Report on
Medicare Compliance

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

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DOJ Trial Attorney Provides Insights Into How to Avoid Medical Necessity Cases

When investigating allegations that medically unnecessary services were performed, the Department of Justice hunts for patterns in physician and hospital billing.

"We are not interested in an occasional blip," said Arthur Di Dio, M.D., a trial attorney in the Department of Justice's commercial litigation branch. "One of the most important factors in deciding whether to go forward is the error rate, and we are looking for patterns." He thinks of it this way: "if a provider does something once, it's is an incident, twice is an occurrence, three times is a trend, four times is a pattern and five times is an agenda," a hierarchy from an assistant U.S. attorney in South Florida. "We are focusing on the last three: trends, patterns and agendas," Di Dio said.

Di Dio spoke Sept. 30 at the Fraud and Compliance Forum co-sponsored by the Health Care Compliance Association and American Health Lawyers Association in Baltimore on the factors that drive medical necessity investigations. He also suggested ways to avoid them. Medical necessity is on the front burner at DOJ, with a number of False Claims Act settlements with hospitals over stents and other procedures *(RMC 1/14/13, p. 1)* and criminal prosecutions or charges pending against physicians *(RMC 8/12/13, p. 1; 6/17/12, p. 3)*.

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As Tuomey Post-Mortem Continues, Judge Orders Health System to Pay $237 Million

A federal judge on Sept. 30 ordered Tuomey Healthcare System to pay more than $237 million for violating the Stark law and False Claims Act and declined to throw out the jury's verdict or grant a new trial. The Sumter, S.C., hospital filed its notice of appeal the following day, continuing a saga over physician compensation that has rocked the legal and compliance world for three years.

On May 8, a federal jury found that the hospital's compensation agreements with 19 employed physicians ran afoul of the Stark law *(RMC 5/13/13, p. 1)*, which turned the hospital's claims for Medicare services referred by the 19 physicians into false claims.

In a statement, Tuomey said "it respectfully disagrees with the ruling" and will ask the U.S. Court of Appeals for the Fourth Circuit for a stay of the judgment pending appeal.

"When you see the numbers, it makes you gasp — even though we knew this would follow from the jury verdict," says Atlanta attorney Alan Rumph, with Baker Donelson.

Meanwhile, former government officials, attorneys and compliance officers continue the post-mortem on the Tuomey case. *One bottom line:* compliance officers should be at the table for strategic planning. There is a perception they will be nay-sayers, but that isn't the case. "You can always get to a deal you are comfortable with to satisfy strategic

objectives…if management is truly informed and willing to accept risks," said Margaret Hambleton, senior vice president of ministry integrity at St. Joseph Health System in California.

In the court order, U.S. District Judge Margaret Seymour in Columbia, S.C., told Tuomey to pay $39,313,065, on the jury verdict that 21,730 false claims were submitted to Medicare, and $237,454,195 in false claim fines.

The story began about a decade ago, when Tuomey panicked that its referring physicians would shift outpatient procedures from the hospital to their own practices or an ambulatory surgery center. To prevent a loss of revenue, the hospital offered 10-year employment contracts to 19 specialists. In exchange for performing all outpatient procedures at Tuomey Hospital or its other facilities, the specialists were paid an annual base salary that varied according to the net cash collections for outpatient procedures and a productivity bonus equal to 80% of net collections, and were eligible for an incentive bonus worth up to 7% of their productivity bonus, court documents say. Not everyone went along for the ride. Orthopedic surgeon Michael Drakeford turned down Tuomey's offer after raising concerns about it, and filed a false claims lawsuit alleging violations of the Stark law. DOJ signed on, and when Tuomey refused to settle, the case went to trial in U.S. District Court in Columbia, S.C. The jury declared the hospital in violation of Stark but not the False Claims Act. The drama, however, was far from over. The judge decided he made a mistake excluding certain evidence and, in a post-trial ruling, ordered a new false claims trial while preserving the government's Stark victory. Tuomey appealed to the U.S. Court of Appeals for the Fourth Circuit, which threw out the entire case on the grounds that the hospital's 7th Amendment right to a jury trial was violated by the post-trial ruling *(RMC 4/16/13, p. 1)*. The government took Tuomey back to trial in May with a new trial judge and this time the jury found the hospital violated both Stark and the False Claims Act.

Judge Disagreed With Tuomey's Arguments

After the verdict was handed down, Tuomey filed motions asking the trial judge to throw out the verdict or grant a new trial. Here are some of Tuomey's arguments, along with reasons why the judge turned it down:

(1) Tuomey argued there was no Stark violation because the government never proved the physicians' compensation took into account the volume or value of referrals. But the judge said "a reasonable jury could have found that Tuomey took into account the volume or value of referrals" based on its perception of the credibility of a valuation consultant and the testimony of various witnesses.

(2) Because the hospital sought the advice of counsel in good faith, Tuomey argued that the government can't prove it "knowingly" submitted a false claim. Tuomey relied on several consultants and lawyers, including its counsel, who said the contracts didn't violate the Stark law. But another lawyer, Kevin McAnaney, former chief of the HHS Office of Inspector General's Industry Guidance Branch, advised Tuomey that the physician contracts were problematic partly because the salaries were above fair market value. Tuomey sent McAnaney packing and told him not to put his opinion in writing. The judge said "a reasonable jury could have found that Tuomey possessed the requisite scienter once it determined to disregard McAnaney's remarks."

(3) The government failed to prove damages, Tuomey argued, and therefore it's entitled to win "as a matter of law." The government got the services it paid for and it would have paid the same amount of money if the services were performed at another hospital. But the judge didn't buy it. She noted that Stark says "no payment may be made…for a designated health service" when it's provided in violation of the law.

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What bothers Rumph most about the way things have shaken out is that the appeals court applied a different standard to the volume or value issue than the trial judge did. The Fourth Circuit said the jury had to decide whether the hospital's contracts, on their face, took into account the volume or value of the physicians' referrals when setting compensation (i.e., how much money the hospital makes in facility or technical charges resulting from procedures performed by the employed physicians). "That was Tuomey's primary argument in asking the court to set aside the verdict — that the documents on their face don't take into account the value or volume of referrals," Rumph says. But in her order, Judge Seymour never addresses the issue. She uses a more "subjective and expansive" definition of "taking into account the volume or value of referrals," he says. "This particular issue is the reason why we are all having so much trouble with Tuomey." He notes, however, that the Fourth Circuit sent mixed signals on the issue.

The Role of the Board Said to Be Paramount

Compliance experts put the Tuomey case under the microscope at the Oct. 1 Fraud and Compliance Forum co-sponsored by the American Health Lawyers Association and Health Care Compliance Association in Baltimore. "We have the benefit of 20/20 hindsight," but it's instructive to look at the board's role, said Lewis Morris, former chief counsel to the HHS Inspector General. Boards generally have a duty of reasonable inquiry. They are supposed to ask the right questions at the right time and use the compliance program as "a critical pipeline of information," he said. When the proposed physician employment contracts were being hashed over at Tuomey, its board "did the right thing by hearing Drakeford out," said Morris, who is with Adelman Sheff & Smith in Annapolis, Md. The hospital and Drakeford agreed to jointly retain an attorney (McAnaney) to review the contract. "This was a critical opportunity for re-evaluation. But then they passed a resolution that no one could come before the board unless the CEO or chair approves it and they bring a lawyer….It seems extraordinary that they cut off communication with a guy who seemed to have a legitimate concern."

Hambleton says it should have been a red flag that the board allegedly didn't want to meet with Drakeford. "Compliance officers face this" — people who raise concerns may be treated like "disgruntled, belligerent troublemakers," she says. Discounting concerns of people like Drakeford "is one of the biggest mistakes that compliance officers can make."

Morris emphasized the importance of hearing people out. "Are all whistleblowers the type of people you want to take a 12-hour car ride with? Perhaps not," he said. "But you have to listen to them. Otherwise they will be out the door, going to the government."

None of the experts were clear on why Tuomey fought the allegations at trial, given the risk of staggering penalties if they lost. "Stark cases are turning into anti-kickback cases dressed up as Stark cases. Juries won't care about technical Medicare payment rules, but they do understand bribes and payments for referrals," said Chicago attorney Daniel Melvin, who is with McDermott, Will & Emery. "Letting Stark cases get before the courts is not a good idea" — at least until the courts sort out some Stark interpretations, such as the volume and value of referrals standard.

Four Corners of Stark Are 'Not Sexy'

Because "the four corners of Stark are not sexy to a jury," prosecutors spent little time there, Hambleton said. There's a message here for compliance officers: In addition to worrying about fair-market value and commercial reasonableness, they should look at physician agreements in context "and have a voice as loud as the CEO," she says. "Dig your heels in if problems are not adequately addressed."

Melvin doesn't think the Tuomey case "stands for the notion that getting a second opinion is shopping for opinions. The Stark law is sufficiently complex that to proceed in the face of dueling opinions doesn't mean you are opinion shopping." McAnaney said at the conference that Tuomey asked him only for his "view of the risks — not his opinion."

DOJ could still agree to settle for a smaller dollar figure in exchange for Tuomey dropping its appeal, according to Rumph.

In its statement, the hospital emphasized that "patient care, safety and the health of the Sumter community remain Tuomey's number-one focus."

In the Sept. 30 order, the judge assessed a higher fine on Tuomey, but corrected it in an Oct. 2 order.

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CMS Throws a New Kind of Program Integrity Contractor Into the Mix

Hospitals, physicians and other providers may soon be getting documentation requests from a brand new kind of CMS auditor. CMS recently unleashed its "strategic medical review contractor" (SMRC) on the health care industry, and there are now 12 types of Medicare audits underway.

"Providers and suppliers need to be aware there is this additional layer out there — one more contractor they need to be responsive to," says attorney Jessica Gustafson, with The Health Law Partners in Southfield, Mich. She thinks the SMRC will come at audits from a somewhat different perspective. "They are going to provide support for a variety of tasks aimed at lowering the improper payment rate and increasing the efficiency of medical review." The company that won the contract — StrategicHealthSolutions, LLC — is focused on Medicare Parts A and B and durable medical equipment.

It's unclear how the SMRC squares with CMS's plan to streamline its program integrity contracts into a unified program integrity contractor (UPIC). The agency is developing a "unified program integrity strategy" that merges some Medicare and Medicaid audits and investigations, exploits data mining and aligns the work of regional contractors with CMS's vision *(RMC 8/5/13, p. 5)*. The Center for Program Integrity will hire five to 15 new UPICs to bring the strategy to life. UPICs will replace zone program integrity contractors (ZPICs) — including their Medicare-Medicaid data match function — as well as Medicaid integrity contractors and program safeguard contractors. However, Medicare administrative contractors and recovery audit contractors will continue their audits and reviews.

"It is interesting they would seem to move to a more consolidated auditing program and at the same time they roll out this additional layer," Gustafson says.

StrategicHealthSolutions says it is now performing medical-record reviews in the following areas:

- Inpatient rehabilitation facility services
- Medicare Part B outpatient therapy services (two jurisdictions)
- Evaluation and management services, mostly 99214 and 99215 (two jurisdictions)
- Non-emergent magnetic resonance imaging of the lumbar spine
- Non-emergency myocardial single photon emission computed tomography
- Power mobility devices
- Hyperbaric oxygen therapy
- HCPCS L7900: male vacuum erection devices
- Transforaminal epidural injection
- DME Part 2 providers

CMS says the audit targets are chosen by CMS data analysis, the Comprehensive Error Rate Testing (CERT) program, professional organizations and Medicare watchdogs.

Very little is known about the SMRC. Some providers and suppliers have been receiving documentation requests from StrategicHeathSolutions, which does not reimburse them for copies of the medical records. But it's clear from the list of audit targets that they are focused on areas seen as "ripe for fraud and abuse," Gustafson says. Whether the SMRC extrapolates large overpayments from statistically valid random samples — the way Medicare administrative contractors do — is unknown, but providers and suppliers should be on alert, she says.

When the SMRC identifies improper payments or noncompliance with documentation requests, it will notify CMS. In response, Medicare administrative contractors may adjust claims or recoup overpayments through the usual process, CMS says.

Contact Gustafson at jgustafson@thehlp.com. View CMS's page on the SMRC at http://tinyurl.com/kb933vb and the StrategicHealthSolutions website at www.strategichs.com. ✧

Eight Common Evaluation and Management Mistakes to Avoid

It seems like everyone wants a piece of evaluation and management coding, the most frequently billed physician service. Auditors, enforcers and whistleblowers have sunk their teeth into it, and health systems, wary of all the attention, are auditing the physician practices they plan to acquire to identify possible E/M liability.

"E/M coding seems to be getting a lot of attention at the federal level," says Kevin Cornish, national director of the healthcare dispute, compliance and investigation practice at Navigant Consulting. Partly as a result of that, E/M coding patterns and trends may change immediately before or after an acquisition. Is it because the practice was upcoding before and it was ripe for compliance? Or was there undercoding?

"We have been spending quite a bit of time dealing with those kinds of issues," Cornish says. Sometimes they lead to an internal compliance review with the potential for self-disclosure. For example, if a pediatric practice has a physician who is billing a lot of level four and five E/M services, which is atypical for pediatricians unless they are treating high-risk children, the practice needs to dig deeper into root causes. Or maybe an inter-

nist trends in a certain way for eight or nine years and then suddenly shifts down or up. "That is another flag someone should look at to identify what caused it," Cornish says. It's better to find out for yourself "before someone [external] does it for you."

Coding spikes are rarely caused by "material changes in types of patients seen or services rendered," Cornish contends. They may result from the use of a consultant who advises physicians to do things differently, he says. "It could be a reorientation toward more accurate coding" or away from more accurate coding — "either you are undercoding or under-evaluating services or you have been doing it too high. It can go in both directions. It depends on the impetus for why the analysis or training was done."

Documentation May Not Support Codes

Cynthia Swanson, a senior manager at Seim Johnson in Omaha, Neb., says E/M reviews by the HHS Office of Inspector General and comprehensive error rate testing (CERT) contractors have found E/M upcoding and inadequate documentation. "We see overinflated E/M usage based on documentation, similar to the E/M information that CERT contractors publish," she says. With the higher level of office-based E/M codes 99214 and 99215, elements are often missing. When billing counseling and/or coordination of care based on time, physicians may neglect to document time, or, if time is recorded, there is nothing written about what physicians counseled the patients on, she says. Self-audits are the best approach to identify potential documentation and begin the process of improvement.

Swanson describes examples she has identified in her reviews where documentation does not support the information on the CMS-1500 claim form or the electronic equivalent:

◆ ***Improper reporting of place of service (POS) codes (11 for office versus 22 for hospital outpatient departments, or 21 for inpatient hospital departments):*** The 2013 OIG Work Plan targets physician place-of-service coding errors. Physicians are required to put POS codes on Medicare claim forms to convey where services were provided. Medicare pays physicians more when a service is performed in a physician's office than it does when services are performed in a hospital outpatient department or, with certain exceptions, an ambulatory surgical center (42 CFR Section 414.32). Also, last year CMS announced in Medicare transmittal 2407 that POS codes must be assigned based on "the setting where the beneficiary received the face-to-face encounter with the physician, nonphysician practitioner (NP) or other supplier," although there are some exceptions *(RMC 2/20/12, p. 4)*.

◆ ***Improper reporting of services by nurse practitioners and physician assistants:*** In a typical example, a physician practice bills a new patient office visit (99203) on the Medicare claim under the physician's name and National Provider Identifier. But according to the documentation, the new patient was treated solely by the mid-level practitioner. "The new patient visit 99203 should be billed to Medicare under the mid-level practitioner's name and NPI. Medicare has specific requirements for reporting and billing mid-level practitioner services," Swanson says.

◆ ***E/M billing for counseling and/or coordination of care:*** The documentation may state that the physician had a "lengthy discussion" with the patient about CT scan findings and treatment options, but it should specify that more than half of the patient encounter — 15 of the 25-minute visit — was spent on counseling the patient on CT scan findings and treatment options, Swanson says.

◆ ***Hospital discharge-day management (CPT code 99239):*** This code is for hospital discharge management services, and may include, if necessary, final examination of the patient, discussion of the hospital stay, prescriptions and referral forms and preparation of discharge records. This code is used when more than 30 minutes of a physician's time is provided to the patient on the day of discharge, assuming it's not the same as the admission date. "Any code defined by time must include time in the medical record documentation," she says. If it takes fewer than 30 minutes, use 99238. Swanson thinks Medicare watchdogs have routine use of 99239 on their radar.

◆ ***Improper units of service on medications or incorrect medication codes:*** Suppose HCPCS code J1020 (methylprednisolone acetate, 40 mg) was reported and billed. Documentation supports 80 mg of the medication was given. The correct HCPCS code J1040 should have been reported and billed, Swanson says. In this case, the physician was reimbursed too little.

◆ ***Billing incorrect date of service based on the date the service was performed:*** Suppose an established patient office visit code (99214) was billed with the date of service 07/15/2013. Documentation supports the patient was seen on 07/16/2013. In this case, an incorrect date of service was reported on the claim. "Corresponding service dates on the claim should routinely coincide with the date(s) of service in the patient medical record," Swanson says.

◆ ***Billing under the incorrect physician name and NPI:*** For example, the service was billed on the claim under the name and NPI of Timothy Black, M.D., but documentation indicates the service was performed by Robert Brown, M.D. "The performing practitioner's information reported on the claim should routinely coincide with the

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performing practitioner documented in the patient medical record," Swanson says.

◆ ***CPT code 99204: Documentation does not support the three key components — comprehensive history, comprehensive exam and moderate complexity medical decision making — required to bill this level of E/M service.*** A "complete" review of systems (ROS) — at least 10 organ systems — is one history element needed for E/M code 99204, Swanson says. The other two elements are history of present illness (HPI) and past, family, and/or social history (PFSH). If documentation shows that only six organ systems were reviewed, this translates to an "extended" ROS (two to nine organ systems) and alters the level of history component, which changes the overall E/M code level. Similarly, E/M code 99204 requires a "comprehensive" exam. "If less than a comprehensive exam is performed and documented, the requirements for E/M code level 99204 are not met, resulting in a lower level E/M service code," Swanson says.

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CMS Transmittals and *Federal Register* Regulations
Sept. 27 — Oct. 3, 2013

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Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- Annual Update for the Health Professional Shortage Area Bonus Payments, Trans. 2794CP, CR 8463 (Sept. 27; eff. Jan. 1; impl. Jan. 6, 2014)

Pub.15-1, The Provider Reimbursement Manual - Part 1

- Chapter 22; Adds Tables 24 and 25 to update the Medicare Payment Rates for routine SNF-type services by swing-bed hospitals during calendar years 2013 and 2014, Trans. 458PR1 (Sept. 27; eff. for services furnished on or after Jan. 1, 2013 and on or after Jan. 1, 2014)

Pub. 100-20, One-Time Notification

- Redaction of Health Insurance Claim Numbers in Medicare Redetermination Notices (R), Trans. 12960TN, CR 8268 (Sept. 25; eff. Jan. 1; impl. Jan. 6, 2014)

Federal Register Regulations

Interim Final Rule

- FY 2014 Inpatient Prospective Payment Systems: Changes to Certain Cost Reporting Procedures Related to Disproportionate Share Hospital Uncompensated Care Payments, 78 Fed. Reg. 61191 (Oct. 3, 2013)

Notice

- Medicare Appeals: Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2014, 78 Fed. Reg. 59702 (Sept. 27, 2013)

Final Rules: Corrections

- Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2014; Correction, 78 Fed. Reg. 61202 (Oct. 3, 2014)
- Prospective Payment Systems for Acute Care Hospitals and the Long- Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status; Corrections, 78 Fed. Reg. 61197 (Oct. 3, 2013)

Medical Necessity Is a DOJ Magnet

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False claims investigations usually are sparked by whistleblowers, although some cases come from zone program integrity contractors. DOJ must be convinced there is (1) falsity (the services weren't medically necessary); and (2) knowledge (the provider who billed for the services knew or should have known they weren't medically necessary). The knowledge aspect is "trickier" to prove with hospitals, Di Dio said; "it's an extra step" to show they knew the clinician's services weren't medically necessary.

Because there is not much regulatory guidance on medical necessity, DOJ relies on professional society guidelines, expert opinions and Medicare national and local coverage determinations.

Every case is different, Di Dio emphasized. When DOJ gets a referral, the first step is to look at the claims data. Does it indicate overutilization? How does the provider named in the complaint compare to his or her peers? "If it's in the 90th percentile, it suggests something may be going on," he said. Investigators also gather the names of patients, dates of service, codes billed and amounts paid.

Then they use the tools at their disposal — primarily the relatively new civil investigative demand and subpoenas — to get medical and other records. Di Dio prefers to look at "raw data," such as hard-copy radiographic images, so he doesn't have to take medical records at face value.

DOJ also gathers complaints, incident reports, credentialing and personnel files, medical executive committee meeting minutes, board meeting minutes, documents on revenue and compensation, peer review and quality assurance documents and bylaws. What did the hospital know and when? Did it do quality assurance? Were there complaints? In terms of compensation, were there incentives that led to overutilization?

The next step in medical necessity investigations is hiring a physician expert. That's not the same as using a professional witness in a medical malpractice case, Di Dio said. "We hear complaints [that medical necessity cases amount to] federalizing malpractice, but it is

not," he said. The experts retained by DOJ are not "hired guns," he said. "We just want to know if a problem exists. If they say, 'I wouldn't have done anything differently,' that's a fine answer and we close our file."

Di Dio adds that DOJ prefers to hire experts in the same area that's under investigation. That means someone who is a leader in their field — they contribute to professional societies, publish articles, write clinical guidelines. If a case is focused on Medicaid dental services, for example, "we want someone who has expertise in that."

Then DOJ decides whether to go forward with a false claims complaint. Here are some factors that affect the decision, according to Di Dio:

◆ ***The nature of the service/procedure.*** For example, "the more invasive it is, the more it piques our interest."

◆ ***Whether there was actual or potential patient harm.***

◆ ***The error rate.*** Is there a pattern, a trend or an agenda?

◆ ***The nature of the errors.*** "We are also interested in [what the heck] was he thinking" when the doctor performed that procedure.

◆ ***Medicare guidance that exists on the procedure in a potential medical necessity case.*** "The more of it, the easier the case is to bring," Di Dio said, because the government can show the doctor and/or hospital deviated from the LCD, NCD or other guidance.

Di Dio said hospitals can minimize the risk of false claims lawsuits for medically unnecessary services by following their own bylaws. "I had a slew of doctor and hospital cases and, in the cases, the bylaws spelled out what the hospital should do and I used the bylaws to hit the hospital over the head," he said. The same goes for credentialing. "I had two cases where the doctor was doing services, and in both cases at their prior employment, the doctor had an adverse event report in the National Practitioner Data Bank." The doctors repeated the conduct at the new hospital that was cited in the NPDB. "So pay attention and if there's such a report, have your antenna up," he says. Licensing boards obviously have useful information as well.

Here are Di Dio's other tips for avoiding allegations of medically unnecessary services:

◆ ***Don't ignore complaints and tips.*** "In two recent cases, there were complaints by ancillary personnel but the hospital turned a blind eye," he said, taking an attitude that the tipsters were not qualified to judge the physician's behavior. It's smart to listen to what nurses and scrub techs have to say.

◆ ***Take peer review and quality assurance activities seriously,*** since they are "not window dressing."

◆ ***Consider external reviews.*** In two of his cases, hospitals hired outside specialists to review the alleged medically unnecessary services — but they did not work in the same specialty as the services under scrutiny.

◆ ***Refund money for medically unnecessary services.*** "It is very compelling when a hospital says 'we did a review and found services that were not medically necessary,'" he said.

◆ ***Be aware of the correlation between miscoding, poor quality of care, medical malpractice and medically unnecessary services.*** Di Dio had several cases where there was more than just one problem.

Payers Look Beyond Incorrect Settings

Most payment denials still stem from incorrect settings, but "there is a growing newer world of 'I want to know if the patient needed this at all,'" says Jeffrey Farber, M.D., chief medical officer at Mount Sinai Care and associate professor at Mount Sinai Medical Center in New York City. For example, spinal fusion, a procedure for back pain, was added to the Program for Evaluating Payment Patterns Electronic Reports (PEPPER), a sign that CMS considers it a risk area. "If your rates are high, you should investigate," Farber says. Hospitals that are a center of excellence for spinal fusion probably have nothing to worry about even if their billing rates are above the 85th percentile. But hospitals that don't look beyond their outliers may face bigger problems. "You want to pre-empt someone like the government doing it for you," Farber says.

Other risk areas are bariatric surgery and total joint replacement. Payers ask for documentation proving that providers tried more conservative treatment before resorting to invasive surgery. "Even with pretty bad arthritis, payers are saying hip replacement is done too early," Farber says. They want to see X-rays showing end-stage arthritis and evidence that pain medication and physical therapy were prescribed first.

Most or all hospital bylaws set forth a process for responding to medical necessity red flags — fact-finding missions, disciplinary hearings, etc. "The real risk is not following them," Farber says. "You could easily get distracted with so many things on your plate. You need someone from compliance or legal to steer the process to ensure it gets the priority it deserves."

The chief medical officer, for example, could ask a physician to review the medical records for 10 procedures performed by another physician whose conduct has been called into question, he says. Is there a troublesome pattern? "If it gets more serious, send it outside" to a third-party reviewer.

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NEWS BRIEFS

◆ **CMS is for the first time allowing physicians to use both the 1995 and 1997 documentation guidelines in some circumstances, which gives them a little more flexibility.** In a new answer to a frequently asked question, CMS says "for billing Medicare, a provider may choose either version of the documentation guidelines, not a combination of the two, to document a patient encounter. However, beginning for services performed on or after September 10, 2013, physicians may use the 1997 documentation guidelines for an extended history of present illness along with other elements from the 1995 guidelines to document an evaluation and management service." Visit http://tinyurl.com/mzsnmw7.

◆ **The New York State Office of the Medicaid Inspector General has posted its audit protocol for the long-term home health care program.** The protocol has 33 audit criteria, including missing or insufficient documentation of hours/visits billed, billing for services in excess of ordered hours/visits, failure to obtain an authorized practitioner's signature within the required time frame and plan of care/orders missing or not signed by an authorized practitioner. Visit http://tinyurl.com/mrwusrz.

◆ **According to court documents and a Sept. 30 press release from the defendants' attorneys, the whistleblower lawsuit against Radiation Oncology Consultants PA of Orlando, Fla., and three of its physicians has been dismissed without a financial settlement.** However, the other defendant in the lawsuit, Winter Park Urology Associates, also of Orlando, has reached a settlement with the government, although the government has not signed off on it or announced a settlement amount. The allegations stemmed from two procedures to treat patients with radiation: image-guided radiation therapy (IGRT) and intensity-modulated radiation therapy (IMRT). The false claims lawsuit alleged the defendants overbilled the government by more than $20 million. The case is *United States v. Winter Park Urology Associates PA et al.*, No. 6:10-cv-00806 (C.D. Fla.). Visit http://tinyurl.com/q66ggoq.

◆ **CMS has announced the amounts in controversy threshold for appeals in 2014.** They are $140 for ALJ hearings and $1,430 for judicial review. See 78 Fed. Reg. 59702 (Sept. 27, 2013) and visit http://tinyurl.com/kkxqjgj.

◆ **Diagnostic Laboratories and Radiology of Burbank, Calif., will pay $17.5 million to settle allegations that it violated the federal and California False Claims Acts by paying kickbacks for referrals of mobile laboratory and radiology services billed to Medicare and Medi-Cal.** According to a Sept. 25 press release from the Department of Justice, Diagnostic Labs, which is the West Coast's largest supplier of laboratory and X-ray services to skilled nursing homes, "took advantage of Medicare's different reimbursement system for inpatient and outpatient services by charging SNFs discounted rates for inpatient services paid by Medicare in exchange for the facilities' referral of outpatient business." The scheme, DOJ alleged, "enabled the SNFs to maximize profit earned for providing inpatient services by decreasing SNFs' costs of providing these services" and "allowed Diagnostic Labs to obtain a steady stream of lucrative outpatient referrals that it could directly bill to Medicare and Medi-Cal." This settlement terminates a whistleblower lawsuit filed by two former employees. The case is *United States and State of California ex rel. Pasqua et al. v. Kan-Di-Ki LLC f/k/a Kan-Di-Ki Inc. d/b/a Diagnostic Laboratories and Radiology, Civ. Action No. 10 0965 JST (Rzx)* (C.D. Cal.). Visit http://tinyurl.com/q6u8fu5.

◆ **Federally qualified health centers will have a new prospective payment system as of Oct. 1, 2014.** CMS issued a proposed rule on Sept. 18 (published in the Sept. 23 *Federal Register*) implementing the Affordable Care Act's mandate for an FQHC PPS. FQHCs, which serve underserved areas or populations and offer a sliding fee scale, currently are paid on a reasonable cost basis with payment limits. As proposed, the FQHC PPS would reimburse these providers using an encounter rate for all services rendered to a beneficiary in a single day and would have no limits. The new PPS is estimated to increase FQHC payments by 30%. Visit http://tinyurl.com/lxs2cxp.

◆ **The HHS Office of Inspector General's first evaluation of "redeterminations," which are the first level of Medicare appeals, found 80% were for Part B services in 2012.** But Part A appeals are on the rise, and recovery audit claim denials account for 39% of them. OIG studied Part A and B appeals from 2008 to 2012. Visit http://go.usa.gov/D6kF.

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