

MEDICARE COMPLIANCE

Weekly News and Compliance Strategies on CMS/OIG Regulations, Enforcement Actions and Audits

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Physician Certifications Take Center Stage As Hospitals Plan for ‘Two-Midnight’ Rule

Physician certifications are about to become decisive documents for Medicare Part A reimbursement. CMS has made a connection between certifications and the medical necessity of admissions, although physicians have until discharge to complete them.

The physician certification requirement is part of the new two-midnight standard for inpatient admissions in the final 2014 inpatient prospective payment system regulation (*RMC 8/12/13, p. 1*). Starting Oct. 1, CMS generally will assume admissions that cross two midnights are medically necessary unless they are delayed on purpose. Auditors will focus on shorter stays except when patients are having procedures on Medicare’s inpatient-only list.

“Having certification for all inpatient admissions is a condition of payment,” says Jessica Gustafson, with The Health Law Partners in Southfield, Mich. “Getting on board with filling out more paperwork will be a struggle, but I think hospitals need to keep in mind it is a requirement for payment and take a proactive approach for compliance rather than anticipate a defense for the appeals process.”

Inpatient stays must kick off with an admission order, but the rest of the certification is due at discharge. Certifications must spell out (1) the reason for the inpatient treatment or diagnostic study; (2) “special or unusual services” the patient will receive; (3) the estimated time the patient will stay in the hospital; and (4) plans for post-hospital care, according to the IPPS rule.

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Consultant-Turned-Whistleblower Drove \$26 Million Medical Necessity Settlement

A consultant hired by Shands Healthcare in Florida to audit one-day stays eventually became the whistleblower behind its \$26 million false claims settlement. In the case, six Shands hospitals allegedly billed Medicare and Medicaid for inpatient admissions that should have been outpatient services between 2003 and 2008, the Department of Justice said on Aug. 19. It rubs one lawyer the wrong way for a consultant to turn in a client, but the whistleblower’s attorney says the consultant had a duty to report alleged fraud when it was not corrected.

The lawsuit was filed in federal court in Jacksonville, Fla., by whistleblower Terry Myers, president of YPRO, a consulting firm in Corydon, Ind. In 2006, YPRO was engaged by Shands’ corporate compliance department to conduct reviews of one-day inpatient stays and observation services, according to the false claims complaint.

When YPRO reviewed documentation at some Shands hospitals, it didn’t like what it found, the complaint says. At one hospital, for example, “case managers were not correctly applying severity of illness and/or intensity of services criteria required to justify an inpatient admission,” the complaint alleges. Physician documentation allegedly was

AWOL, with claims that weren't compliant with government regulations. "Blatant medical necessity errors" were identified at the other Shands hospitals as well, the complaint alleged. Of 148 Medicare inpatient medical records reviewed, the error rate allegedly was 53%, and Medicaid cases had a 78% error rate, the complaint alleged. Three of the hospitals didn't have case management protocols and at five of the hospitals, "there was no institutional commitment to compliance or utilization review," the complaint contended.

After YPRO wrapped up its audit in August 2006, it presented a summary of findings and made recommendations. "The very serious fraudulent abuses found to exist at all the Shands facilities were documented in plain terms with e-logs, back-up data and audit result support" for the interim compliance officer and upper management, the complaint says. In response, Shands developed a plan for refunding overpayments and correcting deficiencies. But six months later, no repayments had been made, the complaint alleged. However, Shands again hired YPRO in August 2007 to "re-assess the accuracy" of billing for short stays and observation.

"The findings of the 2006 audit were bad. The findings of the 2007 audit were much worse," the complaint alleged. One-day stay and medical necessity errors allegedly increased and half the hospitals still lacked case management protocols. YPRO shared its findings in six exit meetings and a spreadsheet. After some frustrating interaction with Shands' new compliance officer, the whistleblower concluded that "Shands wanted no further illumination or auditing of the fraudulent practices," the complaint alleged. He filed a false claims lawsuit in 2008 and the Department of Justice intervened.

It doesn't sit well with Denver attorney Jeff Fitzgerald when consultants blow the whistle on their own clients. "Hospitals are paying fees in an attempt to do things right," he says. "If you can't find a way to get the client to fix a problem, that's partly the failing of the consultant. I find this thing a giant betrayal." Consultants are usually engaged because hospitals know there are operational weaknesses, says Fitzgerald, with Polsinelli, who isn't involved in the case. "You can't be shocked when the audit results come back and aren't perfect." And consultants may miss out on the context of what appears to be an error; "Consultants need to avoid jumping to conclusions," he says.

Consultant-Client Trust Is 'Implicit'

Trust between hospitals and their consultants is "implicit" in these engagements, Fitzgerald says. Still, reviews should be shielded by attorney-client privilege and audit documents marked accordingly. That makes it harder for consultants to send hospital documents to the government, he says. "Most government lawyers don't like the idea of being [given] a stack of privileged documents," Fitzgerald says. "If the Department of Justice is covertly being given attorney-client privileged documents, it opens up the door for the hospital to say the government is inappropriately breaching our right to attorney-client privilege."

But Atlanta attorney Marlan Wilbanks, who represents Shands whistleblower Terry Myers, says integrity trumps job titles. If anything, consultants, auditors and compliance officers are in a unique position because they have first-hand knowledge of alleged misconduct. "It is crucially important for true insiders who have documented proof of the fraud to report it even if it affects their career," says Wilbanks, with Wilbanks & Bridges. "Part of a compliance officer's ethical code is that it is OK to put your obligations and professional responsibility above your duty to protect your employer. That ethic is becoming accepted."

Health care organizations are asking for trouble when the organizational chart has compliance officers reporting to finance, Wilbanks says. "Almost without

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exception, compliance officers want to do the right thing, but many times they are frustrated by executives who put profit over compliance and patient safety," he contends. However, that may change as more compliance officers step forward. "If they see fraud, they have an ethical duty to try to change it internally," he says. "But when you do your job and there is no change, what do you do?"

Shands did not admit liability in the settlement. A statement from Timothy Goldfarb, CEO of Shands Healthcare in Gainesville, emphasized there was "no intentional misconduct or callous disregard of these issues on our part. As a responsible corporate citizen, our intent and practice has always been to comply with government regulations. We have conscientiously worked to create and operate an appropriate, fair and accurate billing system for all payers." The case centered on billing practices, not quality of care, he added.

Shands, which cooperated with the investigation, advocates compliance by encouraging staff to report potential problems, holding annual in-services and promoting its compliance hotlines, Goldfarb said. The health system also changed its case management protocols, contracted with physician advisers who are onsite 24/7, began using new software, implemented new policies and procedures and added employee training, he says.

Contact Fitzgerald at JFitzgerald@polsinelli.com and Wilbanks at mbw@wilbanks-bridgeslaw.com. ✧

SNFs Face PEPPER, Compliance Mandate, Upping the Ante for Audits

The time is ripe for self-audits at skilled nursing facilities (SNFs) with the imminent release of the first Program for Evaluating Payment Patterns Electronic Reports (PEPPER) for SNFs and the Affordable Care Act's new compliance program mandate.

SNFs will start to receive the first round of PEPPER at the end of August, says Kim Hrehor, project director for TMF Health Quality Institute, which generates the data under contract with CMS. Therapy (physical, speech and occupational) is the focus of the SNF PEPPER because it drives Medicare reimbursement.

PEPPER, a free compliance monitoring tool, is already distributed to short-term acute-care hospitals, long-term care hospitals, critical access hospitals, hospices, inpatient psychiatric and rehabilitation facilities and partial hospitalization programs. The reports are used to identify potential overpayments and underpayments.

TMF has focused on SNFs partly because of an HHS Office of Inspector General 2012 report, which found that they were overpaid \$1.5 billion in 2009. Meanwhile, the

Affordable Care Act requires SNFs and nursing homes to implement a compliance program by March 2013. CMS has not issued regulations, but the requirement is in effect anyway, lawyers say.

Medicare beneficiaries are admitted to SNFs (after a qualifying inpatient stay) for up to 100 days of intensive treatment for strokes and other conditions that impede their ability to perform activities of daily living (ADL). Medicare pays SNFs per diems based on resource utilization groups (RUGs). SNFs assign RUGs according to a beneficiary's scores on the minimum data set (MDS), which represents his or her clinical condition, functional status and use of services, but therapy drives RUG assignment. According to the OIG report, RUGs were billed incorrectly on 23% of claims, and in a lot of cases, SNFs billed "ultrahigh therapy RUGs when they should have billed for lower levels of therapy or non-therapy RUGs."

CMS hopes PEPPER will be used by SNFs to identify and reduce their own errors. PEPPER compares a facility's Medicare billing to other SNFs in the state, Medicare administrative contractor (MAC) jurisdiction and nation in certain risk areas. When billing in a risk area is at or above the 80th percentile, it means the SNF bills a higher percentage for that risk area than most SNFs nationally. It's up to the SNF to determine whether billing errors exist or there is some reasonable explanation.

continued

CMS Transmittals and Federal Register Regulations

Aug. 22 — Aug. 29

Live links to the following documents are included on RMC's subscriber-only Web page at www.AISHealth.com. Please click on "CMS Transmittals and Regulations" in the right column.

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- October 2013 Update of the Hospital Outpatient Prospective Payment System, Trans. 2775CP, CR 8428 (Aug. 23; eff. Oct. 1; impl. Oct. 7, 2013)

Pub. 100-05, Medicare Secondary Payer Manual

- Update the Common Working File to Not Allow Certain Diagnosis Codes on No-Fault Medicare Secondary Payer Records, Trans. 95MSP, CR 8351 (Aug. 23, 2013; eff. Jan. 1; impl. Jan. 6, 2014)

Pub. 100-08, Medicare Program Integrity Manual

- Program Safeguard Contractor and Zone Program Integrity Contractor Provider Notification (R), Trans. 485PI, CR 8079 (Aug. 21; eff./impl. Jan. 29, 2013)

Pub. 100-16, Medicare Managed Care Manual

- Chapter 4, Benefits and Beneficiary Protections, Trans. 115MCM (Aug. 23; eff./impl. Aug. 23, 2013)

Federal Register Regulations

- None published.

TMF will provide the nation's 15,700 SNFs with PEPPER data in these six risk areas, according to Hrehor:

(1) and (2) —Therapy RUGs with high ADL and nontherapy RUGs with high ADL: These two risk areas address concerns with accurate reporting on the MDS of the assistance beneficiaries need with ADL, Hrehor says. For example, SNFs may report that beneficiaries required more assistance than is reflected in the medical record, which causes overpayments, she says. Reporting less assistance than documented causes underpayments.

(3) Ultrahigh therapy RUGs: The number of days billed for ultrahigh therapy RUGs is compared to the number of days billed for all therapy RUGs in this risk area.

(4) All-therapy RUGs: This risk area compares days billed for all-therapy RUGs to days billed for all RUGs.

(5) Change of therapy assessment: SNFs have been required since fiscal year 2012 to evaluate beneficiaries to determine whether therapy should be adjusted as the stay progresses. CMS believes if SNFs are conducting a lot of assessments, "it could be an indication the SNF is having trouble anticipating or delivering the services the beneficiary needs," Hrehor says. At the same time, few or no assessments are "not necessarily a good thing" and may be targeted by recovery audit contractors and Medicare administrative contractors.

(6) SNF stays of 90 days or longer: The question is whether beneficiaries really need skilled services for so long and whether they are receiving them the entire time.

SNFs have to become more vigilant in light of the ACA's compliance program mandate, OIG report and PEPPER, say attorneys Brian Bewley and Barbara Miltenberger, with Husch Blackwell in Jefferson City, Mo., and Kansas City, Mo., respectively. Skilled nursing facilities often contract out for therapy, which complicates oversight, Bewley notes. But the SNFs submit the claims so they are the ones on the line. "SNFs will have to become more vigilant to ensure documentation supports the services provided," Miltenberger says.

Suppose the beneficiary had a stroke and requires occupational therapy to regain right-hand function. "When they start, they can't feed themselves, but as they progress they can do more and their ADL scores improve," Miltenberger says. "Facilities need to evaluate whether the patient still needs 500 minutes a week of therapy or if fewer minutes are more appropriate. That is what the PEPPER is trying to have facilities evaluate — how much therapy patients need." A beneficiary with a broken hip who can't walk 50 feet but walks 300 feet in two weeks may not need as much physical therapy at that point, she says.

Certification also is a compliance hot spot. "SNFs have to have certification for continued therapy at certain

CMS's New Two-Midnight Rule for Inpatient Admissions: Strategies for Hospital Compliance

- How does the two-midnight rule change the status quo? (What is CMS's distinction between a two-midnight "presumption" and a "benchmark"?)
- When does the clock start ticking on an admission?
- What services can be counted toward the two-midnight threshold?
- How are RACs, MACs, the CERT contractor and other auditors likely to revamp their audits to conform to the two-midnight rule?
- What new procedures should hospitals implement to make sure they follow this new standard?
- What options are available to hospitals should they receive a denial of Part A inpatient hospital claims or identify an overpayment on audit?
- What are best practices for documentation in light of the new two-midnight rule?
- What Medicare appeals strategies should be followed to transition overpayment determinations to the new requirements?

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periods of time in their Medicare stay and it must be signed by the physician and dated before billing,” Miltenberger says. If SNFs have trouble with timely certifications, medical directors can prod physicians because they respond better to their peers on some regulatory requirements, she says.

Now that PEPPER exists for SNFs, Bewley advises facilities to spring into action and use them to determine if the organization has received improper payments. “Down the road, if you become the subject of a whistleblower lawsuit and the allegations overlap with any areas highlighted in PEPPER, the government can use your failure to take it seriously as potential evidence you acted in reckless disregard,” Bewley says.

Contact Hrehor at khrehor@txqio.sdps.org, Bewley at brian.bewley@huschblackwell.com and Miltenberger at Barbara.miltenberger@huschblackwell.com. The OIG report can be accessed at <https://oig.hhs.gov/oei/reports/oei-02-09-00200.asp>. ↵

Five Mistakes to Avoid When Managing HIPAA Security Breaches

When one health care organization had a significant privacy breach, it informed patients by mailing thousands of letters at the same time. As a result, the organization’s call center was overwhelmed and had to shut down temporarily.

“Not only did they upset patients but they couldn’t take incoming calls about other things,” said Michael Bruemmer, vice president of Experian Data Breach Resolution in Costa Mesa, Calif. “You have to stage the letters over a number of days.” The flurry of calls also will be reduced if breach-notification letters include critical information that answers affected patients’ questions, he said. “If you are impacted by a breach, you want to know four things: What happened? How am I impacted? What do I need to do to protect myself? And am I at risk for anything bad happening in the future?” And the letter should be posted on the organization’s website, with directions on how to put fraud alerts on credit files, get credit reports, cancel health insurance cards and correct medical misinformation that may occur if the breach involves manipulated medical records or stolen insurance cards. And of course the letter must comply with the requirements set forth in the HIPAA/HITECH regulation (e.g., patients must be notified no later than 60 days after the breach was discovered).

Overestimating your internal capability, as this health care organization did, is one of the five mistakes that repeatedly crop up in breach reporting, Bruemmer said at an Aug. 8 webinar sponsored by the Health Care Compliance Association.

Breach notification is looming large for health care organizations with the Sept. 23 compliance deadline for the final omnibus rule spelling out the HIPAA privacy and security provisions in the 2009 HITECH Act. At that point, covered entities must report all breaches — to patients and HHS (immediately or annually) — unless an exception applies or they determine, using a four-step process, there is a “low probability” the PHI has been or will be compromised (*RMC 1/28/13, p. 1*).

Here are four additional mistakes — in addition to overestimating internal capabilities — that are common in breach reporting:

(1) Lack of delegated authority: The incident response team, which must be developed and deployed under HIPAA, shouldn’t have a lot of cooks stirring the pot. “Sometimes you get too many decision makers,” Bruemmer said, and that can sabotage the effective resolution of breaches. For example, his firm was about to mail breach-notification letters for a client when its CFO called to stop the presses. Bruemmer’s contact at the client was baffled. “We had to wait four hours to get a call with everyone and we ended holding up the [letters],” he said. “If you are running up against the 60-day deadline, it makes us a little nervous.” Bruemmer adds that it’s a bad idea to put together an incident response on the fly. He recommended running drills to test preparedness. To ensure an authentic reaction, it’s best to not tell employees it’s a drill. This strategy is used by compliance officers to test their compliance hotlines, when fictitious problems are reported to the hotline and compliance of-

Elements of a Breach Response Plan

This checklist was developed by Paula Stannard of Alston & Bird, who spoke at a Health Care Compliance Association webinar on Aug. 8. Contact her at paula.stannard@alston.com.

Plan Components	
Item	Completed
Designate Response Team + Team Leader	
Establish internal notification/Reporting process	
Checklists of procedures	
Document actions considered/taken and reasons	
Regulatory and law enforcement agencies to contact	
Create Communications Plan	
Identification of external resources/support	
Remediation and Mitigation	
Post-response review, risk mediation and process improvement	
Contact information	
Forms and templates	
Exercise and update Incident Response Plan	

Assistance With New HIPAA Rules

HIPAA covered entities and (now for the first time) business associates must comply with a wide range of new HIPAA/HITECH Act regulations as of Sept. 23. For an 18-page summary of these new provisions prepared by RMC Contributing Editor Francie Fernald, please go to the RMC subscriber-only page at AISHealth.com/newsletters/reportonmedicarecompliance and access “Extensive Summary of 2013 HIPAA/HITECH Act Regs” under “Subscriber Services” in the right column.

ficers follow along to determine if they are documented and investigated appropriately.

(2) **Micromanaging the breach:** Incident response teams are undermined when they can't execute their plans in the event of a breach, Bruemmer said. “You go to the trouble of creating a plan and testing it so it will work effectively during an incident, and you don't want people second-guessing the members of the team.” For example, in two breaches, Experian clients were ready to go live with call centers after sending breach-notification letters, but someone outside the incident response team decided to change the hours of operation to accommodate people who work the third shift. Ultimately, the head of the incident response team overruled the change, but it delayed the response.

(3) **Not engaging outside counsel:** “Breach incident response is very specialized” and requires expert legal assistance, Bruemmer says.

(4) **No single decision maker:** Although the incident response team is a group effort, typically including people from finance, information technology, clinical departments, admissions and privacy/compliance, there should be one top dog.

Contact Bruemmer at Michael.bruemmer@experian.com. ♦

MD Certifications Are Key

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“I am less concerned about the two-midnight rule than I am about how to capture all the required certification documentation,” says Laura Ehrlich, compliance auditor at Hanover Hospital in Pennsylvania.

The different parts of the certification don't have to be in the same place. As CMS says, they may be on records or notes (e.g., history and physical, progress notes) or a “special separate form.” Gustafson recommends the use of a “combined document,” with space for a signed and dated order and the elements of certification. “It

makes sense to keep that information together,” says Gustafson, who also spoke Aug. 23 at a “Finally Fridays” webinar sponsored by the Appeal Academy. Physicians can circle back around to the paper or electronic sheet when they are ready to complete another section. But experts advise waiting for CMS guidance on certifications before making radical changes.

The certification mandate didn't come totally out of left field. Under 42 CFR Sec. 424.13, physicians are required to certify and recertify services when hospital stays will cause cost outliers, says Ronald Hirsch, M.D., vice president of the regulations and accreditation group for Accretive Physician Advisory Services. “All along it has only been in this context. But in my 20 years of practicing, I never remember asking to sign a certification of an outlier stay.” As far as Gustafson is concerned, “certification for short hospital stays is just new.” The requirements don't resemble the pre-IPPS version.

Certification Has Its Gray Areas

There are unknowns about certification, Hirsch says. For example, he wonders whether it's compliant for physicians to give a range when estimating how long the inpatient will be hospitalized (e.g., two to five days). Or is a definitive number of days required? “Does it matter as long as two midnights are passed?”

Because of the uncertainty, hospitals “want to be ready to act but not jump yet,” Hirsch says. That includes working with physicians to improve their documentation. “Get them to document why they could not be treated as outpatients,” he says. And involve the IT department now so the hospital doesn't spend four months testing changes to computerized physician order entry. In fact, hard stops in electronic health records (EHRs) may help with certification compliance, says Michael Salvatore, M.D., physician adviser at Beebe Medical Center in Lewes, Del. Physicians won't be able to close out the EHR until they answer the two-midnight question. “If you have a flexible EHR, you are in good shape,” he says.

CMS also formalized its requirement for admission orders as a condition of hospital payment, which until the IPPS rule was a condition of participation and mandated in the 2012 Medicare physician fee schedule. But say goodbye to specific orders, such as “Admit to tower four” or “Admit to ICU.” To prevent ambiguity about the patient's destination, CMS is requiring physicians to include the word “inpatient” in their orders. “Physicians have to use the magic words — ‘Admit to inpatient’ and ‘I think they will be here for two midnights,’” Salvatore says. “That's a big change in physician behavior.” Again, he says, EHR hard stops will be a boon because physicians can't continue their documentation until they have used the magic words.

Physician orders and certifications aren't a panacea for Part A claims. It's a little confusing, but the IPPS regulation states that "no presumptive weight shall be assigned" to the order or certification "in determining the medical necessity of inpatient hospital services." Salvatore doesn't think that squares with the fact that "how sick you are no longer determines your admission status" under the two-midnight rule. He expects CMS to fall back on the *Medicare Benefit Policy Manual* (Chapter One), which states that "the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors," including the severity of signs and symptoms and the risk of something bad happening to patients if they are discharged.

The two-midnight standard and its certification is "a great educational opportunity for hospitals," says Minneapolis attorney David Glaser, with Fredrikson & Byron. The definition of an "inpatient" is clear and physicians just have to write why they think the patient will be in the hospital for two nights. If they have any doubt, they put patients in observation. There's nothing to lose, Glaser says. When patients are moved from observation to inpatient, the hours count for two-midnight purposes. He thinks they also can be billed separately, citing this language from the regulation: "Those services that require an outpatient status that cannot be billed on a 12x claim — observation services, outpatient hospital visits, and outpatient DSMT— are payable if they were furnished to an outpatient during the 3 day (1-day for non-IPPS hospitals) payment window preceding the inpatient admission and are billed on a Part B outpatient (13x) claim."

Because orders and certifications are now explicitly a condition of Part A payment, hospitals may not be able to bill Medicare if something is amiss. Instead, they should consider a self-audit and rebilling under Part B (RMC 8/12/13, p. 4), Gustafson says, although she is "not

an advocate of RAC-ing yourself"—especially when all required information can be found in the medical records even if it's not documented in the "best" manner. It's always better to get it right at the front end, but if necessary, the administrative law judge may approve Part A payment even if part of the certification is missing, says Sharon Easterling, president of Recovery Analytics in Charlotte, N.C. Hospitals should prepare a certification statement that explains where the pieces can be found, Ehrlich says. "Medicare is looking for a cohesive piece of information."

Vincent Perron, M.D., associate chief medical officer for 1,000-bed Tampa General Hospital, isn't looking forward to telling physicians about the two-midnight rule and its certification requirement. "Most physicians can't define the difference between an observation patient and inpatient and it is something we struggle with daily," he says. "It's all Greek to them." The hospital's clinical documentation improvement team probably will educate physicians and Perron will meet with key physicians. Tampa General already does random chart reviews, giving physicians feedback on deficiencies. If there's a pattern of poor documentation, a physician is referred to the health information management committee and rounds with the EPIC person to develop H&P and other templates, he says. For the "notoriously poor documenters," the hospital may get voice recognition software. Perron notes that great clinicians can be lousy at documentation so there isn't necessarily a correlation.

Contact Gustafson at jgustafson@thehlp.com, Hirsch at rhirsch@accretivehealth.com, Glaser at dglaser@fredlaw.com and Salvatore at msalvatore@bbmc.org. ♦

For information on RMC's Sept. 26 webinar, CMS's New Two-Midnight Rule for Inpatient Admissions: Strategies for Hospital Compliance, with Abby Pendleton and Jessica L. Gustafson, founding partners of The Health Law Partners, P.C., visit the Marketplace at AISHealth.com and click on "webinars."

NEWS BRIEFS

♦ **For the four years included in its Medicare compliance review (2008-2011), the University of Pennsylvania hospital received overpayments of \$538,000, according to the HHS Office of Inspector General.** OIG selectively reviewed 208 claims and found problems with 54 of them. The university's inpatient problem areas were incorrect assignment of DRGs, inpatients that should have been treated as outpatients, and failure to obtain available medical device credits from the manufacturer. On the

outpatient side, the hospital billed five nuclear medicine procedures and added to each claim the HCPCS code for the radiolabeled product used. These products had already been included on other claims. The university generally agreed with the findings, filed adjustment claims and conducted educational sessions with staff to address the problems. Visit <http://go.usa.gov/jGM9>.

♦ **Publication of the HHS OIG Work Plan for FY 2014 has been delayed from October to January.**

NEWS BRIEFS

"We are in a difficult fiscal environment so we are prioritizing and considering how we can best use our resources," OIG Spokesman Don White tells RMC. In addition to the sequester, OIG faces expiration of \$30 million in funding from the 2005 Deficit Reduction Act and the American Recovery and Reinvestment Act. "OIG also exhausted a Medicaid fraud supplemental of \$25 million that remains authorized but has not been appropriated since 2009," he says. However, OIG will continue to focus on Medicare and Medicaid. It has a steady stream of money from the HHS/DOJ Health Care Fraud and Abuse Control program, which recycles recoveries into more enforcement. Visit <http://tinyurl.com/or2y4b3>.

◆ **A Long Island, N.Y., orthopedic surgeon has settled allegations that he improperly coded kyphoplasty procedures to receive higher reimbursement.** In its Aug. 21 press release, the Department of Justice said that Richard Obedian will pay \$388,000, although he did not admit liability. This settlement follows the government's false claims settlements with 55 hospitals in July to pay more than \$34 million to resolve allegations they billed for inpatient kyphoplasty that should have been performed as an outpatient service. A total of 100 hospitals have now settled these cases. Visit <http://tinyurl.com/nxkchze>.

◆ **Most critical access hospitals would lose their CAH status if they were required to re-enroll.** This is the conclusion of an OIG report that reviewed whether the hospitals would meet the distance and rural location statutory requirements, referred to as the location requirements. According to the report, almost two-thirds of CAHs would not satisfy the requirements, primarily because of the distance requirement. However, CMS cannot revoke the CAH status for hospitals designated by states before 2006 as "necessary providers" (NP CAHs). If it could de-certify those that were 15 or fewer miles from their nearest hospitals, the report says, Medicare would have saved \$449 million in 2011. OIG recommended that CMS seek legislation to allow it to review the permanent status of NP CAHs and remove the CAH designation from those that did not meet the distance requirement. In its response, CMS said the president's proposed FY 2014 budget would de-certify any CAHs located fewer than 10 miles from the nearest hospitals and reduce the current reimbursement rate from 101% of reasonable costs to 100%. Visit <http://tinyurl.com/mvzxx3u>.

◆ **Imagimed LLC and its former owners have agreed to pay the government \$3.57 million to resolve false claims allegations that the company submitted claims for procedures that did not meet Medicare requirements.** According to an Aug. 27 press release from the Department of Justice, the company, which operates "Open MRI" imaging centers primarily in New York state, performed MRI scans with a contrast dye without the direct supervision of a qualified physician, which is required by Medicare. The government also alleged that over a two-and-a-half year period, the company violated both the Stark law and anti-kickback statute by entering into sham on-call arrangements, providing pre-authorization services without charge and providing various gifts in exchange for physician referrals. The settlement resolves a whistleblower lawsuit, *United States of America ex rel. Lynch v. Imagimed LLC, et al.* (N.D. N.Y.). Visit <http://tinyurl.com/n53c22p>.

◆ **OIG recently issued two new advisory opinions.** In AO 13-10, it gave the thumbs-up to a proposed contract with hospitals to provide services to patients with certain diagnoses following hospital discharge with the goal of reducing preventable hospital readmissions. In AO-13-12, OIG also gave the nod to the use of a "preferred hospital" network as part of certain Medicare Supplemental Health Insurance (Medigap) policies. For 13-10, visit <http://go.usa.gov/jFW4>; for 13-12, go to <http://go.usa.gov/DcEx>.

◆ **At the request of Congress, the Government Accountability Office reviewed the postpayment review processes used by four types of Medicare contractors — Medicare administrative contractors, zone integrity contractors, recovery auditors and the comprehensive error rate testing contractor.** It found inconsistencies that, if eliminated, could improve administrative efficiency and reduce the burden on providers. GAO cited inconsistencies in the oversight of claims selection, time frame for provider response, communication about the reviews and processes to ensure quality. CMS should examine postpayment review requirements and minimize the differences, as long as the changes do not impede efforts to reduce improper payments, GAO said. CMS agreed with the GAO recommendations and said that it had begun examining the differences. However, it did not provide a time frame for any changes. Visit <http://www.gao.gov/products/GAO-13-522>.

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