Report on
MEDICARE COMPLIANCE

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

Contents

Erasing Doubt, CMS OKs Admissions by Mid-Level Practitioners Without M.D. Co-Signing

CMS has taken some of the mystery out of complying with inpatient admission orders, which are a condition of Medicare payment under the two-midnight rule. In new guidance, CMS says definitively that hospitals are eligible for Part A payments for patients who are admitted by mid-level practitioners, such as nurse practitioners and physician assistants, without physician co-signatures. But they have to comply with certain requirements.

"Mid-level practitioners are permitted to admit inpatients without a physician co-signature" under certain circumstances, according to a provider bulletin developed by CMS and Livanta, one of the two Beneficiary Family Centered Care-Quality Improvement Organizations (BFCC-QIOs) that are auditing short hospital stays. To admit patients, mid-level practitioners must be licensed by the state, have hospital admission privileges and "be knowledgeable about the patient's hospital course, medical plan of care, and current condition at the time of admission," the provider bulletin explains.

One caveat: "The burden of proof is on the facility/hospital regarding all three conditions for admission orders signed by mid-level practitioners that are not co-signed by a physician," the bulletin says.

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Compliance Officer Allegedly Instigated Upcoding at Hospital that Settled FCA Case

St. Agnes Healthcare in Baltimore, Md., agreed to pay $122,928 to settle false claims allegations for upcoding that allegedly was encouraged by the compliance officer, according to the complaint. The U.S. Attorney's Office for the District of Maryland said Aug. 23 that cardiologists employed by St. Agnes billed Medicare for services provided to established patients as if they were new patients, who generate more reimbursement. The complaint, which was initiated by a whistleblower, alleges the cardiologists acted at the behest of the compliance officer shortly after they joined St. Agnes, a 363-bed teaching hospital.

This is the third settlement this summer over Medicare billing for new vs. established patients. In two unrelated civil monetary penalty law settlements, two Massachusetts hospitals—UMass Memorial Medical Center and Boston Medical Center—resolved allegations that they overcharged Medicare by billing for evaluation and management services provided to new patients when they should have been billed as established patients, according to the HHS Office of Inspector General *(RMC 6/26/17, p. 1)*.

The seeds of the alleged false claims were planted when St. Agnes acquired MidAtlantic Cardiovascular Associates, with 12 cardiologists, in June 2011, the U.S. attorney's office said. St. Agnes employed the cardiologists, who now serve patients through Maryland Cardiovascular Associates. The 12 cardiologists entered into

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employment agreements that included a $400,000 base salary plus productivity bonuses based on work relative value units (RVUs) and bonuses for administrative services, according to the false claims complaint. For example, a bonus pool would materialize if their total RVUs exceeded a certain amount, and the bonus pool would then be allocated to cardiologists based on their own RVU levels.

The whistleblower is cardiologist Jonathan Safren, who was one of the 12 cardiologists employed by St. Agnes. The U.S. attorney's office said it intervened in the complaint for purposes of a settlement.

CCO Allegedly Said to Treat Next Visit as New Patient

The cardiologists met in late May 2011 with Brenda Hammerbacher, the director of compliance at the time and a certified coder, the complaint alleged. Hammerbacher allegedly "advised" the cardiologists that after becoming St. Agnes employees, "they should treat the next visit of every patient they saw as a new patient visit, regardless of whether the doctor had seen that patient within the previous three years." Safren spoke up, raising concerns about whether the compliance director's advice comported with billing rules. But he was overruled. "Ms. Hammerbacher and the Maryland Cardiovascular Associates discussed the billing practice, and reached a consensus that the physicians would follow the directive and would bill the initial patient visit with the St. Agnes Maryland Cardiovascular Associates as a new patient visit, even if the physician had provided services to the patient within the previous three years," according to the complaint.

In fact, Safren was told by three or four cardiologists that billing established patients as if they were new patients would help Maryland Cardiovascular Associates get their productivity bonus, the complaint alleged. Dr. Safren should play ball because he "would benefit if he billed in this manner as well since the total productivity bonus, and his portion of it, would be greater," according to the complaint.

The CPT manual and the Medicare Claims Processing Manual (Pub. 100-04) describe the differences between new and established patients. The CPT manual states that "a new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the physician or another physician from the same specialty who belongs to the same group practice within the past three years."

There are five CPT codes for office or outpatient visits provided to new patients (99201 to 99205) and five CPT codes for established patients (99211 to 99215). "These two series of codes are effectively mirror images of one another, and describe patients with corresponding levels of severity and medical need," the complaint states. "If a new patient with a particular medical condition has his office visit classified as 99203, the same patient with the same condition would have his visit classified as 99213 if he were an established patient."

Settlement: Overbilling Lasted Three Years

The Medicare Claims Processing Manual tells providers to "interpret the phrase 'new patient' to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years" (Chap. 12, Sec. 30.6.7).

New patients require a detailed history and exam. "The enhanced payment is intended to ensure that when a physician sees a patient for the first time, the physician is reimbursed for the additional time spent on a comprehensive examination and history," the complaint explains.

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Medicare eliminated the distinction between new and established patients at hospitals, effective Jan. 1, 2014, although it continues for physicians.

The whistleblower says he observed St. Agnes billing Medicare for new patients when they allegedly should have billed them as established patients between June 3, 2011, and Dec. 31, 2011. The settlement takes the ball and runs, with DOJ alleging that for E/M services provided between June 3, 2011, and June 3, 2014, "by the 12 cardiologists from MidAtlantic Cardiovascular Associates who became St. Agnes' employees, St. Agnes improperly submitted or caused to be submitted claims to Medicare using CPT codes 99201-99205 (new patient E&M codes) when CPT codes for existing patients should have been used." By reporting the new patient E&M codes instead of the existing patient codes, DOJ alleges St. Agnes received more Medicare money than it was entitled to, the settlement states.

CCO's Alleged Advice Could Be Misunderstanding

It sounds like the compliance officer believed that as soon as the cardiologists changed groups, they no longer had an established relationship with patients, says Boston attorney Larry Vernaglia, with Foley & Lardner LLP. If the new cardiology group has a different national provider identifier and tax identification number, "a reasonable person might have said that because it's no longer the same group practice, a person who presents there would have a new work-up and it's a new person to the group, which has a new billing system," he says. "That isn't an unreasonable interpretation of the Medicare manual." If Hammerbacher thought she was right and just made a mistake, "it's not a False Claims Act case. It's an overpayment," Vernaglia says. "Maybe the hospital settled because it's cheaper to settle it." Hospitals are wary of fighting false claims allegations, with the risk of per-claim fines of $10,957 to $21,916 plus treble damages if they lose. If the fines seem high, it's because they were increased by the Department of Justice in a rule published in the *Federal Register* on Feb. 2, 2017.

But the question is why the compliance officer allegedly met with the cardiologists to discuss billing in that context, says former compliance officer Debi Hinson, a compliance content developer with HealthStream in Nashville. "It's one thing if she had someone do an audit, but it seems bizarre to [allegedly] go in there and say that because you got purchased, all your patients are new patients," Hinson says. Compliance officers more typically meet with newly acquired practices to give them the hospital's policies and procedures, arrange or provide compliance training, and look at their compliance practices as a continuation of due diligence because "you don't want to purchase someone with liability outstanding," she says. The compliance officer's job is to assimilate a new practice into the hospital's policies and procedures—"not to give directions in how to bill something at the physician level, even if the compliance officer has certification in coding," Hinson says. "The compliance officer has to be independent and objective and make decisions based on facts."

Although the upcoding allegations occurred after St. Agnes employed the physicians, hospitals sometimes find billing time bombs lurking inside their physician-practice acquisitions, Vernaglia says. That raises the stakes for due diligence, which is an expensive

process of poring over physician practices, looking for billing, Stark, anti-kickback and other potential violations that could saddle new owners with enormous liability. "It's a thing we go through in acquisitions, but you only find as much as you are willing to pay auditors to look for," he notes.

Recently, self-disclosures have been figuring more into due diligence, Vernaglia says. Some companies up for sale have been disclosing potential Stark and/or anti-kickback violations to the federal government (e.g., CMS) to protect the buyer, he says. "Lately I am seeing more conservative self-disclosures," he says (*RMC 8/7/17, p. 1; 7/3/17, p. 1*). "A reasonable person might not have done it, but the buyer says it makes them feel better. The buyer makes it a condition of closing. The seller thinks it's a gray area, but the buyer doesn't want a self-disclosure on their watch."

St. Agnes Healthcare did not admit liability in the settlement, which doesn't mention the compliance officer. Hammerbacher is still listed on LinkedIn as an employee of St. Agnes—it states she worked there 18 years—and her title now says vice president. But the hospital switchboard has no one listed by that name. The hospital's attorney didn't respond to a request for comment, and the hospital administration didn't respond to a request for comment. The whistleblower attorney declined to comment.

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IRS Revokes Hospital Tax Exemption For Noncompliance With 501(r)

The IRS has yanked the tax exemption of a nonprofit hospital for failing to perform an adequate community health needs assessment (CHNA) under the 501(r) regulation, which stems from the Affordable Care Act (ACA). This is a wake-up call for hospitals about 501(r) and IRS reviews of compliance with the regulation, which requires hospitals to have a well-publicized financial-assistance policy (FAP) for emergency and medically necessary care and perform a CHNA (*RMC 11/2/15, p. 4; 1/19/15, p. 3*).

In a letter to the hospital released Aug. 4, the IRS says the hospital's exempt status under 501(c)(3) of the Internal Revenue Code (IRC) is revoked retroactive to an unspecified date. The IRS explained that its revocation decision was based on the fact that "you are a hospital organization which failed to comply with the requirements of IRC section 501(r), to conduct a community health needs assessment, adopt an implementation strategy and make it widely available to the public," according to the IRS letter, which doesn't identify the hospital.

This is the first time a hospital lost its tax exemption for failing to comply with the CHNA rules, says Washington, D.C., attorney Alexander Reid, with Morgan Lewis. It probably won't be the last hospital to face revocation once the IRS identifies organizations that run afoul of the 501(r) regulation. He figures the hospital probably also was fined $50,000 under Section 4959.

Oversight of the 501(r) regulation is tailor-made for compliance officers, says Los Angeles attorney Travis Jackson, with King & Spalding. "That probably sends chills down every compliance officer's spine since it's another thing to worry about, but compliance is probably in a better position to lead the charge than the legal or tax finance departments because it's more familiar with doing self-audits and knowing whether to bring in external resources. Most organizations have a schedule of regular reviews and that's what 501(r) really needs." Whatever health systems decide, "there needs to be a coordinated approach."

Meanwhile, the IRS's revocation of the hospital's exemption serves as a reminder that "dual status entities" that no longer need 501(c)(3) status and don't intend to comply with the community health needs assessment should relinquish their 501(c)(3) exemptions using a new IRS procedure rather than waiting for revocation by IRS audit, Reid says. Dual-status entities are hospitals that are tax exempt because they're both government entities and charitable organizations, he says. The hospital that had its tax exemption revoked apparently was a dual-status entity.

IRS Is Doing Annual Reviews

The revocation appears to stem from annual IRS reviews of 501(r) compliance mandated by the ACA, says Indianapolis attorney Jeffrey Carmichael, with Hall Render. "They are supposed to look at every hospital at least once every three years," he says. "This is an area where the IRS is being very vigilant. We are seeing the IRS sending follow-up questions to a lot of hospitals about their compliance with 501(r)." They're mostly "baseline" compliance questions, Carmichael says. For example, hospitals are asked whether the FAP, application and CHNA are posted on their website, which may indicate the IRS had trouble finding them. "Anything the hospital can do to show the IRS up front that it is working to comply with the regulations is a step in the right direction," he says.

Under the 501(r) regulation's FAP requirement, hospitals must limit charges to what insurers generally pay. It's designed to insulate uninsured patients

from the sometimes exorbitant prices listed on hospital chargemasters, which can cause them to pay more than patients covered by Medicare, Medicaid and private insurers. The FAP is, essentially, a charity care policy, which many hospitals already have. If they don't, they need to get an FAP, and if they do, they have to conform it to the IRS rule. 501(r) requires hospitals to describe their discounts available under the FAP and to widely publicize the FAP in their community. The policies have to be posted on their websites with paper versions made available free, if requested. The regulation requires billing statements to include "a conspicuous written notice that notifies and informs the recipient about the availability of financial assistance under the hospital facility's FAP and includes the telephone number of the hospital facility office or department that can provide information about the FAP." Hospitals also must do their best to qualify patients for the FAP before engaging in "extraordinary collection actions."

Hospital Seemed Cavalier About Revocation

The 501(r) regulation also says that every three years, tax-exempt hospitals have to perform a CHNA. The CHNA must describe the "community" the hospital serves, the hospital's process for conducting the CHNA, external input the hospital received and how it was received (i.e., from medically underserved, low-income and minority populations), the health needs of the community and how they are prioritized, and what facilities and resources are available to meet community health needs.

If hospitals fail to comply with 501(r), they could lose their tax exemptions, although they're permitted to remedy minor omissions and violations.

In the letter, the IRS conveys how cavalier the hospital was about losing its 501(c)(3) tax exemption. During interviews with the IRS, the hospital several times stated that it "really did not need, actually have any use for, or want their tax-exempt status under IRC Sec. 501(c)(3). They maintained that there were times that their tax-exempt status actually prevented the facility from becoming involved in some of the various Medicare reimbursement or payment arrangements," the letter notes.

That won't be the norm for typical community hospitals, which are only exempt under 501(c)(3) and must comply with the 501(r) regulation, Reid says. Thumbing their nose at the exemption will, however, be a more adaptive response for dual-status entities that enjoy tax exemption as both a government instrumentality of the state and a 501(c)(3) exempt organization, he says. The reason these hospitals are protected independent of their 501(c)(3) status, Reid says, is that the federal government can't tax the states (and vice versa), a principle enshrined in an 1819 U.S. Supreme Court decision: *McCulloch vs. Maryland*.

"You only have to comply with 501(r) if you are 501(c)(3)," he says. Hospitals also would be free of 990s, the informational forms for charitable organizations, if they give up 501(c)(3) status. But there are some things to consider before hospitals drop their exemptions. They won't be listed in the IRS business master file anymore, which could affect charitable donations, Reid says. "A lot of donors want to see you listed there if they will make charitable donation," he notes. "And it's a bit of a black mark" to lose your 501(c)(3).

The IRS recently created revenue procedure 2017-5 for dual-status hospitals to relinquish their 501(c)(3) exemptions. "This is a better way to go than to wait for the IRS to come calling about your community health needs assessment," Reid says, particularly since it avoids the $50,000 excise tax.

Touch Base With Employees for Better Compliance

To improve compliance with the 501(r) regulation, hospitals should continually touch base with employees who have anything to do with the patient experience, from registration to discharge, Jackson says. "They need to know about 501(r)," he says. "My worry is whether or not hospitals have done the training to reach all these people because patients enter the hospital through multiple avenues and all these employees need to be trained on the basics of 501(r), especially when it comes to the availability of financial assistance." Jackson believes hospitals struggle to ensure employees have the correct answers to patient questions, such as whether the hospital offers financial assistance and, if so, what kind. "Has everyone been trained on how to answer that question?"

More specifically, the IRS is concerned whether hospitals are capable of translating FAPs into another language for people in the community with limited-English proficiency (LEP), Jackson says. The 501(r) regulation mandates FAP translations "in the language spoken by each LEP language group that constitutes the lesser of 1,000 individuals or 5 percent of the community served by the hospital facility or the population likely to be affected or encountered by the hospital facility."

Hospitals will be vulnerable unless they ensure they comply with 501(r) requirements for widely publicizing certain documents. "Make sure documents required to be on the website are on the website and easily found," says Paige Gerich, a tax partner with

BKD in Houston. That includes the FAP and the related application for financial assistance, and the CHNA and its implementation strategy, she says. Although "easily found" may be a subjective standard, the bottom line is that a layperson shouldn't have to go on a treasure hunt to find the documents.

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CDI Should Follow Move to Outpatient Services, Plays Role With HCCs

A patient with a lot of chronic conditions—hypertension, diabetes, congestive heart failure, peripheral vascular disease, chronic kidney disease and a recent transient ischemic attack (TIA)—shows up at her primary care physician's office. The physician orders several prescriptions, tests and an expensive procedure, carotid angioplasty. During the procedure, the patient suffers heart failure, leading to end-stage renal disease, and requires dialysis in the hospital. But the physician only documented the TIA and vascular disease, which means the severity of the patient's illness and clinical complexity weren't captured. That kind of disconnect will costs physicians under the Merit-Based Incentive Payment System (MIPS) of the Medicare Access and CHIP Reauthorization Act (MACRA). Like other pay-for-performance programs, reimbursement is linked to the 79 Hierarchical Condition Categories (HCCs) that map to 9,000 ICD-10 codes, says Ellis "Mac" Knight, M.D., senior vice president and chief medical officer for the Coker Group in Alpharetta, Ga. HCCs, which are also used by Medicare Advantage plans, assign a risk factor based on the patient's health condition and demographics.

If the patient had decompensated seemingly out of the blue after MIPS took effect (Medicare physician payments will be adjusted in 2018 based on 2017 data), "the provider would have been penalized for poor quality outcomes," he said. "Without documentation of the chronic conditions and without their being captured in an HCC, this patient looked much less severely ill than they really were," said Knight, noting this is a real case.

Hospitals and physicians probably will see more gaps between outpatient documentation and clinical reality as services shift to outpatient settings, but clinical documentation improvement (CDI) programs live on the inpatient side. A change is coming, however, he predicts. "Clinical documentation and coding will be extremely important as the health care industry moves more services to the ambulatory sector and more services are reimbursed through pay-for-performance and value-based mechanisms," Knight said Aug. 23 during a webinar sponsored by the Health Care Compliance Association.

Outpatient CDI Is 'A Different Animal'

CDI programs have long focused on improving DRG assignments. CDI specialists work with physicians to ensure documentation is accurate so it translates to the right billing code, and captures the severity of illness or complexity of the population for the sake of physician report cards and in response to CMS's readmission reduction program, hospital-acquired condition reduction program and other pay-for-performance programs, Knight said.

The outpatient side has similar clinical documentation challenges, "but the time frame and volume of encounters makes ambulatory CDI a much different animal," he said. For example, most primary-care office visits last 15 minutes to an hour, compared to an average inpatient hospital stay of three to four days. "That's why I believe ambulatory CDI is going to require much more automation (e.g., voice transcription) than inpatient CDI to make it effective," Knight said.

CDI programs also have compliance risks and require ironclad documentation to minimize them, Knight said. The core elements of compliance are:

◆ **Medical necessity**: Clinical documentation has to support the ordering of tests, the performing of procedures and the prescribing of drugs that Medicare and other payers are expected to cover. Otherwise, "payment may be denied and referrals may not happen and clinical care may suffer," Knight noted. At a hospital's request, he recently reviewed angiographies and angioplasties performed by one vascular surgeon. Payers often require documentation of symptoms, such as of claudication (pain in the legs at rest); signs, such as ischemic changes of the extremities; and less-invasive treatment before surgery (e.g., exercise). "There was very little documentation to justify performing the tests or procedures," he said.

◆ **Services rendered and level of care**: Clinical notes must reflect the services performed and the level of services (e.g., evaluation and management levels). One hospital became anxious about the billing by a group of employed gastroenterologists who used a standardized template in the electronic health record (EHR) system to document their patient visits. "They were seeing 12 patients an hour, five minutes per patient, and most were being coded an E/M level four," he said. The typical amount of time spent with patients who are billed at level four (CPT code 99214) should

be 25 minutes. "It was clear that again, their documentation was being done in a templated fashion, which didn't reflect the level of service rendered," he noted.

◆ **Diagnoses that best fit the clinical situation**: Documentation has to justify the ambulatory payment group (APC), and keep in mind that a single diagnosis can modify the APC. For example, a patient seen for atypical chest pain in the emergency room is admitted as an inpatient and has a work-up (e.g., cardiac monitoring, stress test, cardiac enzyme analysis and series EKGs). All services could have been provided during observation under a single APC. Medicare "will deny that admission and the DRG will not be paid as opposed to the APC for that workup," Knight said.

◆ **Quality of care**: Clinical documentation must include quality measures, including immunizations, tobacco-use identification, smoking-cessation counseling, body-mass index measurement, obesity counseling and preventive care (e.g., colonoscopy, mammography). For example, a physician reports to CMS that all her patients are asked whether they smoke and, when appropriate, get smoking-cessation counseling. But on audit, the EHRs only back her up 70% of the time, and the physician is subject to repayment of CMS performance incentives, Knight says.

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CMS OKs Mid-Level Admission Orders

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Admission orders come up frequently as a cause of claim denials in QIO reviews *(RMC 4/3/17, p. 1)*. Either they're incomplete or unsigned or the orders are signed by people who lack hospital privileges or aren't authorized to admit patients.

Until the bulletin, hospitals were a little uncomfortable about Part A claims riding solely on admission orders from mid-level practitioners—either ordered in person or verbally ordered and later authenticated by them—because CMS's Jan. 30, 2014, guidance on "Hospital Inpatient Admission Order and Certification" wasn't the picture of clarity, says Edward Hu, M.D., system executive director of physician advisor services at UNC Health Care System. "In one paragraph, they seemed to say yes, but a couple paragraphs later, CMS seems to require a separate ordering practitioner to counter-sign the order," he says.

The new bulletin is a "welcome clarification. This opens the door for nurse practitioners and physician assistants in certain states to admit patients independently," Hu says. But it will depend on a state's scope-of-practice laws for mid-level practitioners. "In many states, nurse practitioners can practice independently without a supervising physician, but in others they must be supervised closely by a physician. While all physician assistants require a supervising physician, the level of supervision required by each state also varies widely. A careful review of the laws in your state is imperative if a hospital wishes to utilize this guidance to grant admitting privileges to [mid-levels]."

Only Clinicians In the Know Can Write Orders

The bulletin will come as a relief for hospitals because orders written by mid-levels have not been giving them a peaceful, easy feeling, says Ronald Hirsch, M.D., vice president of R1 Physician Advisory Services. He knows of one hospital that faced a slew of claim denials for inpatient admissions because they were ordered by nurse practitioners, even though they have hospital privileges and are authorized by the state to admit.

CMS emphasizes the need for the physician or mid-level practitioner who writes the order to be involved in the patient's care. As the bulletin states, "CMS considers only the following practitioners to have sufficient knowledge about the beneficiary's hospital course, medical plan of care, and current condition:

CMS Transmittals

Aug. 18 - 24

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. 100-04, Medicare Claims Processing Manual

- Implement Operating Rules—Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule—Update from Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE), Trans. 3841 (Aug. 18, 2017)
- Healthcare Provider Taxonomy Codes (HPTCs) October 2017 Code Set Update, Trans. 3842 (Aug. 18, 2017)
- Influenza Vaccine Payment Allowances—Annual Update for 2017–2018 Season, Trans. 3837 (Aug. 18, 2017)
- Claim Status Category and Claim Status Codes Update, Trans. 3839 (Aug. 18, 2017)

Pub. 100-20, One-Time Notification

- Guidance on Implementing System Edits for Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), Trans. 1910 (Aug. 18, 2017)

a. The admitting physician of record ('attending') or a physician on call for him or her

b. Primary or covering hospitalists caring for the patient in the hospital

c. The beneficiary's primary care practitioner or a physician on call for the primary care practitioner

d. A surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for him or her

e. Emergency or clinic practitioners caring for the beneficiary at the point of inpatient admission

f. Other practitioners qualified to admit inpatients and who are actively treating the beneficiary at the point of the inpatient admission decision."

The Burden of Proof Is on Hospitals

Although the bulletin should put an end to denials based on compliant mid-level practitioner orders, it doesn't extend to orders written by mid-levels covering for other mid-levels in their practice, Hirsch says. "While a physician can sign an order covering for another physician who gives a verbal order, it does not apply to mid-level practitioners," he explains. "The only person who can give the admission order is a mid-level who actually participated in the admission decision. They must sign the order themselves."

It's probably a good idea not to take lightly CMS's statement that the burden is on hospitals to prove mid-level practitioners met all three conditions when their admission orders aren't co-signed by physicians. But it raises the question of whether proof has to be inside the medical record itself or just available when the QIO audits, says Hu, who is president of the American College of Physician Advisors.

Hirsch says hospitals have to maintain copies of all state statutes allowing mid-levels to admit patients "and all up-to-date privileging paperwork available for the mid-level practitioner if audited. The QIO will not research state law to find out if allowed or accept the hospital's word that they are privileged. Remember, privileges must be renewed periodically per rules and bylaws so that must be up to date and not expired or delinquent."

Although the bulletin is very helpful, Hirsch still thinks "CMS makes too much out of orders." For example, if a patient is admitted to a skilled nursing facility after an inpatient stay based on an order that was never authenticated, there is no SNF eligibility in CMS's eyes, he says. "It's ludicrous a signature has so much weight. But I don't make the rules," Hirsch says.

The provider bulletin doesn't otherwise clarify the 2014 guidance on admission orders and certifications. The two-midnight rule requires hospitals to certify the medical necessity of inpatient stays that last 20 days or more and include the reason for the inpatient services and plans for post-hospital care in certifications. Only physicians, dentists and podiatrists may sign certifications, Hu notes. Mid-levels can't certify their own cases.

When the two-midnight rule first debuted, effective Jan. 1, 2014, the certification was required for all inpatient admissions *(RMC 9/2/13, p. 1)*, but CMS revised it.

Contact Hirsch at rhirsch@r1rcm.com and Hu at edward.hu@unchealth.unc.edu. The provider bulletin is available at https://www.bfccqioarea1.com/file/providers_bulletinVII.pdf. ✧

NEWS BRIEFS

◆ **CMS has announced a new web page devoted to the *Jimmo* case.** After a 2013 settlement and subsequent legal skirmishing, *Jimmo* established that Medicare covers skilled nursing care and therapy for patients to maintain function or prevent decline *(RMC 8/22/16, p. 8)*. The plaintiffs in a lawsuit against CMS, *Jimmo vs. Burwell*, had alleged there was "a covert rule of thumb" requiring Medicare beneficiaries to show improvement in order to receive certain benefits (e.g., home health care). The *Jimmo* settlement required manual revisions to restate a "maintenance coverage standard" for skilled nursing and therapy services under these benefits, although there have been disagreements about how it has been carried out. (*RMC 2/20/27, p.1*) Visit http://tinyurl.com/y9vppnr3.

◆ **Peachtree Neurological Clinic in Atlanta uncovered a breach in its computer system while investigating a ransomware attack that turned out to be unrelated.** According to a clinic statement, its electronic medical records were encrypted by the ransomware. Peachtree didn't fork over the ransom and restored its files using backups. But while investigating the attack, the clinic found that its computer system had been accessed by unauthorized people between February 2016 and May 2017. The clinic couldn't tell what was accessed, but said it's possible the electronic medical record system was breached, which would have exposed personal and medical information. Visit http://bit.ly/2vsVIsW.