

MEDICARE COMPLIANCE

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

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Minor Procedures Are Hit Hard in Audits; Outpatient Focus Survives ‘Two Midnights’

With the pain and bleeding associated with “minor procedures,” there is nothing minor about them for doctors and patients. But Medicare figures they generally require fewer than 24 hours in the hospital, which means minor procedures are billed as an outpatient stay, and a CMS official says things stay pretty much the same under the two-midnight rule. But minor procedures are the source of frequent claim denials and appeals, which may continue unless documentation keeps pace with the changes under the 2014 inpatient prospective payment system regulation.

“Minor surgical procedures were almost never appropriate for inpatient admission under the old inpatient admission rule,” Jennifer Dupee, a nurse consultant in the CMS Provider Compliance Group, said on a Jan. 14 CMS conference call about the two-midnight rule (see brief, p. 8). “That does not change under two midnights. But we are saying if there is an unexpected circumstance, such as complications, that it becomes clear at the second day that the beneficiary requires a second midnight, as long as the beneficiary needs medically necessary hospital care for a second midnight, that would be an appropriate inpatient admission.”

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RACs Extended, ALJ Hearings Delayed; Congress Requests More RAC Oversight

CMS has extended the contracts of the existing recovery audit contractors (RACs) — apparently through June — so requests for medical records and claim denials will keep on coming. But attempts to get claim denials overturned will slow down considerably, as the Office of Medicare Hearings and Appeals (OMHA) said in a recent memo that requests for hearings filed with administrative law judges (ALJs) will be delayed for two years.

Meanwhile, Congress has something to say about RAC behavior and program integrity in its omnibus spending bill, the Consolidated Appropriations Act of 2014. One provision talks about the concern that RAC incentives are overly aggressive. Information from OMHA “indicates that about 50 percent of the estimated 43,000 appeals were fully or partially overturned at its level,” the budget document notes. “The fiscal year 2015 budget request should include a plan with a time line, goals, and measurable objectives to improve the RAC process. In addition, CMS is expected to work with Congress and stakeholders to identify challenges and additional reforms. Further, CMS should establish a systematic feedback process with the OMHA, CMS programs, and the RACs to prevent the appearance that RACs are selecting determinations to increase their fees.”

But in another section, Congress urges CMS to intensify its “focus on preventing improper payments and paying claims right the first time.” That includes addressing vulnerabilities identified by RACs.

continued

Emily Evans, a partner in Obsidian Research Group in Nashville, says while it does seem like “doublespeak, the specificity of the RAC language suggests that they want CMS to establish that RACs are being used as intended.” While two-thirds of the claims approved for RAC review are inpatient claims, she says, “the CERT report says that by dollar value, those claims represent about one-third of the \$32 billion in improper payments.”

For now, RACs continue their work uninterrupted. CMS announced on its website Jan. 8 that the current RACs will keep at it while CMS “continues the procurement process for the new Recovery Audit Program contracts.” The same old RACs will engage in “active recovery auditing,” which means sending providers additional documentation requests and semi-automated review notification letters and doing automated reviews. But there won’t be any overlap with the old and new RACs after the next round of five-year contracts is awarded.

“As far as I can tell, it will be business as usual,” says Stephanie Burnside, RAC analyst at St. Francis Medical Center in Monroe, La. RACs, however, cannot review claims with admission dates of Oct. 1, 2013, through

March 31, 2014 — and those will remain forever off-limits except to probe audits by Medicare administrative contractors, says Steven Meyerson, M.D., senior vice president of the regulations and education group at Accretive Physician Advisory Services. Their prepayment reviews of eight MS-DRGs were also cancelled. “Starting April 1, all bets are off,” Meyerson notes.

Burnside predicts RAC activity will pick up after a recent lull, during which she has seen medical-record requests drop significantly. A large number of the audits focus on minor procedures (see story, p. 1) and MS-DRG validations.

Hospitals May Have Appeals Recourse

Because of the overwhelming workload — OMHA says there are 357,000 appeals awaiting attention at the 65 ALJs — Chief Administrative Law Judge Nancy Griswold informed “appellants” to expect “significant delays.” OMHA also announced a Feb. 12 public meeting, where it will explain plans to streamline the review process. But Meyerson wonders what rabbit OMHA will pull out of its hat “when 15,000 appeals are added to the queue each week” and it hasn’t received more funding. So far, OMHA has suggested hospitals waive hearings on their appeals and let ALJs decide them based on the written record. Paper appeals are processed faster, Meyerson says. He also suggests one offbeat strategy: consider asking beneficiaries to file appeals of claim denials under their name, although the hospital would do the legwork. “OMHA said it would process beneficiary appeals much more quickly than provider appeals,” he notes.

Another strategy for hospitals is to get out of the ALJ queue and request escalation to the Medicare Appeals Council, where there is reportedly no backlog, Meyerson says. “A large number of appeals council requests will put stress on the 4th level of appeal and increase the pressure for reform of the entire RAC review process,” he notes (see “Escalation Rights” at <http://tinyurl.com/nys968y>).

ALJ Schedule Is ‘Crazy’

It’s not all quiet on the ALJ front. WellSpan Health in York, Pa., was floored to find out its ALJ just scheduled 13 hearings for one day. “In the past, we could have one or two scheduled on the same day and each appeal could take up to one hour,” says Wendy Trout, director of corporate compliance. “We are being told that these will all need to be done in 20 minutes each. That is just crazy!”

Contact Burnside at Stephanie.Burnside@fmoths.org, Evans at Emily@obsidianresearchgroup.com and Meyerson at smeyerson@accretivehealth.com. Information about the daylong OMHA hearing may be accessed at <http://tinyurl.com/kwj6xn8>. ✧

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DOJ Intervenes in Eight False Claims Act Lawsuits Against HMA

Two major risks facing hospitals — medically unnecessary admissions and inappropriate physician compensation — have come together in one of the largest enforcement actions facing a hospital company in recent years.

The Department of Justice said Jan. 13 that it has intervened in eight false claims lawsuits filed by whistleblowers against Health Management Associates Inc. (HMA), a Naples, Fla.-based for-profit company with 71 hospitals in 15 states. The lawsuits allege the fraud scheme at the hospitals, which are mostly in non-urban areas in the southeast, was engineered by top executives.

HMA hospitals are accused of admitting inpatients who could have been treated as outpatients, in observation or released, DOJ says. HMA allegedly paid kickbacks to physicians for referrals, according to the lawsuits, one of which alleges HMA formed a joint venture and charged physicians a below-market price for a lucrative investment opportunity. The alleged misconduct led to inflated Medicare and Medicaid charges.

“These are some eye-opening allegations if proven,” says Philadelphia attorney Marc Raspanti, who represents two of the whistleblowers. He was surprised by “the degree to which HMA [allegedly] locked down referrals by physicians....Where was their compliance department? Where were their lawyers? I don’t have answers to these questions.”

CFO Allegedly Told to ‘Burn’ Audit Report

Compliance didn’t fare so well at HMA, says Atlanta attorney Marlan Wilbanks, who represents two other whistleblowers. One of them, Ralph D. Williams, the former chief financial officer of Walton Regional Medical Center in Georgia, allegedly was told by a senior leader to “burn” an audit report that showed “overutilization of inpatient admissions and underutilization of observation,” his false claims lawsuit alleges.

HMA allegedly sought to maximize admissions by setting corporate goals. It allegedly “tracked and disseminated each of its hospital’s inpatient admissions versus observations and set forth a delinquency rate and acuity goals for each hospital that failed to achieve the corporate goal for the percentage of various patient populations that should be admitted,” the lawsuit alleges. It was akin to a competition among HMA hospitals, Wilbanks says. “This is the type of mess you get in when compliance is weakened by the corporate drive for profits,” he says.

Another whistleblower filed a false claims lawsuit against Walton Regional Medical Center and Barrow Regional Medical Center, also in Georgia. Emergency

department physician Craig Brummer, M.D., was an ED medical director at both hospitals. According to the complaint, he participated in daily ED “flash meetings,” during which “hospital administrators would pressure ED physicians by reviewing each patient in the ED that had not been admitted as an inpatient to see if that patient should have [been] or could be admitted; and to re-emphasize to the physicians the HMA mandate that they get more patients admitted to the hospital.”

Plan Was Allegedly Hatched by HMA Execs

The push to admit patients allegedly came from the top and filtered down to physicians. “The scheme was directed by top executives at HMA and executed via pressure applied on HMA divisional officers who in turn pressured hospital level executives, who pressured contract physician groups,” the lawsuit alleges.

Although ED physicians don’t write admission orders, HMA directed them to take steps to generate admissions, the lawsuit alleges. For example, ED physicians were required to use the HMA Pro-Med emergency department management computer system, which ordered tests based on a “chief complaint” entered by a nurse instead of the patient’s medical condition as decided by a physician. “HMA pressured ED physicians to follow HMA’s ‘testing guidelines’ and monitored the physicians’ activities in the Pro-Med system to see if they were properly implementing HMA’s corporate mandates,” the lawsuit alleges.

If physicians didn’t play ball, HMA management would approach Brummer about removing them from the schedule, the lawsuit alleges.

Joint ventures were the subject of one of the false claims lawsuits against HMA, which was filed by whistleblowers George Miller and Michael Metts, former CEO and CFO/compliance officer, respectively, of both Lancaster Regional Medical Center and Heart of Lancaster Regional Medical Center in Pennsylvania. When they started their jobs in 2008, the CFO and CEO got the message they should complete as many joint ventures as possible because physician-owned hospitals were facing restrictions under the Affordable Care Act. In 2009, HMA completed 16 whole-hospital joint ventures, the lawsuit alleges.

Miller and Metts were advised in the summer of 2008 to “capitalize on physicians who could refer patients” to Heart of Lancaster by pursuing a “syndication” with them. Under the direction of a regional HMA vice president, the CEO and CFO tailored an HMA joint venture PowerPoint presentation for eligible staff physicians. If the physicians invested in the joint venture — a newly created LLC that would invest in the hospital — the physicians could expect an average return of 20% every year

for five years based on one more patient admission per day, the lawsuit alleges.

HMA would maintain majority ownership of the LLC, with a limited number of physicians allowed to buy 10%. The price for buying into the joint venture was

artificially low, the lawsuit alleges. It was “a heavily discounted investment opportunity utilized to induce targeted physicians to participate in the joint venture” (e.g., a 20% “marketability discount to the wholesale value”).

The lawsuit alleges more shenanigans with a joint venture involving Lancaster Regional Medical Center.

HMA’s joint ventures allegedly violate the anti-kick-back law because an ownership interest was transferred for less than fair market value, the lawsuit contends. “HMA provided an inducement to the joint venture physicians, one purpose of which was to encourage referrals to HMA facilities,” the lawsuit alleges. This allegedly gives rise to false claims liability.

HMA’s outside counsel did not return a call from RMC. In a statement, HMA says “as a matter of policy we do not comment on pending litigation. The existence of the government’s investigation into the issues raised in the unsealed *qui tam* cases has been disclosed for some time in HMA’s public SEC filings. While our legal team addresses these matters and continues to cooperate with the Department of Justice’s ongoing investigation, HMA associates and physicians who practice at our facilities are focused on providing the highest quality patient care in all of our hospitals.”

Contact Wilbanks at mbw@wilbanks-bridgeslaw.com and Raspanti at MSR@Pietragallo.com. The cases are *United States ex rel. Brummer v. Health Mgmt. Assocs. Inc., et al.*, 3:09-cv-135 (CDL)(M.D. Ga.); *United States ex rel. Williams v. Health Mgmt. Assocs. Inc. et al.*, 3:12-cv-151 (M.D. Ga.); *United States ex rel. Plantz v. Health Mgmt. Assocs. Inc., et al.*, 13C-1212 (N.D. Ill.); *United States ex rel. Miller v. Health Mgmt. Assocs. Inc., et al.*, 10-3007 (E.D. Pa.); *United States ex rel. Mason v. Health Mgmt. Assocs. Inc., et al.*, 3:10-CV-472-GCM (W.D.N.C.); *United States ex rel. Nurkin v. Health Mgmt. Assocs. Inc., et al.*, 2:11-cv-14-FtM-29DNF (M.D. Fla.); *United States ex rel. Jacqueline Meyer & Cowling v. Health Mgmt. Assocs. Inc., et al.*, 0:11-cv-01713-JFA (D.S.C.); and *United States ex rel. Paul Meyer v. Health Mgmt. Assocs. Inc., et al.*, 11-62445 cv-Williams (S.D. Fla.). ♦

Auditors Target Spine Procedures; Coding, Medical Necessity Are Key

The heat is on orthopedic procedures as Medicare and private payers question the medical necessity of performing them in certain circumstances and deny claims if the codes don’t square with the procedures. Hospitals and physicians are facing more scrutiny in some areas, such as joint replacement, where the most recent comprehensive error rate testing (CERT) report cites a 12.6% Medicare improper payment rate. It helps to beef up documentation, although it can be an uphill battle

CMS Transmittals and Federal Register Regulations

Jan. 10 — Jan. 16

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Transmittals

(R) indicates a replacement transmittal.

Pub. 100-02, Medicare Benefit Policy Manual

- Manual Updates to Clarify Skilled Nursing Facility, Inpatient Rehabilitation Facility, Home Health, and Outpatient Coverage Pursuant to *Jimmo vs. Sebelius* (R), Trans. 179BP, CR 8458 (Jan. 14; eff./impl. Jan. 7, 2014)

Pub. 100-04, Medicare Claims Processing Manual

- Changes to the Laboratory National Coverage Determination Edit Software for April 2014 (ICD-10), Trans. 2852CP, CR 8585 (Jan. 10; eff. April 1; impl. April 7, 2014)
- Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program - April 2014, Trans. 2853CP, CR 8568 (Jan. 10; eff. April 1; impl. April 7, 2014)
- New Waived Tests, Trans. 2854CP, CR 8560 (Jan. 10; eff. April 1; impl. April 7, 2014)
- Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update, Trans. 2855CP, CR 8561 (Jan. 10; eff./impl. April 7, 2014)

Pub. 100-06, Medicare Financial Management

- Notice of New Interest Rate for Medicare Overpayments and Underpayments - 2nd Qtr. Notification for FY 2014, Trans. 230FM, CR 8624 (Jan. 13; eff./impl. Jan. 21, 2014)

Pub. 100-08, Medicare Program Integrity Manual

- Complex Medical Review (R), Trans. 501PI, CR 8429 (Jan. 9; eff./impl. Oct. 10, 2013)

Federal Register Regulations

Final Rules

- Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services Waivers, 79 Fed. Reg. 2947 (Jan. 16, 2014)
- Correction: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates, 79 Fed. Reg. 1741 (Jan. 10, 2014)
- Correction: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2014, 79 Fed. Reg. 1742 (Jan. 10, 2014.)

Proposed Rule

- Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 79 Fed. Reg. 1917 (Jan. 10, 2014)

because coding rules haven't always kept up with technology advances and operative notes can be maddeningly vague, consultants say.

"There is a way payers can deny and come back and say 'prove it,'" says Carolyn Neumann, senior manager of coding and coverage access at Specialty Healthcare Advisers in Manchester, Conn. And "people don't always understand what they should and shouldn't do to be compliant."

Orthopedic Procedures Are a Major Focus

Orthopedic procedures are taking a lot of hits. The most recent Medicare (CERT) annual fee-for-service improper payment report, released in September 2013, found that "services related to major joint replacements had an improper payment rate of 12.6 percent, accounting for 2.3 percent of the overall Medicare FFS improper payment rate" in 2012. Medicare administrative contractors (MACs) are conducting prepayment and postpayment reviews of joint replacement, wanting proof that hospitals and physicians exhausted less radical treatment before replacing hips or knees (*RMC 9/24/12, p. 1*). Also, spinal fusion has been added to the risk areas of the Program for Evaluating Payment Patterns Electronic Report (PEPPER), underscoring CMS's concerns that hospitals are performing medically unnecessary spinal fusions (*RMC 2/6/12, p. 1*). The *Journal of the American Medical Assn.* on April 7, 2010, published a study citing a 15-fold increase in complex fusion procedures performed on Medicare beneficiaries between 2002 and 2007. And of course there was also the Department of Justice's enforcement action against kyphoplasty, which led 100 hospitals to settle false claims cases for billing for the spine procedure on an inpatient basis when it allegedly should have been performed outpatient (*RMC 6/29/09, p. 1; 9/9/13, p. 8*). And that isn't all. Because musculoskeletal disorders generally consume a large share of Medicare funds, Medicare watchdogs have their eye on all angles (*RMC 2/18/13, p. 1*), including back and neck procedures except spinal fusion and durable medical equipment supplies for orthopedics.

Neumann says there are risks with coding, coverage and medical necessity, which overlap. In her experience, auditors, both internal and external, look first at whether the code matches the documentation. "Maybe the documentation doesn't support it," she says. The next level is whether the service provided conforms to the payer guidelines. "There are so many variables. Trying to do it right is almost impossible," Neumann says. "You are in a situation at every turn. The rules aren't definitive. You are subjecting yourself as a coder and provider of medical care to ambiguity that can then be seen as fraud or abuse. Maybe the code didn't express what the [physi-

cian] did. You have all those questions to ask yourself and you are fearful of doing it wrong."

Complicating matters, starting in January 2013, private payers and Medicare Advantage plans uniformly required preauthorization for spine procedures. But they may deny claims later if the diagnosis codes given up front don't support medical necessity in the payers' eyes. "You have to go in knowing that you have the documentation and support for the procedure on the front end, and on the back end you can get denied anyway and have to appeal," Neumann says. The payer will argue the spine procedure is not covered because it's considered medically necessary only for certain diagnosis codes, which don't match the diagnosis codes on your claim.

The top reason for claim denials is a lack of documentation establishing the medical necessity of a spine procedure, Neumann says. Sometimes it's because hospitals don't have access to the medical records establishing that physicians exhausted more conservative routes of treatment before resorting to surgery (e.g., joint replacement). Sometimes it's because hospitals and physicians used a product where the indications were inappropriate. Suppose they used an interbody device when performing a lumbar fusion and that device is FDA-approved only for L1-L5 fusions. But during the procedure, the device was used on L5-S1 "and that makes it off-label use and payers have guidelines that say they don't pay for off-label use," Neumann says. "If not reviewed that closely before the procedure, it's another reason they could deny." Another documentation disconnect involves the use of the "experimental and investigational" label and the use of radiographic evidence. "Payer policies go into gory detail to say something is 'experimental and investigational,'" which gives them a reason to deny a claim, Neumann says. Suppose a payer denies a claim because the surgeon used a device that was not approved on the grounds it was experimental and investigational. But this gets tricky. For example, the surgeon uses an FDA-approved device in a spinal fusion or decompression and argues accordingly, supporting his or her position with radiographic images. But the payer rejects the appeal on the grounds that the device was approved

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only for one-level uses (e.g., L3), and the surgeon operated on L4 and L5. Sometimes this situation works in reverse, with surgeons able to support their claims using radiographic images, Neumann says. Either way, the scenario highlights how deep auditors are digging into the medical necessity of orthopedic surgery and should send shivers up hospital managers' spines.

Using Wrong Codes Will Always Be a Problem

Finally, payers often deny claims because providers used the wrong code. It wasn't supported by the operative note or office visit notes (e.g., the reason for the surgery wasn't documented or doesn't match the diagnosis code), Neumann says.

She sees a lot of coding errors with lumbar decompression, which attempts to relieve pain caused by pinched nerves. The coding errors probably stem from the fact that there are several ways to approach it. They may do an open procedure, with the spine literally open. They visualize their approach, and then do a microdiscectomy. That method is typical for herniated discs or other types of degenerative disc diseases, Neumann says. But with new technology, there also are arthroscopic or endoscopic procedures. Instead of retractors, which are used in open procedures, surgeons use conduits. "There's less of a visualization here, with the surgeon looking at the spine, and more endoscopic, where they visualize things on a screen," she says. "The CPT coding book tried to keep up with that, but it is vague even with 2012 clarifications." AMA, which owns and updates the CPT code book, created a "T" (temporary) code to try to redirect some of the non-open procedures to a different code, "but it's confusing from the coder's point of view in terms of whether something is an open or indirectly visualized procedure," Neumann says.

There are also percutaneous-based procedures, which are needle based, for spine procedures. But what, exactly, is a needle? Is a conduit or trocar a true needle? "That is not clarified in the CPT coding book," she says. The fuzziness may produce errors on claims, and these kinds of errors "present a fear factor in the coding world." It's one thing when providers exploit ambiguity to extract more money from Medicare and other payers; it's another thing when there is true confusion. "We want to do right, but it's not always definitive," she says. Coders also are faced with vague physician documentation. Sometimes the procedure is not medically necessary based on the diagnosis code, but sometimes the surgeon just needs to improve the specificity of the operative notes. They may not be detailed enough to draw the line between an openly visualized procedure and an endoscopic, indirectly visualized procedure, Neumann says. She has seen documentation that states "in the usual manner," which is not adequate. While surgeons know

whether they looked at the spine — whether it was open or not — and if they used a microscope or endoscope, they need to say in the OP notes if it was directly or indirectly visualized. The coders can't assume what the surgeon's "usual manner" is and auditors won't accept that on review, Neumann says. "When you read that OP note as a coder and are not sure whether to use an open code or an endoscopic code, it is hard to judge which way to go, and the auditor may not support it."

Neumann has two suggestions for defending claims for spine surgery:

(1) **Add more details to documentation.** That includes the name of the device, the name of the procedure, and, if the surgeons are doing more than one level, "what you did at those levels," Neumann says.

(2) **Understand new technologies.** When they provide the latest and greatest, "there is a need for surgeons to understand how to do it and for everyone involved, including coders and facilities, to understand the mechanism for new technologies," she says. With minimally invasive surgery, the medical terms don't necessarily translate to code-speak. "You may market it as minimally invasive, but what are you actually doing? Is it the endoscope alone? Or directly visualized or with a microscope?"

In the recent CERT report, CMS says in the section on joint replacement that "the most common pieces of information missing from the medical record were the pre-operative condition of the joint ailment and any history of non-surgical therapies to treat the ailment (or reasoning for why such treatment was not attempted)."

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Minor Procedures = Major Problems

continued from p. 1

Medicare auditors tend to push the envelope on the definition of "minor procedure," says attorney Jessica Gustafson, with The Health Law Partners in Southfield, Mich. "I have thousands of appeals pending where [minor procedures] are the issue," she says. As they fight denials, hospitals may have some room to maneuver.

Chapter One of the *Medicare Benefits Policy Manual* states that "when patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered outpatients for coverage purposes regardless of the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight."

The term "minor" is not clearly defined, but could encompass many procedures, including cardiac stents, defibrillators, pacemakers, transurethral resection of the prostate, thyroidectomies, major male pelvic procedures,

vascular stents and gallbladder removal. "Classifying it with those words — major and minor — causes you some consternation, but it makes some sense," says Jeffrey Farber, M.D., chief medical officer at Mount Sinai Care and associate professor at Mount Sinai Medical Center in New York City. The patient's experience, including post-op monitoring, is factored into the ambulatory payment. If the patient needs more time in the hospital, an inpatient stay may pass muster.

But recovery audit contractors (RACs) may go too far in their audits, Gustafson says. When RACs audit claims for minor procedures submitted before Oct. 1, 2013, which is the effective date for the IPPS rule, they don't necessarily stick to the entirety of the manual language governing minor surgery or other treatments, she notes. RACs frame the issue as if planned procedures for known diagnoses always must be performed in outpatient settings. "I would argue all day long that is not the rule," she says. "This portion of the manual goes on to say 'if you are expecting a stay of less than 24 hours for your planned procedure, then the procedure is outpatient.' It doesn't say 'if you enter the hospital for a planned procedure, it is outpatient.'" She says RACs have failed to apply the entirety of this manual provision, which, in her opinion, really speaks to the expectation of a 24-hour stay. "I don't believe this portion of the manual is meant to say that anything not on the inpatient-only list is presumptively outpatient," Gustafson says. Instead, it addresses situations where patients aren't expected to stay more than 24 hours, such as routine gallbladder removal, she says.

Fee Schedule Pinpoints 'Minor' and 'Major'

In a twist, the Medicare physician fee schedule distinguishes "minor" surgeries from "major" surgeries (see <http://tinyurl.com/magx8nt>). Qualified independent contractors (QICs), the second level of the Medicare appeal process, have incorporated this distinction into their rulings. The QIC may rule against the hospital, saying "the procedure has not been classified as a 'major surgery'" by the physician fee schedule. If a procedure is classified by the physician fee schedule, "this is persuasive to some judges," Gustafson says. Hospitals may have a better chance of winning their appeals for denial of Part A claims for procedures that are described as "major" by the Medicare physician fee schedule.

While RACs tend to review procedures that fall into the "minor" category, this argument is useful when they review "major" procedures, she says. And the argument "may become less persuasive under the two-midnight rule, as the question becomes whether the admitting physician had a reasonable expectation that a beneficiary would require two midnights of care regardless of the procedure performed."

Moving forward, hospitals and physicians have greater clarity on billing for minor procedures under the two-midnight rule, Farber says. "The minor-procedure issue is largely about elective surgeries," he says. Generally, assuming they are medically necessary, procedures on the Medicare inpatient-only list are billed to Part A, and the rest should be performed on an ambulatory basis and billed to Part B, he says. "It would be an exception if the patient requires an inpatient admission and it is our obligation to document clearly why this patient needs to be admitted when, for the most part, the procedure is done outpatient," Farber says. "You stay overnight in the hospital generally, but one night in the hospital doesn't make you an inpatient."

Conflicting Admission Rules Irk Hospitals

Hospitals also should keep an eye out for intentional delays to cross two midnights. "If 5 percent to 10 percent of the time patients stay an extra night because of pain or bleeding, it's probably fine as long as physicians signed admission orders and documented their treatment plan," Farber says. But Medicare will monitor for changes in patterns in the duration of stay for the same doctor for the same procedure.

There's also a challenge in applying divergent admission standards to patients depending on their insurance coverage — Medicare, Medicare Advantage, Medicaid or private payer. "This is the game for Medicare and not for everyone else. The other world still lives with intensity of services and severity of illness and inpatient decision making," he says. "There are appropriate one-day inpatient admissions but not so much for Medicare." *The two sticking points:* "we are not treating people differently based on insurance," and it's not obvious who the payer is for up to 20% of patients, Farber says. They may turn out to have a different payer source than was believed at the time of admission, which could affect the admission process.

Whether claims for admissions for procedures survive audits under the two-midnight benchmark will depend on the quality of physician documentation, Gustafson says. Particularly when patients enter the hospital for a procedure that CMS and the RACs have historically viewed as minor, such as stent insertions, "it's very important that physicians document why this particular patient requires two midnights or more of hospital care," she says. "Because what you will see the RACs say is with a known diagnosis for this procedure, there is no reasonable expectation to enter the hospital for two midnights."

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NEWS BRIEFS

◆ **The anti-kickback allegations have disappeared from the false claims lawsuit against Halifax Hospital Medical Center and Halifax Staffing, which is set for a March 3 trial.** On Jan. 8, the U.S. District Court for the Middle District of Florida granted the hospital's motion for summary judgment on the kickback claims, which means they won't be litigated. However, allegations of Stark violations and medically unnecessary admissions, lodged by a whistleblower against the Daytona Beach hospital, remain, although the Department of Justice intervened only in the Stark aspect of the case (*RMC 10/21/13, p. 1; 9/26/11, p. 1*). In the new ruling, the judge held that the doctors whose compensation is under fire are Halifax employees and therefore protected by the employment "safe harbor," which confers anti-kickback immunity. The Stark law also has an employment exception, but it didn't protect the hospital. The court previously ruled the hospital's bonus arrangement with six oncologists did not fit within the *bona fide* employment exception and therefore violated the Stark law, although it could not determine the extent of the violation (*RMC 11/18/13, p. 3*). "It's an interesting comparison," says Atlanta attorney Alan Rumph, with Baker Donelson. "The anti-kickback safe harbor is broad and doesn't limit the way doctors are compensated at all. It just says compensation paid to employees in performance of covered services is not considered remuneration under the anti-kickback statute." Under the Stark law's employment exception, Rumph says, compensation can't be more than fair-market value and can't be determined based on the volume or value of the employees' referrals. Also, as for the safe harbor, the court was not impressed that on paper the doctors aren't employed by Halifax Hospital because they are employed by Halifax Staffing, Rumph says. The whistleblower argued the safe harbor shouldn't apply, but the court said Halifax Staffing is just an alter ego of the hospital. Contact Rumph at arumph@bakerdonelson.com.

◆ **The U.S. Court of Appeals for the Fourth Circuit recently held that the government and the plaintiff in a False Claims Act (FCA) case have discretion to request, and the court has authority to impose, less than the statutory minimum penalty under the FCA.** But the holding comes with a catch: the actual calculated penalty must violate the Eighth Amendment's Excessive Fines Clause.

That clause, the court said, turns on the principle of proportionality; that is, "the amount of the forfeiture must bear some relationship to the gravity of the offense," and the "concept of harm" is not confined to economic damage only. For purposes of the FCA, the court must "consider the award's deterrent effect on the defendant and others." The minimum calculated penalty in this case was in excess of \$50 million on presumptive damages of \$837,000, and the district court found this excessive. The plaintiff was willing to accept \$24 million, but the district court determined it did not have authority to reduce the statutorily imposed minimum and awarded nothing. The court of appeals, however, found the reduced amount "proportional" in light of the gravity of the defendant's offenses (bid-rigging for government services). The case is *U.S. v. Gosselin* (No. 12-1369, 4th Cir. Dec. 19, 2013). Visit <http://www.ca4.uscourts.gov/Opinions/Published/121369.P.pdf>.

◆ **CMS released its Medicare Quarterly Provider Compliance Newsletter on Jan. 15.** It describes errors in a number of areas: underpayments, unbundling, MRI scans, annual wellness visits and doses vs. units billed of the drugs adenosine and zoledronic acid. Visit <http://tinyurl.com/k8qvfpf>.

◆ **In its latest Medicare compliance review, the HHS Office of Inspector General says 328-bed Heartland Regional Medical Center in St. Joseph, Mo., collected \$281,997 in overpayments for claims submitted in 2010 and 2011.** Out of 194 inpatient and outpatient claims reviewed, the hospital did not fully comply with Medicare rules for 66 of them. Visit <http://go.usa.gov/Zf9R>.

◆ **Because Medicare admission decisions under the two-midnight rule are based on the medical necessity of hospital care instead of inpatient vs. outpatient status, admission screening tools such as InterQual and Milliman won't play the same role, CMS says.** "It's true that patients don't necessarily need to meet inpatient level of care via one of the screening tools," said Jennifer Dupee, a nurse consultant in the CMS Provider Compliance Group, at a Jan. 14 conference call with the industry. "We are not saying these tools can't be used by hospitals. Often providers say these tools are helpful when doing care planning" and deciding when patients should be discharged. Visit <http://tinyurl.com/nbkf7hf> for the slides from the conference call.

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