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Weekly News and Compliance Strategies on Federal Regulations, Enforcement Actions and Audits

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Publisher's Note

RMC will not be published next week. The next issue will be dated July 13, 2020. Have a great Fourth of July holiday!

HCCA

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In COVID-19 Update, CMS Clarifies Originating Site Fee, But Coding Confusion Persists

CMS has parted some of the clouds around hospital outpatient charges in new guidance on billing during the COVID-19 pandemic and recent stakeholder engagement calls. But there's still uncertainty about when hospitals should bill the originating site fee (Q3014), which pays $33, versus the outpatient clinic visit fee (G0463), which yields $115, for services performed at provider-based departments (PBDs) that include patients' homes and other temporary expansion locations until the public health emergency (PHE) is over.

The appropriate use of the originating site fee was spelled out in a June 19 update to answers to FAQs[1] on Medicare fee-for-service billing. "When a registered outpatient of the hospital is receiving a telehealth service, the hospital may bill the originating site facility fee to support such telehealth services furnished by a physician or practitioner who ordinarily practices there and bills for the telehealth service that is or would otherwise be furnished in the hospital outpatient department. This includes patients who are at home, when the home is made provider-based to the hospital (which means that all applicable conditions of participation, to the extent not waived, are met)," CMS stated in FAQ H3.

CMS also clarified in FAQ H1 that hospital outpatient therapy, education and training services furnished via telehealth to registered hospital outpatients by hospital staff should be billed with Q3014. However, when hospitals perform clinical staff

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Hospital Pays $4M in Settlement Over Call Coverage, APPs; Consider 'Key Value Drivers'

In a case about payments for call coverage and advanced practice providers (APPs), Sitka Community Hospital in Alaska agreed to pay $4.125 million in a civil monetary penalty (CMP) settlement with the HHS Office of Inspector General, which has a COVID-19 twist.

According to the settlement, which was obtained through the Freedom of Information Act, OIG contends that from April 1, 2013, to April 25, 2019, Sitka Community Hospital paid remuneration to 16 providers in the form of excessive compensation under emergency department call coverage arrangements and APP arrangements.

Sitka Community Hospital reported problems to OIG in April 2019 and was accepted into its Self-Disclosure Protocol the following month. OIG alleged the hospital violated the Civil Monetary Penalties Law provisions applicable to kickbacks and "presented claims for designated health services furnished during the relevant time period that resulted from prohibited referrals," the settlement stated.

An addendum to the settlement explains that the hospital asked OIG for more time to fork over the $4.125 million, which it needed "due to effects on their business operations stemming from the COVID-19 pandemic. The OIG has granted that request." OIG confirmed that CMS received Sitka's payment on June 9.

continued

Sitka Community Hospital, which didn't admit liability in the settlement, is now part of the Southeast Alaska Regional Health Consortium. No additional details about the allegations were available, and the hospital didn't respond to *RMC*'s request for comment.

Hospitals often pay specialists for being on call to the emergency room, which means they're available if a patient requires their services. It's also common for hospitals to lend the services of employed APPs free to independent physicians, attorneys say. Free APP services can turn into remuneration if they supplant physician services rather than supplement them. Another hospital, St. Vincent's Medical Center in Bridgeport, Connecticut, recently settled a CMP case[1] over free APP services provided to physicians. Hospitals should be monitoring call coverage and APP arrangements, which must be at fair market value, a linchpin of exceptions to the Stark Law.

Things to Consider When Paying for Call Coverage

"Health systems need to concern themselves with a few key value drivers when determining the fair market value call rate for a particular specialty at a specific hospital," said Joe Aguilar, a partner in HMS Valuation Partners in Atlanta. Here are some things to consider when paying for call coverage:

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- **Concurrent versus nonconcurrent call shifts**. "We worry about concurrent or simultaneous call arrangements," he said. Suppose Dr. Smith, an interventional cardiologist, takes call at Hospital A and Hospital B, which are part of the same health system, and they both pay her $1,000 per 24 hours of call coverage. That amount may be fine in isolation, but together it could exceed fair market value. "The problem lies in the fact that a significant component of the call value is associated with the availability of that particular provider," Aguilar said. In other words, if $500 of the fair market value compensation is just for the physician being available by cell phone, "you can only pay for that once," he explained. In this example, both hospitals are paying for the physician agreeing to pick up the phone. "You can't double dip. I have seen a cardiovascular surgeon take call at four hospitals across the city. You need to be careful." The total amount should be reduced to ensure she is only rewarded once for her availability by the same hospital or health system.
- **The use of APPs, fellows, or residents for call**. "Who is taking call is material to the call value," Aguilar explained. Suppose a neurology group employs an acute-care nurse practitioner who takes the initial call from the hospital, evaluating the patient and briefing the physician. The call value would be different than if one of the neurologists took the call off the bat. "The hospital should be paying a rate that is dependent on the structure of the arrangement," he said. When call coverage contracts are written, hospitals have to dig deeper to recognize the physician may not be taking 100% of the calls. Perhaps a midwife is responding to the hospital, and the attending OB is only brought in when the midwife determines the patient requires a C-section. "Because the midwife cost is less than the OB, the value is potentially less than if the physician is doing it alone," Aguilar said. APPs are highly valuable, but the bottom line is, you are paying the practice at a rate consistent with the OB providing the call—not just 24 hours of availability, but coming in every time patients deliver. The same thing applies to fellows. "We probably see it more in community hospitals with academic programs," he noted. Fellows take the calls and attending physicians get the payments, but if fellows reduce the burden and free up time for the attending physicians, the issue is whether that changes the fair market value of the payments. "Has the compliance officer accurately evaluated the resource costs associated with what they are purchasing?"

- **Restricted versus unrestricted call shifts**. With restricted calls, the physician is on-site and available to treat patients in the emergency room when summoned, and other professional services performed outside the call agreement are limited, Aguilar said. With unrestricted call coverage, the physicians go about their business, although they must be available. "You can pay more if they're restricted," because the hospital is holding physicians back from earning for other services, he said. But without monitoring, hospitals and physicians could cross the line. Suppose an obstetrician who is paid $200 an hour at the upper end of fair market value for restricted call performs a quick exploratory laparoscopy at the hospital and is reimbursed $1,000 for the procedure. "She's potentially over fair market value," Aguilar said. The same can be said for a physician on restricted call who is seeing patients in the medical office building next to the hospital if half a day of visits generates $1,000 of compensation on top of $800 for four hours of restricted call coverage. The reason: They effectively earned $450 an hour for four hours, based on $1,800 (the total of $1,000 for their professional services plus $800 for restricted call coverage) divided by four, Aguilar said, which is more than fair market value.
- **Consideration of a stacking analysis for employed physicians**. The payments for call coverage must be figured into the overall fair market compensation, he said. "It's a matter of looking at the sum of the parts." If the hospital pays a general surgeon $500,000 for clinical and call coverage services and that's fair market value for her specialty, that should be $430,000 for clinical work and $70,000 for call coverage, for example. "A stacking analysis requires the compliance officer or valuation firm to accurately identify the value of each component in isolation and then collectively," he explained. Hospitals also should consider the unique value attached to certain subspecialties like laborists, who provide obstetrics only, Aguilar said. In this case, it may not be appropriate to use OB/GYN data. "There is laborist data that's specific to an OB specialist who does no GYN and spends their day in the hospital delivering babies and triaging in labor and delivery," he said. "The difference in compensation from national survey data between OB/GYNs and OB:Laborists is significant, and the decision to choose one over the other should be based on the resources dictated by the call shift in the agreement."

Contact Aguilar at joe.aguilar@hmsvalue.com. ✧

Endnotes

1. Nina Youngstrom, "Hospital Settles CMP Case Over Free APP Services for Physicians," *Report on Medicare Compliance* 29, no. 22 (June 15, 2020), https://bit.ly/3hZVvCF.

In $16M FCA Settlement, DOJ Alleged Outpatient Orders Were Overturned

Piedmont Healthcare Inc. in Atlanta has agreed to pay $16 million to settle false claims allegations over the twin compliance risks of billing for admissions instead of outpatient or observation services and paying more than fair market value for a medical group in violation of the Anti-Kickback Statute, the U.S. Attorney's Office for the Northern District of Georgia said June 25.[1]

The false claims lawsuit against the health system was set in motion by a former Piedmont Healthcare physician who became a whistleblower. He alleged that procedures were performed on an inpatient basis even though physicians ordered outpatient or observation status.

The U.S. attorney's office said the settlement resolves allegations that from 2009 to 2013, "Piedmont's case managers allegedly overturned the judgment of its treating physicians on numerous occasions and billed Medicare and Medicaid at the more expensive inpatient level of care even though the treating physicians recommended performing the procedures at the less expensive outpatient or observation level of care."

The 2016 whistleblower complaint cites specific procedures, including MS-DRGs 238 (major cardiovascular procedures without major complication or comorbidity [MCC]); 243 (permanent cardiac pacemaker implant with complications or comorbidities [CCs]); 244 (the same, only without CCs or MCCs); 280 (acute myocardial infarction, discharged alive, with MCC); 281 (the same, but with CC) and 282 (the same but without CC or MCC).

"Defendants knew that such inpatient stays for the procedures were, in the vast majority of cases, medically unnecessary," the complaint alleged. But encouraging admissions "maximized profit and revenue."

When the recovery audit contractor started questioning the admissions of patients who were in the hospital fewer than 23 hours from 2011 to 2013, Piedmont allegedly brought "enormous pressure" on employees "to create unjustified explanations exaggerating complexity to medical inpatient admissions," the complaint stated. Physicians who were reluctant to comply allegedly suffered the consequences (e.g., they were "ostracized").

The U.S. attorney's office also said Piedmont settled allegations that in 2007 the health system acquired the Atlanta Cardiology Group "in violation of the federal Anti-Kickback Statute by paying a commercially

unreasonable and above fair market value for a catheterization lab partly owned by the practice group." The complaint alleged that Piedmont bought the cardiology group and a 49% interest in the cath lab "for an inflated and excessive amount of over $15 million."

Piedmont did not admit liability in the settlement. In a statement, Piedmont said, "Staying true to our purpose, Piedmont Healthcare's doctors and nurses always make decisions based on the best interest and the health of the patient. The care provided in these circumstances from over ten years ago was no different. The issue in this matter from 2009 to 2013 involved decisions regarding whether a hospital patient should be classified as an inpatient status or as on observation status, which was a major challenge for every health system in the country at the time. Since that time, the government itself recognized the confusing standards and in 2013 instituted a new 'two-midnight' rule to provide clarity. During the period in question, Piedmont assigned patient status as best it could, in part with the assistance of an industry-leading third-party vendor that helped interpret these technical definitions." ✧

Endnotes

1. Department of Justice, U.S. Attorney's Office for the Northern District of Georgia, "Atlanta hospital system to pay $16 million to resolve false claims allegations," news release, June 25, 2020, https://bit.ly/387Tksj.

Policy on Interpretation Services and Effective Communication for Deaf or Hard of Hearing Persons

Emory Healthcare in Atlanta developed this policy as part of its compliance with Sec. 1557,[1] which prohibits discrimination on the basis of race, color, national origin, sex, age or disability. HHS on June 19 finalized its reinterpretation of the Sec. 1557 regulation, which came from the Affordable Care Act. Contact Toby Morgan, director of compliance, Section 1557 & Section 504 for Emory Healthcare, at toby.morgan@emoryhealthcare.org.

SCOPE:

All Emory Healthcare staff.

PURPOSE:

To identify the process by which information will be provided to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs.

POLICY STATEMENT:

The Hospitals and Hospital-based clinics shall furnish appropriate auxiliary aids and services where necessary to ensure that communication with people who are deaf, hard of hearing, or visually impaired is as **effective** as communication with others. Effective communication is necessary with patients *and* companions who are normally involved in medical decision-making.

Auxiliary aids and services with respect to deaf or hearing-impaired individuals include qualified interpreters on-site or through video remote interpreting (VRI) services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice-, text-, and video-based telecommunications products and systems, including text telephones (TTYs), videophones, and captioned telephones; videotext displays; and accessible electronic and information technology; and with respect to *vision-impaired individuals,* include qualified readers, tape text, audio recordings, Braille materials, and large-print materials. (See https://www.hhs.gov/sites/default/files/1557-fs-disability-discrimination-508.pdf)

PROCEDURE:

Assessment

Staff shall inquire as to the patient's or companion's usual mode of communication and, where reasonable, abide by the patient's or companion's preference. Staff will assess if the patient and/or companion uses American Sign Language (ASL) to communicate or if he/she uses another form of communication like English Sign Language/Signed English, Rochester Method, or Home Signs. The Hospital may, however, choose among various alternative auxiliary aids as long as the result is effective communication.

Assessment to Determine Need for and Type of Auxiliary Aid

Staff shall inquire as to the patient's or a companion's usual mode of communication and, where reasonable, abide by the person's preference. Staff will assess if the patient and/or companion uses ASL to communicate or if he/she uses another form of communication like English Sign Language/Signed English, the Rochester Method, or Home Signs. A *companion* means a family member, friend, or associate of the person seeking medical care, who along with the patient is an appropriate person with whom medical staff should communicate as long as they are part of the patient's care. The Hospital may, however, choose among various alternative auxiliary aids as long as the result is effective communication.

The individualized assessment of a person's communication needs includes consideration of the nature, length, complexity, and importance of the communication; the person's communication skill and knowledge; the patient's health status or changes thereto; and the patient's or companion's request for an interpreter/auxiliary aid.

Examples of situations when it may be necessary to provide interpreters/ auxiliary aid include:

a. Discussing a patient's symptoms and medical condition, medications, and medical history;
b. Explaining medical conditions, treatment options, tests, medications, surgery, and other procedures;
c. Providing a diagnosis and recommendation for treatment;
d. Communicating with a patient during treatment, testing procedures, and during physician's rounds;
e. Obtaining informed consent for treatment(s);
f. Providing instructions for medications, post-treatment activities, and follow-up treatment;
g. Providing mental health services, including group or individual therapy or counseling for patients and family members;
h. During family meetings with social worker, palliative care, physicians and other types of meetings where the patient's care is discussed in detail for purposes of decision-making;
i. Providing information about blood or organ donations;
j. Explaining living wills and powers of attorney;
k. Discussing complex billing or insurance matters; or
l. Explaining patient care and educational materials upon discharge from the facility.

Assistance for the Deaf and Hard of Hearing (HOH)

1. **Video Remote Interpretation (VRI) Services**. VRI services are provided at EUH, EUHM, EUOSH, EJCH, and ESJH. The services are provided by Cyracom Language Solutions.
2. **In-person interpretation**. In some cases, a patient may specifically request an in-person interpreter based on specific needs, or a determination may be made by staff and/or provider involved in treating a patient that an in-person interpreter is needed for effective communication.

   Agency interpreters will need a 24-48-hours advanced cancellation notice. If not cancelled within the time frame required, the charges for all the time that has previously been requested will be applicable for charges.
3. **For after-hours, weekends, and holidays on-site interpreter needs:**

a. If the patient and/or companion use American Sign Language, staff should consider first the use of the VRI laptop, if consistent with the preference of the patient/companion.
b. If it has been determined by staff and/or the provider that an on-site interpreter is required, staff will contact their unit director, manager, charge nurse, or an administrative supervisor, who will approve the request and will assist in locating a qualified interpreter.
c. To contact an agency and request an on-site ASL interpreter after hours, please refer to a list of approved agencies that are on the virtual desktop of EHC intranet under "Departments and Groups." Look under "Administrative Departments," click on "Emory Medical Interpretation and Translation Services," and click on "Approved Agencies" on the left pane. Please take into consideration that the agencies usually will need a 2-hour advanced notice.

4. A TV Closed Caption Encoder is available in facilities, management (in Guest Services at EUOSH) for installation in a hearing impaired patient's room.
5. The use of a white board to exchange notes may be used as an auxiliary aid for communicating effectively with the deaf and/or the hard of hearing, if consistent with the communication preference of the patient/companion. This auxiliary aid is effective as long as the patient, family member, and/or companion knows how to read and write.

Assistance for the Visually Impaired

1. For Braille translations requests, staff should contact EMITS at 7-EMIT (404-727-3648) or send the requested document to translation@emoryhealthcare.org. EMITS will send the document to an approved agency for a quote and turnaround time.
2. Emory Hospitals permits the use of service dogs by blind or visually impaired patients, visitors, and employees pursuant to the Emory Healthcare Patient/Visitor Service Animal Policy.
3. The use of a "Qualified Reader" is necessary when documents are not available in Braille or the Visually Impaired person doesn't know Braille.

   To request a "Qualified Reader" during business hours for ERH, EUH, EUHM, WWH, EUOSH, and EUHM hospital-based clinics, call EMITS at (404-727-3648).

   For after hours, follow the after-hour procedure explained under "Assistance for the Deaf and Hard of Hearing" title, located in the third bullet point.

Documentation Requirements; Interpretation or Communication Assistance of Family Members or Companions

All healthcare providers and staff shall document the offer, request, and use of a qualified interpreter or auxiliary aid in the patient's electronic chart, including the interpreter's full name, the ID number for the VRI interpreters, or the type of auxiliary aid used. The patient/family member/companion should be informed that auxiliary aids and on-site interpretation services are free of charge, confidential, and intended to ensure patient safety, quality care, and satisfaction. Emory Healthcare providers and staff have the prerogative to require the use of qualified interpreters when they deem necessary for the best interests of both parties. When a qualified interpreter is not used, such as when a person refuses and desires the assistance of a family member or a companion, the reason must be documented in the patient's medical record. Please read "Waiver Form" information below.

In general, a patient's family member, companion, or person who is not a qualified interpreter should not be used as the person providing interpretation assistance for purposes of medical care. Minor children are prohibited from interpreting in any instance. In rare circumstances, such as in the case of an emergency involving imminent threat to the safety or welfare of an individual or to others, a companion may be relied upon to interpret or facilitate communication only when a qualified interpreter is not available. Also, if an individual requests that a companion provide interpretation assistance, with the consent of the companion, the individual can provide communication assistance if otherwise reasonable and appropriate under the circumstances. Issues of competency of interpretation, confidentiality, privacy, and conflict of interest should be considered before relying upon a companion.

Waiver form: A waiver form is available when a patient, family member, or companion (as long as they are part of the patient's care) refuses the use of a qualified professional medical interpreter or auxiliary aids. The executed waiver form, valid for only one visit or hospital stay, should be maintained in the patient's medical record.

1. The patient/family member/companion should be informed that auxiliary aids and services are available and are free of charge, confidential, and intended to ensure patient safety, quality care, and satisfaction.
2. The form is located on the EHC intranet under "Departments and Groups." Look under "Administrative Departments," click on "Emory Medical Interpretation and Translation Services," click on "Resources" on the left pane, and click on the link that says "Please print and complete waiver" to print the form.
3. A qualified professional ASL interpreter through VRI or by an on-site interpreter, consistent with the specific needs or preference of the patient/companion, should be used to interpret the waiver form.
4. The waiver form can be revoked at any time by the same person who originally signed it, and a new waiver form is required for each hospital visit or stay.

RELATED DOCUMENTS AND LINKS:

"American Sign Language - Video Remote Interpreting Cultural assessment," Revised August 18, 2017, Lippincott Procedures, Wolters Kluwer Health Inc., 2018, https://bit.ly/3drRBPy

Interpretation Services and Effective Communication for Non-English Speaking or Limited English Proficient Persons

Patient Rights and Responsibilities

Waiver of Interpretation Services Form

DEFINITIONS:

Qualified Medical Interpreter

An Emory or contracted agency Medical Interpreter that has demonstrated proficiency in English and a Target Language.

Qualifications include the completion of at least one Interpreter training course of 40 hours duration or more, has passed a nationally recognized oral test for medical interpreters or has been nationally certified as a Medical Interpreter (CMI), and demonstrates knowledge of the Standards of Practice and code of Ethics set forth by the National Council of Interpreting in Healthcare (NCIHC). All staff and providers at EHC must meet above requirements in order to provide Interpreter Services.

Qualified Dual Role Interpreter

Bilingual Emory Healthcare employees and providers who have met the above requirements may serve as a qualified Dual role medical interpreter at their supervisor's discretion. Employees and providers who have met the above requirements will send a copy of their 40 hours completion certificate and a copy of the results of the oral test to Emory Interpretation Services Department. Fax 404-686-5454. Phone 404-727-3648.

Ad Hoc Interpreters

Family members, companions, bilingual staff or providers who have not have formal training or are not nationally certified as a medical Interpreter.

REFERENCES AND SOURCES OF EVIDENCE:

42 U.S.C. § 12182(a) (Americans with Disabilities Act); 29 U.S.C. § 794(a) (Section 504 of the Rehabilitation Act of 1973); 28 C.F.R. § 36.303(a) (ADA regulations); 28 C.F.R. § 36.303(c) (auxiliary aids, effective communication).

Advancing Effective Communication, Cultural Competence, and Patient-and Family-Centered Care: A Roadmap for Hospitals. http://jointcommision.org/topics/patient safety.aspx. May 30, 2012.

HHS.gov. U.S Department of Health & Human Services, Section 1557 of the Patient protection and Affordable Care Act: Ensuring Effective Communication with and Accessibility for Individuals with Disabilities. https://www.hhs.gov/sites/default/files/1557-fs-disability-discrimination-508.pdf

The Joint Commission. (2018). Standard HR.01.01.01, EP 1. *Comprehensive accreditation manual for hospitals: The official handbook*. Oakbrook Terrace, IL: The Joint Commission.

The Joint Commission. (2018). Standard PC.02.01.21. *Comprehensive accreditation manual for hospitals: The official handbook*. Oakbrook Terrace, IL: The Joint Commission.

The Joint Commission. (2018). Standard RI.01.01.01, EPs 2, 5. *Comprehensive accreditation manual for hospitals: The official handbook*. Oakbrook Terrace, IL: The Joint Commission.

The Joint Commission. (2018). Standard RI.01.01.03, EPs 1-3. *Comprehensive accreditation manual for hospitals: The official handbook*. Oakbrook Terrace, IL: The Joint Commission.

KEY WORDS:

Americans with Disabilities Act, effective communication, hearing-impaired, visually impaired, speech-impaired

Endnotes

1. Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020), https://bit.ly/2YR6vd2.

Denials Are More Complex, Overturn Rate Has Dropped, Experts Say

When an auditor removed a secondary diagnosis of acute and chronic respiratory failure (code J96.21) from a claim for a patient with a history of chronic obstructive pulmonary disease (COPD), the hospital had grounds to appeal. In its denial, the auditor said diagnosing respiratory failure in COPD patients requires a degree of change in their state, not just chronically lower oxygen pressure and increased carbon dioxide. But the auditor was wrong, and the documentation proved it. As the hospital explained in its appeal, when the patient presented to the emergency room in moderate respiratory distress, he had been using three liters of oxygen at night but then required six liters to maintain oxygen saturation of 93%. "The doubling of the patient's oxygen requirements to maintain an oxygen saturation greater than 90% clearly demonstrates a change from the usual state," according to the appeal letter, which also noted that a drop in partial pressure of oxygen equal to or greater than 10 to 15 millimeters of Mercury "generally indicates acute respiratory failure."

The hospital won the appeal, said physician Adriane Martin, vice president of physician services at Enjoin, a clinical documentation improvement company.

With that kind of clinical evidence, hospitals can beat back denials. But they're getting more complex, Martin said during a recent webinar sponsored by RACmonitor.com. "The denials we're seeing are more difficult to overturn," she explained. That's the case whether they're coding or clinical denials. One in 10 claims are denied at a typical 350-bed hospital, and Medicare Advantage (MA) plans and commercial payers are denying an increasing number of claims.

The reason that denials are more complex is that payers change the criteria, Martin said. "It's always a moving target," she contended. For example, providers use validated, universal criteria for diagnosing malnutrition from the American Society for Parenteral and Enteral Nutrition (ASPEN), but she said a lot of MA plans "create Frankenstein criteria. They take a little from here and there. They have not necessarily been clinically validated or widely adopted. They're counting on the fact it is an onerous process to appeal one of these denials and just denying everything and hoping some of them will stick."

Hospitals and other providers are winning fewer appeals, added Andrea Taylor, director of denials management at Enjoin, during the webinar. "The commercial overturn rate is down 11%, and Medicare is down 10%," she noted.

The next wave of denials may be claims for COVID-19, although for now auditors seem to be leaving these claims alone. "I have not seen denials at this time," Martin said. Her concern, however, is that because Medicare and commercial payers are cutting everyone slack during the public health emergency, "people will take it as a free for all" and skimp on documentation.

Auditors perform two types of audits: DRG validations, which focus on whether correct coding or sequencing was applied, and clinical validations, which examine whether the patient truly has the conditions that were documented, Martin said. In addition to reducing reimbursement, denials could affect pay for performance, Martin said. "Often you are getting deletion of secondary codes such as malnutrition. If you delete malnutrition, you weaken the risk adjustment," she noted. "If they kick out the risk adjusters, it doesn't accurately represent your population. That shows how denials have an impact that's not as readily visible."

Auditor May Have Overlooked Physician Query

When considering an appeal, read the denial letter carefully. Is it about coding or clinical validity? If the reviewer refers to *Coding Clinic*, a newsletter published by the American Hospital Association, it's a DRG validation. A denial letter that refers to the *Harrison's Principles of Internal Medicine*, for example, is a clinical validation. The type of review tells you what kind of expertise is necessary to craft the appeal letter. Appeals of denials from DRG validations require a coder, while appeals of denials from clinical validations call for a clinician. Hospitals may be able to reverse denials if auditors applied coding guidelines incorrectly or retroactively, or the *Coding Clinic* wasn't pertinent to your case. Maybe auditors overlooked a physician query that supported the diagnosis, Martin said.

In another case, an auditor recommended changing the principal diagnosis of a patient admitted with syncope (R55), who was also diagnosed at admission with dehydration and acute kidney injury. The hospital reported the principal diagnosis as hypovolemia (E86.1), but the reviewer changed it to acute renal failure (ARF), unspecified (N17.9), saying it was the condition that occasioned the admission. The auditor cited *Coding Clinic* to support this position, including an article from the third quarter of 2002 on ARF due to dehydration and treated with IV hydration only.

"The problem is, that's not the heart of the matter," Martin said. As the hospital explained in the appeal, the physician was queried about the underlying cause of the syncope and responded that it was "truly multifactorial. Hypovolemia probably was the most prominent cause." Consistent with chapter 18 of the *Official Guidelines for Coding and Reporting*,[1] the etiology of syncope was established by query as the principal diagnosis. There also was no clinical support for an ARF diagnosis.

Martin said the hospital won this appeal too.

Contact Martin at adriane.martin@enjoincdi.com and Taylor at andrea.taylor@enjoincdi.com. ✧

Endnotes

1. CMS, *ICD-10-CM Official Guidelines for Coding and Reporting, FY 2020: (October 1, 2019 - September 30, 2020)*, ch. 18, 73-75, https://bit.ly/2Kad977.

CMS Clarifies COVID-19 Billing

continued from page 1

services in the patient's home as a PBD under the physician's overall direction and control, they should be billed as outpatient department services. "Hospitals should bill for these services as they ordinarily bill for services along with any specific billing requirements for relocating PBDs specific to billing during a COVID-19 PHE. That is, hospitals should bill as if the services were furnished in the hospital, including appending the PO modifier for excepted items and services and the PN modifier for non-excepted services and the DR condition code," according to FAQ H2.

But "conspicuously absent" from these explanations is any mention of the codes, said Valerie Rinkle, president of Valorize Consulting. "CMS has not done a good job of explaining what's required to bill the Q code versus the G code," she said. "The answer seems to be that when the doctor is initiating and doing the telehealth service without needing hospital staff, that's when the hospital bills Q3014, but when the hospital staff is doing services without the practitioner involved or the practitioner is doing something extensive like taking history, they bill G0463. But CMS has not spelled this out."

Hospitals can deduce the circumstances when they should bill the Q versus the G code based on comments from CMS officials in June 2 and 9 provider calls, Rinkle said. For example, if a patient is starting a new chemotherapy regimen and the physician orders the nurse to educate the patient about it, which she does via telehealth, that would be billed with G0463, as if the nurse were providing the service in person, Rinkle said. But suppose the physician steps in after the nurse takes the patient's history. "If it were an in-person situation, the hospital would still bill G0463, but I think the FAQs are obtuse." They indicate the hospital bills Q3014 if it's a registered outpatient and the hospital staff doesn't have to do much.

Partly, hospitals are still uneasy about the Q versus G code selection because "CMS hasn't added G0463 to the list of exemplary codes," Rinkle said. "Why haven't they done that? It's not been updated since April 30."

There are other FAQs that providers may want to pay close attention to. For example, CMS seems to be saying it's up to Medicare administrative contractors (MACs) whether to pay for COVID-19 tests that are ordered before patients have procedures or chemotherapy when infection is not suspected, said Ronald Hirsch, M.D., vice president of R1 RCM.

FAQ B13 states:

> Currently, under the hospital OPPS [outpatient prospective payment system] all available COVID-19 clinical diagnostic laboratory tests are paid separately, thus, if a COVID-19 clinical diagnostic laboratory test is performed prior to a procedure and billed separately, it is not bundled into the payment for the procedure. Specifically with regard to the hospital setting, if the hospital is billing for specimen collection for the COVID-19 clinical diagnostic laboratory test along with another hospital service, the payment for the specimen collection would be packaged into that of the procedure. If the ASC [ambulatory surgical center] or physician office has obtained a CLIA [clinical laboratory improvement amendments] certificate, the ASC (enrolled as a laboratory) or physician/Non physician-practitioner office can bill for tests under the clinical laboratory fee schedule (CLFS) that the certificate permits them to perform, separate from billing for the procedure that is being furnished. Practitioners, ASCs, and labs should check with their local Medicare Administrative Contractor regarding specific questions of coverage.

Hirsch finds this worrisome. "If patients are in a presymptomatic phase of infection, their lives would be in jeopardy by proceeding with the procedure," he noted. One study found that 30-day post-surgery mortality in COVID-19-positive patients was almost 24%.[2] "Nobody wants that, but Medicare seems to be saying it will be a MAC decision whether the test is

CMS Transmittals and *Federal Register* Regulations, June 19-25

Transmittals

Pub. 100-04, Medicare Claims Processing Manual

- Quarterly Update to the Long Term Care Hospital (LTCH) Prospective Payment System (PPS) Fiscal Year (FY) 2020 Pricer, Trans. 10191 (June 19, 2020)
- July 2020 Update of the Ambulatory Surgical Center (ASC) Payment System, Trans. 10188 (June 19, 2020)
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.3, Effective October 1, 2020, Trans. 10189 (June 19, 2020)

Pub. 100-20, One-Time Notifications

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)–July 2020 Update, Trans. 10193 (June 19, 2020)

Pub. 100-03, Medicare National Coverage Determinations

- National Coverage Determination (NCD) 160.18 Vagus Nerve Stimulation (VNS), Trans. 10199 (June 23, 2020)

Federal Register

Proposed Regulation

- Medicaid Program; Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third Party Liability (TPL) Requirements, 85 Fed. Reg. 37,286 (June 19, 2020)

Final Regulation

- Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, Fed. Reg. 37,160 (June 19, 2020)

covered and it's a question of medical necessity. How do you define medical necessity in a situation like that?" If the test isn't covered, maybe patients will be dissuaded from getting it, putting themselves at risk by following through with a procedure or chemotherapy, he noted.

A study[3] reported in *JAMA Oncology* on May 27 found that "accumulating evidence suggests that patients with cancer have increased risk for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection and subsequent morbidity and mortality." The researchers found that "[o]ur prospective universal microbiologic screening strategy revealed that 8% (7 of 85) of asymptomatic patients with cancer had COVID-19 at our institution."

Hirsch added that there are implications for the patients after they go home because family members could have the virus. "Hospitals need to be very concerned about this. A decision not to routinely screen pre-op patients and chemo patients because the test is not covered may be a fatal decision, yet who do you put the onus on?" He wonders whether hospitals will eat the cost or ask patients to sign advance beneficiary notices accepting financial responsibility for an expensive test, or perhaps be forced to find a public screening site.

Only One Relocation Request Per Address Is Needed

In FAQ G7, CMS reiterated that hospitals must inform their CMS regional office by email of the locations of relocated PBD, including patients' homes.

> Hospitals have 120 days from the date on which they begin furnishing services at a relocated PBD to submit a temporary extraordinary circumstances relocation exception request," the FAQ stated. "Hospitals can send a request that includes all of the addresses to which the PBD relocated over a period of weeks or months, rather than a single request for each location. The hospital should also notify the Regional Office of the addresses of any patients' homes to which the PBD relocates if the hospital intends to be paid under the OPPS for these services. If a hospital chooses not to submit a patient's home address for an extraordinary circumstances relocation request, the hospital can simply bill for services provided at such relocation site with the 'PN' modifier and receive payment at the PFS [physician fee schedule]-equivalent rate for those services.

CMS noted in another FAQ that a PBD only needs to "submit a relocation request for a particular address once, regardless of how often the PBD provides services at that location."

On another issue, CMS said practitioners who happen to be out of the United States are not permitted to provide telehealth services to Medicare beneficiaries. According to FAQ P2:

> Hospitals do not bill for Medicare telehealth services. However, if a hospital employs certain practitioners who are not authorized to independently bill Medicare for their services, such as respiratory therapists, the hospital may bill for the outpatient hospital services provided by that staff using telecommunications technology. Hospitals should review requirements for providing hospital services in relocated provider based departments including the patient's home and temporary expansion locations as appropriate. We note that Medicare cannot pay for services that are furnished by a physician or practitioner located outside of the United States.

CMS also said diagnosis codes that are captured during telehealth visits (with both audio and visual capacity) count for purposes of risk adjustment in Medicare Advantage and other risk-based arrangements. "In other words, when diagnoses from applicable telehealth visits meet the risk adjustment criteria, they will be used in calculating risk scores for FFS beneficiaries," the FAQ explained.

But the codes captured during telephone-only visits will not, and that was not welcome news by payers, Hirsch said.

Contact Hirsch at rhirsch@r1rcm.com and Rinkle at valerie.rinkle@valorizeconsulting.com. ✧

Endnotes

1. CMS, *COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing*, updated June 19, 2020, https://go.cms.gov/2W7cjzj.
2. COVIDSurg Collaborative, "Mortality and pulmonary complications in patients undergoing surgery with perioperative SARS-CoV-2 infection: an international cohort study," *The Lancet*, May 29, 2020, https://bit.ly/3i325Zi.
3. Humaid O. Al-Shamsi, Eric A. Coomes, and Sadir Alrawi, "Screening for COVID-19 in Asymptomatic Patients With Cancer in a Hospital in the United Arab Emirates," *JAMA Oncology*, May 27, 2020, https://bit.ly/3818akd.

NEWS BRIEFS

◆ **CMS said June 23 it has created an Office of Burden Reduction and Health Informatics**[1] to "unify the agency's efforts to reduce regulatory and administrative burden and to further the goal of putting patients first. The new office is an outgrowth of the agency's Patients over Paperwork (PoP) Initiative."

◆ **The American Hospital Association has lost its bid to stop CMS from requiring hospitals to publicly post payer-specific negotiated rates and other charges**. In a June 23 decision,[2] the U.S. District Court for the District of Columbia sided with CMS, and price transparency requirements[3] are scheduled to take effect Jan 1.

Endnotes

1. CMS, "CMS Unveils Major Organizational Change to Reduce Provider and Clinician Burden and Improve Patient Outcomes," news release, June 23, 2020, https://go.cms.gov/2YpI4UQ.
2. The American Hospital Association, et al. v. Alex M. Azar II, Civil Action No. 1:19-cv-03619 (CJN), memorandum opinion, accessed June 26, 2020, https://bit.ly/3eD9xrQ.
3. Nina Youngstrom, "Hospitals May Consider Defying Price Transparency Rule in Light of Compliance Challenges," *Report on Medicare Compliance* 28, no. 42 (November 25, 2019), http://bit.ly/36919vx.