Flipping Coding Denials To Medical Necessity Complicates Appeals

Broader HIPAA Compliance Reviews Are Expected, Some Fines Required

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Medicare Contractor Downcodes Claims Because of Copy and Paste in EHRs

After years of warning about the risks of cloning and other electronic documentation shortcuts, Medicare administrative contractors (MACs) are starting to hit providers in this area. At least one MAC has downcoded an academic medical center’s claims for evaluation and management (E/M) services — which means it refused to pay at the level of service billed — because it appears that physicians copied and pasted notes from previous patient encounters.

Meanwhile, a top auditor from the HHS Office of Inspector General said on March 18 that Medicare reviewers will develop new techniques to ensure auditors can tell when providers change electronic health record (EHR) documentation.

The MAC’s downcoding of the academic medical center’s subsequent hospital visits reflects CMS escalating concern about cloning or copy/paste, which may undermine support for medical necessity and exaggerate the services billed. According to the MAC’s letter to the academic medical center, obtained by RMC, “documentation from prior visits was carried over, making it difficult to determine what was documented for each specific encounter. Copying information from prior visits and pasting it into the record for a current visit could carry forward information that is not accurate and not appropriate for the encounter.”

New Medicare Rebilling Policy Calls for Two Types of Part B Claims After Part A Denials

Under Medicare’s new rebilling policy, hospitals are instructed to submit two types of Part B claims to replace the medically unnecessary admission denied under Part A, a top CMS official says. Together, the Part B inpatient claim and the Part B outpatient claim will help compensate for the loss of Medicare reimbursement from a claims denial based on incorrect setting, assuming the services were reasonable and necessary in the first place, according to a new CMS ruling.

CMS on March 13 unveiled a landmark ruling and proposed regulation that allow Part B rebilling for Part A denials when claims for inpatient admissions are denied (RMC 3/18/13, p. 1). As the details of the intricate ruling and regulation are hashed over, the challenges of implementing them are coming to light.

“Hospitals submit outpatient claims for preadmission services and inpatient claims for post-admission services,” Marc Hartstein, director of the CMS Hospital and Ambulatory Policy Group, said March 21 in Baltimore at the Medicare and Medicaid Payment Institute sponsored by the American Health Lawyers Association (AHLA). Together, the two Part B claims will presumably capture all of the reasonable and necessary services provided by the hospital.
Part B inpatient services, an obscure category under Medicare, will now include coverage for post admission services, such as:

1. Services payable under the outpatient prospective payment system unless they require an outpatient order;
2. Ambulance services;
3. Prosthetic and orthotic devices;
4. Some lab work and durable medical equipment; and
5. Services provided incident to a physician’s professional services.

The Part B outpatient services that can now be billed under the ruling include observation provided before discharge, “largely goes away” under the proposed rule.

Although CMS created condition code 44 to allow hospitals to salvage some reimbursement when they realized they had admitted an inpatient without medical necessity for the setting, they have complained the process is “burdensome and difficult” because it requires physician and utilization review committee approval to convert the patient status before the patient is discharged. Under the ruling, hospitals are permitted to submit inpatient and outpatient Part B claims despite condition code 44. But unlike the ruling, the proposed rule imposes its own impossible deadline — a one-year timely claim-filing deadline, Polston said. If the regulation is finalized as is, hospitals won’t have time to rebill a lot of claims denials because the timely filing deadline is a year from the date of service and RAC audits generally come much later, says Polston, with King & Spalding in Washington, D.C.

Hartstein also noted that Medicare will give hospitals credit for the Part B inpatient services provided to patients who are headed for a skilled nursing facility. Beneficiaries qualify for SNF stays only if they spend three consecutive days in an acute-care facility.

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Flipping has its surreal moments. At a March 5 hearing with an administrative law judge (ALJ), Dailey came prepared to argue that a patient’s admission for a laminectomy and foraminotomy was medically necessary. But the two RAC representatives—a physician-attorney and a nurse—expected to advocate for their coding denial. The RAC had no idea that its coding denial was flipped, and the ALJ was unsure what to do, Dailey says. “There is a lack of communication,” she contends.

**Communications Are Not Always Effective**

The RAC had denied the claim in July 2011 on the grounds that secondary diagnoses of acute blood loss anemia and acute renal failure were not supported. WellSpan tried to change the RAC’s mind during the discussion period, and when that failed, WellSpan appealed to the MAC in November 2012. That’s when the infamous flipping occurred. All of a sudden the MS-DRG coding was moot, and the denial was about the medical necessity of the setting. Accordingly, WellSpan changed course with its QIC appeal in January 2012 but lost again, so the next step was the ALJ. Finally, the hearing came, and everyone scrambled.

The ALJ offered a compromise: Either he could postpone the hearing pending advice from CMS, or the two sides could argue both the coding and medical necessity issues. Dailey feared a delay would drag out the appeal another year or two—and it took 2 1/2 years to get the ALJ hearing—so she forged ahead with the RAC’s concurrence. “I was unprepared to defend the DRG, but I had the appeal the coders prepared for the discussion period and the MAC appeal, so I read that,” she says.

Another twist: Even though the RAC argued the coding case at the ALJ’s insistence, neither was familiar with Coding Clinic or whether it was approved by CMS, Dailey says. She recommends that all hospitals include standard language in their appeals explaining the role of the quarterly guidance and its CMS imprimatur. The American Hospital Association, which publishes Coding Clinic, says on its website that “coding advice [in Coding Clinic] is approved by CMS for Medicare reimbursement and accepted by many other health care plans, Medicaid programs and state data sets.”

There’s no word yet on the outcome of the strange hearing. The ALJ could agree the admission was medically necessary but downcode the MS-DRG or vice versa. “It’s just crazy,” Dailey says.

The rationale for flipping is the appeals contractors’ “de novo” authority, which means they can look at each claim anew, says attorney Andrew Wachler of Wachler & Associates in Royal Oak, Mich. “If you go from the Medicare Appeals Council to federal court, it is not de novo. They will only look at whether something is arbitrary or capricious or isn’t supported by facts,” he says. “But at the levels below, everyone looks at claims fresh. You don’t have to show the RAC is wrong or the QIC is wrong.” *De novo* is how flipping happens, Wachler says. “Therefore you have to support your coding and your medical necessity,” he says.

Flipping is another twist in the appeals doors that opened and closed with the CMS ruling and proposed regulation, which were announced March 13. The ruling and the regulation both allow hospitals to seek Part B payment when their Part A inpatient claims are denied for lack of medical necessity based on the setting. But the appeals picture is different. Under the ruling, which is now in effect, hospitals may appeal Part A admission denials and, if they lose, they have 180 days to refile the claims for Part B payments. The proposed regulation, which will supersede the ruling when finalized, does the same thing, but it imposed the one-year Medicare timely claims-filing deadline. This controversial provision requires hospitals to rebill Part B claims within a year of the date of service. Lawyers say it’s almost impossible for hospitals to pursue appeals of the Part A medical necessity denials and then seek Part B payment if they lose within a year. In essence, the proposed regulation requires hospitals to choose between appealing Part A medical necessity denials and collecting Part B payment, according to attorneys.

**Strong Cases Should Still Be Appealed**

In light of this landmark change in payment policy, hospitals should continue to appeal strong medical-necessity cases, lawyers say, but perhaps not the weaker ones in favor of seeking Part B payment. “If the hospital is confident that its Part A stay was justified, they should strongly consider sticking with the appeal. Dropping out just to rely on the ruling and get the Part B payments would be less than a Pyrrhic victory,” says Boston attorney Larry Vernaglia, with Foley & Lardner LLP. “On the other hand, if the appeal was a stretch, so there is a real litigation risk, I might take the Part B payments and go home.” Minneapolis attorney David Glaser, with Fredrikson & Byron, agrees. “If it’s a weak case, you may want to just take the outpatient payment. But for strong cases, my advice is fight,” he says.

In terms of flipping, hospitals should keep in mind that appeals are an invitation for contractors to look at all aspects of their documentation, another reason to consider seeking Part B inpatient instead. “One of the checklists of an appeal is to ask if there is any reason we don’t want someone looking at this chart,” he says. “Can they switch or identify another problem?” If that’s the case, maybe forget the appeal. “Under the new ruling, you can still bill Part B,” Glaser says.

continued
Dailey doubts that WellSpan will change its approach to appeals. If an admission was medically necessary, she will fight for it. Like other hospitals, it recovered Part B payments before the CMS ruling, which is what prompted it. At least the CMS ruling frees hospitals from having to appeal to get the Part B payment. “But it will be an increase in the burden for people in the coding and billing departments,” Dailey notes, because there will be a shift from ICD to CPT codes for some claims, which also can now include services that were once bundled because of the DRG window payment policy.

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Broader HIPAA Compliance Reviews Are Expected, Some Fines Required

When the HHS Office for Civil Rights takes an interest in hospitals, it may not be limited to a specific patient complaint or breach. In terms of enforcement, OCR officials have indicated they are focusing on overall privacy and security compliance by covered entities and business associates even if a narrow problem first got them on the OCR radar screen. That’s one of the patient privacy surprises to emerge recently, and more are expected as the industry adapts to the Jan. 25 omnibus rule that spelled out the HIPAA privacy and security provisions in the 2009 HITECH Act (RMC 1/28/13, p. 1).

“Any breach is an invitation for a back-door audit,” says Philadelphia attorney Brad Rostolsky, with Reed Smith. “If there is a complaint or a self-reported breach and it is of a nature that prompts them to investigate, they will not only ask questions about the breach, it will likely result in a broader compliance review.” If recent enforcement trends continue, breaches involving lost laptops or other mobile devices with unencrypted PHI will probably lead to a settlement, Rostolsky says. OCR is expected to release guidance on breach notification in April to help covered entities and business associates appreciate the nuances of the omnibus rule, which requires them to report all breaches unless they are deemed inconsequential according to a new four-part test set forth by HHS.

Although business associates are technically on the same HIPAA compliance hook as covered entities, OCR seems focused on holding the covered entities responsible when their vendors who have not signed business associate agreements impermissibly disclose PHI, Rostolsky says. For example, “if there is a cloud provider that would be a business associate because it’s storing PHI but there is no business associate agreement, the covered entity’s infraction appears to be the primary concern of OCR,” he says. “It’s not clear whether this will remain their focus indefinitely, but covered entities should remain diligent in abiding by the requirement to have vendors who use, maintain, or create PHI sign business associate agreements.”

In light of this evolution, he recommends that covered entities and business associates embrace their com-

Designing a Mobile Device HIPAA Plan:
Risk Analysis, Policies and Procedures for Mitigating Today’s Top Privacy/Security Risk

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➢ What steps should you take to complete an effective mobile device risk analysis? (A checklist of action items will be provided to attendees.)

➢ What options exist for restricting or securely managing workplace use of laptops, tablets and smartphones? What are the pros and cons of each?

➢ What policies and procedures should be considered for implementing the different options for restricting mobile devices? (Sample language for policies and procedures will be provided to attendees.)

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pliance programs. Otherwise, they face the four-tiered penalties created by the HITECH Act and finalized in the omnibus rule:

(1) The first tier is reserved for violations in which the person did not know and would not have known, by exercising due diligence, that he or she violated the statute;

(2) The second tier is for violations due to reasonable cause and not willful neglect;

(3) The third tier is for violations that were due to willful neglect but were corrected in a timely manner; and

(4) The fourth tier is for violations caused by willful neglect and not corrected in a timely manner.

**OCR Has Become More Demanding**

The omnibus rule also requires OCR to formally investigate complaints indicating a violation that stems from willful neglect, and impose fines if allegations of willful neglect are substantiated, Rostolsky says. “Today’s HIPAA enforcement is an entirely different ballgame than in years past. OCR clearly means business, and covered entities and business associates need to approach every interaction they have with OCR more cautiously than before.”

Ami Zumkhawala-Cook, chief compliance officer of Holy Spirit Health System in Camp Hill, Pa., has experienced OCR’s more probing approach in the context of resolving patient complaints. Five or six years ago, when patients complained to OCR because they were not satisfied with the hospital’s response, its interaction with OCR was fairly brief. She would explain her due diligence and send OCR its policies and procedures and internal disciplinary polices, and “OCR would be satisfied.” But the last time that Zumkhawala-Cook interacted with OCR over a patient privacy complaint, “I was surprised by how much detail they wanted,” she says.

“It puts the organization in a funny place with respect to releasing details about the employee who committed the violation and what kind of disciplinary action was committed.” It is hospital policy not to disclose details of a disciplinary action to anyone but the affected employee, so she wasn’t sure what to tell OCR. “We went back and forth with risk management and human resources. We struggled with it,” she says. “After a couple of rounds with OCR, it was satisfied” with the information revealed. But her overriding concern is more clarity on the standard for resolving OCR questions about patient complaints, especially with the potential for penalties. “We never know when something will be escalated to OCR,” Zumkhawala-Cook says.

Meanwhile, Linda Sanches, OCR’s senior advisor for health information privacy, reported on the findings of OCR audits at the 21st National HIPAA Summit in Washington, D.C., in February. Last year, OCR auditors reviewed 95 covered entities, including providers, health plans and clearinghouses, as well as 20 during a pilot. Of the 95, 13 had no findings. Data presented at the summit included all 115.

The audited entities fell into one of four levels depending on their income and asset levels. Level four was “smaller providers” with “10 to 50” providers, whose annual revenue is below $50 million per year and who make “little to no use” of health information technology. Level one, in contrast, was a “large provider or health plan” with $50 billion or more of revenues or assets.

**Auditors found:**

- Of the total, 60% were related to security, 30% to privacy and 10% to breaches.
- Level four (the smallest) entities had the most findings and observations (41%), with the other three levels about equal with 19% to 20% of overall findings.
- Providers, by far, had the most findings at 65% of the total, followed by health plans (32%) and clearinghouses (3%).

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**EHRs = Compliance Risks**

That’s the first time E/M services have been documented directly because of cloning or copy/paste, compliance experts say. But it’s not a surprise in light of recent statements and issuances by CMS, OIG and the Department of Justice. Gloria Jarmon, deputy HHS inspector general for the Office of Audit Services, said that the use of copy and paste may lead to the placement of “inaccurate and potentially dangerous information in patient records and may describe more billable information than was actually performed.” Because it may not be obvious when electronic health records have been manipulated, auditors may “develop new audit techniques” to supplement tried and true methods. This is one of the “new opportunities and challenges with electronic health records that need to be managed and monitored,” along with their potential to improve billing accuracy and increase quality of care, Jarmon said in brief comments at a RACmonitor.com weekly webinar.

Cloning and copy/paste are not the only compliance and quality issues stemming from EHRs. Hospitals face other risks, such as authentication and loss of control of templates. Meanwhile, CMS will choose about 5% to 10% of providers for prepayment audits under the Medicare
EHR incentive program, a spokesperson tells RMC. “Selections will be made both randomly and also based on protocols that identify suspicious or anomalous attestation data. Post-payment audits will also affect approximately 5% to 10% of providers who submit attestations through the program,” the spokesperson said.

To reduce EHR-related risks, hospitals may want to turn to the compliance mainstays of policies and education — especially since basic copy and paste functionality cannot be completely blocked in many EHR systems, says Nina Tarnuzzer, chair of the electronic health records workgroup for the Association of American Medical Colleges’ Compliance Officers Forum. “Much of the mitigation of risks rests on policy and training in the judicious use of the tools,” she says. “A lot of this is judgment in producing a quality note that’s patient-specific and pertinent to the episode of care.”

Hospitals may not have a moment to waste if downcoding becomes the norm, which may be the case considering the MAC’s letter to the academic medical center.

“The documentation for the reduced services supported an expanded problem focused history and exam and medical decision making of moderate complexity,” according to the MAC letter. “Procedure code 99233 supports a patient who is usually unstable or has developed a significant complication or significant new problem. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.” The MAC noted that medical necessity is the most important criterion for payment besides CPT coding requirements, and the primary basis for assigning a CPT code is not the sheer volume of documentation. “Documentation should support the level of service reported. The service should be documented during or as soon as practicable after it is provided in order to maintain an accurate medical record,” the MAC said.

**Cloning Is a Hot Topic**

A number of Medicare administrative contractors have warned about cloning, which is the appearance of identical documentation from one patient encounter to the next, and copy and paste, in which clinicians replicate the notes but hopefully update them. For example, the website for the MAC National Government Services says that documentation is cloned when it’s phrased exactly the same or similar to prior entries or when documentation is the same from patient to patient. “Providers need to be aware that Electronic Medical Records can inadvertently cause some documentation pitfalls, such as making the documentation appear cloned. Cloned docu-

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**CMS Transmittals and Federal Register Regulations**

March 15 — March 21

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

**Transmittals**

**Pub. 100-04, Medicare Claims Processing Manual**

- New Waived Test, Trans. 2671, CR 8212 (March 15; eff./impl. July 1, 2013)
- Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement, Trans. 2672, CR 8246 (March 15; eff./impl. July 1, 2013)
- Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens, Trans. 2675, CR 8203 (March 15; eff./impl. June 17, 2013)
- July 2013 Quarterly Average Sales Price Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files, Trans. 2676, CR 8247 (March 15; eff./impl. July 1, 2013)
- Modification to CWF, FISS, MCS and VMS to Return Submitted Information When There Is a CWF Name and HIC Number Mismatch (R), Trans. 2670, CR 7260 (March 15; eff./impl. April 1, 2013)

**Pub. 100-07, State Operations Manual**

- Revisions to Appendix E and Chapter 2 sections 2290-2308 of the State Operations Manual, Trans. 83 (March 15; eff./impl. March 15, 2013)

**Pub. 100-08, Medicare Program Integrity Manual**

- Progress Notes and Forms (R), Trans. 455, CR 8033 (March 15; eff. Dec. 10, 2012; impl. March 21, 2013)
- Minor Changes to Chapter 1 of the Program Integrity Manual (R), Trans. 454, CR 8205 (March 14; eff./impl. April 1, 2013)

**Pub. 100-20, One-Time Notification**

- Implementation of the Award for Jurisdiction 6 Part A/Part B Medicare Administrative Contractor, Trans. 1197, CR 8227 (March 15; eff./impl. July 1, 2013)
- ICD-10 Conversion from ICD-9 and Related Code Infrastructure of the Medicare Shared Systems as They Relate to CMS National Coverage Determinations, Trans. 1199, CR 8197 (March 15; eff./impl. July 1, 2013)

**Federal Register Regulations**

**Final Rule**

- Requirements for Long-Term Care Facilities, 78 Fed. Reg. 16795 (March 19, 2013)

**Proposed Rule**


**Notice of CMS Ruling**

- Medicare Hospital Insurance (Part A) and Medicare Supplementary Medical Insurance (Part B), 78 Fed. Reg. 16614 (March 18, 2013)
Authorship of Notes Must Be Clear

For example, it’s important to ensure that authorship of different notes is clear. “It matters whether a medical student wrote something versus a teaching physician,” she says. Medical students are allowed to document past family and social history and a review of systems, and if their notes are copied and forwarded they may wind up inadvertently being used beyond the scope of what’s allowed for billing purposes. Ideally, the EHR system would identify medical-student notes by casting them in a different color or font size, Tarnuzzer says.

Templates are also riskier in an electronic world. “They can go viral,” Tarnuzzer says. Suppose a hospital’s new template prompts only for body areas rather than organ systems, which are required for a comprehensive exam. These note shells or templates are often listed in a central pick list so other providers can select and use them. “What might have remained an isolated issue can gain momentum quickly if the template were to become popular,” Tarnuzzer says.

And unlike paper records, where everything is in front of you, auditors or physicians may not see all documentation on screen. “You can’t necessarily see the whole story by just printing the notes,” she says. For the sake of compliance and quality, EHRs must ensure that users have access to links to other data in the chart that provide a more complete picture.

As for the basic copy and paste function, it’s not necessarily a black and white proposition, especially since it can’t be shut down in most EHRs, Tarnuzzer says. “An already populated text may not be accurate or may be out of date,” she says. Users are responsible for what’s in the note. And there are some things with no wiggle room. For example, allowing a scribe to document while the provider is logged in violates access controls, including those that support the electronic signature.

For all these reasons, Tarnuzzer recommends that compliance officers attend training on the vendor’s EHR product and play a role in EHR “development, implementation and optimization.”

CMS Gives ‘Mixed Messages’ on EHRs

Meanwhile, the government crackdown on copy and paste is stirring up resentment. “CMS laid out all this money through meaningful use to get providers to use EHRs,” and templates and other electronic documentation play a big role in Medicare value-based purchasing, the reduction of hospital-acquired conditions/present on admission, the physician quality reporting system, core measures, Joint Commission and other initiatives, says Ed Gaines, chief compliance officer at Medical Management Professionals in Greensboro, N.C. But then CMS finds certain aspects of EHR documentation problematic, even though it has stated in Transmittal 811 that macros may be used in the resident/teaching physician setting. Gaines considers that the ultimate in mixed messages.

Recently, CMS said it discourages the use of templates that provide “limited options and/or space for the collection of information,” including checkboxes and limited space to enter information (RMC 12/3/12, p. 1). “The problem is, it’s easy for Medicare to do Monday-morning quarterbacking and say ‘you picked up patient history from a prior encounter’,” Gaines says. But how much is too much? If a patient with congestive heart failure presents at the hospital twice in six weeks, it seems reasonable to copy and paste the past family and social history, he says. After all, how much has changed since then assuming that the provider discusses this with the patient?

But cloning is bad news for other aspects of the patient encounter, says consultant Stephen Levinson, M.D., president of ASA, LLC in Easton, Conn. “You have to get rid of cloned documentation for all aspects of the history and exam,” he contends. “Every patient is different.”

In terms of audit defense, documentation of the history and exam must have patient-specific detail, including positives and pertinent negatives in the review of systems, Gaines says. “The provider has to add patient-specific documentation about why they are here now, not why they were here six weeks ago,” he explains. Physicians should not rely too much on nurses’ notes without a comment that they reviewed and confirmed that information. “The message to physicians is to be careful pressing the easy button,” Gaines says. “Patient-specific detail of the history, exam, medical decision making and course of treatment is the best defense in an audit, and that shows the differential diagnosis and reflects the medical necessity for the treatments provided or ordered.”

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NEWS BRIEFS

♦ The U.S. Attorney for the Southern District of New York has filed a false claims lawsuit against Park Avenue Medical Associates and Park Avenue Medical Associates, P.C. The complaint alleges that PAMA and PAMA PC billed for services “purposely” provided to elderly, mentally ill patients that were not medically necessary and not documented in the medical record. According to the complaint, PAMA allegedly provided psychotherapy to patients with severe dementia who could not benefit from the care. PAMA PC, the complaint alleges, billed for duplicative psychiatric evaluations and for services that “lacked any documentation whatsoever.” The complaint further alleges that PAMA PC billed Medicare for “a far larger number of services per psychiatrist and psychologist” between 2001 and 2012 “than any other provider with a similar patient population in New York.” The lawsuit was initiated by a whistleblower. PAMA’s attorney, Steven Chananie of Garfunkel Wild in Great Neck, N.Y., told RMC that “it is premature at this time to make a comment because we are in discussions with the government.” Visit http://tinyurl.com/cg6nkqw.

♦ The HHS Office of Inspector General has released another Medicare compliance review (A-02-12-01005), this time of St. Michael’s Medical Center in Newark, N.J. OIG examined 174 inpatient and 56 outpatient claims and determined that 98 did not comply with Medicare rules. Specifically, 71 inpatient claims had billing errors resulting in overpayments totaling $450,942, and 27 outpatient claims had billing errors resulting in overpayments totaling $41,104. Inpatient short stays, where the patient should not have been admitted, accounted for $342,825 of the overpayments. Same-day discharges and readmissions accounted for $82,091. On the outpatient side, the hospital billed incorrectly for modifier -59, which indicates a distinct procedural service, and selected the wrong HCPCS code for the drug doxorubicin hydrochloride. The recommendations were standard: repay the overpayments and strengthen internal controls to ensure compliance. St. Michaels concurred with the OIG findings and recommendations and in its response provided a detailed account of the problem and the corrective actions it has taken. Visit https://oig.hhs.gov/oas/reports/region2/21201005.asp.

♦ The Tennessee-based home health care company Techota, LLC has agreed to pay $150,000 and enter into a corporate integrity agreement to resolve a qui tam lawsuit. The lawsuit alleged that the company had billed Medicare for home health services that were not medically reasonable and necessary or were not provided under a valid plan of care. The settlement was announced March 13 by the U.S. Attorney for the Middle District of Alabama. Techota operated several home health services in Alabama. Visit http://tinyurl.com/blrvnly.

♦ The Department of Justice announced on March 20 that Hospice of Arizona and two related entities will pay $12 million to resolve false claims allegations originally levied in a qui tam lawsuit filed in Maryland by a former hospice employee. The complaint alleges that between 2002 and 2010 the entities engaged in practices resulting in the admission of ineligible patients and inflated bills. Among the practices, according to the DOJ press release, the entities pressured staff to find more eligible Medicare patients, delayed and discouraged staff from discharging patients who no longer needed hospice care and did not have a compliance program that could have addressed these problems. Visit www.justice.gov/opa/pr/2013/March/13-civ-326.html.

♦ Two congressmen are reintroducing the Medicare Audit Improvement Act of 2013, which had originated been introduced in October 2012. According to a March 19 press release from Rep. Sam Graves (R-Mo.), the bill seeks to address the burden on providers of responding to record requests from recovery auditors and other Medicare contractors. The bill also seeks to improve auditor performance by assessing penalties for auditors that do not comply with basic program requirements such as deadlines and issuance of “demand letters.” Visit http://tinyurl.com/cc3nrdd.

♦ Spaulding Rehabilitation Hospital for Continuing Medical Care, North Shore, has agreed to pay $91,800 to settle allegations of improper Medicare billings, according to a press release from the U.S. Attorney for Massachusetts. The government alleged that Spaulding violated the midnight rule, which means it billed Medicare for days when the patient left the facility before midnight. Medicare reimburses only if the patient stays in the facility until after midnight. Visit http://tinyurl.com/a8hh2ls.
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