Report on
MEDICARE COMPLIANCE

Volume 26, Number 6 • February 20, 2017

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

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Hospital Settles CMP Case Over Physician Signatures; EMR Shortcuts Invite Risk

Physician signatures are at the heart of a civil monetary penalty settlement with St. Joseph Hospital, Breese of the Hospital Sisters of the Third Order of St. Francis in Illinois. The hospital agreed to pay $421,692 to resolve allegations that two physicians allowed clinical staff to sign orders for outpatient diagnostic and therapeutic services on their behalf. There allegedly were other problems at the hospital with signatures, an area fraught with compliance challenges, including the "make me an author" function in electronic medical records and the overlapping federal, state and payer requirements for order authentication.

"It's not so much about getting a signature on certain documents. The greater challenge is doctors being busy and wanting others to do the underlying documentation within the medical records, for which their signatures will apply," says Cheryl Rice, vice president and chief corporate responsibility officer for Mercy Health, a health system with facilities in Ohio and Kentucky.

The settlement with St. Joseph Hospital, Breese stemmed from its voluntary disclosure to the HHS Office of Inspector General, which was accepted into OIG's Self-Disclosure Protocol in April 2016. OIG alleged the hospital billed Medicare Parts B and C, Medicaid, TRICARE and Veterans Affairs for items or services that were fraudulent

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Court Tells CMS to Implement Corrective Action in *Jimmo* Case by September

CMS got another push from a federal court earlier this month in a follow-up decision in the so-called *Jimmo* case. The Feb. 1 order instructs CMS to make it very clear that Medicare now pays claims for certain services that maintain, but not necessarily improve, a patient's condition.

The U.S. District Court for the District of Vermont has specified what it expects are the final actions needed to resolve issues outstanding in implementing the settlement in *Jimmo v. Burwell*. The lawsuit, filed in 2011 by the Center for Medicare Advocacy, Inc. and Vermont Legal Aid, challenged CMS, alleging "a covert rule of thumb" required beneficiaries to show improvement in order to receive certain benefits. Chief Judge Christina Reiss approved a settlement in 2013 between CMS and the plaintiffs under which CMS would revise its Medicare Benefit Policy Manual (MBPM) to replace the so-called "improvement standard" with a "maintenance coverage standard." With this revision, Medicare beneficiaries who required home health, skilled nursing and outpatient therapy to maintain their current health condition and avoid deterioration, such as beneficiaries with multiple sclerosis, would not have to show improvement to receive coverage. CMS also agreed to conduct a nationwide "education campaign" to inform payers and providers of the policy interpretation.

Although CMS revised the MBPM and conducted education, such as a national call and open door forums, plaintiffs argued these efforts were inadequate and not always

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accurate. Plaintiffs asked the court to require CMS to effectively implement the provisions of the settlement agreement. In August 2016, Reiss ruled that while the court had no jurisdiction to order further revisions to the MBPM, CMS had not always provided "accurate information" during the education campaign and ordered CMS to propose corrective actions regarding the campaign.

In response to the order, both parties submitted corrective action plans because they could not agree on a single plan. The plans had similar elements but approached implementation differently.

After reviewing both plans, Reiss issued her decision. Overall she accepted CMS's corrective action plan because plaintiffs' proposed educational activities that had not been included in the original settlement. Plaintiffs also had proposed extensive participation in the agency's implementation of the settlement and ongoing monitoring. Reiss rejected the breadth of the plaintiffs' request, stating the court "cannot impose new obligations the parties have not bargained for, correct any disparity in bargaining power, or devise its own scheme for implementing the *Jimmo* settlement."

However, the judge specified two additional items that had to be implemented to meet the court's 2016 order regarding the settlement—the specific description of the settlement's impact on Medicare policy and the need for another national call—and these represent important victories for plaintiffs.

Policy Change or Policy Clarification?

Plaintiffs maintained that the settlement represented a change in Medicare policy, while CMS maintained that the settlement merely clarified Medicare policy. Plaintiffs requested, and CMS agreed, to create a webpage dedicated to the *Jimmo* settlement that will include frequently asked questions. Plaintiffs proposed that the webpage include a clear statement about the changes created by the settlement, particularly that the maintenance coverage standard is a change in policy and practice for providers and adjudicators. CMS, in its plan, said it would "disavow" the improvement standard on the webpage and would summarize the "clarifications." However, the statement also would say that the "improvement standard" had never been Medicare policy.

The judge concluded that the parties would never agree on what the webpage message should say and ordered inclusion of part of the statement proposed by plaintiffs that explicitly states that the Medicare program will pay for skilled nursing care and skilled rehabilitation services when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met). The statement then describes the circumstances under

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Auditing Compliance with the 340B Drug-Discount Program

Even though the HHS Health Resources and Services Administration withdrew proposed omnibus guidance on the 340B drug-discount program (*RMC 2/13/17, p. 8; 9/7/15, p. 1*), hospitals and other covered entities must continue to comply with its existing requirements. Here are the steps of an audit program set forth by Debi Weatherford, executive director of internal audit for Piedmont Healthcare in Atlanta. Contact her at Debi.Weatherford@piedmont.org.

I. Planning and Background Research

1. Research topic to gain an initial understanding of area/department to be reviewed. a. Request organization chart for area being reviewed. b. Examine policies and procedures for the 340B program.
2. Review prior work conducted for this area.
3. Verify key contacts for the area.
4. Review and revise ICQ as required.
5. Review and revise audit program as required.
6. Prepare draft of audit objectives.
7. Meet with audit management to discuss project.
8. Alert area of the audit by phone or email.
9. Contact area and arrange entrance meeting.
10. Conduct entrance meeting to "kick off" project.
11. Finalize audit objectives and scope based on information gathered to date.

II. Audit Objectives and Steps

Objective: Determine internal controls are in place to address 340B annual recertification requirements.	1. Obtain and review policies and procedures to substantiate they address recertification responsibilities as well as all other 340B program requirements. 2. Obtain a copy of entity information from the OPA webpage and review for accuracy: correct authorizing official, correct addresses, all outpatient facilities listed, contract pharmacies listed, etc. 3. Obtain and review all change form submissions, if applicable. 4. Obtain and review recertification confirmation, if applicable. 5. Document any discrepancies.
Objective: Verify controls are in place to ensure the hospital's compliance with prescriber eligibility.	1. Obtain and review eligible provider list for hospital, including: name, NPI, date of eligibility and assigned clinics. 2. Select a sample of 340B outpatient drug transactions and verify prescriber eligibility requirements have been met. Resolve any discrepancies.
Objective: Sample test transactions and reports in order to substantiate achievement of 340B program requirements and the prevention of diversion.	1. Verify patient eligibility by confirming patient status code at time of drug dispensing was "outpatient" and medical records are maintained by entity. 2. Randomly select patients and verify each patient to medical records in EPIC. Substantiate visit was completed in an eligible department. 3. Review 340B summary reports and verify 340B program drugs are not diverted or transferred to any ineligible facilities within the same facility (i.e. imaging center, nursing home, etc.).
Objective: Determine controls are in place to ensure compliance with Medicaid pricing requirements and to prevent duplicate discounts as a result of rebates.	1. Verify that all eligible providers have registered with CMS and have an active National Provider Identifier (NPI). 2. Select and review a sample of Medicaid claims from the outpatient pharmacy and from physician administered settings. Include high, moderate and low drugs. Verify Medicaid was not billed more than acquisition cost plus a reasonable dispensing fee. Resolve any discrepancies. 3. Document billing controls to identify what triggers Medicaid rebates and prevents duplicate discounts. 4. Verify GPO was not used to purchase covered outpatient drugs.
Objective: Determine controls are in place to substantiate the completeness and accuracy of data interfaced if using a split billing system.	1. Review interface configuration (mapping) for appropriateness. 2. Verify the security of the transmission method. 3. Determine the ability of manual data manipulation. 4. Document controls regarding pre/post transmission verification.
Objective: Determine monitoring and reporting controls are in place to meet 340B Program requirements for fiscal management, monitoring and reporting.	1. Determine if a 340B oversight committee has been established and meets routinely to monitor the 340B Program. 2. Verify 340B purchasing, utilization and revenue reports are generated and reviewed on at least a monthly basis.

III. Perform Administrative Steps to Complete the Project

1. As issues become apparent, prepare an Exceptions form that documents the issue/root cause/action plan/education/monitoring/accountable leader/implementation date.
2. Review all exceptions with audit management and the contact. Obtain audit management's documented approval.
3. Meet with audit management to get approval of draft report.
4. Send draft report to contact (and others as needed) for responses/edits etc.
5. Have an exit meeting with area as may be appropriate to discuss draft report in detail.
6. Prepare final report.
7. Obtain audit management approval to issue the final report.

which the services would be covered. It concluded with this statement:

"The *Jimmo* Settlement may reflect a change in practice for many providers, adjudicators, and contractors, who may have erroneously believed that the Medicare program pays for nursing and rehabilitation only when a beneficiary is expected to improve. The Settlement correctly implements the Medicare program's regulations governing maintenance nursing and rehabilitation in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and maintenance nursing and rehabilitation in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide. These regulations are set forth in the Medicare Benefit Policy Manual."

National Call is Mandated

Plaintiffs also had proposed eight additional open door forums and a new national call on the *Jimmo* settlement to correct the errors in the information dispensed during the first national call on Dec. 13, 2013. CMS only proposed to revise and disseminate its document summarizing the questions and answers from the first national call in December 2013. The judge stated that because this document gave rise to the court's determination that the settlement agreement had been breached, "the errors in the summary must be corrected."

CMS had not provided a transcript of the national call to the court, and the judge said the court "must therefore proceed on the assumption that the Summary reflects certain erroneous and misleading information provided by the Secretary in the national call. Based on this assumption, the court agrees that a corrected Summary will not cure the deficiencies in the national call." The court ordered CMS to hold another national call in which the corrective statement is orally disseminated. CMS must provide at least 14-days notice to plaintiff's counsel before holding the call, and the notice of the call must include the following: "This call will include corrective action mandated by the court overseeing the *Jimmo* settlement, clarifying the rejection of an improvement standard and explaining the maintenance coverage standard now included in the Medicare Beneficiary Policy Manual."

CMS must certify compliance with its corrective action plan, including the new additional items added by the court, by Sept. 4, 2017. Once implemented, the plan "will cure agency's breach of the Settlement Agreement and fulfill its remaining obligations for an Educational Campaign."

Read the decision at http://tinyurl.com/zjknxzl. ✧

With Errors Tied to Documentation, Stakes are High for SNF Certs

Insufficient documentation was the big driver of the Medicare improper payment rate for 2016, according to a detailed report released by CMS in January. No provider types were spared the criticism in the supplementary appendices to the annual fee-for-service report, including skilled nursing facilities (SNFs), which have come under fire in recent audits and enforcement actions. SNF stays accounted for 7.8% of the improper payment rate last year, and the bulk of it—76.7%—was attributed to insufficient documentation. Exactly how documentation fell short was not explained, but Donna Thiel, former vice president and chief compliance officer for a large SNF chain, has a pretty good idea. She says problems with certifications and documentation of medical necessity for the level of therapy provided are areas that probably go wrong.

Medicare beneficiaries are admitted to SNFs (after a three-day qualifying inpatient stay) for up to 100 days of skilled nursing and/or physical, occupational and speech therapy to treat strokes and other conditions that impede their ability to perform activities of daily living (ADL). Medicare pays SNFs per diems based on resource utilization groups (RUGs), and SNFs assign RUGs according to a beneficiary's scores on the minimum data set (MDS), which represent his or her clinical condition, functional

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, www.hcca-info.org.

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status and use of services. SNFs have a target on their back in the 2017 HHS Office of Inspector General Work Plan *(RMC 11/14/16, p. 1*), and they have settled a number of false claims settlements (*RMC 1/18/16, p. 3*).

Fundamental to a SNF admission and ongoing services are the certification and recertifications. Physicians must state why the patient's condition requires admission to a SNF—linking it to skilled nursing and therapy—and how many days will be necessary, says Thiel, director of Compliance Integrity Advisors and former chief compliance officer at Fortis Management Group and Extendicare Health Services. Recertifications have to be specific enough to justify the need to continue with therapy in a SNF and/or how the case is clinically complex to the point it still requires skilled nursing services (e.g., IV therapy).

"The forms have to be properly signed by the physician," Thiel says. "It seems easy, but they can be incomplete at times."

SNFs complete the first certification within three days of admission, and the recertification must be done 14 days later. Another is repeated every 30 days until patients max out at 100 days. "You have to have a planning mechanism to make sure you're staying on top of recertifications," she says. "Some doctors are very good —they sign their recertifications timely and everything is peachy. With other physicians, you have to go to their offices. It's a process." Either way, she says, "it's a collaboration between the physician and SNF."

CMS doesn't require SNFs to use a specific form for certifications and recertifications. If SNFs haven't created their own forms and neglected to fill one out, and auditors request a copy, don't panic, Thiel says. "There are other things you can use to try to build a case," she says, including progress notes. Although Medicare administrative contractors are looking for recertification forms, "you still have the opportunity to support the need for SNF care with other documentation," she says. However, "it's frustrating from a compliance officer perspective if you are an organization that has a form. You want to see that form—it's easier and cleaner," Thiel says.

Another documentation risk area is quality. "When you read a lot of charts, you see documentation isn't as thorough as you want it to be," she says. "It doesn't always go from your brain to your pen." Auditors expect to see "consistent documentation of skilled services provided," as well as evidence that the condition of the patient justifies skilled services, Thiel says. It may help to have an MDS specialist—a registered nurse who is held accountable for ensuring the MDS is completed appropriately and that the documentation supports the RUGs score. At Extendicare, she says, the MDS nurse wrote the first skilled note "so everyone could see the depth and quality of a good note." It should state (1) the primary reason/diagnosis for admitting the patient to the SNF under Medicare Part A; (2) the daily skilled nursing services the patient receives that are related to the primary diagnosis; and (3) evidence to support the first two.

Here's an example of a "structured note" for daily skilled nursing services provided to a patient with congestive heart failure (CHF), according to Thiel:

"Resident admitted with CHF, therapies came out, resident with weight gain, on daily weights, significant increase in LE [i.e., lower extremity] edema, LE increasing erythema and elevated temperature. Skilled note: 7/15/16: Resident requires close observation by skilled nursing personnel for signs of decompensation, abnormal fluid balance. Skilled observation is needed to determine if new antibiotic ordered 7/15/16 is effective in treating increasing LE erythema and elevated temperature or whether other therapeutic measures should be considered until resident treatment regimen is essentially stabilized."

With most RUGs driven by therapy services, Thiel encourages compliance or internal audit to take a close look at therapy documentation, whether rehab is provided by employees or a third-party vendor. Auditors should look at the make-up of the interdisciplinary team; the relationship between nursing and therapy so there's documentation of why patients were referred to therapy; whether the rehab director attends clinical meetings and the ongoing documentation of the therapists. Documentation, which physicians use to determine whether patients need to continue therapy, should show the patient's improvement (e.g., speaking more clearly, taking more steps).

At the end of the month, Thiel recommends a sit-down with therapists, MDS nurses and billers to review claims before they're submitted. "Ensure documentation supports the claim and the RUG score is accurate," she says. "It's an internal presubmission check."

Contact Thiel at dthiel@providertrust.com. View the appendix from the 2016 Improper Payments Report at http://tinyurl.com/hxna7l9. ✧

Extrapolation Questioned as OIG Expands Malnutrition Reviews

The stakes of compliance with coding rules for malnutrition are getting higher, with OIG moving from audits of kwashiorkor to audits of severe malnutrition and extrapolating overpayments into the millions of dollars.

In an audit posted to its website on Feb. 3, OIG said Vidant Medical Center in Greenville, N.C., was overpaid $1.4 million for inpatient claims that included a diagnosis

code of severe malnutrition. OIG audited 941 claims that had a secondary diagnosis ICD-9 code of 261 (nutritional marasmus) or 262 (severe protein-calorie malnutrition) and concluded removing the diagnosis from 404 claims would change the MS-DRG. Of the 404, OIG reviewed a random sample of 100 claims submitted by the 909-bed teaching hospital. OIG said 87 of the claims should have had a secondary diagnosis code besides 261 or 262, which resulted in a net overpayment of $401,971. "On the basis of our sample results, we estimated that the Hospital received overpayments of at least $1,403,132 for the audit period," OIG stated. Vidant disagreed with its findings.

The Vidant audit came down less than two weeks after OIG concluded that Northside Medical Center was overpaid $1.3 million for severe malnutrition over a two-and-one-half-year period, based on extrapolation from a $463,619 net overpayment (*RMC 1/23/17, p. 8*).

OIG's use of sampling and extrapolation should make providers uneasy, says Frank Cohen, director of analytics for Doctors Management in Knoxville, Tenn. "I am a fan of extrapolation, but it doesn't always work," he notes.

OIG's extrapolation and sampling methodology isn't consistent with federal guidance, he says. A May 5, 2010, Office of Management and Budget report states that federal agencies are required to produce a statistically valid error estimate that meets a precision level of plus or minus 2.5 percentage points with a 90 percent confidence interval. Similar standards are set forth in the 2007 Federal Register, which states that "error estimate should meet precision levels of plus or minus 2.5 percentage points with a 90-percent confidence interval" (*72 Fed. Reg. 50490*). The confidence interval refers to how many times the results would be replicated on a random sample of claims (i.e., 90 out of 100).

But the numbers in Appendix C of the Vidant report don't add up, Cohen argues. There is a precision level of plus or minus 13 percent, he says, way above the government's own standards. He determines this by subtracting the lower limit in Appendix C ($1,403,132) from the point estimate ($1,611,905)—which equals $208,773—and calculating the percentage of the point estimate. "They didn't meet that here, so the extrapolation would not be valid," Cohen says. He feels it's a typical example of the government not abiding by its own rules while providers are held to exacting Medicare requirements.

Also, sometimes there is gamesmanship in hospital coding to increase reimbursement, says one industry coding expert, who asked not to be identified. It starts out in good faith—"we need to capture how sick our patients are"—and turns into "75 percent of our patients will have malnutrition" because it drives up the MS-DRG payment when it's the only complication and comorbidity (CC) or major CC, says the expert. In ICD-10, for example, severe protein calorie malnutrition is an MCC, moderate protein calorie malnutrition is a CC and mild protein calorie malnutrition is a CC. "You want to have good care. In doing so, you want to make sure the patient is appropriately diagnosed and treated for severe protein calorie malnutrition," the expert says. "I don't think clinical documentation improvement programs are monitored themselves or have other people monitoring to keep them from tipping too much either way."

Contact Cohen at frank@frankcohengroup.com. View the audit at http://go.usa.gov/x962B. ✧

Hospital Settles Signature Case

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because they weren't provided as claimed, according to the settlement. In addition to clinical staff signing orders for two physicians, they allowed clinical staff to use pre-signed orders and signature stamps on orders. The conduct occurred between Feb. 23, 2009, and Feb. 23, 2015. The hospital didn't admit liability in the settlement and declined to comment. The physicians were independent contractors.

Physician orders are a complex area, and CMS has updated its guidance in this area over the years. But CMS isn't the only player in town; hospitals are also bound by state laws, which vary depending on the type of orders and prescriptions, as well as payer coverage rules, Rice says. One thing is clear, auditors are more adept now at identifying shortcuts that result in upcoding or degrade quality of care, Rice says.

CMS generally forbids the use of signature stamps, so that's a no-brainer.

"Stamped signatures are only permitted in the case of an author with a physical disability who can provide proof to a CMS contractor of inability to sign due to a disability," according to CMS.

"Make Me an Author" May Mess with E/M Level

Order sets and signatures on behalf of physicians are thornier areas and implicate other medical record functions. Physicians and hospitals are vulnerable with the make-me-an-author and copy/cut/paste and pull-forward functionality, which creates the illusion that physicians wrote notes that others penned or were written at other times, Rice says. "The architects of electronic medical record systems set up that exchange as a convenience to care teams. The functionality can give the appearance the doctor did all the documentation when in fact the nurse or someone lower level did it and at the last minute flipped it to the doctor. The doctor reviews

the documentation and pushes a button and that signs the doctor's name and date stamps it, but the doctor may have spent almost no time writing," she explains.

The government has its eye on signature abuses because many components of evaluation and management (E/M) services depend on the direct time that physicians spend documenting or performing services. "If the nurse or medical assistant is doing it all and they're just handing it over to the doctor for a signature, the doctor gets zero credit for that portion of the time associated with the activity that's used in assigning the E/M," she explains. E/M visit levels are partly time based and certain elements, such as medical decision making, must be documented by the physician. "The doctors are shooting themselves in the foot if they delegate their portion of documentation to others," she says. The government is sending communications to physicians who have aberrant E/M distributions relative to their peers nationally and within their specialty, Rice says. "The information is indicative of robust data mining on physician billing activity."

The EMRs Are Watching

To monitor documentation exchanges, many EMRs have added transparency features. There are electronic documentation tracking logs behind the scenes that show who (e.g., nurse, physician) makes an entry, regardless of whether the person identifies himself or herself, and the date and time spent in the entry and when the entry is flipped to another person. "EPIC has that kind of log, and if the nurse is doing a section of the medical record they are not supposed to be documenting in and handing it off to the doctor and the doctor is pressing the button for the make-me-an-author functionality, we can see that," Rice says. "The government knows it's there, and if they suspect the physician is taking credit for doing something they didn't do, it can be requested as part of an audit. The log is like a trail of bread crumbs. This is the risk that physicians face in documentation in using new functionality features. The risk and responsibility lies squarely on the physician and their staff to use functionality features compliantly so they don't falsify or upcode the services rendered, especially time-based services."

Orders are a related challenge. In terms of preventing clinical staff from ordering diagnostic tests and therapeutic services on behalf of a physician, hospitals need effective "provisioning controls," Rice says. They restrict who can access certain sections of the EMR and author an order. "That can be a challenge because doctors want order sets, but you have to look at state and federal laws on who can even create an order, act on an order or take a verbal order," she says.

CMS gave hospitals more flexibility in the May 2012 final update to the Medicare hospital conditions of participation (CoPs). CMS eliminated the 48-hour deadline for signing and dating medical records, including verbal orders, and now defers to hospitals and/or state laws, just requiring prompt authentication (*RMC 5/21/12, p. 1*). The CoPs also gave the green light to pre-printed protocols and electronic standing orders, which allow nurses to get treatment or diagnostic tests under way and get physician signatures after the fact, if a hospital:

(1) "establishes that such orders and protocols have been reviewed and approved by the medical staff in consultation with the hospital's nursing and pharmacy leadership;

(2) "demonstrates that such orders and protocols are consistent with nationally recognized and evidence-based guidelines;

(3) "ensures that the periodic and regular review of such orders and protocols is conducted by the medical staff, in consultation with the hospital's nursing and

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

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-20, One-Time Notification

- Guidance on Implementing System Edits for Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), Trans. 1797 (Feb. 10, 2017)
- Advance Care Planning (ACP) Implementation for Outpatient Prospective Payment System (OPPS) Claims, Trans. 1795 (Feb. 10, 2017)

Pub. 100-07, State Operations Manual

- Revision to State Operations Manual (SOM) Appendix PP - Incorporate revised Requirements of Participation for Medicare and Medicaid certified nursing facilities, Trans. 167 (Feb. 10, 2017)

Pub. 100-04, Medicare Claims Processing Manual

- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April CY 2017 Update, Trans. 3719 (Feb. 15, 2017)
- Instructions to Process Services Not Authorized by the Veterans Administration (VA) in a Non-VA Facility Reported With Value Code (VC) 42, Trans. 3718 (Feb. 14, 2017)
- Extension of the Transition to the Fully Adjusted Durable Medical Equipment, Prosthetics, Orthotics and Supplies Payment Rates under Section 16007 of the 21st Century Cures Act, Trans. 3716 (Feb. 10, 2017)
- Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens, Trans. 3717 (Feb. 10, 2017)

pharmacy leadership, to determine the continuing usefulness and safety of the orders and protocols; and

(4) "ensures that such orders and protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or another practitioner responsible for the care of the patient."

But there are other factors to consider with orders. "State laws are all over the place," Rice says. "Some people assume if they can take an order for admission, they can take it very generally." But as she learned when looking at laws in the two states served by Mercy Health, there are variances among states in terms of what's allowed by type of order, who is taking the order and what services are being provided.

States vary in terms of when they require authentication of verbal orders (some say 48 hours, others require it sooner) and who is permitted to take verbal orders for various drugs and other services, including lab tests, imaging, home care and physical therapy, Rice says. "People want to help make the physicians' day-to-day procedures easier, but they don't realize there are state laws and other regulatory restrictions on who can take the order, act on the order and sign off on the order," she explains. "Not all services can be ordered verbally under state law. It's been a challenge to educate staff on order exceptions."

The scope of practice, federal law and payer coverage rules must be synthesized in the thinking of hospitals, Rice says. A particular type of clinician may have the authority to write an order under state law, but CMS or Medicaid may not pay for it. That complexity played out in Ohio when the state allowed more nonphysician practitioners (NPPs), such as nurse practitioners and advanced nurse practitioners, to order diagnostic tests and prescribe drugs under certain circumstances, Rice says. To have prescription-writing authority, NPPs have to have separate certification and licensure and a collaborative relationship with a physician, who can restrict the privileges as he or she sees fit. That means in Ohio, compliance officers should review federal laws, state laws, prescription authority and the collaborative agreement with a supervising physician.

Orders also have an impact on the incentive payment program for meaningful use of electronic health records, "and keeping your dollars for meaningful use," Rice says. CMS determines whether hospitals and physicians satisfy their meaningful use core objectives based on a calculation—numerator divided by denominator. One of the core measures in meaningful use is whether hospitals and physicians are using e-prescribing, Rice says. The numerator is how many eligible providers prescribe electronically and the denominator is how many eligible providers are authorized to write prescriptive orders in the EMR. Rice cautions hospitals to tread carefully in this area. While states allow physicians to write prescriptions unhindered, NPPs in most states require an extra certification for prescription authority. "You can't take all your doctors and NPPs and throw them in your denominator," she says. Misrepresenting who is signing orders can have an impact on your meaningful use money. "You can only count people whose scope of practice allows them to perform the actual service" according to the most restrictive standard—federal, state, hospital bylaws or rules and/or physician collaborative agreement, she says. What the hospital or physician measures and reports affects whether it keeps its meaningful use money, Rice says. "Nonphysicians shouldn't sign orders they aren't authorized to sign, and whoever's name is on the order is ultimately responsible for the services provided."

Contact Rice at clrice@mercy.com. View CMS guidance on Medicare signature requirements at http://tinyurl.com/7rvdsv5. ✧

NEWS BRIEFS

◆ **HHS has delayed the regulation on the Confidentiality of Substance Use Disorder Patient Records for 60 days.** The regulation, which "updates and modernizes the Confidentiality of Alcohol and Drug Abuse Patient Records regulations," was supposed to take effect Feb. 17, 2017, according to the *Federal Register* notice. It's being delayed in response to the "Regulatory Freeze Pending Review" published in the Jan. 24, 2017 *Federal Register* (82 Fed. Reg. 8346). Visit http://tinyurl.com/hrv3f2o.

◆ **A Florida ear, nose and throat (ENT) physician and his practice agreed to pay $750,000 to settle false claims allegations that he billed federal health care programs for surgical endoscopies with debridement and laryngeal stroboscopies that were not provided or were medically unnecessary,** the U.S. Attorney's Office for the Southern District of Florida said Feb. 13. Paul B. Tartell, who practices in Plantation, and his practice Paul B. Tartell, M.D., P.L., was originally accused of submitting false claims by former patient Theodore Duay, who filed a whistleblower lawsuit. The lawsuit alleged the ENT physician routinely did diagnostic endoscopies, but billed them as if he performed more lucrative, intrusive surgical debridements. Tartell didn't admit liability in the settlement. Visit http://tinyurl.com/jfps2p5.