Report on
MEDICARE COMPLIANCE

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

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Inpatient Reviews Are Expected to Shift to Whether Hospital Care Was Needed at All

When the dust settles and auditors are unleashed again on inpatient admissions, they probably will have a different bent. Rather than tunnel vision about hospitals billing Medicare for inpatient admissions that should have been billed for outpatient or observation services, auditors will likely turn their attention to the broader concept of whether patients needed to be in the hospital at all or for as long as they were, one expert said. There is overlap with classic patient-status reviews, but there will be a different way to think about audits, reinforcing the importance of the documentation required to support the medical necessity of hospital care — including the risk of adverse outcomes.

"I expect the primary focus of auditors will be whether the patient needed to be in the hospital," said Ralph Wuebker, M.D., chief medical officer of Executive Health Resources in Newtown Square, Pa., at the Health Care Compliance Association's Compliance Institute in Orlando, Fla., on April 20. The three areas he believes they will focus on are whether care was custodial, whether it was provided for the convenience of the patient and whether the discharge was delayed to ensure the hospital could generate Part A payment under the two-midnight rule.

Although they are auditing MS-DRG coding and the medical necessity of inpatient procedures, some auditors' hands are partly or completely tied in terms of patient-status reviews. They are off the table for recovery audit contractors this year; Congress blocked

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HIPAA, National Labor Relations Act Put Social Media Use in Hospital Crosshairs

Emergency room technician Kathryn Knott was fired from Lansdale Hospital-Abingdon Health in Pennsylvania last year after complaining about patients on her Twitter account and posting pictures of them — including a severed finger — and in the process became a vivid example of how social media can go awry in health care. This and other incidents underscore the importance of implementing a social media policy.

"We can't leave it up to chance," said Jennifer Maggiore, CEO of Red Balloon Inc. in Phoenix. "Never assume employees will use the same good judgment that you would."

With the social-media revolution — Americans spend 510 minutes on Facebook a month on average, she said — compliance and privacy officers are considering how it implicates different laws, including HIPAA and the National Labor Relations Act (NLRA). Employers may assume that Facebook posts that bash or embarrass them are grounds for employee termination, but that's not necessarily the case, says Minneapolis attorney Norah Olson Bluvshtein, with Fredrikson & Byron. The answer is it depends. If employees post a picture of themselves taking a bath in a sink at work, fire away, she says. "But other situations are more complicated," with the National Labor Relations Board (NLRB) putting the cutting-edge fact patterns of social media through the prism

of the 1935 NLRA. It probably doesn't help that only one-third of health care organizations have social media guidelines (see box, p. 3), Maggiore said.

Front and center in social media use is the risk to patient privacy and potential HIPAA violations. Against a backdrop of respect for free speech, hospital and clinic employees are held to certain restrictions, says Nickie Braxton, privacy officer at Boston Medical Center. Health care workers may not mention patients or post photos of them on social media sites they use privately, she says. Employees may think it's none of the hospital's business because they use their own devices and personal accounts for Facebook, Twitter or other social media sites, and employees have blurred the lines sometimes between professional and personal. The superseding message: "What you learn in the hospital stays in the hospital," Braxton says.

But it may sometimes seem like hospitals are talking out of both sides of their mouth. Hospitals have their own Facebook pages for communication and education, but they warn employees not to talk about their patients on their personal Facebook pages and, to some extent, the hospitals themselves. "On the one hand we are fostering the use of social media, and on the other hand we are saying, 'you have to be very careful when you go on social media, and you can't share patient information in any way or refer to patients in any way under threat of discipline,'" Braxton says. "It goes against the general cultural norm for employees who are so used to sharing their lives on social media." In particular, nurses and other clinicians can form intimate relationships with patients and may be tempted to friend each other on Facebook or Instagram, she says. "The challenge is to help people understand there is a professional life and there is a personal life. In your professional life, you are expected to be friendly toward patients, but you are not expected to friend a patient," Braxton says. "People come here not because we are friends but because we uphold a certain professionalism and standard of care that we are expected to maintain at all times."

Pictures on social media are off-limits. Even when everyone has agreed to take pictures, there is still a risk. Maybe the patients misunderstood or changed their mind later, or unrelated patients in the background show up in the picture and they haven't given consent, Braxton says.

Social Media Fires Up NLRB

Anonymous postings will not protect employees and physicians, a lesson learned in a blogger case, Maggiore said at a May 13 Health Care Compliance Association webinar. A Boston pediatrician, who was a popular, award-winning but anonymous blogger, shared his experiences in medicine. "People loved it," Maggiore said. "Things took a wrong turn when he published blogs" about serving as an expert witness for the defendant in a wrongful death case. The blogger, known as "Flea," revealed too much, she said. The blogger was outed in 2007 as physician Robert Lindeman, and he admitted it, according to *The Boston Globe*. "There's no such thing as anonymity online," Maggiore cautioned. People have the illusion of invisibility, and "that fans the fame of aggressive behavior." Employees should be trained to post only items they can stand behind, she said. "Be proud of those posts, and if not, don't post them," she said.

Employees also use social media to comment on hospitals and other employers, and how they react — firing employees for nasty posts, for example — may have consequences. The NLRB, which enforces the NLRA, may uphold the termination, or not, which means back pay for the employee and reinstatement. The NLRA applies to union and non-union workers, Bluvshtein says.

Sec. 7 of the NLRA gives employees the right to discuss the terms and conditions of employment. It's construed broadly, she says, and covers wages, other compensation and how their supervisors treat them. That

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means employees can talk to each other critically about management, she says. Social media is turning into a flash point with the NLRB, which is "heavily focused on social media firing cases," Bluvshtein says.

Here are a couple of examples:

◆ ***American Medical Response:*** A paramedic was fired in 2010 after posting remarks on Facebook about her supervisor, Bluvshtein says. The paramedic wrote that "looks like I'm getting some time off. Love how the company allows a 17 to be a supervisor," referring to a psychiatric-patient code. A colleague asked what happened, and the paramedic responded that the supervisor was being a jerk (using a vulgar word). "Chin up," the co-worker said. The NLRB declared the paramedic's termination unlawful, Bluvshtein says, because "employees have the right to criticize supervisors." The NLRB protected her posts also because "her fellow employees posted support," Maggiore said. "They voiced their frustration."

continued

Policy on Use of Social Media

Here is Boston Medical Center's policy and procedure on the use of social media. Contact Privacy Officer Nickie Braxton at Nickie.Braxton@bmc.org.

Purpose: To provide guidance to the Boston Medical Center (BMC) workforce on the appropriate use of social media as it relates to BMC and its patients.

Policy Statement: BMC is committed to providing exceptional care without exception, as well as maintaining a work environment that is respectful, ethical, and compassionate. Like many organizations, BMC participates in social media to help educate potential patients, current patients and families about BMC and the care that we provide. Only workforce members specifically designated by BMC have the authority to speak on behalf of the organization using social media or any other medium. BMC recognizes that workforce members take part in social media, but all workforce members must respect patient privacy, our organization and other workforce members who work here. **Workforce members may not share information about BMC patients or hospital business matters on any social media sites.**

Application: BMC's workforce and its subsidiary corporations, including, but not limited to, the Faculty Practice Foundation, Inc. and providers at community health centers who are credentialed at BMC.

Exceptions: None

Definitions:

Social media: text messages, audio, video, images, blogs, wikis, message boards, chat rooms, electronic newsletters, online forums, social networking sites and other sites and services that permit users to share information with others

Workforce members: employees, Licensed Independent Practitioners (as defined in the Medical/Dental Staff Bylaws), interns, house staff, volunteers, and all others who work or provide services on behalf of BMC including contractors.

Procedure: Workforce member's behavior on social media sites should be handled carefully to avoid reflecting poorly on BMC.

I. *General Behavior on Media Sites*

1. Information posted on social media is public for an extended period of time. Workforce members must be mindful of the effect their posts may have on BMC's image as well as their own.
2. Workforce members must use their **personal e-mail addresses, not their BMC e-mail addresses,** as their primary means of identification on social networking sites.
3. HIPAA and applicable Commonwealth of Massachusetts privacy rules and regulations apply at all times. **Posting any information about a current or past BMC patient is prohibited.** This includes not only BMC patient names but also descriptions of patients and those who visit patients at BMC. **Patient photos must never be posted on social media sites, even with the patient's permission.**
4. Never use profane, obscene, or sexually explicit language on social media sites.
5. Workforce members must promptly report any identified breach of this policy or other BMC confidentiality or privacy policies to their supervisors, to the BMC Privacy Officer or to the BMC Compliance Hotline at 800-586-2627.
6. Any inappropriate social media activity that violates BMC's Code of Conduct may result in disciplinary action up to and including termination of employment.
7. Personal use of social media sites on work time is prohibited and may result in disciplinary action.

II. *Professionalism on Social Media Sites*

1. All BMC workforce members must be careful to maintain professional relationships with BMC patients and their families. Although it is important for workforce members to be friendly, it

The lesson here, Maggiore said, is that managers and human resources are not grasping the fact that social media is another communication tool that's often protected.

◆ ***SkinSmart Dermatology:*** An employee was fired from the dermatology clinic after daring her supervisors to do it on a social media site, Bluvshtein says. The employee said the supervisors were full of it and seemed to be steering clear of her because she didn't bite her tongue anymore. "She claimed the post was protected because she has a right to badmouth her supervisor," but that was not upheld by the NLRB. "No co-workers joined in the criticism. To be protected, it can't be a single employee," Bluvshtein says.

Because social media is a popular forum to comment on jobs, Maggiore suggested employers ask their employees to include a disclaimer with their posts. "The NLRB says you can't require a disclaimer, but you may suggest it," she said. The disclaimer can be very simple

Policy on Use of Social Media (continued)

is inappropriate for workforce members to become social media "friends" with our patients or their families. Workforce members must consistently uphold professional boundaries in relation to BMC patients, former patients and their families. The fact that a patient may initiate or invite contact does not permit an employee to engage in a personal relationship with the patient. If an employee has a question about social media relationships, the employee should consult with the appropriate supervisor for guidance.

2. BMC Workforce members' participation in social media is expected to be courteous and respectful at all times. Workforce members must not engage in disparaging remarks on social media sites regarding BMC, other workforce members, or current or past patients, and may not threaten, harass, degrade or embarrass them, even if they are not identified. This includes use of inflammatory language regarding race, creed, color, religion, sexual orientation or gender.
3. Workforce members must be aware of and comply with BMC information security policies regarding the use of employer-owned computers, cameras and other electronic devices, and use of personal devices in the workplace.

III. *Representing Boston Medical Center on Social Media Sites*

1. If a workforce member is contacted by the press or another media outlet about something that was posted on a social media site, all questions should be referred to the Communications Department at BMC.
2. BMC logos, trademarks, and photographs may not be used on social media sites without written permission from the BMC Communications Department. Workforce members must always respect copyright laws and reference sources appropriately. Workforce members should also be aware that they can be liable for plagiarism in online posts if they copy content not their own without the permission of the original author or creator.
3. Workforce members should not post or discuss any information about BMC that is considered to be confidential. If you have a question about what is appropriate to post, please contact the Privacy Officer or the Chief Compliance Officer.
4. If a workforce member is offered compensation to participate in an online forum about BMC s/he should consult with her/his supervisor prior to accepting the offer. Compensation for the use of BMC medical information is prohibited. If an employee is uncertain about participation s/he should consult with her/his manager or supervisor.
5. BMC's social media site is the responsibility of the Communications and Marketing Departments and the Development Office, and only they are authorized to respond to questions and concerns posted by patients and others. If workforce members wish to add a comment in response to a question or issue on the site, they **must receive prior written approval** from the Communications and Marketing Departments.
6. Particular employee grievances should never be posted on BMC's site, but should be brought to the appropriate individual or department for resolution (i.e., HR, supervisor, the Compliance Office).
7. Individuals and departments of BMC **may NOT create their own BMC sites** without the written permission of the Communications and Marketing Departments.
8. BMC workforce members are not authorized and may not respond to health questions posed on social media sites, including BMC's own site, unless authorized by the Communications or Marketing Departments. For example, if a patient posts a question about flu vaccines, a nurse, employed by BMC, should never respond or provide health care information without prior written authorization from the Communications and Marketing Departments.

Nothing in this policy is intended to or will be applied in a manner that limits employees' rights to engage in protected concerted activity as prescribed by the National Labor Relations Act.

— "opinions expressed are my own" — and preserve the objectivity of the comments, whether positive or negative.

Boston Medical Center continually trains employees on social media, Braxton says. She distributes the policy, writes articles and does email blasts. "It's not just about what you can and can't do, but why," she says. "It's trying to let people understand the reasoning behind the rules." Braxton attends meetings with the leadership forum — managers, executives and directors — to talk about compliance issues, including social media. "We have huddle cards sent every week to our hospital managers, which they discuss with their teams, and social media issues are on a number of them," she says.

Contact Braxton at Nickie.Braxton@bmc.org, Bluvshtein at nolsonbluvshtein@fredlaw.com and Maggiore at jennifer@redballooninc.com. ✧

Allegedly Playing Exclusion Games Leads to False Claims Settlement

A Pennsylvania man who was kicked out of Medicare in 2002 allegedly orchestrated the formation of a new company to provide diabetic services and supplies to nursing facility residents in his wife's name. When the Department of Justice caught on, it determined that exclusion wasn't getting the message across and filed a False Claims Act lawsuit against him, his wife and the company.

On May 12, John Hastings, Sarah Cintron Hastings and Diabetic Care Solutions agreed to pay $200,000, stay out of Medicare and face more consequences "if they continue to flout the rules," says Michael Macko, an assistant U.S. attorney with the U.S. Attorney's Office for the Eastern District of Pennsylvania. John Hastings' exclusion from federal health care programs will be extended, and his wife will also be excluded, according to the stipulated order and consent judgment, which requires them to routinely disclose financial documents to the government, Macko tells *RMC*.

"The whole idea of exclusion is an administrative remedy in the hands of the HHS Office of Inspector General, and they often address exclusion as a civil monetary penalty case" when providers bill for excluded employees or vendors, says Margaret Hutchinson, chief of the civil division in the U.S. attorney's office. "But at times when the conduct is more a pattern and practice of abusing exclusion, it's something we want to take a look at," she says.

It's an unusual resolution and underscores the dangers of billing Medicare for services provided, directly or indirectly, by excluded parties. The case also raises the question of how hospitals and other facilities should screen their vendors when excluded people hide behind the "corporate veil," says Michael Rosen, president of ProviderTrust in Nashville, Tenn. It's a best practice for hospitals to ask vendors to complete a form with key pieces of information, including the legal name of the company, tax identification number and names of people who own 5% or more of the company, he says.

The complaint against Hastings, his wife and Diabetes Care Solutions describes a Medicare supplier that allegedly had an excluded man as the showrunner although on paper it was owned and operated by his wife.

Medicare Started Poking Around

John Hastings pleaded guilty to mail fraud and tax evasion in 1999 in connection with his work for a health care company that provided supplies to Medicare patients, and he was excluded from Medicare in August 2002 for 10 years, the complaint says. That means he could not bill federal health care programs, directly and indirectly.

Hastings tried in vain to get reinstated around 2007 and again in 2009 after seeing his name on the OIG list of excluded individuals and entities (LEIE). When he sought reinstatement in 2013, OIG held his application pending an investigation. Meanwhile, he and his wife created Diabetic Care Solutions, registering it initially in Puerto Rico. The supplier was allowed into Medicare because "Hastings and Cintron Hastings checked a box to indicate that there was no history of exclusion by any owner or manager," the complaint alleges.

They moved the supplier to Drexel Hill, Pa., and incorporated it without mentioning John Hastings because of his exclusion, the complaint alleges. On a site visit to Diabetic Care Solutions by a Medicare contractor, John Hastings said Sarah Cintron Hastings was sole owner and manager, and he provided a list of all managers and employees without including his name. In reality, Hastings worked for Diabetic Care Solutions and controlled the company from June 6, 2007, to Oct. 7, 2011, the feds allege. For example, he handed out company business cards bearing his name, hired a dozen employees, fired one, entered into contracts, and signed checks and credit card receipts on behalf of Diabetic Care Solutions, says the complaint. John Hastings also allegedly directly provided items and services to Medicare patients, fitting them for shoes at more than a dozen nursing homes and senior living facilities on behalf of Diabetic Care Solutions.

"To conceal his involvement at the company, Hastings and Cintron Hastings omitted Hastings from the company's payroll. Cintron Hastings then drew a salary from Diabetic Care Solutions and deposited the funds

into a bank account that Hastings jointly owned," the complaint alleges.

The alleged scam started to unravel when OIG agents poked around, the complaint says. As part of an investigation, the agents interviewed John and Sarah Cintron Hastings, asking John about his involvement in Diabetic Care Solutions. He allegedly responded that he "makes 15 to 20 deliveries per month to patients," according to a handwritten statement copied into the complaint. Shortly after, on Oct. 7, 2011, the company closed its doors. Hastings still maintains he was never an employee of Diabetic Care Solutions, the complaint says, and it wasn't mentioned on his Medicare reinstatement application.

Even if John Hastings wasn't steeped in the details of Diabetic Care Solutions, excluded people can't serve in executive or leadership posts (e.g., CEO, CFO, general counsel, director of health information technology) or provide any type of administrative and management services (e.g., strategic planning, billing, accounting) if the company bills Medicare for goods or services, according to OIG's 2013 special advisory bulletin on exclusion *(RMC 5/13/13, p. 1)*, which updated 1999 guidance in this area. It also says that "although an exclusion does not directly prohibit the excluded person from owning a provider that participates in Federal health care programs, there are several risks to such ownership. OIG says providers may be excluded if they are owned in part — 5% or more — by an excluded person.

Watch Out for Excluded Vendors

But the worm really turns when hospitals, skilled nursing facilities (SNFs) and other entities do business with excluded vendors and, perhaps, vendors that are partly owned by excluded individuals, Rosen says. How can hospitals and SNFs know? He hopes for guidance from OIG in light of its interest in this area. OIG is on the hunt for information, with an ongoing evaluation and inspection cited in the 2014 Work Plan, Rosen says. For example, the 2014 Work Plan says OIG will "determine the extent to which States and CMS collect and verify required ownership information for provider entities enrolled in Medicare and Medicaid. We will also review States' and CMS's practices for collecting and verifying provider ownership information and determine whether States and CMS had comparable provider ownership information for providers enrolled in both Medicaid and Medicare." OIG notes that for 2015, this is still a work in progress.

It's still unclear whether hospitals will suffer consequences if they don't pierce the corporate veil of the dozens or hundreds of vendors they use, says Rosen. "To what extent will OIG punish ABC Hospital for doing business with a vendor and not knowing the owner of the vendor is excluded?" While hospitals should search the LEIE for the vendor as an entity or person, "the next evolution is whether you need to know the exclusion of a manager or owner," Rosen says.

Hutchinson notes that the number of voluntary disclosures to the U.S. attorney's office is increasing, and some are from hospitals and nursing homes that realize an employee lacks proper credentials. Perhaps the employee has been excluded or doesn't have a current license for whatever reason or is not properly credentialed. Voluntary disclosure is more compelling now because there could be improper payment retention under the False Claims Act when providers don't return reimbursement stemming from excluded or ineligible providers, she says.

The Hastings' attorney was unavailable for comment.

Contact Rosen at mrosen@providertrust.com and Macko at Michael.macko@usdoj.gov. ✧

CMS Transmittals and *Federal Register* Regulations
May 8 – May 14

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. 100-04, Medicare Claims Processing Manual

- Quarterly Healthcare Common Procedure Coding System Drug/Biological Code Changes - July 2015 Update, Trans. 3254CP, CR 9167 (May 8; eff. July 1; impl. July 6, 2015)
- Correction to the Multi-Carrier System Editing on the Service Location National Provider Identifier Reported for Anti-Markup and Reference Laboratory Claims, Trans. 3255CP, CR 9150 (May 8; eff. Oct. 1; impl. Oct. 5, 2015)
- Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program - July 2015, Trans. 3256CP, CR 9140 (May 8; eff. July 1; impl. July 6, 2015)

Pub. 100-20, One-Time Notification

- Section 504: Implement National Medicare Summary Notices in Alternate Formats, Trans. 14990TN, CR 9153 (May 8; eff. Oct. 1; impl. Oct. 5, 2015)
- Modification to Telehealth Originating Site Facility Fee Billing Requirements for Rural Health Clinics and Federally Qualified Health Centers, Trans. 14960TN, CR 9144 (May 8; eff. Oct. 1; impl. Oct. 5, 2015)

Pub. 15-1, The Provider Reimbursement Manual - Part 1

- Provider Reimbursement Manual Part 1, Chapter 14, Reasonable Cost of Therapy and Other Services Furnished by Outside Suppliers, Trans. 469PR1 (May 8, 2015)

Federal Register Regulations

- None published.

Audits May Have New Focus

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them through Sept. 30, 2015, and CMS told *RMC* in January the incumbent RACs would not perform patient-status reviews through Dec. 31, 2015 *(RMC 1/12/15, p. 1)*. Medicare administrative contractors are limited to probe and educate reviews, which evaluate hospital compliance with the two-midnight rule for inpatient admissions and will continue through Sept. 30. Hospitals report they are starting to face the third round of probe and educate reviews.

The two-midnight rule changed the calculus of inpatient vs. outpatient decisionmaking. The way CMS framed it, patients either require hospital care, or they don't. If they require hospital care, for how long is the next question. And, of course, the hours patients spend in observation or outpatient services, including the emergency room (after medical care is initiated), count toward the two midnights because what matters is their total time spent in the hospital *(RMC 12/23/13, p. 1)*. What auditors will question is whether hospitals are delaying care to get patients across two midnights. "Medicare contractors will probably start to scrutinize the way commercial payers do," Wuebker said. "Being in the hospital can be unsafe, so reviewers will ask whether the patients need to be there." CMS has explicitly warned against admitting for convenience; classic examples are a Friday admission for a Monday diagnostic test because the hospital isn't staffed to perform it on the weekend and admitting patients the night before a procedure to perform pre-procedure testing. And social admissions/custodial care *(RMC 2/16/15, p. 1)* are not covered by Medicare, although CMS says the risk of an adverse outcome is a piece of the medical-necessity puzzle, and hospitals often have social admissions to prevent adverse outcomes.

Also, he said, "I think auditors will target when there is a contradiction in the order and length-of-stay expectation." Physicians sometimes write conflicting information, such as "I anticipate one midnight in the hospital, and hence she will be admitted under observation." There's no way to defend admissions pursuant to that kind of order, he said. "These are things that case management should watch like a hawk," Wuebker said. "They are layup denials."

'Midnights' Are Alien to Physicians

While the audit focus is shifting, the fundamentals of establishing medical necessity in physician documentation are the same, he said. The one exception is physicians expressing their expectation of patients' staying two midnights. But that doesn't mean hospitals should hammer away at it with physicians. While "two midnights" is evocative terminology to regulatory experts, such as compliance officers and attorneys, it doesn't necessarily resonate with physicians. Because patients can receive the same medications, treatments and diagnostic tests in inpatient, observation and outpatient beds, acknowledging to physicians this is purely a reimbursement concept helps defuse tension and establish rapport.

"Don't speak to physicians in terms of midnights," he advised hospitals. "They think in terms of days in the hospital." If physicians believe patients will be discharged the same day or the day after they come into the hospital, most of the time physicians should order observation or outpatient services. "That's really straightforward and will help doctors get it right most of the time." Patients having an endoscopy who are expected to go home later that afternoon are outpatients, while patients undergoing a coronary artery bypass graft typically are inpatients for three days because that's the standard of care, Wuebker said. Similarly, patients given IV fluids for gastroenteritis belong in observation, and it could be a red flag if they're admitted. The same goes for cardiac catheterizations because the patients typically are sent home the same or following day. "That's where case management is critical," he said. "Those cases should be on the top of the list and ensure documentation is supportive."

Here are the seven key pieces of documentation for medical necessity under the two-midnight rule, said Wuebker, summarizing CMS's "inpatient" definition:

(1) Physician order

(2) Past medical history (e.g., comorbidities)

(3) Severity of signs and symptoms (e.g., pertinent positives on physical exam)

(4) Current medical needs (e.g., plan of care and accompanying orders)

(5) Facilities available for adequate care

(6) Predictability of an adverse outcome (e.g., suspected diagnosis and need for hospital services)

(7) Expectation of length of stay

Physicians generally do a pretty good job documenting the patient's history, current medical needs, severity of signs/symptoms and facilities available to provide adequate care, but they may drop the ball when

it comes to documenting the risk of an adverse outcome, Wuebker said. They tend to write down symptoms rather than diagnoses or tentative diagnoses, which explain the potential for adverse outcomes. "What is your concern, and why are you concerned?" he said. It's straightforward; physicians can fill in the blanks of "I suspect that…" or "I am worried about this, and here's why" or "Given the patient's history of X and current presentation of Y, adverse outcomes are likely," with details.

It's not that enlightening to put down "nausea and vomiting." They could be a sign of the stomach flu or a bowel obstruction, with door No. 1 vs. door No. 2 meaning a big difference in acuity, Wuebker said. "Acknowledge to physicians that 'we don't need you to be perfect. We are not keeping a batting average on you,'" he said. Rather, "'we need you to document your primary concern or two.'"

Driving this point home will have a tremendous impact on chest pain, the catch-all diagnosis and compliance black hole. Chest pain is a symptom, not a diagnosis, and could explain a multitude of conditions, including unstable angina, pneumonia, gastroesophageal reflux disease (GERD) and heart attack.

Suppose a 76-year-old man comes to the hospital after having 20-minute episodes of chest pain for a couple of days. He has a history —— a previous heart attack, stent placement and diabetes — and now his left arm is tingling, and he feels the same way he did during his last heart attack. The physician documents "chest pain, EKG, enzymes, maybe stress test in the morning." With that documentation, said Wuebker, "that case is at high risk of denial." The auditor would contend the doctor wasn't concerned about anything and just cited the symptoms and plans for tests. Proper documentation would connect the dots, he said, such as "due to pain similar to a prior MI [myocardial infarction] and cardiac history, I am concerned about unstable angina. Based on concern for unstable angina, we will do a stress test." Even if everything turns out fine, the physician gave a clear rationale for the hospital care, Wuebker said. "If you can wipe out symptoms from documentation, it will go a huge way toward reducing exposure," he said.

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NEWS BRIEFS

◆ **Billing compliance lapses around place-of-service codes have reared their heads again in a new audit** (A-01-13-00506). The HHS Office of Inspector General (OIG) says Medicare contractors possibly overpaid physicians about $33.4 million for incorrectly coded services provided between January 2010 and September 2012. The cause: Physicians performed the services in facilities but coded them as if they were performed in nonfacilities. For years, place-of-service coding has driven OIG to distraction. Using the wrong place-of-service code triggers overpayments because Medicare Part B pays more for certain physician services when they are provided at offices or freestanding clinics rather than at hospital departments, including provider-based entities. The reason: Professional fees include overhead when services are provided at practices and freestanding clinics. But Medicare Part B reduces professional fees when physicians treat patients in outpatient departments because hospitals foot the bill for overhead and recover the money through APC payments for facility fees. CMS will address the problem partly with new modifiers and codes for services rendered at provider-based clinics *(RMC 11/10/14, p. 1)*. Meanwhile, OIG wants to see Medicare recoupment and better internal controls and data matching, according to the new report. Visit http://go.usa.gov/3kqQm.

◆ **All home health agencies do background checks on prospective employees, and about half screen them periodically after they are hired although it's not mandated by federal law,** OIG said in a May 13 report (OEI-07-14-00130). In its review of background checks, OIG found that 4% of home health agency (HHA) employees had at least one criminal conviction that possibly would have blocked their employment. It was hard to tell because "FBI criminal history records were not detailed enough to enable us to definitively determine whether employees with criminal convictions should have been disqualified from HHA employment," OIG said. It recommends CMS advocate minimum standards in procedures for background checks. Visit http://go.usa.gov/3kvjT.

◆ **The Department of Justice said May 12 it will take over a False Claims Act case filed in California by whistleblowers against the owners of Bay Sleep Clinic and their related businesses, Qualium Corp. and Amerimed Corp.** The sleep clinic allegedly billed Medicare for diagnostic sleep tests that were done in unapproved locations by technicians who didn't have licenses or certifications required by Medicare, according to the U.S. Attorney's Office for the Northern District of California. Visit http://go.usa.gov/3BuGJ.

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