Report on
Medicare Compliance

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

Contents

Publisher's Note

RMC will not be published for the next two weeks. The next issue will be Jan. 8, 2024. We wish you a safe and happy holiday season!

HCCA

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Incident-to Billing Drives $1M Settlement; Lawyer: 'New Problems' Aren't in Regs, Manuals

In another reminder that incident-to billing is a potential compliance landmine, Graybill Medical Group Inc. in California agreed to pay $1.061 million in a settlement with the HHS Office of Inspector General (OIG).[1] The settlement stemmed from Graybill's self-disclosure to OIG.

According to OIG's website, Graybill charged Medicare for services performed by nonphysician providers (NPPs) incident to a physician's services "when the services did not satisfy the incident-to requirements because the physician did not initiate the plan of care or remain actively involved in the course of treatment as required by the incident-to rules," OIG alleged. Also, Graybill submitted claims for services performed by NPPs although they weren't properly credentialed with Medicare or TRICARE. OIG alleged Graybill violated the Civil Monetary Penalties Law. No additional details were available by press time and Graybill didn't respond to *RMC*'s requests for comment. In 2020, it joined forces with Arch Health to become Palomar Health Medical Group.[2]

Incident-to billing offers physician practices more reimbursement for services provided by NPPs—such as physician assistants and nurse practitioners—if they comply with certain Medicare rules. For example, physicians must establish the course of treatment and provide direct supervision. Historically, to provide direct supervision, physicians were required to be in the office suite and immediately available to help the

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Contract for Health Care in Jails Shows Compliance Adaptability, a GCPG Recommendation from OIG

When Harris Health System in Texas got a contract to provide health care services at Harris County jails, it introduced challenges in both health care delivery and compliance. All of a sudden, compliance had to consider risks related to 10,000 inmates and the physicians, nurses, pharmacists and psychiatrists who would serve them.

It was a live-action version of one of the nine "primary responsibilities" of compliance officers cited in the HHS Office of Inspector General's new *General Compliance Program Guidance*, said Carolynn Jones, chief compliance and risk officer at Harris Health System.[1] Specifically, OIG said compliance officers are responsible for "revising the compliance program periodically in light of changes in the needs of the organization, applicable law, and policies and procedures of third-party payors."

That perhaps is an understatement when it came to the contract with the Harris County Sheriff's Office. Harris Health System agreed to provide health care services to inmates, who are screened at intake, entitled to health care on demand and treated for chronic conditions, Jones said. "It was almost as if we opened a new hospital." Because of the volume of services, Harris Health hired more employees and added some of the sheriff's employees who had been providing care. "The expansion of the workforce creates some risk," Jones explained. "They were educated on our compliance program, and we hung up hotline posters in their breakroom."

continued

Based on the new jail contract, the compliance team did a risk assessment and added the top risks to its work plan. One is evaluating the assessment of patients at intake. "The likelihood is you lose them to the process," Jones said. "We ended up auditing and it's in good shape now." Another risk is the medication administration process for patients with chronic conditions. "How are we ensuring those patients receive the medication as expected because it's not a prescription they can always carry around with them," Jones explained. A third risk area is the safety of employees.

As she took on the compliance aspects of the jail contract, Jones was surprised to learn it wasn't as rare as she had assumed. "There are a lot of contracts between jail and prison systems and local health care provider networks," she said. "It's not super uncommon with law enforcement because health care is not their thing."

The experience has been an object lesson in the importance of rolling with the compliance punches. "If you're not changing how you approach compliance year to year, you are falling behind," Jones said Dec. 8 at HCCA's regional conference in Houston.

Living the Other GCPG Responsibilities

She walked through other *General Compliance Program Guidance* (GCPG) expectations for compliance officers and how they play out for her.[2] The GCPG states that compliance officers should report to the CEO "with direct and independent access to the board or to the board directly" and "have sufficient stature within the entity to interact as an equal of other senior leaders of the entity." At Harris Health, Jones reports to the CEO and the compliance and audit committee, which meets quarterly. Also, she has a "predesignated space on the agenda" in case something comes up. "I have a direct line of communication to board members," said Jones, who is able to contact the board chair through cell phone or email.

To underscore that as compliance officer she's on the same level as the rest of leadership, her office is in the C-suite. "I'm wedged between our chief operating officer and chief people officer." Jones is included in C-suite meetings, even if she's just there to listen when they discuss operational changes. "There's a change in the air sometimes when the compliance officer comes in, and I'm making sure I'm not talking if I don't need to. Let the operational teams come to their conclusions. I'm there to listen and support them, but I raise a red flag if there's something off base."

The GCPG also states that compliance officers should show "unimpeachable integrity, good judgment, assertiveness, an approachable demeanor, and the ability to elicit the respect and trust of entity employees." Jones said that includes "not losing your cool" in difficult situations. For example, Harris Health faced challenges with CMS "in the compliance quality realm" (i.e., conditions of participation), and the board asked Jones to be the liaison between it and operations. "It was a very large project." She had to build relationships in a way that allowed her to challenge the organization for not meeting standards. "You have to be really mindful of how you present yourself–the words you use and the tone you use," Jones said.

'Talking to Who You Need to Talk To'

In terms of the specific primary responsibilities of a compliance officer, in addition to responding to new risks, the GCPG cites "overseeing and monitoring the implementation and operation of the compliance program." Jones said compliance officers should do an internal assessment to determine whether their compliance program is effective. For example, her department surveyed employees to gauge their awareness of compliance (see box, pages 3 and 4) and "We got good feedback to continue to mature our compliance program."

Another primary responsibility is "independently investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations (e.g., responding to reports involving, for example, compliance concerns or suspected legal violations) and to make recommendations for process and policy changes and corrective action."

To Jones, that includes having the authority to review all documents relevant to compliance and "talking to who you need to talk to." Compliance professionals should be able to go anywhere in the organization they need to go to accomplish their goals. Senior leaders and board members should make it clear to everyone that that's your role "and

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it's incumbent on us to go about this in a respectful way," Jones said. When she goes to a Harris Health hospital during an investigation, she stops by the executive administration to let them know she's in the building, but "I don't say anything more" other than "I will swing by when I'm done."

Another primary responsibility is "coordinating with human resources to ensure that all directors, officers, employees, contractors, and medical staff, if applicable, are screened before appointment or engagement and monthly thereafter against the LEIE and any applicable State Medicaid program exclusion lists." Jones said Harris Health has had situations where it thought everyone had been screened but that wasn't the case. She encourages compliance professionals to have a policy and process that sets forth next steps for when employees or contractors show up on the List of Excluded Individuals and Entities and senior leaders or board members push back on terminating the excluded employee or canceling the contract of the excluded vendor.

Contact Jones at carolynn.jones@harrishealth.org. ✧

Endnotes

1. Nina Youngstrom, "New OIG Compliance Program Guidance Puts Risk Assessment in Committee's Hands," Report on Medicare Compliance 32, no. 41 (November 13, 2023), https://bit.ly/3sVPl0O.
2. U.S. Department of Health and Human Services, Office of Inspector General, *General Compliance Program Guidance*, November 2023, https://bit.ly/3FREWGe.

Survey of Compliance Culture

Harris Health System in Texas recently asked its employees questions about the compliance program and got useful feedback, said Carolynn Jones, chief compliance and risk officer (see story, p. 1). Contact her at carolynn.jones@harrishealth.org.

2023 Culture of Compliance Survey

Compliance Cares! We want to hear your thoughts and feedback on our Compliance Program through this short survey. Your responses are 100% anonymous and confidential.

*** 1. The following describes my job title or job duties:**
❒ Medical Staff ❒ Director and Above ❒ Manager/Supervisor ❒ Clinical Staff-Non-Supervisory
❒ Non-Clinical Staff Non-Supervisory ❒ Student ❒ Volunteer

*** 2. How long have you been employed or affiliated with Harris Health System:**

❒ Less than 1 year ❒ 1-2 years ❒ 3-4 years ❒ 5-6 years ❒ 7-8 years ❒ 9-10 years ❒ More than 10 years

*** 3. Please select your current work location:**

Other location (please specify):

*** 4. How familiar are you with the following?**	**Familiar**	**Somewhat Familiar**	**Somewhat Unfamiliar**	**Unfamiliar**	**Not at all familiar**
Harris Health's Office of Corporate Compliance?	❒	❒	❒	❒	❒
Harris Health's Chief Compliance and Risk Officer, Carolynn Jones	❒	❒	❒	❒	❒
Harris Health's Deputy Compliance Officer, Anthony Williams	❒	❒	❒	❒	❒
Harris Health's Code of Conduct?	❒	❒	❒	❒	❒
Harris Health's Compliance Hotline?	❒	❒	❒	❒	❒
Harris Health Policy 3.31, Preventing Fraud, Abuse and Wrongdoing?	❒	❒	❒	❒	❒
Harris Health Policy 3.58, Non-Retaliation for Reporting Fraud, Abuse, and Wrongdoing?	❒	❒	❒	❒	❒

*** 5. To what extent do you agree or disagree with the following statements?**	**Strongly Agree**	**Agree**	**Neither Agree Nor Disagree**	**Disagree**	**Strongly Disagree**
I know where to find Harris Health's Code of Conduct.	❒	❒	❒	❒	❒
I know where to find information on Harris Health's policies and procedures.	❒	❒	❒	❒	❒
I know how to report ethical concerns or observed misconduct, including fraud, abuse, or wrongdoing, at Harris Health.	❒	❒	❒	❒	❒
Harris Health System has clearly communicated disciplinary guidelines to me; therefore, I am aware of the consequences of misconduct, including fraud, abuse, or wrongdoing.	❒	❒	❒	❒	❒
The Code of Conduct explains what is expected of me as I conduct Harris Health business.	❒	❒	❒	❒	❒
Harris Health System policies and procedures effectively explain what is expected of me as I conduct Harris Health business.	❒	❒	❒	❒	❒

*** 6. If I were to observe ethical concerns or observe misconduct, including fraud, abuse, or wrongdoing, I would be willing to report it.**

❒ Strongly Agree ❒ Agree ❒ Neither Agree Nor Disagree ❒ Disagree ❒ Strongly Disagree

*** 7. Over the past 12 months, have you reported potential ethical concerns or misconduct, including fraud, abuse, or wrongdoing at Harris Health System to your supervisor, another member of management, the Office of Corporate Compliance, or the Corporate Compliance Hotline?**

❒ Yes ❒ No ❒ Unsure/Decline to Answer

*** 8. To what extent do you agree or disagree with the following statements?**	**Strongly Agree**	**Agree**	**Neither Agree Nor Disagree**	**Disagree**	**Strongly Disagree**
I feel comfortable reporting incidents or concerns of non-compliance to my supervisor or another member of management	❒	❒	❒	❒	❒
I feel comfortable reporting incidents or concerns of non-compliance to the Office of Corporate Compliance	❒	❒	❒	❒	❒
I feel comfortable reporting incidents or concerns of non-compliance to the Corporate Compliance Hotline	❒	❒	❒	❒	❒
I feel I would be protected from retaliation if I report a suspected compliance violation.	❒	❒	❒	❒	❒

*** 9. To what extent do you agree or disagree with the following statements?**	**Strongly Agree**	**Agree**	**Neither Agree Nor Disagree**	**Disagree**	**Strongly Disagree**
I believe appropriate actions are taken when individuals engage in unethical behavior or misconduct, including fraud, abuse,or wrongdoing at Harris Health System.	❒	❒	❒	❒	❒
I believe the rules and appropriate actions for unethical behavior or misconduct, including fraud, abuse,or wrongdoing are the same for every workforce member.	❒	❒	❒	❒	❒
If I raise a concern about potential unethical behavior or misconduct, including fraud, abuse,or wrongdoing, I believe Harris Health System will fully investigate it.	❒	❒	❒	❒	❒

*** 10. How familiar are you with the following:**	**Strongly Agree**	**Agree**	**Neither Agree Nor Disagree**	**Disagree**	**Strongly Disagree**
Harris Health's Cyber/Information Security department, led by Chief Cyber and Information Security Officer (CCISO), Jeff Vinson?	❒	❒	❒	❒	❒
What functions Harris Health's Cyber/Information Security department provides?	❒	❒	❒	❒	❒
Harris Health's Annual Mandatory Cyber Security Training (completed in the summer)?	❒	❒	❒	❒	❒

*** 11. How familiar are you with the following:**	**Strongly Agree**	**Agree**	**Neither Agree Nor Disagree**	**Disagree**	**Strongly Disagree**
Harris Health's Accreditation & Regulatory Affairs team, led by Administrative Director, Vivian Ho-Nguyen?	❒	❒	❒	❒	❒
What functions Harris Health's Accreditation & Regulatory Affairs team provides?	❒	❒	❒	❒	❒
Harris Health's various accreditations, such as DNV?	❒	❒	❒	❒	❒

*** 12. Additional Comments**

Please share any additional feedback or issues you'd like Harris Health System to be aware of, along with suggestions for how to make the organization's Compliance Program better.

If you have an issue to report, please use one of the available reporting options.

Navex online:

https://secure.ethicspoint.com/domain/media/en/gui/ 78122/index.html

Hotline xxx-xxx-xxxx

If you have questions about the survey, please contact the Office of Corporate Compliance at xxx-xxx-xxxx or [its email address].

CMS Is Validating Service Locations, Another Good Reason for Internal PBD Audits

The use of modifier PO instead of PN on claims for services performed at an off-campus provider-based department (PBD) is worth eyeballing because it may generate overpayments. Hospitals could be reversing them without considering the compliance ramifications and the fact that this mistake may become more transparent now that CMS turned on validation edits Aug. 1 that will reject Medicare claims for services provided at off-campus PBDs if their addresses on claims aren't a perfect match with their addresses on 855A enrollment forms or hospitals with multiple service locations don't report the correct place where services were provided on claims.

The edits are intended to help Medicare pay off-campus PBDs accurately, CMS said in a revised version of an MLN Matters released Dec. 7, which has new information on verifying and updating service locations and using claim modifiers.[1] CMS is watching the way hospitals report practice locations to distinguish between non-excepted, off-campus PBDs, which are paid significantly less for services than excepted, off-campus PBDs. To make sure Medicare knows which is which, non-excepted locations are required to report claim lines with a PN modifier, which triggers 40% of the outpatient prospective payment system (OPPS) payment versus the PO modifier, which triggers the full OPPS payment rate.

Integration is Required

"I have seen situations where large organizations are not communicating like they should be," said Melody Mulaik, president of Revenue Cycle Coding Strategies LLC. Someone in IT or finance told the billing department to use the PO modifier without thinking about the compliance implications, she explained.

That just scratches the surface of what can go awry with compliance at PBDs. There's a long list of Medicare requirements that are always ripe for monitoring, Mulaik said at an HCCA webinar Oct. 30 (see a sample audit checklist published in the June 20, 2022, *RMC*, at https://bit.ly/4ajWaKm).

"While there is not a specific government initiative targeted at provider-based departments, I have seen quite a few organizations voluntarily self-disclose overpayments due to incorrect system setups during electronic medical record conversions or inadvertent errors caused by well-meaning staff," she explained. "For this reason, I think it is important that all organizations validate that things are as they should be and not assume accuracy without verification."

Mulaik summarized the CMS requirements for off-campus PBDs and suggested that compliance professionals use the audit checklist to evaluate compliance with them. PBDs are required to be clinically and financially integrated with their host hospitals. They must operate under the same license as the hospital unless the state requires a separate license, and professional staff at the PBD must have privileges at the hospital. For example, if the PBD is an imaging center, the reporting structure must go up to the administrator of radiology. Similarly, "The medical director should have direct line reporting," and the same goes for quality assurance, utilization review, health information management and compliance, she explained. From a financial standpoint, the clinic should be presented to the public and payers as part of the main hospital and integrated into its Medicare cost report, Mulaik said. PBDs also are required to meet various other rules, such as the Emergency Medical Treatment and Labor Act and anti-discrimination provisions, and they must treat all Medicare patients as hospital outpatients.

Think About All the Documentation

PBDs must be marketed appropriately. "It has to be clear to patients that it's one of your locations," Mulaik said. Does the PBD have the name of the hospital on its sign? Even if a hospital donor wants the PBD named after them, it still must be obvious to people that the PBD is a hospital department. Also, hospitals should think about all the documentation—patient registration forms, letterhead, bills, signage and website—that's seen by patients, Mulaik said. It should be screamingly obvious it comes from the hospital. "Make sure you're not just checking the box—'I have this sign, but it's over in the corner and nobody can really see it.' We want to make sure any person can see it and know it's a hospital department," she explained.

Deciding to Open a New PBD

Although Congress in Sec. 603 of the Bipartisan Budget Act of 2015 ended regular OPPS billing for PBDs that open for business after Nov. 2, 2015, new PBDs may be worth establishing for other reasons, including eligibility for 340B drugs.

Mulaik suggests a systematic approach to planning the development of a PBD, including an "appropriate multi-disciplinary review" (see box, p. 6). She predicts it will take six months because of myriad requirements. For example, "we have to validate the physical location." Off-campus PBDs generally must be more than 250 yards from the hospital's main campus but within 35 miles. There are a lot of decisions to make (e.g., what services will be provided?) and hoops to jump through (e.g., Medicare enrollment, CLIA accreditation).

The pending PBD also will require many approvals, including legal (requirements are met); finance (budgets, cost report inclusion); managed care (adding the location, completing enrollment); chargemaster (e.g., setting prices); IT (e.g., ensuring the correct modifiers are appended); revenue cycle (e.g., validating accurate billing practices); and operations (e.g., reviewing "the setup aligns with operational objectives").

Contact Mulaik at melody.mulaik@rccsinc.com. ✧

Endnotes

1. Centers for Medicare & Medicaid Services, "Activation of Validation Edits for Providers with Multiple Service Locations," MLN Matters Number: SE19007 Revised, December 7, 2023, https://go.cms.gov/3uZOsoD.

In Phishing-Related HIPAA Settlement, Medical Group Pays $480,000

Lafourche Medical Group (LMG) in Louisiana has agreed to pay $480,000 in the first HIPAA settlement related to phishing, the HHS Office for Civil Rights (OCR) said Dec. 7. Phishing is a kind of cybersecurity attack used to trick people into revealing sensitive information by email or other electronic communication through impersonation of a trusted source.

According to LMG's resolution agreement with OCR, LMG filed a breach notification report in May 2021 explaining it discovered two months earlier that an unauthorized person had gained access to one of its owner's email accounts through phishing.[1] LMG ascertained the email account had the protected health information (PHI) of patients. Because it was unable to identify which patients were affected, LMG told all 34,862 patients what happened.

In January 2022, LMG was informed that its compliance with aspects of the privacy and security rules and the breach notification rules were under investigation. OCR concluded that before the breach, LMG hadn't done a risk analysis to identify possible threats to electronic PHI and it didn't have policies or procedures "to regularly review information system activity to safeguard protected health information against cyberattacks," OCR noted in its press release.

Those gaps, and the number of people affected, are probably why the settlement amount was so high, said Robert Trusiak, an attorney in Buffalo, New York. "The requirements of the HIPAA Security Rule have been in effect since 2005" and covered entities have had plenty of time to get up to speed. "You have to have built into your security risk analysis regular phishing exercises," he noted.

That said, phishing has evolved and is increasingly hard for employees to detect, Trusiak said. Gone are the days of phishing emails that are obviously garbled and don't "pass the eyeball test." They tend to be perfect now. Trusiak had

Sample Request Form for New Provider-Based Departments (PBDs)

Here's a form to get the ball rolling on new PBDs (see story, p. 5). It was developed by Melody Mulaik, president of Revenue Cycle Coding Strategies. Contact her at melody.mulaik@rccsinc.com.

Sample Request Form

Requestor Information		
Name	Title	Request Submitted Date
Email		Phone
☐ I attest that the Department Requirements Checklist has been completed and that I will submit the checklist with this request form.		
Service Location Information		
☐ New Service and Location ☐ New Service at Existing Location ☐ Other_____		
DBA Information		
Legal Name		Proposed Opening Date
Physical Address		
City		Zip
Provider and Hospital Information		
Affiliated Hospital	Affiliated Hospital Tax ID#	
Location	☐ On-Campus ☐ Off-Campus	If Off-Campus, how many miles from Affiliated Hospital?

Services Provided per Location	
Services Provided ☐ ED ☐ Diagnostic Imaging ○ Has the ACR Accreditation application been submitted? ☐ Lab with Onsite Processing ○ Has a CLIA Certificate been requested with Form CMS-116? ☐ Lab with Collection Only ○ Where will samples be sent?_____ ☐ Rehab ☐ Other_____	Will the services provided be a duplicate of an existing location? ☐ Yes - Existing Location Name_____ ☐ No Additional Information:

a hospital client shut down for three days because of an email ostensibly from a law firm. The law firm showed up on Google; "It's just that their likeness had been hijacked by this malware actor," said Trusiak, with Trusiak Law PLLC. He has also seen phishing emails purportedly from an organization's IT department that tell employees, "You need to call in the next 30 minutes to avoid losing your IT functionality. Please provide your user name and password. There are users in the organization who will view the email as legitimate." That's why Trusiak believes it's necessary to have a zero-trust solution. "It's important to have phishing exercises, but they are rudimentary," he said. No matter how much organizations educate, a percentage of their employees will click on phishing email.

Lawyer: Zero Trust Is Tied to Cyber Insurance

The concept of zero trust has been around since 2010, and it's becoming the norm for protecting devices. As the name implies, zero-trust technology prevents anyone from connecting to a device in the network unless a person has specifically been given permission through authentication.

"It doesn't allow the threat to mitigate across servers and then you kill it," Trusiak said. Another important reason: It will take zero-trust solutions to get adequate cyber insurance.

LMG didn't admit liability in the settlement. Its owner didn't respond to *RMC*'s request for a comment.

Contact Trusiak at robert@trusiaklaw.com. ✧

Endnotes

1. U.S. Department of Health and Human Services, "Lafourche Medical Group, LLC Resolution Agreement and Corrective Action Plan," resolution agreement, content last reviewed December 7, 2023, https://bit.ly/3Rs3DP5.

Practice Settles Incident-to Billing Case

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patient, but CMS now allows physicians to be offsite if they're available via audio/visual communication (virtual supervision). Also, incident-to services must be billed under the supervising physician, who doesn't have to be the same physician who initiated the course of treatment.

And although Medicare administrative contractors (MACs)—and seemingly the world at large—insist NPPs aren't permitted to treat patients for "new problems," that's a fiction, said attorney David Glaser, with Fredrikson Byron in Minneapolis. The regulations and Medicare manuals never mention new problems with respect to incident-to billing, something that physician practices should keep in mind before they return overpayments based on new problems treated by NPPs and billed incident to, he said.

The upside for practices of incident-to billing: Services performed incident to the physician are billed at 100% of the Medicare Physician Fee Schedule. Otherwise, NPPs' services are billed under their own National Provider Identifier (NPI) at 85% of the fee schedule. The 15% differential is what practices owe Medicare if they don't comply with incident-to requirements.

Incident-to billing gets under physicians' skin because one false move and they face repayment or worse. "It's a huge risk area and to get to a $1 million settlement"—like Graybill Medical Group did—is unusual, considering it's based only on the 15% spread between 100% and 85% reimbursement, although some of the settlement dollars stem from the NPPs who were not properly credentialed, Glaser said.

"This is a risk area so fraught with risk for overpayments," said Jean Acevedo, president of Acevedo Consulting in Delray Beach, Florida. She has encountered more practices lately that have abandoned incident-to billing in favor of direct billing by the NPP at the 85% rate.

The framework is contradictory from the get-go, Glaser said. According to the regulation on incident-to billing, "services and supplies must be an integral, though incidental, part of the service of a physician (or other practitioner) in the course of diagnosis or treatment of an injury or illness."[3] Glaser thinks "integral" and "incidental" conflict; "integral means it's a core part of the thing and incidental is mostly irrelevant but the rule says it has to be both."

Even more inexplicably, the regulation allows NPPs to bill incident to the physician for both diagnosis and treatment, but the *Medicare Benefit Policy Manual* just mentions treatment, he noted. That could lead people to conclude CMS got rid of diagnosis by NPPs for incident-to billing, except the regulation allows both diagnosis and treatment and it trumps the manual. In other words, NPPs are permitted to diagnose new problems. He's baffled why it's not clear to everyone that new problems are included in incident-to billing. A new problem by definition is a diagnosis and the rule explicitly authorizes "diagnosis" to be performed incident to, Glaser said. But for whatever reason,

CMS Transmittals and *Federal Register* Regulations, Dec. 8-14

Transmittals

Pub. 100-04, Medicare Claims Processing

- New Place of Service (POS) Code 27 - "Outreach Site/Street", Trans. 12,411 (Dec. 14, 2023)
- CY 2024 Home Infusion Therapy (HIT) Payment Rates and Instructions for Retrieving the January 2024 Home Infusion Therapy (HIT) Services Payment Rates Through the CMS Mainframe Telecommunications System, Trans. 12,406 (Dec. 13, 2023)

Pub. 100-20, One-Time Notification

- Updating Calendar Year (CY) 2024 Medicare Diabetes Prevention Program (MDPP) Payment Rates, Trans. 12,410 (Dec. 13, 2023)
- Direct Mailing Notification to Hospice Providers Regarding the Value-Based Insurance Design (VBID) Model, Hospice Benefit Component, Participating Medicare Advantage Organizations, Trans. 12,405 (Dec. 13, 2023)

"everyone believes new problems can't be handled incident to. Every MAC says you can't treat new problems."

The phrase that carries weight is "course of treatment," he said. As the *Medicare Benefit Policy Manual* notes, "Such a service or supply could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment. (However, the direct supervision requirement must still be met with respect to every nonphysician service.)."[4]

Suppose the NPP is administering chemotherapy to treat a cancer patient. Along the way, the patient comes down with an infection. "It's clearly a new problem," Glaser said. "Is it part of the course of treatment? Absolutely. It's related to the chemotherapy. It's billable incident to and we know this because of the regulation that says diagnosis and treatment."

Reassignment Mistakes Are Not Overpayments

Certain unforced errors come with incident-to billing. For example, it's clearly unavailable when the patient is brand new to the practice, Acevedo said. But there's a disconnect when a patient who has already seen the physician and has a plan of care arrives for a follow-up with the physician assistant (PA), who recommends a change in medication or dose. "I said, you have created a new plan of care. It's a new problem," Acevedo explained. "They said, 'I can treat a new problem.'" Acevedo's answer: The PA can, in fact, under her scope of practice, but not for Medicare billing purposes. All that means is the PA bills the evaluation and management visit under her own NPI. "That's the biggest thing." (Her view on new problems differs from Glaser's.)

Acevedo also has found that physician practices don't always realize their NPPs must be enrolled in Medicare to bill incident to. It's not good enough to be licensed by the state.

She noted that in the Graybill case, OIG alluded to the continuing involvement of physicians, but that concept has never been defined. She hasn't able to pin down for her clients how often the physicians must see the patients to feel comfortable about the NPPs billing incident to the physician. "I've never seen any of the MACs or CMS document anything definitive," Acevedo said.

Another common mistake with incident-to billing is when the practice bills for incident-to services under the NPI of the physician who initiated the course of care instead of the physician who supervised the care, Glaser said. The good news is it doesn't translate into an overpayment. "An otherwise correct Medicare payment made to an ineligible recipient under an assignment or other authorization by the provider does not constitute a program overpayment," according to the *Medicare Claims Processing Manual*.[5] But "it's not a good thing to do," Glaser noted. "You can lose your ability to do reassignment, but it's not an overpayment."

Contact Glaser at dglaser@fredlaw.com and Acevedo at jacevedo@acevedoconsulting.com. ✧

Endnotes

1. U.S. Department of Health and Human Services, Office of Inspector General, "Graybill Medical Group Agreed to Pay $1 Million for Allegedly Violating the Civil Monetary Penalties Law by Submitting Claims for Incident-to Services Not Covered and for Service by Uncredentialed Providers," enforcement action, November 3, 2023, https://bit.ly/3Ns2AgH.
2. City News Services, "Medical companies merge to form Palomar Health Medical Group," *Poway News Chieftain*, December 1, 2020, https://bit.ly/46XF9mn.
3. 42 C.F.R. § 410.26, https://bit.ly/3GHWvsM.
4. Centers for Medicare & Medicaid Services, "Chapter 15 – Covered Medical and Other Health Services," *Medicare Benefit Policy Manual*, Pub. 100-02, revised October 12, 2023, https://go.cms.gov/2VSe3Mn.
5. Centers for Medicare & Medicaid Services, "Chapter 1 – General Billing Requirements," *Medicare Claims Processing Manual*, Pub. 100-04, revised January 19, 2023, https://go.cms.gov/3uQPvak.

NEWS BRIEFS

◆ **The Program for Evaluating Payment Patterns Electronic Report (PEPPER), CMS's free compliance monitoring resource, is unavailable for unknown reasons.** A CMS spokesperson told RMC that "CMS understands the importance of PEPPERs to the hospital community and is working to make them available again in the near future." Ronald Hirsch, M.D., vice president of R1 RCM, said many hospitals normally use the early December PEPPER release "to formulate their compliance plans for the next calendar year. Add to that the lack of communication from CMS or the contractor on the delayed release and this becomes not simply an inconvenience but also a mystery."

◆ **The HHS Office of Inspector General on Dec. 14 released a toolkit to "help decrease improper payments in Medicare Advantage through the identification of high-risk diagnosis codes."**[1]

◆ **CMS announced place of service (POS) code 27 (Outreach Site/Street).**[2] "This is a non-permanent location on the street or found environment, not described by any other POS code, where you provide preventive, screening, diagnostic, or treatment services to unsheltered, homeless patients."

Endnotes

1. Amy Frontz, Deputy Inspector General for Audit Services, *Toolkit To Help Decrease Improper Payments in Medicare Advantage Through the Identification of High-Risk Diagnosis Codes*, December 2023, A-07-23-01313, https://bit.ly/3RLF6WF.
2. Centers for Medicare & Medicaid Services, "New Place of Service Code 27 for Outreach Site/Street," MLN Connects, December 14, 2023, https://bit.ly/3NsTa4M.