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Outpatient PPS poses a web of compliance traps

Final rule goes into effect in just two weeks, with numerous billing questions still unanswered

Hospitals that were hoping the implementation date for the hospital outpatient prospective payment system (PPS) would be pushed back beyond Aug. 1 should expect no such reprieve, according to the Health Care Financing Administration (HCFA). Another delay is always possible, but don't count on it, says one agency official. That leaves hospitals facing a host of unanswered questions, many of which could land them in trouble with federal regulators.

In fact, Sacramento, CA-based Sutter Health's chief compliance officer, **Sheryl Vacca**, warns there are as many as two dozen issues related to the new payment system that could pose compliance problems for hospitals. She says the myriad issues included in the outpatient PPS loom like a huge spider web. "If you are not accurately coding, that is a compliance issue; and if you do not group them correctly, you won't be reimbursed correctly," she warns.

Department of Health and Human Services' (HHS) Office of Inspector General (OIG) **Mac Thornton** responded to similar concerns voiced by the Chicago-based American Hospital Association (AHA) June 26 by asserting that when honest mistakes or negligence result in erroneous claims, the hospital will be asked to return the funds without penalties. But he added that even "inadvertent billing errors" are a "significant drain" on the Medicare program, and hospitals must be vigilant to avoid them.

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HHAs brace for wave of Medicare appeals

Home health agencies (HHAs) facing implementation of the Medicare home health prospective payment system (PPS) in two months should brace for even more Medicare appeals than they now confront. "Home health is going to be vulnerable every day in every way," warns **Ann Howard**, executive director of the Washington, DC-based American Federation of HomeCare Providers.

Medicare will not only have its fiscal intermediaries scrutinizing providers, it will also have its new Medicare Integrity Program contractors closely

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HCFA outlines exceptions to final Stark II regulation

The prohibitions against health care provider self-referral, commonly referred to as Stark I and Stark II, are routinely attacked by critics for their complexity. In fact, there are so many exceptions to the law as written that many health care attorneys refer to it as "an exception statute."

Health Care Financing Administration (HCFA) insurance specialist **Joanne Sinsheimer** recently outlined the exceptions that are likely to be included in the final Stark II regulation — which may be published after Labor Day — at the American Health Lawyers Association's conference in Washington, DC.

One area of much concern has been the "direct supervision" requirement included in the proposed Stark II regulations that HCFA published January 1988. Sinsheimer reports that HCFA received a flood of comments on its proposal to use the standard Medicare definition of "direct supervision," which means that a physician must

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Outpatient PPS

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Thornton said that the OIG's decision to impose civil or criminal penalties in individual cases will turn, in part, on the clarity of the rule, the complexity and novelty of the billing system, and the efforts of hospitals to train personnel.

The new outpatient PPS is "a necessary tool of compliance" that hospitals must understand in order to check HCFA's payments for accuracy, according to **Debra Williams**, senior associate director at the AHA. "One thing we have clearly learned from the last few investigations is that if HCFA mispays you and you don't catch it, you are in some ways held responsible," she warns.

According to Williams, understanding payment rules well enough to check the remittance will be no easy task, because hospitals do not yet have all the tools required to do that. "In order for hospitals and vendors to adopt HCFA's pricing rules, they must know what they are," she explains. "But HCFA has not yet released the logic for the pricer."

In addition, she says, HCFA has not yet shown what the remittance will look like. "It is not exactly clear how easy that will be for people to use, or whether all the information they need will be on there," she explains.

Williams says that educating physicians about what the hospital will be paid for under Medicare will also be crucial, because if a service is performed on an outpatient basis but falls into HCFA's new "inpatient-only category," they will face heightened legal liability.

That means hospitals must master inpatient-only services even though it will be largely left to physicians to notify patients that they must be admitted for certain procedures previously performed on an outpatient basis. "There is no obligation to notify the beneficiary that the service will not be paid for," says Williams. But she adds that hospitals might consider an informal process to accomplish that, even though it could turn into a complicated arrangement between the hospital and the physician.

Williams also notes that what was once a small number of medical devices has mushroomed into a list of nearly 300 that hospitals will be reimbursed for separately. "HCFA is saying that anything that is on that add-on list is one-time use only," she explains. "It is our initial reading that if you bill for a reused item, you have a problem."

The bad news for hospitals is that all of those challenges don't even begin to address the ambulatory payment classifications (APCs) that hospitals must master. "The complexity of the groupings of APCs is probably where the crux of our problems lies," says Vacca. "There are so many issues associated with APCs that I don't know if we can be entirely accurate on Day One," she adds.

In theory, APCs are designed to work much like diagnosis-related groups, with a national rate adjusted to the local labor market, says health care attorney **Dennis Barry** of Washington, DC-based Vinson Elkins. Each of the 450 APCs will have its own weight, ranging from 0.38 to 115.31. "This is an incredible range," he asserts.

Making matters even worse, Vacca says, the rates keep changing. The final APC methodology was included in the regulation published in April, but just two weeks ago, HCFA added roughly 200 additional APCs. Vacca says that makes the APCs a moving target. In fact, the new rates are so complex, and there is so much confusion among hospitals and fiscal intermediaries, that HCFA may not implement them until Oct. 1. But HCFA has yet to confirm that.

Barry says that the consolidated billing rules for skilled nursing facilities (SNFs) represent yet another "compliance trap" confronting hospitals in

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the final rule. Under the new requirements, if a SNF patient comes to the hospital and the treatment at the hospital is part of the plan of treatment at the SNF, the hospital may not bill Medicare. Instead, the hospital must bill the SNF, and the SNF must absorb the hospital's bill as part of its costs under the resource utilization group payment per diem methodology.

However, in other instances where a SNF patient comes to the hospital with an emergency situation or for other services such as chemotherapy, those services will not have to be bundled with the SNF bill.

"You have a situation where the hospital sometimes must bill the SNFs, and other times bill the program," Barry explains. "There is no default position that you can use to instruct your billing people." That means personnel in low-level positions sometimes must make important judgment calls, he warns.

With the implementation date just two weeks away, many hospitals have yet to fully address other key parts of the regulation that kick in Oct. 1, such as the new provider-based status requirements. **(See "New provider-based status rules catch hospitals," *Compliance Hotline,* May 22, 2000, p. 1.)** "That will take time to sort out," warns Vacca. "But you can only do so much at one time." ■

Stark II regs

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be in the office when services are performed. "A lot of comments pointed out that for health and safety, this definition is certainly not needed, and Medicare already has coverage and payment regulations that set forth standards for physician supervision," Sinsheimer reports. She says the agency may be making changes in that area.

The exceptions for profits and productivity bonuses is another "big kicker," according to health care attorney **Gregg Wallander** of Indianapolis-based Hall Render. He notes that physicians cannot be paid directly or indirectly for the volume or value of referrals except for a share of overall profits or a productivity bonus based on services that are personally performed. Wallander says that issue frequently surfaces with multioffice and multispecialty physician groups.

Sinsheimer promises that the final rule will be "less intrusive" in that area. "We did not intend to recognize one single specialty over a multispecialty," she asserts. "I am willing to admit that we went too far as to how the physicians split the money."

According to Wallander, another controversial section of the proposed rule is the unified business requirement, which states that the methods used to allocate overhead expenses must reflect centralized decision-making rather than each satellite office operating as if it were a separate practice site.

Sinsheimer predicts that the final rule will be more lenient in that area. She says HCFA was mainly concerned about so-called "groups without walls," where physicians would only refer to specialists who were part of their group. "We were hoping to stop this," she asserts. But she says the proposed rules in that area were "too restrictive," and would have had too much influence on how groups would be structured. "We needed to take into account that there are lots of legitimate ways of setting up a group," she admits. "We are not going to be as intrusive."

Wallander also notes that in its commentary on the proposed rule, HCFA states that it believes an employer can provide a bonus or compensation to a physician for referrals for nondesignated health services. But, he says, some people believe that flies in the face of HCFA's proposed language regarding other business generated between the parties.

Sinsheimer says the agency was blindsided in this area, and adds that HCFA believed Congress was seeking a limited number of compensation-related relationships, and HCFA proposed several others, most importantly the fair-market value. "We think there are other relationships that are appropriate that are not abusive," she explains. "The first one that comes to mind is the ability of a hospital to lend physicians money or physicians to lend money to the hospitals."

"I can see where we have trouble with this one," she concedes. "We have a conflict there, and I don't think we intended to interfere with the other services — if that is really what you are getting paid for." ■

Medicare appeals

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watching reimbursement, says Howard. “Agencies will also be vulnerable through the state survey process because they will have to reduce services to some patients,” she adds.

According to Howard, Medicare will continue to look at claims filed until Sept. 30 on a retroactive basis. “They are still going to be looking at the same types of issues such as medical necessity,” she adds. “There are still going to be massive numbers of appeals on both pre-PPS and post-PPS allowances.”

Likewise, HHAs will still face reimbursement on a per-visit basis and the question of whether beneficiaries are deemed eligible for home care in the first place, notes Howard. For example, Medicare recently determined that wound care patients are not supposed to continue receiving home care services if their wounds are not healing. “I can see that opening up a Pandora’s box of all kinds of trouble,” she asserts. “The agency will argue the patients needed the services, the fiscal intermediary will disallow the care, and the agency will have to appeal to the administrative law judge.”

The focus of Medicare home health audits used to be on high-utilization providers. Since the interim payment system was implemented, the focus has shifted to discrepancies over billing, documentation, and coverage, according to **Denise Bond**, of the Washington, DC-based firm Schmeltzer, Aptaker & Shepherd.

Bond reports that some fiscal intermediaries have demanded payment for extrapolated amounts. She adds that many HHAs have challenged their methodology, but to no avail.

In other instances, Bond says intermediaries have claimed they are simply following up on a review by surveyors who uncovered problems. “In other cases, we saw variations where the periods didn’t match,” she reports. “The intermediaries looked at one time period, the surveyors looked at a different time period, and it caused problems for the providers.”

Bond says that HHAs confronted with a situation like that should immediately review their claims and look at the medical charts even if the intermediary says they have no right to reconsideration. “Don’t give up your appeals rights,” she warns. Instead, she says that if intermediaries are doing an extrapolation, HHAs should review their overpayment calculations and point out any errors or inconsistencies. “A number of providers uncovered all kinds of problems with the calculations and the extrapolations, and were able to get revised overpayments,” she reports.

Bond says an overpayment letter would be issued notifying the provider of the number of claims denied, number of visits denied, and what was not paid under waiver. That amount would then be extrapolated over the entire fiscal year, and HHAs would be required to make a repayment within 30 days. “It was terrifying to a lot of providers because the figures were in the millions of dollars in many cases,” Bond asserts.

The first thing HHAs confronted with this situation should do is file for an extended repayment plan, according to Bond. “It is very unlikely that you are going to otherwise be able to pay back the money,” she warns. "You want to do this very quickly before the intermediaries begin an offset, which is generally within 30 days of the overpayment letter.” ■

Lab company to pay $53M for overcharging Medicare

GAMBRO Healthcare has agreed to pay $40 million for overcharging Medicare, Medicaid, and TRICARE, the U.S. Department of Justice (DOJ) announced July 13. The Swedish-owned system and another subsidiary, Dialysis Holdings Laboratory Services, also agreed to pay $13.1 million to settle similar allegations.

DOJ reports that in 1997, the Health and Human Services’ Office of Inspector General started investigating the billing practices of a GAMBRO renal dialysis laboratory in Fort Lauderdale, FL, and another lab as part of Operation Restore Trust. DOJ says investigation turned up evidence that the Fort Lauderdale lab billed federal health care programs for medically unnecessary lab tests for end stage renal disease patients and double-billed.

DOJ spokesman **Charles Miller** says the agreement was unexpectedly revealed by GAMBRO earlier than anticipated, and DOJ has yet to receive a copy of the final settlement. ■