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

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CMS Finalizes M.D. Payment Changes, With Delay And Level Five; Documentation Is Eased

Medicare payments for outpatient/office visits and related documentation requirements are getting a makeover, but not until 2021, according to the final 2019 Medicare Physician Fee Schedule regulation announced Nov. 1. CMS modified its controversial proposed regulation, which would have paid physicians the same for CPT code levels two through five *(RMC 7/16/18, p. 1)*. Instead, there will be three payment levels for new and established patients, with a blended payment for levels two through four and separate payments for levels one and five. Plenty of other changes take effect Jan. 1, including relaxed documentation standards in other areas and separate payments for virtual check-ins with physicians.

Because the payment changes are delayed, physicians also have to wait two years for new documentation options that CMS cooked up in the proposed regulation. When 2021 rolls around, physicians may stick with the 1995 and 1997 Medicare documentation guidelines or support their evaluation and management (E/M) services with medical decision-making only—forget the exam and history—or the time they spend with patients, and they only have to document to E/M level two for payment and medical review purposes (unless they bill for level five CPT codes). All these documentation methods will be on the menu.

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CMS Proposed Rule Expands MA Telehealth Coverage to All Part B Services, All Regions

Telemedicine would have equal footing to in-person visits under Medicare Advantage in the 2020 plan year under a proposed regulation with policy and technical changes for MA, which was published in the *Federal Register* Nov. 1. CMS would require MA plans to pay for the telehealth version of all covered Part B in-person services. The kicker: MA plan enrollees would be eligible for telehealth services whether they live in urban, suburban or rural areas, and they could receive them from home, freed from the geography ties that bind telehealth under Original (fee-for-service) Medicare.

"That is huge," says attorney Sidney Welch, with Akerman in Atlanta, Georgia. "It's great in the sense so many providers are now in the throes of telehealth programs and they have the ability to get those services reimbursed fully" by MA plans. And this represents "a shift in thinking," she says. "We are getting over the hump of suspicion that telehealth services aren't as good as in-person touch and seeing the value of services outweighing the fear of fraud." But providers shouldn't get complacent because telehealth already has attracted more audit and enforcement attention. For example, a Connecticut psychiatrist in 2016 settled a false claims case over Medicare charges for telephone consults with beneficiaries in an urban area *(RMC 8/1/16, p. 1)*. The potential for abuse with telehealth "isn't going unnoticed by the government," she says. In April, the HHS Office of Inspector General reported finding a significant error rate on a sample of telehealth claims in Original Medicare.

continued

In light of the significant move the regulation represents, maybe the government will open telehealth doors wider for the rest of the Medicare population, says Douglas Grimm, an attorney with Arent Fox in Washington, D.C. "This is a quantum leap," he says. "What they are proposing to do for MA plans is hopefully a stepping stone for traditional Medicare for the future."

The proposed regulation implements provisions in the 2018 Bipartisan Budget Act that expanded telehealth under MA and Original Medicare *(RMC 9/17/18, p. 1)*. Sec. 50323 of the Bipartisan Budget Act permits MA plans to provide "additional telehealth benefits" starting in 2020 and to "treat them as basic benefits for purposes of bid submission and payment by CMS," the regulation explains. Currently, telehealth coverage is optional, a bonus that MA plans may offer to attract beneficiaries.

However, if MA plans are in for a penny, they're in for a pound: whatever Part B services are covered in person would have to be covered by telehealth. CMS is not inserting itself into the process of selecting the services, however, the way it does for Original Medicare, where the telehealth expansion has been incremental, CPT code by CPT code, although that's coming along. CMS is leaving it to MA plans to decide what services will be covered by telemedicine, which the regulation refers to as "electronic exchange" (e.g., secure messaging, store and forward technologies, telephone, videoconferencing, other internet-enabled technologies). That means if the MA plan covers certain neurology services when patients have a face-to-face visit, the MA plan has to cover neurology services delivered by telemedicine—although it's up to the MA plan whether to cover them at all.

"We believe that MA plans are in the best position to identify each year whether additional telehealth benefits are clinically appropriate to furnish through electronic exchange. MA plans have a vested interest in and responsibility for staying abreast of the current professionally recognized standards of health care, as these standards are continuously developing with new advancements in modern medicine," the proposed regulation states.

CMS Highlights Treatment for Opioid Use

MA plans—and by extension providers—are also free to serve patients by telehealth without the geographical constraints of Original Medicare. That's a radical change, because original Medicare only covers telehealth visits provided in a rural area, which means counties outside of metropolitan statistical areas (MSAs) or in health professional shortage areas either outside of an MSA or in a rural census tract. Telehealth services have to be delivered to patients in an "originating site," such as hospitals, physician practices and other approved locations by distant site providers (e.g., physicians, nurse practitioners and physician assistants). That's in the Social Security Act, and CMS can't do much about it for Original Medicare without congressional intervention.

But Congress authorized CMS to change the game for MA. "That's the payoff," Grimm says. "Why should telehealth be restricted to rural areas when people in urban areas are just as sick?" Grimm notes. "For the elderly, the infirm or folks who don't have ready access to transportation or can't leave their homes for medical reasons, there are certain types of health care that should be available for them on their PCs."

Also in the regulation, CMS said the providers' costs of infrastructure for telehealth, including extra computers and wireless services, can't be included in payments, which would essentially shift the costs to MA plans. "They can't charge that back to MA plans or beneficiaries," Welch says.

And MA enrollees have to be informed about the telehealth option in the evidence of coverage (EOC) document. "In proposed regulation text at § 422.135(c)(2), we propose to require MA plans to use their EOC (at a minimum) to advise enrollees that they may receive the specified Part B service(s) either through an in-person visit or through electronic exchange. Similarly, as we propose at § 422.135(c)(3), MA plans would have to use their

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provider directory to identify any providers offering services for additional telehealth benefits and in-person visits or offering services exclusively for additional telehealth benefits," the proposed regulation says.

Behavioral health and opioid use treatment are areas ripe for telehealth services because they require no physical contact with providers, Grimm and Welch say. That's clearly on CMS's mind. According to the regulation, "Behavioral health, in particular, is a prime example of a service that could be provided remotely through MA plans' offering of additional telehealth benefits under this proposal. The President's Commission on Combating Drug Addiction and the Opioid Crisis recommends telehealth as useful in the effort to combat the opioid crisis, especially in geographically isolated regions and underserved areas where people with opioid use disorders and other substance use disorders may benefit from remote access to needed treatment."

Auditors Are Watching Telehealth

Meanwhile, as coverage slowly expands in Original Medicare, expect more scrutiny from Medicare watchdogs. The connection between originating and distant sites was examined in an April audit report on telehealth from the HHS Office of Inspector General. "We reviewed 191,118 Medicare paid distant-site telehealth claims, totaling $13.8 million, that did not have corresponding originating-site claims," the report stated. "We reviewed provider supporting documentation for a stratified random sample of 100 claims to determine whether services were allowable in accordance with Medicare requirements."

The findings: 31 were not compliant. For the majority—24—patients received services at non-rural originating sites, seven claims were submitted by ineligible institutions, three claims were for services provided at unauthorized originating sites, two involved unauthorized means of communication, one claim was for a noncovered service, and one service was provided by a physician outside the United States.

Contact Welch at sidney.welch@akerman.com and Grimm at douglas.grimm@arentfox.com. View the proposed rule at http://bit.ly/2DeymLG. ✧

Former Prosecutors: Data Drives More Cases, Consider Same Metrics

Data analysis is changing the complexion of civil and criminal investigations, serving as a sort of X-ray vision of providers and their financial relationships with other entities, two former prosecutors say. Data speaks in a different way to jurors than witnesses, and has now been used as a surrogate for an insider in a False Claims Act case, and with the government increasing its investment and reliance on analytics, health care organizations should follow suit, they say.

"The idea a prosecutor can show a jury how one doctor compares to his peers—that's a powerful piece of evidence that didn't exist five years ago," said Jason Mehta, a former assistant U.S. attorney in the middle district of Florida, at a Health Care Compliance Association webinar Oct. 30. "It's one thing to say, 'This guy gave everyone a stent.' It's another thing to say, 'This doctor is the number one physician with stenting in the country.'"

While it's hard to make a criminal case without live testimony from a witness, prosecutors have been able to settle civil False Claims Act cases without a witness, relying instead on data, said A. Lee Bentley III, the former U.S. attorney for the middle district of Florida, at the webinar. "Data is even more critical on the civil side," he contended. For example, false claims cases with compounding pharmacies in Florida "were built almost exclusively on data," Mehta said. They resulted in big-dollar settlements with Med Match Pharmacy in Jacksonville, which paid $4.7 million, OHM Pharmacy in Auburndale, which paid $4.1 million, and others.

From Subpoenas to Statistics

Bentley said more data is available—including a database that ranks physicians by their Medicare payments—and the government is improving its analytic capability with outside help. For one thing, the government has a 3% fund. "3% of *qui tam* recoveries go into a fund the government can use to develop more whistleblower cases, and the government increasingly is spending that money to retain top-flight companies" in data analytics, such as Acumen Data, he noted.

Data alone is driving a new False Claims Act lawsuit filed by Integra Med Analytics LLC of Austin, Texas. The company used statistical analysis of Medicare data to allege that Providence Health & Services in Renton, Washington, added "unsubstantiated" major complications and comorbidities (MCCs) to increase its MS-DRG reimbursement, egged on by a consultant *(RMC 9/10/18, p. 4)*.

According to its complaint, which was filed Aug. 10 in the U.S. District Court for the Central District of California, Integra's proprietary analysis of Medicare claims submitted nationally since 2011 allegedly showed "that Providence Health & Services and its affiliated hospitals…routinely used unwarranted Major Complication and Comorbidity secondary codes, which falsely inflated claims submitted to Medicare."

This is a remarkable shift. "In the good old days, the primary way an investigation was conducted was that the government would get a tip, get a grand jury

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subpoena or execute a search warrant, and then review the patient files and identify specific instances of upcoding," said Bentley, a partner with Bradley in Tampa, Florida. "Now the government can much more efficiently look across an entire industry and determine where the outliers are. Not all outliers are outlaws, but this helps in identifying fraud. Some of the statistical data and peer comparisons are much more persuasive at trial than having a battle of experts over whether a procedure is medically necessary" (see box, p. 4).

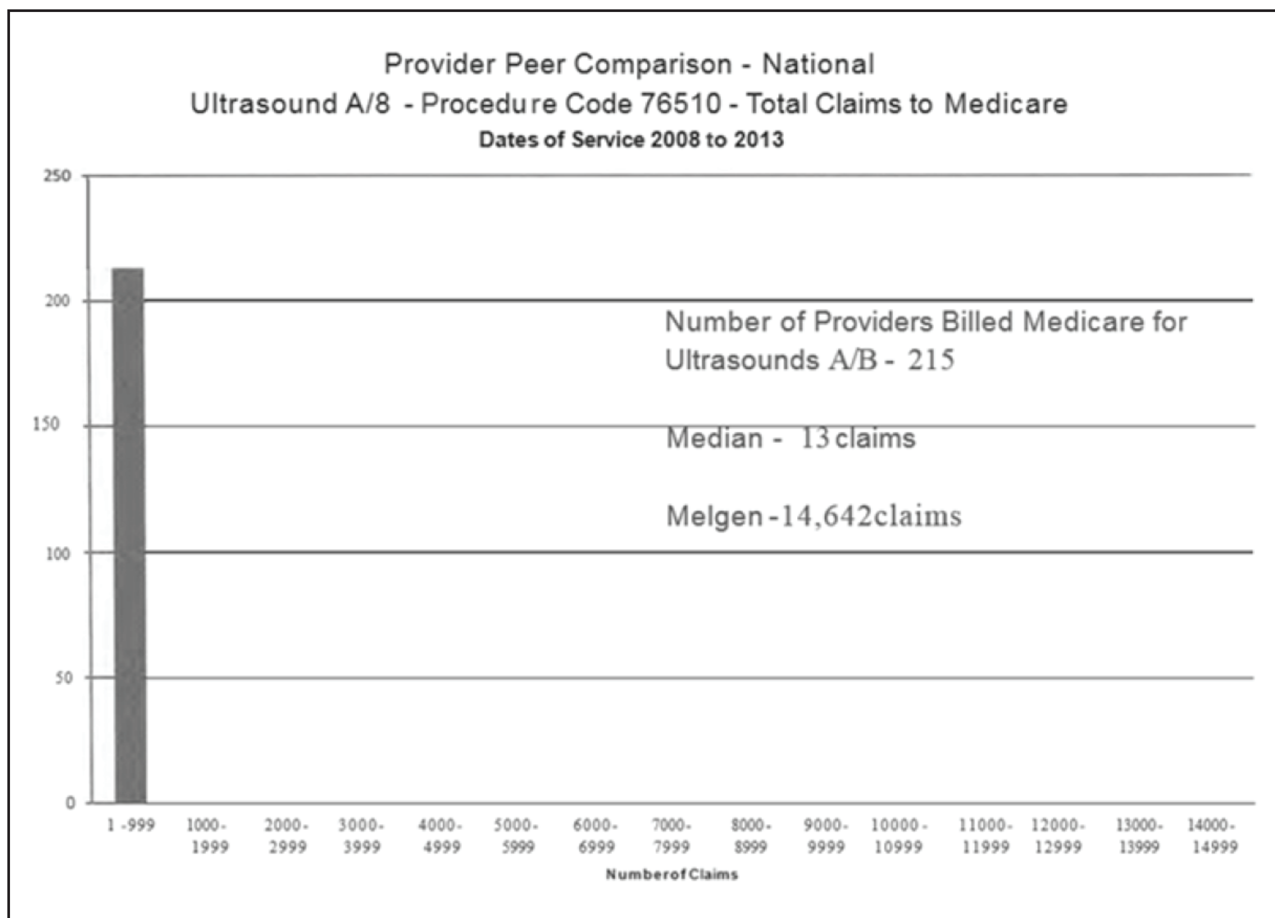
The Department of Justice and HHS use metrics to identify possible targets, and health care organizations can do the same with publicly available databases, including data.cms.gov, www.healthdata.gov, and https://graphics.wsj.com/medicare-billing, according to Mehta and Bentley. Here are some of the metrics:

◆ **Peer comparison generator:** Compare peers (e.g., physicians, hospitals) on the basis of billing or payment. How do they rank in terms of evaluation and management coding or modifier use in their specialty? Which

Using Data to Identify Outliers: A Powerful Example

This chart was used in the health fraud trial of Florida ophthalmologist and retina specialist Salomon Melgen to compare his billing to other physicians, said attorney Jason Mehta, with Bradley in Washington D.C. Melgen was convicted by a jury last year of 67 counts related to false claims and false entries in patients' medical charts, the U.S. Attorney's Office for the Southern District of Florida said. Melgen falsely diagnosed Medicare patients with macular degeneration and then performed and billed for medically unnecessary tests and procedures. As the chart shows, his billing exceeded his peers to the extent that they don't even show up, Mehta said. Data mining is increasingly used by the government, with greater sophistication, in civil and criminal health fraud cases (see story, p. 3). Melgen was sentenced to 17 years in prison. Contact Mehta at jmehta@bradley.com.

Example of Data in *Melgen*



physicians are outliers (e.g., do they fall off a bell curve when compared to other physicians in the same specialty in the same geographic area)? "Think about your own risk factors and outliers," Mehta said. "Which doctors are the top billers? Someone has to be number one. If someone is receiving a lot of money from a pharmaceutical company, they have to be able to explain why."

◆ **Link analysis:** Look at the relationship between providers. For example, the government might wonder why Dr. Jones refers all his patients to Dr. Smith, a hospice provider. Is there a financial link?

◆ **Payments by geographic area:** Ask questions if payments are concentrated in a region. If all your referrals come from one physician four counties away, the government probably will have questions, said Mehta, who is also with Bradley in Washington, D.C. "You can really get ahead of the curve by doing a compliance analysis so you can explain it." Or "if you are a pharmacy and all your patients are coming from another state, you ought to be able to explain why you're doing so well in a geographic area you have no connection to," he said.

◆ **Statistical models to calculate risk scores for providers who may be defrauding Medicare:** The government has an internal list of 10,000 physicians ranked by their risk of fraud and abuse that's not available to hospitals, Bentley said, but they can develop their own version. Hospitals could build multidimensional risk profiles for physicians by benchmarking them against their peer groups on certain metrics (e.g., E/M services, modifiers and the top procedures) and incorporating "risk thresholds" *(RMC 5/22/17, p. 3)*.

"Understanding and leveraging data and using it as a sword and shield will be so critical," Bentley said. "It's important to include data analytics in your compliance program." He and Mehta recommend asking the questions the government would ask. For example, does your hospice have patients with lengths of stay of three to five years? Is there a pattern of patients who are in hospice a set number of days (e.g., 180) and then discharged? In medical groups, are physicians billing more than 24 hours a day in face-to-face time with patients? In hospitals, who are the top referral sources and prescribers? "The government often looks at those facilities where two, three or four doctors account for 80% or more of the volume," Mehta said.

To "harness and leverage the power of data," he said health care organizations have to educate employees about the importance of collecting accurate data. For example, coders and billers should complete all fields in the electronic health records, even if they're not billed. That means all comorbidities, not just the primary and secondary diagnoses.

They also advise capturing as much relevant data as possible. According to a recent study at a University of Michigan ophthalmology clinic, electronic health record (EHR) data matched against patient-reported data in only 23.5% of records, Mehta said. "When patients reported having three or more eye health symptoms, their EHR data did not agree at all," he noted.

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Hospital Settles Case for $2.27M Over M.D. Lease With Other Entity

UNC REX Healthcare (UNC Rex), a hospital in Raleigh, North Carolina, agreed to pay $2.27 million to settle allegations over a physician lease that violated the civil monetary penalty law prohibiting kickbacks, the HHS Office of Inspector General said.

UNC Rex reported a problem with the lease to OIG earlier this year and was accepted into its Self-Disclosure Protocol on May 30. The hospital explained that it loaned one of its employed cardiologists to another entity for the purpose of providing cardiology services from Sept. 26, 2015, through Feb. 20, 2018. The hospital paid the cardiologist's salary and bonus, while the entity paid a fee to the hospital for the lease of the cardiologist, according to the settlement.

But the money didn't match. OIG alleges the hospital paid the cardiologist remuneration in the form of salary and bonuses that were greater than the entity's lease fee to UNC Rex, "and that should have been paid by" the entity. The settlement resolves the hospital's "alleged liability under the Civil Monetary Penalties Law for its improper submission of claims to Federal health care programs when its arrangement with [the entity] allegedly violated the Anti-Kickback Statute," according to the OIG's "event narrative."

Leases: 'A Perfectly Appropriate Arrangement'

UNC Rex didn't admit liability in the settlement. Its attorney didn't respond to *RMC*'s request for comment.

Hospitals often rent their physicians to other entities, usually hospitals—often smaller, rural ones—that lack specialists, says attorney Bob Wade, with Barnes & Thornburg in South Bend, Indiana. The smaller hospitals set up clinics for a day or more with the leased physicians—a perfectly appropriate arrangement as long as it's commercially reasonable and the compensation is fair-market value, two pillars of the Stark Law, he says. Commercially reasonable means the deal between the parties would still be worthwhile even if there were no referrals.

If that's not the case, however—when the physician lease is not fair-market value or commercially

reasonable—the hospital could run afoul of the Anti-Kickback Statute or Stark Law, Wade says. Maybe the physician's compensation is too generous or the larger hospital is undercharging a smaller, rural hospital for a lease to induce its patient referrals.

"You have to look at the business risk," Wade says. "If a hospital is leasing a physician and not getting the same payment they are making to the physician, they are providing a benefit to the other entity. So when you're leasing a physician, you want to make sure you're covering your costs to employ the physician, and that gets into a commercial reasonableness issue." In other words, hospitals have to make sure they're not absorbing a business risk—the dollar amount being paid—on behalf of the entity they're leasing physicians to. The lease is not commercially reasonable when hospitals are losing money, Wade explains.

However, he says, there may be other fair-market value and commercially reasonable factors to charging a leasing health care entity less than what the physician is paid as an employee, including the hospital's mission to serve indigent patients.

"Does the hospital need to pay the doctor as an employee the same amount it is receiving from [the other hospital]?" Wade says the answer is no. Hospitals often accept revenue losses from mission-based care through other entities, he says.

"As long as a hospital is paying fair-market value, I don't believe the fact that the hospital employer enters into a business relationship with another hospital is a per se violation when the hospital employer is paying on an hourly basis more than the other hospital pays the independent contractor," Wade says. "This is a fact-specific analysis, and the primary issue is whether the leasing entity is paying fair-market value for commercially reasonable services regardless of what the hospital employer is paying the specialist being leased to the other health care provider."

He notes that problems with leases could lead to high-dollar repayments because specialists are usually leased, and they generate expensive fees. If hospitals self-disclose or face false claims cases over leased physicians, the government probably will require repayments and fines dating back six years. That could send settlement amounts skyrocketing. With the Self-Disclosure Protocol, damages are usually limited to 1.5 times the overpayment amount, which refers to the reimbursement the hospital received for Medicare referrals.

Contact Wade at bob.wade@btlaw.com. ✧

M.D. Payment Changes Are Final

continued from p. 1

The proposed regulation set forth a blended payment rate for new and established office/outpatient E/M visit levels two through five. CMS acknowledged that "most commenters opposed this proposal" because of "the potential negative implications of the proposal for patients with the most complex needs and the clinicians who serve them," even though there's widespread agreement the E/M coding structure is outdated. In response to comments, CMS is "finalizing for 2021, a single payment rate for levels 2 through 4 E/M office/outpatient visits (one rate for new, and one for established patients) and maintaining separate payment rates for new and established patients for level 5 E/M office/outpatient visits to account for the most complex patients and visits." CMS noted level four

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is the most commonly reported code, and it will "monitor utilization of these services."

On another documentation front, CMS lightened the paperwork burden for established patients at E/M office/outpatient visits that take place before the blended rule is applied. Effective Jan. 1, physicians are allowed to focus their documentation on what's new with the patient "or on pertinent items that have not changed, rather than re-documenting a defined list of required elements such as review of a specified number of systems and family/social history," the final regulation states. The policy is designed to simplify the documentation of history and exam. Allied health staff can take down the information, and physicians will review it and document accordingly, although they still have the option to start from scratch. "Practitioners would conduct clinically relevant and medically necessary elements of history and physical exam, and conform to the general principles of medical record documentation in the 1995 and 1997 guidelines. However, practitioners would not need to re-record these elements (or parts thereof) if there is evidence that the practitioner reviewed and updated the previous information," the regulation stated.

That's a welcome move, says attorney Richelle Marting, with the Forbes Law Group in Overland Park, Kansas. The way the 1995 and 1997 documentation guidelines are interpreted, nurses and other ancillary staff are allowed to record reviews of systems, as well as past family and social history, but the physician must document the history of present illness and chief complaint. That didn't match the workflow of physician practices and clinics, where nurses take patients to rooms and do the preliminaries. The final regulation changes all that, although "it's still the physician's responsibility to ensure the pertinent information gets documented in the medical record," Marting says. Other payers may not embrace this change, however, she notes.

Risk of a Burden Without Other Payers

And CMS finalized, without modification, the relaxation of teaching physician documentation requirements. "The extent of the teaching physician's participation may be demonstrated by the notes in the medical records made by a physician, resident, or nurse," the proposed regulation states *(RMC 7/23/18, p. 1)*.

There are pros and cons to the payment and documentation changes, Marting says. "Providers can take advantage of relaxed documentation requirements for the majority of office visits, which are levels two to four, and they may not have to worry quite as much about audits for the vast majority of visits, because in that range of level two to four visits, Medicare says you only need to meet the documentation requirements of level two." The difference between levels three and four causes a lot of the clashes between auditors/payers and providers. "Getting rid of that can let providers go back to focusing on what documentation they need and what is best for patients and not so much on how many boxes they are checking on an E/M audit tool," Marting noted.

However, it sounds better in theory because physicians will have to follow different documentation standards for office visits and all other services, and for Medicare versus commercial payers if commercial payers don't parrot CMS's payment changes anytime soon. That's a big con, at least in the short run.

"CMS acknowledges this as an issue but goes no further," added Ronald Hirsch, M.D., vice president of education and regulations at R1 Physician Advisory Services. "It is still a significant concern that in 2021, when the CMS regulations go into effect, other payers may choose not to adopt them, especially if their internal projections suggest it will result in higher overall payments to physicians." In fact, CMS noted in the regulation that "America's Health Insurance Plans believed documentation requirements

CMS Transmittals and *Federal Register* Regulations
Oct. 26–Nov. 1

Live links to the following documents are included on *RMC's* subscriber-only webpage at hcca-info.org. Please click on "CMS Transmittals and Regulations."

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- Redesign of Hospice Periods – Additional Requirements, Trans. 4152 (Oct. 26, 2018)

Pub. 100-19, Demonstrations

- Next Generation Accountable Care Organization (NGACO) Model Post Discharge Home Visit HCPCS, Trans. 213 (Oct. 26, 2018)

Pub. 100-20, One-Time Notification

- Correction to Common Working File (CWF) Informational Unsolicited Response (IUR) 7272 for Intervening Stay, Trans. 2174 (Oct. 26, 2018)
- Update to Common Working File (CWF) Edit of Medicare Advantage (MA) Enrollees' Inpatient Claims from Approved Teaching Hospitals Billed with Indirect Medical Education (IME) or Coverage with Evidence Development (CED), Trans. 2156 (Oct. 26, 2018)

Federal Register

Proposed Regulation

- Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 83 Fed. Reg. 54982 (Nov. 1, 2018)
- Medicare Program; International Pricing Index Model for Medicare Part B Drugs, 83 Fed. Reg. 54546 (Oct. 30, 2018)

should continue to be linked to complexity." Hirsch says "if even a few payers do not adopt the change, this will create a huge burden for physicians from a rule change that is intended to reduce burden."

This also could potentially affect physician contracts and the way physicians are compensated, Marting says. "Each level of office visit has different relative value units assigned to it, and in 2021, the work RVUs for levels two through four units will be the same because the payments are the same," she explains. That means hospitals and physician groups that base compensation on a productivity model using RVUs will have to do modeling and data analysis to determine how this affects physician compensation.

Marting doubts hospitals will have to do comprehensive training of physicians on the new payment and documentation changes. That would just confuse and irritate physicians. Instead, hospitals will have more documentation options to use on the back end to support the codes when they're challenged in an audit.

CMS also finalized separate add-on payments for primary care and non-procedural specialty care, as well as separate payments for extended visits through HCPCS G-codes. "We are finalizing for 2021 the proposal to introduce add-on codes that would adjust payment for new and established E/M office/outpatient visits to account for inherent complexity in primary care and non-procedural specialty care," the regulation states. Compared to the proposed rule, CMS increased the amount paid to primary care physicians to give them parity with specialists, Marting says. The add-on codes are only reportable with E/M levels two to four, and they're not restricted by specialty. But there's still the question of the hassle of more codes at a time CMS is promoting its burden-reduction efforts, Hirsch says. "Every time a new code is required, there is the burden of figuring out when it is appropriate and the burden of actually adding the code to the claim, even if that is simply one more click in an [electronic medical record], and the burden of wondering if an auditor will second-guess the physician's use of the code. Burden reduction? I don't think so."

A brand-new payment was established for a brief technology-based communication service, also known as a virtual check-in (HCPCS code). CMS will pay separately "when a physician or other qualified health care professional has a brief nonface-to-face check-in with a patient via communication technology, to assess whether the patient's condition necessitates an office visit," the regulation states.

Physicians will be paid for calls that weren't the result of an office visit in the previous seven days or don't lead to one within 24 hours. The provider has to communicate with the patient to bill for the service; Medicare isn't paying for communication with nursing staff. "This is good for doctors, but from the compliance side, CMS is requiring that the patient give verbal consent to the visit being billed to Medicare and that the consent is documented in the record. That may prove to be a difficult process to operationalize and certainly will be an easy target for auditors," Hirsch notes.

Some payment changes from the proposed regulation were dropped in light of comments. CMS is not reducing payment when E/M office/outpatient visits are furnished on the same day as certain procedures, establishing separate podiatric E/M visit codes, or standardizing the allocation of practice expense RVUs for E/M visit codes.

Contact Marting at rmarting@forbeslawgroup.com and Hirsch at rhirsch@r1rcm.com. View the rule at http://bit.ly/2qrVwpn. ✧

NEWS BRIEFS

◆ **CMS on Nov. 2 finalized the 2019 Hospital Outpatient Prospective Payment System (OPPS) regulation.** Among other things, CMS extended 340B payment cuts to off-campus provider-based departments that are paid under the Medicare Physician Fee Schedule. In the 2018 OPPS regulation, CMS reduced the amount that will be paid for 340B drugs from average sales price (ASP) plus 6% to ASP minus 22.5% *(RMC 11/6/17, p. 1)*, but off-campus provider-based departments that no longer are allowed to bill the OPPS because of Sec. 603 of the Bipartisan Budget Act of 2015 were spared. Now CMS has applied the 340B payment cuts to them as well, finalizing the provision in the proposed regulation *(RMC 7/30/18, p. 1)*. Visit http://bit.ly/2zrPzwO.

◆ **Two home health owners and two employees were convicted by a jury in Texas in a Medicare and Medicaid fraud scheme, the Department of Justice said Oct. 30.** Celestine "Tony" Okwilagwe, Paul Emordi, Adetutu Etti, and Loveth Isidaehomen were convicted of conspiracy to commit health care fraud. Okwilagwe and Emordi ran Elder Care in Garland, Texas, even though they were excluded from participating in any federal health care benefit program, DOJ said. Etti, the administrator of Elder Care, hid Okwilagwe's ownership and the Medicare/Medicaid exclusions, signing false documents that indicated no one involved with Elder Care was excluded, according to DOJ. Visit http://bit.ly/2Qda2N5.

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