MDS Alert

COMPLIANCE NEWS: CMS to Medicare Contractors: Target These Potential Problem Areas Identified by the OIG

Consolidated billing for ambulances is on the list, as is hospice for nursing home residents.

If you tend to think of OIG reports as a lot of barking without much of a bite, consider this: CMS has already directed its Medicare contractors to put providers on a shorter leash because of overpayments identified by the OIG in reports last year.

Specifically, CMS Transmittal 620, issued on Jan. 15 with an effective and implementation date of Feb. 16, directs MACs and FIs to "strengthen program safeguards"related to OIG reports looking at SNF consolidated billing for ambulances, and Medicare hospice care for nursing home beneficiaries. Also on the list: Medicare payments for pressure-reducing support services, and pricing for negative pressure wound therapy pumps.

Faster on the draw: Attorney **Paula Sanders** reports seeing "a quicker turnaround" where the OIG finds problems and CMS then tells "the MACs to start auditing all providers on that particular issue." For example, the OIG report on hospice coverage issues related to nursing home patients came out in September 2009, observes Sanders, in Harrisburg, Pa.

No Free Ride Under Consolidated Billing

The OIG report on consolidated billing for ambulance services affects SNFs most directly. And many ambulance rides -- for example, taking a Part A SNF patient to and from the physician's office -- should be bundled in Part A consolidated billing.

Keep in mind: Medicare only covers ambulance transportation when any other form of transportation would be contraindicated based on the resident's condition.

Resource: To review consolidated billing requirements, including ambulance transportation that can be billed separately for residents in a Part A stay, go to www.cms.hhs.gov/snfconsolidatedbilling/.

Hospice Report Has Consequences for Nursing Homes

OIG Memorandum Report, "Medicare Hospice Care for Beneficiaries in Nursing Homes: Compliance with Medicare Coverage Requirements" (OEI-02-06-00221), found that a full 82 percent of all hospice claims for nursing home residents failed to meet at least one Medicare requirement, says attorney **Mary Michal,** with Reinhart Boerner Van Deuren in Madison, Wis. These included "failure to meet care planning requirements, or providing fewer services than set forth in the plan of care," says Michal. "As a result of this report, hospices can expect more stringent auditing of claims overall," she warns.

But what does the report have to do with your organization if it doesn't have a hospice? More than some people might think, at least in the survey realm.

Key example: The F309 interpretive guidance talks about nursing homes coordinating care with the hospice and having a coordinated plan of care, says attorney **Meg Pekarske,** also with Reinhart Boerner Van Deuren. She has, in fact, worked with facilities cited because surveyors couldn't tell by looking at a resident's care plan that the person was on hospice.

The nursing home may also be in hot water if auditors or surveyors determine the resident did not receive medically necessary care specified by the care plan or otherwise, cautions Sanders.

Resource: See the OIG report titles, numbers, and links below: "Payments for Ambulance Transportation Provided to Beneficiaries in Skilled Nursing Stays Covered Under Medicare Part A in Calendar Year 2006" (A-01-08-00505). http://oig.hhs.gov/oas/reports/region1/10800505.pdf.

"Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements" (OEI-02-06-00221) http://oig.hhs.gov/oei/reports/oei-02-06-00221.pdf.