

# MEDICARE COMPLIANCE

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

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## Medicare Advantage Denials Rival FFS; Readmissions, Inpatients Are Hot Spots

Some Medicare Advantage plans are denying claims for readmissions and keeping patients in observation for days instead of certifying them as inpatients, experts say. Hospitals are scrambling to keep up with language in their contracts that seems to open the door to the denials. There are ways to improve their chances for ensuring admissions are certified and succeeding with appeals, but hospitals also should consider fighting for certain guarantees in their next contracts because Medicare Advantage patients are a growing part of the rejection pile.

Although many hospitals still seem unaware of it, Medicare Advantage plans are commercial plans, said Day Egusquiza, president of AR Systems in Twin Falls, Idaho. While they have to provide the same benefits as traditional (fee-for-service) Medicare, the Medicare Advantage plans are free to create their own billing and payment procedures, and that's what's causing so many denials. They rival traditional Medicare denials for inpatient admissions and DRG downcoding and now are showing up in the readmission area, she said. "The contracting piece has become the bigger problem," Egusquiza explained at a webinar sponsored by Compliance 360 on Aug. 16.

It may come as a surprise, but inpatient readmissions are becoming a thorn in hospitals' sides. It's especially frustrating when they stem from Medicare Advantage plans not authorizing skilled nursing facility admissions after discharge from the first admission, said Maria Johar, M.D., system physician adviser for ProMedica Health System in Ohio.

*continued on p. 5*

## Vanguard SNFs, COO Accused of Billing For 'Worthless Services' in FCA Case

Trouble was brewing at Imperial Gardens Health and Rehabilitation, a Tennessee skilled nursing facility (SNF) owned by Vanguard Healthcare LLC, even though it survived CMS's scrutiny as a "special focus facility." But problems allegedly persisted with wound care, nutrition, medication, and infection control — one nurse reported a nurse to patient ratio of 1:80 — and in February 2013 CMS terminated Imperial's Medicare provider agreement, according to a False Claims Act complaint filed against Vanguard and its chief operating officer, the Department of Justice said Sept. 7. Although Imperial shut its doors two months later, the setback allegedly didn't change the way Vanguard operated.

"Vanguard Parent and Vanguard Corporate continued to focus on growing patient census above delivering quality resident care at the other Grossly Substandard Defendant Facilities that were still operating," the complaint alleged. As a result, the Vanguard SNFs "provided and billed the government for non-existent, grossly substandard, and/or worthless care to their residents" from around January 2010 through 2015,

depending on the facility. Aside from Imperial, the SNFs are Boulevard Terrace LLC, Vanguard of Crestview LLC, Glen Oaks LLC, Vanguard of Memphis LLC and Vanguard of Manchester LLC.

Vanguard's corporate office did not respond to RMC's request for comment.

It's not new for the government to turn alleged substandard care into false claims allegations, says Denver attorney Jeffrey Fitzgerald, with Polsinelli. When quality is substandard or medically unnecessary, DOJ may step in with a false claims lawsuit. A prevailing theory is that the services provided by a facility were so worthless that it amounts to no care at all (*RMC 5/25/15, p. 3*).

It's interesting, however, that DOJ is pursuing false claims allegations against the chief operating officer, who oversaw all of Vanguard's long-term care facilities from 2011 to 2014, instead of Vanguard's CEO or another top dog, Fitzgerald says. It may be a manifestation of the Yates Memo, which states that DOJ won't settle fraud cases with corporations until they reveal "culpable" individuals, who will be pursued in civil and criminal cases — even though DOJ acknowledged it's hard to prove

they knew about the fraud or participated in it (*RMC 5/23/16, p. 5; 12/14/15, p. 1*).

In the Vanguard case, the fact that DOJ named only the chief operating officer means DOJ "probably didn't have evidence the CEO knew or was involved in the underlying allegations," Fitzgerald says. Even the allegations against the chief operating officer weren't all that impressive. "It wasn't obvious to me what DOJ thought the chief operating officer did that was different from what the typical chief operating officer does to improve a struggling facility," he said. For example, with respect to Imperial Gardens, the chief operating officer allegedly directed the SNF not to use temporary staffing company nurses. "Hiring long-term staff rather than using pool is a chronic struggle for some in nursing facilities," Fitzgerald says. SNFs should try to replace temp nurses with permanent staff because permanent staff improves quality of care, he says. Temp nurses also cost more money.

The false claims lawsuit was filed against Brentwood, Tenn.-based Vanguard by DOJ and the state of Tennessee, which was billed by Vanguard for long-term care services. Unlike many complaints and settlements in the health care space, this isn't a whistleblower case.

### Patient Needs Were Allegedly Unmet

The complaint describes how the SNFs allegedly disregarded the patients' needs, partly because they were short staffed, even though they signed Medicare and Medicaid forms certifying their compliance with program requirements. According to the complaint, SNFs are required to submit a minimum data set (MDS) form to Medicare and TennCare, which is Tennessee's Medicaid managed care plan. The MDS represents the patient's clinical condition, functional status and use of services and is used to assign patients to resource utilization groups (RUGs), the unit of payment under the SNF prospective payment system (*RMC 9/2/13, p. 3*). "Based upon the MDS assessments that a nursing home submits to the government for each eligible resident, nursing homes are paid a *per diem* reimbursement for each day they provided the required nursing home care to such residents," the complaint states. Tennessee also requires SNFs to submit a pre-admission evaluation (PAE). Physicians complete PAEs certifying patients are eligible for skilled nursing services, the complaint said.

SNFs agree to abide by the Nursing Home Reform Act of 1987, which requires the manager to "fulfill the residents' plans of care by providing, or arranging for the provision of, nursing and related services and medically-related services that attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, pharmaceutical services, and dietary services," the complaint stated.

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But things allegedly went wrong in the Vanguard SNFs named in the false claims complaint. They billed the government for “worthless services,” the complaint alleged. For example, the SNFs allegedly failed to:

- ◆ “Provide skilled nursing services in accordance with physicians’ orders.”
- ◆ “Provide standard infection control, resulting in urinary tract infections (UTIs) and wound infections.”
- ◆ Give patients medications the way their physicians prescribed them. Either patients got too much, too little or the wrong medications.
- ◆ Render wound care as directed by physicians or take measures to prevent pressure ulcers (e.g., turning and repositioning).
- ◆ Sufficiently manage patients’ pain.
- ◆ “Prevent excessive falls.”
- ◆ Achieve the basic nutrition and hygiene requirements of patients consistent with their plans of care.

The complaint alleges several grounds for false claims. DOJ says Vanguard allegedly submitted a false record on the MDS submitted to Medicare and Tennessee and on its PAEs. And the SNFs “wrongfully received and retained the benefit of federal and state monies paid from the TennCare and Medicare programs for nursing home services” that were substandard or worthless.

Contact Fitzgerald at JFitzgerald@polsinelli.com. ✧

## Get Ready for Increase in CMPs; Stakes Are Raised for Compliance

Civil monetary penalties (CMPs) of all kinds are now higher — considerably in some cases — according to an HHS interim final rule published in the *Federal Register* Sept. 6. The CMPs are being updated for inflation as required by the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 after no movement for almost 20 years.

The update affects dozens of CMPs levied by CMS, the HHS Office of Inspector General, the Office for Civil Rights, FDA, the Health Resources and Services Administration and the Agency for Healthcare Research and Quality. Some will come as a shock to providers, says attorney Paula Sanders, with Post & Schell in Harrisburg, Pa. For example, hospitals with more than 100 beds will face an increase from \$50,000 to \$103,139 in fines for each violation of the Emergency Medical Treatment and Labor Act (EMTALA), which hospitals may be overlooking in their compliance monitoring (*RMC 9/5/16, p. 1, 3*). The OIG can assess these fines against the violating hospital as well as the responsible physician.

The CMP hikes “really underscore the needs for all kinds of facilities and physicians to strive harder to stay in compliance,” Sanders says. She’s concerned, however, about the magnitude of some of the increases. “Some might argue the whole purpose of CMPs is to be a deterrent, but when they are forcing providers to pay so much more in penalties, is it a true deterrent or is it punitive? For some organizations, these penalties will be cost prohibitive,” she says.

According to the regulation, the CMPs apply only to violations that happened after Nov. 2, 2015, the date of enactment of the 2015 amendments, and are assessed after Aug. 1, 2016. Because they are long overdue, HHS said it opted for an interim final rule without prior notice and comment.

The Federal Civil Penalties Inflation Adjustment Act Improvements Act, which amended the Federal Civil Penalties Inflation Adjustment Act of 1990, was designed “to improve the effectiveness of civil monetary penalties and to maintain their deterrent effect,” the rule states. It also uses a new method to calculate penalties to “ensure that penalties will be increased each year to a figure commensurate with the actual calculated inflation.”

Here are a few of the CMP increases:

- ◆ The penalty for submitting or causing to be submitted claims in violation of the Stark Law rises from \$15,000 to \$23,863.
- ◆ The penalty for knowingly presenting or causing to be presented a false claim increases from \$10,000 to \$15,024.
- ◆ The penalty for employing or contracting with an excluded person rises from \$10,000 to \$14,718.
- ◆ The penalty for knowing and willful solicitation, receipt, offer, or payment of remuneration for referring a person for a service or for buying, leasing, or ordering an

### CMS Transmittals and Federal Register Regulations Sept. 1 – Sept. 8

Live links to the following documents are included on RMC’s subscriber-only Web page at [www.AISHealth.com](http://www.AISHealth.com). Please click on “CMS Transmittals and Regulations” in the right column.

#### Transmittals

(R) indicates a replacement transmittal.

#### Pub. 100-20, One-Time Notification

- Editing Update for Screening for Sexually Transmitted Infections (R), Trans. 17130TN, CR 9719 (Sept. 1; eff. Oct. 1; impl. Jan. 3, 2017)

#### Federal Register Regulations

##### Interim Final Rule

- Adjustment of Civil Monetary Penalties for Inflation, 81 Fed. Reg. 61537 (Sept. 6, 2016)

item to be covered by a federal health care program will increase from \$50,000 to \$73,588.

◆ The penalty for a Medicare Advantage plan that engages in a practice that would reasonably be expected to result in denying or discouraging enrollment will rise from \$100,000 to \$147,177.

The CMPs in the long-term care arena jump quite a bit, Sanders says. “You are already seeing six-figure penalties in some long-term care survey enforcement cases. Imagine doubling that,” she says. Increases in the CMPs are imposed by CMS for deficiencies in Medicare conditions of participation. For example, the per-day penalty for a skilled nursing facility that has a category 2 violation of certification requirements ranges from a minimum of \$103 (rising from \$50) to a maximum of \$6,188 (up from \$3,000). Similarly, the per-day penalty for a category 3 violation of certification requirements increases from a minimum of \$6,291 (from \$3,050) to a maximum of \$20,628 (from \$10,000).

Contact Sanders at [psanders@postschell.com](mailto:psanders@postschell.com). View the regulation at <http://tinyurl.com/zcz8j8o>. ✦

## New OCR Initiative Shines Spotlight On Small HIPAA Breaches

Since 2009, covered entities (CEs) have been sending annual reports to the HHS Office for Civil Rights (OCR) that tick off every small breach that exposes the protected health information (PHI) from a single person and up to 499 people, in addition to the quicker reporting (60 days) required when more than 500 individuals are affected.

OCR has evidently been doing little or nothing with reports of the small breaches, by its own admission and according to findings by the HHS Office of Inspector General that were released last year.

But that’s about to change. In an interview with RMC sister publication *Report on Patient Privacy*, OCR Director Jocelyn Samuels shared the details of a new enforcement push that OCR is undertaking, which it first announced on Aug. 18 to its privacy and security list servs with the subject line “OCR Announces Initiative to More Widely Investigate Breaches Affecting Fewer than 500 Individuals.”

As of August, OCR regional staff began “increasing” its efforts to zero in on the “root causes of breaches affecting fewer than 500 individuals.”

“Regional Offices will still retain discretion to prioritize which smaller breaches to investigate, but each office will increase its efforts to identify and obtain corrective action to address entity and systemic noncompliance related to these breaches,” the emails said. “The odds of an investigation, specifically where there are multiple small

data breaches by the same entity, just went up,” warns Marcy Wilder, director of the global privacy and cybersecurity practice at Hogan Lovells LLC, a Washington, D.C.-based law firm.

The announcement is not posted on OCR’s website, so some CEs and business associates (BAs) might not have gotten the word and could be unprepared.

Wilder and other HIPAA experts say the initiative means more OCR investigations and should prompt proactive efforts by CEs and BAs, including breach notification drills.

### Small Breaches May Be a Big Deal

In the interview, Samuels said the initiative is not so much “a change in our practice as much as it is a recognition that small breaches can manifest the same kinds of evidence of systemic noncompliance that dictate our approach to large breaches, and we want to ensure that our regional offices undertake those kinds of investigations in a concerted way and we want to let the regulated community know that we’re going to be doing this.”

Asked whether the announcement was meant to also send a message to OCR’s regional staff, Samuels responded: “I don’t want there to be a misconception that small breaches are not significant sources of concern for us and we are undertaking an initiative to more systematically identify situations in which small breaches indicate the possibility of systemic noncompliance, and where they do, to ensure that our regional offices follow-up with the appropriate investigations and efforts to secure relief.”

Details are scant on the extent to which OCR investigated small breaches prior to this new initiative, and much of the data on these breaches are limited and outdated. But one telling fact is that OCR had not investigated any small breaches in a sample of 150 that was studied by OIG.

Just as CEs are required to report breaches to OCR, the agency itself was mandated under the HITECH Act to submit annual reports on breaches and HIPAA cases to Congress. Since then, it has released two reports that each cover two-year periods: calendar years 2009-2010 and 2011-2012. A new report picking up with 2013 data is expected soon.

The most recent publicly available data on small breaches is from 2012, during which OCR received 21,194 reports, affecting a total of 165,135 individuals. In the 2012 report, published in 2014, OCR confirmed that, per its policy, it had opened investigations into all large breaches and conducted “a number” following small breaches. It did not specify how many.

Small breaches were among the areas of focus for OIG, which issued two reports on OCR’s enforcement

efforts in September of last year; one specifically called out the agency for its failure to collect information on small breaches and failure to enter the data into any sort of searchable database. The OIG reports also provide some insight into the staffing levels for breach investigations. It's not evident from the reports when OIG conducted its analysis, but it was working with fairly old data. It did conduct electronic surveys, however, gaining participation of all appropriate OCR staff. OIG reported that nationwide, 83 OCR staff members "worked on breach cases"; of these "61 reported that they worked on large breaches and 52 reported that they worked on small breaches."

### OCR Will Look for Patterns

OCR's recent announcement that it would be looking into more small breaches reiterated the value of these investigations. "The root causes of breaches may indicate entity-wide and industry-wide noncompliance with HIPAA's regulations, and investigation of breaches provides OCR with an opportunity to evaluate an entity's compliance programs, obtain correction of any deficiencies, and better understand compliance issues in HIPAA-regulated entities more broadly," OCR said.

The announcement states that regional officials will review a number of factors in choosing which small breaches to investigate, including (but apparently not limited to) the following:

- ◆ "The size of the breach;
- ◆ "Theft of or improper disposal of unencrypted PHI;
- ◆ "Breaches that involve unwanted intrusions to IT systems (for example, by hacking);
- ◆ "The amount, nature and sensitivity of the PHI involved;
- ◆ "Instances where numerous breach reports from a particular covered entity or business associate raise similar issues;
- ◆ "The lack of breach reports affecting fewer than 500 individuals when comparing a specific covered entity or business associate to like-situated covered entities and business associates."

According to Samuels, "Our regions have always, and consistently, looked at the small breach reports that we receive to evaluate appropriate next steps with regard to them [and], have opened investigations where that has seemed appropriate." The intent of the new program is to "standardize our approach to small breaches.... This is consistent with our efforts to focus our resources on the most systemic problems," she said.

If OCR receives "numerous reports of small breaches that, in individual terms, do not affect more than 500 people, but cumulatively suggest a continuing issue at

an entity," then it "makes sense for us to address through compliance reviews and work with an entity to ensure that it engages in the kind of comprehensive evaluation of its practices that we undertake with regard to the large breaches," Samuels said.

Rebecca Herold, president of Rebecca Herold & Associates, says she welcomes the news that breaches affecting fewer than 500 people will get new attention. Herold always found it "arbitrary" that 500 was assigned as the number of individuals affected by a breach that triggers an automatic OCR investigation, noting that sometimes a breach involving just one person can have devastating consequences to those affected by it.

That was the case with the televised death of a New York resident, which led to OCR's recent \$2.2 million settlement with New York Presbyterian Hospital, which the man's widow watched on TV. This is an example of a small breach that did lead to OCR action.

Even if the announcement is just a warning shot, OCR has already made its point with recent multimillion-dollar settlements, Wilder notes.

Asked if OCR's bark could be worse than its bite in this instance, Wilder leaves little room for complacency, noting, "the bite can be significant."

Contact Wilder at [mwilder@hhlaw.com](mailto:mwilder@hhlaw.com) and Herold at [rebeccaherold@rebeccaherold.com](mailto:rebeccaherold@rebeccaherold.com). ♦

*This article was excerpted from RMC sister publication Report on Patient Privacy. For more information or to order, visit <http://AISHealth.com/MarketPlace>.*

## Part C Denials Rival FFS Denials

*continued from p. 1*

"Readmissions are the most ugly denials we are having," Egusquiza said. Some Medicare Advantage (Part C) plans have added language in their provider contracts that penalize hospitals for readmissions more than traditional Medicare, she said. There are two policies in fee-for-service Medicare: (1) When a patient is discharged from the hospital and readmitted on the same day for symptoms related to the evaluation and management of the condition treated earlier, the two stays must be combined on a single claim; and (2) Under the Hospital Readmission Reduction Program, CMS slices off a percentage of the DRG base rate at the end of the year if hospitals have excess readmissions (*RMC 10/20/14, p. 1*).

Egusquiza urged hospitals to familiarize themselves with Medicare Advantage contract language around readmissions. For example, Aetna Inc. first mirrored the routine same-day readmission policy, and then extended it to 30 days for commercial members that use DRG methodology, according to Egusquiza. UnitedHealthcare

states that it will have a nurse (vocational, practical or registered) review the medical records to determine if the admissions are related. If it appears the second admission is related to the first and could have been prevented, the nurse sends the case to a medical director for further review. The medical director reviews the medical records and decides whether the readmission was preventable and/or there are signs the hospital was playing games with the prospective payment system. "Readmissions are full denials," she noted.

Because contract language is negotiated by payers and hospitals, Egusquiza is surprised by some of the things that hospitals agree to. It's far beyond what traditional Medicare demands and there are no definitions of "related" and "preventable," giving Medicare Advantage plans leeway to deny the claims, she said.

A similar vagueness plagues inpatient vs. outpatient decisions with Medicare Advantage plans, which means financial issues related to patient-status decisions are "silent" in the contracts, Egusquiza said. "Medicare made it easy with the two-midnight rule," she said. What's the definition of an inpatient in traditional Medicare? "Care that can only be safely provided in a hospital setting, the patient will be in the hospital two midnights and here is the plan that will take two midnights," she said. "What does your Medicare Advantage plan have to say about inpatient status? They either use InterQual or Milliman" or "medically appropriate care — whatever that means. That's jim-dandy — you'll get denied on those."

Because they require preauthorization for inpatient stays or observation, Medicare Advantage plans will approve days of observation, but it's an uphill climb to

### CMS Releases Latest Results of RAC Findings

#### Medicare Fee for Service National Recovery Audit Program (April 1, 2016 – June 30, 2016)

	OVERPAYMENTS COLLECTED	UNDERPAYMENTS RETURNED	TOTAL QUARTER CORRECTIONS	FY TO DATE CORRECTIONS
Region A: Performant	\$13.41	\$3.45	\$16.86	\$54.30
Region B: CGI	\$10.50	\$1.12	\$11.62	\$37.00
Region C: Cotiviti	\$23.04	\$9.34	\$32.37	\$166.42
Region D: HDI	\$28.28	\$10.38	\$38.66	\$176.80
<b>Nationwide Totals</b>	<b>\$75.22</b>	<b>\$24.29</b>	<b>\$99.52</b>	<b>\$434.52</b>

Note: Figures rounded to nearest tenth; Nationwide figures rounded based on actual collections. Figures provided in millions. All correction data current through June 30, 2016.

#### TOP ISSUE PER REGION

\*Based on collected amounts from April 1, 2016 through June 30, 2016

<b>Region A:</b>	<p>(Issue # A000382009) (complex review)</p> <p><b>MS-DRG Coding Validation: Severe Sepsis</b></p> <p>MS-DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate for MS DRGs 177, 189, 193, 291, 438, 441, 444, 592, 602, 682, 689, 691, 693; principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the MS-DRG.</p>
<b>Region B:</b>	<p>(Issue # B001012013) (complex review)</p> <p><b>Outpatient Therapy Claims above \$3,700 Threshold - Skilled Nursing Facility</b></p> <p>Targeted post-payment review of outpatient therapy claims paid in 2014 that reached the \$3,700 threshold for PT and SLP services combined and/or \$3,700 for OT services. When one or more lines of a claim have reached a therapy threshold, all lines of therapy services on that claim are subject to review.</p>
<b>Region C:</b>	<p>(Issue # C002492013) (complex review)</p> <p><b>Outpatient Therapy Claims above \$3,700 Threshold - Outpatient Hospital</b></p> <p>CMS determines an annual per beneficiary therapy cap amount for each calendar year. Exceptions to the therapy cap are allowed for reasonable and necessary therapy services. Per beneficiary, services above \$3,700 for PT and SLP services combined and/or \$3,700 for OT services are subject to manual medical review</p>
<b>Region D:</b>	<p>(Issue # D001712010) (complex review)</p> <p><b>MS-DRG Coding Validation: Infections</b></p> <p>DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate for MSDRGs 094, 095, 096, 853, 854, 855, 867, 868, 869, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRGs. (At this time, Medical Necessity excluded from review)</p>

SOURCE: CMS. Visit <http://tinyurl.com/jbo5lk7>.

get the go-ahead for inpatient care and the same goes for additional days after the initial stay is certified, Egusquiza said. The Medicare Advantage plan will insist on speaking to the attending physician and after the call, he will say, “we both agreed the patient was very ill.” Then the inpatient stay won’t be authorized, and the attending physician will throw up his hands. But the acuity of the patient was never in dispute. “They were never discussing the care. They were disputing care as an inpatient,” Egusquiza said. The Medicare Advantage plan bases the decision on the admission screening criteria it favors — Milliman or InterQual — and hospitals probably won’t pass go unless they use it for the patients covered by that plan, she said.

All bets are off when hospitals don’t have contracts with Medicare Advantage plans and patients present for treatment who are covered by those plans, Egusquiza said. There’s no contract to guide the patient-status decision making (e.g., InterQual, Milliman). “They may refer you to their website,” she said. The good news: In the absence of a contract, traditional Medicare is used (the two-midnight rule with five levels of appeal).

### Consider Separating Key Functions

With so much hitting hospitals on the front end from Medicare and Medicare Advantage plans, Egusquiza thinks hospitals should separate the discharge planning function from the utilization management/patient status function. Case managers often wear both hats, but discharge planning may take precedence because it’s mandated by Medicare. However, case managers are the first “point of contact” with payers, she said, and it may be time to let case managers focus on patient status.

“Teams that have more success have immediate contact with the ordering physician, talk to payers and schedule calls to get inpatient certification when they won’t give it to us,” Egusquiza said. They have to invest time learning the Medicare Advantage plan’s contract language for inpatient admission, its chosen screening tool and its rules for resolving patient-status disagreements. Too many hospitals haven’t split the function, she said, and “overloaded care managers are trying to do discharge planning and patient status, and patient status usually takes a back seat.” Eventually things blow up, she said. Getting patient status right doesn’t get the attention it needs, and the CFO sees the effect on revenue. “I hear from a lot of upset CFOs — ‘Where are all my inpatients?’”

Egusquiza also suggested developing a template for contract terms for Medicare Advantage and other commercial payers, aside from the usual payment stuff. The template should include:

◆ **A timeline to submit clinical information for patient status determinations.** “How fast do they have to give you a ruling on inpatient or observation,” she said. “The worst thing you can do is send emergency room records and let them decide, in or out. Tell the Medicare Advantage plans this is inpatient. You are using Milliman and this is medically necessary care, it’s on page 82 of Milliman and the physician wrote the order for inpatient. If you don’t tell them that, you are begging for observation and you will have days of observation and fight every day.”

◆ **A timeline for the payer’s determination** (e.g., 12 hours, 24 hours).

◆ **Immediate appeals and peer-to-peer calls within 24 hours.**

◆ **Language stating the payers will abide by all correct coding guidelines.** That’s useful because Medicare Advantage plans often downcode DRGs by disallowing complications and comorbidities (CCs) and major CCs.

◆ **Language on readmissions that’s consistent with fee-for-service Medicare.** Get definitions for “related,” “preventable,” and other denial/downcoded challenges.

For hospitals that have been told by payers that they never received appeals (never mind they were sent by registered mail or some other reliable method), Egusquiza suggested invoking HIPAA. Hospitals could respond by saying something like this: “Would you like me to contact the [HHS] Office for Civil Rights and file the HIPAA breach report for you since you lost PHI that I can prove was in your possession?”

As Johar and her utilization review team and appeals nurses push for inpatient certifications and appeal claim denials, she has found it helpful to build bridges to Medicare Advantage plans. “We need to know where they are coming from. We have to find a middle ground,” she said. “I have tried to meet with them personally. I need to know when and who to escalate the cases to.”

The ProMedica team focuses on the front end. What does the contract say? Does the Medicare Advantage plan use Milliman or InterQual? Is ProMedica’s appeal of the plan’s refusal to authorize an inpatient admission or continued stay complete and accurate? Sometimes when Johar gets on the phone with the plan’s medical director for a peer-to-peer review, he or she finds that the information submitted by ProMedica for this initial

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challenge is new, and that could turn the case around. The reason may be that what ProMedica sent wasn't up to snuff. "Sometimes the information we send to payers is misleading. We might say 'the vitals are fine' or the information in there clues the payer to say the patient is no longer acute. We can't give them non-acute info and still

want them to be in [the hospital as an inpatient]," Johar said. She advised hospitals to do more peer-to-peer calls because they can be very effective. ProMedica's overturn rate for managed care denials is 85% and rising.

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## NEWS BRIEFS

◆ **It looks like the "omnibus guidance" on the 340B discount drug program will come out by the end of the year.** The Health Resources and Services Administration, which administers the 340B program, has sent it to the Office of Management and Budget (OMB) for approval, says Emily Evans, managing director of health policy for Hedgeye Risk Management in Washington, D.C. Normally, only regulations are reviewed by OMB, but "they are still following the process" as if the guidance — also known as "mega guidance" — were a regulation, Evans says. It's on the unified agenda, which is the master list of all regulations that will be tackled by OMB and their completion date. The mega guidance addresses key aspects of the 340B program, including the definition of "eligible patient" and "covered outpatient drugs," program eligibility and termination and guidance relative to duplicate discounts for Medicaid managed care patients. (*RMC* 9/7/15, p. 1). View the OMB agenda at <http://www.reginfo.gov/public>.

◆ **Prime Healthcare, Prime CEO Prem Reddy, M.D., and its 14 hospitals have filed a blistering response to the Department of Justice's allegations that they pressured emergency department (ED) physicians to admit patients without the medical necessity for an inpatient admission and "coached" physicians to "embellish" medical records to help them support appeals in the event of claim denials, as alleged in a false claims lawsuit** (*RMC* 5/30/16, p. 1; 7/4/16, p. 5). In its motion to dismiss, filed Sept. 1, Prime argues that the government has shown no facts establishing that the treating physician's admission decision was objectively false and no facts with respect to any particular Medicare claims establishing that the admitting physicians were not exercising their best clinical judgment or did not believe that the patients needed inpatient care when they certified them as such. The defendants' response points to Medicare's allegedly "confusing, subjective and time-based coverage standards for inpatient admissions versus outpa-

tient observation care." These standards, the motion says, "involve subjective physician time predictions for which there is no objective basis to determine falsity." Without a showing of objective falsehood and specific facts supporting its allegations, the motion says the government has failed to state a claim actionable under the False Claims Act. "The government must allege more than a Medicare reimbursement dispute to establish that the Prime Defendants' inpatient claims were objectively false." The defendants' rely on two recent district court cases (*U.S. v. AseraCare Inc.* and *U.S. ex rel. Wall v. Vista Hospice Care, Inc.*). They involve the Medicare hospice coverage standard, which requires the physician to certify that the patient had six months or less to live. As stated in the motion to dismiss, the courts ruled that "the government cannot prove the 'falsity' of claims under the FCA as a matter of law based solely on another physician's disagreement with the physician's subjective judgment, but instead must prove verifiable facts establishing that the physician's certification of coverage was objectively false." *U.S. ex rel. Bernsten v. Prime Healthcare Services, Inc., et al.*, No. 2:11-cv-8214 (C.D. Cal., Sept. 1, 2016?).

◆ **Senior Healthcare Associates (SHA), a practice owned by Mercer County audiologist John Balko, agreed to pay \$930,000 to settle false claims allegations, the U.S. Attorney's Office for the Western District of Pennsylvania said on Aug. 30.** SHA contracted with providers to perform services, such as ear wax removal and optometric and podiatric services, in nursing facilities in Pennsylvania and four other states. SHA billed for the services, paid the providers and kept a percentage. But SHA allegedly billed Medicare for earwax removal, nail debridement and evaluation and management (E/M) services that weren't medically necessary, lacked documentation or weren't authorized, or the E/M services included modifier -25, according to the settlement. Balko did not admit liability in the settlement. SHA agreed to a 10-year Medicare exclusion. Visit <http://tinyurl.com/zq5vu6n>.



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