Report on
Medicare Compliance

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

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Managing Editor
Nina Youngstrom
nina.youngstrom@hcca-info.org

Copy Editor
Bill Anholzer
bill.anholzer@hcca-info.org

With Telehealth on OIG Work Plan, Beware Pitfalls; CMS Proposes HHA Telehealth Past PHE

When a physician's telehealth visit with a Medicare patient on FaceTime cut out after five minutes, they shifted to an audio-only visit, with the physician and patient speaking on the telephone. Although the call lasted for an hour, the physician didn't document the time. That put her in a bind. To bill a time-based evaluation and management (E/M) service, such as a phone call, providers have to document the total time. They can only use medical decision-making to support office visit codes when the audio and visual components are live for the majority of the encounter.

"Defaulting to the telephone-only visits (99441–99443), which were opened up for reimbursement a month into the COVID-19 public health emergency, must be based on time," said Terry Fletcher, a consultant in Laguna Beach, California. "Without time documented, this encounter has no value to bill to a payer."

That's a potential "downfall" of telehealth reimbursement, Fletcher said. Providers also will "tap out" at 21 minutes with the telephone codes, she noted. These are things to keep an eye on, especially now that the HHS Office of Inspector General has added Medicare telehealth services during the COVID-19 pandemic to its Work Plan.[1]

Telehealth continues to be a focal point during the COVID-19 public health emergency (PHE), as providers parse billing nuances, adapt to new developments and worry what the future holds. CMS already embraced permanent changes to telehealth in its proposed 2021 home health prospective payment system regulation,[2] which was published in the June 30 *Federal Register*, and is poised to broaden the

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Appeals Court Restores Big FCA Verdict; SNFs Hit With $255M in Whistleblower-Only Case

A federal appeals court has reinstated a huge jury award in a False Claims Act (FCA) case against a Florida skilled nursing facility (SNF) management company that was pursued by a whistleblower after the Department of Justice (DOJ) declined to intervene.

In a June 25 ruling,[1] the U.S. Court of Appeals for the 11th Circuit reversed in part a federal district court decision to set aside the jury verdict against CMC II and related entities. The 11th Circuit ruled the district court was wrong to throw out Medicare-related fraud claims about upcoding and ramping, although the Medicaid fraud claims about plans of care are history. The case turned partly on the materiality of the claims, which has become a litmus test of FCA violations since the landmark 2016 U.S. Supreme Court decision in *United States ex rel. Escobar v. Universal Health Services, Inc.*[2]

"In light of our reversal on the Medicare claims, we remand with instructions for the district court to reinstate the jury's verdict in favor of the relator [i.e., whistleblower], the United States, and the State of Florida and against the defendants

continued

on the Medicare claims in the amount of $85,137,095, and to enter judgment on those claims after applying trebling and statutory penalties," the appeals court said. That adds up to about $255 million. In pursuing this long-running case, the whistleblower was partly funded by an outside investor, which the court said didn't jeopardize her standing because the investment was so small (less than 4%).

"I expect you will see more of these cases in coming years," said former federal prosecutor Robert Trusiak, an attorney in Buffalo, New York. In March, DOJ announced a national initiative[3] to crack down on nursing homes that provide grossly substandard care, which will be "exacerbated by COVID-19," he said. The whistleblower's victory in the CMC II case also will encourage attorneys to pursue FCA cases against nursing homes and other health care organizations with or without DOJ, especially if they have funding from private litigation partners, Trusiak said. "Success breeds imitation."

The 2011 FCA lawsuit against CMC II et al. was filed by whistleblower Angela Ruckh, a registered nurse, who worked on resource utilization group (RUG) assessments at two SNFs: Marshall Health and Rehabilitation Center and Governor's Creek Health and Rehabilitation Center, according to the appeals court decision. RUGs are payment units in Medicare's SNF prospective payment system, and the amount of therapy provided to patients drove RUG payments until Medicare switched to the Patient Driven Payment Model in 2020.

Ruckh named five defendants in the lawsuit: Sea Crest Health Care Management LLC, which did business under the name La Vie Management Services of Florida; CMC II LLC, La Vie's successor-in-interest; Salus Rehabilitation LLC, which provided rehabilitation at Marshall; Marshall Health and Rehabilitation Center; and Governor's Creek Health and Rehabilitation Center. La Vie provided management services to 53 SNFs in Florida, including Marshall and Governor's Creek.

During the five months she worked at the two SNFs, Ruckh alleged the defendants defrauded Medicare by upcoding RUGs and "ramping," and defrauded Medicaid by billing without treatment plans. Evidence was presented at trial that the defendants exaggerated the therapy and nursing services provided to residents, according to the court decision.

Expert witness Shirley Bradley, who testified on behalf of the whistleblower, audited 300 claims from the 53 SNFs. On 56 of them, "defendants inflated the number of therapy minutes actually provided to residents." She also concluded 45 had "higher levels of nursing services than actually provided to residents."

The trial started in January 2017, and the jury in the U.S. District Court in the Middle District of Florida ultimately found the defendants submitted 420 fraudulent Medicare claims and 26 fraudulent Medicaid claims. The jury awarded $115 million in damages, which the judge trebled to $348 million under the FCA. But the whistleblower's victory was fleeting. CMC II appealed, and the district court set aside the verdict in January 2018, saying the "relator failed to introduce evidence of materiality and scienter at trial."

And then the tables turned again. When the whistleblower appealed, the 11th Circuit sided with her, but only with respect to the Medicare fraud. "Having held that the relator introduced sufficient evidence to permit a reasonable jury to find the defendants liable for Medicare-related fraud, and not for Medicaid-related fraud, we hold that the district court abused its discretion in conditionally granting the defendants' request for a new trial as to liability on the Medicare claims," the appeals court ruled.

Court Found 'Plain and Obvious Materiality'

Materiality played a big role in the decision. Under an implied certification theory of the FCA, a violation must be material to the government's decision to pay, according to the Supreme Court decision in the *Escobar* case. Implied certification means the submission of

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a claim for payment carries with it the assurance that providers have complied with all conditions of payment, even if they haven't expressly certified compliance. But the Supreme Court didn't make it too easy to connect the dots to a False Claims Act violation. The decision set forth two conditions under which the implied certification theory can be a basis for liability: (1) "The claim does not merely request payment, but also makes specific representations about the goods or services provided"; and (2) "The defendant's failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths." The Supreme Court explained further that "proof of materiality can include, but is not necessarily limited to, evidence that the defendant knows that the Government consistently refuses to pay claims in the mine run of cases based on noncompliance with the particular statutory, regulatory, or contractual requirement."

In the CMC II SNF case, the appeals court refuted the district court's finding that the relator's Medicare allegations weren't material. "The district court dismissed the relator's upcoding theory as 'a handful of paperwork defects.' That characterization misses the mark. At its core, the concept of upcoding is a simple and direct theory of fraud," the decision stated. "SNFs receive money from Medicare based on the services they provide. In this case, the SNFs indicated they had provided more services—in quantity and quality—than they, in fact, provided. Therefore, Medicare paid the SNFs higher amounts than they were truly owed. This plain and obvious materiality went to the heart of the SNFs' ability to obtain reimbursement from Medicare."

Missing Care Plans Are Not Material

The appeals court came to the same conclusion with the ramping allegations. Ramping is the "artificial timing of services to coincide with Medicare's regularly scheduled assessment periods and thereby maximize reimbursements," the court explained. Bradley testified she identified 112 cases of ramping, and, the court noted, "ramping is material, as it directly affects the payments Medicare makes to SNFs."

The case shows that "*Escobar's* materiality standard will not be a broad brush to sanitize direct upcoding fraud," Trusiak said. Materiality doesn't depend on whether the government paid the claims. "That's an important point," he said. "The court said you can't argue post-payment government conduct bears on the materiality of fraud."

But the court found in favor of the defendants on the Medicaid allegations about missing care plans. At trial, Bradley testified that care plans were absent for about 52 SNF residents. "Even if we accept this allegation as true, we hold that the failure to do so cannot establish Medicaid fraud as a matter of law. Under *Escobar*, the relator was required to prove not only that the defendants failed to comply with this requirement, but that their failure to do so was material," the appeals court ruled. That didn't happen.

An attorney for the defendants didn't respond to *RMC's* request for comment.

Contact Trusiak at robert@trusiaklaw.com. ✧

Endnotes

1. Angela Ruckh v. Salus Rehabilitation, LLC, No. 18-10500 (11th Cir. June 25, 2020), https://bit.ly/2Dl0cHy.
2. United States ex rel. Escobar v. Universal Health Services, Inc., 842 F.3d 103 (2016), http://bit.ly/2rC1abg.
3. Department of Justice, "Department of Justice Launches a National Nursing Home Initiative," news release, March 3, 2020, http://bit.ly/2TnrvGV.

Oklahoma Hospital, Physicians Settle FCA Case for $72M; FMV Is Theme

In a complicated false claims case that boils down to fair market value allegedly run amok, an Oklahoma hospital, related entities and two physicians agreed to pay $72.3 million to settle allegations a physician group got sweetheart deals in exchange for referrals, the Department of Justice (DOJ) said July 8.[1] This is another high-dollar False Claims Act (FCA) result stemming from a case pursued by a whistleblower even though DOJ bowed out.

Oklahoma Center for Orthopaedic & Multi-Specialty Surgery (OCOM), a specialty hospital in Oklahoma City; USP OKC Inc. and USP OKC Manager Inc. (collectively USP), its part owner and management company; Southwest Orthopaedic Specialists PLLC (SOS), an Oklahoma City-based physician group; and two SOS physicians resolved allegations under the federal and Oklahoma Medicaid FCA of "improper relationships" between OCOM and SOS from 2006 through 2018, DOJ said. In exchange for patient referrals from SOS physicians, OCOM and USP allegedly provided remuneration in the form of:

- Free or below fair market value office space, employees and supplies;
- Above fair market value compensation;
- Equity buyback provisions and payments for certain SOS physicians that were above fair market value; and
- Preferential investment opportunities related to OCOM anesthesia services.

As a result, false claims allegedly were submitted to Medicare, Medicaid and TRICARE, DOJ said.

"DOJ's press release indicates what really drove this case is fair market value," said attorney Jeff Fitzgerald, with Polsinelli in Denver, Colorado. "This reinforces to everyone in the compliance world that fair market value is an important construct."

The whistleblower, Wayne Allison, who was the SOS practice administrator for 15 years, alleged the "defendants' unlawful conduct and fraudulent schemes arise from their entangled history of using their patient referrals and various entities as a self-interested, profit-oriented, multi-million-dollar money-making machine," according to the June 2018 second amended complaint.

OCOM is managed by USP, the complaint said, and Tenet Healthcare Corp. owns 95% of USP, although Tenet isn't a party to the settlement. Of the settlement amount, USP will pay $60.86 million to the United States, $5 million to Oklahoma, and $206,000 to Texas. SOS and the two physicians, Anthony Cruse and R.J. Langerman, will pay $5.7 million to the feds and $495,619 to Oklahoma. None of the defendants admit liability in the settlement.

Rent Allegedly Based on Volume, Value of Referrals

SOS was created by Cruse and Langerman, who also opened OCOM with orthopedic surgeons they recruited to join the SOS practice. In 2004, the SOS physicians partially sold OCOM to USP Oklahoma, which bought equity interest in OCOM and took over its management. The complaint alleged SOS and OCOM engaged in overlapping "schemes" that tainted all OCOM's reimbursement from certain government payers because they resulted from referrals from SOS physicians.

One was an equity scheme. The complaint alleged that OCOM equity was transferred to SOS physicians in violation of the OCOM operating agreement and the Stark Law or Anti-Kickback Statute. OCOM equity was allegedly used to reward SOS doctors who referred to OCOM the majority of its business, the complaint alleged. Also, the SOS and OCOM defendants based their decisions on which physicians could buy OCOM equity on the volume and value of their referrals for designated health services to OCOM, the complaint alleged.

Another alleged scheme related to employment. According to the complaint, Cruse, Langerman and other SOS physicians directed OCOM to enter into employment agreements with orthopedic surgeon prospects, who agreed to work for OCOM for two years. The new physicians would buy a 1% membership interest in OCOM and had the opportunity for a bonus if they provided services through SOS for 18 months after the agreement ended. OCOM also rented clinic space from SOS where the physicians could practice. Rental payments were based on the volume or value of the physicians' referrals, and they increased monthly, the complaint alleged. Eventually, the physician transitioned to SOS employment and bought more OCOM equity.

Physicians Paid Good Chunk of Settlement

Attorneys think it's significant that a medical group on the receiving end of the hospital payments—and two physicians—had to pay a chunk of the settlement amount, because typically only the hospital or other facility is held liable in an FCA case. "I would use this case when talking to doctors" to show Stark and Anti-Kickback Statute compliance is not just a hospital problem, said attorney John Joseph, with Post & Schell in Philadelphia. "This is a doctor problem too." When the hospital has to charge more for rent or the services of medical assistants, for example, physicians may not be so dismissive of the compliance risks when they learn about the Oklahoma settlement and the other occasional cases where physicians were on the hook for FCA liability, Joseph said.

The case also is a "cautionary tale that the whistleblower can be anyone," Fitzgerald said. A longtime practice manager is the top nonphysician executive in a practice, he noted. "It rubs me the wrong way when someone's job is to make sure the company is compliant, and then they file a complaint."

In a statement, an OCOM spokesperson said, "Our core values prioritize ethical, responsible behavior, and we will accept nothing short of that from our teams. We have taken numerous steps to strengthen compliance safeguards at OCOM to ensure our programs and staff meet the highest standards of integrity—and that we continue to earn the trust of our patients and physicians based only on the quality of care we deliver. We are a stronger organization today with tighter processes, sharper controls, more stringent compliance oversight and a culture that supports our values."

Contact Fitzgerald at jfitzgerald@polsinelli.com and Joseph at jjoseph@postschell.com. ✧

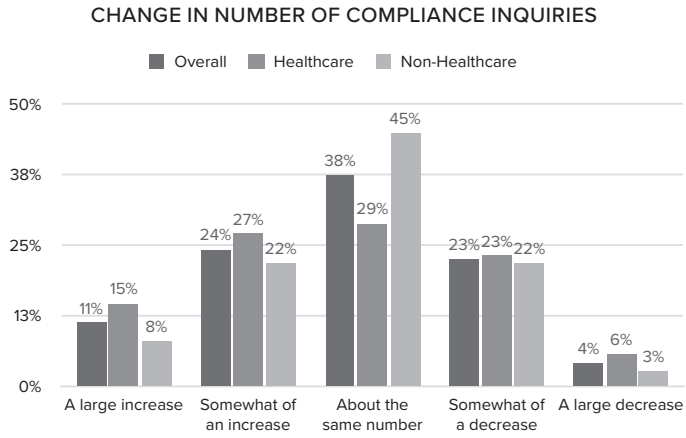
Endnotes

1. Department of Justice, "Oklahoma City Hospital, Management Company, And Physician Group To Pay $72.3 Million To Settle Federal And State False Claims Act Allegations Arising From Improper Payments To Referring Physicians," news release, July 8, 2020, https://bit.ly/2ZeNra4.

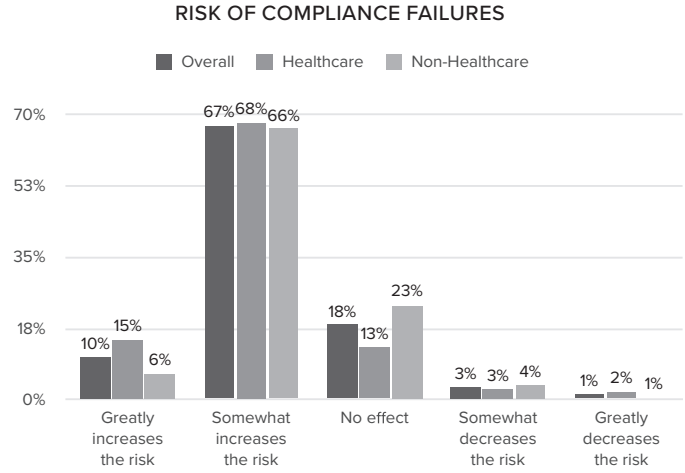
Snapshots of COVID-19's Impact on Compliance Programs

Here are some of the results of a June survey, "Compliance and the COVID-19 Pandemic,"[1] which was conducted by the Society of Corporate Compliance and Ethics & Health Care Compliance Association (SCCE & HCCA). Results are based on 343 responses from compliance and ethics professionals in the SCCE & HCCA database. They were analyzed using SurveyGizmo, a third-party system that's web based.

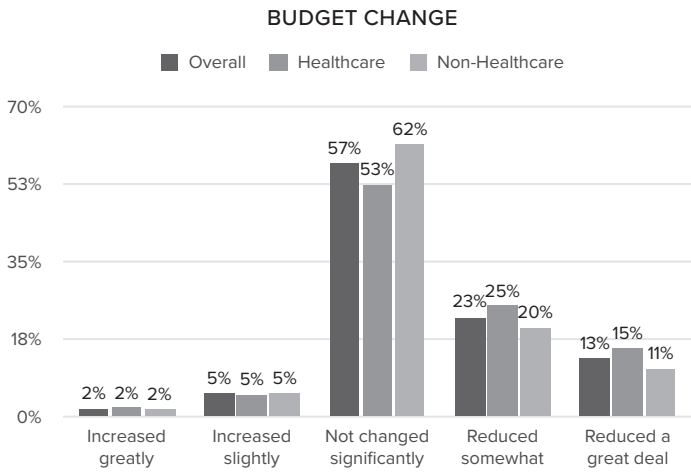
The pandemic has seen a reported increase in the number of inquiries to the compliance team. Across industries, 36% reported that there has been a somewhat or large increase in inquiries, compared to just 27% showing a decrease. Notably, the healthcare respondents were much more likely to report an increase (42%) than those outside of healthcare (30%).



Survey respondents expressed significant concerns about an increased risk of compliance failures as a result of the pandemic. The assessment that the pandemic somewhat increased the risk of failures was shared by 67% of respondents, and another 10% felt it greatly increased.



In a troubling—but not unexpected—development, budgets are starting to feel pressure. Compliance budgets, including staffing, have been somewhat reduced according to 23% of survey respondents. Another 13% reported they had been reduced a great deal.



Endnotes

1. Society of Corporate Compliance and Ethics & Health Care Compliance Association, "Compliance and the COVID-19 Pandemic," June 2020, https://bit.ly/3ebPQGB.

Beware Pitfalls of Telehealth

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telehealth benefit generally beyond the PHE in the 2021 Medicare Physician Fee Schedule, which is due out any minute. There's also momentum in Congress to improve access to telehealth services. Most pending bills address the originating site requirement, which limits Medicare coverage of telehealth to services provided at hospitals and other providers in rural areas, said attorney T.J. Ferrante, with Foley & Lardner in Tampa, Florida. "If I were a gambler, that's what I would bet they would change," he said. Congress suspended the originating site requirement during the PHE, which expires July 25, although Michael Caputo, HHS assistant secretary for public affairs, has tweeted that it would be extended another 90 days. HHS Sec. Alex Azar still has to make it official, and even when that happens, he has the option to revoke the PHE early, without giving providers notice, Ferrante said. The same goes for President Trump and his Jan. 31 declaration of a national emergency, which is supposed to last for one year. "It leads to uncertainty," Ferrante said.

While both the PHE and the national emergency are required to continue with Sec. 1135 waivers, most aspects of telehealth expansion fall outside the Sec. 1135 process, said Chicago attorney Sandra DiVarco, with McDermott Will & Emery. Because most of the telehealth flexibilities, including those related to the originating site, are the result of the Coronavirus Aid, Relief, and Economic Security Act[3] and not the waivers, they will continue even if the national emergency is revoked or expires, she said.

When Visual Fails, Which Medium Do You Bill?

Because the ramping up of telehealth services happened so fast and may continue permanently, the stakes are high for providers to comply with billing and documentation requirements. Some of the same telehealth questions keep coming up on CMS's weekly stakeholder engagement calls. The audiovisual to telephone-only services is a biggie.

When the technology changes, providers should bill the medium that is used for 50% or more of the visit, said Marion Salwin, director of physician and regulatory compliance at Trinity Health in Livonia, Michigan. "I have heard more than one person say the code is based on the intent [of the visit]," but that's not true. CMS has clarified and elaborated in answers to frequently asked questions[4] on its website, although it has declined to give a specific percentage:

> Question: If the video connection is disconnected during an audio-video Medicare telehealth visit due to technological issues, can the visit still be billed as Medicare telehealth?
>
> Answer: Practitioners should report the code that best describes the service. If the service was furnished primarily through an audio-only connection, practitioners should consider whether the telephone evaluation and management or assessment and management codes best describe the service, or whether the service is best described by one of the behavioral health and education codes for which we have waived the video requirement during the PHE for the COVID-19 pandemic. If the service was furnished primarily using audio-video technology, then the practitioner should bill the appropriate code from the Medicare telehealth list that describes the service...

No Need to Document Exam

Only physicians and certain qualified health professionals (QHPs) (i.e., nurse practitioners and physician assistants) are permitted to bill CPT codes 99441–99443, Fletcher said. All is not lost, however. Medicare will pay for audio-only telehealth services provided by other QHPs (e.g., certain social workers, physical therapists), but with CPT codes 98966–98968. The provision, however, has been misapprehended, Fletcher said. "Nowhere does it say medical assistant or nurse."

Another gap in knowledge has been around documentation requirements, Salwin said. It appears many providers are still trying to document telehealth services with the exam, she said. But during the PHE, they only have to use time or medical decision-making to assign an E/M code, because CMS has said it recognizes an exam is limited using audiovisual technology. "For now, you use all the time associated with the E/M service on the day of the encounter, from start to finish," Salwin noted. That won't be the case when the 2021 Medicare Physician Fee Schedule regulation takes effect, because it changes the definition of time.[5] She also reiterated that time or medical decision-making (MDM) applies only to 99201–99205 and 99211–99215, and, until January rolls around, the CPT code book only allows providers to use time to assign codes when more than 50% of the encounter is for counseling or coordination of care. "In 2021, the American Medical Association's MDM and time requirements associated with 99201–99205 and 99211–99215 are increased and are more detailed," Salwin said. "Time is 'longer' for each code, and MDM has some differences compared to what we are accustomed to considering when choosing a code."

'It's a Start-to-End Workflow'

The provider optimization team at Novant Health in North and South Carolina and Virginia developed processes and templates to distinguish up front whether a physician has an audiovisual, telephone-only or in-person visit, said Jill Anderson, assistant director of compliance for the physician network. Billing is tied to that, with modifiers and place of service codes indicating where the patient was seen. "It's a start-to-end workflow," Anderson said.

During the PHE, Medicare is not requiring place of service 02 to be submitted to indicate a telehealth visit, Anderson said. Instead, providers are allowed to report modifier 95 for telehealth visits, along with the place of service (e.g., 11 for a freestanding clinic). When the patient is registered, a note is dropped in that indicates how the services will be delivered, and that supports billing on the back end. "Documentation in the medical record looks different and claims look different for all these scenarios," she noted. For video visits, documentation indicates that both audio and visual technology were used and modifier 95 is appended to the services on the claim to indicate telehealth, Anderson explained. For telephone encounters, documentation indicates an audio-only interaction, and the claim shows a telephone-encounter CPT code. "Traditional face-to-face encounters will not have these types of statements and will bill without a telehealth modifier to denote the office visit," she explained.

Novant isn't worried about overpayments in terms of telehealth vs. face-to-face visits, because Medicare pays the same either way during the PHE, said Kelly Patterson, senior director of compliance for the physician network. Even so, telehealth will be added to its work plan later this year, although "we're spot-checking now," she said. "For a lot of our providers, this is very new, and they are overly cautious their documentation is there. The situation is helping them prepare for guidance that goes into place in 2021" for outpatient/office visits, Patterson said.

CMS Proposes Home Health Telehealth After PHE

Telehealth services in home health will continue after the PHE is over, according to the proposed 2021 home health payment regulation. But there are limitations, said attorney Marcia Augsburger, with King & Spalding in Los Angeles. "I hope it doesn't signal CMS will be super conservative" when it expands telehealth in other areas.

In the regulation, CMS proposed to finalize provisions in the first PHE interim final rule[6] that allows home health agencies to use various kinds of telecommunications, on top of remote patient monitoring, "in conjunction with in-person visits." The technology must be related to the skilled services provided by the therapist, nurse or therapy assistant during the home health visit and "must be included on the home health plan of care along with a description of how the use of such technology will help to achieve the goals outlined on the plan of care without substituting for an in-person visit as ordered on the plan of care," according to the rule.

Although CMS "did more in two weeks to increase reimbursement for telehealth than it did in 29 years" because of the pandemic, this proposal for a permanent change may result in a big reimbursement cut to home health agencies, Augsburger said. "Redoing the plan of care to incorporate telehealth visits may give physicians some additional reimbursement—$50–$112 per month depending on various factors—and if those physicians add telehealth visits to the plan of care, the home health agency that must perform those services will not receive additional reimbursement for them because these agencies are paid a fixed sum per patient based on the number of in-person visits," she said. The proposal also is somewhat burdensome, because telehealth visits can't be a substitute for in-person visits, Augsburger said. Avoiding in-person visits is usually where the return on investment is for telehealth providers, but not under the interim final rule. "If the physicians decide that the telehealth visits they add to a plan of care obviate the need for one or more in-person

CMS Transmittals and *Federal Register* Regulations, June 26-July 9

Transmittals

Pub. 100-04, Medicare Claims Processing Manual

- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment, Trans. 10217 (July 8, 2020)
- July 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS), Trans. 10207 (July 2, 2020)
- October 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files, Trans. 10201 (July 2, 2020)
- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2021, Trans. 10202 (July 2, 2020)
- Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS), Trans. 10198 (June 26, 2020)
- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2020 Update, Trans. 10196 (June 23, 2020)

Pub. 100-20, One-Time Notification

- New Point of Origin Code for Transfer From a Designated Disaster Alternate Care Site, Trans. 10205 (July 1, 2020)

Federal Register

Proposed Regulation

- Medicare and Medicaid Programs; CY 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Services Requirements, 85 Fed. Reg. 39,408 (June 30, 2020)

visits, the home health agency's reimbursement will drop via a dreaded low utilization payment adjustment from CMS, because only in-person visits count toward the number necessary to qualify for a level of payment. As one of my clients said, more telehealth visits should enhance the quality of care, but if a lot of physicians consider telehealth visits to make an in-person visit unnecessary, no home health agency will survive." This problem doesn't exist for telehealth under Medicare Part B.

Augsburger hopes CMS is bolder in the Medicare Physician Fee Schedule regulation, although in the past CMS has said its hands are somewhat tied by the statutory originating site requirement, which only Congress can remove for good.

There will come a time when the PHE ends, and providers have to plan for how that may play out in terms of telehealth. "I have a number of clients that have been very opportunistic in building out, and I have to warn them, 'You are building a business model, and you don't know when the rug could be pulled out from under you,'" Ferrante said. "While many of these exceptions will continue, we know some will sunset."

One of the most popular exceptions came from the Drug Enforcement Administration (DEA), which allows telehealth for prescribing controlled substances (e.g., medication-assisted treatment for opioid use disorders) without an initial in-person visit during the PHE. If companies expand substance abuse and mental health clinics and are relying partly on telehealth, but the patient and physician have never been in the same room for an in-person visit, the physician won't be able to prescribe controlled substances when the PHE ends, Ferrante said. "It's working now and you can grow fast, but if the law reverts back, the model may not be able to continue as-is in a compliant way."

Amid all the enthusiasm for telehealth services, Fletcher is a voice of skepticism. "People are saying it's the answer to our prayers…but it's not perfect." Although telehealth is necessary during a pandemic and generally appropriate for people in remote areas, Fletcher said the technology has limitations, and some physicians are relying on patients' self-reporting (e.g., blood pressure), which may be unreliable. She also worries telehealth isn't up to the task of treating chronic conditions and opens the door to absurdity and abuse. "I had an acupuncturist tell me he wanted to do telehealth."

Contact Anderson at kjanderson@novanthealth.org, Patterson at kwpatterson@novanthealth.org, DiVarco at sdivarco@mwe.com, Augsburger at maugsburger@kslaw.com, Salwin at marion.salwin@trinity-health.org, Ferrante at tferrante@foley.com and Fletcher at terryfletchercpc@aol.com. ✧

Endnotes

1. Office of Inspector General, "Use of Medicare Telehealth Services During the COVID-19 Pandemic," Work Plan, accessed July 9, 2020, https://bit.ly/31FT96m.
2. Medicare and Medicaid Programs; CY 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Services Requirements, 85 Fed. Reg. 39,408 (June 30, 2020), https://bit.ly/2Z9vSrT.
3. Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, H.R. 748, March 27, 2020, https://bit.ly/2xMtITW.
4. CMS, *COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing*, updated June 19, 2020, https://go.cms.gov/2W7cjzj.
5. Nina Youngstrom, "New E/M Documentation Guidelines, Table Take Effect Soon; 'There Is a Different Mindset,'" *Report on Medicare Compliance* 29, no. 19 (May 18, 2020), https://bit.ly/2BIbF3C.
6. Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 85 Fed. Reg. 19,230 (April 6, 2020), https://bit.ly/3c4dqo1.

NEWS BRIEFS

◆ **Ophthalmic Consultants PA in Sarasota, Florida, agreed to pay $4.8 million to settle false claims allegations that it billed Medicare and other federal payers for multi-dosing patients from single-use vials of ranibizumab and Eylea**, the U.S. Attorney's Office for the Middle District of Florida said June 30.[1] The practice didn't admit liability in the settlement.

◆ **CMS has tweaked its guidance on the CR modifier and DR condition code.** An *MLN Matters* (SE20011 Revised)[2] adds information about "services provided by the hospital in the patient's home as a provider-based outpatient department when the patient is registered as a hospital outpatient."

◆ **The HHS Office of Inspector General's Work Plan has been updated with several items on COVID-19.**[3]

◆ **Charlene Frame, a Georgia woman who operated a telemedicine network through two companies, has pleaded guilty in a Medicare fraud scheme**, the U.S. Attorney's Office for the Southern District of Georgia said July 9.[4] Frame, who operated Royal Physician Network LLC and Envision It Perfect LLC, copped to conspiracy for conspiring to pay physicians and other providers for durable medical equipment (DME) orders that would be sold to DME suppliers and billed to Medicare.

Endnotes

1. Department of Justice, U.S. Attorney's Office for the Middle District of Florida, "Sarasota-Based Ophthalmic Consultants Agrees To Pay $4.8 Million To Resolve Claims Of Multi-Dosing Patients," news release, June 30, 2020, https://bit.ly/3eQdaL6.
2. CMS, "Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)," *MLN Matters*, SE20011 Revised, July 8, 2020, https://go.cms.gov/3b1ckZQ.
3. HHS Office of Inspector General, "A Review of Medicare Data To Understand Hospital Utilization During COVID-19," Work Plan, accessed July 10, 2020, https://bit.ly/3dQEdF3.
4. Department of Justice, U.S. Attorney's Office for the Southern District of Georgia, "Telemedicine company owner pleads guilty to telemedicine fraud conspiracy: Defendant is one of 26 charged in largest fraud operation ever prosecuted by Southern District of Georgia," news release, July 9, 2020, https://bit.ly/2BWS2EW.