

pay \$2.87 million in restitution. He was caught misdiagnosing patients with a rare vascular

Issue II, 2004

# Value ~ Added

A Publication of the Feeley & Driscoll, P.C. Health Care Services Group

## **Bed Expansion Guidelines for Chronic Disease and Rehabilitation Hospital Beds to be Extended Another Year**

*Commonwealth continues to assess need for increased capacity.*

At the March 30<sup>th</sup> meeting of the Public Health Council, the Director of the Massachusetts Determination of Need ("DoN") Program first announced that her staff was planning an additional one-year extension of the current DoN guidelines covering Chronic Disease and Rehabilitation hospital beds. The requested extension was formally approved at the Council's April 27<sup>th</sup> meeting.

The "interim" guidelines were first issued in March 2000, and have since been continued through a number of similar one-year extensions. Without these intervening one-year extensions, the guidelines would revert to the prior rules. A reversion would effectively prohibit the addition of any Chronic Disease (*i.e.* long-term care) or Rehab hospital beds in Massachusetts, because the old guidelines indicate there is no need for any more post-acute hospital beds in the state.

Under the extended interim guidelines however, a hospital can still apply for a limited, one-time increase to the number of Chronic Disease or Rehab beds at the hospital's main campus if:

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**FEELEY & DRISCOLL, P.C.**  
Certified Public Accountants / Business Consultants

200 Portland Street, Boston, MA 02114, (617) 742-7788  
154 Broad Street, Nashua, NH 03063, (603) 889-0444  
[www.fdcpa.com](http://www.fdcpa.com)

## Credit Balance Reporting

1. The hospital has an occupancy rate of 90% at its main site for chronic/rehab services over the past six months, with similar projections for the next three years

- and -

2. The hospital has existing shell space to accommodate additional beds while staying within the DoN expenditure minimum.

But the guidelines do include restrictions intended to limit expansion to main facility sites, thus limiting the growth of “satellite” units. For example, any facility that has transferred beds from its main campus or satellite sites within the past six months is ineligible to apply for new beds. In addition, the guidelines prohibit a hospital that obtains additional beds from transferring any of its beds to another site for eighteen months after the increase is granted.

The DoN regulations do still allow the development of satellites at any time. At past Public Health Council meetings, it has been suggested by regulators that prohibiting the development of satellites seems good public policy, at least until the Department of Public Health has completed a comprehensive reassessment of the Chronic Disease and Rehab services delivery system, (*i.e.* because satellites may cause unnecessary duplication of services in particular service areas.) However, regulators do not actually have to authority to prohibit the development of satellites unless the development would require the expansion of bed capacity (or otherwise trigger the DoN expenditure minimum thresholds.)

During the March 30<sup>th</sup> meeting, the Director of the DoN Program also indicated that following a shortage of medical-surgical bed availability during this past year’s flu season, it had been suggested that increasing the number of post-acute hospital beds in Massachusetts may alleviate the strain on acute hospitals.

The DoN program intends to take a serious look at these recommendations, and return to the Council at a later date to propose permanent guidelines.

Please be advised that the Credit Balance Reporting Requirements posted on the [www.AHSMedicare.com](http://www.AHSMedicare.com) website have been updated. Please refer to Medi-Message dated 09/24/03, subject Credit Balance. Please note the following updates:

- o Effective with the 12/31/03 quarter ending, Credit Balance Forms must be OMB approved, number 0938-0600. If the appropriate form is not submitted, the report will be returned.
- o On CMS 838 detail page, column 13, if indicating “3-Other,” please provide a brief explanation as to why the credit balance occurred.
- o On CMS 838 detail page, column 11, there is a new code. “Z”- payment by combination of check and adjustment bill.
- o On CMS 838 detail page, column 14, there are two new MSP codes. “44-conditional payment” & “47-Liability.”
- o Please be sure all provider adjustments have been initiated prior to mailing the report. Demand letters will be issued within 15 calendar days of the due date for which payment (by check or adjustment bill) was not made with the submission of the CMS 838.
- o For providers who report to Associated Hospital Service, effective with the 09/30/03 quarter ending, reminder letters will no longer be sent. An “Important News” will be posted on our website reminding providers of the due date. Please sign up for list serve to be sure you receive these notices.
- o Suspension of Payments –If no CMS 838 report is received, demand letters will be sent. Demand letters will be sent five days after the due date to providers who have not submitted a completed report. The letter states that a 100% suspension of payments will be imposed if the report is not submitted within 15 days from the date of the letter.

Please note that Home Health Request for Anticipated payment (RAPS) are not considered a “credit balance.”

## Final Rule: LTCH PPS Rate Year 2005

CMS has issued a FINAL RULE outlining the payment changes for long-term care hospitals for rate year 2005 (i.e. July 1, 2004 through June 30, 2005). Several of the rate related changes are positive. However, it does appear that CMS is going to go forward with their planned revisions to the interrupted stay policy. The following is a brief summary of the key elements of the final rule.

- The base rate will increase by 3.1% rather than the proposed rate of 2.9%
- The budget neutrality adjustment will be 0.5% rather than the proposed adjustment of 3%. This is a decrease from the 2004 adjustment factor of 6%.
- The fixed outlier threshold will be \$17,864, the proposed threshold was \$21,864. This is a decrease from the 2004 threshold of \$19,590.

There are several other elements of the final rule that are not related to the rate:

- The final rule expands the existing interrupted stay policy to include a discharge to an acute care hospital, inpatient rehabilitation facility (IRF), skilled nursing facility (SNF) or to the patient's home and readmission to the long-term care hospital *within three days*. All inpatient and outpatient services (other than physician services) provided to the patient during the interruption will be the responsibility of the LTCH provider. CMS is creating a one-year exception to this rule, allowing an acute care hospital providing care to an LTCH patient which is grouped to a surgical DRG under the acute care hospital inpatient prospective payment system (IPPS) to receive a payment under the IPPS. (It is unclear how this policy will be implemented.)
- The final rule adopts the explicit guidance outlined in the proposed rule with respect to the calculation of the qualifying average length of stay. Under the final rule patient days will be counted in the year of the discharge. CMS is creating a one year extension to the "current policy" of allowing patient days to be counted in the year in which they occur.

Feeley & Driscoll will be scheduling a Roundtable meeting to discuss these elements and to outline issues related to the implementation of this rule.

Feeley & Driscoll, P.C.

## Federal Register Summary

### Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2004

3-26-04 (Vol. 69, No. 59, Pages 15729-15730)

**Agencies:** Centers for Medicare & Medicaid (CMS), HHS

**Action:** Correction of final rule with comment period.

### Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II)

3-26-04 (Vol. 69, No. 59, Pages 16053-16146)

**Agencies:** Centers for Medicare & Medicaid (CMS), HHS

**Action:** Interim final rule.

This interim final rule with comment period (Phase II of this rulemaking) incorporates into regulations the provisions concerning ownership and investment exceptions in paragraphs (c) and (d) and the compensation exceptions in paragraph (e) of section 1877 of the Social Security Act (the Act). Phase II also addresses comments concerning the reporting requirements in section 1877 (f) of the Act.

Phase I addressed the majority of issues in implementing section 1877 of the Act. Phase II both addresses the remaining issues not addressed in Phase I and responds to public comments. In general, in response to public comments, the Department has attempted to reduce regulatory burden by broadening exceptions using the Secretary's discretionary authority under the statute to create exceptions that pose no risk of fraud or abuse. For the convenience of affected parties, CMS has set out the entire rule as previously promulgated, including the changes made by this rulemaking.

### Changes to the Medicare Payment for Drugs for Calendar Year 2004; Correction

3-26-04 (Vol. 59, No. 20, Pages 15703-15729)

**Agencies:** Centers for Medicare & Medicaid (CMS), HHS

**Action:** Correction of interim final rule.

### Durable Medical Equipment Regional Carrier (DMERC) Service Areas and Related Matters

3-26-04 (Vol. 69, No. 59, Pages 15755-15761)

**Agencies:** Centers for Medicare & Medicaid (CMS), HHS

**Action:** Proposed rule.

### Revisions to the One-Time Appeal Process for Hospital Wage Index Classification

2-13-04 (Vol. 69, No. 30, Pages 7339-7345)

**Agencies:** Centers for Medicare & Medicaid (CMS), HHS

**Action:** Notice.

## Medicare Reimbursement for Assistants-at-Surgery

As you may already know, a recent report from the US Government Accounting Office has suggested that Congress should consider consolidating all Medicare payments for assistant-at-surgery services under the hospital inpatient prospective payment system. The proposed change in Medicare reimbursement policy was recommended by the GAO after the agency concluded that Medicare currently may be overpaying for some hospital care by reimbursing assistant-at-surgery services through both the inpatient PPS and the Medicare Physician Fee Schedule.

The report – “Medicare Policy Changes Needed for Assistants-at-Surgery” (GAO-04-97, January 13, 2004) – has generated a strong industry response. On March 17, the American College of Surgeons released a letter to Congress warning that implementation of the rec-

ommendations in the GAO report would interfere with the professional judgment of surgeons regarding medical necessity and patient safety. The letter also argues that there are no indications that the current Medicare payment policy provides any incentives for the improper use of assistants-at-surgery. In fact, the implementation of GAO’s recommendations could create a new financial disincentive, potentially discouraging hospitals from providing appropriately skilled assistants. The American College of Surgeons letter to Congress is co-signed by 37 concurring medical specialty societies.

As the official investigative arm of Congress, the GAO mission is serve as an independent and non-partisan watchdog agency – to help improve the performance and accountability of the Federal government – by auditing the use of public funds, evaluating Federal programs and activities, and providing analyses, opinions, and recommendations to help the Congress make oversight, policy, and funding decisions. In 2001, Congress directed GAO to prepare a report on the potential impact of allowing Medicare Physician Fee Schedule payments to Certified Registered Nurse First Assistants for assistant-at-surgery services.

According to the GAO report, there are three flaws in Medicare’s current structure for assistant-at-surgery reimbursement. However, the GAO’s comments do not seem to reflect a complete understanding of either the Medicare payment regulations or the practical clinical function of assistants-at-surgery.

First, the GAO asserts that Medicare currently pays for assistant-at-surgery services under both the hospital inpatient PPS and the Physician Fee Schedule (i.e. be-

cause hospital payments for surgical care are not adjusted when an assistant receives payment under the Physician Fee Schedule). Therefore, Medicare may be paying too much for some hospital surgical care.

According to the GAO, Medicare reimburses hospitals for assistant-at-surgery services under Part A through the hospital inpa-

tient PPS, under which a fixed, per-discharge payment is made for all inpatient hospital services, including assistant-at-surgery services. In addition, Part A reimbursement is also available to teaching hospitals for providing graduate medical education to residents employed by the hospital (Surgical residents are required to serve as assistants-at-surgery as part of their training, and some non-surgical residents also have surgical rotations in which they serve as assistants-at-surgery).

But when a surgeon requests an assistant-at-surgery, s/he is actually asking for what amounts to additional physician-type services. These are often provided by advanced nurse practitioners, advanced registered nurses, and in some cases even specialized physician assistants. By their nature, these services are not intended to be covered under the PPS per-discharge rates. They are “professional component” services, and as such are specifically carved out from Part A reimbursement. An NP/RN/PA performing assistant-type services is not part of the typical “scrub team” covered by the PPS payment amount. Assistants-at-surgery are an augmentation to the scrub team. Their cost is segregated and (should be)

### The GAO's Three "Flaws" in Medicare Payment for Assistants-at-Surgery

1. Medicare currently pays under Inpatient PPS and Physician Fee Schedule
2. Paying under Fee Schedule vs. All Inclusive provides no incentive
3. Distinction between those eligible for payment and not eligible

treated as a professional cost carved out of the hospital cost report.

The “professional component” of assistant-at-surgery services is reimbursed under Medicare Part B (which generally does not reimburse assistant-at-surgery services unless the practitioner is billing appropriately for services performed as a physician, physician assistant, clinical nurse specialist, or nurse practitioner.) For approved assistant-at-surgery services performed by a physician, Medicare reimbursement equals 16% of the Physician Fee Schedule amount otherwise applicable for the surgery. In contrast, for assistant-at-surgery services performed by a mid-level practitioner like an NP, allowed amounts may not exceed 85% of the physician fee schedule amount that would be allowed under the physician fee schedule if the assistant-at-surgery service were performed by a physician. In other words, nurse practitioners receive 85% of 16% of the published Physician Fee Schedule amount for the surgical procedure – or about 13.6% of the lead surgeon rate.

The GAO also maintains that paying a health professional under the Physician Fee Schedule to be an assistant-at-surgery, instead of including this payment in an all-inclusive payment, gives neither the hospital nor the surgeon an incentive to use an assistant only when one is medically necessary.

But as a matter of coverage policy, Part B already does not pay for services of an assistant-at-surgery in a surgical procedure (or class of surgical procedures) for which assistants-at-surgery on average are used in fewer than 5% of such procedures nationally. Otherwise, the need for assistant-at-surgery services is determined based on the primary surgeon’s determination of medical necessity. (Medicare regulations specifically require that all assistant-at-surgery services for cataract cases be reviewed by for medical necessity by the governing Peer Review Organization.)

As a general rule, a physician’s professional judgment is the “gold standard” for the medical necessity of services, but those determinations remain open for review by the Part A fiscal intermediary, the Part B carrier, the Office of the Inspector General, and any other appropriate regulatory entity designated by Health and Human Services.

The third flaw, according to the GAO, is that distinctions between those health professionals eligible for payment as an assistant-at-surgery under the Physician Fee Schedule and those who are not eligible are not based on surgical education or experience as an assistant.

While Medicare regulations do not specify education requirements for assistants-at-surgery, the GAO report gives the misleading impression that hospitals and surgeons are simply asking a member of the scrub team to “step in” and help in a procedure. In our experience, that is not the practical reality. Certainly, a member of the scrub team may be called upon in an emergency to assist in a manner beyond their initial duties. However, those cases generally are not considered to qualify for separate reimbursement as assistant-at-surgery services. Reimbursement under Part B for assistants-at-surgery is intended for services provided by healthcare professionals who are specifically designated for this type of services. These people are almost always scheduled ahead of time to participate in the procedure, or they respond in an “on-call” manner should a surgeon require them.

The use of specifically designated people indicates that there is a reasonable expectation that the person’s services may be required. This reasonable expectation means that the staff member would have to be credentialed to provide that service. Accredited hospitals are required to credential physicians who are allowed to practice in their facilities.

Credentialing includes a review of a practitioner’s qualifications not only to practice medicine in their general area of training (e.g. Medicine, Anesthesia, Radiology, Surgery, et cetera), but all of their qualifications to perform specific procedures (e.g. Cardiac Catheterization, Interventional Radiology, Gastric Bypass Surgery, et cetera). Credentialing also extends to advanced licensed practitioners (e.g. NPs, PAs, et cetera) who provide services that would have otherwise been provided by a physician.

In addition to these protections, state law outlines the allowable scope of practice for healthcare providers. Regulations generally outline the necessary thresholds required to meet advancement beyond a practitioner’s base scope of practice.



## Compliance Corner

*An update on recent activity by the Department of Health and Human Services Office of Inspector General (HHS-OIG)*

The OIG is responsible for conducting audits, evaluations, and both criminal and civil investigations for all HHS agencies. These functions are performed by the OIG's Office of Audit Services (OAS), Office of Evaluation and Inspections (OEI), and Office of Investigations (OI), respectively.

### **OIG Alerts Physicians About Added Charges for Covered Services**

The OIG released a Fraud Alert warning Medicare participating physicians that they cannot charge Medicare patients for services that are already covered by Medicare.

For example, the OIG recently alleged that a physician violated his assignment agreement when he presented to his patients, including Medicare beneficiaries – a “Personal Health Care Medical Contract” asking patients to pay an annual fee of \$600. According to the OIG, some of these contracted services were already covered and reimbursed by Medicare.

*To read the full alert, go to:*

<http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA033104AssignViolationI.pdf>

### **Effect of Staffing on Quality of Care at Nursing Facilities**

The OIG has reported on several facilities compliance with quality of care regulations provided in nursing homes.

The Omnibus Budget Reconciliation Act of 1987 established legislative reforms to promote quality of care in nursing homes. This act requires nursing homes to have sufficient nursing staff to provide nursing and related services “to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.” In addition, Title 42, Code of Federal Regulations, Section 483.30 requires nursing homes to provide sufficient nursing staff on a 24-hour basis.

*The latest report on this topic was for NHC Healthcare Fort Oglethorpe in Georgia. To read, go to:*

<http://oig.hhs.gov/oas/reports/region4/40404001.pdf>

### **Review of Claims Paid for Clinical Diagnostic Laboratory Services Under the Massachusetts Revised Fee Schedule – July 1999 through March 2002**

The objective of this review was to determine whether Medicaid payments for hospital outpatient laboratory and pathology tests complied with rates allowed by the Medicare program. Section 1903(i)(7) of the Social Security Act limits Medicaid payments for clinical laboratory tests to the amounts payable for the same tests under the Medicare fee schedule.

The OIG analysis showed that of the \$29 million in hospital outpatient laboratory claims submitted by the State for the period July 1999 through March 2002, \$8.2 million (\$4.1 million Federal share) exceeded the Medicare fee schedule amounts. The State's procedures were not adequate to ensure that the amounts claimed for Medicaid laboratory services and submitted for Federal reimbursement complied with the Medicare fee schedule.

*To read the full report, go to:*

<http://oig.hhs.gov/oas/reports/region1/10200015.pdf>

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## Financial Integrity of Public Charities

In 2003 Congress enacted the Sarbanes-Oxley Act in response to many high profile corporate accounting and oversight scandals. The Act was intended to restore public trust in corporate oversight and the financial statements issued by public companies. Although not applicable to non-profit organizations, the provisions of Sarbanes-Oxley had far-reaching effects on all organizations. Many states moved to adopt similar legislation and non-profit organizations instituted policies to mirror some of the requirements of Sarbanes-Oxley.

The Massachusetts Attorney General has now taken the issue of non-profit organization financial integrity and public trust to a new level. The Attorney General has drafted legislation to provide clearer standards with respect to financial oversight of and by charities and their officers and directors. The introduction to the legislation states, “in return for the tax-exempt status granted these charities by the state and federal government and their ability to fundraise from the public, charities should follow stricter rules for fiscal soundness and transparency”. The introduction goes on to state that the legislation is intended to strengthen public trust in charities by requiring the certification of financial information and the adherence to specific procedures when entering into agreements with related parties.

Some of the more relevant specific provisions of the proposed legislation are as follows:

- Increase of the annual revenue threshold that triggers an audit requirement from \$250,000 to \$750,000
- Requirement that managing officers of small public charities (less than \$750,000 in revenues) expressly certify the accuracy of the financial statements submitted to the Attorney General
- Requirement that managing officers of larger public charities (revenues over \$750,000) certify, not only the accuracy of the financial statements submitted to the Attorney General, but that the officers have established disclosure controls and internal controls over financial reporting
- Requirement that larger public charities establish an audit committee comprised of independent members of the board
- Requirement that related party transactions undergo a more stringent review and approval process within the board, similar to those imposed by the provisions of the IRS Intermediate Sanctions legislation

The Massachusetts Attorney General has made it very evident that the accountability standards and fiduciary responsibilities of public charities will be held to a higher standard. To be ready for the eventual enactment of this legislation, management and the board should read the full text of this proposed Act to obtain a fuller understanding of its requirements and the impact that it will have on the Organization. To read the Act or a summary, visit the Attorney General’s page on the Commonwealth of Massachusetts website at:

<http://www.ago.state.ma.us/charity/legislation.asp>

### Contact Feeley & Driscoll

Please visit [www.fdcpa.com/healthcare.htm](http://www.fdcpa.com/healthcare.htm) to receive the latest health care news and the dates and agendas of our upcoming Reimbursement Roundtables for Hospitals and Long Term Care Providers

If you have any questions or would like to discuss further any of the issues discussed in Value Added with one of our health care specialists, please contact us at (617) 742-7788 or

Douglas J. McGregor - [DougM@fdcpa.com](mailto:DougM@fdcpa.com)  
Mark J. Rich - [MarkR@fdcpa.com](mailto:MarkR@fdcpa.com)  
Stephen J. Doneski - [SteveD@fdcpa.com](mailto:SteveD@fdcpa.com)



## FEELEY & DRISCOLL, P.C.

Certified Public Accountants/Business Consultants

200 Portland Street  
Boston, MA 02114

ADDRESS SERVICE REQUESTED

PRSRT STD  
U.S. POSTAGE  
PAID  
BOSTON, MA  
PERMIT NO.  
56243

### Coding Tip - "Incident-To" Services

The latest OIG focus on cardiac rehabilitation services has caused industry wide confusion concerning incident-to services. It is incumbent upon providers to familiarize themselves with the ins and outs of "incident-to" guidelines.

Incident-to refers to services or supplies that are integral, although incidental to a physician's professional service. Such services are defined in the Medicare Carrier's Manual section 2050.1 as those services or supplies that are an integral, although incidental, part of the physician's professional services in an office setting. Providers familiar with these incident-to guidelines will be aware that the guidelines state there is no incident-to in a hospital setting. This is where a lot of the confusion stems from. What the guidelines fail to clarify is that there is no incident-to a physician's professional services for inpatient services. However, incident-to does apply to outpatient services in a hospital setting, such as cardiac rehabilitation. These services are governed under section 410.27 of the Code of Federal Regulations. Let's take a closer look at the requirements for both the office setting and the hospital outpatient setting.

*What exactly does "incident-to" mean?* Incident-to allows a non-physician practitioner (Nurse Practitioner, Physician Assistant) to render a service and bill for that service using the physician's provider number and receive 100% of the fee schedule payment as opposed to the reduced percentage paid to non-physician practitioners. (Nurse practitioner's and physician assistants receive 85% of the fee schedule payment rate if billed under their own provider number.)

#### *What does an integral part of the physician's service mean?*

Integral means that the physician has seen the patient and has established a treatment plan for the patient's condition. The supervising physician must perform this initial visit. New patient visits and established patient visits with a new problem cannot be considered incident-to because the patient must be seen by the supervising physician first to establish a course of action.

Incident-to requires direct supervision. This does not mean that the physician must be in the exam room at the time of service – this would undermine the whole purpose of the incident-to guideline. In an office setting, the physician must be present in the office suite and immediately available for assistance. Being available by phone does not constitute being immediately available. In the hospital outpatient setting, the direct supervision requirement is assumed to be met given the location of the department. Because the department is located on hospital premises it is assumed a physician is immediately available at all times.

The supervising physician must still be involved in the care of the patient once the course of treatment is established. The physician must see the patient frequently and consistently enough to substantiate his / her involvement in the treatment of the patient.

Each State governs the non-physician practitioner's scope of practice. To review what services an NP or PA can perform in Massachusetts, go to:  
<http://www.state.ma.us/reg/boards.htm>.

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