Leery of Audits, Some Physicians Resist Admissions Despite Two-Midnight Rule

Despite their training on the two-midnight rule, some physicians at Sinai Hospital of Baltimore resist admitting patients who are expected to stay at least two days. “They are very gun shy” after years of Medicare claim denials for admissions that auditors determined should have been outpatient or observation services, says Physician Advisor David Zolet, M.D. “It’s a problem.” He has been trying to turn things around, explaining to hospitalists and residents that if they expect patients to be in the hospital for several days — perhaps they have been treated before for asthma, chronic obstructive pulmonary disease or heart failure — they should admit them and document accordingly. “But they are reluctant to do this,” he says. “They put them in observation.”

In fact, sometimes physicians hesitate to admit observation patients as the second midnight approaches when they are probably home free. “They say the patients are getting better, and there’s a feeling if they’re improving and almost there, they will send them home tomorrow,” Zolet says. The attitude is, “why incite a denial by moving them to inpatient? That is kind of the experience I see and hear from other places. It’s really hard to change that” — although he is making headway with one-on-one education.

The experience of Sinai Hospital and other hospitals that find their physicians wary of admissions is partly a hangover from years of audits and partly a reflection of how hard it is to reverse course in light of a regulatory change. That puts hospitals at compliance and revenue risk as it becomes increasingly clear the two-midnight rule is not going away and audits of short stays resume, this time with quality improvement continued on p. 5
(RMC 9/30/13, p. 8) The hospital allegedly “offered and paid excessive remuneration and other things of value to actual and potential referring physicians or others, including amounts for ‘marketing’ or ‘advertising.’” Payments also were made in the form of cash and gift cards/coupons for luxury items,” according to the U.S. Attorney’s Office for the Northern District of Texas. These kickbacks, the Department of Justice alleged, were targeted at inducing TRICARE referrals. Forest Park Medical Center also entered into a nonprosecution agreement with the government and accepted a federally imposed compliance monitor for not more than 24 months. The monitor was assigned to review and evaluate inpatient compliance.

Also, LipoScience, Inc., a Raleigh, N.C., diagnostic lab company, agreed in 2012 to settle allegations that it violated the CMP law related to kickbacks by giving gift cards to employees in referring doctors’ offices, according to a settlement with OIG (RMC 9/24/12, p. 3). LipoScience, which self-disclosed the conduct to OIG, agreed to pay $151,785 in a CMP for distributing 4,312 gift cards between Dec. 20, 2005, and March 31, 2011. Each gift card was worth about $25, and the company’s sales force distributed a total of about $100,000 worth of gift cards to staff in physician offices over a five-year period.

In the new case, Jupiter didn’t admit liability in the settlement. Its attorney, Julie Kass of Ober Kaler in Baltimore, tells RMC that Jupiter identified the gift cards “through the normal compliance efforts of the company. They looked at the issue and thought they would disclose and resolve things with the government.” Kass notes the settlement amount was modest, adding she doesn’t find this to be a “particularly groundbreaking issue.”

But health care organizations have to tread lightly when they give anything of value to referral sources, says Washington, D.C., attorney Jacob Harper, with Morgan Lewis. “Providers have to decide how much risk they are willing to take on with their marketing because anything you provide to a referral source could be considered an inducement even if just one purpose is to reward that referral source.” The straw that may break the camel’s kickback is calculating the gift (or other item) based on the volume or value of the physician’s referrals, Harper notes.

Favoritism Is Risky Business

If health care organizations opt to give gifts to referral sources, the dollar value should be nominal. While OIG has not defined what it considers nominal in terms of referral sources, it has set a limit on gifts and free services to patients of $10 per transaction or an aggregate of $50 per year. “That framework can offer an idea of what might be considered low risk versus high risk,” Harper says.

There’s a separate Stark threshold under the non-monetary compensation exception to the law that provides for higher limits, but that’s a CMS authority, he notes. Moreover, any evidence of noncompliance with the anti-kickback statute or hint that compensation was based on referrals defeats that protection. “That’s why you can’t show favoritism,” Harper explains. “If you routinely work with 20 doctors and want to provide gifts to them, give them all the same thing, and don’t discriminate based on the number of referrals. If most referral sources get $25, but the highest source gets $200 and the lowest gets $10, that provides pretty strong evidence that the gifting is directly tied to inducing referrals.”

And keep in mind that gift cards pose more compliance risk. Although they may not be considered “cash or cash equivalents,” gift cards — as opposed to a gift basket or other item — walk the line between gift and cash, says Harper.

Outside the rarified world of health care, doing something nice for business partners — giving them something nice for business partners — giving them


Copyright © 2016 by Atlantic Information Services, Inc. All rights reserved. On an occasional basis, it is okay to copy, fax or email an article or two from RMC. But unless you have AIS’s permission, it violates federal law to make copies, or fax or email an entire issue, share your AISHealth.com subscriber password, or post newsletter content on any website or network. To obtain our quick permission to transmit or make a few copies, or post a few stories of RMC at no charge, please contact Eric Reckner (800-521-4323, ext. 3042, or erekner@aishealth.com). Contact Bailey Sterrett (800-521-4323, ext. 3034, or bsterrett@aishealth.com) if you’d like to review our very reasonable rates for bulk or site licenses that will permit weekly redistributions of entire issues. Contact Customer Service at 800-521-4323 or customerserv@aishealth.com.

Report on Medicare Compliance is published with the understanding that the publisher is not engaged in rendering legal, accounting or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought.

Managing Editor, Nina Youngstrom; Assistant Editor, Angela Maas; Contributing Editor, Francie Ferrand; Executive Editor, Jill Brown; Publisher, Richard Bleth; Marketing Director, Donna Lawton; Fulfillment Manager, Tracey Filar Abwood; Production Editor, Carrie Epps.

Subscriptions to RMC include free electronic delivery in addition to the print copy, e-Alerts when timely news breaks, and extensive subscriber-only services at www.AISHealth.com that include a searchable database of RMC content and archives of past issues.

To order an annual subscription to Report on Medicare Compliance ($764 bill me; $664 prepaid), call 800-521-4323 (major credit cards accepted) or order online at www.AISHealth.com.

Subscribers to RMC can receive 12 Continuing Education Credits per year, toward certification by the Compliance Certification Board. Contact CCB at 888-580-8373.
muffin baskets or gift cards — is de rigueur, Harper says. But this is the business of health care, and the government perceives even small gifts as having the potential to influence where patients receive services or reward an ongoing relationship with a referral source, he notes.

“Gifts are a tricky thing,” Harper contends. Health care organizations should ensure they have policies and procedures governing them “so everyone in the office is on notice that gifts to referral sources must receive extra vetting.” Physician offices also should educate their compliance officers and office staff about the potential landmines in gifts, he says, and develop methods to ensure that gifts to referral sources are assessed through the compliance program.

Contact Harper at jharper@morganlewis.com and Kass at jekass@ober.com. 

**Hospital Settles FCA Case; Stark Self-Disclosure Started With OIG**

After it identified financial arrangements with physicians that allegedly didn’t comply with the Stark law, Tri-City Medical Center in Oceanside, Calif., hoped to resolve its problems with the HHS Office of Inspector General (OIG). The hospital was accepted into OIG’s Self-Disclosure Protocol, which offers reduced penalties to health care organizations that voluntarily come forward and reveal potential violations.

Unfortunately for Tri-City Medical Center, the Department of Justice (DOJ) pursued the case under the False Claims Act. The hospital wound up settling the case, which involved 97 physician contracts, for $3.278 million, DOJ announced Jan. 15.

The vast majority of Self-Disclosure Protocol cases are settled by OIG without DOJ involvement. DOJ always reviews submissions to the Self-Disclosure Protocol, and, if prosecutors see fit, it will step in and turn the OIG self-disclosure into a false claims case. That’s a rare event, but it happened with Tri-City Medical Center. “The OIG was amenable to trying to do the resolution, but the U.S. attorney here in the San Diego area wanted to pursue the issues,” Chief Compliance Officer Cheryle Harper tells RMC. “We were just as surprised by what was happening as anyone else.” She notes the management in place at the time the hospital entered into the physician arrangements is gone now, and there was a different compliance officer.

The settlement agreement with 397-bed Tri-City Medical Center addressed the following:

- **Nine-two arrangements with various community-based physicians and practices** from July 1, 2009, to June 30, 2010, that allegedly violated the Stark law for various reasons, DOJ said. For example, written agreements had expired, lacked signatures or couldn’t be found at all, according to DOJ. The arrangements were for all kinds of services, including anesthesiology coverage; information technology physician liaison; EEG interpretation; medical directorships; quality assurance committee meetings; medical executive committee meetings; and a pediatric cardiology panel. The settlement noted the Stark problems were “unrelated to the fair market value or commercial reasonableness of the arrangements.”

The hospital did not admit liability in the settlement and wasn’t required to implement a corporate integrity agreement. Bernard-Shaw notes the physician contracts are now in compliance, and the hospital has a rigorous process to monitor contracts.

It was a former CEO who first realized the contracts were allegedly problematic and decided self-disclosure was the right move, she explains. At that point, reforms were put in place, but that was before Bernard-Shaw’s time. “We have just maintained and augmented what they have done,” she says. That includes obtaining fair-market-value assessments of physician compensation; ensuring contracts have signatures; and withholding payments until physicians submit time sheets documenting their services and the services are verified. Also, the hospital begins the process of reviewing physician contracts three months before they expire, Bernard-Shaw says. “We have software that alerts us,” she notes.

Contact Bernard-Shaw at Bernard-ShawCT@TCMC.com.

**Enrollment Application Needs Tending as CMS Flexes Its Muscles**

The Medicare enrollment process has become another way for auditors and enforcers to crack down on abuses, and CMS is increasingly using it to keep out or oust bad apples, police financial relationships and revoke billing privileges, experts say.

“Enrollment is one of the top enforcement tools,” said attorney Judy Waltz, with Foley & Lardner LLP in San Francisco. CMS reported it revoked or deactivated 166,293 Medicare enrollments last year, Waltz said.

In particular, CMS has been ramping up its revocation of providers’ billing privileges, which means they can’t bill Medicare for a specified time period — typically...
one to three years. Though CMS formalized this power in the Medicare Program Integrity Manual in June 2006, it has been used much more frequently over the past few years.

Another enforcement tool, payment suspension, leaves enrollment intact but “is a time out” for providers and suppliers, Waltz said. CMS and its contractors can take away providers’ and suppliers’ billing privileges for numerous reasons, with the latest set forth in a Dec. 5, 2014, regulation (RMC 12/14/15, p. 1). The most controversial addition is suspension of billing privileges for repeatedly submitting noncompliant claims.

“These provisions allow CMS to act more quickly and effectively than they could by terminating the provider agreement through survey and certification or through Medicare exclusion,” but it has virtually the same effect: no Medicare payments, Waltz said. Payments are credited, but they are not made until CMS is convinced the situation has been resolved. Then CMS will take any determined overpayment out of the accumulated payments before the remainder, if any, is released to the provider, she said at a recent conference sponsored by the American Health Lawyers Association.

Payment suspensions are being used in new ways in the war on fraud and abuse. “They can be collateral to large investigations,” said Waltz. For example, provider suspensions were part of the June 2015 Medicare strike force takedown in 17 federal districts by the Health Care Fraud Prevention & Enforcement Action Team (HEAT), a Department of Justice-HHS initiative.

And CMS may suspend payments “despite an ongoing federal investigation being run by the Department of Justice,” Waltz said. The physician in one Florida case (U.S. ex rel Green v Institute of Cardiovascular Excellence, No. 5:11-CV-406-OC-37TBS) felt the threat of suspension was used “to pressure him to settle,” she said.

Enrollment is considered the moat protecting the Medicare castle. Provisions in the Affordable Care Act gave CMS more tools to carry out this function, Waltz said. For example, CMS can impose moratoria on provider enrollment — and it’s flexed those muscles in the ambulance and home health arenas so far (RMC 2/9/15, p. 8). That means a specific category of prospective providers is prevented from enrolling in Medicare. CMS also now requires physicians who don’t participate in Medicare themselves to enroll only for the purpose of ordering or certifying items or services for their Medicare patients, such as home health care or lab work. They complete a form — the 855O — and if they drop the ball, Medicare won’t pay hospitals and other entities for the home health, lab tests and other services they order.

**OIG Plans to Penalize Omissions, Lies**

Enrollment applications must be complete and accurate because of intensified scrutiny, according to Waltz. Errors can lead to enrollment rejections or worse. The HHS Office of Inspector General (OIG) has proposed regulations that would impose civil monetary penalties (CMPs) for making false statements, omissions or misrepresentations in an enrollment or similar application. Under OIG’s proposal, a provider or supplier could be assessed a CMP of $50,000 for each false statement, omission or misrepresentation, she noted.

Lots of information is requested and verified as part of the enrollment process. For example, all practice locations and their phone numbers must be listed on the enrollment form unless they have their own Medicare billing number. Medicare contractors will check locations against Qualifier.net, and if they are missing, you can expect to be questioned. Phone numbers also will be called to verify they are in working order.

After the application is submitted, Medicare administrative contractors (MACs) determine whether it includes all necessary data elements and documentation. “Have your most obsessive person check the application before it goes in because there will be delays or possibly very bad effects if the application is not complete and accurate,” Waltz recommended.

MACs check whether anything conflicts with publicly available information (e.g., IRS, state licensing boards, Qualifier.net). If the application asks whether any adverse action has ever been taken against the physician listed on the enrollment application and the provider said no because the state medical board’s letter of reprimand doesn’t seem like a big deal, you can get in big trouble. It’s easy for contractors to check for sanctions with the state, and don’t think they won’t. Within 15 days of receiving the application, contractors will ask for anything missing and give 30 days to produce it. If MACs see signs of fraud, they’re required to refer the matter to a zone program integrity contractor.

Enrollment forms also are used to detail financial relationships. For example, because providers must enter taxpayer identification and employer identification numbers, the forms could potentially be used to crosscheck financial relationships for Stark or kickback purposes (ordering and referring information must be included on claim forms), and to identify individuals or entities responsible for Medicare debts that the government

---

**Get RMC to others in your organization.**

Call Bailey Sterrett to review

AIS’s very reasonable site license rates.

**800-521-4323, ext. 3034**

---

*Web addresses cited in this issue are live links in the PDF version, which is accessible at RMC’s subscriber-only page at http://aishealth.com/newsletters/reportonmedicarecompliance.*
might recover from other government payments (e.g., tax refunds), Waltz said.

The fact that the provisions discussing enrollment and revocation appear in the Medicare Program Integrity Manual means “CMS is viewing these as enforcement provisions.”

There are three grounds for deactivating a provider or supplier’s Medicare billing number. For example, the provider or supplier doesn’t report a change of information that was supplied on the enrollment application or fails to report a change in ownership or control within 30 calendar days.

CMS also can revoke a provider’s billing privileges, which means its Medicare provider agreement is automatically terminated.

CMS set forth 12 grounds in Chapter 10, Sec. 13.2 of the Medicare Program Integrity Manual. They include putting misleading or false information on enrollment applications and knowingly misusing a national provider identifier. In a regulation finalized Dec. 5, 2014 (RMC 12/8/14, p. 1), CMS added new grounds for revocation. It may now revoke Medicare billing privileges if:

- Providers repeatedly submit noncompliant claims (i.e., they have a “pattern or practice of billing for services that do not meet Medicare requirements,” including lack of medical necessity, the regulation states).
- The managing employee of a provider or supplier was convicted of certain felonies.

Contact Waltz at jwaltz@foley.com.

Some MDs Are Reluctant to Admit

organizations (QIOs), experts say. “Most hospitals will end up being more conservative than they should be,” says Ralph Wuebker, M.D., chief medical officer of Executive Health Resources in Newtown Square, Pa. As a result, sometimes they are keeping patients in observation who should be admitted, he says. “They are going so conservative on one midnight stays that 99% or 100% of the stays are being classified as observation,” he says. The reason: “Everyone is beaten down by the auditors and the confusion.”

Hospitals are doubling down on the conservative approach to the two-midnight rule because they are regularly hit by CMS’s subregulatory guidance and revisions to that rule. “It takes a while to undo that,” he contends. But as of Jan. 1, they have less reason to be so cautious, because in the 2016 outpatient prospective payment system regulation, CMS created an exception that allows for inpatient admissions even when the physician doesn’t believe the patient will stay in the hospital for two midnights, although it was designed to be used only in “rare and unusual circumstances” (RMC 11/9/15, p. 1). Regardless of how loosely hospitals interpret the exception, “CMS has given more leeway for more one-midnight cases,” Wuebker says. “If you have 0% one-midnight inpatient cases, you have documentation improvement opportunities.”

Notwithstanding the language of the exception, Wuebker thinks there are “significant situations where one-midnight stays would be appropriate for inpatient.” They are high-acuity stays in facilities that are very efficient at treating some conditions, such as acute myocardial infarctions, strokes and congestive heart failure, and performing certain procedures, including cardiac surgery. That’s the perverse incentive of the two-midnight rule, he contends. Sometimes hospitals that are the most effective are penalized financially for it because their patients don’t cross two midnights even when their treatment is resource intensive, Wuebker says. “It’s one of the biggest downfalls of the two-midnight rule. If they get someone in and out of the hospital [quickly], they are rewarded with a Part B payment,” he says. “It’s insane. It’s a disincentive to provide efficient care and an incentive to process patients.”

---

**CMS Transmittals and Federal Register Regulations**

Jan. 15 – Jan. 21

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**

- Calendar Year 2016 Eligibility Changes to the End-Stage Renal Disease Prospective Payment System Low-Volume Payment Adjustment (R), Trans. 219BP CR 9468 (Jan. 13; eff. Jan. 1; impl. Jan. 22, 2016)

**Pub. 100-04, Medicare Claims Processing Manual**

- Healthcare Common Procedure Coding System Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments Edits, Trans. 3439OP CR 9502 (Jan. 15; eff. Jan. 1; impl. April 4, 2016)
- New Waived Tests, Trans. 3440CP CR 9515 (Jan. 15; eff. April 1; impl. April 4, 2016)

**Pub. 100-06, Medicare Financial Management**

- Notice of New Interest Rate for Medicare Overpayments and Underpayments - 2nd Qtr Notification for FY 2016, Trans. 258FM CR 9532 (Jan. 12; eff./impl. Jan. 18, 2016)

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

- Award of Durable Medical Equipment Medicare Administrative Contractor Contract for Jurisdiction D, Trans. 15920TN CR 9453 (Jan. 15; eff. Sept. 14, 2015; March 1, 2016)

**Federal Register Regulations**

- None published.
to be inefficient.” He hopes the outpatient prospective payment system will fix some of these situations.

Zolet says Sinai Hospital is in the process of “redoing how we approach observation.” Physicians are encouraged to think about the observation versus admission decision earlier in the patient’s hospital stay. In conjunction with the director of care management, Zolet is adding a utilization reviewer to address observation exclusively. That person will approach hospitalists when the patient’s stay is perilously close to a second midnight with the idea of pushing him or her into an admission “so we don’t miss these opportunities to be compliant,” he says.

Vertebroplasty/Kyphoplasty Coverage Tool for Medicare Patients

This checklist may help physicians and hospitals think through the medical necessity of patients having either of two similar spine procedures, vertebroplasty or kyphoplasty, according to their Medicare local coverage determination (LCD). The checklist was developed by Jeannine Engel, M.D., physician advisor for billing compliance at University of Utah Health Services in Salt Lake City, based on the requirements set forth in the LCD for hospitals in her Medicare administrative contractor (MAC) jurisdiction. She emphasizes the checklist applies to only the LCD for her hospital’s MAC, Noridian Healthcare Solutions. “It’s probably about the same everywhere, but you can’t rely on it unless you check your LCD,” Engel cautions. Several years ago, the MAC put a number of hospitals on 100% prepayment review for vertebroplasty based on the LCD (L32032), and she developed the checklist as a pre-billing tool for physicians to use before ordering the procedure.

“What’s most beneficial in developing these tools is you learn the coverage criteria,” Engel says. “I use it as a baseline, but I check the criteria very carefully.” She suggests using other people’s tools only as a starting point: “If I develop my own tool, I am responsible for my own facility.” Noridian has since taken her hospital off prepayment review for vertebroplasty. Kyphoplasty, of course, is familiar as the source of a national enforcement initiative over procedures performed on inpatients that the Department of Justice alleged should have been performed on outpatients (RMC 12/21/15, p. 7). While patient status remains an issue, the LCD addresses the medical necessity of the procedure itself. “Recent literature, including a widely cited article in the New England Journal of Medicine, has suggested that kyphoplasty and vertebroplasty were no better than placebo,” says Ronald Hirsch, M.D., vice president of education and regulations at Accretive Physician Advisory Services. “As a result, MACs are now looking at the medical necessity of the procedure itself.” Contact Engel at Jeannine.Engel@hsc.utah.edu and Hirsch at rhirsch@accretehealth.com. Read the New England Journal of Medicine article at www.nejm.org/doi/full/10.1056/NEJMoa0900429.

<table>
<thead>
<tr>
<th>Patient Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vertebral compression fracture (VCF) ≤4 months old; T5-L5 levels only; 3 or fewer levels per procedure</td>
</tr>
<tr>
<td>Pain level is:</td>
</tr>
<tr>
<td>□ ____ on VAS 1-10 pain scale (≤7)</td>
</tr>
<tr>
<td>□ and/or pain interferes with independent activities of daily living when ADLs were previously independent</td>
</tr>
<tr>
<td>□ Pain refractory to non-invasive pain intervention(s)</td>
</tr>
<tr>
<td>Interventions attempted:</td>
</tr>
<tr>
<td>□ Fracture confirmed by</td>
</tr>
<tr>
<td>□ plain X-ray date ________ OR □ MRI date ________</td>
</tr>
<tr>
<td>□ Patient does NOT have unstable fracture or require stabilization procedure</td>
</tr>
<tr>
<td>□ Patient does NOT have osteomyelitis or any other active infection including UTI</td>
</tr>
<tr>
<td>□ Patient does NOT have uncorrected coagulation disorders</td>
</tr>
<tr>
<td>□ Patient does NOT have bone fragment retropulsion or radicular symptoms related to the VCF level</td>
</tr>
<tr>
<td>□ Patient does NOT have radicular symptoms related to the VCF level</td>
</tr>
<tr>
<td>□ Patient does NOT have painful metastases to other areas of the spine; spinal cord compression; primary bone tumor or a solitary plasmacytoma</td>
</tr>
<tr>
<td>□ Patient does NOT have a known allergy to any of the materials; or any condition that is a contraindication in the FDA labeling</td>
</tr>
<tr>
<td>□ Patient does NOT have foraminal stenosis or other spinal degenerative disease, facet arthropathy or other significant coexisting spinal or bony pain generators</td>
</tr>
</tbody>
</table>
Not only did the two-midnight rule guarantee Part A payment for patients whose medically necessary hospital stays crossed two midnights (absent gaming), but it said patients could not linger in observation. “We’re encouraging them to make the decision about observation or admitting,” he explains. Because Sinai Hospital is in Maryland, it’s also under the purview of the state Health Services Cost Review Commission and its timelines about the conversion of patients from observation services to inpatient admission.

Zolet finds himself educating physicians one on one. Although he has done the dance in monthly meetings of hospitalists, he finds it far more effective to catch them one at a time and mention actual patients — and do it repetitively. He says something like, “this person couldn’t go home yesterday, so make them inpatient.” Zolet says that “it’s hard to do classroom stuff. Physician advisers all say you have to get on the floor and teach them one on one.”

Hospitals also may want to use admission screening criteria — InterQual or Milliman Care Guidelines (MCG) — for their first level of review, Wuebker says. Although they seemed to be moot when the two-midnight rule came to town because time, not severity of illness or intensity of services, became the determinant of inpatient admission, InterQual and MCG are players, partly because CMS introduced the exception to the two-midnight rule and partly because QIOs will be using InterQual in their audits of short inpatient stays, says Wuebker. “Even if they don’t meet screening criteria, those are cases that should get second-level physician review,” he says. Physician advisers will determine whether the admissions are warranted or whether there is compliance vulnerability, Wuebker says. Hospitals also have to guard against medically unnecessary admissions stemming from custodial delays (e.g., patients who remained only because the hospital could not locate a relative who would care for the patient); the attempt to qualify patients for a skilled nursing facility admission, which requires a consecutive three-day inpatient stay; or convenience (e.g., the patient is admitted on a Friday for a nuclear stress test, but the patient is kept until Monday instead of being discharged and readmitted), he says. “If I were an auditor, that’s where I’d start,” he says.

Sometimes hospitals make the mistake — to their own detriment — of neglecting to do a second-level review of admissions when the first-level review comes

Vertebroplasty/Kyphoplasty Coverage Tool for Medicare Patients (continued)

**Documentation Requirements Prior to Procedure**
- Comprehensive pain evaluation and examination.
- Pain management treatment plan addressing all pain generators, and beginning with the least invasive approach.
- Complete history and physical examination by operating provider.
- Appropriate imaging has been performed pre-operatively and the findings correlate unequivocally with the patient’s pain.
- Patient’s pain is predominantly, if not solely, related to the demonstrated fracture.

**Documentation Requirements for Procedure and Post-procedure**
- Procedure must be performed with CT or fluoroscopic, real-time imaging guidance, with retained images of final trocar placement and retained images of the vertebral body at the end of the procedure.
- Detailed operative procedure narrative report.
- Plan for F/U patient assessment at 1 week, 1 month, 3 months and 1 year post-operatively with outcomes. Telephone F/U is acceptable. (3 month and 1 year F/U may be deferred to PCP with appropriate communication and documentation.) Documentation will include patient’s comfort/activity/pain scores.

**Contraindications/Limitations**
1. Not payable when performed immediately following acute compression fractures or diagnosis of them.
   a. Delay may not always be in patient’s best interest. If so, provider must clearly and legibly document the rationale for this decision in the medical record.
2. Will not be paid in combination with any open spine procedure.
3. Bone biopsy done at the same level as part of same procedure will not be payable.

REMINDER: Absent clear medical record documentation to the contrary, these procedures are not performed on an inpatient basis and do not, in and of themselves, ever require inpatient admission.

VAS = visual analog scale
One reason for this upside-down development: Hospitals are not admitting patients after a night in observation if they don’t meet InterQual and MCG admission screening criteria, even when they need two midnights in the hospital. “Admission screening criteria don’t apply after a night in observation,” Meyerson says. “That’s why it’s important for hospitals to have physician advisers. It will allow the admission of patients based on the expectation of two midnights.”

Also, patients who are initially treated in observation but require a second midnight in the hospital should be admitted. If they are kept in observation too long — more than 48 hours — hospitals have missed the opportunity to admit and, in fact, are out of compliance with the IPPS, which limits observation time. “When it comes to the second night in the hospital, throw away InterQual and MCG. That is not criteria for the second night,” Meyerson contends.

Contact Zolet at dzolet@lifebridgehealth.org, Meyerson at stevenjmeyerson@gmail.com and Wuebker at rwuebker@ehrdocs.com.

**NEWS BRIEFS**

◆ A New Jersey man pleaded guilty to one count of paying kickbacks to a sports medicine doctor on behalf of a compounding pharmacy. Howard Wertheim of Manchester admitted that in 2013 he worked for Vladimir Kleyman, president and pharmacist-in-charge of Prescriptions R Us, who “paid him to help recruit and pay physicians to refer their prescriptions” to the pharmacy; including “tens of thousands of dollars in cash bribes” to physician James Morales “in exchange for referring pain cream prescriptions,” according to the U.S. Attorney’s Office for New Jersey. Wertheim is scheduled to be sentenced April 25; the charge carries a maximum of five years in prison and a fine of $250,000. Wertheim also must forfeit $25,000, which represents the money he made through the scheme. In November, Kleyman was sentenced to 20 months in prison for his part in the scheme (RMC 11/9/15, p. 8). Visit http://tinyurl.com/zo5pkaf to view the press release.

◆ The HHS Office for Civil Rights (OCR) has amended the HIPAA privacy rule to specifically add the National Instant Criminal Background Check System (NICS) to §164.512, “Uses and disclosures for which an authorization or opportunity to agree or object is not required,” according to a final rule published in the Jan. 6 Federal Register. The focus of the rule, which goes into effect on Feb. 5, 2016, is covered entities (CEs) that “either make the mental health determinations that disqualify individuals from having a firearm or are designated by their States to report this information to NICS.” View the final rule at https://federalregister.gov/a/2015-33181.

◆ D&G Holdings, a medical lab in Louisiana, has brought suit against CMS to, in essence, stop recoupment of amounts CMS maintained it owed due to overpayments before the lab exhausted its administrative processes. D&G presented a number of arguments to the U.S. District Court in the Western District of Louisiana, but the court found that it had authority only to hear the plaintiff’s procedural due process claim and its challenge to the agency’s authority to recoup before the administrative process was complete. Generally an agency’s decision to recoup monies owed is not reviewable by the courts, but here the court found that the lab’s procedural due process claim was collateral to the substantive claim for Medicare benefits, and it had provided evidence of irreparable harm if the recoupment did not stop. These findings were sufficient to grant what is termed a “Mathews” waiver of the general rule. However, the lab’s complaint did not adequately flesh out its arguments regarding CMS’s authority, and the court ordered it to file an amended complaint by Feb. 9. The order in D&G Holdings, LLC v. Burwell (No. 15-2624) is available at http://tinyurl.com/grlpuux.
If you are a subscriber and want to provide regular access to the newsletter — and other subscriber-only resources at AISHealth.com — to others in your organization:

Call Customer Service at 800-521-4323 to discuss AIS’s very reasonable rates for your on-site distribution of each issue. (Please don’t forward these PDF editions without prior authorization from AIS, since strict copyright restrictions apply.)