



## **News to Note – Early December 2019**

- A hospital recently noted that they were cited during their Joint Commission survey because although they give every patient a list of available nursing homes and home care agencies as required, they could not produce a copy of the actual list provided to a particular patient. This led to a review of the regulations and the survey guidelines. In most instances, when CMS wants proof a form was provided to a patient, they require the patient to sign the form and the hospital to keep a copy of the signed form, as with the Important Message (IM) and the Medicare Outpatient Observation Notice (MOON). But, that's not the case with patient choice. Further research found that in fact, saving a copy of the actual document was not a CMS requirement; they only require staff to demonstrate how the form is generated to give to the patient.
- The Office of the Inspector General (OIG) released a report in September on Medicare's oversight of ambulatory surgery centers (ASCs). Like hospitals, surgery centers have conditions which must be met to receive Medicare payment. Surgery centers can either contract with an organization such as the Joint Commission to perform a survey or allow the state to complete it. States are required to survey every ASC at least every six years and survey at least 25% of the state's ASCs every year. The OIG found that 35 of 50 states surveyed enough ASCs each year and every ASC was surveyed every six years in 22 states. Over 75% of the ASCs surveyed had a deficiency. One in four had a serious deficiency. 50% of the deficiencies were related to infection control.
- Medicare announced a new payment structure for skilled nursing facilities (SNFs), the Patient Driven Payment Model (PDPM).
- CMS is changing the payment structure for home health agencies, calling it the Patient Driven Groupings Model (PDGM). The payment rate will be in part based on where the patient is located when referred to home care. There will be one rate for referrals from most hospital settings and one rates from what CMS calls "community settings." This

might make sense if considering that home care needs for a patient who is not hospitalized would be less than those for hospitalized patients. But, CMS is identifying hospitalized patients in Outpatient status with Observation services and hospitalized Outpatient surgical patients into the community category. It is feared by some that this could lead to home health agencies refusing to accept these patients if the costs will exceed the payment.

- A Wall Street Journal article (<https://www.wsj.com/articles/doctors-sound-an-alarm-over-leg-stent-surgery-11568127286>) detailed how Johns Hopkins researchers used Medicare claims data to find a small group of physicians who were performing an unusually large number of atherectomies of the leg for peripheral vascular disease. The issue of medical necessity was questioned as many of the patients were referred for evaluation through community screenings at churches. CMS hopes to reduce the number of these outliers and one method is through the use of comparative billing reports (CBRs). Nina Youngstrom from the Report on Medicare Compliance wrote about these in September, as well. CBRs are similar to PEPPERS with comparison of physician billing of specific codes to their peers in the state and nation. Doctors in the top 10% are informed they are outliers but, as with PEPPER, being an outlier does not mean there is a problem. However, outliers certainly need to take a closer look at their coding practices.

\* The news above in addition to many other points of interest for Physician Advisors and other leaders in health care can be heard weekly during Dr. Ronald Hirsch's Monday Rounds segment on RACmonitor.com's Monitor Monday webcast/podcast. Learn more at <https://www.racmonitor.com/monitor-mondays-podcasts/welcome>