

Medicare Compliance Week

News & Analysis On Fraud & Abuse, Kickbacks, Compliance Plans, & Enforcement

Volume 7, Number 37

October 10, 2006

In This Issue...

- **Brace Yourself For A 2-Percent Payment Decrease If Your Quality Reporting Isn't Up To Par.** Warning: Hospitals that failed the submission requirements or didn't participate at all in the Medicare quality-reporting initiative will see a 2-percent pay cut in their Medicare payments for FY 2007.....289
- **CMS Clarifies PMD Coverage Determination.** Why CMS' assurances aren't comforting worried PMD suppliers290
- **Get Ready For Quick P4P Phase-In.** How a recent IOM report could expedite P4P-program implementation for HHAs291
- **Big Victory In Congress For Oxygen Stakeholders.** Good news: Senator pledges to drop consideration of the 13-month rental cap for oxygen equipment. Check out what's in store now for oxygen suppliers292
- **Manage Significant Change Assessments Before They Drain Your Coffers.** Know when and how to do significant change-in-status assessments so you won't leave deserved reimbursement on the RUG table293
- **Industry Notes**295-296
 - CMS Boosts Competition With A Call For 3 New MACs
 - Doctors Not E-Mailing Patients Due To Legal Fears
 - In Other News...

We welcome your comments and suggestions!

Sarah Terry
Managing Editor
(828) 297-6449
saraht@medville.com

Sean McPartland
Associate Publisher
(585) 292-4358
seanm@elijournals.com

Hospitals

BRACE YOURSELF FOR A 2-PERCENT PAYMENT DECREASE IF YOUR QUALITY REPORTING ISN'T UP TO PAR

► ***CMS hits hospitals in their pocketbooks for not participating in quality reporting***

Many hospitals that reported data on the quality of care they deliver will enjoy a 2-percent annual payment boost as a reward. But for those unlucky 171 hospitals that either didn't participate or failed the submission requirements, the **Centers for Medicare & Medicaid Services (CMS)** will slap them with a 2-percent reduction in their annual Medicare fee-schedule update for fiscal year (FY) 2007 — a startling change from last year's 0.4-percent-point reduction.

Only 28 of the 3,490 eligible acute-care hospitals in the United States chose not to participate in reporting quality-of-care data to CMS, the agency said in a Sept. 29 announcement. Approximately 143 hospitals "failed the submission requirements," CMS reports.

These statistics come from CMS' initiatives to provide "transparency in information for consumers on quality performance measures linked to payments hospitals receive for treating Medicare beneficiaries," according to the agency. And hospitals are seeing stiffer penalties for not participating in quality-reporting initiatives or not meeting the requirements.

Continued on next page

We welcome your comments and suggestions!

Please call Sarah Terry, Managing Editor, at (828) 297-6449.

But for those hospitals that are faced with the steep 2-percent reduction in Medicare reimbursement for falling short on quality measures, there is a light at the end of the tunnel, CMS says. “[A hospital] not meeting the quality data requirements for FY 2007 may exercise its right to appeal and submit a letter to CMS outlining its reasons for requesting reconsideration by no later than November 1, 2006,” the agency explains.

The quality reporting initiative stems from the Medicare Modernization Act of 2003 and the Deficit Reduction Act of 2005. And although CMS calls hospitals’ participation “voluntary,” the agency has found that 99 percent of hospitals are choosing to report quality data rather than face the 2-percent reduction in Medicare reimbursement.

The agency hopes that patients will use the quality data to evaluate care choices and that hospitals will use it to improve performance, CMS administrator **Mark McClellan** said in a statement. “This unprecedented, consistent information on the quality of hospital care is possible because of the collaboration of hospitals, consumers, insurers, and employers working together to achieve a more transparent health care system,” he adds.

The 10-measure starter set has expanded to 21 measures for 2007, which address heart attack, heart failure, pneumonia and surgical care — the most common reasons for hospital stays for Medicare beneficiaries, CMS maintains. CMS wants to expand the set of measures even more for FY 2008, according to the Outpatient Prospective Payment System proposed rule, which is open for comments until Oct. 10. The additional quality measures would include more surgical care measures, mortality measures and a patient satisfaction survey.

To view the proposed rule, go to www.cms.hhs.gov/HospitalOutpatientPPS/HORD/itdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1185569.

For more information on hospital quality reporting, go to www.cms.hhs.gov/HospitalQuality

Initiatives, or visit www.qualitynet.org for a full list of eligible hospitals. □

PMDs

CMS CLARIFIES PMD COVERAGE DETERMINATION

► *Implementation on codes, LCD delayed until Nov. 15*

Medicare will still pay for a Group 2 power mobility device (PMD) when appropriate, say the feds in a recent “clarification” from the **Centers for Medicare & Medicaid Services (CMS)**.

A Fact Sheet issued by CMS on Sept. 20 clarifies the point, saying that many have “misinterpreted” a local coverage determination (LCD) that was set to go into effect Oct. 1. The LCD was widely held to mean that Medicare would deny many claims for Group 2 (general use) power wheelchairs.

“Unless they require special seating, people needing a power wheelchair will only receive coverage for what many wheelchair users call a ‘junk wheelchair,’ a device that has no ability to ride over even the smallest bump and has extremely limited battery power,” protested the **Medicare Rights Center**, an advocacy organization with offices in New York City and Washington, DC, in a statement issued earlier this month, before the clarification.

The LCD does not call for such a blanket down-coding of Group 2 (general use) to Group 1 (light weight) power wheelchairs, assures the **CMS Office of External Affairs**.

“We commend [CMS] for recently issuing a Fact Sheet/Press Release and revision of its Local Coverage Determination in an effort to ensure that Medicare beneficiaries receive the most appropriate power mobility devices to meet their medical needs,” said **Mike Pfister**, president of the New Braunfels, TX-based firm **The Scooter Store**, in a statement released Sept. 26.

As result of that change and other, relatively minor tweaks, the effective date for the new codes and LCD will be changed to claims with

dates of service on or after Nov. 15, 2006. The feds will amend the LCD issued by the Durable Medical Equipment (DME) Medicare Administrative Contractors, making the interpretation official and binding.

“The LCD will be modified to incorporate this and other changes so that there will be no confusion surrounding the basic intent of Medicare’s policy,” according to CMS.

The clarified LCD will be issued by the durable medical equipment Program Safeguard Contractor Medical Directors, says CMS, adding that the clarified LCD has been adopted by the DME Medicare Administrative Contractors.

In addition, CMS says it will issue the long-awaited fee schedule corresponding to the new HCPCS codes “in the near future.”

The clarified policy is available at the following Web sites: www.trustsolutionsllc.com/DRAFT_LCD_Status.asp, www.tricenturion.com, and www.edssafeguardservices.eds-gov.com/providers/dme/lcd.asp.

Many PMD Suppliers Are Leery Of CMS’ Assurances

Restore Access to Mobility Partnership

(RAMP), a coalition based in Bethesda, MD, is calling on the CMS for more policy revisions and pricing information relating to the newly revised LCD.

The group applauded CMS for working with stakeholders to clarify some issues in the revised LCD. However, the coalition of power mobility manufacturers and suppliers reiterated industry concerns that additional policy revisions and pricing information are still needed.

While RAMP said it appreciates the change, it is requesting additional assurances from CMS that downcoding will not occur. “At this point, stakeholders are merely seeking a letter or some kind of other written confirmation that this will be the policy so that it won’t ever be an issue in the future when claims are under appeal or under review,” the organization said.

RAMP also said CMS should eliminate the stand-and-pivot criterion used to determine whether a Medicare beneficiary qualifies for a Group 3 power wheelchair. Only patients who are incapable of an “independent transfer” qualify for a Group 3 chair, but some stakeholders are concerned that a literal interpretation of “independent” could include people who face a severe struggle to transfer themselves.

This requirement should be replaced with clinical criteria that will provide access to the proper medical equipment for patients requiring complex rehabilitation, RAMP said. □

HHAs

GET READY FOR QUICK P4P PHASE-IN ► *IOM recommends measures including clinical outcomes, efficiency and patient centeredness*

The sooner the feds bring pay-for-performance (P4P) programs to home health agencies (HHAs) the better. So concludes a new report from the influential **Institute of Medicine** (IOM), a non-governmental advisory panel.

Positive results: P4P programs in hospitals are already saving Medicare money while improving care — and the same could be true in HHAs, the study suggests.

The report is noteworthy in two respects, observes **Judy Adams** of **LarsonAllen** in Chapel Hill, NC: It adds new support for the value of pay-for-performance to Medicare across the continuum of care and it calls for speedy implementation of P4P within the home health arena.

Prepare For Implementation Beginning In 2009

The report, “Rewarding Provider Performance: Aligning Incentives in Medicare (Pathways to Quality Health Care Series),” calls on the **Centers for Medicare & Medicaid Services** (CMS) to begin P4P programs on existing measures “immediately” and to move toward “comprehensive per-

Oxygen

BIG VICTORY IN CONGRESS FOR OXYGEN STAKEHOLDERS

► *Senate interest in 13-month cap proposal dwindles*

Sen. **Charles Grassley's** (R-IA) recent pledge to drop consideration of a 13-month rental cap for oxygen equipment has oxygen suppliers and manufacturers cheering.

The 13-month cap proposal, included in **President Bush's** budget for fiscal year 2007, had garnered support from Grassley and others in the wake of a report from the **HHS Office of Inspector General** (OIG) released in September. The news of Grassley's shift on the cap question came of Sept. 26.

In the report, "Medicare Home Oxygen Equipment: Cost and Servicing," the OIG argued that, even with a 36-month cap, Medicare and its beneficiaries will continue to pay more than 12 times the purchase price for stationary concentrators.

Continued on page 294

formance assessment systems and sizeable reward during the next three years."

The IOM calls for CMS to implement P4P based on clinical quality standards in 2009 and for expanding P4P reimbursement to include patient-centeredness and efficiency measures by 2010. The timelines in the IOM report are likely to stand as "good target dates," says Adams, adding that "CMS is very interested" in moving forward on P4P.

Prepare Now For New Realities

To get your agency P4P-ready, begin to school managers and even field staff about how the new payment system is likely to reshape the way you do business, say the experts.

Basics: Keep in mind that P4P programs offer financial rewards to clinicians who provide care that meets certain standards or "measures" intended to gauge quality and cost-effectiveness. An estimated 30 million Americans are already enrolled in private health plans with P4P programs, reports the **American Geriatrics Society**.

For HHAs, the impact of P4P depends in large part on how P4P measures evolve, offers **Ron Clitherow**, senior manager for health care consultants **Larson, Allen, Weshair & Co.** in Charlotte, NC.

CMS has been discussing process measures that HHAs should report, but no one has yet devel-

oped the format to report additional data, says Adams. "Nor is there any full consensus on what key data should be submitted related to processes," she adds.

Likely: HHAs will probably start out with P4P based on the current home health quality improvement (HHQI) measures they already report, noted **Sharon Bee Cheng**, an analyst for the **Medicare Payment Advisory Committee** last March during the **National Association for Home Care and Hospice's** annual policy conference in Washington, DC.

Vital concern: That may not be good news, many experts agree.

"Problems with Home Health Compare continue to raise questions about how much HHAs are truly able to impact outcomes in an environment in which the physicians and hospitals have a much bigger stake in controlling where patients will be treated," says Adams.

To stay in the game, agencies will have to monitor CMS' moves toward P4P closely. Only those who prepare now are likely to thrive, or even survive, during the transition.

Key to survival: The primary goals should be making care more cost-efficient while improving outcomes, reminds Adams.

Note: The report is available on the IOM Web site at www.iom.edu/CMS/2955.aspx. □

*Long-Term Care***MANAGE SIGNIFICANT CHANGE ASSESSMENTS BEFORE THEY DRAIN YOUR COFFERS**

► *Follow these strategies to secure fair reimbursement for services*

MDS teams that don't know when and how to do significant change-in-status assessments for Part A-stay residents will end up leaving more than chump change on the RUG table.

That's because a significant change in a resident's condition can lead to a new RUG score and different payment, according to **Christine Twombly, RNC**, chief clinical consultant for **Reingruber & Company** in St. Petersburg, FL.

The first step: Know what the RAI user's manual counts as a significant change and the time frame for completing an SCSA, which is 14 days from when you determine a resident has improved or declined in a way that:

- will not normally resolve itself without staff intervention or by implementing standard disease-related clinical interventions; e.g., it isn't self-limiting;
- impacts more than one area of the resident's health status; and
- requires interdisciplinary review and/or revision of the care plan.

What wouldn't count as a significant change? "The RAI manual says you don't do an SCSA for a self-limited condition but rather for a decline or improvement in two areas now thought to be permanent," says Twombly. And a resident with a UTI who develops confusion and urinary incontinence may appear to require an SCSA because he's had changes in two or more areas, she notes. But the UTI is causing the mental status change and incontinence, which will likely resolve when the infection clears, she adds.

"So that's one situation where an SCSA isn't really warranted," Twombly says. Even so, the care plan should always be up to date.

Conversely, some resident declines may actually require a SCSA that could result in a new RUG category, even though the change doesn't appear initially to affect more than one area of the resident's functioning or clinical status.

Example: A new Stage II pressure ulcer may not appear to meet the definition of an SCSA if you go strictly by the manual's criteria, observes **Cathy Sorgee, RN**, a consultant with **The Broussard Group** in Lake Charles, LA.

But in such cases, you will usually find the resident has experienced more than one decline. "Maybe the person required extensive assistance with bed mobility and transfer but now requires total assistance," says Sorgee. "The person may

Medicare Compliance Week

News & Analysis On Fraud & Abuse, Kickbacks, Compliance Plans, & Enforcement

Subscriber Services: (800) 874-9180

Fax: (919) 544-3147 **E-mail:** saraht@medville.com

Subscriber Services E-mail: service@medville.com

Web Site: <http://www.eliresearch.com>

Sarah Terry, Managing Editor, (828) 297-6449

Rick Runyan, Editorial Director (888) 779-3718 x323

Sean McPartland, Associate Publisher (585) 292-4358

Bulk Sales (800) 508-1316 ext 2313

Unauthorized reproduction prohibited by federal law. This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional service. If legal advice or other expert assistance is required, the services of a competent professional should be sought. *Medicare Compliance Week*™ (USPS 022-087) (ISSN 1548-9906) is published weekly, except the publishing dates the weeks of the following holidays: New Year's Day, MLK Day, Easter, Memorial Day, 4th of July, Labor Day, Thanksgiving, and Christmas, by Eli Research, 2222 Sedwick Rd. Durham, NC 27713. Periodicals Postage is Paid at Durham NC 27705 and additional entry offices. Subscription price is \$649. Subscriptions are also available in e-mail PDF format. Bulk pricing available. POSTMASTER: Please send address changes to Medicare Compliance Week, PO Box 413006 Naples FL 34101-3006.

Have information on copyright violations? Call us! We'll share with you 25% of the net proceeds of all awards related to copyright infringement that you bring to our attention. Direct your confidential inquiry to Mark Lydard, Medallion Group Supervisor, Tel: 1-800-508-1316, Email: markl@medville.com.

We welcome your comments and suggestions!

Please call Sarah Terry, Managing Editor, at (828) 297-6449.

Continued from page 292

Based on the 2006 median fee schedule amount, Medicare will pay \$7,215 over 36 months for concentrators that, on average, cost \$587 to purchase.

“If Medicare rental payments for oxygen concentrators were limited to 13 months, the program and its beneficiaries would save approximately \$3.2 billion over 5 years,” the OIG stated.

The **Council for Quality Respiratory Care**, a coalition of 11 oxygen suppliers and manufacturers, criticized the study’s “limited scope, small sample selection and failure to consider critical patient services.”

Study Backs Up Industry Claims

The group pointed to an **American Association for Homecare**-commissioned study released in June that analyzed data from 74 suppliers who provide oxygen therapy to more than 600,000 beneficiaries. Services make up 72 percent of the costs of providing oxygen, the study found.

Grassley has “heard from his constituents” regarding his comments relative to the OIG report supporting capping oxygen reimbursement at 13 months, announced **Invacare** CEO **Mal Mixon** Sept. 26 during Medtrade.

To conduct the study, the OIG collected surveys from only 150 beneficiaries who rented oxygen in 2004. It also collected information from suppliers, and during site visits with suppliers in California and Florida, observed operations, service practices and beneficiary relationships.

Senator Grassley and the **Senate Finance Committee** were considering using the \$6.5 billion savings (estimated by the CBO should oxygen equipment reimbursement cap at 13 months) to offset the “doc fix,” according to **John Gallagher**, of Waterloo-IA based **VGM Group**. As of Jan. 1, 2007, physicians are scheduled to receive a 5.1-percent reduction in Medicare reimbursement. The Senate Finance Committee proposed to eliminate the cut via the savings realized from the additional oxygen cap. □

have had a decline in nutritional intake or weight.”

Strategically Manage The ARD

You have 14 days to do an SCSA after determining a resident has had a significant change. Within that time frame, select an ARD for the assessment that doesn’t penalize the facility financially, says **Marilyn Mines, RN, BC**, director of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL. To pull that off, consider two objectives:

Goal #1: Set the ARD within the 14-day time frame to capture the “worst” clinical picture of the resident where he used the most services, resulting in a RUG with the highest case-mix index and, thus, best payment.

Examples: The resident develops a Stage III pressure ulcer that becomes infected, and he receives IV fluids and IV antibiotics. The staff determines the person has also had an ADL decline. You’d want to set the ARD to capture both of the IV services because that can affect what SE category the person goes into — and the ADL score for SE, which is a minimum of 7, says **Patricia Boyer, RN, MSM, NHA**, president of **Boyer & Associates** in Brookfield, WI.

A resident receiving rehab who develops an infected pressure ulcer and receives IV medication or IV fluids and has an ADL score of at least 7 would go into one of the new rehab plus extensive services groups. But you’d have to set the ARD to capture the services, Boyer notes.

Goal #2: Set the ARD for a sicker resident at the best payment level as early as possible because

the new RUG rate changes as of the ARD.

Example: A resident is coming up on a 30-day Medicare-required assessment, offers Boyer. And you determine on day 21 that he has suffered a decline that will put him in a RUG with a higher case-mix index. If you set the ARD on day 21 for a combined SCSA and 30-day Medicare-required assessment, then the payment would change on day 21 and run through the entire cycle for the 30-day MDS or until the patient is discharged.

You could also identify the SCSA on day 18 and set the ARD on day 21 for the combined SCSA and 30-day Medicare MDS assessment, as long as you capture the resident's highest acuity/service utilization, Boyer adds.

When The Resident Improves

How would you manage the ARD in doing an SCSA for a resident who is improving? Say a resident starts eating again so his nutritional and ADL status improves and his two Stage II pressure ulcers heal. "Strategically managing the ARD, you could wait until your next MDS-required assessment — if it's within 14 days of when you determined the resident had a significant change," says Boyer. Anytime you can combine assessments, that's a plus, she adds, because staff don't spend extra time doing two MDSs.

One day can make a difference: Say you note a resident has a significant change by the 14th day of his stay resulting in a lower-paying RUG category.

If you set the ARD even for day 15 rather than day 14 for a combined SCSA and 14-day MDS, the payment will change on day 15 rather than day 14 — and run through day 30, notes Mines. That means the facility won't lose the 14th day of higher payment, since the payment changes as of the ARD, she says. One day of higher payment may not sound like much, Mines notes, but if it's happening 10 times a month, that adds up, she says. □

Industry Notes

CMS BOOSTS COMPETITION WITH A CALL FOR 3 NEW MACS

► **Plus: Physicians not using even low-cost IT tools, survey finds**

The **Centers for Medicare & Medicaid Services (CMS)** is forging ahead with its plans to get the new Medicare Administrative Contractors (MACs) up and running.

On Sept. 29, the agency issued a Request for Proposal for three of 15 separate contracts that will be issued in the transition from Medicare fiscal intermediaries and carriers to the MACs. On the same day, CMS announced that it would award the contract as a disputed contract for the specialty Durable Medical Equipment (DME) MAC in Jurisdiction C.

Earlier this year, the **Government Accountability Office** sustained a protest of the award for DME MAC Jurisdiction C. Now, after taking "corrective action," according to the announcement, CMS is awarding the disputed DME MAC contract to **CIGNA Government Services**. Originally, CMS had awarded the contract to **Palmetto GBA**.

Additional information on Medicare contracting reform can be found on the Medicare contracting reform Web site at www.cms.hhs.gov/MedicareContractingReform.

Doctors Not E-Mailing Patients Due To Legal Fears

Not only are providers shying away from electronic medical records and e-prescribing, but they are also not using cheaper, widely accessible information technology in their practices, such as e-mail, a new report reveals.

Fewer than 4 percent of physicians communicate via e-mail with their patients, according to a study that *eWeek* says will be published in the *Journal of Internal Medicine's* November issue. Approximately 30 percent of doctors e-mail with other clinicians and only 40 percent "use

real-time computerized decision support, including government and professional society Web sites and searchable databases,” *eWeek* reports.

But more surprising are the reasons that physicians cite for not using e-mail more often to communicate with patients and other health care providers. Physicians say that they generally don’t receive payment for e-mail communications with patients because the communication is outside the patient visit, *eWeek* says. “Not only will they not be paid for their e-mail tasks, doctors worry that the contents of their e-mails, whether to patients or fellow clinicians, could be used against them in legal cases.”

The study also found that: recent medical graduates were more likely to use IT tools, as opposed to more experienced physicians; doctors in two-person or solo practices were less likely to use IT tools regardless of age; and more than 40 percent of physicians working in academic practices or HMOs used most of the basic IT tools cited in the survey, as opposed to only 12 percent of doctors in solo or two-person practices.

In Other News...

- There’s now a companion to the Hobson-Tanner bill in the Senate, thanks to Senators **Orrin Hatch** (R-UT) and **Kent Conrad** (D-ND).

The bill, the Medicare Durable Medical Equipment Access Act (S. 3920), aims to ease the effects of Medicare DME competitive bidding for small providers. The House version of the Hobson-Tanner bill (H.R. 3559) has gathered 145 co-sponsors in the House since it was introduced last summer.

- CMS has issued a “special edition” *MLN Matters* article to help providers bill for influenza vaccines. The article, SE0667, lists a variety of educational resources to ensure that Medicare fee-for-service (FFS) health care professionals have the information needed to bill Medicare correctly for the Medicare-covered flu vaccines and help promote increased awareness and utilization of the flu vaccine among beneficiaries and providers.

The article is at www.cms.hhs.gov/MLNMattersArticles/downloads/se0667.pdf.

- The 2007 Work Plan from the **HHS Office of Inspector General** (OIG) adds accuracy of data on the Home Health Compare site to its list of priori-

ties. Home health outliers, cyclical noncompliance, and the appropriateness of enhanced payments for home health therapy, among other concerns, remain in the plan.

- Using an online survey could help during an influenza pandemic, according to a column by Dr. **Benjamin Brewer** in the *Wall Street Journal*.

Clinicians could use the online survey for surveillance purposes, and using clinical guidelines, without an in-person physical exam, the survey would be 77 percent accurate in diagnosing the flu, Brewer says. After taking the survey, patients would learn if they are negative for flu symptoms or positive.

Depending on a patient’s answers to the survey questions, he would be directed to visit either a pharmacy immediately for medication or a hospital or physician’s office if he has severe symptoms, Brewer writes. Brewer concedes that the online interview approach is “an imperfect solution that involves real departures from what we’re used to, and real risks.” But he writes that the approach “needs to be weighed against the alternative — untrained volunteers with clipboards trying to respond to an overwhelming number of panicked people fighting for attention in a doctor’s office or emergency room.” □

SUBSCRIBE TODAY!

Yes! Enter my one-year subscription to *Medicare Compliance Week* for just \$649.

Extend! I already subscribe. Please extend my subscription for one year at only \$649.

Subscription Version Options: *(check one)*

Print Online* Both* *(Add online to print subscription FREE)*

E-mail _____

* Provide e-mail address to receive issue notifications

Payment Information:

Check enclosed for \$649 *(payable to MCW)*

Bill my credit card: MC VISA AMEX DISC

Exp. date _____ Acct. # _____

Signature _____

Bill me P.O. _____ *(please add \$15 processing fee for all billed orders)*

Name _____

Title _____

Office _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

E-mail _____

To help us serve you better, please provide all requested information

Medicare Compliance Week • New Hill Services
Dept. 1380 • Denver, CO 80291-1380
Call: (800) 874-9180 • Fax: (800) 508-2592