Report on
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Weekly News and Compliance Strategies on Federal Regulations, Enforcement Actions and Audits

Contents

CMS to MA Plans: Make Five-Step Appeals Process Available to Non-Contracted Hospitals

In a Sept. 18 memo,[1] CMS reminded Medicare Advantage organizations (MAOs) that a five-step appeal process is available to non-contracted hospitals and other providers when they appeal claim denials for MAO enrollees. Claim denials are not stuck inside an MAO's internal appeal process if the hospitals that provide the services don't have a contract with the MAO.

CMS wrote the memo because MAOs may not always properly process appeal requests from non-contracted providers (NCPs). Specifically, CMS said it has been informed that MAOs don't always give NCPs proper administrative appeal rights "after revising an organization determination." The first two steps of the five-step appeals process are internal to the MAO, and the last three steps are the same as Original Medicare (administrative law judge, Medicare appeals council and federal district court).

"It's pretty huge," said Lisa Banker, M.D., former chief medical adviser for revenue integrity at CarolinaEast Health System in North Carolina. "It's a shot across the bow to Medicare Advantage (MA) plans to stop doing what they are doing." CMS clarified that determinations include denials that result in "lower, but non-zero payment rates," said Edward Hu, M.D., system executive director of physician advisor services at UNC Health in Chapel Hill, North Carolina. He cautioned, however, that there's some ambiguity in how the memo applies.

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Vendor Credentialing Requires Consistency; Hospitals Limit Access Because of COVID-19

When there was an inkling at UNC Health in Chapel Hill, North Carolina, that its hospitals and clinics might be managing vendor representatives differently, the compliance team decided to take a look. Vendors should pretty much get the same treatment across health systems, with some variations based on the goods and services they provide, in terms of screening for Medicare exclusions and turning down gifts, for example.

"We did a system evaluation to better understand the process for credentialing vendor representatives who want to come into the hospitals," said Patrick Kennedy, executive director of hospital compliance. What exactly does it take for a vendor to earn the right to be on the premises? UNC wanted to standardize expectations and pre-boarding for vendor reps coming into the hospitals. Among other things, vendors should have a flu shot and background check, and agree to UNC's code of conduct and vendor relations policy.

"We found there's quite a bit of inconsistency across hospitals," Kennedy said. "We also found some issues with reps taking liberties with freedom and a lack of controls and had to address those." For example, UNC had a situation with a vendor rep who brought free iPads to several clinics. The vendor said the goal was to enable more timely transmission of patient urology information. When the clinic managers realized the iPads were a problem, they contacted compliance. "It was one of those

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rogue vendors," Kennedy said. "We had a conversation with the rep and said, 'This can't happen, but here is what you can do.' They tried to circumvent it, but it happened again," he said. "We banned them."

UNC has since developed a new policy for vendor reps (see box, p. 3)[1] and a vendor code of conduct (see next week's issue of *RMC*) and will educate hospital and clinic staff and vendors on them. "We don't want to prohibit reps from doing what they need to do to help patients," he said. But managing vendors is about protecting the health and safety of patients and staff and ensuring "we are conducting business in an ethical manner and that patients are involved in their health care decisions, and that we are not inappropriately directing patients to one particular vendor or another." For example, there are thousands of post-acute providers in the Research Triangle, "and it's become more challenging to manage that," Kennedy said. CMS requires hospitals to give appropriate patients a list at discharge of home health agencies, skilled nursing facilities, long-term acute care hospitals or inpatient rehabilitation hospitals in the geographic area of their choice.

COVID-19 Has Shut Out Some Vendors

Because of the COVID-19 pandemic, only vendor reps who are "integral to patient care" (e.g., required in the operating room) are allowed at Novant Health right now, said Loree Simmons, assistant director of compliance and integrity. "Our usual policies have been suspended." Under normal circumstances, vendor credentialing is a struggle because it varies by type—should the vendor who refills the soda machines be credentialed exactly like the vendor in the operating room?—and because it requires coordination among employees with different expertise and responsibility (e.g., human resources, credentialing, compliance, supply chain), she said. Everyone is required to have flu shots, for example, and some vendor reps will be checked against the state sex offender registry in addition to the usual background checks. Novant Health, which has hospitals in North and South Carolina and Virginia, uses a third party to manage its vendor credentialing process.

Her tip: Empower employees to ask people questions if faces are unfamiliar. They can say something polite like, "Can I help you find your way?" Especially in a health system with a lot of entrances and exits, vendor reps who haven't been vetted and other people who don't belong may pose a danger to your employees and patients, Simmons noted. "Even if you have a good policy and process, anyone can become risky if you don't follow [them]."

'We Have Locked Down'

During the public health emergency, vendor reps temporarily are not allowed at hospitals owned by Baptist Memorial Health Care Corp. in Nashville, Tennessee, unless their visits are approved by a vice president or above for a specific project, said Corporate Compliance Officer Kim Danehower. "We have locked down."

Baptist Memorial avoids having vendor reps in the operating room, although sometimes it's allowed if the physician needs training on a device or piece of equipment. "They have to get clearance on a case-by-case basis," she said. "They may not be licensed to be in the surgery suite, and we don't need a vendor catering to the physician. It needs to flow through our business model." Baptist Memorial may already have a contract for the same type of device because it was able to get better pricing and quality, Danehower said.

Vendor reps are required to use credentialing process software to come into Baptist Memorial. That ensures they've met all qualifications to be in the hospital. After vendors sign in and print a badge, they're accompanied everywhere by an employee. "It reduces to a small potential a vendor rep coming into patient areas who is not who they say they are," Danehower explained.

Contact Kennedy at patrick.kennedy@unchealth.unc.edu, Simmons at clsimmons@novanthealth.org and Danehower at kim.danehower@bmhcc.org. ✧

Endnotes

1. Nina Youngstrom, "Hospital Policy on Vendor Visitation," *Report on Medicare Compliance* 29, no. 34 (September 28, 2020).

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Hospital Policy on Vendor Visitation

UNC Health Care in Chapel Hill, North Carolina, has just revised its policy on vendor representatives (see story, p. 1)[1] and its vendor code of conduct, which will be published next week. Contact Patrick Kennedy, executive director of hospital compliance, at patrick.kennedy@unchealth.unc.edu.

UNIVERSITY OF NORTH CAROLINA HEALTH CARE SYSTEM
- DRAFT SYSTEM POLICY -

POLICY NAME Vendor Visitation for Network Entities
RESPONSIBLE FOR CONTENT UNC HC Supply Chain & Compliance

I. DESCRIPTION

This policy details requirements and expectations for vendor representatives who visit UNC Health Care (HC) Network Entities representing or promoting products or services that could be used by or sold to the UNC HC Network Entity, as well as vendor representatives promoting referrals for patient care or post-hospitalization services (e.g., durable medical equipment providers, home health providers).

II. DEFINITIONS

Vendor – any business that provides or has potential to provide services or products to UNC HC, its Network Entities or its patients.

- ***Examples of Vendor***s – medical device/supply company, pharmaceutical company, software and programming service providers, insurance company, post-acute care placement provider.

Vendor Representative – any person representing a vendor to UNC HC or its Network Entities.

Independent Contractor – any individual person classified and approved to provide services to UNC HC or its Network Entities under the terms of a contract or agreement in exchange for payment via IRS Form 1099.

- ***Examples of Independent Contractors*** – sole proprietors, window repairperson, caterer, specific clinical care providers.

Business Contractor – any corporation, business, or limited liability corporation classified and approved to provide services to UNC HC or its Network Entities under the terms of a contract or agreement in exchange for payment.

- ***Examples of Business Contractors*** – building construction company, paper shredding company, drink and snack vending machine company, landscaping company, window-washing company, contract clinical care teams, operational business consultants, operational fiscal auditors.

Post-Acute Care Service Provider – any business that provides or has potential to provide post-acute services or products to the patients of UNC HC or its Network Entities.

- ***Examples of Post-Acute Care Service Providers*** – long-term acute care (LTAC) hospitals, skilled nursing facilities (SNFs), durable medical equipment (DME) providers, home oxygen providers, managed care representatives.

Auxiliary and/or Gift Shop Vendors – any business or person solely providing services to hospital gift shops and in support of approved auxiliary sales events.

- ***Examples of Gift Shop and Auxiliary Sales Vendors*** – decorative gift item company, community member donating/selling handmade breast cancer awareness items, annual book sale company.

Visitor Attending a Business Meeting – any person not considered a vendor, independent contractor, business contractor, or post-acute care service provider visiting UNC HC and/or its Network Entities for the purposes of attending a scheduled business meeting with covered personnel.

- ***Examples of Visitors Attending a Business Meeting*** – Community leaders, local business persons, health care providers considering employment with UNC HC or its Network Entities, health care industry leaders.

III. RATIONALE

This policy provides regulatory and behavioral guidelines for vendor representatives and others providing, consulting or soliciting services, as well as referrals for patient care services. Vendor representatives are considered guests of UNC HC and, as such, should provide services in accordance with accepted rules of conduct and in a manner that provides the greatest benefit to UNC HC's patients and Covered Personnel.

IV. POLICY

A. Vendor Registration and Credentialing

1. Vendor representatives must be credentialed in advance of entering a UNC HC Network Entity. Vendor credentialing should be accomplished using a vendor credentialing system and process adopted by the Network Entity. All vendor credentialing shall include vendor education regarding:
   a. Compliance, including fraud, waste and abuse.
   b. Privacy, including protected health information (PHI) and confidentiality.
   c. Office of Inspector General sanction screening.
   d. UNC HC and/or entity-specific vendor visitation requirements and behavioral expectations.
   e. Immunization and health requirements, including annual influenza vaccination.
2. Vendor representatives entering a UNC HC Network Entity must have a previously scheduled appointment or arrangement, e.g., involvement in a surgical case. It is unacceptable for vendors to enter the Network Entity for drop-in visits. Vendor representatives should arrive prior to their appointment and depart immediately after. Unsolicited presence in or about patient care areas, medical staff offices, or other public or private areas for the purpose of making an appointment, or of detailing product or product lines without an appointment, is not permitted. The use of any Network Entity's paging system by vendor representatives is expressly prohibited.

a. Some Network Entities may have dedicated vendor representative liaisons. Dedicated liaisons may locate themselves in public areas of the facility to accommodate timely assistance to departments and hospital staff. All other requirements outlined in this policy must be followed.

3. Vendor representatives are required to sign in using the entity's vendor management software or designated process and receive temporary identification upon arrival at the Network Entity facility. The temporary identification badge must clearly state "Vendor."
4. Vendor representatives are required to also sign in to the department(s) the vendor is visiting. These department vendor visitation logs will be retained for seven (7) calendar years for auditing purposes.
5. The temporary vendor identification shall only allow access for the specific date of visit. All vendors must visibly and prominently display the temporary identification at all times during their visit to the Network Entity. A multiday identification badge may be issued upon approval of entity Supply Chain leadership to vendor representatives working under the supervision of a departmental director on a multiday project.
6. Security access may be added to vendor representative temporary identification badges only upon approval of entity Supply Chain leadership and designated entity leadership. Annual renewal of temporary identification badges with security access is required. It is the sole responsibility of the vendor to provide timely notification to the applicable UNC HC entity in advance of a specific vendor representative leaving the vendor's employment. Vendors failing to do so may be denied the privilege of visiting and/or providing products and services to UNC HC and/or the Network Entity, as well as revocation and declination of security access for all the vendor's representatives.
7. Vendor management credentialing and completion of education and health requirements outlined above in A.1 must be renewed annually by each vendor representative. Annual completion will be accomplished using a vendor management software or another process as defined by a specific entity. Failure to complete the annual education and health requirements will result in loss of privileges to visit and/or provide products and services to the Network Entity.
8. It is the sole responsibility of the vendor representative or their company to pay any associated fees for use of a designated vendor management software product.
9. Upon sole discretion of UNC HC and/or the Network Entity, vendors failing to continually meet and adhere to this policy, including behavioral expectations, may be denied the privilege of visiting and/or providing products and services to UNC HC and/or the Network Entity.

B. Authorized Vendor Representative Access

Representatives may only access patient care areas (e.g., Emergency Department, off-site clinics, Operating Room areas) for appointments prearranged with a member of the medical staff, the area director or designee or other Network Entity department head. Single invitations are not to be construed as blanket approval for future visits. Vendors must remain in designated areas as specified by a member of the medical staff, the area director or designee at all times, or the staff member must be aware and manage vendors within their areas.

C. Vendor Representative Behavioral Expectations

All vendor representatives must:

- Comply with all Network Entity policies and procedures and the Vendor Representative Code of Conduct associated with this policy (Appendix A).[2]
- Present only products or services that have been reviewed and approved by Network/Entity Purchasing or the Director of Pharmacy, as applicable.
    - Pharmaceutical vendors visiting hospital departments:
        - Unless modified by local policy, only Formulary medications may be detailed in hospital departments. Nonformulary medication information may be presented to the appropriate Pharmacy employee listed above.
        - If there are restrictions placed on a formulary medication by the system or hospital pharmacy and therapeutics committee, the representative may only detail the product within those restrictions. It is the responsibility of the representative to inquire about any restrictions.
        - Representatives may not detail off-label uses for their products.
- Provide no product samples to individuals, patients, clinicians, or in departments without prior approval of Purchasing or the director of pharmacy, as applicable.

D. Vendor Representatives Visiting Specific Departments

Individual departments such as Surgical Services and Pharmacy may have department-specific policies, requirements and behavioral expectations. Department-specific guidelines may not conflict with this policy. It is the responsibility of the vendor representative to ensure department-specific requirements are adhered to at all times.

Pharmaceutical vendors who wish to discuss hospital formulary contracting shall contact the system sourcing team at formulary@unchealth.unc.edu.

Pharmaceutical vendors who wish to provide clinical information with the local hospital pharmacy departments may contact the local Director of Pharmacy or designee.

E. Vendor Representative Prior UNC Health Care Employment

Effective 00/00/2021 (1 year from adoption of this policy), UNC HC employees who choose to leave employment for a position with a vendor may not represent the vendor at the UNC HC entity where the person worked as a UNC HC employee for a period of one year from the date of termination with the UNC HC Network Entity. The vendor representative may represent the vendor at another UNC HC entity where the person was not assigned to work immediately upon leaving UNC HC employment. (For example: A nurse working solely in Caldwell Memorial Hospital's cardiac cath lab leaves employment on December 12, 2020. The nurse may begin visitation as a vendor representative to all UNC HC entities other than Caldwell on December 13, 2020, and begin visiting Caldwell as a vendor representative on December 13, 2021.)

F. Determination of Business Representative Role

The nature of business conducted when present at UNC HC or a Network Entity determines if a person is a vendor representative, independent contractor, business contractor representative, representative of a post-acute care service provider, or visitor attending a professional meeting for purposes of this policy. It is possible for a person to at times act as one type of representative, and at other times act as another. For example: A representative of a DME company who makes an appointment with Care Management to market available services the company provides is acting as a vendor representative. This same DME company representative present in a Network Entity solely to deliver an ordered walker for a patient in anticipation of discharge to home is acting as a post-acute care service provider.

G. Service and Manufacturing Product Maintenance, Delivery, and Pick-Up

Business representatives of companies providing service and manufacturing product maintenance, delivery and pick-up may enter UNC HC facilities only upon coordination with Supply Chain, Bio-Medical Engineering or other applicable department directors. Credentialing of such representatives as a vendor is not required when all requirements are met:

- Business representatives must wear visible company photo identification at all times.
- Supervision by appropriate UNC HC personnel is required for such representatives entering patient care areas.
- Employing company must maintain documentation of employee criminal background check, and compliance with mandatory health requirements and immunizations. This required documentation must be provided to UNC HC upon request. Business representatives may not conduct any type of marketing on behalf of the company while providing service and manufacturing product maintenance, delivery and pick-up.

H. Facility Construction and Maintenance

Credentialing as a vendor of company representatives providing contracted services related to facility construction and maintenance is not required when all requirements are met:

- Business representatives must wear visible company photo identification at all times.
- Business representatives provide service as specified in applicable contract and/or agreement with UNC HC.
- Business representatives may enter patient care areas and patient rooms only upon direction of UNC HC leadership, departmental director or other appropriate personnel.
- Employing company must maintain documentation of criminal background check and compliance with mandatory health requirements and immunizations. This required documentation must be provided to UNC HC upon request.
- Business representatives may not conduct any type of marketing on behalf of the company while providing contracted service.

I. Delivery of Post-Acute Equipment Needed for Patient Discharge

Representatives of post-acute care providers may assess acute care patients in UNC HC facilities for appropriateness of post-acute care services. In addition, companies providing durable medical equipment and oxygen equipment for patient home use may make such deliveries to acute care patients in anticipation of discharge to home. Credentialing as a vendor of such post-acute care provider representatives is not required when all requirements are met:

- Representatives must wear visible company photo identification at all times.
- Representatives must coordinate on-site assessment of acute care patients with Care Management, and schedule this assessment in advance.
- Representatives from retail and/or specialty pharmacies must have approval from the director of pharmacy before visiting patients or staff within the hospital/clinic setting.
- Representatives must check in with Care Management or appropriate clinical staff upon arrival, and enter patient care areas and patient rooms only upon their direction.
- Employing company must maintain documentation of employee criminal background check and compliance with mandatory health requirements and immunizations. This required documentation must be provided to UNC HC upon request.
- Representatives may not conduct any type of marketing on behalf of the company while delivering equipment.

J. Business Contractor and Independent Contractor Services

Business and independent contractors provide specified services upon agreement or contract. Credentialing as a vendor of such business and independent contractors is not required when all requirements are met:

- Contractor must wear visible company photo identification at all times.
- Contractor must coordinate provision of agreed-upon service with the appropriate departmental director in advance of arrival at a UNC HC facility.
- Contractor may enter patient care areas and patient rooms only upon direction of UNC HC leadership, departmental director or other appropriate personnel.
- Contractor must maintain documentation of criminal background check and compliance with mandatory health requirements and immunizations. This required documentation must be provided to UNC HC upon request.
- Contractor may not conduct any type of marketing on behalf of the company while on-site providing agreed-upon service.

K. Auxiliary and/or Gift Shop Vendors

Vendors providing sales to hospital/auxiliary gift shops and/or participating in hospital leadership and hospital auxiliary approved events (e.g., book sales, medical uniform sales) are not required to be credentialed as a vendor when all requirements are met:

- Vendor must wear visible company identification at all times.
- Vendor must coordinate provision of agreed-upon service with the appropriate departmental director in advance of arrival at a UNC HC facility.

- Vendor may not enter patient care areas and patient rooms.
- Vendor must maintain documentation of annual influenza vaccine. UNC HC and/or Network Entity may require documentation of additional immunizations and mandatory health requirements as deemed necessary by applicable UNC HC and/or Network Entity Infection Prevention Director. This required documentation must be provided to UNC HC upon request.
- All marketing materials advertising hospital/auxiliary sponsored events bearing the vendor's name, logo or other business identification must be approved by the department director in advance of distribution. All other types of marketing by vendor on any UNC HC property is prohibited.

L. Visitors Attending a Professional Business Meeting

Visitors attending scheduled business meetings with UNC HC and/or Network Entity covered personnel not considered vendor representatives, business contractor, independent contractors or post-acute care service providers as defined above are not subject to this policy.

Endnotes

1. Nina Youngstrom, "Vendor Credentialing Requires Consistency; Hospitals Limit Access Because of COVID-19," *Report on Medicare Compliance* 29, no. 34 (September 28, 2020).
2. Appendix A will appear in next week's issue of *RMC*.

Texas Hospital Settles CMP Case Over Orthopedic Call Coverage

St. Luke's Baptist Hospital in San Antonio, Texas, agreed to pay $232,200 to settle allegations that it overpaid two orthopedic surgeons for being on call to the emergency room, according to a civil monetary penalty settlement with the HHS Office of Inspector General (OIG).

OIG contends between April 1, 2017, and Sept. 30, 2018, the hospital paid remuneration to two physicians "in the form of a disproportionate amount of compensated orthopedic surgery emergency on-call coverage." The hospital allegedly violated the Civil Monetary Penalties Law provision applicable to kickbacks and "presented claims to the Medicare program for designated health services" that resulted from prohibited referrals, OIG alleged.

The settlement stemmed from St. Luke's self-disclosure to OIG. The hospital was accepted into OIG's Self-Disclosure Protocol in January 2020, according to the settlement, which was obtained through the Freedom of Information Act. No additional details were available, and the hospital didn't respond to *RMC*'s requests for comment. It didn't admit liability in the settlement.

This is the second civil monetary penalty settlement in five months about on-call coverage compensation. Sitka Community Hospital in Alaska shelled out $4.125 million after OIG alleged the hospital paid remuneration to 16 providers in the form of excessive compensation under emergency department (ED) call coverage arrangements and advanced practice provider arrangements.[1]

Payments to physicians for serving on ED call panels must be fair market value (FMV) to comply with the Stark Law and the Anti-Kickback Statute. There are many moving parts to FMV when it comes to call coverage, according to Joe Aguilar and Don Crawford, who are partners at HMS Valuation. Here are ways FMV can go awry, they said:

- A physician tells Hospital A that it must match what Hospital B pays for call coverage. But the call volume may be far higher at Hospital B and the payer mix entirely different (e.g., more Medicaid/self-pay patients). "There could be a wide disparity between the hospitals in orthopedic coverage," Crawford noted. But hospital executives may be pushed to get call coverage and unwarily ask what the going rate is, without considering "that every hospital is nuanced."
- A hospital contracts with a locum tenens agency for call coverage at high rates because it has no other options until local physicians on the medical staff say they will take over. The problem is the local physicians ask for the same pay as the locum tenens agency. The rate the hospital pays the agency isn't comparable to the compensation paid by the agency to the physicians who provide call coverage, Aguilar said. Physicians working for the locum tenens agency generally make 50%-65% of the locum rate because of the agency's overhead. "The economics aren't apples to apples," Crawford said. A payment rate that's close to the locum tenens may be too high.
- An on-call orthopedic surgeon comes in, does the casework and heads back to her practice, leaving the post-surgical rounding and discharge to a hospital-employed nurse practitioner or physician assistant. "That's something normally done by the on-call physician and reimbursed through the surgery service performed," Crawford said. Depending on the rate, the hospital may essentially be paying the physician for services he or she isn't providing. In addition, the undue benefit associated with the post-

surgical rounding provided by the hospital-employed nurse practitioner may pose a billing compliance risk.

- Orthopedic trauma physicians, who earn more than general orthopedic surgeons, may demand more money to serve on general orthopedic call panels even though generally "that's not what rolls into the ED," Crawford said. There's some risk in paying based on the specialty instead of the services.

"There are pitfalls if hospitals don't have the details or the data and just use rules of thumb instead of trying to get a rate that's specific to a hospital for a specific service," Aguilar said.

Contact Crawford at don.crawford@hmsvalue.com and Aguilar at joe.aguilar@hmsvalue.com. ✧

Endnotes

1. Nina Youngstrom, "Hospital Pays $4M in Settlement Over Call Coverage, APPs; Consider 'Key Value Drivers,'" *Report on Medicare Compliance* 29, no. 24 (June 29, 2020), https://bit.ly/35ZNha7.

CMS Transmittals and *Federal Register* Regulations, Sept. 18-24

Transmittals

Pub. 100-04, Medicare Claims Processing Manual

- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2021, Trans. 10372 (Sept. 24, 2020)
- October 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS), Trans. 10373 (Sept. 24, 2020)
- Penalty for Delayed Request for Anticipated Payment (RAP) Submission – Implementation, Trans. 10396 (Sept. 24, 2020)
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment, Trans. 10367 (Sept. 24, 2020)
- October 2020 Update of the Ambulatory Surgical Center (ASC) Payment System, Trans. 10366 (Sept. 23, 2020)
- Update to the Medicare Claims Processing Manual, Trans. 10356 (Sept. 18, 2020)
- Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 9, Section 70.7 and 70.8., Trans. 10357 (Sept. 18, 2020)
- Fiscal Year (FY) 2021 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes, Trans. 10360 (Sept. 18, 2020)
- Change to the Payment of Allogeneic Stem Cell Acquisition Services, Trans. 10371 (Sept. 24, 2020)

Federal Register

Final Regulation

- Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Final Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals, 85 Fed. Reg. 58,432 (Sept. 18, 2020)

MAOs Must Give NCPs 5-Step Appeals

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Although the *Medicare Managed Care Manual*[2] already establishes that the CMS administrative appeals process is available to non-contracted providers for MA claim denials, "MA plans wouldn't apply it," Banker said. She's a little worried the memo "fell short because it wasn't a revision to manual language. Then again, CMS felt what was written was good enough. We are hoping a memorandum does the trick."

The memo explained that according to 42 C.F.R. § 422.566(b)(3), an MAO's "refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for" by the MAO is an organization determination. A non-contracted provider can be party to an organization determination and request reconsideration. "In such situations, an NCP who is the enrollee's assignee must be afforded full administrative appeals rights in accordance with 42 C.F.R. Part 422 Subpart M," which is the section on MAO grievance procedures.

CMS gave four examples of organization determinations that have come to its attention:

- **Diagnosis code/DRG payment denials**. MAOs approve claims submitted by non-contracted providers and then later reopen the case and deny the DRG code "on the basis that a different DRG code should have been submitted."
- **Downcoding**. MAOs approve inpatient services provided by a non-covered hospital, then later decide the enrollee should have gotten outpatient services.
- **Bundling issues and disputed rate of payment**. For example, MAOs deny procedure codes on the grounds they're mutually exclusive to another paid procedure code because they're included in a previously paid global surgical package.
- **Level of care or rate of payment denials**. MAOs pay a reduced fee schedule amount for a course of treatment. For example, a non-contracted hospital bills a procedure code for a visit, and the MAO reimburses based on a lower level of care.

The memo follows on the heels of CMS's confirmation in 2018 that MAOs have to follow Original (fee-for-service) Medicare in terms of payment, appeals and program integrity if they don't have contracts with hospitals.[3] In an email to Phillip Baker, M.D., medical director of case management at Self Regional Healthcare in Greenwood, South Carolina, a CMS official said that MA plans are required to apply the two-midnight rule and pay clean claims in 30 days, and deny or adjudicate other claims in 60 days when they're submitted by non-contracted hospitals.

"They finally put in writing what we have been saying for a long time," Baker said in response to the

September memo. "Anything where they reduce payment, you have a right to the Medicare appeals process."

Payment Disputes Stay In MAO Appeal Process

Hu said there are some things for hospitals to keep in mind when they read the memo. CMS only cited examples of reopenings, so perhaps the memo only applies to them. Even if that's the case, non-contracted providers derive their rights from regulations, independent of whether there was a reopening, he noted.

CMS also addressed what may be adjudicated in an MA plan's internal appeals process—a "payment dispute"—which is defined as a calculation of the amount an NCP could collect if the enrollee had Original Medicare. "Although organization determinations can affect items that affect the original Medicare payment amount, CMS is clearly referring to disputes regarding the calculation of payment in full, such as determining the payment for a certain DRG, or whether sequestration or bad debt are considered," Hu said. "These calculational issues are not organization determinations, which is the key differentiator of when the internal payment dispute process is appropriate."

The memo doesn't specifically mention the activities of an MA plan's delegated entities. MA plans are responsible for them, as CMS explains in the *Medicare Managed Care Manual*, Hu said. "Thus, denials from delegated entities must adhere to the same standards for organization determinations, including affording the right to access the CMS administrative appeals process."

'The Market Forces Are So Tremendous'

A full-fledged appeal process and fewer claim denials are some of the advantages of being a non-contracted hospital, Baker said. It's a no-brainer for Self Regional Healthcare, a sole community hospital, because MA enrollees are treated there without any concessions by the hospital. "If you're the only hospital in the market, I don't know why in the world you want to contract" with MA plans, he said.

Many hospitals contract with MA plans, however, because "the market forces are so tremendous," Banker said. They fear losing patients to competitors.

There are other kinds of pressures. Banker said one commercial plan threatened to kill her hospital's annual fee increase unless it also joined the MA product. "It's really important that people not contract and bow to those pressures," although it's a tough sell in urban areas with a lot of competitors.

Even NCPs find themselves in a bad spot, which was the impetus for enlisting CMS's help. For example, MA plans may shut down appeals by calling debates over clinical validation "payment disputes" instead of denials, Banker said. Without denials, there's no adverse organization determination forcing "a path that required clear notification and appeals rights based on CMS regulations," Banker said. Payment disputes are adjudicated internally by the MA plan.

Contact Baker at roy.baker@selfregional.org and Hu at edward.hu@unchealth.unc.edu. ✧

Endnotes

1. Jerry Mulcahy, "Non-Contract Provider Access to Medicare Administrative Appeals Process," memo, September 18, 2020, https://bit.ly/36726Yy.
2. CMS, "Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance," *Medicare Managed Care Manual*, Pub. 100-16, chap. 13, effective January 1, 2020, https://go.cms.gov/33XHzmt.
3. Nina Youngstrom, "CMS: MA Follows Original Medicare Without Contracts, All Plans Defer to Medical Judgment," *Report on Medicare Compliance* 27, no. 32 (September 10, 2018), https://bit.ly/3hZvLoV.

NEWS BRIEFS

◆ **In a settlement of potential HIPAA violations with a business associate, the HHS Office for Civil Rights (OCR) said Sept. 23 that CHSPSC LLC has agreed to pay $2.3 million related to a breach affecting more than six million people and implement corrective actions.**[1] CHSPSC provides business associate services, such as health information management, to hospitals and clinics indirectly owned by Community Health Systems Inc., in Franklin, Tennessee. In April 2014, the FBI informed CHSPSC that it had traced a cyberhacker group's advanced persistent threat to CHSPSC's information system. "Despite this notice, the hackers continued to access and exfiltrate the protected health information (PHI) of 6,121,158 individuals until August 2014," OCR said. "The hackers used compromised administrative credentials to remotely access CHSPSC's information system through its virtual private network." An investigation by OCR allegedly found "systemic noncompliance with the HIPAA Security rule." CHSPSC did not admit liability in the settlement.

◆ **The Department of Justice said Sept. 23 that Gilead Sciences Inc. has agreed to pay $97 million to settle false claims allegations** that it used a tax-exempt foundation as a "conduit" to pay the copays of thousands of Medicare patients taking the Gilead drug Letairis for pulmonary arterial hypertension.[2]

◆ **The HHS Office of Inspector General has updated its Work Plan.**[3] New items include an audit of infection control at home health agencies during the COVID-19 pandemic.

Endnotes

1. OCR, resolution agreement for CHSPSC, accessed September 25, 2020, https://bit.ly/3mLaPWj.
2. Department of Justice, "Gilead Agrees To Pay $97 Million To Resolve Alleged False Claims Act Liability For Paying Kickbacks," news release, September 23, 2020, https://bit.ly/2RY6JMn.
3. "Recently Added," Work Plan, Office of Inspector General, HHS, accessed September 25, 2020, https://bit.ly/2AxFtyP.