

# MEDICARE COMPLIANCE

Weekly News and Analysis on New Enforcement Initiatives and Billing/Documentation Strategies

## Contents

- 3** CMS Gives 'Mixed Signals' in New Physician Supervision Guidance
- 5** Device Maker, Two Hospitals Pay Nearly \$4 Million in Fraud Case
- 8** News Briefs

## ED Is Ground Zero for Medical Necessity Documentation; Docs Must Connect Dots

To typical emergency department (ED) physicians, it may seem obvious that a patient who's not responding to anti-nausea drugs needs to be admitted. But often they document only "not responding to anti-emetics" in the medical record, when they also need to write "intractable vomiting."

Medicare auditors don't take anything for granted, so whatever rationale ED physicians have should appear in the chart if hospitals expect an inpatient stay to be deemed medically necessary. Intractable vomiting despite the administration of anti-emetics warrants an inpatient admission, according to Milliman, a screening tool used by many hospitals, recovery audit contractors and Medicare medical reviewers. But ED physicians need to connect the dots between anti-emetics and vomiting, since auditors won't do it for them.

This kind of documentation disconnect is not uncommon in the emergency department. Though the ED is ground zero for most patients, physician documentation there has gotten less attention in the quest to improve documentation for medical necessity and quality of care. "It's becoming clear this whole medical-necessity thing starts in the emergency department," says Justin Chang, M.D., medical director of Exempla St. Joseph Hospital in Denver and chief of emergency services for Kaiser Permanente Colorado. "When Medicare audits charts, they go all the way back to the beginning of the hospital encounter, which is the ED. What happens there is part of the whole spectrum of the acuity level, so it's hard to justify a status that's radically different from what the ED chart reflected." As CMS states in its Medicare Benefit Policy Manual, "All practitioners involved with and responsible for the patient's care are expected to have knowledge of the patient's hospital course, medical plan of care, condition, and current status."

*continued on p. 6*

## Judge Grants Feds Second False-Claims Shot at South Carolina Health System

Tuomey Healthcare System had only two months to savor its False Claims Act victory over the Department of Justice before the federal judge who presided over the landmark trial said he would grant the government a second bite at the false-claims apple.

Not only will Tuomey have to repay CMS almost \$45 million because a jury declared on March 29 that some of its physician employment deals violated the Stark self-referral law (*RMC 04/12/10, p. 3*), but the South Carolina health system will again have to face the government over allegations that the Stark violations caused the submission of false Medicare claims.

Senior U.S. District Judge Matthew Perry Jr. on June 4 granted DOJ a new trial on the false claims allegations against Sumter-based Tuomey. The judge said he made a mistake in excluding certain evidence from the trial. The jury's Stark law findings stand,

**Managing Editor**  
Nina Youngstrom  
nyoungstrom@aispub.com

**Associate Editor**  
Eve Collins

**Executive Editor**  
Jill Brown

and Perry will require Tuomey to pay \$44.8 million in Medicare reimbursement that was collected in violation of the Stark law.

Pittsburgh attorney Dan Mulholland, who represents Tuomey, says “no orders have been formally entered by the court as of now. When and if such orders are entered, then Tuomey will determine what to do.” Motions filed by Mulholland object to the new trial but ask the judge to require the government to retry the entire case.

It was unusual the case ever went to trial because most hospitals settle false claims cases to avoid the risk of treble damages. The U.S. attorney’s office in Columbia, which tried the case, alleged that Tuomey’s part-time employment contracts with specialists were designed to lock in their patient referrals (*RMC 12/7/09, p. 1*). Compensation allegedly exceeded fair-market value and, therefore, violated the Stark law. As a result, the feds

alleged, hospital claims for services referred by these physicians were false claims.

The false claims lawsuit was initially filed by orthopedic surgeon Michael Drakeford, one of the physicians offered an employment contract. After consulting with two attorneys who raised Stark concerns, Drakeford refused to sign the contract, according to the false claims complaint. Eventually he became a whistleblower, and the U.S. attorney’s office ultimately took over the case.

According to the lawsuit, increased competition for outpatient surgery in Sumter County environs prompted Tuomey to offer employment agreements to 18 community physicians. Under the 10-year employment contracts, the physicians were required to perform all their outpatient procedures at Tuomey.

Two compensation models were offered, the lawsuit alleged. Both called for base salary plus bonuses based on either the dollar value of the receipts that Tuomey received in connection with a physician’s services or the number of procedures performed by that physician.

The lawsuit alleged the gastroenterologists were paid a base salary of \$120,000. To earn that salary, they had to perform at least 615 covered outpatient procedures during the previous year. If they didn’t, their base salaries drop to \$60,000. However, Tuomey also pays the gastroenterologists 80% of their cash collections as a productivity bonus and another 5.4% as a quality incentive.

### MD Pay Was Allegedly 131% of Earnings

The base salary that Tuomey paid the surgeons, obstetrician-gynecologists and the lone ophthalmologist was based on the cash collections they generated for their respective Tuomey specialty group during the previous year for covered outpatient services.

“Tuomey represented to the physicians that the bonuses would result in, on average, the physicians receiving approximately 131% of the actual amount of payments received in connection with the physicians’ services,” the complaint states. That compensation exceeded fair-market value and was not commercially reasonable, as Stark requires, the government alleged.

Tuomey adamantly denied its contracts were problematic and had one law firm opinion to back it up. After a three-week trial, the jury announced a split verdict: The hospital violated the Stark law but not the False Claims Act. The two sides then began to argue over whether the jury’s decision meant the hospital had to repay the \$44.8 million the government alleged the hospital collected for services stemming from referrals by physicians who had the employment agreements that violated Stark.

The legal landscape may be different during the second trial. The judge agreed with Assistant U.S. Attorney Norm Acker, who is litigating the Tuomey matter, that it

**Report on Medicare Compliance** (ISSN: 1089-6872) is published 45 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

Copyright © 2010 by Atlantic Information Services, Inc. All rights reserved. No part of this publication may be reproduced or transmitted by any means, electronic or mechanical, including photocopy, FAX or electronic delivery without the prior written permission of the publisher.

**Report on Medicare Compliance** is published with the understanding that the publisher is not engaged in rendering legal, accounting or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought.

Managing Editor, Nina Youngstrom; Associate Editor, Eve Collins; Executive Editor, Jill Brown; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Gwen Arnold; Production Coordinator, Darren Jensen.

Call Nina Youngstrom at 800-521-4323 with story ideas for future issues. Subscriptions to *RMC* include free e-mail delivery in addition to the print copy. To sign up, call AIS at 800-521-4323. E-mail recipients should whitelist [aisalert@aispub.com](mailto:aisalert@aispub.com) to ensure delivery.

#### To order **Report on Medicare Compliance**:

- (1) Call 1-800-521-4323 (major credit cards accepted), or
- (2) Order online at [www.AISHealth.com](http://www.AISHealth.com), or
- (3) Staple your business card to this form and mail it to:  
AIS, 1100 17th St., NW, Suite 300, Wash., DC 20036.

Introductory Discount Price:

Payment Enclosed\*  \$468

Bill Me  \$498

\*Make checks payable to Atlantic Information Services, Inc. D.C. residents add 6% sales tax.

**Subscribers to *RMC* are eligible to receive up to 12 Continuing Education Credits per year, which count toward certification by the Compliance Certification Board. For more information, contact CCB at 888-580-8373.**

Call 800-521-4323 (or visit the Marketplace at [www.AISHealth.com](http://www.AISHealth.com)) to order **Report on Medicare Compliance on CD**, a searchable CD with all issues of the newsletter published from January 2007 through December 2008. (\$89 for subscribers; \$389 for non-subscribers.)

was a mistake to exclude a deposition given by Tuomey Chief Operating Officer-Senior Vice President Gregg Martin, according to a lawyer with inside knowledge of the case. In the deposition, Martin was asked how much he knew about an independent opinion on the employment deals. The formal opinion came from Kevin McAnaney, former chief of the HHS Office of Inspector General's industry guidance branch. McAnaney had expressed Stark compliance concerns to both Tuomey and Drakeford, who jointly requested the advice. "When Mr. Martin was asked in his deposition how much detail Mr. Hewson [Tuomey's lawyer] had told him about the conference call with Mr. McAnaney, he said that there had been 'a good bit of discussion,'" according to the government's motion. "This portion of the deposition would have been crucial to show the jury" that Hewson and Martin "knew about these warnings, and yet failed to heed them or even explore them further with Mr. McAnaney."

At the hearing, Cam Lewis, an attorney for Tuomey, argued to the judge that "Mr. Martin's testimony is...a little cumulative and...makes no difference," according to a transcript. And in a motion, Mulholland said that "unfortunately, the government mischaracterized the contents of the deposition designation."

But the judge, who had barred Martin's deposition as hearsay for technical reasons, will allow the evidence the second time around.

### **Knowledge and Intent Are Key**

The excluded evidence may be a game-changer because it gets at whether Tuomey knew it was violating the Stark law when it submitted Medicare claims for services, says Macon, Ga., attorney Alan Rumph.

"The issue of whether the False Claims Act was violated comes down to the hospital's knowledge and intent," says Rumph, with Smith, Hawkins, Hollingsworth & Reeves. "For false claims liability, you have to have known that the claim was false or fraudulent. In addition to actual knowledge, 'knowing' under the FCA includes reckless disregard for truth or falsity of the claim. It's a standard that requires presumably more than ordinary negligence but certainly less than actual knowledge." He says the government doesn't have to prove Tuomey actually knew it was filing claims in violation of Stark; just that it recklessly disregarded whether Stark was violated.

If the government gets a false claims settlement or victory at trial, the whistleblower will get a piece of the action. That hasn't been the case so far because the jury found the hospital to be liable only for Stark violations and there is no whistleblower reward in the Stark law.

Contact Rumph at alan@shrlaw.com. ✦

## **CMS Gives 'Mixed Signals' in New Physician Supervision Guidance**

CMS has again put its pen to paper on the outpatient supervision requirement, this time fleshing out its expectations for supervising physicians' competence and availability. In Medicare transmittal 128, which updates the outpatient prospective payment system (OPPS), CMS adds a fair amount of new language on the physician and nonphysician practitioner (NPP) supervision requirement.

Some lawyers think the transmittal contradicts April guidance posted on the CMS website, muddying the waters of a mandate already perceived as unreasonable.

"CMS is giving mixed signals," says Portland, Ore., attorney Bernie Thurber, with Davis Wright Tremaine. The physician supervision requirement "is like a giant pendulum swinging back and forth and CMS can't make up its mind."

The 2010 OPPS regulation, which took effect in January 2010, requires physician supervision of outpatient diagnostic and therapeutic services and allows NPPs to supervise outpatient therapeutic services. Outpatient therapeutic services require direct supervision, which means the physician must be on campus and immediately available the whole time services are provided. CMS has defined "immediately available" as meaning "without interval of time." Lawyers have interpreted this to mean supervising physicians can't be performing another procedure that can't be interrupted and shouldn't have to sprint to prevent harm from coming to the patient in need of intervention.

### **Three Levels of Supervision Exist**

There are three levels of supervision for outpatient diagnostic tests, according to the Medicare physician fee schedule: direct; general (which means the physician's presence is not required when services are performed); and personal (which means the physician has to be in the same room).

The straightforward part of the transmittal emphasizes the limits of NPP supervision. NPPs can supervise only outpatient therapeutic services. CMS states that "diagnostic X-ray and other diagnostic tests must be furnished under the appropriate level of supervision by a physician." While some types of NPPs may order and perform diagnostic tests without supervision, they can't supervise diagnostic tests when performed by other hospital staff, CMS asserts.

Then CMS takes a stab at explaining the meaning of "immediately available" for purposes of satisfying the direct supervision requirement for outpatient therapeutic services. "CMS has not specifically defined the

word ‘immediate’ in terms of time or distance; however, an example of a lack of immediate availability would be situations where the supervisory physician is performing another procedure or service that he or she could not interrupt. Also, for services furnished on-campus, the supervisory physician may not be so physically far away on-campus from the location where hospital outpatient services are being furnished that he or she could not intervene right away,” the transmittal says.

### CMS Sets Forth the Qualifications of Docs

CMS also addresses the qualifications of supervising physicians. He or she “must have, within his or her state scope of practice and hospital-granted privileges, the knowledge, skills, ability, and privileges to perform the service or procedure” the transmittal says. While certain specialized diagnostic testing equipment is operated by technicians — and CMS doesn’t necessarily expect supervising physicians to stand in for them — the supervising physician should be knowledgeable about the test and “clinically appropriate to furnish the test.”

Being a supervising physician involves “more than the capacity to respond to an emergency, and includes the ability to take over performance of a procedure” and perhaps alter its course, the transmittal states. But supervising physicians would not necessarily make these decisions without contacting the patient’s treating physician or NPP.

Thurber says the transmittal is a step backward for hospitals after it seemed like CMS was lightening up. First it announced a one-year moratorium on enforcement of the physician supervision rule at critical-access

hospitals. Then CMS published the answers to frequently asked questions (FAQs) in April.

In the FAQs, hospitals got the green light to let emergency department (ED) physicians double as supervising physicians for other outpatient services provided on campus (*RMC 5/24/10, p. 1*). CMS said that physicians can be “reasonably interrupted to furnish assistance and direction in the delivery of therapeutic services” under their supervision. CMS also stated that “most emergency physicians can appropriately supervise many services within the scope of their knowledge, skills, licensure and hospital-granted privileges.”

But “now CMS comes up with this [transmittal], which goes back to where they started,” Thurber says. The language in the transmittal hews to the language CMS used in the *Federal Register* when it first changed the rules of the physician supervision game, which stirred hospital anxiety and outrage. For example, Thurber says, contrary to the FAQs, the OPPTS final 2010 requirement states “we do not believe that allowing supervisors to be responsible for emergencies only would satisfy the standard ‘to furnish direction and assistance throughout the performance of the procedure.’”

### CMS ‘Lacks Understanding’ of Operations

The content of the transmittal also reflects CMS’s lack of understanding of hospital operations, Thurber says. When CMS asserts that physicians should supervise within the scope of their hospital-granted privileges, it’s ignoring the reality of medical-staff politics. “Most hospitals don’t just willy-nilly give doctors the credentials to do different procedures because they need someone to supervise. Specialists carefully guard the quality of their specialty,” Thurber says. For example, the process of changing medical staff bylaws to allow credentialing of ED docs to supervise other services would be difficult and “move at a glacial pace,” he says.

Thurber has doubts that hospitals are twisting themselves into a pretzel to comply with this rule, especially as clarifications continue to emerge. “Hospitals will do the best they can to meet CMS’s stated expectations but inevitably there will be some shortcomings,” he says.

Other lawyers don’t think the transmittal strays far from CMS’s other statements on physician supervision. Houston attorney Nancy LeGros notes the transmittal is consistent with its statements in the November OPPTS regulation’s preamble.

The transmittal is challenging because “CMS said what they wanted in broad strokes, but it is complex to implement for hospitals,” LeGros says. Hospitals have to adopt some kind of policy that cites the services physicians are supervising. One option is for hospitals to change their privileging forms, which address what

## Check Out Two Web-Based Compliance Services from AIS

✓ **High-Risk Areas in Medicare Billing**, which is packed with “how-to” compliance auditing tools for hospitals and providers that were prepared by experienced compliance consultants from Strategic Management Systems, Inc. See a demo at [www.MedicareRiskAreas.com](http://www.MedicareRiskAreas.com).

✓ **Report on Patient Privacy and AIS’s HIPAA Compliance Center** will help safeguard your patient privacy and data security. Subscriptions include a monthly print newsletter and access to a Web site — with narrative sections written by HIPAA experts in 30 areas of privacy and security compliance. Review samples at [www.AISHIPAA.com](http://www.AISHIPAA.com).

Visit the AIS MarketPlace at  
[www.AISHealth.com](http://www.AISHealth.com)

services physicians can perform, to also describe what services they can supervise, says LeGros, with King & Spalding. If a hospital is audited, it should be able to produce a roster or some other form of documentation that shows supervision was provided (e.g., Dr. Smith was responsible for supervising XYZ service on May 15, 2010), she says.

Contact Thurber at [berniethurber@dwt.com](mailto:berniethurber@dwt.com) and LeGros at [nlegros@kslaw.com](mailto:nlegros@kslaw.com). ✧

## Device Maker, Two Hospitals Pay Nearly \$4 Million in Fraud Case

A medical device company and two hospitals have settled a civil case with the federal government involving kickbacks that allegedly were disguised as rebates, the Department of Justice said June 4.

Medical device compliance is dangerous territory for hospitals. A total of 18 hospitals now have settled allegations that they performed a spinal procedure called kyphoplasty on an inpatient basis to leverage more reimbursement when the procedure could have been done in an outpatient setting (*RMC 5/24/10, p. 4*). The investigations began with a whistleblower suit filed by two former employees of a company that developed and marketed a kit used during the procedure.

In the new case, Minnesota-based St. Jude Medical, Inc., which makes cardiovascular medical products, including pacemakers and implantable cardioverter defibrillators, is at the heart of the new case.

The company allegedly paid kickbacks to the two hospitals to secure their heart-device business between April 2003 and September 2005, the feds say. The alleged kickbacks were in the form of rebates that were paid based on a facility's previous purchase of St. Jude's equipment, along with rebates the company paid for purchases of its competitors' devices, the feds explain. The kickbacks caused false claims to be submitted to federal health care programs, the government alleges.

St. Jude will pay \$3.725 million to settle the case. The company says in a statement that it does not admit liability or wrongdoing in the settlement. "The allegations centered on small, isolated product rebates that the company paid more than five years ago," it says. "The company entered into a settlement agreement in order to avoid the potential costs and risks associated with litigation."

Two hospitals also are settling with the government. Norton Healthcare in Louisville, Ky., will pay \$133,300, and Parma Community General Hospital (PCGH) in Parma, Ohio, will pay \$40,000. "The government asserted that Parma and Norton were recipients of improper rebates from St. Jude," DOJ said in a statement.

*continued*

### Hospital-Acquired Conditions: Effective Strategies for Reducing Their Occurrence

- How to identify potential obstacles when it comes to health plan and hospital interface issues, such as contracting and reporting. Learn why business strategies, such as "enterprise risk management," must be included.
- Which hospital errors to focus on in contracts...and which ones may be secondary.
- Which services associated with HACs health plans should pay for.
- How to examine HACs from a risk-avoidance perspective instead of a cost-savings perspective.
- Guidance on how often claims of what nature should be audited to uncover potential problems.
- What steps hospitals and health plans can take together to ensure that patients remain the top priority.
- What to look for in MD contracts and whether HAC language should be incorporated.

Join **Robert F. Bunting, Jr.** of WellPoint, Inc., and **Peggy Nakamura** of Adventist Health for a July 13 Webinar.

Visit [www.AISHealth.com](http://www.AISHealth.com) or call 800-521-4323

According to the agreement, St. Jude entered into contracts with the facilities and offered them membership in a Cardiology Savings Program (CSP) under which they could earn rebate credits for certain products they purchased. For example, in Norton's case, St. Jude agreed to give the facility a credit for each coronary stent it purchased from another company if Norton met a 40% market-share target for St. Jude pacemakers. The CSP covered other devices as well, including biventricular devices once they received FDA approval. "Under the CSP, [St. Jude] paid Norton the rebates, processed as account credits which Norton could use only to purchase SJM's biventricular devices," the document says.

### Deals Involved Product Discounts

In addition to the CSP, St. Jude also had a two-year contract with PCGH under which the facility could earn discounts on St. Jude products if it guaranteed to use set percentages of other St. Jude devices (e.g., 90% of mechanical heart valves in one year). "From the inception of the contract in April 2003 to April 2004, the point at which [St. Jude] obtained approval to sell its own biventricular devices, [St. Jude] paid the rebates to PCGH. The payments were processed as account credits," the feds say.

Norton says in a statement that it opted to resolve the issue with the feds rather than get into litigation. "Norton Healthcare has no other similar vendor arrangements and has now satisfactorily concluded this matter without acknowledging any inappropriate internal business practices," it says.

PCGH said in a statement that it "properly documented and reported the transactions of St. Jude's rebate program and believed it was in compliance with all federal regulations." PCGH said it also thought a settlement was a "better use of financial resources" than the costs of litigation.

### Whistleblower to Pocket Nearly \$1 Million

The settlements stem from a whistleblower lawsuit filed in September 2006 by Jerry Hudson, who was a regional sales manager for St. Jude's Northeast Ohio region from February 2004 through September 2005. He will receive \$640,050 as part of the settlement. St. Jude also will pay Hudson \$325,000 for attorney's fees and for settlement of Hudson's claims that he was wrongfully discharged.

Sean Lavin, one of the attorneys representing Hudson, says they are happy with the settlement. "Like any litigation, it is stressful on the parties and especially on Mr. Hudson. He was resolute. He knew that there was wrongdoing at St. Jude. We think he was proven correct," Lavin tells RMC. "At the time, St. Jude did not have a big market share and did what it could to gain more, and it took on these improper rebates," he contends.

Boston attorney Larry Vernaglia says there are several issues of note in this case. First, it should remind providers to look hard at terminated employees and carefully question them in exit interviews. Hudson "also alleges that he was retaliated against for bringing a compliance concern to their attention," Vernaglia says.

Also of interest is the area of discounts and rebates in the anti-kickback statute. "These are not the kind of brazen acts that you sometimes hear about in cases. ... There is an exception in the law, and it is pretty straightforward," says Vernaglia, with Foley and Lardner.

There also is a safe harbor for rebates in the anti-kickback statute, and it "is one of the more complicated morasses that people hate to wade into," continues Vernaglia. "They are extremely complicated based on what kind of provider you have and what discounts are available. I think the complaint was trying to show that [this example] didn't make the safe harbor," but that still didn't make them illegal, Vernaglia points out.

"The lack of really egregious facts probably explains why the settlement dollars are low here," he says. "A lot of people may argue that there was no wrongdoing at all."

Visit [www.justice.gov](http://www.justice.gov) and click on "Briefing Room." Contact Vernaglia at [lvernaglia@foley.com](mailto:lvernaglia@foley.com). ♦

## It's All Happenin' in the ED

*continued from p. 1*

Hospitals may continue to experience Medicare claims denials unless ED physicians improve documentation of their medical decision making, Chang says. ED physicians tend to focus on the tasks at hand (e.g., tests ordered, medications administered) rather than describing, for example, how sick patients are, the risks of discharging them, comorbidities (i.e., other medical conditions) that necessitate admission, and failed outpatient treatments. Like hospitalists and other admitting physicians, ED physicians should document not just what they did, but also what they are worried about, he says.

Establishing the medical necessity of the site of service is a hot topic in the Medicare compliance arena. Recovery audit contractors (RACs) are working their way toward postpayment medical necessity audits and when they get there, large recoupments are expected.

During the RAC demonstration project, RACs "often went back to what the ED doctors were thinking and often it was not enough documentation to support" short-stay admissions, says Jeff Wajda, M.D., vice president of compliance for Picis-owned LYNX Medical Systems, a medical-necessity software company.

Medicare administrative contractors (MACs) also have their sights set on site-of-service medical necessity,

and can audit hospitals' prepayment and postpayment. MACs on the west coast are data mining observation versus inpatient admissions, says Wajda, who is also an ED physician at Northwest Hospital and Medical Center in Seattle. At least one MAC is targeting hospitals with a high percentage of short inpatient stays compared to observation, he says, with an emphasis on short stays for diagnoses like chest pain, syncope and patients with altered mental status. And PEPPER (Program for Evaluating Payment Patterns Electronic Report), CMS's data mining tool for potential hospital overpayments and underpayments, is focusing on inpatient medical necessity for certain diagnoses, such as one-day stays for medical DRGs.

### **Patients May Be Sickest in ED**

The ED is often the place where medical necessity comes into focus. "Medical necessity should be judged at the time when the patients were sickest, which often is when they are in the ED," Chang notes. For example, an emphysema patient may present with air hunger, speaking in one or two word sentences and suffering from respiratory failure as defined by *Coding Clinic*, the American Hospital Assn.'s coding newsletter, Wajda says. After being "pounded with meds by paramedics and treated aggressively in the ED, the patient looks close to normal by the time he sees the admitting hospitalist," he says. "If you don't have ED documentation to capture how sick the patient is and you only have the hospitalist's notes, it doesn't do much for the hospital's case that there was medical necessity for an inpatient admission."

To reduce medical-necessity denials and improve quality of care through better ED physician documentation, Exempla St. Joseph Hospital enlisted Chang's help. Chang is encouraging ED physicians to put more emphasis on medical decision making — "not just what you did but why you did it."

### **Physician Judgment Is Not Questioned**

Chang repeatedly explains to physicians that he's not challenging their decision-making process; he's just asking them to document it. When an 89-year-old woman with chronic obstructive pulmonary disease (COPD) who is on two liters of oxygen presents at the ED for shortness of breath and the physician documents only that her oxygen saturation is 92% on six liters, that alone won't explain an admission. "But if you say this person is 92% on six liters but normally she wears two liters, now you have justified an admission," Chang says.

Chang also is adapting a Picis/LYNX software template to draw out ED physicians' medical decision making. "We are trying to capture more advanced documentation," he says. Among other things, the template elicits details from ED physicians on the patient's disposition and risk. For example:

◆ Continued abnormal vitals despite ED interventions (e.g., appropriate amount of IV fluid and oxygen administration).

◆ Outpatient treatment failed to improve the condition. Documentation of cellulitis on the foot may not require inpatient admission but continued cellulitis despite appropriate outpatient therapy will trigger an admission.

◆ Comorbidities, such as extreme age, cancer, severe COPD, and cellulitis in a diabetes patient. "You can't just give a problem list of 50 things. You have to mention the conditions you are worried about," Chang explains. Physicians might argue the comorbidities are already documented in the past medical history, but that won't satisfy auditors, Chang says. It's up to physicians to make clinical connections in the chart. For example, when a normally healthy 30-year-old is diagnosed with community-acquired pneumonia, the ED physician might prescribe an antibiotic and send him home. But if community-acquired pneumonia hits a 98-year-old with COPD who takes interferon for rheumatoid arthritis and therefore is immune-compromised, the ED physician may admit the patient and should document accordingly. "There's a risk of mortality so you don't go home for what is otherwise an outpatient illness," Chang says. "ED physicians implicitly understand the difference but we don't always document our decisions."

### **A New Ballgame for Docs**

The software template also prompts ED physicians to chart anticipated admission needs. That's a new ballgame for ED physicians, who haven't been asked to think beyond a patient's immediate needs, Chang says. So it helps demonstrate medical necessity when ED physicians document that the patient probably will require, upon admission, IV antibiotics, IV anticoagulants, nebulizer treatments, etc. ED physicians are also prompted to enter other information, including where the patient should be sent (e.g., ICU, telemetry), test results and the length of time until improvement is expected (e.g., 24, 36, 48 hours).

After ED physicians check off all the boxes in the software, it gives real-time feedback about whether they have justified an inpatient admission according to Exempla's admission policy. If not, the ED physicians can expand upon their documentation. "I am not asking them to make decisions differently and the government is not telling them who gets admitted," Chang says. "This is about learning new lingo because it's unfortunate when you don't get paid for services you provided."

Contact Chang at [Justin.c.chang@kp.org](mailto:Justin.c.chang@kp.org) and Wajda at [jeff\\_wajda@picis.com](mailto:jeff_wajda@picis.com). ♦

## NEWS BRIEFS

◆ **HHS and the Department of Justice have asked state attorneys general for help in a campaign to educate seniors and other beneficiaries about how to prevent Medicare fraud**, according to a June 8 letter to state officials. Other efforts to stem fraud include cutting the improper payment rate in half by 2012, having regional fraud prevention summits around the country, holding regular health care fraud task force meetings to coordinate anti-fraud efforts, and doubling the size of the Senior Medicare Patrol. The state officials also were given a heads-up that seniors in the Part D coverage gap will be receiving their \$250 refund checks and are facing identity theft and other scams. "The more we can educate the American people about fraud prevention, the better chance we have to protect taxpayer dollars and the Medicare trust fund," the letter says. "The Affordable Care Act also contains some important new tools and resources that will directly help law enforcement officials crack down on fraud." Visit [www.hhs.gov](http://www.hhs.gov) and click on "News."

◆ **A bill recently enacted by the Vermont state senate amends the state's vendor gift policy and includes transparency provisions applicable to drug and device makers.** The bill (S.B. 88) requires companies that produce drugs, medical devices and biological products to annually report to the state attorney general the amount of free samples they send to providers, according to an analysis of the bill by Epstein Becker Green (EBG). The first report is due by April 1, 2012, for the period of January-December 2011. S.B. 88 also clarifies some definitions, including that of "health care professional," which is described as someone "who regularly practices in this state," according to the analysis. EBG also notes that manufacturers will have reporting requirements as part of provisions of the new federal health care reform law. To read more, visit [www.ebglaw.com](http://www.ebglaw.com), click on "News & Publications," and click on "Client Alerts."

◆ **Cochlear Americas, a Colorado-based firm that makes cochlear implants, has agreed to pay \$880,000 to resolve civil allegations that it used a credit program and gifts to induce providers to buy cochlear implant systems**, DOJ said June 9. The feds allege that from Jan. 1, 2001, through March 1, 2004, Cochlear "paid remuneration to audiologists, surgeons, audiology clinics, and hospitals that purchased and/or ordered [the] cochlear implant products that were paid for by a federal health care program," in violation of the

False Claims Act, the agreement says. The agreement also resolves a civil monetary penalties investigation. According to the feds, the company offered a Cochlear Advantage Program, "which provided credits that could be used to purchase other [Cochlear] products," plus gifts, donations and sponsorships to providers. The settlement stems from a whistleblower suit filed by Brenda March, who was hired in 1997 as Cochlear Americas's vice president of finance. Cochlear Americas is a subsidiary of Australia-based Cochlear Limited. The parent company said in a statement that it disputes and denies the allegations in the case. But to avoid the uncertainty and expense of litigation, Cochlear decided to resolve the matter with the government. Visit [www.justice.gov](http://www.justice.gov) and click on "Briefing Room."

◆ **A proposed rule published in the May 26 Federal Register would ease the credentialing process for physicians providing telemedicine services at hospitals and critical access hospitals (CAHs).** Starting July 15, 2010, the Joint Commission will begin enforcing CMS requirements on privileging physicians and practitioners, including at the accredited hospitals that provide or receive telemedicine. Hospitals and CAHs with small staffs were concerned about the burden of privileging hundreds of specialty physicians and practitioners made available to them by large academic medical centers. Under the proposed rule, the facilities can rely on information from the hospital providing the telemedicine service. To read the rule, visit AIS's Government Resources at the Compliance Channel at [www.AISHealth.com](http://www.AISHealth.com), and click on "2010 Federal Register."

◆ **Wisconsin Physician Services (WPS) should recover nearly \$650,000 in overpayments it made to hospitals during calendar years 2004 through 2007 for a cancer drug**, OIG says in an audit report (A-05-09-00070) posted June 9. WPS, the Medicare carrier for Illinois, Michigan, Minnesota and Wisconsin, processed more than 130,000 claims for Neulasta injections. The inappropriate payments occurred because providers claimed excessive units of service. Although providers used the new HCPCS code (J2505), some still submitted claims for six units of service (instead of one unit), and carriers did not identify the error. OIG says WPS should recover the overpayments and improve internal controls for the injection of Neulasta. WPS agreed. visit AIS's Government Resources at the Compliance Channel at [www.AISHealth.com](http://www.AISHealth.com), and click on "OIG Audit Reports."

**IF YOU DON'T ALREADY SUBSCRIBE TO THE NEWSLETTER,  
HERE ARE THREE EASY WAYS TO SIGN UP:**

1. Return to any Web page that linked you to this issue
2. Go to the MarketPlace at [www.AISHealth.com](http://www.AISHealth.com) and click on “newsletters.”
3. Call Customer Service at 800-521-4323

**IF YOU ARE A SUBSCRIBER AND WANT TO  
ROUTINELY FORWARD THIS PDF EDITION OF  
THE NEWSLETTER TO OTHERS IN YOUR ORGANIZATION:**

Call Customer Service at **800-521-4323** to discuss AIS's very reasonable rates for your on-site distribution of each issue. (Please don't forward these PDF editions without prior authorization from AIS, since strict copyright restrictions apply.)