attached floor plan)} [2] and shared use of the waiting area, reception area and dictation area identified on Exhibit A (the **"Common Areas"**). Tenant shall have exclusive use of one room per time block during periods reserved by Tenant. Tenant may lease more than one time block at the same time. {Landlord will assign Tenant to use any room (or rooms depending on the number of time blocks reserved by Tenant) listed on Exhibit A [3] Other tenants may occupy other rooms during Tenant's reserved time.

Rent. Tenant shall pay Landlord rent for the Leased Space. Furnishings and Services as set forth on Exhibit B. {Tenant shall pay rent to Landlord monthly, in advance, without prior demand} [4] {Tenant shall pay Landlord for all reserved time blocks regardless of whether Tenant actually uses all reserved time blocks} [5] The reserved block rate shall {adjust annually effective on the start of each renewal term, to reflect changes in the consumer price index ("CPI",} [6] The index to be utilized for such adjustment shall be "All cities—All urban consumers - U.S. All items, 1982 - 84 + 100," prepared by the Bureau of Labor Statistics of the U.S. Department of Labor or any successor index. If Tenant fails to pay rent within ten days after the due date, Tenant shall pay a [$___] late payment penalty (the **"Late Fee"**). Landlord is entitled to all remedies to collect all unpaid amounts pursuant to this Agreement, including without limitation, the Late Fee, collection expenses, including actual attorneys' fees and costs of any action or proceedings. The parties agree that the payments are consistent with fair market value in an arms length transaction and were not determined in a manner that takes into account the volume or value of Tenant's referrals to Landlord.

Part-time Lease Cheat Sheet

EXHIBIT B

Tenant shall pay Landlord rent no later than the ___ day of each month.

Half Day Block (__hours) $_____ Full Day Block (__hours) $_____

Number of Reserved Blocks (Annual): Half Day_____ Full Day _____

Monthly Rent Due: $_________ (Amount due for all reserved blocks divided by 12)

Half Day Block (__hours) $_____ Full Day Block (__hours) $_____

Number of Reserved Blocks (Annual): Half Day_____ Full Day _____

Monthly Rent Due: $_________ (Amount due for all reserved blocks divided by 12)

Effective: __________ Approved: LL _____ Tenant __________

He explains that "compensation is presumed to be at fair-market value" if these three parts are met, reflecting the IRS rebuttable presumption of reasonableness: (1) an authorized body whose members have no conflicts of interest approve compensation; (2) compensation is based on a reliable set of data; and (3) the authorizing body has a documented basis for setting pay.

Contact Edquist at dedquist@vonbriesen.com. ✧

OIG Finds Errors in Readmissions Audit as Area Moves to Forefront

The HHS Office of Inspector General is cracking down on same-day hospital readmissions against the larger backdrop of reduced Medicare payments for readmissions within 30 days.

OIG on Jan. 12 announced its first audit report on same-day readmissions since unveiling it as a topic on the 2012 Work Plan *(RMC 11/14/11, p. 1)*. In the report (A-03-10-00013), auditors examined same-day readmissions at University of Pittsburgh Medical Center Presbyterian Shadyside Hospital, a 1,312-bed acute care facility. The hospital received $913,555 for 47 readmissions in 2008 and 2009, which means an inpatient was discharged and readmitted on the same day. OIG reviewed 27 of these cases and concluded that seven of them were improper because the second admission should have been combined with the initial hospital stay.

As a result, the hospital collected overpayments of $26,547, which OIG said were caused by insufficient training to review and prevent same-day readmissions.

According to the Medicare Claims Processing Manual (Chapter 3, Sec. 40.2.5), hospitals must combine the bills of patients who are discharged or transferred from an acute care prospective payment system hospital and readmitted to the same hospital on the same day for symptoms or evaluation and management services related to the original stay. In other words, Medicare expects hospitals to treat the admission and readmission as a continuous stay. When readmissions are unrelated — for example, were a patient to get in a car crash on the way home from the hospital and return to the emergency room — hospitals can charge a second MS-DRG. But they must indicate the admission is for a different reason by using condition code B4.

In a letter at the back of the OIG report, the Pittsburgh hospital said it has repaid the overpayment and improved its training. "The Care Managers were retrained on how to review these claims. After the initial review by the Care Management Staff, the cases are sent to the Physician Advisor for final recommendation on the readmission decision. The process enhancement to include the physician advisor review was implemented in May of 2011 for the Presbyterian campus and September 2011 for the Shadyside Campus. Additionally, we have added periodic monitoring of same day readmissions to our compliance plan to support ongoing compliance," according to a letter, which was co-signed by the CFO and chief compliance officer. "UPMC is committed to having a strong compliance program with ongoing training and monitoring to support accurate billing."

Readmissions are a hot potato for hospitals. In addition to OIG scrutiny, the health reform law requires CMS to implement the "hospital readmissions reduction program" for discharges on or after Oct. 1, 2012. So far, the program is being implemented for three diagnoses — acute myocardial infarction, heart failure and pneumonia — with respect to readmissions within 30 days. The final 2012 inpatient prospective payment system rule explains how payments to hospitals will be reduced when they readmit patients within 30 days of discharge and describes the methodology that will be used to calculate excess readmission rates.

Everyone Should Be Looking at Readmissions

Against this backdrop, "there's a big push for everyone to look at readmissions across the board," says Catherine Hicks, manager of compliance for University of Colorado Hospital in Aurora.

Some disease processes fall into MS-DRGs that are more prone to readmissions. "We have work groups working on congestive heart failure and pneumonia because we recognize that across the country, those are two diagnoses that people who are readmitted often have," she says. But she warns against using a "retroscope to say 'patients came back the next day so obviously they were not stable for discharge.'"

Sometimes patients who are discharged with all conditions appearing stable wind up back in the hospital through no fault of the hospital, which will get dinged, she notes. For example, some patients are admitted for wound treatment after being in an accident and then, when they go home, will relax in a recliner without moving around much, except in ways that irritate the wound. The wound gets infected, so the patients return to the hospital for IV antibiotics. "Medicare says it's our fault," she says. Another example is congestive heart failure

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patients who are discharged and then immediately readmitted after eating salty foods. "If they're very fragile, it could happen overnight," Hicks says.

In terms of billing, University of Colorado Hospital prevents compliance problems by involving case management. If the readmission seems related, the bills are combined. "Case management follows the person and reviews the medical records," Hicks says. "They report to patient finance to say 'yes, it should be combined', or 'no, it's totally separate,' and then we put B4 on the claim."

But Hicks says hospitals should be wary of the coding contradiction around readmissions. According to coding guidelines, when there are two or more diagnoses that could warrant principal-diagnosis status, hospitals are allowed to decide which should be principal, and obviously they pick the diagnosis that groups to the higher-paying MS-DRG. But suppose the hospital coder picks congestive heart failure on admission and readmission, even though pneumonia qualified as the principal diagnosis on one of these. "You put yourself in a bad place because you have caused yourself to have a readmission for the same diagnosis, even though that may not have been the case," Hicks says. The coder made a strategic decision based on physician documentation of both diagnoses, forgetting about the possible readmission penalty. But that decision may not reflect a readmission for a premature discharge or inadequate follow-up care. The message here, Hicks says, is that "all departments should talk to each other to understand the intricacies and ramifications" of the readmission policy.

Contact Hicks at Catherine.hicks@uch.edu. ✧

Infusion Can Be Complex to Code

continued from p. 1

To improve compliance, hospitals should ensure they bill for all drug administrations — and do it in the right order as set forth by Medicare, he says. "But infusion coding is not intuitive," Gillis contends.

According to Medicare, hospitals are required to bill for initial and sequential infusions of each drug using time-based CPT codes. The longer the infusion, the more reimbursement, with Medicare paying more for initial infusions because they require set up (see box, p. 7). That puts a premium on the documentation of start and stop times, also called "up/down times." *But there's a twist:* regardless of the order in which infusions or injections are administered, they are reported to Medicare in a certain order. The CPT manual put it in hierarchy form to help hospitals apply Medicare rules on drug-administration reporting:

- ◆ Chemotherapy infusions,
- ◆ Chemotherapy injections,
- ◆ Non-chemotherapy therapeutic infusions,
- ◆ Non-chemotherapy therapeutic injections,
- ◆ Other injections, and
- ◆ Hydration.

Applying this in the real world can be like falling down the rabbit hole. Hospitals often misunderstand the rules, says Barbara Carter, compliance analyst and educator at Mass General. For example, only one initial infusion can be billed per patient encounter. "Often people will bill an initial infusion in each category and they

CMS Transmittals and *Federal Register* Regulations
For the week of January 9 - 13

Transmittals ((R) indicates replaced transmittal)

Pub. 100-01, Medicare General Information, Eligibility, and Entitlement
- Allowing Physician Assistants to Perform Skilled Nursing Facility Level of Care Certifications and Recertifications, Trans. 76, CR 7701 (Jan. 13; impl. Feb. 13, 2012)

Pub. 100-02, Medicare Benefit Policy Manual
- Allowing Physician Assistants to Perform Skilled Nursing Facility Level of Care Certifications and Recertifications, Trans. 153, CR 7701 (Jan. 13; impl. Feb. 13, 2012)

Pub. 100-04, Medicare Claims Processing Manual
- January 2012 Update of the Hospital Outpatient Prospective Payment System (R), Trans. 2386, CR 7672 (Jan. 13; impl. Jan. 3, 2012)
- Quarterly Update to the Correct Coding Initiative Edits, Version 18.1, Effective April 1, 2012, Trans. 2384, CR 7726 (Jan. 13; impl. April 2, 2012)
- FISS Claims Processing Updates for Ambulance Services (R), Trans. 2383, CR 7557 (Jan. 12; impl. April 2, 2012)

Pub. 100-06, Medicare Financial Management
- Notice of New Interest Rate for Medicare Overpayments and Underpayments - 2nd Notification for FY 2012, Trans. 203, CR 7570 (Jan. 11; impl. Jan. 19, 2012)

Pub. 100-08, Program Integrity
- Advanced Diagnostic Imaging (ADI) Accreditation Enrollment Procedures (This CR Fully Rescinds and Replaces CR 7177), Trans. 402, CR 7681 (Jan. 13; impl. Jan. 27, 2012)

Federal Register Regulations

Link to the rules at www.federalregister.gov/articles/current; in the menu on the right, find the date of publication and CMS.

Final Rule
- Medicare Advantage and Prescription Drug Benefit Programs: Negotiated Pricing and Remaining Revisions; Prescription Drug Benefit Program: Payments to Sponsors of Retiree Prescription Drug Plans, 77 Fed. Reg. 1877 (Jan. 12; eff. March 12, 2012)

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should not," she says. Hospitals should bill Medicare only for the initial purpose of the visit, and if that is chemotherapy, "that trumps everything."

Hospitals also lose revenue when they neglect to charge for "premeds," Carter says. For example, Medicare Part B covers the potent anti-nausea drug Emend — which is an OIG audit target *(RMC 11/14/11, p. 1)* — only when it's part of a three-drug cocktail with Dexamethasone and a 5-HT3 antagonist (e.g., Zofran). "If the nurses forget to charge one of the other two drugs, you could unnecessarily open your hospital up to audit because in the OIG's eyes, you shouldn't be paid for Emend," Gillis says.

Another common error is failure to document infusion start and stop times. If the stop time is missing, hospitals are only paid for an IV push, regardless of how long the infusion lasted, Carter says. Medicare pays much less for an IV push and it may not be an accurate description of what took place.

Underlying these types of errors is the fact that infusion nurses manage both the medical and charge aspects of drug administration. Their focus, of course, is quality of care. But it means nurses may wait until the end of the day to fill out encounter forms, which are used for billing, Carter says. "They try to recall all the meds they gave to patients, which opens up the possibility of errors," she notes.

Here's an example of how daunting drug administration compliance can be now that "chair time has increased significantly," Carter says.

The nurse administers the chemo drug Gemcitabine to the patient for 120 minutes (CPT code 96413, initial chemo up to one hour, and CPT 95415, each additional 31 minutes). The oncologist also orders two more chemotherapies: Oxaliplatin for 62 minutes (CPT 96417, chemo infusion up to one hour) and an IV push of 5 fluorouracil, known as FU, (CPT 96411, chemo infusion under 16 minutes). Concurrently, the patient is receiving calcium leucovorin (CPT 96368), a nonchemotherapy drug that supplements the chemo. But that's not all. There are the premeds, other drugs that address the effects of the chemo (e.g., nausea, vomiting, anxiety). The patient gets separate IV pushes of Zofran, dexamethasone, Benadryl and Ativan (each billed under CPT 96375). Then the patient is administered hydration (CPT 96361 for each additional hour, greater than 30 minutes). Hydration is a mistake waiting to happen because hospitals can only bill Medicare if it lasts at least 31 minutes, and yet the minutes don't count when hydration runs simultaneously with chemotherapy, Carter says. Finally, the patient receives a different form of hydration designed to boost electrolytes diminished by the chemo: calcium and magnesium (96367 or, if it runs two hours, 96368).

That's a lot of drugs and a lot of start-and-stop time documentation. Medicare messes with your mind a bit because "the longest running chemo administration should be the initial one [on the bill], regardless of the order it is given," Carter notes.

Within infusion CPT codes, Medicare includes payment for routine patient education and counseling (perhaps less than 15 minutes). But some patients

Infusion Billing Fundamentals

With nurses expected to juggle more infusion balls during the typical patient encounter, it's easy to make a mistake that either costs hospitals revenue or causes an overpayment. This description was written by Barbara Carter, compliance analyst and educator at Massachusetts General Hospital. Contact her at bacarter@partners.org.

Infusions: Key Elements

Initial Service

- Bill only 1 initial code per visit
- The initial code represents the purpose of the visit and is billed irrespective of the order of the infusions
- When chemo is administered, it is always the initial code
- The longest running chemo should be the initial code regardless of the order administered
- Do not select an initial code in both chemo and non-chemo categories

Concurrent

- 2 different drugs mixed in separate bags flowing in through the same vein at the same time
- Only 1 concurrent code can be used per encounter
- Use the concurrent category that corresponds to the type of infusion: chemo vs non-chemo

Sequential

- Following completed administration of a previous drug.
- Greater than 30 minutes rule does not apply to these drugs.
- Use the sequential code that corresponds to the infusion time, e.g. <16"; up to 1 hour (16-60")
- Use specific codes for repeated doses of same medication given >31" apart

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need more time because, for example, they are anxious or have a learning disability or adverse reaction (e.g., a rash), Carter says. Hospitals may bill separate evaluation and management services (99211-99215) when nurses go above and beyond in this department, she says. Hospitals should use the E/M coding criteria they developed for facility fees, at CMS's direction, under the outpatient prospective payment system, and add modifier 25 to signify there's been a significant, separately identifiable service. "The challenge is to make sure your nurses understand the criteria so they know when they have done more than what's bundled into the procedure," Gillis says.

Drug administration errors are virtually undetectable in claim pre-submission editing systems on the front end of the hospital billing process, Gillis says. The reason is that claims logic in billing systems won't pick up on incongruities. The logic sees a chemo drug and looks for a chemo infusion code. Two chemo drugs on the claim can pass the claim logic with only one chemo infusion code, he says. The number of units reported on the claim form is not evaluated as part of the logic. That means the hospital could be over- or under-reporting infusion administration codes and units and this would not be flagged for secondary review, Gillis says.

The same concept applies for non-chemo drug administration codes, which is an argument for internal audits of drug administration, especially before Medicare watchdogs come your way, he contends.

Mass General has both prevention and detection measures in place. Its nurse manager for the infusion unit reviews all encounter forms daily in conjunction with a coder. And Mass General does routine audits in this area. Every quarter, Carter audits 20 to 30 infusion nurses, "10 cases apiece." A detailed report on the results is shared with the nurse managers, who use them in education. "We are seeing improvement," Carter says. "The nurses do amazingly well for the number of patients they see per day and the complexity of regimens and complexity of rules."

Contact Gillis at sjgillis@partners.org and Carter at bacarter@partners.org. ✧

NEWS BRIEFS

◆ **Eastern Connecticut Hematology and Oncology (ECHO) has agreed to pay $316,513 to resolve allegations that it violated the False Claims Act,** according to the U.S. Attorney's Office for the District of Connecticut. The feds allege that between Jan. 1, 2001, and March 31, 2008, ECHO used unlicensed medical assistants to administer injections of medications, including Epogen, Neupogen, Neulasta and Aranesp. Because medical assistants are not authorized to administer medication in Connecticut, ECHO allegedly submitted false claims to Medicare, Medicaid and TRICARE. In entering into the settlement agreement, ECHO did not admit liability, according to the U.S. attorney's office. ECHO's attorney did not return *RMC's* request for comment.Visit www.justice.gov/usao/ct/.

◆ **Larry Bernhard, a podiatrist in Gambrills, Md., was sentenced on Jan. 11 to 54 months in prison for bilking Medicare out of $1.1 million,** according to the U.S. Attorney's Office for the District of Maryland. Bernhard was also sentenced to three years of supervised release and ordered to pay over $1.1 million in restitution. According to his plea agreement, Bernhard admitted that immediately after signing a settlement agreement in 2007, which included exclusion from Medicare, Medicaid and all other federal health care programs, he billed Medicare Advantage plans and collected $1.1 million. Of the $1.1 million received by Bernhard, at least $1 million was allegedly for services not rendered, said the U.S. attorney's office. Bernhard also admitted that he used the names and personal identifying information of approximately 200 nursing home patients to submit claims for podiatry care that he never performed, according to the plea agreement. Visit www.justice.gov/usao/md/Public-Affairs/index.html.

◆ **RAC audits are generally the responsibility of the compliance department,** according to a new survey by the Health Care Compliance Assn. Overall, 57% of the 418 survey respondents reported that their organizations have one full-time employee dedicated to RAC audits, and 27% have two dedicated FTEs. The numbers did not vary much based on the size of the organizations, HCCA reported on Jan. 18. Even among organizations with 5,000 or more employees, 64% had three or fewer FTEs working on RAC audits. The survey also found that RACs were not throwing budgets out of whack. Half of respondents reported that budgets had not increased at all, and 5% reported that budgets had decreased slightly. Just 10% reported a significant increase as a result of RAC audits. To view a copy of the survey, go to http://tinyurl.com/6t4oyh3.

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