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Contents

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Managing Editor
Nina Youngstrom
nina.youngstrom@hcca-info.org

Copy Editor
Bill Anholzer
bill.anholzer@hcca-info.org

CMS: New Addendum Is Required for Non-Covered Services as a Hospice Condition of Payment

After a patient with a terminal diagnosis of end-stage renal disease (ESRD) was admitted to hospice care, he continued to receive treatment for diabetes. Because the diabetes is related to the ESRD, the hospice absorbs the costs of the diabetes medication and treating his diabetic wounds. But when the patient sees a podiatrist for brittle nails, there's a question of where the charges should land. If they're unrelated to the diabetes, the podiatrist will bill Medicare directly, but related services are the hospice's responsibility. The answer, writ large across Medicare, is potentially a very expensive one, and CMS wants more transparency to avoid separate charges for goods and services that should have been included in hospice per diem payments.

To that end, hospices are now required to give patients, at their request, a hospice election statement addendum—which notifies them of items, services and drugs not covered under the Medicare hospice benefit—in addition to the election statement. The addendum, which was announced in the 2020 Hospice Payment Rate Update final rule,[1] didn't take effect until Oct. 1, said Regina Alexander, director of IRO Services at BerryDunn. CMS also modified the election statement in the 2021 hospice regulation and provided a model hospice election statement and addendum[2] (see box, p. 7).[3]

continued on p. 5

Newer COVID Risk Areas Include Vaccine Administration; More 'Risk Tolerance' Is Seen

When Providence St. Joseph Health discovered that a large order of personal protective equipment (PPE) was fraudulent, the health system, which has hospitals and clinics in seven states, set a chain of events in motion.

"We had to track the supply, get it off the shelves, and identify where it went and who used it," said Sheryl Vacca, senior vice president and chief risk officer, at the Health Care Compliance Association's regional conference[1] in Alaska Feb. 25. "It was a forensic investigation, right down to the person level to make sure they weren't exposed to COVID while working for us. This was a tough thing."

PPE fraud and issues around PPE testing and availability are some of the new and emerging compliance risks of the COVID-19 pandemic. Even though Providence St. Joseph Health's supplier had given its assurance about the PPE, including N95 masks, "they didn't meet the quality test," Vacca said. "Hopefully, you can demonstrate you have a process where you looked at the integrity of everything."

Vaccine administration is another new risk. "The Department of Justice has started to investigate the inappropriate administration of vaccines to people who don't meet guidelines," Vacca said. "I am aware of several organizations where the Department of Justice is looking into their activities around vaccine administration and not meeting eligibility criteria" from the Centers for Disease Control and Prevention (CDC). Most or all states have adopted CDC guidelines for the first and second priority groups (e.g., frontline health care workers, nursing home residents

continued

and people over age 75), according to KFF,[2] although "in some cases, states are broadening and simplifying the priority groups."

The states provide the doses to hospitals, pharmacies and other providers, which put shots in arms. "There are organizations that said, 'Come one, come all,' and there are others who tried to stick closely to the [CDC] guidelines," Vacca said. "We know at the end of the day there were doses left over, and no one wants to see a wasted dose." But compliance professionals want to be able to say the hospital didn't give donors or board members special access to the vaccine and complied with eligibility criteria with the exception of doses that were about to expire and would have otherwise gone to waste if they hadn't been administered to people who were available.

Another angle: Providers that bill for vaccine administration could face False Claims Act allegations if they did not meet eligibility requirements, Vacca noted.

More Risk Tolerance From Management

There are many other pandemic-related risks, including audits of the $178 billion made available to providers from the Provider Relief Fund, telehealth (see story, p. 3)[3] and cybersecurity, to name a few. Yet "we have seen an increased risk tolerance by management," said Debbie Troklus, president of Troklus Compliance Consulting, at the conference. The attitude is, "we can't handle this because of COVID," she said. "Risks that should have been addressed by management have been pushed aside, and compliance has been left out of conversations." The minutes of one organization that normally discussed compliance in executive meetings had no mention of it recently "because of the other C: COVID."

Some organizations also are delaying audits. A delay in risk assessments and audits will translate to "problems down the road," Troklus said. There also are facilities that have discontinued compliance and privacy training for employees, "which is dangerous," she said. "You have to keep that in the forefront of people's minds."

Because COVID-19 is "a clinical emergency," Vacca has found that people are so focused clinically they tend to leave out colleagues who could advise or help them proactively. If compliance professionals don't keep their seat at the table and remind people of risks, "you will be forgotten." Vacca also encouraged compliance officers to be part of the process as organizations make decisions about growth. "Our compliance risks are not just related to where we give care. We have to make sure we have a voice" when looking at enterprise risks.

Conflicts of interest, which are a perennial compliance risk area, take on a new spin with the pandemic. "This is a very emotional one," Vacca said. Some COVID-19 patients who have long hospital stays may insist on giving large-dollar gifts (e.g., $1,000) to nurses or other clinicians who cared for them. Relationships are formed during extended stays, and the patient may say something like, "I want to give you money. I know you need it. I have to show my appreciation," she said. "It is when patients target a small group of individuals, we try to discourage that."

Cybersecurity and privacy are pressing concerns, magnified with the growth in telehealth and remote work. "Think how many meetings occurred virtually, and information could have been overheard," Vacca said. At the same time, "bad actors are learning more about how to hack into the systems, and we were not as careful because we were responding quickly to an emergent situation. As a result, there was a tightening of the screws." Although the HHS Office for Civil Rights "gave us some grace in some areas around the privacy aspects" with its HIPAA enforcement discretion, she said they will be back.

Another privacy concern is the additional data requests from states and counties. For example, they want to know who was sickened with COVID-19 at work at the individual caregiver level. "We had to think about the privacy of those individuals versus the need

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for the public to know," Vacca said. The decision was made to report the data in an aggregated way in smaller communities "so you couldn't reverse engineer and identify who the individual was."

With the vaccine shining a light at the end of the pandemic tunnel, compliance officers should be preparing for the new normal, whatever that will be, Vacca said. Will the compliance department continue to work virtually, go back to the office or have a hybrid environment? What kind of space will there be, with some hospitals reducing their real estate footprint? And what about business travel? It will be disrupted for some time, with health care expected to take two years to get back to some version of normal, Vacca said. "The question is, how do you identify what is right in coming back, while decreasing bricks and mortar and travel costs and still maintaining a culture of relatedness? It's tough."

Contact Vacca at sheryl.vacca@providence.org and Troklus at debbie@troklusconsulting.org. ✧

Endnotes

1. Debbie Troklus and Sheryl Vacca, "The COVID Pandemic, Current State, and Emerging Risks," Alaska Regional Healthcare Compliance Virtual Conference, Health Care Compliance Association, February 25, 2021.
2. Jennifer Kates, Jennifer Tolbert, and Josh Michaud, "The COVID-19 'Vaccination Line': An Update on State Prioritization Plans," KFF, January 11, 2021, http://bit.ly/37PENTn.
3. Nina Youngstrom, "Telehealth Risks Come into Focus; Some Payers Don't Cover Audio-Only," *Report on Medicare Compliance* 30, no. 8 (March 1, 2021).

Telehealth Risks Come into Focus; Some Payers Don't Cover Audio-Only

After the 2021 Medicare Physician Fee Schedule extended coverage of many telehealth services until the end of the public health emergency (PHE), including audio-only visits by physicians and nonphysician practitioners, UofL Health in Louisville, Kentucky, was informed that one of its commercial insurers wouldn't be jumping on that bandwagon. Some commercial payers insist on real-time audiovisual technology for telehealth services to qualify for reimbursement, said Shelly Denham, senior vice president of compliance, risk & audit services. "It's a challenge," she said. "I thought the whole idea is to not make it burdensome to provide telehealth services. We are put in a bad situation when it comes to navigating telehealth" because payers have different rules.

Because it's a matter of a negotiated contract with a commercial payer versus a regulation, however, there's always room for discussion. UofL hopes to persuade the commercial payer to recognize and reconsider its position on audio-only telehealth services. "It's still evolving," Denham said.

These are the kinds of challenges that led UofL to create a telehealth service line and hire a full-time executive director. "We are looking to grow the service line because of COVID-19 and the public health emergency," she said. "We see opportunities for growth in rural areas," which will continue when the PHE ends because Medicare coverage of telehealth is limited by the originating site and rural area requirements without the PHE. The originating site requirement restricts coverage to services delivered to patients at hospitals and other provider locations (not patient homes), and the rural area requirement limits coverage to counties outside a metropolitan statistical area or in a rural health professional shortage area. Only Congress can eliminate these requirements, and several bills have been proposed to that effect. During the PHE, however, Medicare pays for telehealth services in all corners of the country and in patients' homes.

Denham said telehealth audits continue as well, and there are areas ripe for education and documentation improvement. Some areas to pay attention to: the provider's failure to document patient consent in the record and billing for telehealth services that may not qualify as telehealth. Also, in Kentucky, telehealth encounters must be signed in 48 hours. Another problem that has cropped up, and apparently it's not uncommon, is that documentation sometimes makes it seem like the services were delivered in person.

"Services provided by telehealth aren't always documented with the right modifier or the right information to know it's a telehealth versus an in-person visit," said Lori Laubach, a partner in the health care consulting practice at Moss Adams. As an independent review organization, Moss Adams just completed a claims review for a facility that's under a corporate integrity agreement. Some claims have modifiers they shouldn't have because they weren't telehealth services and vice versa. Even without a payment difference, "you should be able to tell which are telehealth services and which aren't."

What Will an Auditor Think Two Years From Now?

The many moving parts of telehealth make it a big compliance risk area. CMS has added telehealth services, some permanently and others until the end of the year in which the PHE ends,[1] and has been flexible with licensure. The greatest challenge may be keeping track of what telehealth services are covered during the PHE and who may provide them, and ensuring that when the PHE ends, there's documentation to show future auditors that services were provided consistent with CMS and state requirements in place at the time, Laubach said. With a good monitoring system,

"you would know why you used those bill types or revenue codes," Laubach said. For example, outpatient occupational, speech and physical therapy provided by telehealth may be billed during the PHE (for dates of service starting March 1, 2020), until the end of the PHE. It's paid separately with the 95 modifier, not bundled into the institutional payment.

There are challenges with workflow "because every organization is set up differently," she said. For example, organizations have to decide how to code and bill when the technology fails and the physician defaults to a phone call, or patients don't have access to a computer or the internet or they are uncomfortable with smartphones or computers. "Make sure the workflows are discussed and captured," Laubach said. "A lot of people don't have broadband, so getting to telehealth is very difficult. People think everyone is on computers, but they're not." When audiovisual technology is available but it's disrupted and the physician and patient switch to a phone call, there has been confusion about whether to bill it with the usual evaluation and management codes or the audio-only codes (CPT 99441-99443) for physicians and nonphysician practitioners. CMS gave some guidance in its answers to COVID-19 frequently asked questions[2] : "Practitioners should report the code that best describes the service. If the service was furnished primarily through an audio-only connection, practitioners should consider whether the telephone evaluation and management or assessment and management codes best describe the service, or whether the service is best described by one of the behavioral health and education codes for which we have waived the video requirement during the PHE for the COVID-19 pandemic. If the service was furnished primarily using audio-video technology, then the practitioner should bill the appropriate code from the Medicare telehealth list that describes the service."

Workflow is one of the telehealth topics addressed in a series of free presentations for ambulatory providers by Telemedicine Hack,[3] a resource provided by Project ECHO and the University of New Mexico, Laubach said.

There also may be concerns that telehealth services don't meet quality of care expectations, she said. "There have been clients who received calls about telehealth services and didn't think anything was solved. All that happened was a chat with a provider." On the flip side, "one provider mentioned to me she is probably doing a better job on quality of care because she can see why the patient is always falling down." The iPhone camera lets the provider see inside the patient's house, and her son gave the provider a tour for potential fall risks. Providers should think through whether telehealth is the right way to deliver care and the substance of their telehealth encounters and perhaps survey patients afterward.

Laubach also recommended mining data to identify telehealth risks, although it's easier said than done. On one project, her first inclination was to pull data with the telehealth modifier, but "it was an exercise in futility. I should be able to find the telehealth modifier, but the government hasn't held you accountable for that." As a result, the universe of telehealth services may not be big enough or accurate. "If you ask for every outpatient, you will have a very large file," she noted. "It was very hard to do." One approach may be a random probe sample to identify which providers are delivering telehealth services in certain departments. Data mining also will turn up anomalies. "I was surprised to see chiropractors in there," she said.

Chart reviews also are foreshadowing compliance problems post-PHE. "During this period, we have seen in chart reviews where providers used telehealth, but the supervision wasn't documented or entered into the system," Laubach said. "We see a future where providers who are not qualified outside the PHE to provide these services" continue when the PHE ends, she said. "Make sure you have controls in place when the PHE ends."

Contact Denham at shelly.denham@ulp.org and Laubach at lori.laubach@mossadams.com. ✧

Endnotes

1. Nina Youngstrom, "Final Physician Rule Changes Supervision, Adds Telehealth Codes, Some Permanently," *Report on Medicare Compliance* 29, no. 43 (December 7, 2020), http://bit.ly/35jzF8w.
2. CMS, "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing," updated February 19, 2021, https://go.cms.gov/2W7cjzj.
3. "Telemedicine Hack," The University of New Mexico, accessed February 25, 2021, http://bit.ly/3pTuwLV.

Federal Register Regulations, Feb. 19-25, 2021

Federal Register

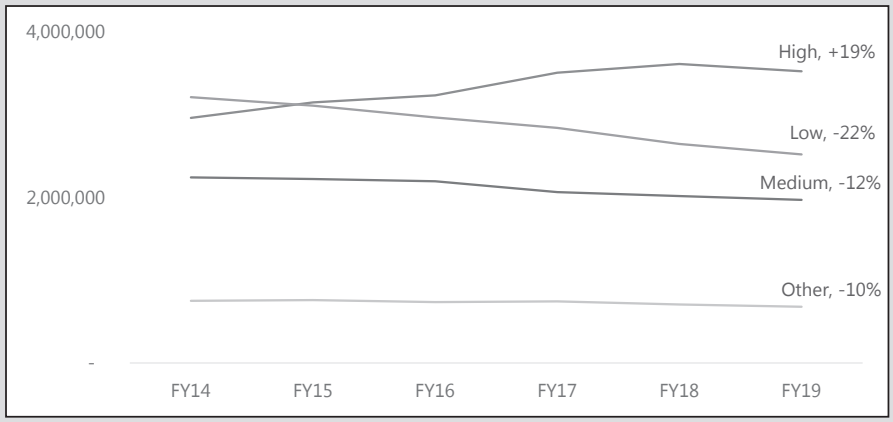
Final rule with comment period and interim final rule; correction

- Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; Physician-Owned Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity To Apply for Available Slots; Radiation Oncology Model; and Reporting Requirements for Hospitals and Critical Access Hospitals (CAHs) to Report COVID-19 Therapeutic Inventory and Usage and To Report Acute Respiratory Illness During the Public Health Emergency (PHE) for Coronavirus Disease 2019 (COVID-19); Correction, 86 Fed. Reg. 11,428 (Feb. 25, 2020)

OIG: Medicare Billing for Expensive Inpatient Stays Rose 20%

Hospitals have been billing for more inpatient stays for patients at the highest severity level, even though the average length of stay has decreased for the same patients, according to a new report from the HHS Office of Inspector General (OIG).[1] The number of stays at the highest severity level climbed almost 20% from fiscal year (FY) 2014 through FY 2019, "ultimately accounting for nearly half of all Medicare spending on inpatient hospital stays," OIG said. "Stays at the highest severity level are vulnerable to inappropriate billing practices, such as upcoding." The highest severity levels are reflected in claims with a principal diagnosis and secondary diagnoses that are considered complications and comorbidities, increasing the reimbursement of the MS-DRG. OIG recommended CMS do targeted reviews of MS-DRGs, inpatient stays that are vulnerable to upcoding and the hospitals that show up in the reviews. "The pandemic has placed unprecedented stress on the country's health care system, making it more important than ever to ensure that Medicare dollars are spent appropriately." CMS wasn't receptive. It said recovery audit contractors (RACs) already conduct DRG validation reviews of higher-paying DRGs, although it will share OIG's findings with the RACs. Also, CMS said there could be other reasons for the drop in the length of stay. "Without conducting targeted medical review, it is unclear whether the trend could be explained by other factors such as increases in efficiencies of care, advancements in technology, the transition to the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Clinical Modification (ICD-10-CM), or other changes during this period."

Exhibit 2: The number of stays at the highest severity level increased while stays at each of the other severity levels decreased from FY 2014 through FY 2019.



Endnotes

1. HHS Office of Inspector General, *Trend Toward More Expensive Inpatient Hospital Stays in Medicare Emerged Before COVID-19 and Warrants Further Scrutiny*, OEI-02-18-00380, February 2021, https://bit.ly/2PafgxC.

CMS Requires Addendum on Request

continued from page 1

Hospices should be on high alert. The addendum is a condition of payment, and it has precise requirements, Alexander said. Also, the HHS Office of Inspector General has an audit item[4] on its Work Plan of Medicare payments made outside of the hospice, which it said it will issue this year. "The hospice agency assumes responsibility for medical care related to the beneficiary's terminal illness and related conditions," OIG explained. "Medicare continues to pay for covered medical services that are not related to the terminal illness." The new, mandatory addendum lists the noncovered items and services that relate to the hospice patient's terminal illness and related and unrelated diagnoses after consultation with the hospice physician, Alexander said. Medicare requires hospices to give patients or their representatives the addendum within five days of signing the election statement (if they want it) or three days after they request it if it was initially declined.

Because the addendum is a condition of payment, hospice claims may be denied when the addendum is not in the medical records. If the hospice claims are audited, and the addendum is missing, inaccurate or provided late, "the claim is at risk for recoupment," Alexander said Feb. 22 at a Health Care Compliance Association webinar.[5] "Every day that you are late getting a notice from the patient, you may lose payment for that day."

Sometimes patients decline the addendum, but that isn't necessarily burden relief for hospices. "It may seem like a win when a patient or representative declines the election addendum at the time of admission, but not so fast," she said. They may reconsider, and the hospice

only has three days to comply. "Electing hospice is not an easy decision for patients or their families. Staff should avoid the temptation to rush through explaining the choice to receive an addendum on the notice of election form, because if that 'no thanks' changes to a 'yes please' just a day or two later, the hospice provider has now lost two calendar days to provide the notice," she explained.

Addendum Must Be Easy Reading

Although the addendum is a list of items and services that are not covered by the hospice, it shouldn't be confused with an advance beneficiary notice, which warns patients of their liability for items and services not covered by Medicare. The addendum is designed to help prevent Medicare Parts B and D from picking up the tab for items and services that are the hospice's responsibility and help the hospice understand what items and services the patients need, Alexander said. "The addendum is supposed to provide clarity and should generate a more fulsome conversation with a patient about what care they receive and their comorbidities."

CMS has very specific requirements for the presentation of the addendum. "All of the requirements are important, but arguably the most challenging to operationalize and comply with" is that the written clinical statement on the addendum must be in plain language, she said. The clinical statement explains why the item or service is not covered (i.e., unrelated to the terminal diagnosis). Plain language could be a fifth-grade reading level, for example, depending on what's appropriate for your patient population, Alexander said. Hospices can run their addendum through free readability tools online, such as Flesch-Kincaid, to evaluate the reading level necessary to comprehend a document on first reading.

CMS also requires hospices to translate the addendum into another language, if necessary, Alexander said. "This is an anti-discrimination aspect that could cause delays if the hospice is not prepared," she explained. Hospices should be familiar with the most common languages spoken in their service area and "have a strategy for translation in a tight turnaround time."

OIG Report Led to Addendum

The impetus for the changes to the hospice election statement and the creation of a mandatory election statement addendum was a 2016 OIG report[6] urging CMS to improve their election statements and certifications of terminal illness, Alexander said. OIG found that hospices "did not always mention—as required—that the beneficiary was waiving coverage of certain Medicare services by electing hospice care or that hospice care is palliative rather than curative," the report stated. Some hospices gave the election statement another name (e.g., financial agreement) or used small print to explain the palliative nature of hospice care, which may make it hard for some patients and caregivers to read.

At the same time, CMS has wondered why it pays for items and services under Part B and D (e.g., drugs) when patients are in hospices because their flat fee should cover most items and services, Alexander said. The filing of the notice of election serves to notify the Medicare administrative contractor and Common Working File of the patient's hospice election, and claims for services performed by other providers should be flagged on the back end. The addendum could help prevent the payments on the front end.

Dementia Diagnosis: What's Related?

The decision about whether an item, service or drug is related is made by hospice physicians, although they don't have to personally complete the form. "Relatedness is not determined by the CFO [chief financial officer] or administrator based on the cost to the hospice provider," Alexander said. It's a medical decision, and decision pathways should be documented and consistent, "not anecdotal or varied based on the day of the week or clinician on duty," she said. For example, as end-stage dementia becomes a more common primary diagnosis for hospice patients, "I can see people debating what's related to what. You have to be judicious" when items, services and drugs are put on the noncovered list, "and you have to be able to defend it." The addendum also may have to be modified if the patient's condition changes, so it should be part of the interdisciplinary group's discussions when it meets every 15 days.

As of Oct. 1, 2020, CMS also requires hospices to add new language to the election statement about the "holistic, comprehensive nature of the Medicare hospice benefit" and the possibility there will be items, drugs or services that are not covered by hospice (a reference to the addendum), "although it would be rare." Hospices also must provide information about cost-sharing for hospice services and their right to object to the hospice's determination that an item is unrelated to the hospice care to a beneficiary and family centered care quality improvement organization.

Contact Alexander at ralexander@berrydunn.com. ✧

Endnotes

1. Medicare Program; FY 2021 Hospice Wage Index and Payment Rate Update, 85 Fed. Reg. 47,070 (August 4, 2020), https://bit.ly/3bz5Lzy.

continued on p. 8

Sample Document: CMS's New Notice of Non-Covered Items, Services and Drugs for Hospice Patients

As of Oct. 1, 2020, CMS requires hospices to offer patients a hospice election statement addendum—which notifies them of items and services not covered under the Medicare hospice benefit—in addition to the election statement. Because the addendum is a condition of payment, hospice claims are at risk of denial when the addendum is not in the medical records, is inaccurate or provided late (see story, p. 1),[1] said Regina Alexander, director of IRO Services at BerryDunn. Contact her at ralexander@berrydunn.com.

Patient Notification of Hospice Non-Covered Items, Services, and Drugs Example

Date of Request _____ **Hospice Agency** _____

(Hospice must furnish this addendum within 5 days if requested at the time of hospice election and within 72 hours if requested during the course of hospice care.)

Patient Name _____ **MRN** _____

Diagnoses Related to Terminal Illness and Related Conditions (hospice is responsible to cover all items, services and drugs):

1.	**4.**
2.	**5.**
3.	**6.**

Diagnoses Unrelated to Terminal Illness and Related Conditions:

1.	**4.**
2.	**5.**
3.	**6.**

Non-covered items, services, and drugs determined by hospice as not related to my terminal illness and related conditions:

Items/Services/Drugs	Reason for Non-coverage

Note: The hospice makes the decision as to whether or not conditions, items, services, and drugs are related for each beneficiary. This addendum should be shared with other healthcare providers from which you seek items, services, or drugs, unrelated to your terminal illness and related conditions to assist in making treatment decisions.

Right to Immediate Advocacy

As a Medicare beneficiary you have the right to appeal the decision of the hospice agency on items not be covering because the hospice has determined they are unrelated to the individual's terminal illness and related conditions. You have the right to contact the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) for immediate assistance.

Visit this website to find the BFCC-QIO for your area. https://qioprogram.org/contact-zones or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Acknowledgement of non-covered items, services, and drugs not related to my terminal illness and related conditions

The purpose of this addendum is to notify beneficiary (or representative), in writing, of those conditions, items, services, and drugs the hospice will not be covering because the hospice has determined they are unrelated to the individuals terminal illness and related conditions. I acknowledge that I have been given a full explanation and have an understanding of the list of items, services and drugs not related to my terminal illness and related conditions not being covered by hospice. Signing this addendum (or its's updates) is only acknowledgement of receipt of the addendum (or its updates) and not necessarily agreement with the hospice's determinations.

_____ _____

Signature of Beneficiary/Representative **(Date Signed)**

☐ Beneficiary is unable to sign -Reason: _____

_____ _____

Witness signature **(Date Signed)**

Endnotes

1. Nina Youngstrom, "CMS: New Addendum Is Required for Non-Covered Services as a Hospice Condition of Payment," *Report on Medicare Compliance* 30, no. 8 (March 1, 2021).

2. "Model Example of 'Patient Notification of Hospice Non-Covered Items, Services, and Drugs,'" CMS, accessed February 25, 2021, https://go.cms.gov/3dLJzVu
3. Nina Youngstrom, "Sample Document: CMS's New Notice of Non-Covered Items, Services and Drugs for Hospice Patients," *Report on Medicare Compliance* 30, no. 8 (March 1, 2021).
4. "Medicare Payments Made Outside of the Hospice Benefit," HHS Office of Inspector General, accessed February 25, 2021, http://bit.ly/3dLxeke.
5. Regina K. Alexander, "2021 Home Health & Hospice Compliance Work Plans: Addressing New Risks and Fresh Takes on Old Favorites," Health Care Compliance Association webinar, February 22, 2021, https://bit.ly/37Nib5A.
6. Suzanne Murrin, *Hospices Should Improve Their Election Statements and Certifications of Terminal Illness*, OEI-02-10-00492, September 2016, https://bit.ly/3dWK8fx.

NEWS BRIEFS

◆ **According to a CMS spokesperson, "CMS has not yet determined when Targeted Probe and Educate reviews will resume."** Meanwhile, "CMS continues to temporarily pause the performance of retroactive short-stay reviews to reduce burden on providers for consistency with COVID-19 waivers," the spokesperson told *RMC*. Livanta, a beneficiary and family-centered care quality improvement organization, performs "retrospective reviews of Medicare Part A claims to ensure care provided by the Medicare program is medically necessary and reasonable, meets professionally recognized standards, and is provided in the appropriate setting." It's unclear when they will be back. Livanta also reviews higher-weighted DRGs, the spokesperson said.

◆ **Grant Memorial Hospital in Petersburg, West Virginia, agreed to pay $320,175 to settle allegations it submitted false claims to Medicare, Medicaid, TRICARE and Railroad Retirement programs from September 2014 to March 2016**, the U.S. Attorney's Office for the Northern District of West Virginia said Feb. 24.[1] The hospital billed for outpatient and inpatient services and items with the National Provider Identifier and name of a credentialed physician when the services and items were in reality provided by a noncredentialed physician, the U.S. attorney's office said. The settlement stemmed from a self-disclosure to the HHS Office of Inspector General.

◆ **In the first *MLN Matters* article (SE21001)[2] issued under the Biden administration, CMS addresses hospital compliance with Medicare's transfer policy "with the resumption of home health services & other information on patient discharge status codes."** The *MLN Matters* was published in the wake of OIG reports that found noncompliance with the Medicare post-acute care transfer (PACT) payment policy, which requires hospitals to bill for per diems instead of MS-DRGs when patients are transferred to home health, skilled nursing facilities and other facilities. Hospitals are permitted to bypass the PACT policy under certain circumstances using condition code 42 or 43. "Medicare's IPPS [inpatient prospective payment system] post-acute care transfer policy requires hospitals to apply the correct discharge status code to claims where patients receive HH [home health] services within 3 days of discharge. This includes the resumption of HH services in place prior to the inpatient stay," CMS noted.

◆ **CareOne Management LLC, now known as ABC1857 LLC (CareOne), a New Jersey senior care company, will pay $714,996 to settle false claims allegations related to Medicare bad debt, the U.S. Attorney's Office for the District of New Jersey said Feb. 18.**[3] Medicare reimburses providers for deductible and coinsurance amounts they can't collect from Medicare beneficiaries, which is known as bad debt. The U.S. attorney's office said that according to the allegations in the settlement, CareOne "submitted claims for payment to Medicare for reimbursement of Medicare bad debt from Jan. 1, 2012, to July 2, 2018. The company made false representations of compliance with applicable statutory and regulatory criteria, including 'criteria for allowable bad debt,' which require a provider to 'be able to establish that reasonable collection efforts were made' of amounts owed by beneficiaries before a provider submits the claim as bad debt to Medicare." The case was originally filed by a whistleblower. CareOne didn't admit liability in the settlement.

Endnotes

1. Department of Justice, U.S. Attorney's Office for the Northern District of West Virginia, "West Virginia hospital to pay more than $300,000 for Medicare fraud," news release, February 24, 2021, http://bit.ly/2O1qns4.
2. CMS, "Review of Hospital Compliance with Medicare's Transfer Policy with the Resumption of Home Health Services & Other Information on Patient Discharge Status Codes," *MLN Matters*, SE21001, February 22, 2021, https://go.cms.gov/3kgkQdp.
3. Department of Justice, U.S. Attorney's Office for the District of New Jersey, "Senior Care Company Agrees to Pay $714,996 to Resolve False Claims Act Allegations," news release, February 18, 2021, https://bit.ly/2Me8fKX.