

Kennedy

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Kennedy Health Law News

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HHSC RELEASES WITHHELD FUNDS & MEDICAID PAYMENT HOLD

HHSC repaid withheld funds back to a provider, released a payment hold imposed for over year and returned a medical equipment supplier to payment status after a suit was filed alleging violation of Due Process of Law.

Kennedy, Attorneys & Counselors at Law, filed the federal lawsuit and asserted that healthcare providers are entitled to appeal Medicaid overpayments and that state officials had acted under a scheme to extort repayment of disputed debts while refusing to extend appeal rights required by law. The class action lawsuit also seeks relief for similarly situated healthcare providers whose Due Process rights have been violated by illegal payment hold while participating in Texas' Medicaid program.



COMPETITIVE BIDDING IS EXPANDED

Citing a 20% savings for Medicare due to the 2002 demonstrations in Florida and San Antonio, Texas, CMS has expanded Competitive Bidding for DMEPOS to a second round including the following MSA areas in Texas and Oklahoma include: Austin/Roundrock; Beaumont/Port Arthur; El Paso; Houston/Sugarland/Baytown; McAllen/Edinburg/Mission; and San Antonio, Texas. In Oklahoma, the Oklahoma City and Tulsa MSA's are included in round two. Kerry Weems, acting director of CMS made this announcement on January 8, 2008.

Eight DME product lines are included in the competitive bidding, as are other states and MSAs nationwide. Please check with CMS for your particular area and which product lines are included.

HOME HEALTH IS UNDER FIRE FROM SURVEYORS

It has come to my attention that surveyors are now going directly to the patients and asking them questions that lead the surveyors to suspend payments, and demand payment be disgorged by the home health agency (overpayments) due to the "condition" of the patient.

As you know, some patients move in and out of being "homebound" during their treatment episodes. Depending on their injury/illness, and future treatment, a patient can recover during an episode, and no longer require home health prior to the end of the 60-day period. Other patients can get better, go in for another surgery, and then require home health again during a single episode.

I have been told by another health care attorney (an accurate source) some home health patients are receiving visits from surveyors who ask them a few questions. The questions are not the most accurate way to assess whether the patient is homebound or not. If the surveyor asks "can you drive," the answer from the patient may be "yes," but if the surveyor asks "when was the last time you drove a car," the answer will probably be "oh, not since the surgery."

Surveyors have been determining from these type of visits that patients are not homebound. While it is arguable as to exactly when the patient was no longer homebound (if they truly are no longer homebound), the surveyors are demanding repayment for the entire episode.

You must make certain your field nurses note when the patient is no longer homebound, if they in fact have improved before the end of the episode. The field nurses notes are your only proof of whether a patient is homebound and qualifies for continued treatment by the home health agency. The home health care agency cannot be paid for service to a patient who is not homebound.



NEW HOME HEALTH BILLING REQUIREMENTS FOR SUPPLIES

Beginning in 2008, Home Health Agencies will begin billing for supplies. There is a grace period until September, but if you are not on board by September, your end of episode claims will be denied if the supply billing is not correct. This gives you 7 and one-half months to practice.

A hint to assist you in the “smooth transition” to supply billing is to please take note of the language or verbage used by the payor for Home Health supplies. If you misname the supplies, the computer program that double checks the claims and payments for your agency might not recognize your supplies as proper, thus either denying your claim, getting an ADR, or getting into an overpayment situation when TriCenturion goes back after a couple of years and audits HHA billings for improper supply billing.

Since your supply tracking system will need to be agency specific, go ahead and learn the “proper names” and coding for the supplies early. The law school mantra “get behind early, there’s more time to catch up” does not apply here.



Lurese A. Terrell is an associate attorney at KENNEDY, Attorneys and Counselors at Law, a health law boutique, in Dallas, Texas. The KENNEDY Law Firm is focused on health law and assisting providers with regulatory matters.

Lurese has a broad base of experience in both administrative law and more typical litigation. Prior to joining Kennedy, Attorneys and Counselors at Law, she litigated cases before the workers compensation system for both claimant and later for the insurer. At Kennedy, Lurese handles healthcare regulatory and administrative cases in addition to District Court litigation and business matters.

Lurese is licensed to practice before the Texas State Courts, as well as in Federal Court, in the Northern and Southern Districts of Texas. She is admitted to the 5th Circuit of the U.S. Court of Appeals. She is a member of the State Bar of Texas, the Dallas Bar Association, Delta Theta Phi Law Fraternity International, and through KENNEDY, the Texas Association for Home Care and the Medical Equipment Suppliers Association.

TRUSTSOLUTIONS OXYGEN DOCUMENTATION

TrustSolutions, L.L.C., the government payment safeguard contractor (PSC) for jurisdiction C has issued new information regarding documentation requests for oxygen.

For pre-payment and post-payment audits, when TrustSolutions sends their notification letter requesting documentation to support your billing and charges, they are specifically requesting the documentation you send to them include **MEDICAL RECORDS FOR THE BENEFICIARY.**

While the medical records are not required by the billing sections under the CMS regulations, the PSC contractor is requiring medical records that corroborate the need for oxygen. The physician’s statement of certification is no longer the only documentation you will have to present to TrustSolutions.

Some of you have been caught in this “gap” between the PSC and the billing requirements in regards to power wheelchairs and the upper body strength of the beneficiary. While the requirements for you to operate a DME have nothing to do with knowing what a medical record would say to justify oxygen use, you are now on notice that your response to a request for records from TrustSolutions for a Pre-Payment or Post-Payment audit should include the pulmonary testing done prior to the prescription for oxygen. These records will have to come from the beneficiary’s physician.

Please read and memorize, or at least keep handy, the documentation from TrustSolutions website that addresses these issues. You can locate TrustSolutions at TrustSolutions L.L.C.

Go to the DME Region C Medical Policy, Medical Policy Updates and Articles, and find the two policies that involve Oxygen and Documentation for May 2007.



A NEW HICCUP FOR OVERPAYMENT APPEALS

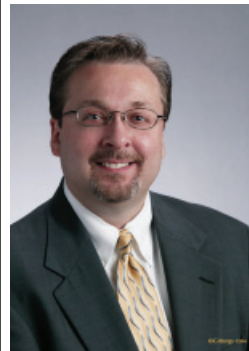
As our firm has filed providers' appeals of overpayment determinations under Medicare to Q2 Administrators (Q2A), we have encountered a troubling component in the decisions by Q2A. Some of the appeals have had "partially favorable" results from Q2A. That means that some of the claims in the sample used to calculate the initial total overpayment were actually decided in the provider's favor and would have to be removed from the claim sample total. In calculating the alleged overpayment, TriCenturion, the payment safeguard contractor, usually takes a small sample of 30-50 actual claim records and calculates the error rate for those claims. Then TriCenturion puts those numbers into a statistical formula to create their "projection" of what the total overpayment for all the claims in the "universe" (all the claims being looked at by TriCenturion) even though not all the claims were actually reviewed. That way, they don't have to look at, say, 5269 claims, but just 30 or so claims.

Whenever the sample calculations are changed, (any TriCenturion calculation reversed by Q2A would be deducted from the sample) then the resulting "projection," or total overpayment, would change too. Therefore, TriCenturion's calculations for the total overpayment would be wrong.

Instead of declaring the overpayment calculated by TriCenturion "wrong" and dismissing the overpayment, Q2A has been sending the calculations back to TriCenturion for a new projection on the total overpayment. This is forcing the providers to appeal to the ALJ level without an actual determination of the overpayment.

Presently, few of these have been appealed to the ALJ level, so we don't know how the ALJ's are going to approach their hearings when TriCenturion hasn't recalculated an overpayment.

The attorneys at our firm all agree that the government should not get to keep moving the target while the provider has to continue to fight the battle. These outcomes are so new, we don't know how the ALJs we begin to treat the providers in these cases. We will keep you posted.



Mark S. Kennedy is the founder of KENNEDY, Attorneys & Counselors at Law, a health law boutique in Dallas Texas. Mark focuses his practice in health law and regulatory compliance. He has handled a wide array of cases and has broad based experience. He formerly was Assistant Regional Counsel to the U.S. Department of Health and Human Services. He served nine years in the Dallas Region and was lead litigation attorney for the 5-state region. He represented the Health Care Financing Administration (now Centers for Medicare and Medicaid Services, "CMS"), Inspector General, and other Departmental Agencies in the federal trial and appellate

courts and various administrative tribunals. He represented the government in a multitude of cases concerning Medicare and Medicaid involving payment and reimbursement disputes, fraud and abuse enforcement, health and safety compliance, and provider bankruptcy. Prior to his work with HHS, Mark was associate counsel for Blue Cross Blue Shield of Oklahoma and Blue Cross Blue Shield of Tennessee.

PHYSICIAN PROFILING TO IDENTIFY INEFFICIENCY

A recent GAO report recommended that CMS develop a profiling system that identifies physicians with inefficient practice patterns.

GAO examined the potential for profiling physician efficiency in traditional fee-for-service Medicare and using the results along the same lines as other public and private sector healthcare purchasers to encourage efficient medical care. The report focused on generalist physicians in 12 metropolitan areas. It found that Medicare beneficiaries who saw "inefficient" physicians were more likely to have been hospitalized multiple times and to have used home health services. They were less likely to have been admitted to a skilled nursing facility.

Policy makers predict that Medicare funds will be exhausted by 2018 and contend that "dramatic health care reform" is needed. Many private and public healthcare payors are now looking to find "efficient" physicians and encourage patients to obtain care from them.

These purchasers identify efficient physicians by examining data obtained from medical claims to measure an individual's performance relative to a benchmark, a method known as profiling. According to the report, "physician profiling activities occur in Medicare today" but they focus largely on improper billing practices rather than on "efficient care delivery." Some policy makers have suggested using a profiling approach in Medicare to pay physicians based on their meeting quality and efficiency performance standards.

THE NEW OASIS FORM — THE PAPER TRAIL JUST GETS LONGER

When compiling the diagnoses that will go on the new OASIS forms, you will need to include those diagnoses that have an impact on your services. Not all of those diagnoses will come from your referring physician.

In order to corroborate your diagnoses, you will have to get some sort of documentation for the diagnoses that are not included in the paperwork from the referring physician. While you may not be able to get documentation from the physician for a secondary diagnosis right away, you will have to get the documentation during the episode, and the diagnosis will have to cover the episode period.

An example would be the diagnosis of ‘depression.’ The home health services you render may not be due to the diagnosis of depression, but your services may be affected by the client’s depression. If you include depression as a diagnosis on the new OASIS form, you will have to have documentation of that diagnosis. Possibly the referring physician, who you would deal with primarily for this client, may not be the physician who diagnosed the depression. In order to use the diagnosis, you may have to go to the secondary physician for documentation of that diagnosis.

In order to get paid for the episode using the OASIS as filled out with the depression diagnosis, you should submit the depression diagnosis documentation with the end of episode claim. Otherwise you risk the possibility of receiving either an ADR for the claim, or a denial of the claim. For the ADR, you would have to get the diagnosis documentation anyway, and if the claim is denied, you would have to appeal. Getting the documentation up front should save time on the payment end. Remember, this is an example and not advice as to whether or not to use the diagnosis of depression on any OASIS form. ~

The Kennedy Health Law News is intended to be informative. The statements herein are not intended as legal advice about a specific matter but rather are general information about legal issues and developments. The particular facts of a matter determine legal rights and obligations.

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