

MEDICARE COMPLIANCE

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

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Managing Editor
Nina Youngstrom
nyoungstrom@aishealth.com

Contributing Editor
Francie Fernald

Executive Editor
Jill Brown

2014 IPPS May Call for Multiple Orders, Electronic Record Certification Reminders

When CHE Trinity Health set out to reduce compliance risks and revenue losses from missing or ambiguous physician orders, it had no idea what was coming in the 2014 inpatient prospective payment system regulation. The health system had already streamlined the ordering process and driven down the number of patients admitted to its hospitals without physician orders when the two-midnight rule and certification requirement materialized. As Trinity again retools forms in its electronic health records and monitors its progress, the compliance challenges and the potential benefits both loom large.

“We still have an occasional patient get in and out without an order, but only one or two out of 7,000 discharges a month,” said Mary Beth Place, director of system case management at CHE Trinity Health, a Livonia, Mich.-based system with 40 hospitals in nine states on one electronic health record (EHR) system. “There were about 50 a day being flagged when we started.”

Trinity began the “journey” toward compliant orders three years ago, Pace said Dec. 11 at a Health Care Compliance Association webinar. Orders are a medical-necessity risk if they don’t exist at all, if documentation is missing or incomplete for the level of care (inpatient vs. outpatient), if they reflect inappropriate changes between the level of care, or if there’s confusion between the level of care and social admissions, which Medicare doesn’t cover.

continued on p. 5

RAC Audits to Slow as CMS Revises Bids; Existing Contracts Extended for Appeals

The next round of recovery audit contracts probably will be awarded by the end of March 2014, and providers shouldn’t expect much audit activity until the latter part of 2014, experts say. It will take six to nine months for the regional RACs and a new national home health and durable medical equipment RAC to dig in, partly because CMS redrew the map so RACs and Medicare administrative contractors (MACs) align. But the transition also may be slowed now that CMS on Dec. 6 sought a revised bid for RAC region C, eight months after it closed the bidding process, and is expected to do the same for the other RAC regions and the national RAC, sources say.

Meanwhile, CMS extended existing contracts through Dec. 31, 2015, for the RACs to work on appeals of claims they denied. But the scope of the extension may get broader. A CMS spokesman says the agency is “temporarily allowing active recovery auditing,” such as semi-automated reviews, while it works through the contract process.

As all of this gets sorted out, providers will see a slackening in their RAC claim denials and requests for medical records, especially since CMS suspended RAC audits of admission necessity in terms of site of service for claims submitted between Oct. 1, 2013,

and March 31, 2014 (*RMC 11/11/13, p. 1*). “They will stop new auditing activity this month,” says Emily Evans, a partner in Obsidian Research Group in Nashville. Although hospitals will get a breather from the RACs, the claims they submitted will eventually be audited because there is a three-year look-back period, she notes. Some hospitals say RACs are still on the prowl, asking for lots of medical records.

In April, CMS closed out the request for proposal portion of the bidding process for the next set of five-year RAC contracts (*RMC 5/6/13, p. 3*), but never awarded them. There have been distractions, Evans says, including the federal government shutdown, troubles with the rollout of HealthCare.gov and the increasingly political nature of the RAC experience. Now CMS is tinkering with the request for proposals.

CMS also had to respond to a protest filed by one RAC over the possibility that a contract would be turned over to another RAC when claim denials were still on appeal. The protest was withdrawn after CMS decided to keep existing RACs on board through 2015 to help with appeals already in the pipeline. “The intent of the exten-

sion is to ensure existing RAC contracts are supported,” says Maria Perrin, chief marketing officer for HMS Holdings, which owns HealthDataInsights, the RAC for region D. The new contracts also require RACs to provide “support to CMS throughout the administrative appeals process and, where applicable, a subsequent appeal to the appropriate federal court” and to participate in at least 25% of cases that reach the administrative law judge level.

When the new RAC contracts are awarded — “hopefully by the end of the first quarter,” Evans says — it will be a while before audits get under way. If new vendors win one or more of the RAC contracts, there will be a learning curve as they take over from the existing RACs. CMS also is shifting some of the states in the four regions of the RACs to correspond to the MAC jurisdictions (i.e., two MACs per RAC). And if incumbent vendors lose their RAC contracts — and some wonder about the fate of CGI Federal, the company that has been involved in problems related to the HealthCare.gov website — they may file a protest with the Government Accountability Office (GAO), which will delay the transition by 100 days, Evans says. Finally, the new national RAC — which will audit home health, DME and hospice claims — has to get up and running. *The bottom line:* there won’t be a single start date for audits under the “new” RACs. “The program is in a constant state of flux,” Evans says. When hospitals receive additional documentation requests (ADRs) will depend on the pace of CMS’s re-bids, whether CMS selects a new RAC in their region and, if so, how quickly it gets up to speed, and how well the RAC/MAC transition goes.

Some Providers Prefer to Not Change RACs

Providers aren’t necessarily yearning for a change in RAC vendors when the contracts expire Feb. 4. At the National RAC and MAC Summit in Crystal City, Va., on Dec. 5, some state hospital association officials said they have developed effective working relationships with their RACs and starting over is not an appealing prospect. Charles Cataline, senior director of health policy for the Ohio Hospital Association, said “we have CGI and we get along well with them.” Also, there is always “conversion confusion. I have never gone through a clear conversion, whether a RAC, MAC or otherwise.”

Some hospitals are still getting new rounds of ADRs, said Stewart Presser, vice president of patient financial resources for the Greater New York Hospital Association. “Some large academic medical centers are being unduly ADR’d,” he said. The association will meet with CMS after Christmas to discuss the problem.

For more information, contact Evans at emily@obsidianresearchgroup.com. ✧

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Hospitalists Under Scrutiny in E/M False Claims Complaint, Audits

Hospitalists are attracting attention from auditors and enforcers, who have set their sights on evaluation and management services. At least one Medicare administrative contractor (MAC) is reviewing claims for upcoding and the Department of Justice on Dec. 9 intervened in a false claims lawsuit that alleges hospitalists overcharged Medicare and Medicaid in 12 states.

The lawsuit alleges that IPC The Hospitalist Co. Inc. and its subsidiaries violated the federal False Claims Act and numerous state false claims laws. Whistleblower Bijan Oughatiyan, M.D., who worked for IPC from 2003 to 2008, alleges IPC hospitalists, egged on by their employer, upcoded evaluation and management (E/M) services for initial and subsequent hospital visits and discharge day management. "IPC hospitalists regularly submitted daily billing records for services that would have taken in excess of 24 hours to perform, even using extremely conservative estimates," the lawsuit alleges. The U.S. Attorney's Office for the Northern District of Illinois, which announced its plans to intervene, asked the U.S. District Court in Chicago for 120 days to file its own complaint against IPC. The request was granted.

IPC declined to comment because "this is an ongoing matter," says spokeswoman Elaine Murphy.

E/M services are generally a target of Medicare auditors and investigators, who are dogging upcoding and documentation shortcuts in electronic health records, as

highlighted in a new OIG report (see brief, p. 8). Some of the RACs and MACs are looking at E/M coding, with an emphasis on higher-level services, says John Paul Spencer, director of regulatory and coding compliance at Providence Health Services, which is part of Providence Hospital in Washington, D.C. "I am surprised it took this long. Studies by the comprehensive error rate testing contractor say the highest-level codes are the ones most abused." Hospitalists have not escaped scrutiny. Novitas, a MAC, recently audited claims for high-level E/M services submitted by physicians at his facility and presumably other hospitals in the MAC jurisdiction, Spencer says. Most of Providence's claims passed muster, but Spencer says hospitalists generally could use more training on documenting reviews of systems and the time spent with patients.

Time is a centerpiece of the false claims complaint against North Hollywood, Calif.-based IPC, which employs 650 physicians and other clinicians who work at 1,300 facilities in 28 states. The thrust of the whistleblower's complaint is that some IPC hospitalists billed for more services than they could have performed on certain days based on the time required to perform the services, according to CPT descriptions of the E/M levels of service.

Hospitalists often bill for three types of services, according to the complaint, which uses Medicare reimbursement rates for Texas in 2009:

◆ *Initial hospital care (three levels of E/M service):*

CMS Transmittals and Federal Register Regulations

Dec. 6 — Dec. 12

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

Transmittals

(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*, Trans. 175BP, CR 8458 (Dec. 6, 2013; eff. Jan. 1; impl. Jan. 7, 2014)

Pub. 100-04, Medicare Claims Processing Manual

- Home Health Agency Reporting Requirements for the Certifying Physician and the Physician Who Signs the Plan of Care (R), Trans. 2833CP, CR 8441 (Dec. 6, 2013; eff. July 1; impl. July 7, 2014)

Pub. 100-07, State Operations Manual

- Appendix J, Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities, Nomenclature Revisions, Trans. 94SOMA (Dec. 6; eff./impl. Dec. 6, 2013)

Pub. 100-08, Medicare Program Integrity Manual

- Additional Updates to Chapter 15, Trans. 492PI, CR 8393 (Dec. 6, 2013; eff. Jan. 1; impl. Jan. 7, 2014)

Pub. 100-20, One-Time Notification

- Informational Unsolicited Response or Reject for Ambulance SNF to SNF Transfer (R), Trans. 13260TN, CR 8408 (Dec. 6, 2013; eff. April 1; impl. April 7, 2014)

Federal Register Regulations

Final Rules

- Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records Incentive Program; Provider Reimbursement Determinations and Appeals, 78 Fed. Reg. 74825 (Dec. 10, 2013)
- Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014, 78 Fed. Reg. 74229 (Dec. 10, 2013)

Advance Notice of Proposed Rulemaking

- Medicare Secondary Payer and Certain Civil Money Penalties, 78 Fed. Reg. 75304 (Dec. 11, 2013)

(1) CPT code 99221 requires a detailed or comprehensive history, detailed or comprehensive exam and low or straightforward medical decision making. Physicians typically spend 30 minutes by the patient's bedside and on the hospital floor (\$87.61).

(2) CPT code 99222 requires a comprehensive history, a comprehensive exam and medical decision making of moderate complexity. Physicians typically spend 50 minutes at bedside and on the hospital floor (\$119.63).

(3) CPT 99223 requires a comprehensive history, a comprehensive exam and medical decision making of high complexity. Physicians usually spend 70 minutes at bedside or on the hospital floor (\$175.88).

◆ **Subsequent hospital care (three levels of E/M service):**

(1) CPT 99231 requires two of three components: a problem-focused interval history, a problem-focused exam, and medical decision making that's straightforward or low complexity. Physicians usually spend 15 minutes at bedside and on the hospital floor (\$36.17).

(2) CPT 99232 requires two of three components: an expanded problem-focused interval history, an expanded problem-focused exam and medical decision making of moderate complexity. Physicians typically spend 25 minutes at bedside and on the hospital floor (\$64.98).

(3) CPT 99233 requires two of three components: a detailed interval history, a detailed exam and medical decision making of high complexity. Physicians typically spend 35 minutes at the bedside and on the hospital floor (\$93.14).

◆ **Hospital discharge day management, CPT 99238, 30 minutes or less (\$64.25); and hospital discharge day management, CPT 99239, more than 30 minutes (\$93.41).**

Oughatiyan analyzed billing records from IPC's software and alleged that some hospitalists "demonstrate

a disproportionately high use of the highest level CPT codes, and almost no use of the lowest level CPT codes," the complaint stated.

For example, one San Antonio IPC hospitalist billed for treating 65 patients on April 5, 2008. Hardly any of his claims were for low level codes (99221, 99231), but 18 were for the highest-level subsequent hospital visit, 13 for the second highest, and 16 for the highest level initial hospital visit. Assuming the minutes required by the CPT code descriptions, the doctor allegedly would have had to work 43 hours to provide all the services he billed that day, which were performed at two facilities half an hour apart, according to the complaint. It also describes seven other days this hospitalist would have had to work between 18 and 34 hours to fulfill the time requirements of the E/M services he allegedly billed for. The hospitalist was approached by Oughatiyan, who warned him to "be careful about his billing practices," the complaint alleges. But the hospitalist "was unmoved." The whistleblower complained to a member of the IPC regional administrative team, but the hospitalist's overbilling allegedly continued. The complaint cites other examples of alleged upcoding by IPC hospitalists.

Be Scrupulous in Recording Time

In light of the focus on E/M coding, Spencer, who is not involved in the lawsuit, advises hospitalists to keep track of the time they spend with patients. For example, the average amount of time spent with a patient for a 99223 visit is 70 minutes. "If you spend at least 70 minutes and over half of it is coordination of care and you noted what care you provided, you have met the criteria for 99233 based on time," Spencer says. It must be documented and worded as a percentage of time. For example, he says, physicians could state that "I spent 75 minutes on the admission of this patient, with more than half spent in coordination of care as indicated in my assessment and plan of care." But make sure the assessment and plan reflect the details of coordination of care (e.g., "we will call in cardiology for a consult"). "Something that just says 'care coordination' is not enough," Spencer says.

Hospitalists may need to improve their documentation of review of systems, Spencer says. "They were taught 10 systems was the magic number, so they may say 'a 10-system review was conducted and it was negative'" and expect to bill a 99222 or 99233, he says. But at least 10 of 14 systems must be reviewed for a comprehensive history, and referring to 10 begs the question of which systems the physician reviewed. "It is an error I have corrected more than once with hospitalists around the country," says Spencer, who is a former consultant.

Contact Spencer at paul.spencer@provhosp.org. ✧

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New Code Will Tell CMS When Two Midnights Started With Outpatient

Hospitals now have a code at their disposal to let Medicare know when admissions conform to the two-midnight rule through a combination of outpatient and inpatient care. The National Uniform Billing Committee (NUBC) refined occurrence code 72 so it can identify one-day stays before inpatient admissions on hospital claim forms, effective Dec. 1, 2013. NUBC includes CMS, the American Hospital Association and other payers and provider groups.

Occurrence code 72 will signal to Medicare “there were outpatient services provided contiguous to an inpatient admission,” Kathy Reep, vice president of financial services for the Florida Hospital Association, said Dec. 5 at the National RAC/MAC Summit in Crystal City, Va. CMS is expected to issue instructions on occurrence code 72 soon.

How Useful Will Occurrence Code 72 Be?

But the jury is out on how useful the occurrence code will be in heading off audits of inpatient admissions.

The use of occurrence code 72 was welcomed by some experts as a way to avoid audits of two-midnight stays when the first night was spent in an outpatient bed. CMS said two-midnight stays are off limits to auditors in terms of admission (although auditors are free to review DRG coding and the medical necessity of performing the services). But lawyers say claims for inpatient stays that cross the two-midnight threshold will still be pulled for review if patients spend the first night in observation or the emergency room because, on the surface, they resemble one-day stays (*RMC 10/14/13, p. 1*). Unless they delve into the medical records, auditors won’t be able to distinguish between dubious one-day stays and medically necessary two-midnight stays where only the second midnight followed an inpatient order.

Occurrence code 72 seems to solve a logistical problem, some experts say. It lets auditors know the outpatient services were wrapped into the two-midnight stay. But attorney Jessica Gustafson, with The Health Law Partners in Southfield, Mich., says that misses the point.

“I don’t think occurrence code 72 will have too much of an impact on CMS audit activity,” she says. “It’s for inpatient claims that don’t cross two midnights from the time of the order. The occurrence code captures those cases where you satisfy the two-midnight benchmark, but not the two-midnight presumption.”

The 2014 IPPS rule distinguished between these two concepts. While the two-midnight “presumption” means that hospitals get an audit pass for patients who are inpatients from the get-go (with some caveats), the

two-midnight “benchmark” means auditors will focus on shorter stays — including two-midnight stays where one of the days was spent in observation or other outpatient settings, Gustafson says. “Therefore, even if a claim is billed with occurrence code 72, the claim falls within the category of cases that will likely be pulled for review, and will be reviewed to determine whether the order and certification requirements were satisfied, whether there were unnecessary delays in the provision of care, what time the care began in the hospital and the timing of the order,” she says. The timing of the order matters because some MACs will frown on discharges in the hours immediately after the admission regardless of whether the two-midnight benchmark was met.

However, she says occurrence code 72 “will be beneficial to hospitals to establish good-faith efforts to comply with the two-midnight rule.”

Contact Gustafson at jgustafson@thehelp.com. ✦

New Orders, EHR Flags Help COs

continued from p. 1

There were some bumps in the road. Trinity’s EHR system and its admission/discharge/transfer software went in only one direction; the A/D/T spoke to the EHR but it didn’t talk back. There was also an electronic obstacle to obtaining timely orders in the emergency room, Pace said. Some ER registrars sit in nurses’ stations with the physicians, while others sit around the corner in a room and still others down the hall in admissions. “Their communication to the registration team was verbal, by email or phone. It was outside the order process because they typically worked in the A/D/T system and not in the EHR system,” she said.

As a result, it was too late to submit a compliant claim by the time Trinity realized there was no order for the admission or observation. “The patient was already upstairs or in the hospital a few days or discharged when we realized we didn’t have an order for the level of care or the order in the EHR may not mirror the level of care in the A/D/T,” Pace says.

continued

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At the time, there were six types of inpatient orders: place in inpatient status, place in inpatient status from the ER, behavioral medicine admit to intensive outpatient, behavioral medicine admit to partial hospitalization, place in inpatient rehab, and place in inpatient hospice status, with a sub-type under behavioral medicine for voluntary and involuntary admissions. That's too many choices to ensure physicians use them consistently and compliantly, Pace said.

Physicians Must Provide the Details

To improve its compliance with CMS's expectations for orders and stem its revenue losses from claims without them, Trinity replaced this with two options: inpatient or outpatient. Then physicians must provide a few details. On the inpatient side, they put "acute," "hospice," "rehab," "behavioral medicine" or "skilled nursing." As with all orders, physicians must sign and state the reason for admission, and they have the option to comment (e.g., put patient in isolation).

There were six ways to get into an outpatient bed when Trinity began the process improvement: place in outpatient status, place in outpatient status (ambulatory), place in outpatient status (ambulatory surgery home today), place in outpatient status (ambulatory surgery overnight stay), place in outpatient status (infusion/transfusion), place in outpatient status (procedure). Trinity simplified outpatient orders and now physicians pick the outpatient status and document whether the patient is there for a procedure, infusion/transfusion, surgery (extended stay) or observation. As always, physicians must sign the order and note the reason for admission of the patient.

After patients have been in bed for four hours, a soft alert pops up in the EHR if the physician hasn't signed an order. "It's not a hard stop because we never want to interrupt patient care," Pace said. The soft alert — which states "no order" — also appears every time clinicians open a patient's EHR. Trinity's compliance staff monitors the soft alerts for compliance with order requirements.

Example of Updated Inpatient Order

This is one of CHE Trinity Health's revised inpatient order forms. The Livonia, Mich.-based health system developed several forms to reduce the number of patients who are admitted or placed in observation without compliant physician orders and to comply with the two-midnight rule and the order and certification mandates in the 2014 inpatient prospective payment system regulation. The forms were developed by the chief medical information officer, with input from the case management and organizational integrity departments. Contact Mary Beth Pace, system director for case management, at pacem@trinity-health.org and Harriet Kinney, manager of organizational integrity, at kinneyh@trinity-health.org.

Date: _____
Time: _____

Orders: **Inpatient**

Admit patient to Inpatient:

- Expect Stay 2 midnights or greater
- Expect Stay shorter than 2 midnights
- Procedure on the CMS IP only list



Patient Stamp

I have reviewed the care and treatment for my patient. It is my intention for an inpatient stay for the following reasons:

Diagnosis: _____

Treatment plan: _____

Patient risk factors: _____

Here are the follow up care plans (if known): _____

I certify that my determination is in accordance with my understanding of Medicare's requirements for reasonable and necessary inpatient services [42 CFR 412.39e]

Provider Signature _____

Trinity is still frustrated with physicians' resistance to writing orders for Medicare inpatient-only procedures, Harriet Kinney, organizational integrity manager, said at the webinar. The 2005 outpatient prospective payment system final rule stated that without a pre-procedure inpatient admission order, hospitals can't bill Medicare Part A or B, she said. It's a stubborn compliance problem. But another challenge has since come roaring in: the two-midnight rule and changes to the order and certification requirements. Generally, CMS will presume inpatient admissions that cross two midnights are medically necessary unless they are delayed on purpose, and auditors will turn their attention to shorter stays except for procedures on the inpatient-only list (*RMC 8/12/13, p. 1*). The clock starts ticking when patients receive hospital care, including observation and emergency room services, but auditors probably will review claims when patients spend the first night as outpatients. Physicians are required to sign and date the order before the patient's admission. Prior to discharge, physicians must complete certifications that explain the reason for the inpatient stay, the expected length of stay and plans for post-hospital care (*RMC 9/2/13, p. 1*).

Health System Had a Three-Part Response

Trinity responded to the new compliance requirements in three parts:

(1) Orders: Trinity updated its orders in the EHR system to reflect the physician's expectation for the amount of time the patient needs to be in the hospital (see example, p. 6). The inpatient order asks physicians to check the pertinent box: two midnights or more; shorter than two midnights; or inpatient-only procedures. Patients undergoing procedures on the Medicare inpatient-only list don't have to remain in the hospital for two midnights, which "was a huge learning curve for our physicians," Pace said.

When physicians place patients in observation, they have two choices: either they expect the patient to stay one midnight or less or more than one midnight. If it's the latter, they are encouraged to flag a case manager because maybe the patient should be admitted as an inpatient.

Trinity also created two new orders that enable physicians to change patient level of care. The "change to inpatient status" orders are used when physicians want to move outpatients (e.g., observation patients). But the orders can't be presented as brand new; the EHRs tell the physician "they are placing a duplicate order and they need to do a change order," Pace said. "That's a trigger to discuss with a case manager if the patient should be put in inpatient from the beginning." Then there's the "change to outpatient status" orders. "That's where

physicians apply condition code 44," she said. When case managers and physicians agree patients don't have a medically necessary reason for crossing the two-midnight threshold (e.g., surgery extended care), they may be reclassified as outpatients.

There are also visual cues in the order set to signal attending physicians they still haven't co-signed orders initiated by residents and nurse practitioners. When residents and NPPs order admissions after discussing them with attending physicians (*RMC 10/28/13, p. 1*), the verbal orders must be authenticated by attending physicians. If they fail to co-sign, a "caduceus" — the familiar medical symbol of snakes wound around a winged staff — appears on screen. Attending physicians can click on the caduceus, which takes them straight to the co-signature line.

(2) Certification: The second time physicians sign into a patient's EHR, a pop-up tells them to complete the certification form. "The goal is a hard stop so nothing can be done until the certification is completed," Pace said. Trinity is working on auto-populating most of the certification based on the physician documentation, including the expected length of stay. "But we are struggling with the plan for post-hospital care," she said. Some hospitals want a note that says "see discharge plan," but Pace said "I don't think that's right. Doctors need to know the plan, so we added a spot for them to put the post-hospital plan, especially since this needs to be signed prior to discharge."

(3) Communication: Trinity holds its own version of CMS open-door forums. Every other Wednesday, Pace and Kinney are the "talking heads" on a one-hour call-in session for anyone in the health system with questions on the two-midnight rule, orders and certifications, Pace said. They also created a toolkit for the case management and medical office leadership teams at each hospital. The toolkit consists of a decision tree for inpatient vs. outpatient decision making; answers to frequently asked questions; "downtime" orders (the paper version of the EHR order); and a short PowerPoint deck that explains the IPPS rule and Trinity's compliance plans. "Our chief medical officer asked us to create a document for physicians without technical mumbo jumbo that tells them how they have to react to the new orders," according to Pace.

Kinney says Trinity is monitoring compliance using the soft alerts and daily and weekly reports identifying patients admitted or discharged without orders. When 2013 gives way to 2014, it will consider a formal audit of hospital performance on order and certification requirements.

Contact Pace at pacem@trinity-health.org and Kinney at kinneyh@trinity-health.org. ✦

NEWS BRIEFS

◆ **The HHS Office of Inspector General has issued a report on the degree to which users of electronic health records have policies addressing the use of the copy-paste function in EHRs and have implemented fraud safeguards.** The copy-paste function in EHRs poses a substantial risk of fraud, according to OIG. Only 24% of hospitals that receive EHR meaningful use incentive payments had policies in place regarding use of copy-paste, and only 44% of hospital audit logs recorded the method of data entry, which would flag copy-paste. The risk arises because providers may not update the copied information to ensure accuracy, and the function could be used to inflate claims and duplicate or create fraudulent claims. Hospitals and vendors both reported that modifying or disabling the copy-paste function was not possible. OIG recommended that CMS work with the Office of the National Coordinator for Health Information Technology (ONC) and hospitals to develop guidelines for using the copy-paste feature in EHR technology and consider whether the risks of some copy-paste practices outweigh their benefits. OIG also found that most hospitals were implementing to some degree four recommended safeguards — audit functions, user authorization and access controls, data transfer standards, and patient involvement in anti-fraud activity — but not to their full extent. OIG recommended that CMS and ONC continue their collaborative efforts to develop a comprehensive plan to address fraud vulnerabilities in EHRs. CMS and ONC concurred. Visit <http://tinyurl.com/m2cf29m>.

◆ **OIG recently posted two Medicare compliance reviews with recommendations that Medicare be repaid more than \$7 million.** The huge overpayment amounts are the result of the use of random samples and extrapolation, rather than the judgmental sample selection OIG has used in most of its Medicare compliance reviews. OIG has extrapolated only a few times before in Medicare compliance reviews to arrive at much larger overpayment determinations (*RMC 10/14/13, p. 1*). In both reviews, OIG randomly selected 200 claims, almost all of which were inpatient. OIG's Medicare compliance review of JFK Medical Center in Atlantis, Fla., extrapolated errors totaling \$293,869 to an overpayment of \$4,395,269. The review covered claims paid in 2009 and 2010. Most of the errors were for inpatients who should have been billed as outpatients. St. Vincent's Medical Center, Inc., in Jacksonville, Fla., had a simi-

lar outcome. From the \$282,217 in overpayments in the sample, OIG extrapolated an overpayment for 2009 and 2010 of \$3,248,566. Both hospitals challenged OIG on its authority to reopen and recover on the claims and on its sampling methodology and use of extrapolation. Their responses, which were written by the same law firm, Dentons US LLP, laid out the two governing rules: the reopening rule and the recovery rule. Claims with 2009 dates of service, the response said, could be reopened only "for good cause," which the hospitals maintained OIG did not have. Even if they could have been reopened, recovery on the 2009 claims expired on Dec. 31, 2012, because by statute providers were deemed to be "without fault subsequent to the third calendar year after the year of payment." OIG countered that the claims from 2009 were eligible to be reopened under the "similar fault" provisions of the reopening regulations, which provide that an initial determination or redetermination can be reopened at any time if there is "reliable evidence of fraud or similar fault." Although OIG did not allege that either hospital committed fraud, their improper billings, OIG said, were sufficient to establish "similar fault." OIG also rejected the hospitals' argument that the Social Security Act prohibited recovery because they were "without fault" due to expiration of the recovery time period. Under CMS guidance, OIG said, a provider is not "without fault" if it should have known the policy or rule published in Medicare guidance. Visit <http://tinyurl.com/m3ck89a> for the JFK compliance review and <http://tinyurl.com/n22kxw5> for the St. Vincent's compliance review.

◆ **OIG has taken the HHS Office for Civil Rights to task for not meeting all the federal requirements in its oversight and enforcement of the HIPAA security rule.** OIG reviewed OCR's security rule activities that took place between July 2009 and May 2011. It found that the office "had not assessed the risks, established priorities, or implemented controls for its HITECH requirement to provide for periodic audits of covered entities." In its response, OCR pointed out actions it had taken since 2011, such as establishing the audit protocol and conducting pilot program audits, but told OIG that "no funds had been appropriated...to maintain a permanent audit program and that funds used to support audit activities previously conducted were no longer available." Visit <http://tinyurl.com/pj55cnr>.

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