KING & SPALDING

Health Headlines

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Improper Billing of ASC Services for SNF Residents – On December 17, 2010, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) released a report, "Payments for Ambulatory Surgical Center Services Provided to Beneficiaries in Skilled Nursing Facility Stays Covered Under Medicare Part A in Calendar Years 2006 through 2008." According to the report, the OIG estimates that Medicare contractors made at least $6.6 million in overpayments to ambulatory surgical centers (ASC) for services provided to skilled nursing facility (SNF) beneficiaries in CYs 2006 through 2008.

The report states that the objective of the review was to determine whether ASCs complied with consolidated billing requirements. Under the prospective payment system, Medicare reimburses SNFs for all covered SNF services. For services provided to Part A SNF beneficiaries by outside suppliers, the suppliers are generally required to bill the SNFs, not Medicare Part B. According to the report, none of the 100 services sampled complied with the consolidated billing requirements. Thus, Medicare paid twice for these services because Medicare paid the SNF under the Part A prospective payment system and paid the ASC under Part B. The overpayments identified within the sample group totaled $102,879.

The OIG report lists several factors that contributed to these overpayments.

- ASCs were either unaware of or did not fully understand the consolidated billing requirements.
- ASCs did not have the necessary controls to prevent improper Part B billing.
- ASCs did not ask beneficiaries during the check-in process whether they were currently Part A SNF residents.
- The Centers for Medicare and Medicaid Services' (CMS) Common Working File was not designed to prevent and detect Part B overpayments to ASCs for services subject to consolidated billing.

The OIG recommends that CMS instruct its contractors to recover the overpayments identified for the 100 sampled services. In addition, the report recommends that CMS review the 20,806 Medicare Part B ASC facility services that were not reviewed and recover the estimated $6.5 million in additional overpayments. The OIG report also recommends that CMS provide guidance to ASCs on consolidated billing requirements. Finally, the OIG recommends that CMS establish an edit in the Common Working File to prevent Part B payments for ASC services that are subject to consolidated billing.

According to the report, CMS concurred with the OIG's recommendations and stated that it would share the report and the additional claims with recovery audit contractors (RACs).

The complete report is available by clicking here.

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CMS Announces 3-Month Reprieve from the Physician Signature Requirement on Requisitions for Laboratory Tests – Effective January 1, 2011, all requisitions for clinical diagnostic laboratory tests paid on the basis of the clinical laboratory fee schedule must be signed by a physician or qualified nonphysician practitioner. *See* MPFS Final Rule, 75 Fed. Reg. 73170, 73480-83 (Nov. 29, 2010). Laboratories performing reference testing for Medicare patients are very concerned that they will have to absorb losses resulting from physician noncompliance with this new requirement. In response to these concerns, CMS has announced that it will delay enforcement of this requirement until it is able to educate physicians about the new policy. CMS will spend the first quarter of 2011 developing educational and outreach materials that will be posted on the CMS website. "Once our first quarter of 2011 educational campaign is fully underway, CMS will expect requisitions to be signed." CMS's announcement is available by clicking here.

Although a physician's or practitioner's signature has long been required on written *orders* for clinical laboratory tests, *requisitions* have not previously required a signature as long as it is evident that a physician or qualified practitioner ordered the services. CMS has defined an "order" as "a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary." A "requisition," on the other hand, is "the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient." CMS views requisitions as essentially ministerial documents that serve as an administrative convenience to providers and patients. Although there is lingering confusion over the distinction between the two types of documents, the new signature requirement for requisitions parallels the signature requirement for written orders.

There is no requirement that physicians and practitioners use requisitions to request clinical diagnostic laboratory tests. Tests may still be requested through other means that do not implicate the new signature requirement, including through the use of annotated medical records, documented telephonic requests, or electronically. For telephone orders to be found proper upon audit, they must be supported by the record in the physician's office as well as the laboratory's records. It is likely that in an audit, the burden would be on the laboratory to obtain copies of the physicians' office records to support a telephone order. Electronic orders should have electronic signatures which conform to applicable requirements.

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CMS Solicits Comments on EMTALA Applicability to Inpatients and Hospitals With Specialized Capabilities – In the December 23, 2010 Federal Register, the Centers for Medicare & Medicaid Services (CMS) published an advance notice of proposed rulemaking (ANPRM) with comment, requesting comments regarding whether it should revisit its policies regarding the applicability of the Emergency Medical Treatment and Labor Act (EMTALA) to inpatients, as well as to hospitals with specialized capabilities that may be asked to accept a transfer patient from another hospital that has been unable to stabilize an admitted patient. 75 Fed. Reg. 80,762 (Dec. 23, 2010). In the ANPRM, CMS reiterates its policies relating to these issues, originally stated in the September 9, 2003 (68 Fed. Reg. 53,243) and August 19, 2008 (73 Fed. Reg. 48,656) final rules, respectively: (1) a hospital's obligation under EMTALA ends either when the individual's emergency medical condition (EMC) is stabilized or when the hospital admits an individual with an unstable EMC as an inpatient; and (2) if an individual with an unstable EMC is admitted as an inpatient, the EMTALA obligation has ended, even if the individual's EMC remains unstabilized and the individual requires treatment only available at a hospital with specialized capabilities. The hospital with specialized capabilities has no EMTALA obligation to accept a transfer patient who has been admitted (in good faith) as an inpatient at the first hospital.

However, because the various Circuit Courts of Appeals have differed in their interpretations of EMTALA's application to inpatients, and the EMTALA Technical Advisory Group established by Congress believes it is necessary for CMS to address situations involving transfers of unstable inpatients to more specialized hospitals, CMS believes it may be necessary to revisit its policies. CMS has specifically requested that interested parties: (1) comment on whether CMS should revisit the policies that were established in the September 9, 2003 final rule on EMTALA and the August 19, 2008 IPPS final rule; (2) submit specific real world examples that demonstrate whether it would be beneficial to revisit the 2003 and 2008 final rules; (3) recount any situations where an individual who presented under EMTALA with an unstable EMC was admitted to the hospital where he first presented and then was transferred to another facility, even though the admitting hospital had the capability of treating the EMC; (4) comment regarding the accuracy of CMS's belief that a hospital with specialized capabilities would accept the transfer of an inpatients with an unstabilized EMC, absent an EMTALA obligation; and (5) recount any situation where an individual with an unstabilized EMC was admitted as an inpatient to one hospital, but continued to have an unstabilized EMC, and a hospital with more specialized capabilities

refused to accept the transfer of the patient because current CMS policy does not require the more specialized hospital to do so.

Comments on these issues are due to CMS by 5pm on February 22, 2011. A copy of the ANPRM is available by clicking here.

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