Long-Term Care Survey Alert

Industry Notes:

HHS Lawsuit Settlement Bucks 'Improvement Standard'

A recent court decision is changing the "improvement standard" for home health, outpatient therapy services and skilled nursing facilities. On Jan. 24, the **U.S. District Court for the District of Vermont** gave a final approval on a settlement with **HHS** in the class-action lawsuit Jimmo v. Sebelius.

Under the settlement, HHS has agreed to clarify that Medicare covers home health, therapy services and SNFs regardless of whether the beneficiary's condition is expected to improve -- known as the "improvement standard," reports Leading Age.

Back in January 2011, the **Center for Medicare Advocacy and Vermont Legal Aid** filed the lawsuit on behalf of four individuals and five health organizations, Leading Age says. The final settlement could spark re-review of Medicare claims prior to Jan. 18, 2011 involving denials for beneficiaries seeking SNF or home health services. The lawsuit alleges that the improvement standard violates Medicare law.

Although HHS denied any wrongdoing or that the improvement standard even existed, under the settlement the department agreed to clarify in the Medicare Benefit Policy Manual that there is no requirement for improvement. Specifically, **Centers for Medicare & Medicaid Services** will re-write certain parts of the Manual to include rules to "maintain the patient's current condition or prevent or slow further deterioration" for skilled nursing and home health services, Leading Age explains. CMS will also launch an educational campaign for providers, contractors, Medicare Advantage plans, administrative law judges and Quality Improvement Organizations.

Feds Boast Huge ROI On Healthcare Fraud-Fighting

Government watchdogs are raking in the dough from fraud enforcement, and the federal government is cheering these successes. During the last three years, for every $1 spent on healthcare fraud and abuse investigations, the federal government recovered $7.90, according to a Feb. 11 announcement from U.S. Attorney General **Eric Holder** and the **U.S. Department of Health and Human Services** Secretary **Kathleen Sebelius**.

This is the highest return-on-investment in the 16-year history of the Health Care Fraud and Abuse Program. For fiscal year 2012, government fraud-fighting teams raked in a record-breaking $4.2 billion worth of fraud recoveries, HHS and the **U.S. Department of Justice** announced. And since 1997, the HCFAC Program returned more than $23 billion to the Medicare Trust Funds.

HHS and the DOJ released these figures in its annual HCFAC Program report, which monitors spending and enforcement recoveries by various government agencies and fraud-fighting teams, such as the Health Care Fraud Prevention Enforcement Action Team and the nine Medicare Fraud Strike Force teams.

Among the report's highlighted successes for FY2012 was the bust of a Texas physician and the office manager of his medical practice, along with five HHA owners. This was the single largest fraud scheme orchestrated by one physician in the history of HEAT and the Medicare Fraud Strike Force operation.

Check Out This Educational Resource

If you're seeking educational materials to introduce the concept of palliative care to your patients, you may want to turn to a new resource from The Joint Commission. The accrediting body formerly known as JCAHO has introduced a brochure on the topic as part of its "Speak Up" campaign to educate patients on health care topics.

The brochure, which is available in English and Spanish online at www.jointcommission.org/speak_up_palliative/, covers issues ranging from where to access palliative care to how to secure payment for it.

Make Sure Your Records Are Legible

If paper records make up any part of your charting system, you'd better pay attention to penmanship. So warns a newly revised MLN Matters article from CMS. "When determining the medical necessity of an item or service billed, Medicare's review contractors must rely on the medical documentation submitted by the provider in support of a given claim," CMS says in MLN Matters article SE1237. "Therefore, legibility of clinical notes and other supporting documentation is critical to avoid Medicare FFS claim payment denials."

Your clinicians should ensure that their documentation is legible -- not only by staff members familiar with it -- but also by anyone who might be reading the notes.

Resource: The article is at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1237.pdf.