Report on
Medicare Compliance

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

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Hospitalist Group Settles FCA Case Over E/M Coding that Diverges from CMS Averages

It should give physicians pause when their billing for evaluation and management (E/M) services outstrips Medicare averages, but Fredericksburg Hospitalist Group (FHG) in Virginia allegedly plowed ahead anyway. And when this pattern allegedly continued for years across a variety of E/M services, FHG and 14 of its physician-shareholders found themselves in the middle of a False Claims Act lawsuit in 2014. Three years later, they agreed to pay $4.2 million to settle the allegations, the Department of Justice and U.S. Attorney's Office for the Eastern District of Virginia said June 2.

DOJ alleged that FHG, which provided services at Mary Washington Hospital in Fredericksburg, Va., and Stafford Hospital in Stafford, Va., upcoded E/M services to the highest levels on claims they submitted to Medicare, Medicaid and other federal payers from January 2010 to April 2015.

"The amazing thing about this case is it's so simple," says Betsy Nicoletti, a consultant in Northampton, Mass. It's inexplicable that Medicare contractors didn't pick up on the E/M levels of service, she says. Instead, the alleged upcoding was exposed by whistleblower Richard Morrow, FHG's former chief operating officer. His review of FHG's coding data allegedly found the hospitalists "were uniformly using the higher or highest possible CPT codes," according to the complaint. Morrow allegedly was "literally laughed at" when he tried to discuss his billing and coding concerns

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'Five-to-One Feedback' and Other Tools Could Improve Compliance, Patient Safety

Finding out they deviate from a compliance or patient-safety norm is not a pill employees like to swallow, but it goes down easier if they regularly hear about their good work—which makes them more motivated to improve their behavior. That's the thinking behind "Five-to-One Feedback," one of several strategies developed by Texas Health Physicians Group in Arlington, Texas, to identify and address compliance and quality problems and to encourage reporting, says Lynn Myers, M.D., vice president of quality.

"If they only hear about the negative things, they are less likely to be receptive to making improvements in processes," Myers says. And like most organizations, Texas Health Physicians Group could jump all over problems 24/7, but it tries to put noncompliance and safety lapses in a broader context to encourage employees to change them. "We have an intentional effort to positively reinforce the actions and behaviors five times more often than we do for opportunities to correct things," she says.

For example, sometimes physicians get behind on documentation of their medical records, and "from a compliance perspective, completing documentation of all encounters is mission critical," Myers says. If she has commented on the physician's great

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patient care, open communication and continuity of care and emphasized that getting a bit behind in authenticating records, for example, doesn't reflect badly on their quality, then the documentation problem doesn't hit him or her so hard. Myers also generally tries to convey how much the physicians are valued and encourages them to share what's going on in their practices rather than only showing up to wag her finger at them about the rules and warn them to fix their snafu.

Of course, it's not credible to inundate physicians with compliments only at the time they're going to learn about their compliance or safety issue, Myers says. "I look for opportunities to acknowledge something [positive]," she says. It can be related to work or not, such as how they've decorated their offices. "It's an intentional effort over the course of a relationship," she explains. "It's about changing behavior and having that place where they don't necessarily like it, but they will change their behavior because they understand how they fit in the organization and why it matters." People are also more likely to report events "when the culture celebrates opportunities for improvement," Myers notes.

Texas Health's approach was on display recently when a patient had a heart attack at one of its practices. While waiting for an ambulance, a physician requested nitroglycerine for the patient but found that the practice's supply had expired. The physician made the clinical decision to administer the nitroglycerine; the patient was transported and did well. After, the physicians "huddled to make sure everyone was OK," and then the practice did a root cause analysis of the drug's expiration, Myers says. It turned out the medical assistant in charge of ensuring stocked medications are not expired hadn't had time to complete the task. But there were no recriminations, Myers says. The event was used as an opportunity to come up with a reliable process for checking on potentially expired medications, giving the medical assistant dedicated time every month to get the job done. "This response to the event makes it more likely that going forward, other staff will speak up for safety," Myers says.

Here are other tools developed by Texas Health Physicians Group to advance patient safety and compliance:

◆ **STAR (Stop, Think, Act and Review):** This is designed to raise employees' awareness so they think carefully before they follow through with routine activities that have compliance and patient-safety implications, Myers says. For example, before hitting the send button on the fax machine, double check that the fax number is correct for the intended recipient and ensure there is a cover sheet. "It can prevent inappropriate sharing of protected health information," she notes. Also, before sending lab results to a patient through snail mail, ensure every page pertains to that patient.

◆ **SBAR (Situation, Background, Analysis and Request/Recommendation):** That promotes communication and encourages requests in a recognizable format so they can be acted on quickly, Myers says. She typically writes multiple SBARs per week. For example, an employee recently asked if a friend's son, who is studying to become an emergency medical technician, could observe physicians at a Texas Health medical group. Myers was inclined to say yes, but she had to ensure the student's presence didn't run afoul of HIPAA, and SBAR gives her a ready format. Myers will probably reach out to leadership and say, "The situation is: I have a student who wants to shadow a physician; the background is: the student is in a technical school for EMTs; the analysis is: we want to protect [PHI] and comply with HIPAA; and my request is: we initiate an agreement with the school so we can onboard the student with appropriate HIPAA protections."

◆ **CUS (Concerned, Uncomfortable, Stop):** This is akin to the "if you see something, say something" method used by the police and Department of Homeland Security to promote public awareness and reporting of potential dangers. Suppose a surgeon in the operating room is moving forward with the procedure but hasn't bothered to do a "safety timeout," which is a checklist

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that confirms essential information. For example, the patient going under the knife is, in fact, John Smith, and that he was born on Jan. 1, 1955, and is having his right hip replaced. The surgical technician speaks up, saying, "I'm concerned that we haven't done a timeout," but the surgeon tries to override him. As a respected, veteran surgeon, she says, "I do this procedure every day. Let's just go ahead." Reciting in his head the CUS acronym, the technician says, "Doctor, I'm uncomfortable that we haven't done a timeout." The surgeon still attempts to proceed with the surgery, but the technician says, "Stop – this is a safety issue." Hearing this, the surgeon finally realizes the need to perform the timeout.

Myers says the tools are widely distributed and have the support of senior leaders. "The commitment to quality and safety has to start at the highest levels because attention is the currency of leadership," she notes. "If we are getting attention on something from our leaders, then everyone will know it's important."

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In Proposed Rule, CMS Allows Mandatory Arbitration by LTC Facilities

In an about-face, CMS has decided to let long-term care facilities require residents to do arbitration if a dispute arises, according to a proposed regulation published in the June 8 *Federal Register*. That doesn't mean long-term care facilities have to force arbitration agreements on people, but they would be free to require it as a condition of admission. The proposed regulation (*82 Fed. Reg. 26649*) reverses course from an October 2016 final regulation, which prohibited long-term care facilities from requiring pre-dispute arbitration agreements and linking arbitration to admission.

The 2016 Reform of Requirements for Long-Term Care Facilities Final Rule was in limbo after it was challenged in court by the American Health Care Association and a group of nursing homes. They won an injunction in November 2016 to stop enforcement of the mandates, and CMS told state survey agency directors to hold off.

Now here comes the proposed regulation, which, if finalized as proposed, appears to put the arbitration dispute to rest, says attorney Paula Sanders, with Post & Schell in Harrisburg, Pa. "CMS realized it potentially overstepped their authority in the 2016 final rule and recognized its chances of success in litigation may not have been as strong as they would have liked and came up with a fair and balanced solution in the new proposed regulation," she says.

The proposed regulation is sort of a ban on a ban: Rather than saying long-term care facilities may use binding arbitration clauses, CMS says it's not banning them anymore. "We propose to remove the requirement at §483.70(n)(1) precluding facilities from entering into pre-dispute agreements for binding arbitration with any resident or resident's representative, which we do not believe strikes the best balance between the advantages and disadvantages of pre-dispute arbitration," the preamble to the regulation explains. "For the same reason, we also propose removing the prohibition at §483.70(n)(2)(iii) banning facilities from requiring that residents sign arbitration agreements as a condition of admission to a facility."

If the proposed regulation is finalized, long-term care facilities that participate in Medicare and Medicaid,

including nursing homes and skilled nursing facilities, will have three options for residents/patients, Sanders says. Long-term care facilities could:

(1) Skip arbitration agreements because they're voluntary anyway;

(2) Offer residents/patients the opportunity to enter into arbitration agreements, which they can reject or accept; or

(3) Require binding arbitration as a condition of admission. Some facilities will do this, she says, although they may still let in patients who decline.

Transparency, however, is something CMS is holding onto in the new version of the regulation. If long-term care facilities require arbitration agreements, they must be written in plain language and preserve the residents' right to discuss it outside the long-term care facility. "We propose to retain the requirements that the agreement be explained to the resident and his or her representative in a form and manner that he or she understands, including in a language that the resident and his or her representative understands; and the resident acknowledges that he or she understands the agreement," according to the regulation. "We also propose to retain the requirements that the agreement must not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representatives of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k)."

Sanders sees this as achieving a balance between allowing binding arbitration and protecting residents and their representatives from any attempts at obfuscation by long-term care facilities. One of the complaints that led to the 2016 regulation was a perception that a stack of papers was shoved at incoming residents/patients for them to sign, with the arbitration requirement tucked in, she says. "Some folks complained that they had no idea what they were signing," she notes.

The benefit of arbitration, Sanders says, is it saves time and money compared to long, drawn-out litigation.

Contact Sanders at psanders@postschell.com. View the regulation at http://tinyurl.com/y9tpv3r3. ✧

CMS Transmittals and *Federal Register* Regulations

June 2 - 8

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

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- July 2017 Update of the Ambulatory Surgical Center (ASC) Payment System, Trans. 3788 (June 2, 2017)

Pub. 100-20, One-Time Notification

- Targeted Probe and Educate Pilot, Trans. 1855 (June 2. 2017)

Federal Register

Proposed Regulation

- Medicare and Medicaid Programs; Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements, 82 Fed. Reg. 26649 (June 8, 2017)

Enlist Accounts Payable Department in Stark Compliance; Audit AP As Well

There may be times when the accounts payable (AP) department is the only thing standing between your hospital and a noncompliant payment to a physician. If there is no contract for services provided by a physician or the services are not spelled out, which is a risk under the Stark law, AP is a logical place to stop the check.

"The risk area is physicians receiving payments when you don't have a contractual relationship to pay them," says Debi Weatherford, executive director of internal audit at Piedmont Healthcare in Atlanta. "That could be a problem because the Stark law establishes that physicians have to be paid fair-market value" and that the terms are commercially reasonable. Compliance with those requirements is complicated if there are multiple payments to the same physician (e.g., medical director, on-call panels), which in the aggregate may not be fair-market value (see audit checklist for physician contracts, p. 6).

The Stark law prohibits Medicare payments to entities for designated health services (DHS), such as hospital inpatient and outpatient services, if they were ordered by physicians who have a financial relationship with the entities, unless an exception applies. Many exceptions require the agreements between DHS entities and physicians to be in writing.

One way to prevent inappropriate physician payments is to build in checks and balances in the AP department, Weatherford says. "A lot of people don't look in their AP system at what payments are going to their doctors and what contracts are in place to match those payments," she notes. Payments may occur without corresponding contracts. In the absence of a written contract, hospitals usually run afoul of the Stark law, although CMS gave hospitals some breathing room under the compensation exception in the 2016 Medicare physician fee schedule regulation (*RMC 2/1/16, p. 1*). While CMS said having a formal contract is best practice, hospitals can support their payments to physicians with

contemporaneous documents, such as board meeting minutes approving payments and time sheets documenting services.

While there is a back-up plan now under the Stark compensation exception, your best bet is to routinely check whether the AP department issues checks based on contracts that are still in effect and that dollar figures mesh, Weatherford says.

At Piedmont, the internal audit department audits physician payments made through the AP system. Who is paid and who approved the payment (i.e., what is his or her title and does it match the Limits of Authority Policy)? "We go back and look at what the contract states," Weatherford says. Also, it's a good idea to screen contracts that are older to determine if services have been added since their inception, she says. For example, physicians may have signed a contract to provide on-call coverage, but now are paid an additional sum for performing peripherally inserted central catheter (PICC) procedures during a call. The contract, meanwhile, hasn't been updated. Another suggestion: Review physicians who have become medical directors to confirm contract revisions are in place, if applicable.

Not only is there an obvious problem with paying physicians for services in the absence of supporting documentation, additional payments could push the total compensation over fair-market value, piling on the Stark risks.

"The focus should be on making sure that all invoices have appropriate supporting documentation and the contracts, as well as the invoices, are approved in compliance with the Limits of Authority Policy for your organization," Weatherford notes.

Audits Look Behind Payments

Sometimes things don't go according to plan because health care organizations often operate in silos. Typically the chief operating officer or chief medical officer is in charge of physician contracting, while the finance department processes payments and legal and compliance oversee fair-market value. "Making sure there are communication channels can be challenging," Weatherford notes.

To head problems off at the pass, Piedmont does a lot of education about physician arrangements and has set forth in policies and procedures "how things should be done," she says. For example, Piedmont's Limits of Authority Policy addresses who can sign contracts and at what level of invoice (i.e., managers seeking the contracts sign contracts up to a certain dollar amount; beyond that, they must seek the CFO's approval).

Weatherford audits whether payments made by AP are supported by contracts and invoices—which should reflect services rendered—and have been appropriately documented for approval.

"Education and monitoring help this process improve," Weatherford says.

Contact Weatherford at debi.weatherford@piedmont.org. ✧

MDs Are Treating Asymptomatic Bacteriuria, Often Without Reason

Many physicians have a hard time walking away from asymptomatic bacteriuria, although it overwhelmingly doesn't require treatment, a physician adviser said. In the rare circumstances asymptomatic bacteriuria calls for treatment, physicians tend not to explain why in documentation.

"It's a problem everywhere," said Michael Salvatore, M.D., physician adviser at Beebe Healthcare in Lewes, Del., at the June 2 Finally Friday webinar sponsored by the Appeal Academy.

Asymptomatic bacteriuria refers to the presence of bacteria in urine without the signs of a urinary tract infection (UTI). Normally, the physician only checks for a UTI when patients describe symptoms, including burning pain during urination and passing blood, Salvatore said. The doctor orders a culture, and if it comes back positive, the patient is treated with antibiotics. But cultures may be ordered when it's unclear whether there are symptoms, he said. For example, sometimes patients are brought into the emergency room because they are confused, and the physician can't get a history. Maybe it turns out they are septic "and it's possible the sepsis is caused by a UTI, so you culture the urine and find it's positive and treat it," Salvatore said.

However, there are other patients brought in with altered mental status, which by itself is not a reason to culture the urine, he noted. However, the physician looks at the patient, and because he is old and frail and perhaps undergoing treatment, such as chemotherapy, the physician sends out the urine for testing. It shows an increase in the white blood cell count, but that doesn't necessarily mean a UTI, Salvatore said. "In an overwhelming majority of cases of asymptomatic bacteriuria, to diagnose UTI you need symptoms and a positive culture," he says. "It takes discipline to say the result [of the culture] is meaningless." There's room for clinical judgment, but physicians must document their rationale for treating a condition that has no symptoms, Salvatore said. Otherwise, in the absence of documentation, physicians are ordering antibiotics without support for them. "Most of these cases have no documentation why they treat it," he maintains.

Contact Salvatore at msalvatore@bbmc.org. ✧

Physician Contract Internal Control Questionnaire

This checklist is designed to help hospitals evaluate the compliance of their physician arrangements, says Debi Weatherford, executive director of internal audit at Piedmont Healthcare in Atlanta. Contact her at debi.weatherford@piedmont.org.

	Physician Contracts/Agreements	Yes	No	Comments
1	Are there written policies/procedures governing the financial relationship with physicians and/or the physician contract process?			
2	Are signed agreements/contracts in place for all physicians (i.e. Employment, Medical Directors, On-Call, etc.)?			
3	Are all physician contracts executed in compliance with the Limits of Authority policy?			
4	Are contract files maintained to include authorization of pay rates and effective dates?			
5	Is a central contract database, repository or similar system being used?			
6	Are contracts monitored for renewal dates?			
7	Are contracts reviewed for overlapping duties among multiple agreements?			
8	Are independent contractors paid through the AP department or payroll?			
9	Are manual or electronic time sheets used to record hours worked? If electronic, provide the name of the software used.			
10	Is the record of hours worked approved by a supervisor when applicable?			
11	Are time sheets monitored to verify maximum work hours have not been exceeded?			
12	Are on-call coverage hours specifically documented in the contract/agreement?			
13	Are salary amounts monitored to verify maximum salary amounts have not been exceeded?			
14	Is someone authorized to approve payments over the maximum stated in the contract? List authorized persons, if applicable.			
15	Are paid time off (PTO) days accrued for medical directors?			
16	Are expense allowances or expense reimbursements granted for medical directors?			
17	Are fringe benefits routinely monitored for inclusion in wages or compensation?			
18	Are medical directors eligible for organizational bonuses and/or awards?			
19	If so, are the bonuses or awards monitored for inclusion in wages and compensation?			

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Hospitalist Group Settles Case

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with FHG's partners, who said they had no intention of changing their billing and coding practices, the complaint alleged.

Generally, compliance experts recommend that hospitals benchmark their physician billing and compare it to CMS averages to identify outliers because that's how Medicare auditors do it. Then hospitals should use the results to create a risk profile (*RMC 5/22/17, p. 3*).

In fact, the false claims complaint does a sort of benchmarking of its own. It compares CMS data to FHG's data on the codes that hospitalists typically bill for, including CPT codes 99221-99223 (initial hospital care); 99231-99233 (subsequent hospital care); 99238-99239 (discharge day management); 99218-99220 (initial observation care); and 99224-99226 (subsequent observation care).

Here are some of the differences between FHG's and CMS's billing for E/M levels of service, according to allegations in the complaint:

◆ On average, CMS data show 5% of initial hospital care is billed at CPT 99221, 29% are billed at 99222 and 67% at 99223. When FHG billed these codes, 86.8% were for 99223—the highest level code, so it pays the most—while .2% were for 99221 and 13% were for 99222.

◆ On average, CMS data indicates 52% of discharge day management is billed at CPT 99238 and the rest at 99239. That contrasts with billing by FHG; when it billed for these codes, allegedly 95% were for 99239 and 5% were for 99238. The reimbursement difference is stark: 99238 pays $69.56 and 99239 pays $102.95, according to the complaint.

◆ On average, CMS data shows that 4.24% of initial observation care is billed at 99218, 28.39% was billed at 99219 and 67.35% at 99220, which is the highest level of E/M service. When FHG billed these codes, the bulk of them—82.19%—were for 99220. CPT code 99218, the lowest-level code, was billed .25% of the time, and 99219 was billed 17.56% of the time, the complaint alleged.

◆ On average, CMS data indicates that 15% of subsequent hospital care was billed at CPT 99224, 62% at 99225 and 23% at 99226. "When FHG billed for these

Physician Contract Internal Control Questionnaire (continued)

	Physician Contracts/Agreements	Yes	No	Comments
20	Are there W-9 forms on file for all medical directors that are classified as independent contractors?			
21	Are Forms 1099 being provided for all individuals who are not employees, and for all unincorporated entities paid $600 or more annually?			
22	Are 1099s or W-2 wages reconciled to the general ledger accounts and quarterly payroll tax returns, if applicable?			
23	Are term limits and/or termination provisions addressed in the contract?			
24	Are restrictive covenants or non-solicitation provisions addressed in the contracts?			
25	Are self audits routinely performed on physician contracts to verify compliance with contract terms and applicable laws and regulations?			
26	How is fair-market value evaluated and monitored?			

Preparer's Signature/Title _____ Date _____

codes, however, 1.19% were for 99224, 22.71% were for 99225 and 76.10% were for 99226," which is the highest-paying code," the complaint alleged. The difference in payment between the lowest and highest paying codes for subsequent hospital care is $61.71.

"It's really jaw-dropping to read this," Nicoletti says.

In the compliance world, sometimes physicians lose sight of medical necessity as they focus on the elements of E/M coding, Nicoletti says. "Even if you document at the highest level of the history and exam, you are guided by medical decision making and medical necessity when billing for patients," she says. As CMS says in Chapter 12 of the Medicare Claims Processing Manual (Sec. 30.6.1), "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. 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."

MACs Do Prepayment Reviews of E/Ms

Although E/M coding may not always be a target of postpayment auditors, because they don't generate a lot of reimbursement per claim compared to, for example, surgeries, they still require medical-record reviews in light of high E/M billing volumes, Nicoletti says. That opens up a different can of worms. For example, the MAC for New England, NGSMedicare, is doing prepayment reviews of high-level E/M services, she says. With prepayment reviews, the MAC doesn't shell out a dime on claims until it confirms they were medically necessary, supported by documentation and billed at the appropriate level of service. NGS will send additional documentation requests for E/M services billed by a practice at a particularly high rate, such as initial or subsequent hospital visits; review them before payment; and downcode some or all of them, Nicoletti explains. Then the physician practice gets the MAC's feedback on the billing and documentation behavior. Other MACs do E/M prepayment reviews.

HHS Inspector General Daniel Levinson also has encouraged CMS to get Medicare contractors to review physicians' E/M services. This was a response to OIG's finding of "a growing trend of billing at the higher levels for E/M codes in all types of E/M services," according to a May 2012 report (OEI-04-10-00180).

FHG did not admit liability in the settlement. Its lawyers did not respond to *RMC*'s request for comment.

Although it wasn't mentioned in the settlement, the complaint also alleged that FHG billed for services provided by new hospitalists under an existing physician's national provider identifier. The whistleblower refunded the reimbursement to the payers. "That's something every hospital administrator should remember," Nicoletti says. "When you hire someone new, it takes 90 days to get them enrolled in Medicare." Although CMS allows hospitals that own practices to bill for services retroactively as soon as the physician is enrolled, "there are limits as to how far Medicare will let you go back."

Contact Nicoletti at betsy@betsynicoletti.com. Visit http://TinyURL.com/ybavpezz. ✧

NEWS BRIEFS

◆ **The HHS Office for Civil Rights has posted a checklist and infographic that are designed to help covered entities understand the steps they should take in response to a cybersecurity incident (*RMC 6/5/17, p. 3*).** View the checklist at http://tinyurl.com/ycfud3z4 and the infographic at http://tinyurl.com/yc96xqax.

◆ **The Department of Justice's criminal division is looking for a new compliance counsel.** It has posted a listing for the job, which is now held by Hui Chen, whose contract ends soon. She was the first person to hold the compliance-counsel position, which was created in November 2015. The DOJ compliance counsel advises line prosecutors on the scope and effectiveness of an organization's compliance program as part of giving it credit during the process of settling corporate fraud cases. Visit http://tinyurl.com/yckmpfs5.

◆ **The 340B drug-discount program is in for some Congressional scrutiny.** Three members of the House of Representatives—Greg Walden (R-Ore.), chairman of the Committee on Energy and Commerce; Tim Murphy (R-Pa), chairman of the Subcommittee on Oversight and Investigations; and Michael Burgess, M.D., (R-Tex.), chairman of the Subcommittee on Health—have asked the Health Resources and Services Administration, which oversees 340B, to turn over all documents related to 340B audits from 2015 and 2016. Visit http://tinyurl.com/y8rzec97.