

# Report on Medicare Compliance Volume 30, Number 8. March 01, 2021

## News Briefs: March 1, 2021

---

By Nina Youngstrom

◆ According to a CMS spokesperson, “CMS has not yet determined when Targeted Probe and Educate reviews will resume.” Meanwhile, “CMS continues to temporarily pause the performance of retroactive short-stay reviews to reduce burden on providers for consistency with COVID-19 waivers,” the spokesperson told RMC. Livanta, a beneficiary and family-centered care quality improvement organization, performs “retrospective reviews of Medicare Part A claims to ensure care provided by the Medicare program is medically necessary and reasonable, meets professionally recognized standards, and is provided in the appropriate setting.” It’s unclear when they will be back. Livanta also reviews higher-weighted DRGs, the spokesperson said.

◆ Grant Memorial Hospital in Petersburg, West Virginia, agreed to pay \$320,175 to settle allegations it submitted false claims to Medicare, Medicaid, TRICARE and Railroad Retirement programs from September 2014 to March 2016, the U.S. Attorney’s Office for the Northern District of West Virginia said Feb. 24.<sup>[1]</sup> The hospital billed for outpatient and inpatient services and items with the National Provider Identifier and name of a credentialed physician when the services and items were in reality provided by a noncredentialed physician, the U.S. attorney’s office said. The settlement stemmed from a self-disclosure to the HHS Office of Inspector General.

◆ In the first *MLN Matters* article (SE21001)<sup>[2]</sup> issued under the Biden administration, CMS addresses hospital compliance with Medicare’s transfer policy “with the resumption of home health services & other information on patient discharge status codes.” The *MLN Matters* was published in the wake of OIG reports that found noncompliance with the Medicare post-acute care transfer (PACT) payment policy, which requires hospitals to bill for per diems instead of MS-DRGs when patients are transferred to home health, skilled nursing facilities and other facilities. Hospitals are permitted to bypass the PACT policy under certain circumstances using condition code 42 or 43. “Medicare’s IPPS [inpatient prospective payment system] post-acute care transfer policy requires hospitals to apply the correct discharge status code to claims where patients receive HH [home health] services within 3 days of discharge. This includes the resumption of HH services in place prior to the inpatient stay,” CMS noted.

◆ CareOne Management LLC, now known as ABC1857 LLC (CareOne), a New Jersey senior care company, will pay \$714,996 to settle false claims allegations related to Medicare bad debt, the U.S. Attorney’s Office for the District of New Jersey said Feb. 18.<sup>[3]</sup> Medicare reimburses providers for deductible and coinsurance amounts they can’t collect from Medicare beneficiaries, which is known as bad debt. The U.S. attorney’s office said that according to the allegations in the settlement, CareOne “submitted claims for payment to Medicare for reimbursement of Medicare bad debt from Jan. 1, 2012, to July 2, 2018. The company made false representations of compliance with applicable statutory and regulatory criteria, including ‘criteria for allowable bad debt,’ which require a provider to ‘be able to establish that reasonable collection efforts were made’ of amounts owed by beneficiaries before a provider submits the claim as bad debt to Medicare.” The case was originally filed by a whistleblower. CareOne didn’t admit liability in the settlement.

- 1** Department of Justice, U.S. Attorney’s Office for the Northern District of West Virginia, “West Virginia hospital to pay more than \$300,000 for Medicare fraud,” news release, February 24, 2021, <http://bit.ly/2O1qns4>.
- 2** CMS, “Review of Hospital Compliance with Medicare's Transfer Policy with the Resumption of Home Health Services & Other Information on Patient Discharge Status Codes,” *MLN Matters*, SE21001, February 22, 2021, <https://go.cms.gov/3kgkQdp>.
- 3** Department of Justice, U.S. Attorney’s Office for the District of New Jersey, “Senior Care Company Agrees to Pay \$714,996 to Resolve False Claims Act Allegations,” news release, February 18, 2021, <https://bit.ly/2Me8fKX>.

This publication is only available to subscribers. To view all documents, please log in or purchase access.

[Purchase Login](#)