WINTER 2016 ISSUE

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Welcome!

Welcome to the Winter edition of the Leading Edge. Since it is 2016 (!), we have the expected updates from Medicare that, this year, include new and revised POS codes.

Our features highlight the bundled reimbursement for knee and hip surgery coming April 1: the Medicare Comprehensive Joint Replacement. While it won't immediately affect billing, it will determine who gets incentive or penalty payments, which means hospitals will be modifying their partnerships.

Next we cover expanding Out of Network regulations and laws. For those physicians who aren't able to negotiate fair in-network rates, these regulations can add significant administrative burden and/or financial constraints.

Recent legislation will reduce the reimbursement rates for new HOPDs in 2017. But starting January 1, services performed in HOPDs must be reported with POS 19 if off-campus and POS 22 if on-campus.

Our last feature describes proposed regulations that would greatly expand hospitals’ legal requirements when discharging a patient. While the implications are not fully understood, any final regulations in this area are likely to be significant for hospitals and, potentially, for physicians.

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We appreciate your feedback and suggestions. Please call or email me with comments and topics: bgilbert@ahsrcm.com and (908) 279-8120.

Bill Gilbert
New Medicare Joint Replacement Model April 1

The Comprehensive Care for Joint Replacement (CJR) model is set to begin on April 1, 2016. It holds hospitals accountable for Medicare hip and knee replacements and/or other major leg procedures from surgery through recovery. Hospitals in 67 geographic areas receive one flat fee for the procedures instead of multiple payments for each individual service provided by the hospital, physicians and other providers. Hospitals that meet certain benchmarks for quality and cost measures will receive a bonus payment. On the other hand, hospitals can be penalized for a portion of their spending above a set target.[1]

The new model obviously impacts hospitals and physicians but the biggest impacts may be on Post Acute Care providers such as Skilled Nursing Facilities and Home Health Agencies. In fact, Leavitt Partners is projecting that CJR hospitals will increase SNF and HHA integration and narrow their post-acute care networks, with CJR having more impact on SNFs and HHAs than any reimbursement change in memory.

The CJR model offers financial incentive to hospitals to coordinate physicians, home health agencies, skilled nursing facilities, and other providers to ensure beneficiaries get the best possible care. Often, beneficiaries receive care from many providers and suppliers, which can lead to confusion and, in some cases, multiple care plans that conflict and can lead to re-hospitalizations and complications. HHS Secretary Sylvia Mathews Burwell has said, “By focusing on episodes of care, rather than a piecemeal system, we provide hospitals and physicians an incentive to work together to deliver the best care possible to patients.” HHS and CMS hope the new model will allow hospitals to improve care delivery and care coordination by providing spending and utilization data and facilitating the sharing of best practices.[2]

On November 16th, CMS finalized the new model. CMS proposed the CJR model for hip and knee replacements earlier this year in effort to “address the low quality and high costs that come from fragmentation.”

Background

Hip and knee replacements are the most commonly performed inpatient surgeries for Medicare beneficiaries. According to CMS, there were more than 400,000 Medicare inpatient knee and hip replacements in 2014, accounting for $7 billion in hospitalization costs. Despite the high volume of these surgeries, quality and costs of care for these surgeries vary greatly among providers. For example, the rate of complications, such as infections or implant failures following surgery can be more than three times higher for procedures performed at some hospitals than others. And the average Medicare expenditure for surgery, hospitalization, and recovery ranges from $16,500 to $33,000.

CMS feels when physicians, hospitals and other providers approach care without examining the big picture, the possibility of missing crucial information or not coordinating across different care settings is substantial. Historically, this approach has led to more complications after surgery, higher readmission rates, protracted rehabilitative care, and variable costs.

Details of the Final Rule

CMS and HHS state the CJR model incorporates successful design elements from other initiatives and also reflects best practices from the private sector, where major employers and leading providers and care systems are moving towards bundled payments for orthopedic services.[3]

Some highlights from the Final Rule include:[4]

1. Billing will continue in a normal "Fee for Service" manner. Acute-care hospitals in certain selected geographic locations will receive retrospective bundled payments or penalties for episodes of care for lower extremity joint replacement or reattachment of a lower extremity.

2. The hospital in which the hip or knee replacement and/or other major leg procedure takes place will be accountable for the costs and quality of related care from the time of the surgery through 90 days after hospital discharge—what is called an “episode” of care.

3. Hospitals in the model will be provided access to additional tools – such as spending and utilization data and sharing of best practices – to improve the effectiveness of care coordination. The model also gives providers additional flexibilities that are not otherwise available under Medicare so they can better manage the care of patients, including patients who are at home.

4. By “bundling” payments for an episode of care, hospitals, physicians, and other providers have an incentive to work together to deliver more effective and efficient care.

5. To allow hospitals time to gain experience under the new model, CMS is finalizing a payment policy for participating hospitals that includes:

   - No repayment responsibility in performance year one
   - A stop-loss limit of 5% in performance year two
   - A stop-loss limit of 10% in performance year three
   - A stop-loss limit of 20% in performance years four and five


6. Patient aide and security:

- Beneficiaries will benefit from protections including: additional monitoring of claims data from participant hospitals to ensure that hospitals continue to provide all necessary services; continued protection of patient data under the HIPAA and other applicable privacy laws; and patient notification by providers and suppliers. Further, all existing safeguards to protect beneficiaries and patients will remain in place.
- Patients can continue to choose their doctor, hospital, skilled nursing facility, home health agency, and other provider, but with the CJR model, their providers have incentives to better coordinate their care. From surgery to recovery, patients can receive more comprehensive, coordinated care from their providers focusing on the most appropriate options for their recovery and rehabilitative care.

Preparing for the CJR Model

Lower extremity joint replacements are the most commonly performed Medicare inpatient surgery and more are projected as Baby Boomers age. These surgeries can require long recoveries that may include extensive rehabilitation or other post-acute care, which provides many opportunities to reward providers that improve patient outcomes. By including all eligible hospitals in numerous geographic locals across the country, the model drives significant movement towards new payment and care delivery models for an important set of conditions and surgeries for Medicare beneficiaries.

Hospital-based physicians in the CJR hospitals should proactively reach out to their administration to determine how they can assist in meeting the CJR goals. Collaborating with other providers to redesign care and align financial incentives will become essential. Proactive engagement will not only help ensure CJR success, but can also create a path that extends to other service lines, thereby positioning an organization as a key part of the value-based future.

It is important to recognize that CMS is likely to implement more programs of this nature, and across broader geographies. They will be necessary to achieve the CMS goals of tying 30% of traditional Medicare payments to quality or value through alternative payment models by the end of 2016 and 50% of by the end of 2018. [5]

Out of Network Laws Expand

The “battle” between insurers and providers (both physicians and hospitals) over the parameters for, and restrictions on, out-of-network billing continues in many states. Unfortunately, consumers can be caught in the middle by balance billing requirements. The consumer angle makes good press with “balance billing” and “out of network” now common in general publications (e.g. the Wall Street Journal).

State legislatures and regulators often find themselves pressured to act. There are no federal guidelines [except a newly issued rule here]. However, at least a quarter of states have laws that affect balance billing in at least some circumstances. In a related move, CMS is seeking comment on a requirement that health plans in the federal Marketplace count certain unexpected out-of-network services towards the annual out-of-pocket maximum. [Currently, these out-of-network charges are not counted towards the out-of-pocket maximum].[1]

“Among the most recent states to take action is New York, which has a new statute that is cited by consumer advocates as a model. That law, which became effective in 2015, significantly expands existing consumer protections and may be the most comprehensive law of its type, says Jack Hoadley, a research professor at Georgetown University’s Health Policy Institute, who recently co-authored a study that examined balance billing protections in seven states.

‘If the pieces work like they set them up to, it feels like they’ve got all the bases covered,’ Hoadley says.

Under the New York law, patients are generally protected from owing more than their in-network copayment, coinsurance or deductible on bills they receive for out-of-network emergency services or on surprise bills.” [2]

On September 1, 2015, Texas law was updated to allow consumers to challenge surprise OON bills larger than $500. At almost the same time, in June Texas Governor Greg Abbott signed House Bill 574 protecting physicians and other providers from having their participating provider agreements terminated by an insurer solely because the provider’s patients use out-of-network providers. The law aims to address aggressive tactics employed by many insurers in recent years to curb physicians’ referrals to out-of-network providers. [3]

Other states have active legislation under consideration, including Florida. But the state with the most action at the moment appears to be New Jersey.

On November 23rd, two highly anticipated and controversial state Assembly bills cleared the NJ Financial Institutions and Insurance Committee.


Both bills were originally introduced earlier this year as a single bill and cover changes in the administrative process for hospitals during non-emergency procedures, in addition to creating the Health Price Index (HPI), a new transparency tool to determine what providers are charging for care. If passed, the out-of-network bill would rely on the state Department of Banking and Insurance to find an organization to collect and maintain the Health Price Index.

While the creation of a new price tool is likely to increase the already too-high-cost of insurance plans, the out-of-network bill is raising concerns about the increased burden on health care professionals. Despite many remaining concerns from both payers and providers, the two bills are one step closer to becoming law.

Those in opposition of the bills say the administrative burden on doctors to know the details of every health insurance plan is unrealistic and would result in less time spent with patients. Others, such as the New Jersey Business and Industry Association (NJBIA), oppose the creation of an HPI, claiming surcharges on health insurers and benefits plans “will ultimately increase health care costs for New Jersey employers” and that the services are duplicative, noting “existing sources collect and provide in-network and out-of-network cost information from physicians, hospitals, health care facilities and insurers.”[4]

The New Jersey Association of Health Plans released a statement supporting various aspects of the bill, but stated concerns with the peer review process, cost sharing for emergency services and the $1,000 threshold for arbitration — all of which were urged by hospitals and health care providers.

For non-emergency situations, the bills impose the following requirements on health care facilities:

- Disclose whether the facility is in- or out-of-network.
- Advise the patient to check with the doctor arranging the services to determine whether or not the doctor is in- or out-of-network.
- Advise the patient if a change in network status has occurred between the time the appointment was made and the time of the procedure.
- Advise that the patient contact his or her insurance carrier for further consultation regarding costs.
- Make publicly available a list of standard charges for the items and services it provides.
- Follow a binding arbitration process to allow consumers a chance to fight surprise bills.
- Publish online the names, mailing addresses and telephone numbers of physicians working at the facility and hospital-based physician groups with which it has contracted to provide services, including anesthesiology, pathology and radiology.

The bills’ sponsor believes that physicians and health care professionals should be responsible for tracking insurance information. “If they were given the choice between continuing with medical care that ultimately would lead to substantial out-of-pocket costs and considering other options that carry a lower price tag, the vast majority of reasonable New Jersey residents certainly would choose the latter. The problem, at present, is that they don’t have that choice,” said sponsor Gary Schaer.

The Medical Society of New Jersey criticized earlier attempts by the N.J. legislature to pass similar bills, claiming it “punishes all doctors for the bad practices of a few.” The Out-of-Network bill is the latest in the attempts to harness the $1 billion problem that contributes to the increasing premium costs for policyholders. [5]

Lawmakers hope to pass the bill before the end of the NJ legislative session in January.

New and Revised POS Codes for Hospital Outpatient Departments

Effective for all dates of service beginning January 1, 2016, there are new and revised place of service codes (POS) for Hospital Outpatient Departments.

Place of Service (POS) code 22 has been changed to On Campus-Outpatient Hospital, with a new POS code 19 for Off Campus-Outpatient Hospital.[1]

These changes are important for most hospital-based physicians and others. Off-campus is generally defined by CMS as more than 250 yards from the main hospital campus. The POS code changes are:

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<th>Off Campus-Outpatient Hospital</th>
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<td>22</td>
<td>On Campus-Outpatient Hospital</td>
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POS codes are described on the CMS site here.

CMS Proposes Major Changes to Discharge Process

CMS recently proposed to “modernize discharge planning requirements by: bringing them into closer alignment with current practice; helping to improve patient quality of care and outcomes; and reducing avoidable complications, adverse events, and readmissions.” The rule would also implement the discharge planning requirements of the Improving Medicare Post-Acute Transformation Act of 2014 (IMPACT Act 2014) which requires hospitals, critical access hospitals, and certain post-acute care providers to use data on both quality and resource use to assist patients during the discharge planning process, while taking into account the patient’s goals of care and treatment preferences. [1]

Published in the Federal Register on November 3, the Discharge Planning Proposal has specific revisions to the discharge planning requirement within the Conditions of Participation 482.43 (c)(3). Currently, they only require that a hospital must arrange for the initial implementation of the patient’s discharge.

These revisions would require hospitals and critical access hospitals to [2]:

- Develop a discharge plan within 24 hours of admission or registration and complete a discharge plan before the patient is discharged home or transferred to another facility. This would apply to all inpatients and certain types of outpatients, including patients receiving observation services, patients who are undergoing surgery or other same-day procedures where anesthesia or moderate sedation is used, and emergency department patients who have been identified by a practitioner as needing a discharge plan.
- Provide discharge instructions to patients who are discharged home.
- Have a medication reconciliation process with the goal of improving patient safety by enhancing medication management.
- Establish a post-discharge follow-up process.
- For patients transferred to another facility, send specific medical information to the receiving facility.
- For patients enrolled in managed care organizations, make the patient aware that they need to verify the participation of Home Health Agencies (HHAs) or Skilled Nursing Facilities (SNFs) in their network.

In addition, Home Healthcare Agencies would be required to develop and implement an effective discharge planning process that focuses on preparing patients and caregivers/support person(s) to be active partners in post-discharge care, effective transition of the patient from HHA to post-HHA care, and the reduction of factors leading to preventable readmissions.

“The proposed rule emphasizes the importance of the patient’s goals and preferences during the discharge planning process. These improvements should better prepare patients and their caregivers to be active partners for their anticipated health and community support needs upon discharge from the hospital or post-acute care setting. Hospitals and critical access hospitals would be required to consider several factors when evaluating a patient’s discharge

needs, including but not limited to the availability of non-health care services and community-based providers that may be available to patients post-discharge.” [2]

Proposal Cost Estimates:

**Hospitals:** It is estimated that one-time costs for these new requirements would be $3,424 per hospital for 4,900 hospitals for a total onetime cost of $17M.

CMS estimate that only 5% of emergency department (ED) visits would need a discharge plan and 5% of hospital outpatient visits would need one. Therefore, the estimate is 5 minutes per patient and $107 million annually.

**Home Health Agencies:** It is estimated that the new requirements would have a one-time cost of $2,816 per HHA for a total of $34 million and would add $21,710 per HHA or $259 million annually for the 10 minutes per patient needed to comply. Then the discharge summary would add 2.5 minutes per patient for administrative staff, adding $1,984 per HHA or $24 million annually. Therefore, the one-time cost is $34 million and ongoing is $283 million.

**Critical Access Hospitals:** It is estimated that the one-time costs would be $5,271 per CAH or $7 million and the ongoing costs would add $4,518 per CAH or $6 million annually.

**Background**

The financial impact associated with Hospital readmissions are significant and a recent study conducted at Johns Hopkins found hospital readmission rates following major surgical procedures may be widely underestimated. [3]

As a cost-containment measure, CMS launched its Hospital Readmissions Reduction Program in 2012, requiring hospitals to publicly report their readmission rates and tying financial reimbursement to readmissions. Though the proposed rule far surpasses the $100M threshold, CMS hopes to ensure more successful discharges through streamlined processes with improvements in quality, resulting in lower readmission rates and costs.

A thoughtful, comprehensive approach to discharge preparations and post-acute care planning can enhance patient and family caregiver experiences, reduce admission rates, lower health care costs, and elevate HCAHPS scores. Additionally, reducing avoidable readmissions can assist health care systems in achieving the goals of accountable care organizations (ACOs), bundled payment initiatives, and other performance-based arrangements. An estimated one-third of re-hospitalizations could be avoided with improved comprehensive transitional care from the hospital to the community per the proposed rule. [4]

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OIG’s 2016 Work Plan

In 2015, the Office of Inspector General (OIG) reported expected recoveries of over $3 billion. 4,112 individuals and entities were excluded from participation in federal programs. 925 criminal and 682 civil actions (an increase of 28% compared to FY 2014) were brought, including false claims and unjust-enrichment lawsuits.

As part of the OIG’s role to enforce federal health care laws (by identifying and holding accountable those violating Medicare and Medicaid program rules), OIG tools include audits, investigations, imposition of civil penalties, and administrative sanctions. Every year, the OIG publishes its Work Plan for the next 12 months: the latest was effective October of 2015.

**All Medicare and Medicaid providers** should be prepared for a potential review of:

- Medical records to establish service necessity and to support claims
- Medicare and Medicaid patient accounts with credit balances as indicators of overpayments (self-disclosure protocols)
- Excluded provider list checks for employees and vendors

Here are excerpts from the 2016 OIG Work Plan of most interest to AdvantEdge clients. “New” indicates an item added for 2016.

**Billing and Payments**

**Anesthesia**

Anesthesia Services—Payments for Personally Performed Services

We will review Medicare Part B claims for personally performed anesthesia services to determine whether they were supported in accordance with Medicare requirements. We will also determine whether Medicare payments for anesthesia services reported on a claim with the “AA” service code modifier met Medicare requirements. Physicians report the appropriate anesthesia modifier code to denote whether the service was personally performed or medically directed. (CMS, Medicare Claims Processing Manual, Pub. No. 100-04, Ch. 12, § 50.) Reporting an incorrect service code modifier on the claim as if services were personally performed by an anesthesiologist when they were not will result in Medicare’s paying a higher amount. The service code “AA” modifier is used for anesthesia services personally performed by an anesthesiologist, whereas the “QK” modifier limits payment to 50 percent of the Medicare-allowed amount for personally performed services claimed with the “AA” modifier. Payments to any service provider are precluded unless the provider has furnished the information necessary to determine the amounts due. (Social Security Act, §1833[e].) (OAS; W-00-13-35706; W-00-14-35706; W-00-15-35706; various reviews; expected issue date: FY 2016)

NEW Anesthesia Services—Non-Covered Services

We will review Medicare Part B claims for anesthesia services to determine whether they were
supported in accordance with Medicare requirements. Specifically, we will review anesthesia services to determine whether the beneficiary had a related Medicare service. Medicare will not pay for items or services that are not “reasonable and necessary.” (Social Security Act, §1862(a)(1)(A)) (OAS; W-00-15-35749; expected issue date: FY 2016)

Pathology
Selected Independent Clinical Laboratory Billing Requirements

We will review Medicare payments to independent clinical laboratories to determine laboratories’ compliance with selected billing requirements. We will use the results of these reviews to identify clinical laboratories that routinely submit improper claims, and we will recommend recovery of overpayments. Prior OIG audits, investigations, and inspections have identified independent clinical laboratory areas at risk for noncompliance with Medicare billing requirements. Payments to service providers are precluded unless the provider has and furnishes upon request the information necessary to determine the amounts due. (Social Security Act, §1833(e).) We will focus on independent clinical laboratories with claims that may be at risk for overpayments. (OAS; W-00-14-35726; W-00-15-35726; various reviews; expected issue date: FY 2016)

Annual Analysis of Medicare Clinical Laboratory Payments

We will analyze Medicare payments for clinical diagnostic laboratory tests, including the top 25 clinical diagnostic laboratory tests by Medicare expenditures in 2014. Previous OIG work has found that Medicare pays more than other insurers for certain high-volume and high-expenditure laboratory tests. Section 216 of the Protecting Access to Medicare Act of 2014 requires new Medicare payment rates for laboratory tests beginning in 2017 that are based on private payer rates and establishes processes for determining initial payments for new laboratory tests. Pursuant to a requirement of the Protecting Access to Medicare Act, OIG will conduct an annual analysis and monitor Medicare expenditures and the new payment system for laboratory tests. (OEI: 00-00-00000; expected issue date: FY 2016)

NEW Histocompatibility Laboratories–Supplier Compliance with Payment Requirements

We will determine whether payments to histocompatibility laboratories were made in accordance with Medicare requirements. From March 31, 2013, through September 30, 2014, histocompatibility laboratories reported $131 million in reimbursable costs on their most recent cost reports. Histocompatibility laboratories are reimbursed on the basis of reasonable costs. Costs claimed in the cost report must be related to the care of beneficiaries; reasonable, necessary, and proper; (42 CFR § 413.9(a), (b), and (c)(3)) and cost information must be accurate and in sufficient detail to support payments made for services provided (42 CFR § 413.24(a) and (c)). (OAS; W-00-15-35742; expected issue date: FY 2016)

Radiology
Imaging Services—Payments for Practice Expenses

We will review Medicare Part B payments for imaging services to determine whether they
reflect the expenses incurred and whether the utilization rates reflect industry practices. For selected imaging services, we will focus on the practice expense components, including the equipment utilization rate. Practice expenses may include office rent, wages, and equipment. Physicians are paid for services pursuant to the Medicare physician fee schedule, which covers the major categories of costs, including the physician professional cost component, malpractice insurance costs, and practice expenses. (Social Security Act, § 1848(c)(1)(B).) (OAS; W-00-13-35219; W-00-14-35219; W-00-15-35219; various reviews; expected issue date: FY 2016)

**Portable X-Ray Equipment—Supplier Compliance with Transportation and Setup Fee Requirements**

We will review Medicare payments for portable x-ray equipment services to determine whether payments were correct and were supported by documentation. We will also assess the qualifications of the technologists who performed the services. Prior OIG work found that Medicare may have improperly paid portable x-ray suppliers for return trips to nursing facilities (i.e., multiple trips to a facility in 1 day). Medicare generally reimburses for portable x-ray services if the conditions for coverage are met. (42 CFR §§ 486.100–486.110.) (OAS; W-00-15-35464; various reviews; expected issue date: FY 2016)

**Emergency Medicine**

**Ambulance Services—Questionable Billing, Medical Necessity, and Level of Transport**

We will examine Medicare claims data to assess the extent of questionable billing for ambulance services, such as transports to dialysis facilities that potentially never occurred or potentially were medically unnecessary. We will also determine whether Medicare payments for ambulance services were made in accordance with Medicare requirements. Prior OIG work found that Medicare made inappropriate payments for advanced life support emergency transports. Medicare pays for emergency and nonemergency ambulance services when a beneficiary’s medical condition at the time of transport is such that other means of transportation would endanger the beneficiary. (Social Security Act, § 1861(s)(7).) Medicare pays for different levels of ambulance service, including basic life support, advanced life support and specialty care transport. (42 CFR § 410.40(b).) (OAS; W-00-11-35574; W-00-12-35574; W-00-13-35574; W-00-14-35574; various reviews; expected issue date: FY 2016)

**Other Specialties and Topics**

**Sleep Disorder Clinics—High Use of Sleep-Testing Procedures**

We will examine Medicare payments to physicians, hospital outpatient departments, and independent diagnostic testing facilities for sleep-testing procedures to assess the appropriateness of Medicare payments for high-use sleep-testing procedures and determine whether they were in accordance with Medicare requirements. An OIG analysis of CY 2010 Medicare payments for Current Procedural Terminology codes 95810 and 95811, which totaled approximately $415 million, showed high utilization associated with these sleep-testing procedures. Medicare will not pay for items or services that are not “reasonable and necessary.” (Social Security Act, § 1862(a)(1)(A).) To the extent that repeated diagnostic testing is performed on the same beneficiary and the prior test results are still pertinent, repeated tests may not be reasonable
and necessary. Requirements for coverage of sleep tests under Part B are in CMS’s Medicare Benefit Policy Manual, Pub. No. 100-02, Ch. 15, § 70. (OAS; W-00-10-35521; W-00-12-35521; W-00-13-35521; W-00-14-35521; W-00-15-35521; various reviews; expected issue date: FY 2016)

NEW Physicians–Referring/Ordering Medicare Services and Supplies

We will review select Medicare services, supplies and durable medical equipment (DME) referred/ordered by physicians and non-physician practitioners to determine whether the payments were made in accordance with Medicare requirements. Pursuant to ACA Sec. 6405, CMS requires that physicians and non-physician practitioners who order certain services, supplies and/or DME are required to be Medicare-enrolled physicians or non-physician practitioners and legally eligible to refer/order services, supplies and DME. If the referring/ordering physician or non-physician practitioner is not eligible to order or refer, then Medicare claims should not be paid. (OAS; W-00-15-35748; expected issue date: FY 2016, ACA)

NEW Physician Home Visits–Reasonableness of Services

We will determine whether Medicare payments to physicians for evaluation and management home visits were reasonable and made in accordance with Medicare requirements. Since January 2013, Medicare made $559 million in payments for physician home visits. Physicians are required to document the medical necessity of a home visit in lieu of an office or outpatient visit. Medicare will not pay for items or services that are not “reasonable and necessary.” (Social Security Act, §1862(a)(1)(A)) (OAS; W-00-15-35754; expected issue date: FY 2016)

NEW Prolonged Services–Reasonableness of Services

We will determine whether Medicare payments to physicians for prolonged evaluation and management (E/M) services were reasonable and made in accordance with Medicare requirements. Prolonged services are for additional care provided to a beneficiary after an evaluation and management service has been performed. Physicians submit claims for prolonged services when they spend additional time beyond the time spent with a beneficiary for a usual companion evaluation and management service. The necessity of prolonged services are considered to be rare and unusual. The Medicare Claims Process (MCP) manual includes requirements that must be met in order to bill a prolonged E/M service code. (MCP manual, Pub. 100-04, Ch. 12, Sec. 30.6.15.1(OAS; W-00-15-35755; expected issue date: FY 2016)

Provider Eligibility

Enhanced Enrollment Screening Process for Medicare Providers

We will determine the extent to which and the way in which CMS and its contractors have implemented enhanced screening procedures for Medicare providers pursuant to the ACA, § 6401. We will also collect data on and report the number of initial enrollments and enrollment revalidations approved and denied by CMS before and after the implementation of the enhanced screening procedures. As part of an effort to prevent fraud, waste, and abuse resulting from vulnerabilities in the Medicare enrollment process, CMS is implementing new authorities that include site visits, fingerprinting, and background checks, as well as an automated provider
Delivering System Reform
Use of Electronic Health Records to Support Care Coordination through ACOs

We will review the extent to which providers participating in ACOs in the Medicare Shared Savings Program use electronic health records (EHRs) to exchange health information to achieve their care coordination goals. We will also assess providers’ use of EHRs to identify best practices and possible challenges to the exchange and use of health data, such as degree of interoperability, financial barriers, or information blocking. The Medicare Shared Savings Program promotes accountability of hospitals, physicians, and other providers for a patient population, coordinates items and services, and encourages investment in infrastructure and redesigned care processes for high-quality and efficient service delivery. (ACA, § 3022.) OEI; 00-00-00000; expected issue date: FY 2017; ACA)

NEW Accountable Care Organizations: Strategies and Promising Practices

We will review ACOs that participate in the Medicare Shared Savings Program (established by section 3022 of the Affordable Care Act). We will describe their performance on the quality measures and cost savings over the first three years of the program and describe the characteristics of those ACOs that performed well on measures and achieved savings. In addition, we will identify ACOs’ strategies for and challenges to achieving quality and cost savings. The Medicare Shared Savings Program is a key component of the Medicare delivery system reform initiatives and is a vehicle through which providers who work in ACOs can share in Medicare cost-savings while providing high-quality care to patients. (OEI; 02-15-00450; expected issue date: FY 2017; ACA)

Other Items

NEW Medicare Payments for Unlawfully Present Beneficiaries in the United States – Mandated Review

We will review the procedures established by CMS to prevent and recoup Medicare payments for items and services furnished to unlawfully present beneficiaries in the United States. Pursuant to section 401 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, CMS’s Medicare Claims Processing Manual, Ch. 1, §10.1.4.8 states that Medicare payment may not be made for items and services furnished to alien beneficiaries who are not lawfully present in the United States. Section 502 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), enacted in April 2015, requires the Secretary of Health and Human Services to establish and maintain procedures to ensure that payment is not made for Medicare services rendered to individuals not lawfully present in the United States. Prior OIG review identified $91.6 million of improper payments made to providers for services rendered to unlawfully present beneficiaries for CYs 2009 through 2011. OIG is required to submit to Congress a report on such activities established by CMS no later than 18 months after the date of the enactment (MACRA, §502(b).) (OAS; W-00-15-35625; various reviews; expected issue date: FY 2016; work in progress).
NEW Medicare Payments for Incarcerated Beneficiaries—Mandated Review

We will review the procedures established by CMS to prevent and recoup Medicare payments for items and services furnished to incarcerated beneficiaries. Medicare, in general, does not pay for services rendered to incarcerated beneficiaries because they do not have a legal obligation to pay (Social Security Act, § 1862); however, the regulation does permit Medicare payment where an incarcerated beneficiary has an obligation for the cost of care. (42 CFR § 411.4.) Section 502 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), enacted in April 2015, requires the Secretary of Health and Human Services to establish and maintain procedures to ensure that Medicare does not pay for services rendered to incarcerated beneficiaries. Prior OIG review identified $33.6 million of improper payments made to providers for services rendered to incarcerated beneficiaries for CYs 2009 through 2011. OIG is required to submit to Congress a report on such activities established by CMS no later than 18 months after the date of the enactment (MACRA§502(b)). (OAS; W-00-15-35624; W-00-16-35624; various reviews; expected issue date: FY 2016; work in progress)

NEW CMS Management of the ICD-10 Implementation

We will review aspects of CMS’s early management of the implementation of the 10th version of the International Classification of Diseases (ICD-10) codes in Medicare Parts A and B. This may include reviewing CMS’s and its contractors’ (e.g., MACs) assistance and guidance to hospitals and physicians and assessing how the transition to ICD-10 is affecting claims processing, including claims resubmissions, appeals, and medical reviews. We may also determine how ICD-10 diagnosis codes are being applied to selected CMS payment rules and safeguards (e.g., national or local coverage decisions related to coverable conditions). Starting on October 1, 2015, Medicare claims with a date of service on or after October 1, 2015, are required to contain a valid ICD-10 code. The ICD-10 system includes about 70,000 diagnosis codes and replaces the use of ICD-9 in Medicare, which included only about 15,000 codes. CMS has advised providers that it will allow for some flexibility during the first 12 months of implementation; e.g., Medicare review contractors will not deny claims billed under the Part B physician fee schedule based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a code from the correct “family” of codes. (OEI; 00-00-00000; expected issue date: FY 2017).

To view the OIG Work Plan FY2016 in its entirety, click here.
Corporate Compliance & Ethics Week 2015

National Compliance and Ethics week was a successful AdvantEdge event that reinforced the organization’s commitment to compliance and ethics.

Employee education is one of the seven elements required for an effective compliance and ethics program. By participating in the designated week, the company and employees raised awareness in ways that reinforce not just specific rules and regulations, but the overall culture of compliance. It was not lost on team members that the organization’s top executives and managers were supporting and taking part in the week’s celebrations. The message is clear: compliance and ethics are a big priority at AdvantEdge.

Focusing on gamification in education was a key way to engage team members in overall awareness for this year’s activities. Online compliance challenge games included; Crossword, Find-a-Word, Word Scramble, Attitude and Sudoku and all had excellent participation from our offices in NH, ME, NY, NJ, PA, OH, IL and Bangalore, not to mention many home workers who jumped in for a chance to win too! The [unsolicited] feedback from the online games was positive and also included very some good ideas for next year.

Jeanne Gilreath and Lisa Pettengill visited NH, NY and IL during the week, and participation in the onsite Jeopardy Game and PHI Office Rules was substantial and enthusiastic. Participants enjoyed themselves and many commented on how they were surprised at what they didn’t know, proving that gentle reminders of the seemingly obvious can be a good thing!

When asked to provide feedback, here is a sample of what was offered;

**Staten Island** – Engaging in team activities / games proves a way to learn/grow as a company. It should be done more often to promote positive attitude in the workforce.

**Lombard** – I thought it was a great idea; all employees were engaged and enthusiastic when the games started. Great idea! Hope to see this event next year.

**Salem** – It identified and filled a few knowledge gaps, great team building too.

**Bangalore Office** – Jyothi Kiran, Assistant Manager of Learning & Development, was the onsite liaison for compliance jeopardy and feedback from the staff was that they enjoyed it and learned a lot!

The Compliance Department is looking forward to next year, and remember ... “We’re Listening”!

~ Jeanne Gilreath and Lisa Pettengill
To celebrate Compliance week, Jeanne Gilreath and Lisa Pettengill hosted a game of Jeopardy. All employees were encouraged to participate. It was a great way to remind us of the HIPAA and Compliance Rules and Regulations while having a good time. Prizes were awarded to the winning teams!