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

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Without Self-Disclosure, Hospitals Settle Case for Transfers Billed as Discharges

Two Connecticut hospitals have settled civil monetary penalty (CMP) cases for billing transferred patients as if they were discharges. Hartford Hospital agreed to pay $2.46 million to settle allegations it violated the CMP law on the submission of false claims, and Midstate Medical Center agreed to pay $436,748 over the same allegations, according to the HHS Office of Inspector General.

The hospitals allegedly coded patients as discharges although they received home health care within three days of leaving the hospital. Under Medicare's post-acute care transfer (PACT) payment policy, the patients should have been coded as transfers, which generally confers less reimbursement than the usual DRG payment.

Neither hospital self-disclosed the overpayments to OIG, says Nancy Brown, OIG senior counsel. "There were two things going on with both entities: they didn't know, but then they did know and didn't take corrective action," Brown tells *RMC*. "The onus is on providers to tell the government about [an overpayment] once they know something about it. If you do that and enter into the Self-Disclosure Protocol, then you get the benefits of a lower-damages multiplier and typically no corporate integrity agreement."

The alleged overpayments for transferred patients were flagged by the Consolidated Data Analysis Center (CDAC), which is OIG's data mining arm, and pursued by its litigation team. "This is not an area we are specifically targeting, but I don't think it would be odd to see more of these kinds of cases, especially with our partnership with CDAC," Brown says. "Based on these settlements, I would identify this as an area you should police."

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Payer Denials Hit Sepsis Amid Conflicting Clinical Protocols; Diagnosis is Doubted

Claim denials are coming in for sepsis from Medicare and commercial payers, fueled by the use of different clinical standards and documentation problems, compliance officials say.

As the medical profession debates the most clinically meaningful ways to evaluate the signs and symptoms of sepsis, hospitals are caught in the crossfire of payer denials, says Leslie Slater, a specialist leader with Deloitte Advisory in New York City. "It's so convoluted and messy, and the fact that CMS" is slow in adopting newer guidelines for the Inpatient Quality Reporting program "is making it even more difficult," she says. Payers also are challenging the physicians' decisionmaking over a notoriously difficult diagnosis, Slater notes.

Here's the dilemma: Hospitals and physicians may use different sepsis protocols than payers. Many physicians use the presence of systemic inflammatory response syndrome (SIRS) to diagnose sepsis based on the Society of Critical Care Medicine's

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(SCCM) 1991 consensus definition, known as Sepsis-1, which continued with its 2001 Sepsis-2 definition and remained through 2015, says Andrew Rothschild, M.D., a consultant in Austin, Tex. But in February 2016, the SCCM's Sepsis Definitions Task Force published guidelines in the *Journal of the American Medical Association* that define sepsis as "life-threatening organ dysfunction caused by a dysregulated host response to infection." The guidelines, known as Sepsis-3, recommend the use of the sequential organ failure assessment (SOFA) scores to determine organ dysfunction. Sepsis-3 also defined septic shock as "a subset of sepsis in which particularly profound circulatory, cellular, and metabolic abnormalities are associated with a greater risk of mortality than with sepsis alone." The overarching goal of Sepsis-3 is early identification of patients at risk of sepsis to prevent organ failure, Slater says. It also can be a coding challenge, because coding guidelines prohibit capturing diagnoses that aren't present yet, while allowing early diagnoses that just started, Rothschild says.

"This is a moving target," says Maria Johar, M.D., system physician adviser for ProMedica Health System in Toledo. "Just when you get something on paper, it gets old. It's like technology." Payers use the variances between sepsis clinical standards to downcode claims, compliance officials say. That happens with other conditions, but sepsis is a magnet for denials because there are a lot more dollars associated with it, Johar says. When payers downgrade an MS-DRG by knocking off the sepsis secondary diagnosis, they save $10,000 to $12,000, which is a substantial blow to a hospital in light of the number of sepsis cases it probably sees in a given year, Johar says. "We will be disputing it a lot more" in discussions with medical directors and in formal appeals.

The financial pain is being felt at various hospitals. "We are losing quite a bit on payer denials" outside of Medicare, says one compliance officer. A lot of payers use the Sepsis-3 criteria for clinical validation of the diagnosis, while Medicare uses Sepsis-2 criteria, she says. "We are going to look at our contracts to see if we can hold the Medicare Advantage plans to Medicare's criteria so we have one standard for coding," says the compliance officer, who prefers not to be identified. "We can't be focused on two different things for coding purposes based on payer."

Sepsis Often Is 'Insufficiently Supported'

Payers deny claims even when they don't dispute that the physician has documented sepsis, Slater says. That's called clinical validation, where auditors look behind the coding and if they don't like what they see in the medical records, they challenge the diagnosis. In one denial letter to a hospital, the reviewer wrote, "we acknowledge the condition as documented but don't think this was a valid diagnosis." Slater says the payer was capitalizing on the gaps between the Sepsis-2 and Sepsis-3 clinical criteria.

"If physicians use the Sepsis-3 criteria and coders are coding it, those are not the cases getting denied," she says. But many physicians are still using Sepsis-2, which is reinforced by CMS. The problem with Sepsis-2 is "it gives you many false positives," Slater says. SIRS is overly sensitive, drawing too many patients into its universe. SIRS generally refers to the body's systemic response to infection, trauma/burns or other insult, with symptoms including fever, tachycardia, tachypnea and leukocytosis.

"When reviewers are looking at the cases, they're saying there isn't clinical evidence to support a diagnosis of sepsis, so they're denying them," Slater says. "They feel it's just an infectious process, such as pneumonia." Sepsis is a syndrome and affects multiple organs, she says. Hospitals should be able to fend off some of the denials if their documentation supports sepsis. "Where it falls down is physicians don't always document their thought process or they have conflicting diagnoses," Slater says. For example, the attending physician and infectious disease specialist may use different criteria or write different diagnoses in their notes. "It makes it difficult to code or fight the denial," she says.

Ultimately, clinical validation is about ensuring the evidence justifies the diagnosis, Rothschild says. "It's a

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combined responsibility of coding, clinical documentation specialists and providers," he says. "Coders and CDS ensure clinical indicators clearly support a diagnosis, while insufficient support should prompt a query for provider review and clarification."

This may come up a lot with sepsis because it's "one of the most insufficiently supported, upcoded diagnoses," Rothschild says. Combining that with the high-dollar value of the claims, it's not surprising sepsis is a common audit target, he notes.

Two-day hospital stays for patients with a sepsis diagnosis will be a target, Slater says. "Under Sep-3, there is supposed to be organ failure," she notes. Auditors will question whether patients who are discharged after two days really had sepsis or instead suffered from an organ-specific infection, such as pneumonia. "I suggest hospitals do pre-bill reviews of two-day sepsis stays," Slater says.

Meanwhile, many hospitals rely on InterQual and MCG (formerly Milliman) to confirm patient diagnoses, but they haven't adopted Sepsis-3 yet, Johar says. "They haven't caught up with the SOFA scores, and that may not match your sepsis protocol and the payers may be on a different version," she says. "That's how they're denying cases and reducing reimbursement." It's unfortunate because SOFA is designed to flag sepsis early and prevent patients from going into septic shock, Johar says. The sooner sepsis is recognized, the faster the patient receives the appropriate treatment and hopefully recovers, which benefits everyone, she says. But that doesn't mean payers will accept the argument if they're wedded to a different protocol and determined to downgrade the MS-DRG. "If they are not recognizing qSOFA, it's more work on our part to justify the case," she says.

There's Room for Documentation Improvement

Documentation shortcomings are another roadblock. "If you don't have good documentation, it's more difficult to get sepsis past the insurer," Johar says. It's in hospitals' best interest to ensure everyone is on the same page with the clinical criteria and strong, accurate documentation so a united front is presented to the payer's medical director. With Sepsis-3, for example, the organ dysfunction should be shown by the qSOFA score of two or more. "These patients are at a higher risk for poor outcomes. Prevention is better than the cure, but the cure is paid more than the preventive measures. Everyone is trying hard to present the accurate picture to get the optimal reimbursements," she says.

In terms of minimizing denials when physicians believe they have a valid sepsis diagnosis with "soft evidence," Rothschild suggests reinforcing it by tying together observations, indicators, logic or other reasons that convinced them the patient was septic. In the event payers deny sepsis claims with questionable clinical evidence, they're usually escalated to a clinician reviewer. "If the reviewer finds and agrees with the provider's explanation, the claim is much less likely to be denied," he says. "This will usually hold true, regardless of the sepsis definition in question."

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Multiple Metrics Allow Hospitals To Build Physician Risk Profiles

When health systems receive documentation requests about physician billing, they probably aren't limited to evaluation and management (E/M) errors. Auditors won't waste their time on low-dollar overpayments unless they sense trouble on a larger scale, and health systems should follow suit.

"No one is getting big-dollar audit requests because a physician overcoded an E/M service by one level," said Jared Krawczyk, a mathematician with Nektar Analytics. "E/M services are just one of many areas they could be investigating, but the reality is that because there are areas that are much more lucrative, E/M investigations can be a lower priority for outside auditors."

With so many auditors in play, health systems may want to build multi-dimensional risk profiles for physicians by benchmarking them against their peer groups on certain metrics and incorporating "risk thresholds," he said. Metrics that point the way to compliance problems include E/M services, modifiers and the top procedures, as well as an analysis of highly productive physicians and Medicare payment data per physician. Filtering the data to develop a risk profile helps pick out physicians who may present the most compliance risk.

"If you have 1000 doctors and have two auditors and can only audit 200 doctors this year, you want to make sure you find the right 200 doctors," Krawczyk said at the Health Care Compliance Association's Compliance Institute March 28.

The point is to focus audits on the physicians that are potentially overcharging Medicare and other payers—although the data itself isn't necessarily conclusive. "This is just data leading us in the right direction," said Andrei Costantino, vice president of integrity and compliance at Trinity Health in Livonia, Mich. "You can't make any conclusions until you look at the underlying information. People get a little freaked out when you show them outliers, and they think they did something wrong and they may not have."

To compare physicians to their peers in each of the risk areas, Krawczyk recommends using CMS data. "It makes sense to compare your physicians against the

same data CMS auditors are comparing you to and not just look at internal network averages," he said.

Costantino uses CMS and Medical Group Management Association (MGMA) data for audits. The CMS data are a complete summary of all Part B carrier claims processed through the common working file and stored in the National Claims History Repository. It's available broken down by carrier, pricing locality, HCPCS code, modifier, specialty, type of service and place of service. MGMA data can be used to benchmark physicians' work relative value units (wRVUs), which are an indicator of productivity (e.g., physician visits per day).

Combining Billing and Payment Metrics

Keep in mind, however, what data are included in the universe and how it affects peer-group comparisons. For example, if there are only four physicians in a peer group data set, "you probably don't want to compare the doctor against it," he said. Data is never going to be perfect, "but you need to be aware of what the data set is comprised of so you can understand the biases."

Here are details on the metrics:

◆ **E/M audits:** Health systems typically use a bell curve to identify outliers in E/M billing. At Trinity Health, "we are looking at a physician in comparison to his peers," Costantino said. For example, the E/M codes for a family practice in Michigan is benchmarked against CMS data for family practices in Michigan, "which shows on average what everyone else bills," he said. "It gives us an idea if they fall out of the bell curve in that peer analysis" (e.g., the CMS data shows on average that family-practice physicians bill CPT code 99214 50% of the time, but Trinity's physician bills 99214 80% of the time).

The Medicare data also can be benchmarked against MGMA data (see box, p. 5). For example, compare the total days worked, the total number of patient encounters, the average number of encounters per day and the total wRVUs of select physicians against MGMA compensation percentiles (e.g., 70th, 80th, 90th). This metric provides a visits per day analysis and can gauge how many visits a physician performs on average. If a physician is performing 30 plus visits a day at the highest E/M levels, you may have a problem, Costantino says. More investigation is necessary to determine if the physician is spending enough time with the patients to justify that level of billing.

Costantino suggests keeping your eye on subsequent care E/Ms because "there's a huge focus" on them by auditors and this area is easily overlooked. "I have seen a lot of repayments over the past few years for subsequent care."

◆ **Modifier use (24, 25, 58, 59, 62, 63, 76, 78 and 80):** There are two ways to calculate modifier use. One method is to divide the physician's use of modifiers by their total number of services billed in a given date range, and then to repeat that with a peer group. The second method, "which may be more telling," is to calculate utilization based on the billing requirements of that modifier. For example, select a very high-risk modifier, such as 25, and determine how many times it was billed divided by the total number of office visits, Krawczyk said.

◆ **Top billed services (also known as procedure utilization analysis):** "You list the 25 services the physician billed for based on frequency, then calculate their utilization across the entire universe of their billing for that data period," Krawczyk said. Then do the same analysis with CMS data for the nation and state and compare the physician to the CMS data. "We also like to isolate high-value services, where the physician collected a lot of money for a service or the service itself reimburses at a high rate," he said.

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CMS Transmittals and *Federal Register* Regulations

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Live links to the following documents are included on *RMC*'s subscriber-only webpage at www.hcca-info.org. Please click on "CMS Transmittals and Regulations."

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July CY 2017 Update, Trans. 3772 (May 12, 2017)
- Changes to the Payment Policies for Reciprocal Billing Arrangements and Fee-For-Time Compensation Arrangements (formerly referred to as Locum Tenens Arrangements), Trans. 3774 (May 12, 2017)
- Two New "K" Codes for Therapeutic Continuous Glucose Monitors, Trans. 3775 (May 18, 2017)
- New Waived Tests, Trans. 3771 (May 12, 2017)

Pub. 100-08, Medicare Program Integrity Manual

- Clarifying Medical Review of Hospital Claims for Part A Payment, Trans. 716 (May 12, 2017)

Pub. 100-20, One-Time Notification

- Update FISS Editing to Include All Three Patient Reason for Visit Code Fields, Trans. 1852 (May 17, 2017)
- Implementation of Modifier CG for Type of Bill 72x, Trans. 1849 (May 12, 2017)
- MCS Implementation of the Restructured Clinical Lab Fee Schedule, Trans. 1846 (May 12, 2017)

Federal Register

Proposed Regulation

- Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2018 Correction, 82 Fed. Reg. 22304 (May 15, 2017)

Who Is Auditing Health Care Providers? - An Example: Illinois

Hospitals and other providers are under scrutiny by a variety of auditors and will soon face oversight from the unified program integrity contractors (UPICs), who recently were hired to carry out CMS's new consolidated Medicare-Medicaid program integrity strategy. Contact Andrei Costantino, vice president of integrity and compliance at Trinity Health in Livonia, Mich., at costanta@trinity-health.org.

Type	Contractors	Comments
Medicare Administrative Contractors (MACs)	- National Government Services	- Process claims and provider payments - Reduce payment error rates
Zone Program Integrity Contractors (ZPICs)	- Cahaba Safeguard Administrators	- Focus on identifying fraud - All providers - Data mining and analysis
Supplemental Medical Review Contractor (SMRC)	- Strategic Health Solutions	- Nationwide claim review - All providers - Data mining and analysis
Comprehensive Error Rate Testing Contractors (CERT)	- Multiple contractors	- Annual audits to determine FFS error rates - All provider types
Recovery Audit Contractors (RACs)	- CGI Technologies (Medicare) - HMS (Medicaid)	- Identify over and under payment errors
DHHS - Office of Inspector General (OIG)	- N/A	- Audits and investigations - Annual Work Plan published
Department of Justice (DOJ)	- N/A	- Enforcement actions under the False Claims Act
Medicaid Inspector General	- IL Dept. of Healthcare and Family Services	- Aggressively using extrapolation for repayment liabilities

Benchmarking Physicians: Analysis of Visits Per Day

Develop an internal average per day analysis:

- Use MGMA data
- Physician paid claims
- CPT codes, volume, date of service
- MGMA Visit Data 70th, 80th and 90th
- Outlier?
- How many visits per day?

CPT Code	Typical Time for Code
99212	10 min
99213	15 min
99214	25 min
99215	40 min

Provider Information		MGMA Percentiles		
Criteria	Actual	70th	80th	90th
Total Days Worked	256	240	240	245
Total Encounters	6764	4508	5067	6127
Avg. Encounters/Day	26	19	21	25
Total Work RVUs	9439	5672	6279	7390

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◆ **Medicare payment utilization data:** CMS now makes data on every physician's total payments, number of patients and payments per patient from 2012 to 2014 available. "This benchmarking data is becoming more of a hot topic because everybody has access to your data," Krawczyk said. For auditing purposes, he says the utilization data "opens up the opportunity for three unique analytics:" (1) the total number of payments received by a physician compared to other physicians in the same specialty in the state; (2) the number of patients the

Using Thresholds to Prioritize Physicians Who May Pose More Compliance Risk

This is a list of fictional physicians and how they compare on the E/M bell curve analysis, says Jared Krawczyk, a mathematician with Nektar Analytics. They are prioritized based on their utilization of at-risk established office visit codes. For example, Dr. Mercury used the codes 98.59% of the time, or 1,300 times for the audit period. That's 68% higher than her CMS peer group and it makes her a prime candidate for a closer look. Contact Krawczyk at jkrawczyk@nektaranalytics.com.

Provider	Specialty	At Risk CPT	CPT Vol.	CPT Util.	CPT Diff.
JULIA MERCURY MD	Obstetrics & Gynecology	99214	1330	98.59%	68.00%
XIANG VENUS MD	Diagnostic Radiology	99213	1025	89.75%	54.00%
REZA EARTH MD	Diagnostic Radiology	99213	1792	74.14%	38.00%
MINCHUL MARS MD	Diagnostic Radiology	99213	1991	70.06%	34.00%
TIMOTHY JUPITER CRNP	Nurse Practitioner	99214	1213	67.02%	29.00%
LEONARD SATURN MD	Diagnostic Radiology	99214	568	64.91%	41.00%
SARA URANUS MD	Diagnostic Radiology	99213	1875	64.32%	28.00%
KRISTINA NEPTUNE MD	Diagnostic Radiology	99213	2048	63.82%	28.00%
RALPH PLUTO MD	Vascular Surgery	99215	48	32.65%	30.00%

How Benchmarking and Thresholds Work Together

This is an example of how risk profiles are used to drill deeper into the data of physicians who are flagged as compliance risks. This fictional doctor rang alarm bells on all the metrics measured. For example, 100% of her new office visits are billed at the second highest evaluation and management level of service.

Category	CPT	Description	Applicable Util.	Gross $
JULIA MERCURY MD				
> 5K Hours			0.00%	$0.00
New Office	99204	Office/outpatient visit new	100.00%	$15,616.22
Est Office	99214	Office/outpatient visit est	98.59%	$143,812.90
Init Hospital	99223	Initial hospital care	93.73%	$51,927.76
Subs Hospital	99231	Subsequent hospital care	50.43%	$9,299.16
New_Est Consuls	99244	Office consultation	90.67%	$12,563.00
Excessive Billing	93351	Stress TTE complete	2.26%	$63,544.80

physician treats vs. his or her peers; and (3) how much money the physician is collecting from Medicare on a per-patient basis compared to his or her peers. *The Wall Street Journal* has a database that ranks physicians according to their percentile. "You can look up every doctor and see where they're ranked," he said. Physicians don't want to be number one, Costantino added. "The number ones are either in jail, being prosecuted or being looked at," he noted. One of the nation's top-billing physicians, ophthalmologist Salomon Melgen of Florida, was just convicted of 67 counts of health fraud and false claims (*RMC 5/8/17, p. 8)*.

◆ **Highly productive physicians:** Consider looking at the billing patterns of the most highly paid physicians to determine if their services are medically necessary and adhere to professional standards, Costantino said. One way is to compare their annual wRVUs to MGMA's compensation survey. If they are greater than the 90th percentile, "it doesn't mean they did anything wrong, but it means they are highly productive and further review may be required," he said. "This area can be a great risk for hospitals as it relates to quality and medical necessity of care provided," Costantino says, and a peer review in these areas is a good move.

Next Step Is Building Thresholds

Once all the data is gathered, "you build metric thresholds across every type of analysis to determine if a physician is a risk," Krawczyk said. "You combine the metrics into a scorecard or risk profile" (see box, p. 6). There are different statistical ways to build thresholds—for example, there is the chi-squared method, which Trinity Health uses, or you can flag billing patterns that are two standard deviations from the mean—with the ultimate goal of prioritizing risk.

"Thresholds get you to a smaller subset of your providers who are exhibiting risk," Krawczyk said.

After audit findings are in, Costantino doesn't cite error rates. "We focus our audits to identify process improvement and educational opportunities relating to coding, billing and documentation processes affecting physician coding assignments," he said. "Because we only use limited, non-statistical judgmental sampling when reviewing records, the sample selection is controlled by the auditor and can't be measured (e.g., error rates, extrapolation)."

Trinity Health also changed its auditing process in response to the Medicare 60-day rule, which requires providers to quantify and return overpayments within 60 days of identifying them. If Trinity Health finds systemic issues, it does a more detailed review to determine if a payback is necessary. Trinity Health spells this out in a policy called "Correction of Errors in Federal and State Programs," which covers procedures to meet the 60-day rule.

"We do paybacks and have a system in place to track paybacks and also perform a root cause analysis to determine why it happened to avoid future errors. Do you want to pay them all that money back? No, so it kills you, but you have to pay it back if you did it wrong."

Contact Costantino at costanta@trinity-health.org and Krawczyk at jkrawczyk@nektaranalytics.com. Visit the CMS data at http://tinyurl.com/z7o4fru. *The Wall Street Journal* CMS toolkit is at http://graphics.wsj.com/medicare-billing/. ✧

Hospitals Settle Transfer Cases

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In a statement, Hartford Hospital and MidState Medical Center said a 2011 upgrade to their billing systems caused some Medicare claims "to inadvertently misstate whether patients were to receive related home health services within three days after discharge." The problems were identified and fixed more than two years ago by the hospitals. "This matter concerns Medicare reimbursement only, and had nothing to do with patient care," according to the statement. Both hospitals are owned by Hartford Healthcare.

Under the PACT payment policy, when patients assigned to certain MS-DRGs receive post-acute care after inpatient hospitalization, they are classified as transfers instead of discharges. Hospitals are paid per diems instead of MS-DRGs up to the full amount of the MS-DRG. Post-acute care is defined as home health care provided within three days of discharge, and services in skilled nursing facilities and other hospital units that are not reimbursed under the inpatient prospective payment system (e.g., psych, inpatient rehab and long-term care). Hospitals are required to use discharge status codes on all Medicare claim forms, which tells Medicare when the PACT payment policy is set in motion. The codes include 06 for home health, 03 for SNFs and 62 for inpatient rehab.

Unlike an audit, which would lead to a straight overpayment, or a self-disclosure, where providers come forward on their own, OIG initiated the case against the Hartford Healthcare hospitals in what's known as an "affirmative action," and that presumably means at least double damages, says Washington, D.C., attorney Jacob Harper, with Morgan Lewis. "I'm surprised it's an affirmative case," he says. "This seems to be a technical issue that providers could unwittingly mess up." Because OIG alleged the hospitals identified the miscoded transfers without reporting them, "this case ties back to the larger issue of the 60-day overpayment rule," Harper says. "If providers know of an issue, they are getting signals from

a lot of different sources that they need to fix it and fix it promptly." With Medicare contractors and OIG CDAC mining claims data to expose certain errors without breaking a sweat, "ignoring errors raises the stakes from a simple overpayment to potentially something significantly more damaging" unless it's repaid, Harper says.

There's growing urgency to correct coding errors because some of CMS's zone program integrity contractors and its new unified program integrity contractors, such as AdvanceMed, which were recently hired to implement a consolidated Medicare-Medicaid program integrity strategy, "have so much power with predictive-modeling," he says. "In situations like this, they don't have to have someone on the ground doing medical-necessity determinations. It's a lot easier for them to slice and dice data to identify possible errors."

Hospital Audits All PAC Claims on Back End

To ensure compliance with the PACT payment policy, hospitals may be stuck with monitoring on the back end. "We went from retrospective review when Medicare kicked the claim back to us—and we had to correct—to 100% audit of Medicare claims post-acute discharge," says Kathy Perkins, compliance officer at Pomona Valley Hospital in California. It had two recent audit outliers: a patient who was discharged but went on his own to another facility and a patient whose physician ordered home health services from the office after discharge. The hospital is following up to determine if this is a trend with the physician.

To improve compliance, the hospital assigned a program integrity team to the PACT payment policy through its revenue cycle committee. "The discharge status code is assigned, and case management staff follows up three days post discharge with a call to the home health agency, skilled nursing facility, patient home" or other possible PAC location to confirm the discharge status code is accurate, Perkins says.

"If for some reason the provider cannot verify—usually in the case of home health—another call is placed in three days, and then again "until it can be verified the patient refused the service or for another reason our discharge status code was correct," she says. "This has helped us to get the status right before we drop the bill."

There may be only a few situations where hospitals are unaware of discharged patients' post-discharge plans, Harper notes. However, "it makes sense to follow up both from a continuity-of-care perspective and to avoid problems with the PACT policy."

Contact Harper at jacob.harper@morganlewis.com and Perkins at kathy.perkins@pvhmc.org. ✧

NEWS BRIEFS

◆ **Acting Assistant Attorney General Kenneth Blanco said "health care fraud is a priority for the Department of Justice" at the American Bar Association's National Institute on Health Care Fraud in Fort Lauderdale, Fla., on May 18.** "The investigation and prosecution of health care fraud will continue; the department will be vigorous in its pursuit of those who violate the law in this area," said Blanco, who heads the criminal division. He cited some recent cases, including the April indictment of two Detroit physicians for allegedly participating in a scheme to perform female genital mutilation on minors. To read the speech, visit http://tinyurl.com/lo5sxb6. To read about the genital mutilation cases, visit http://tinyurl.com/lb95hvy and http://tinyurl.com/kbckycj.

◆ **In a refresher on medical review of hospital stays under the two-midnight rule, CMS reminds hospitals that they don't have to create a separate form to document that patients are expected to cross the two-midnight threshold.** "Physician/practitioners need not include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician/practitioner's standard medical documentation, such as his/her plan of care, treatment orders, and progress notes," according to the new *MLN Matters* article (MM10080). CMS backed off its demand for an attestation in 2015, but some hospitals think it's required and continue to include the "I expect to see two midnights" language in their admission order sets, says Ronald Hirsch, M.D., vice president of R1 Physician Advisory Services. It's not necessary, and "removing that phrase will also reduce confusion for admissions of inpatient-only surgery where discharge is expected in under two midnights and the allowable exceptions" (e.g., mechanical ventilation initiated during the present visit), he says. Contact Hirsch at RHirsch@R1RCM.COM. To learn more, visit http://tinyurl.com/kytba3l.

◆ **OIG has released its 2017 compendium of unimplemented recommendations.** It focuses on the top HHS programs that would have the most impact "in terms of cost savings, program effectiveness and efficiency, and quality improvements," OIG says. Visit https://go.usa.gov/xNZUc.