KING & SPALDING

Health Headlines

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Hospital IPPS Proposed Rule for FY 2012 – On April 19, 2011, CMS issued a proposed rule to revise the Medicare hospital inpatient prospective payment systems (IPPS) for acute care hospitals and the prospective payment system for inpatient services provided by long-term care hospitals for fiscal year (FY) 2012. The proposed rule implements certain statutory provisions set forth in the Affordable Care Act as well as updates Medicare payment policies and rates. The changes under the proposed rule would be applicable to discharges occurring on or after October 1, 2011.

The rule proposes to change and/or implement the following, among others:

- MS-DRG classifications and recalibrations of relative weights;
- hospital-acquired conditions (HACs) and a listing and discussion of HACs, including infections, that would be subject to the statutorily required quality adjustment in MS-DRG payments for FY 2012;
- hospital wage index for acute care hospitals using wage data from cost reporting periods beginning in FY 2008;
- IPPS for operating costs and GME costs including proposed payment adjustment for low-volume hospitals;
- FY 2012 policy governing the IPPS for capital-related costs;
- payment rates for certain excluded hospitals;
- quality data reporting program for long-term care hospitals; and
- threshold amounts for outlier cases.

When grouped with certain policy changes, the average decrease in payments under the proposed rule would be 0.55 percent. The FY 2012 estimate of the market basket rate-of-increase is 2.8 percent for hospitals that submit data on quality measures. The rule makes a productivity reduction of 1.2 percent and an additional market basket reduction of 0.1 percent as required under the Affordable Care Act. There is also a negative "documentation and coding" adjustment in the amount of -3.15 percent along with other positive and negative adjustments. While CMS estimates that the average decrease in payment is 0.55 percent, individual hospitals may experience greater or lesser adjustments, due in part to volatility in the wage index figures.

CMS will accept comments on the proposed rule until June 20, 2011, and the final rule will be issued by August 1, 2011. The proposed rule is available **here.**

Reporter, *Juliet M. McBride*, Houston, +1 713 276 7448, jmcbride@kslaw.com.

OIG Reports Medicare Paid Nearly $38 Million in 2008 for Improper Radiology Claims – According to a report from the U.S. Department of Health and Human Services Office of Inspector General (the "OIG"), CMS paid nearly $38 million in 2008 for improper diagnostic radiology services performed in hospital outpatient emergency departments. The OIG based the $38 million figure off of its review of a 440-claim sample of outpatient diagnostic radiology services in

2008, the results of which it extrapolated to the claims population (9.6 million allowed claims in 2008 totaling approximately $215 million). The Social Security Act and CMS regulations governing Medicare payments for radiology services require that such services be ordered by physicians, have supporting documentation and be medically necessary. Additionally, as a condition of fee schedule payment, services must contribute directly to the diagnosis or treatment of an individual beneficiary.

Specifically, the OIG examined a sample of 220 claims for computed tomography (CT) and magnetic resonance imaging (MRI) services, and 220 claims for x-ray services and determined that, out of a total of nearly 3 million allowed claims for interpretation and reports of CT and MRI services, Medicare allowed 19 percent in error, totaling nearly $29 million in improper payments and, out of a total of nearly 6.6 million allowed x-ray claims, Medicare allowed 14 percent in error, totaling nearly $9 million in improper payments. In reviewing the sample claims, the OIG analyzed whether each claim included supporting documentation and considered a claim to be erroneous if the documentation did not support the claim or if the claim lacked a physician order.

The OIG also analyzed whether the corresponding interpretation and reports were performed during beneficiaries' diagnoses and treatments in hospital emergency departments, and whether the interpretation and reports were consistent with the American College of Radiology's suggested documentation practice guidelines. The OIG found that 16 percent of interpretive x-ray diagnostic services and 12 percent of interpretive CT and MRI diagnostic services were performed after the patient left the emergency room, and that 71 percent of x-ray services and 69 percent of CT and MRI services did not follow suggested American College of Radiology documentation guidelines.

The OIG recommended that CMS: (1) educate providers on the requirement to maintain documentation on submitted claims, including a reminder that the medical record documentation must include physicians' orders to support diagnostic radiology services and complete interpretation and reports; (2) adopt a uniform policy for single and multiple claims for interpretation and reports of diagnostic radiology services to require that claimed services be contemporaneous (or identify circumstances in which noncontemporaneous interpretations may contribute to the diagnosis and treatment of beneficiaries in hospital outpatient emergency departments; and (3) take appropriate action on the identified, erroneously allowed claims.

CMS concurred with the first and third recommendations, stating that it would issue an educational article to the provider community and take appropriate action on the erroneously allowed claims, including forwarding the list of questionable claims to Recovery Audit Contractors and Medicare Administrative Contractors. As for the second recommendation, CMS did not concur, and stated that it did not believe that a single billed interpretation must, in all cases, be contemporaneous with the beneficiary's diagnosis and treatment to contribute to that diagnosis and treatment. CMS further stated that continued diagnosis and treatment can extend beyond the emergency encounter to other settings, such as a physician's office. For the full text of the OIG's report, click **here**.

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Proposed Changes for Inpatient Rehabilitation Facilities – On April 22, 2011, CMS issued a proposed rule to update the Medicare rates for inpatient rehabilitation facilities (IRFs) in Fiscal Year (FY) 2012 and to establish a new IRF quality-reporting program authorized by the Affordable Care Act.

The proposed payment increase under the IRF PPS is 1.5 percent, an estimated $120 million nationwide which would apply to more than 1,200 Medicare-participating IRFs. With respect to the quality-reporting program, IRFs would be required to submit data on quality measures to CMS. If an IRF does not submit quality data, its payments would be reduced by two percentage points starting in FY 2014. "The measures IRFs would report under the proposed rule will pave the way for Medicare to work with IRFs to improve patient safety, prevent patients from picking up new illnesses during a hospitalization, and provide well-coordinated person-and-family-centered care," said CMS Administrator Donald Berwick, M.D.

Another significant provision in the proposed rule, among others, includes a proposal to allow IRFs to receive temporary adjustments to their full-time equivalent intern and resident caps where they accept interns and residents who are unable

to complete their training because the IRF that had been training them either closed or ended its resident training program.

CMS will accept comments on the proposed rule until June 21, 2011, and the final rule will be issued by August 1, 2011. The proposed rule is available **here** and the CMS press release regarding the proposed changes for IRFs is available **here.**

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King & Spalding Upcoming Roundtable on Environmental Management for Health Care Facilities on April 29, 2011 – On Friday, April 29, 2011, we will be hosting a new Roundtable focused on environmental management for the healthcare industry from 1:00 p.m. to 2:30 p.m. Eastern. By ensuring compliance with mandatory requirements imposed by state and federal regulators, a properly executed Environmental Management System (EMS) will minimize the risk of incurring significant fines and penalties. Furthermore, because implementation strategies usually include minimizing waste, an EMS will often produce substantial efficiencies and cost-savings. **You can register to attend by Webinar by clicking here**.

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