Report on Medicare Compliance

Volume 27, Number 16 • April 30, 2018

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

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Proposed IPPS Rule Would End Link Between Admission Orders and Payment, With Kinks

Inpatient orders wouldn't be required anymore for Medicare Part A payments as long as hospitals have other evidence to support the admissions, according to the proposed 2019 inpatient prospective payment system (IPPS) regulation, which was released April 24. But there may be less to this proposal than meets the eye because of CMS guidance to the contrary and because the regulation reiterates that inpatients are "formally" admitted when there's an order for admission. The change, however, is expected to reduce claim denials, and that was welcomed by compliance officers.

CMS presented the proposal, which is not a done deal unless it makes it into the final regulation, as proof it's keeping its promise to reduce the administrative burden on health care organizations *(RMC 4/23/18, p. 1)*. "We are proposing to revise the inpatient admission order policy to no longer require a written inpatient admission order to be present in the medical record as a specific condition of Medicare Part A payment. Hospitals and physicians are already required to document relevant orders in the medical record to substantiate medical necessity requirements," the proposed rule stated. CMS said it doesn't believe orders are necessary if other documentation, including progress notes and physician certification, are available to support the medical necessity of the admission and coverage criteria.

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Stipends for Physician Supervision of NPPs Gain Traction, But Some Stark Risk Exists

The use of nonphysician practitioners (NPPs) and payments to physicians for supervising them are growing in tandem, partly driven by state laws that require supervision. That presents some risk under the Stark Law and the Anti-Kickback Statute for hospitals, which may prefer to pay physicians stipends for supervision rather than other kinds of payments, experts say.

"We are seeing a lot of these supervision stipends pop up," said Darcy Devine, president of Buckhead FMV in Atlanta, Georgia, at an April 24 Health Care Compliance Association webinar. Physicians may be stuck with modest stipends, however, because there isn't enough meaningful market data on how to price the services. Instead, the cost-based approach for valuation may be the way to go, but hospitals still have to be mindful of the fair-market value and commercial reasonableness tenets of the Stark Law.

There are compelling reasons to pay physicians for supervising NPPs, who are also known as advanced practice clinicians (APCs), Devine said. Over the next decade, the number of APCs, which include nurse practitioners (NPs), physician assistants (PAs), nurse midwives and clinical nurse specialists, will grow exponentially at the same time a physician shortfall is projected, Devine said. For example, the ranks of PAs are expected to swell 37%. At the same time, APCs are a natural fit for pay-for-performance

continued

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models where value is provided by a multidisciplinary team, she said. In many circumstances, APCs will require supervision, and hospitals that employ physicians will be expected to pay for the supervision services, said attorney Joseph Wolfe, with Hall Render in Milwaukee, Wisconsin, who also spoke at the webinar.

"Sometimes health care organizations think about incorporating APCs into the delivery model because physicians request it," Wolfe said.

Supervision is baked into Medicare reimbursement models for APCs and/or required by state laws. Under Medicare, there are three models for billing services performed by APCs who work in physician practices: billing for services under their own provider numbers, which Medicare reimburses at 85% of the physician fee schedule; billing incident-to the physician's services, which pays 100% of the fee schedule but requires direct physician supervision and has other strings attached; and billing for split/shared services, which is similar to incident-to but applies to the hospital setting and has slightly different requirements.

This is where the Stark Law dovetails with APC supervision and the billing requirements, Wolfe said. If hospitals have financial relationships with referring physicians, they have to satisfy a Stark exception, and for employed physicians, that's the employment exception or in-office ancillary exception for physicians employed by a Stark group practice. "How the APC bills may drive the exception that is relied upon and the supervision model that is used," he explained. "For example, a group practice can allocate incident-to work relative value units under the Stark regulations, so allocating APC productivity under the physician's compensation model is clearly an option for group practices. Under direct employment models, a stipend approach based on personally performed supervision may provide a safer alternative."

States Drive Supervision Payments

States indirectly drive payments for supervision because it's often part and parcel of the scope of practice of APCs, Wolfe noted. For example, 46 states and the District of Columbia require supervision of PAs, and 26 states require physicians to cosign a certain percentage or number of PAs' charts. In Tennessee, supervising physicians have to review 20% of PAs' and NPs' charts, and in California, supervising physicians must cosign 5% of PAs' charts, Devine said.

"In states with a high level of supervision…obviously it will take more time and effort on the physician's part, and you should pay your physicians more because [supervision] is required by state law," she noted.

All of these supervision obligations create opportunities or obligations—depending on how you look at it—for hospitals to pay physicians for supervision, while upping the risk of Stark violations and the urgency of ensuring fair-market value and commercial reasonableness in their compensation.

There's some breathing room for supervision payments under the Stark Law and Anti-Kickback Statute. The kickback law has a safe harbor that protects employer payments to employees, as long as they're fair-market value, Wolfe said. There are Stark Law complications with hospital payments to physicians, even if they're employed, that are connected to APCs.

Supervision payments under Stark still have to satisfy what he called the "three tenets of defensibility": they are consistent with fair-market value "as supported by the physician's quantity and intensity of work effort"; they are commercially reasonable (i.e., supervision payments make sense even if the physician doesn't refer patients to the hospital); and compensation doesn't take into account the volume or value of the physician's referrals.

Wolfe and Devine recommend stipends in particular partly because Phase II of the Stark regulations gave them a green light. "We see nothing in the exception that would bar flat-fee compensation based on the

Report on Medicare Compliance (ISSN: 1094-3307) is published 45 times a year by the Health Care Compliance Association, 6500 Barrie Road, Suite 250, Minneapolis, MN 55435. 888.580.8373, hcca-info.org.

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number of mid-level providers under the physician's supervision, as long as the compensation is fair-market value for actual time dedicated to supervision services and is not determined in any manner that takes into account, directly or indirectly, the volume or value of DHS referrals generated by the physician," CMS said in the Stark II rule.

But hospitals still have to come up with a payment that will pass muster under Stark. Devine thinks they can rule out two of the classic valuation methods. The income approach, which looks at cash flow or income-generating ability, doesn't really apply to supervision, she said. "Is it a stretch to tie the value of supervision to the APCs' billing? It's not clean. It doesn't really reflect the value of those services."

Cost Approach Can Be Customized

The market approach is popular with appraisers because there's a lot of data about what physicians get paid generally. But it barely exists for physicians supervising APCs, Devine said. "You can't open a compensation survey for physicians and find out what comparable organizations pay for supervision," she said. "The market approach is something we'd like to use, but it's not that dependable because it's not at the state or specialty level."

For APC supervision, she recommends the cost approach. Appraisers break down the components related to supervision, list the major duties of the supervising physician and estimate the number of hours required to perform them (see box, p. 5). A fair-market hourly rate for the physician's services is then applied to the estimated hours, she said. The result is an indication of the fair-market value of the physician's services. The cost approach can be customized for the APC's specialty; the setting where services are provided; state, payer and employer requirements; the provider's experience, training and need for supervision; and the APC's productivity. Sometimes appraisers use market data to determine the physician's hourly rate. "It's a little bit of a hybrid of cost and market [approaches]," Devine said.

If physicians supervise more than one APC, they are often paid the stipend times the number of APCs supervised. "A cost approach is a good way to determine how much those stipends should be."

Contact Devine at ddevine@buckheadfmv.com and Wolfe at jwolfe@hallrender.com. ✧

CMS Transmittals and *Federal Register* Regulations April 20–26

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

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2018 Update, Trans. 4025 (April 20, 2018)

Federal Register

Proposed Regulation

- Medicare Program; Extension of the Payment Adjustment for Low-Volume Hospitals and the Medicare-Dependent Hospital (MDH) Program Under the Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals for Fiscal Year 2018, 83 Fed. Reg. 18301 (April 26, 2018)

More Hospitals Address Overlapping Surgery, an Area Under Pressure

Possibly the fastest policy ever written at UNC Health Care was its policy on overlapping surgeries. After the American College of Surgeons (ACS) put out its 2016 Statement of Principles on overlapping surgeries and the Senate Finance Committee chimed in, and with a number of enforcement actions in this area, UNC rolled up its sleeves and got the job done. Until then, it was far from the only academic medical center (AMC) that didn't have a policy on overlapping surgeries—which are subject to Medicare billing requirements—and the time had come.

"Based on the ACS guidelines and Senate Finance Committee, we wanted to get ahead of the game and have a policy in place before an audit," says Robin Shuping, director of professional compliance at UNC, which is in Chapel Hill, North Carolina. The compliance team was concerned that the HHS Office of Inspector General would add overlapping surgeries to its Work Plan or CMS would increase scrutiny in light of a Senate Finance Committee investigation. And there was sensitivity about patient-safety implications. "In the end, we were able to accomplish incorporating both ACS recommendations and Medicare requirements" on overlapping surgeries, she says.

The audits haven't come to pass yet, but overlapping surgeries are a risk area under the False Claims Act, and hospitals are adopting or upgrading their policies *(RMC 10/3/16, p. 1)*, says attorney Sara Kay Wheeler with King & Spalding in Atlanta, Georgia. "There's a tension between physicians wanting to practice freely, and having to comply with Medicare and documentation standards and industry standards," she notes. "We think the most effective changes have occurred when multiple stakeholders are at the table."

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Overlapping surgeries are just what they sound like—two surgeries performed almost at the same time. In the teaching context, Medicare allows surgeons to bill for two overlapping surgeries if the "critical or key portions" don't take place simultaneously. "When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure," according to Chap. 12 of the Medicare Claims Processing Manual. "The teaching surgeon must personally document in the medical record that he/she was physically present during the critical or key portion(s) of both procedures. When a teaching physician is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, he/she must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise." Overlapping surgeries are different from concurrent surgeries, which are "procedures in which a surgeon is involved in two operations—both of which are in the critical stages simultaneously," ACS states. The ACS guidance on overlapping surgeries is similar to Medicare's.

Vanderbilt Settled FCA Case

That's the bulk of Medicare policy on overlapping surgeries, which have come under a microscope. After an Oct. 26, 2016, newspaper article on overlapping surgeries in the *Boston Globe*, the Senate Finance Committee began a broad inquiry, and in December 2016 published a report sounding the alarm about patient safety and improper payments. The Senate Finance Committee called on CMS and OIG to increase their oversight of overlapping surgeries, and encouraged hospitals to "develop overlapping surgical policies that require surgeons to inform patients sufficiently in advance that the surgery will be an overlapping one" and take other actions.

Meanwhile, the enforcement machinery grinds on. In July 2017, Vanderbilt University Medical Center in Nashville, Tennessee, agreed to pay $6.5 million to resolve allegations that it billed Medicare, Medicaid and TRICARE for services performed in the operating room and intensive care unit by attending physicians when they were actually performed by unsupervised residents and for "overlapping surgeries where the surgeons were not immediately available to respond to emergencies."

There have been other settlements where overlapping surgeries were a factor. For example, University of Pittsburgh Medical Center; University of Pittsburgh Physicians; UPMC Community Medicine, Inc.; and Tri-State Neurosurgical Associates-UPMC, Inc. agreed to pay $2.52 million in 2015 to settle false claims allegations that partly involved overlapping surgeries. And Medical College of Wisconsin agreed to pay $840,000 in 2015 to settle false claims allegations that two of its teaching physicians charged Medicare for performing more than one neurosurgery at the same time *(RMC 1/19/15, p. 1)*.

Pending cases are more of a mixed bag. A false claims lawsuit against Massachusetts General Hospital is probably dead now that it was dismissed because the court ruled March 30 that the whistleblower didn't plead fraud with "particularity," as required by the rules of procedure, although she has a small window to try again, says attorney Lauren Gennett, with King & Spalding. It's unclear, however, how the whistleblower, Lisa Wollman, M.D., could satisfy the court, because she has acknowledged that she doesn't have access to billing records and specific claim information, Gennett says.

"This holding is helpful for providers who may be facing scrutiny in this renewed era of enforcement of overlapping surgeries," she says. "At this time, courts vary somewhat in their approaches to False Claims Act pleading standards, so other jurisdictions could come down differently."

Mass General Case Is Probably Over

Wollman, a former Mass General anesthesiologist who provided anesthesia for inpatient surgeries, alleged the hospital violated Medicare billing rules on overlapping surgeries, anesthesia and informed consent. "She witnessed the department's practice of scheduling overlapping surgeries that required the participation of residents and fellows outside of the presence of a teaching physician, but she never observed a double-booked surgeon designate another teaching physician to be immediately available while he or she was involved in an ongoing procedure," the court decision stated. In some cases, patients allegedly were kept under anesthesia for an excessive amount of time, waiting for the surgeon to arrive, and in one case, the surgeon never showed for one of the procedures.

The complaint listed the date, surgeon, scheduled start time, location, duration, and surgery type for more than 20 sets of overlapping surgeries that were performed from July 2011 to March 2013.

As the decision explained, whistleblowers are required to plead false claims allegations "with plausibility and particularity under Federal Rules of Civil Procedure 8 and 9(b)." That's been interpreted to mean they must provide details about claims submitted to the government for payment. Wollman failed to do that, according to the court. Although she had all kinds of details about Mass General's overlapping surgeries, "plausibly suggesting that the overlapping surgery

Using the Cost Approach to Price the Services of Physician Supervision

With the use of nonphysician practitioners (NPPs) and payments to physicians for supervising them growing in tandem, hospitals need a defensible method for valuing their payments (see story, p. 1), said Darcy Devine, president of Buckhead FMV in Atlanta, Georgia. She prefers the cost approach over the market approach because there's not enough specific information in surveys about physicians who supervise NPPs at the state or specialty level, and the income approach doesn't really fit with this kind of payment. Here's her example of the cost approach for physician supervision of NPPs. Contact Devine at ddevine@buckheadfmv.com.

Cost Approach Example

Physician Supervisor Duties and Responsibilities:

◆ **Determining the Appropriate Level of Supervision:** Often a written document is produced that outlines the drugs, devices, medical treatment, tests and procedures that may be prescribed, ordered, and performed by the APC along with a list of procedures for emergency situations.

◆ **Communicating and Consulting with the APC:** The supervisory physician meets periodically with the PA or NP, provides telephone and in-person consultations, and is available for emergency situations.

◆ **Providing Oversight and Reviewing Quality of Care:** The supervisory physician will review and cosign (when necessary) the APC's chart notes and orders, monitor performance to ensure protocols and procedures are being met, and evaluate APC competency.

Applying a Cost Approach

Itemize the physician's duties and responsibilities under the supervision arrangement and estimate the time requirements. Apply an FMV hourly rate to the annual time estimates.

Duties	Hours Per Year	FMV Hourly Rate	Annual Stipend
Review and update supervisory agreement	4	$125	$500
Monthly in-person meeting with NP	12	$125	$1,500
Telephone consultations (10 per month, 15 minutes @)	30	$125	$3,750
Chart review (10% of all charts = 276 chart reviews, 10 minutes @)	46	$125	$5,750
Annual evaluation and feedback sessions with management	4	$125	$500
	96		**$12,000**

The aggregate amount is an indication of the FMV for the supervisory services.

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rules were violated in some instances," Wollman's complaint doesn't address the "actual submission of claims; no dates, identification numbers, amounts, services, individuals involved, or length of time are provided for a single claim on any overlapping surgery," the court decision explains.

As a result, the complaint "falls short of the particularity standard," the court said, and dismissed it. Because it appears unlikely Wollman could get her hands on claims in the 45 days she has to refile, Gennett says, her guess is the case ends here.

Meanwhile, on April 23, another false claims lawsuit that deals with teaching surgeries was partially dismissed. A resident turned whistleblower, Luay D. F. Ailabouni, M.D., filed a lawsuit against Advocate Health and Hospitals Corp. in Illinois, alleging that some surgeons billed Medicare for assistant surgeons even when residents were available. "Medicare and Medicaid reimbursement is not allowed when the resident performs the duties of an assistant surgeon" because "the salary and expenses of residents in teaching hospitals are reimbursed directly" through direct graduate medical education and indirect medical education payments, the complaint alleged.

When residents are unavailable, surgeons may use assistant surgeons and physician extenders and bill separately for their services with modifier 82. But that allegedly wasn't always the case; the whistleblower contends he was often "present and qualified to assist." The Department of Justice declined to intervene in the Advocate complaint.

The U.S. District Court for the Northern District of Illinois let the case stand against an Advocate hospital, but dismissed the allegations against Advocate Medical Group and one of its physicians, Gennett says. In contrast to the Mass General decision, the court "found no basis to require that the relator 'plead more facts pertaining to the billing process,'" she notes. "The bottom line appears to be that certain courts may give relators more flexibility with pleading the submission of false claims in the teaching and overlapping surgery context than others."

How UNC Approached Its Policy

Policy development is something to consider because of all the activity in this area. At UNC Health Care, the compliance committee and legal department joined forces to develop the policy with "great thought and input" from the UNC Medical Center's Committee of Perioperative Leaders, a multidisciplinary team of surgery leaders, Shuping says. They had insight about what's compliant with Medicare teaching physician guidelines, patient safety and best practices.

In developing the policy, the compliance team was determined to come up with something that incorporated the spirit of the ACS Statement of Principles and Medicare rules and also "could be operationalized," Shuping says. They defined the terms—key and critical portions, immediately available, primary attending surgeon, backup surgeon, and informed consent—and hashed over their implications.

For example, the compliance team and surgical leaders deconstructed three hypothetical cases to better understand when the critical and key portion begins and ends and when a backup surgeon would be needed for an overlapping surgery. They didn't want to put something on paper that would be divorced from surgical reality, she says.

Informed consent is a biggie. "We discussed the need to be transparent with the patient during the informed consent process," Shuping says. "The patient or caregiver should be made aware of the roles of each member of the surgical team, and if there was a change in the primary attending, this should be communicated to the patient or caregiver prior to surgery."

Now that UNC's overlapping-surgeries policy is in place, the next step is to audit compliance with the policy. "I would pull out the policy and try to identify start and stop times and see whether we had documentation as required in the policy," Shuping says, as well as informed consents that discuss surgical team members.

Contact Gennett at lgennett@kslaw.com, Wheeler at skwheeler@kslaw.com and Shuping at robin.shuping@unchealth.unc.edu. View the Senate Finance Committee report at https://tinyurl.com/yb4p9v9a. ✧

IPPS Proposal Addresses Orders

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On its face it sounds great, but without corresponding changes to subregulatory guidance on orders, this may be sound and fury signifying nothing, says Edward Hu, president of the American College of Physician Advisors. "I'm not sure this alone changes a lot," he says. "It's a good first step, but it opens a lot more questions that CMS has to clarify." CMS elaborated on its expectations for orders and certifications in Sept. 5, 2013, and Jan. 30, 2014, subregulatory guidance on the two-midnight rule, and they stand. For example, the latter guidance states that "if the physician or other practitioner responsible for countersigning an initial order or verbal order does not agree that inpatient admission was appropriate or valid (including an

unauthorized verbal order), he or she should not countersign the order and the beneficiary is not considered to be an inpatient."

In this circumstance, Hu wonders what hospitals should do if the proposal takes effect. "Removing orders as a condition of payment opens the door for claims to be paid despite not meeting the full letter of the regulation. It could become a deficiency to be corrected," Hu says. "But that doesn't give hospitals the green light for claims to be submitted for Part A payment that aren't authenticated before discharge absent further clarification from CMS of subregulatory guidance."

Claims Were Denied for Signature 'Issues'

CMS changed its tune on orders because of a chain of events that began with the two-midnight rule, according to the proposed IPPS regulation. For the first time, the 2014 regulation made a written inpatient admission order a condition of Part A payment. Because of the audits that followed, hospitals were vulnerable to claim denials for failure to have admission orders.

There was an out—CMS told Medicare administrative contractors (MACs) they had the discretion to put the claim through "in the extremely rare circumstance the order to admit is missing or defective, yet the intent, decision, and recommendation of the ordering physician or other qualified practitioner to admit the beneficiary as an inpatient can clearly be derived from the medical record."

Although MACs could give hospitals a pass, CMS said "it has come to our attention that some otherwise medically necessary inpatient admissions are being denied payment due to technical discrepancies with the documentation of inpatient admission orders." They include missing admission signatures and signatures added after discharge, and sometimes that's the "primary reason" claims are denied.

That's not how CMS wants things; medical reviews should largely focus on whether inpatient admissions are medically necessary rather than "occasional inadvertent signature documentation issues unrelated to the medical necessity of the inpatient stay," according to the proposed rule.

While CMS would cut ties between admission orders and Medicare conditions of payment, the regulation reiterates that "this proposal does not change the requirement that an individual is considered an inpatient if formally admitted as an inpatient under an order for inpatient admission." That limits the benefits of the proposal because hospitals don't submit claims based on whether they will pass muster with auditors, Hu notes. The litmus test is whether they are compliant with Medicare policies on the front end, although it's marginally helpful to avoid denials when claims slip through without orders.

It's also unclear whether CMS plans to treat inpatient admission orders like any other verbal order, subject to countersignature within time frames determined by state law or hospital bylaws. "If so, that guidance will be needed straight from CMS, because currently the guidance is that the order must be countersigned prior to discharge in order to be a valid inpatient order, regardless of whether the inpatient order is a condition of payment," says Hu, system executive director for physician advisor services at UNC Health Care in Chapel Hill, North Carolina.

This Is a Backup Plan

The impact of the proposed would be felt in prevention of claim denials. "It would be huge" if finalized, says Laura Shawhughes, MD, physician advisor to utilization review, care management, and CDI at Kent Hospital in Warwick, Rhode Island. "It would reduce the administrative burden." Sometimes orders fall through the cracks—residents sign them, but they aren't cosigned by attending physicians for various reasons—and the proposed CMS change may prevent the hospital from losing Part A reimbursement as a result, Shawhughes says.

Kent Hospital recently put a hard stop in its electronic medical records (EMRs) system to prevent patient discharges until the attending physician signs the chart or cosigns the chart if the resident treated the patient. That ensures compliance with the admission order requirement in an ideal world, but then there's this world, because EMRs "aren't a perfect fix." If something goes wrong, the hospital may have to eat the cost of a 25-day stay, for example. "We are spending a lot of time and resources getting people to comply," Shawhughes says.

But CMS has come up with a proposal that gives the hospital some room for error. They could still receive Part A reimbursement when orders are deficient, as long as medical reviewers determine the overall medical record supports the admission, she said. "Most times we get it right, but we don't want to miss reimbursement" if something goes wrong, she notes.

CMS Makes Minor Change on Certifications

Also in the proposed regulation, CMS would give certain types of hospitals a small break on their documentation of certifications. Hospitals that are required to certify the medical necessity of inpatient stays—acute-care hospitals by the 20th day of the stay, inpatient psychiatric facilities and inpatient rehabilitation facilities (IRFs)—wouldn't have to include a table of contents that directs auditors to the elements of the certification.

"As part of our ongoing initiative to identify Medicare regulations that are unnecessary, obsolete, or excessively burdensome on health care providers and suppliers—and thereby free up resources that could be used to improve or enhance patient care—we have been made aware that the provisions of § 424.11(c) which state that it will suffice for the statement to indicate where the information is to be found may be resulting in unnecessary denials of Medicare claims," CMS stated.

"As currently worded, this last sentence of § 424.11(c) can result in a claim being denied merely because the physician statement technically fails to identify a specific location in the file for the supporting information, even when that information nevertheless may be readily apparent to the reviewer. We believe that continuing to require the location to be specified in this situation is unnecessary."

The next question, Hu says, is whether CMS will tackle more substantive documentation burdens. IRFs, for example, must follow exacting coverage guidelines that require them to complete medical-necessity documentation, including preadmission screening and post-admission physician evaluations, at certain intervals *(RMC 9/25/17, p. 1)*.

CMS is accepting comments on the proposed regulation until June 25.

Contact Hu at edward.hu@unchealth.unc.edu and Shawhughes at lshawhughes@kentri.org. View the proposed rule at https://tinyurl.com/y98pxxqv. ✧

NEWS BRIEFS

◆ **Gainesville Hospital District, which does business as North Texas Medical Center, agreed to pay $1.32 million to resolve allegations over its payments to a physician, the U.S. Attorney's Office for the Eastern District of Texas said April 24.** The settlement stems from remuneration the hospital paid Dr. Ramin Roufeh that was above fair-market value, not commercially reasonable, and/or not properly memorialized in writing, the U.S. attorney's office alleged. "At least one purpose of the remuneration provided by North Texas Medical Center to Dr. Roufeh was to induce the referral of federal health care program patients and that the remuneration induced such referrals in violation of the federal Anti-Kickback Statute," according to the U.S. attorney's office. North Texas Medical Center disclosed its alleged problems first to the HHS Office of Inspector General and then to the U.S. attorney's office, which set in motion the events leading to the settlement. Visit https://tinyurl.com/ycvsxkw8.

◆ **Hospitals would be required to post their prices online under a provision in the proposed inpatient prospective payment system (IPPS) regulation, unveiled April 24.** "Under current law, hospitals are required to establish and make public a list of their standard charges. In an effort to encourage price transparency by improving public accessibility of charge information, CMS is updating its guidelines to specifically require hospitals to make public a list of their standard charges via the Internet," CMS said. View the proposed rule at https://tinyurl.com/y98pxxqv.

◆ **The owner of an Ohio home health agency was sentenced to 36 months in prison for committing health care fraud and willful failure "to pay over tax," the U.S. Attorney's Office for the Southern District of Ohio said April 26.** Cheryl McGrath, who owned and operated Home Health Care of Southeast Ohio in Guysville since 1993, billed Ohio Medicaid for home health nursing services that were never provided between 2009 and 2015. "The defendant routinely changed the claim information in the billing software to falsely reflect that additional hours of nursing services had been provided and falsely increased the number of nursing visits from one visit per week to between three and five visits per week," the U.S. attorney's office said. The fraud totaled $2.2 million, according to the U.S. attorney's office, which said McGrath pleaded guilty to health care and tax fraud in June 2017. Visit https://tinyurl.com/y9sry27p.

◆ **The University of Virginia Health System is warning nearly 2,000 patients that their private health information may have been viewed by an unauthorized third party on a UVA physician's laptop computer and other devices between May 2015 and December 2016.** The doctor's devices were infected with malware that gave the third party access to what the physician was reviewing. The FBI has arrested the hacker. Get more details at https://bit.ly/2Ja0qjl.

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