Report on
Volume 15, Number 3 • January 16, 2006

MEDICARE COMPLIANCE

Weekly News and Analysis on New Enforcement Initiatives and Billing/Documentation Strategies

Contents

4 *Decision Trees for Proper Use of Modifiers 25, 59*

5 CMS Clarifies MD Supervision for Cardiac Rehab, but No Big Changes

6 *Table*: DRGs Tied to Short Stays

8 *News Briefs*

Managing Editor
Nina Youngstrom

Assistant Editor
Eve Collins

Editor
Angela Maas

Executive Editor
James Gutman

Various Approaches Cut Social Admissions, Other Medically Unnecessary Short Stays

Some hospitals have reduced medically unnecessary inpatient short stays by marshaling community resources for patients and solving non-medical problems (e.g., patients with no caretaker). Addressing so-called social admissions takes a big bite out of inappropriate hospitalizations — notably three-day stays that occur before skilled nursing facility (SNF) admissions, according to MPRO, the Medicare quality improvement organization in Michigan.

In fact, the extent of medically unnecessary short stays before SNF admissions has been reduced in Michigan under a project conducted by MPRO for the Hospital Payment Monitoring Program (HPMP), CMS's main strategy for reducing inpatient payment errors. The 73% error rate for three-day stays before SNF admissions dropped to 50% in one year at Michigan hospitals, according to Benrong Chen, Ph.D., MPRO statistical analyst, and Kristy Wietholter, HPMP project manager for MPRO.

continued on p. 6

Time Is Ripe to Improve Modifiers 25 and 59 Compliance; OIG Audit Cites High Error Rate

With the December 2005 HHS Office of Inspector General (OIG) findings that error rates for modifiers 25 and 59 are prevalent, hospitals should consider closer inspection of their compliance with modifier billing criteria. The OIG audit findings are probably a sign of more scrutiny to come. But compliance can be tricky because potential wrong turns abound, says Nickie Braxton, former vice president of corporate compliance and legal services at Masonicare in Connecticut. If modifiers are overused, hospitals and physicians collect overpayments — and a pattern could lead to false claims accusations. "Providers often don't take the time to follow all coding requirements. They may attach modifiers indiscriminately to ensure claims are paid. Because the rules for using modifiers are complex and nuanced, they are not always easily understood or applied," she says. "It behooves providers to review their coding practices to ensure compliance, even when claims are not being denied."

Modifiers are two-digit codes that allow providers to override National Correct Coding Initiative (NCCI) edits. NCCI edits are designed to block double payments when services should be bundled. But 35 modifiers were created to bypass the edits when there is a legitimate reason to collect separate payments for two services or procedures provided to the same patient on the same day (see decision trees, p. 4).

NCCI, which was developed through CMS, established in a code matrix a collection of correct coding combinations now incorporated into all Medicare carriers' claims processing systems, Braxton says. This matrix automatically identifies inappropriate CPT code combinations, such as "comprehensive and component code combinations." Comprehensive codes are in column one, and component codes are in column two. "To bill Medicare, a provider must have performed all of the services included in the CPT

Published by Atlantic Information Services, Inc., Washington, DC • 800-521-4323 • www.AISHealth.com
An independent publication not affiliated with hospitals, government agencies, consultants or associations

code descriptor or bill a less comprehensive code," she says. The code describing the most extensive procedure performed should be submitted. Providers shouldn't bill codes describing components of a comprehensive code in addition to the comprehensive code.

Although ancillary services may have their own CPT codes, Medicare considers all necessary services to be included in the description of procedure as defined by CPT. Billing component services is considered unbundling.

NCCI also created mutually exclusive coding combinations, which are services/procedures that, based on either the CPT definition or standard medical practice, would not or could not reasonably be performed at the same session by the same provider on the same patient. Modifiers can bypass all this — but do it wrong at your own peril.

Report on Medicare Compliance (ISSN: 1089-6872) is published 45 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

Copyright © 2006 by Atlantic Information Services, Inc. All rights reserved. No part of this publication may be reproduced or transmitted by any means, electronic or mechanical, including photocopy, FAX or electronic delivery without the prior written permission of the publisher.

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, Eve Collins; Editor, Angela Maas; Executive Editor, James Gutman; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Laura Baida; Production Coordinator, Melissa Muko.

Call Nina Youngstrom at 800-521-4323 with story ideas for future issues.

Go to www.AISHealth.com to join your colleagues at the *Report on Medicare Compliance* Listserv.

Subscriptions to *RMC* include free e-mail delivery in addition to the print copy. To sign up, call AIS at 800-521-4323. E-mail recipients should whitelist **aisalert@aispub.com** to ensure delivery.

To order **Report on Medicare Compliance:**

(1) Call 1-800-521-4323 (major credit cards accepted), or

(2) Order online at www.AISHealth.com, or

(3) Staple your business card to this form and mail it to:
AIS, 1100 17th St., NW, Suite 300, Wash., DC 20036.

Payment Enclosed* ❑ $566

Bill Me ❑ $596

*Make checks payable to Atlantic Information Services, Inc.
D.C. residents add 5.75% sales tax.

Subscribers to *RMC* are eligible to receive 1.0 Continuing Education Credit for each issue of the newsletter, in order to be certified in healthcare compliance by the Healthcare Compliance Certification Board. For more information, contact HCCB at 888-580-8373.

Call 800-521-4323 (or visit the Marketplace at www.AISHealth.com) to order ***Report on Medicare Compliance on CD***, a searchable CD with all issues of the newsletter published from January 2004 to June 2005. ($89 for subscribers; $389 for non-subscribers.)

Modifier 25 allows providers to collect separate payments for certain evaluation and management services performed by a provider on the same day as a procedure, as long as the E/M service is "significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure," OIG said. To show the magnitude of this modifier, Medicare paid $1.96 billion for 29 claims in 2002.

For the audit, OIG randomly selected 431 Medicare claims billed in 2002 with modifier 25. Coders were hired to review them. *The findings:* 35% of the claims were bad news. Either the E/M services were not significant and separately identifiable and above and beyond the usual preoperative and postoperative care associated with the procedure, or the claims didn't meet basic Medicare documentation requirements. *The result:* $538 million in Medicare overpayments.

"One of the concerns of OIG is that providers are attaching 25 unnecessarily because they don't understand the criteria for its correct use," Braxton says. For example, providers can't append 25 to new patient E/M visits or to E/M visits when no other same-day E/M is being claimed.

Here are her tips on modifier 25:

(1) If a procedure is the reason for a scheduled visit, then some E/M service is expected to accompany the procedure and is included in the E/M service payment. If the visit is scheduled but the procedure is not, and a procedure is performed, then E/M with modifier 25 may be appropriate.

(2) Modifier 25 is intended to designate a significant, separately identifiable E/M service coded at an appropriate service level (99211-99215).

(3) CPT doesn't define "significant," but the E/M must be able to stand on its own as billable.

(4) Modifier 25 can be utilized for any site of service (hospital, outpatient or office facility).

(5) There may be two unique diagnoses evaluated on the same E/M service, such as a patient seen because he is unconscious from a fall, and then a laceration that is discovered and requires stitches.

(6) There may be two unique E/M services on the same day at different times of the day, and both are medically necessary. For example, the patient presents with the flu and later steps on a nail. Modifier 25 is appended to the second visit.

(7) Modifier 25 may be utilized in conjunction with critical care. For example, the patient is brought to the emergency room with mild chest pain and then released. Prior to leaving the hospital, the patient suffers cardiac arrest, requiring critical care. Medicare will pay for both emergency room and critical care if the modifier is used.

EDITORIAL ADVISORY BOARD: ***MICHAEL BELL***, Esq., Mintz Levin Cohn Ferris Glovsky and Popeo, ***TONY CAPULLO***, Professional Provider Services, ***PAUL R. DeMURO***, Esq., CPA, MBA, Latham & Watkins, ***JOHN J. FOLEY,*** CPA, Parente Consulting, ***EDWARD GAINES***, Esq., Healthcare Business Resources, ***CAROLYN McELROY,*** Esq., Mintz Levin Cohn Ferris Glovsky and Popeo, ***WALTER METZ***, CPA, MS, Brookhaven Memorial Hospital Medical Center, ***DAVID B. ORBUCH***, Allina Hospitals & Clinics, Minneapolis, ***MARK PASTIN***, PhD, Council of Ethical Organizations, ***ANDREW RUSKIN***, Esq.,Vinson & Elkins L.L.P. ***DAVID SCHIMEL***, National Health Resources, ***L. STEPHAN VINCZE***, TAP Pharmaceutical Products Inc., ***BOB WADE***, Esq., Baker & Daniels, ***D. McCARTY THORNTON***, Esq., Sonnenschein Nath & Rosenthal

(8) Modifier 25 can be related to preventive service. Hospitals should document important notable distinct signs and symptoms to demonstrate a distinct problem.

(9) E/M for established visits requires two of the three key components (history, exam, decision making) and must include the management component as well as evaluation of the problem.

(10) Do not append modifier 25 to new-patient E/M visits since new-patient E/M is billable. It's inappropriate to attach modifier 25 to a new-patient visit because a new visit is by definition a stand-alone billable visit.

(11) Do not append modifier 25 to E/M services resulting in the decision to perform surgery within 24 hours; that E/M should carry modifier 57.

(12) E/M medical records must support the level of E/M services billed.

(13) In instances where a single E/M visit results in multiple E/M claims (i.e., two distinct diagnoses, etc.), organize notes so documentation of problem-oriented E/M service is noted separately from documentation for preventive service or procedure — utilize language such as "a significant, separate E/M service was performed to…."

(14) Modifier 25 should not be appended routinely. Never use it simply to enhance reimbursement.

(15) Level of service should exclusively document the significant, separately identifiable finding and management (not pre/post operative/procedural evaluation, which is included in global).

(16) Questions to ask in determining whether to utilize modifier 25: Were key components of problem-oriented E/M service performed and documented? Could complaint E/M stand alone as billable? Was there a different diagnosis, service, incision or anatomical site for this portion of the visit?

The Uphill Battle of 59

Modifier 59 tells Medicare that a distinct procedure or service was performed on the same day as another procedure or service, which should trigger another payment. It may represent a different session, different procedure or surgery, different anatomical site or organ system, separate incision or excision, separate lesion or separate injury (or area of injuries in extensive injuries). Providers are required to append modifier 59 to the secondary, additional or lesser service in the code pair.

OIG selected a random sample of 350 code pairs for services that bypassed NCCI edits using modifier 59 in fiscal year 2003. An independent contractor conducted a coding review to determine whether the modifier was used properly. *The findings:* 40% of code pairs billed with modifier 59 were not billed correctly because the services were not distinct from each other or the services were not documented — to the tune of $59 million in improper Medicare payments. Also, the audit found that 11% of code pairs billed with modifier 59 were paid when the modifier was billed with the wrong code — the primary code instead of the secondary code. This led to $27 million in Medicare overpayments.

Braxton's tips on modifier 59:

(1) Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if a more descriptive modifier is not available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. She notes that 59 is appended to the column 2 codes that meet the exception criteria, and will override an NCCI edit that would otherwise bundle the service/procedure with something else.

(2) Modifier 59 should not be appended indiscriminately. It must be verifiable and supported in the medical record. Documentation is subject to review.

(3) If a procedure code has a modifier indicator on the Medicare Physician Fee Schedule of 1, then you may use modifier 59, but if 0, you may not use modifier 59.

(4) Modifier 59 should be utilized only if there is no other appropriate modifier, i.e., HCPCS modifiers E1-E4 (upper/lower right/left eyelid), FA, F1-F9 (right hand, thumbs digits), etc.

(5) Questions to ask for appropriateness of 59 utilization: Is it a separate site? Separate session? Does physician documentation support it?

(6) You can't append 59 to a procedure to indicate that it took a lot longer to complete the single procedure.

(7) Append to secondary, component service/procedure.

(8) Do not append to E/M codes or weekly radiation therapy management codes (77419-77430).

(9) Make sure 59 is the appropriate modifier. Maybe the correct choice is really modifier 51, which indicates that multiple procedures (other than E/M) not typically performed in conjunction were provided at the same session by the same physician, and there is no reasonable expectation that the services will be bundled into one payment. Codes exempt from requiring 51 include codes designated as "add on" codes and certain CPT codes as listed at Appendix F of the CPT manual.

(10) Modifier 79 must be reported if the services are unrelated to the original surgery for which the post-operataive period exists. If 79 is not reported, services will be considered related to surgery and be denied as postoperative care.

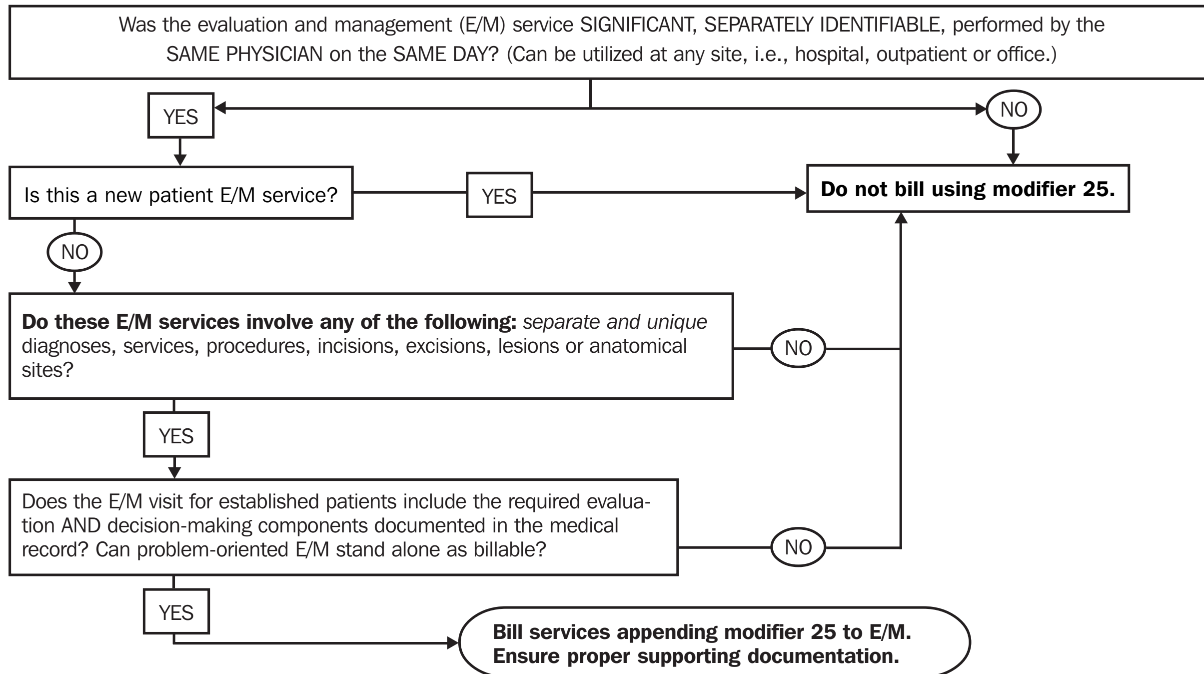
Contact Braxton at nickiebraxton@gmail.com. ✧

Go to www.AISHealth.com to sign up for FREE e-mail newsletters —
Business News of the Week, Government News of the Week *and* Today in E-Health Business.

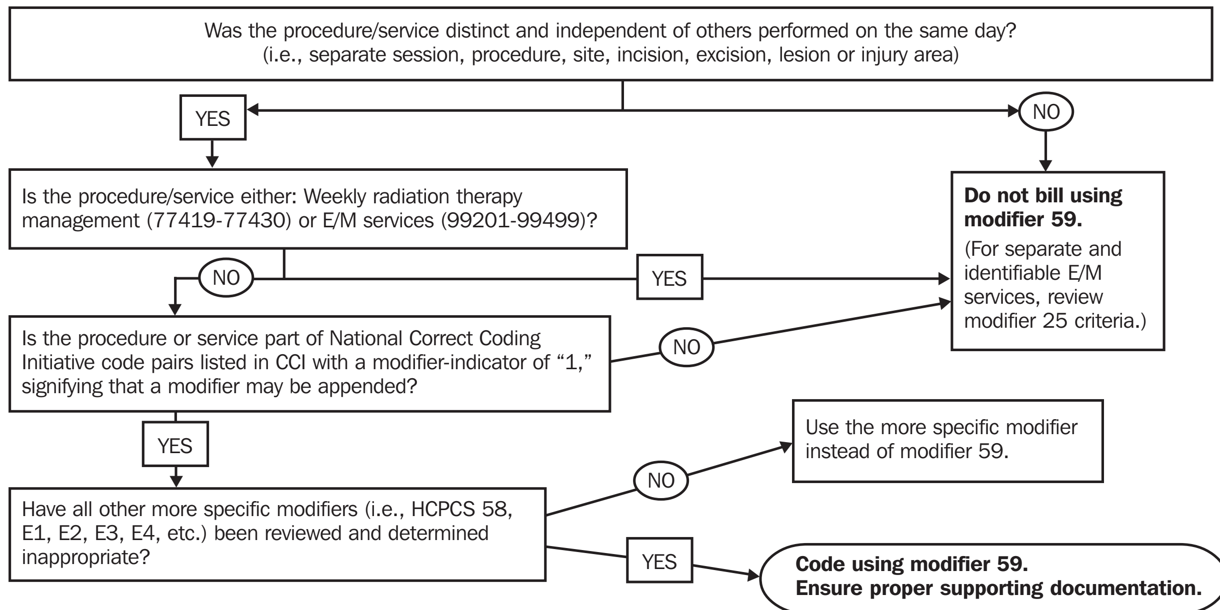
Decision Trees for Proper Use of Modifiers 25, 59

With the OIG's recent reports citing frequent errors in the use of modifiers 25 and 59, hospitals might want to ramp up their oversight of this area (see story, p. 1). Here are decision trees to help. They were developed by Nickie Braxton, former vice president of corporate compliance and legal services at Masonicare in Connecticut. Contact Braxton at nickiebraxton@gmail.com.

MODIFIER 25 DECISION TREE



MODIFIER 59 DECISION TREE



Call 800-521-4323 or visit www.AISHealth.com to order at 30-day free trial and review of AIS's comprehensive looseleaf **A Guide to Complying With Stark Physician Self-Referral Rules** *(with quarterly updates and e-Alerts).*

CMS Clarifies MD Supervision for Cardiac Rehab, but No Big Changes

A key CMS official tells *RMC* that the newly proposed cardiac rehabilitation National Coverage Decision (NCD) clarifies the physician supervision requirements without changing them. The NCD's only significant policy change: expanding cardiac rehab coverage to additional diagnoses. While additional coverage is welcome, the physician supervision clarification may bring a bit of compliance relief to an area rife with anxiety and paperwork hassles, some compliance officers say.

"We opined in our NCD that any physician capable of responding to emergencies that may occur in the cardiac rehab facility can serve as supervising physician, but it would have to be in the same facility," says Steve Phurrough, M.D., director of the coverage and analysis group in CMS's Office of Clinical Standards and Quality. "A hospital with an [emergency room] and the ER doctor on duty at all times where somewhere in another wing of the hospital there is a cardiac rehab program — that is OK. But it's not OK to [have the supervising physician] in an office on the other side of town or at home or in a building in another part of campus."

Cardiac Rehab Coverage Expanded

Medicare now covers cardiac rehab for heart attack, coronary artery bypass surgery and angina. On Jan. 4, CMS announced that on Dec. 22 it had posted on its Web site a proposed decision to expand national coverage for cardiac rehab to Medicare beneficiaries who have had heart valve repair or replacement, percutaneous transluminal coronary angioplasty, and heart or combined heart-lung transplant. It declined to cover cardiac rehab for congestive heart failure.

Cardiac rehab is an exercise program for certain cardiac patients who meet stringent Medicare diagnosis criteria. Services must be provided in a hospital, hospital outpatient department or physician-directed clinic, and there are strict staffing and physician supervision requirements. Cardiac rehab falls under the "incident-to" benefit, which means it's not a stand-alone benefit under Medicare law and must be directly supervised by a physician. That status ushered in a host of coverage and compliance problems, notably in the physician supervision arena.

Nonphysician practitioners provide cardiac rehab, but it is ordered by a physician, who provides direct supervision and has regular face-to-face visits with patients. "Direct supervision means that a physician must be in the exercise program area and immediately available and accessible for an emergency at all times the exercise program is conducted," the Medicare coverage manual states. But exactly what that means in the real world has been confusing for hospitals, and they have struggled to translate the requirement — and get approval for their physician supervision arrangements from their fiscal intermediaries (FIs).

Providers have been pushing CMS for enlightenment for years, and they hoped the NCD would provide that. A little light was shed in the NCD, but there was no policy change, Phurrough says. Cardiac rehab is still provided as an incident-to benefit; Congress would have to act to make it a stand-alone benefit. The NCD just clarifies that the physician who is billing cardiac rehab incident to his or her professional services is the referring physician, he says.

The NCD also appears to give hospitals a bit more latitude with physician supervision when cardiac rehab is provided in a hospital setting. It says, "The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises; the hospital medical staff that supervises the services need not be in the same department as the ordering physician."

However, the news is not so good when cardiac rehab is located elsewhere on the hospital campus or in physician offices. The NCD states, "If the services are furnished outside the hospital, they must be rendered under the direct personal supervision of a physician who is treating the patient."

Don Koenig, vice president of corporate responsibility and assistant general counsel at Catholic Healthcare Partners in Ohio, sees the NCD as giving hospitals more freedom. "Cardiac rehab provided in a hospital setting is assumed to meet the 'incident-to' supervision requirements, and we would not have to have a physician within 'lunge reach' of the cardiac rehab lab that is on the hospital's premises at all times it is operating," he says.

Wendy Trout, director of corporate compliance at WellSpan Health in York, Pa., agrees the NCD language is great for the cardiac rehab program in her hospital. But WellSpan also has one in a separate building, with

Part D Implementation: New Pitfalls to Avoid for Health Plans, PBMs and Pharma Companies

Join **S. Lawrence Kocot,** Senior Advisor to the Administrator at CMS, and **David Ralston** of Schering-Plough Corp., for a **January 18 audioconference**.

Visit www.AISHealth.com

the doctor located downstairs. "We have timed how fast he can get downstairs," she says, and that proximity and speed have been approved by the hospital's FI. "But we would feel more comfortable if" the setup comported perfectly with the supervision language in the Medicare regulations, says Trout.

The industry has 30 days from Dec. 22 to comment on the proposed NCD, and then CMS has up to 60 more days before it's required to finalize the NCD.

View the proposed coverage policy at www.cms.hhs.gov/coverage/. Contact Koenig at dkoenig@health-partners.org and Trout at wtrout@wellspan.org. ✧

Social Admissions Pose Problems

continued from p. 1

MPRO targeted three-day stays before admission to a SNF for beneficiaries discharged with any one of 17 DRGs (see table, this page). This is a hot topic because of payment abuses associated with the Medicare rule requiring a three-day "qualifying" acute-care hospital stay before admission to a SNF for up to 100 days of Medicare-covered skilled care. However, compliance may go awry when patients are hospitalized in order to try and justify a subsequent SNF admission.

Social admissions are not covered by Medicare, and hospitals lose money when these medically unnecessary admissions are denied. Hospitals could ask patients to sign hospital-issued notices of noncoverage (HINNs), which would indicate that the patients accept financial responsibility for noncovered stays. But hospitals are not big on securing HINNs, especially from the vulnerable elderly.

"Often these patients are depressed, they have neither family nor close friends nearby, and they have multiple chronic illnesses" — but an admission still isn't medically necessary, says James Mitchiner, M.D., Medicare medical director for MPRO. Examples of social admissions are when the exhausted children of an elderly person bring her to the emergency department because they no longer can cope with her care, or a patient doesn't meet InterQual criteria for an inpatient admission but has the flu, is elderly and alone, and may not be safe to send home from the ED in the middle of a cold winter night.

Try Alternatives to Unnecessary Stays

Hospitals are starting to implement more creative approaches to prevent social admissions, Mitchiner says. While it's an up-front investment, the payoff is clear in terms of reducing claims denials and keeping beds unoccupied so they will be available for acutely ill patients.

For example, Iron County Community Hospital in Iron River, Mich., created a respite program to prevent social admissions (and other medically unnecessary short stays), as well as to give caregivers a break from their elderly charges, says Elaine Baumgartner, director of social services for the hospital.

For $100 a day out of pocket, patients can get a respite-care bed at this hospital. With it, patients get a cross between custodial and light nursing care — which is all they really need, because these are people who don't qualify for inpatient or even outpatient observation, or they'd be there instead.

"We [wanted] something to respond to the community's needs, but we didn't want to go through all those claims denials, and we hate to give out notices of non-coverage," she says. "And we didn't want to make [the respite service] so expensive that our community couldn't use it."

Typical uses of Iron County's respite care include:

(1) Patients are at the end of a hospital stay and no longer qualify for Medicare coverage on the basis of medical necessity, but they don't feel comfortable going home. They tell their doctor they want to stay in the hospital. But without Medicare footing the bill for additional time as an inpatient, the patients may opt to switch to respite care and pay $100 a day themselves.

(2) The "bowel prep respite." Seniors having an outpatient colonoscopy the following day have to drink MagCitrate the night before to help evacuate their bowels. They may need help going to the bathroom all night

DRGs Tied to Short Stays

MPRO, the Medicare quality improvement organization in Michigan, examined three-day hospital stays before skilled nursing facility transfers for beneficiaries with these DRGs (see story, p. 1). Contact MPRO's Susan Burns at sburns@mpro.org.

DRG	Description
018	Cranial & peripheral nerve disorders w/ CC
139	Cardiac arrhythmia & conduction disorders w/o CC
247	Signs & symptoms of musculoskeletal system & connective tissue
248	Tendonitis, myositis & bursitis
278	Cellulitis age >17 w/ CC
425	Acute adjustment reaction & psychosocial dysfunction
429	Organic disturbance & mental retardation
012	Degenerative nervous system disorders
297	Nutritional & misc. metabolic disorders age >17 w/o CC
243	Medical back problems
321	Kidney & urinary tract infections age >17 w/o CC
188	Other digestive system diagnoses age >17 w/o CC
249	Aftercare, musculoskeletal system & connective tissue
294	Diabetes age >35
331	Other kidney & urinary tract diagnoses age >17 w/o CC
397	Coagulation disorders
449	Poisoning & toxic effects of drugs age >17 w/o CC

Call Customer Service at 800-521-4323 for rates on bulk subscriptions or site licenses, electronic delivery to multiple readers, and customized feeds of selective news and data…daily, weekly or whenever you need it.

and may feel sick, but this doesn't justify an observation admission under Medicare rules. However, Baumgartner says some beneficiaries prefer to come to respite the day before and get assistance with preparation for the colonoscopy. Iron County drops the respite price to $60 for this service.

(3) After a trip to the ED for some incident (e.g., the elderly patient fell but is not seriously injured), the patient's family is determined to place the patient in a nursing home. Since there's no medical reason to admit the patient to observation or an inpatient bed, respite acts as a place to leave the patient while the family searches for a nursing home. "If they need help in organizing a nursing home placement while in respite, we add a minimal nursing home charge," she says.

(4) Caregivers going on a business trip or weekend vacation who need a place for a very elderly parent also use the hospital's respite care.

Respite care has been very successful for Iron County. It rarely issues HINNs for medically unnecessary admissions related to short stays, says Baumgartner.

Other approaches bear fruit as well, MPRO officials say. Some hospitals have a nurse stationed in the ED who troubleshoots what a patient needs to prevent a social admission. For example, when an older patient is treated for a broken wrist in the ED, it has a profound effect if he lives alone and is unable to drive or care for his personal needs. "This is a social need instead of a medical problem," Mitchiner says. "The discharge planner would work with the patient or family to set up an outpatient plan of care, thereby preventing a medically unnecessary admission to the hospital."

Other hospitals have "patient resource managers," who work with patients to find the right setting for them (e.g., nursing home for custodial care).

As an ED physician, Mitchiner also has learned to approach these patients with a fresh perspective in terms of what may warrant testing and admissions. Because the patients are older, their medical problems present differently than those of younger people. "We are lowering the threshold for tests" in terms of vague symptoms and their implications, he says. "'I am weak and I don't feel good' has turned out to be a heart attack in old people, or weakness has turned out to be a stroke, so we are casting a wider net in terms of ED evaluations and admissions," Mitchiner says. "They don't always know how to tell you what is wrong with them."

MPRO's goal in this project was to prevent or reduce inappropriate Michigan hospital admissions related to three-day stays with discharge to a SNF. MPRO focused on the proportion of short stays for 17 DRGs that did not meet clinical criteria for hospitalization, according to Chen and Wietholter.

All prospective payment system (PPS) acute-care inpatient hospitals in the state were included. A total of 130 medical records were abstracted from cases for the 17 DRGs identified as having a relatively high failure rate. When the project started, hospitals averaged payment errors for three-day stays before SNF admissions of 73.1%.

MPRO then identified 10 hospitals with high discharge volumes for those DRGs and worked with those facilities on identifying and eradicating the root causes of social admissions, Chen and Wietholter say. Hospitals were invited to participate in an MPRO-facilitated collaborative entitled "Addressing the Gap: Social Admissions through the ED." About 20 hospitals came together to brainstorm and test interventions to reduce social admissions over a year's time, working both at their own hospitals and with the collaboration through MPRO (e.g., SNFs, home health, respite care, assisted living facilities).

continued

Health Plan Books and Directories From AIS

✔ ***AIS's Directory of Health Plans***, a 487-page softbound book with the most comprehensive data available on the managed care market; a CD database is sold separately.

✔ ***A Basic Guide to Health Savings Accounts,*** a 110-page book that weaves together all statutory provisions, regulations and Treasury guidance to present clear explanations on funding, eligibility, contributions, portability and more.

✔ ***Managed Care Facts, Trends & Data***, a 372-page softbound book with health plan news, trends, data, directories and other practical resources.

✔ ***Managed Medicare & Medicaid Factbook***, a 554-page softbound book packed with rates, benefit designs, trends, directories and strategies on Medicare Advantage and managed Medicaid.

✔ ***Consumer-Directed Health Care: Facts, Trends and Data***, a comprehensive 240-page softbound book featuring case studies, results, plan designs, strategies, directories and other practical information.

✔ ***Case Studies in Health Plan Pay-for-Performance Programs,*** a softbound book with the details of P4P programs of seven leading health plans, featuring practical guidance on designing and implementing effective programs.

Visit the AIS MarketPlace at www.AISHealth.com

To evaluate the success of the short-stay project, MPRO took a random sample of 500 medical records from all PPS hospitals in Michigan. The error rate dropped from 73.1% at baseline to 50.3% at remeasurement, saving Medicare about half a million dollars per year, Chen and Wietholter say.

Another MPRO HPMP project, conducted in parallel with the short-stay project, focused on unnecessary admissions. MPRO found that despite the improvements with hospitals in the past few years, 27 out of 114 had medical-necessity shortcomings *vis-à-vis* admissions. On average, their error rate initially stood at 17.6% — which meant $3.34 million in overpayments, Chen and Wietholter say.

MPRO looked closely at 10 of the 27 hospitals and offered them an on-site visit to review and discuss their denied cases, and technical assistance to pinpoint the root cause of denials. After this intervention, the hospitals showed a "19.9% absolute improvement in the error rate" for medically unnecessary admissions, MPRO says.

Contact Mitchiner at jmitchin@mpro.org and Wietholter at kwiethol@mpro.org. ✧

NEWS BRIEFS

◆ **An Ohio appeals court judge ruled on Dec. 28 that state law protects the medical records of the third party to a lawsuit, and that HIPAA does not pre-empt Ohio's law protecting patient privacy in this case.** The Court of Appeals of Ohio, Ninth Judicial District reversed the order of a lower court when it said that Northeast Ohio Nephrology Associates, Inc. and Summit Renal Care LLC would not have to turn over the medical records of a patient, Carmella Pleli, who was involved in a car accident. The other person in that accident, Marvin Grove, is suing the clinics, saying that Pleli should not have been allowed to drive after her treatment. "While we acknowledge that a patient owns the privilege, we cannot see the sense in charging a medical professional with confidentiality, then eviscerating their ability to protect that confidentiality," the court said. To read the decision, go to www.ninth.courts.state.oh.us, click on "Decisions," and search for HIPAA in the "Full Text" field.

◆ **On Dec. 30, the U.S. Court of Appeals for the Eleventh Circuit reversed a district court's decision and said that a whistle-blower in a False Claims Act suit has provided sufficient evidence of alleged false Medicare claims submitted by her former employer for the case to proceed.** The suit was brought by Karyn Walker, who worked as a nurse practitioner from February 1997 until May 1999 for Leesburg Family Medicine (LFM, now R&F Properties of Lake County, Inc.), which operates clinics in Florida. According to the suit, LFM billed Medicare for services rendered by nurse practitioners and physician assistants as if they were rendered "incident to" a physician. LFM argued that federal language on incident-to billing is vague, but the appeals court says that "what is at issue is whether any evidence outside the language of a Medicare regulation…can be consulted to understand the meaning of that regulation. We hold that it can." Walker provided CMS manuals, bulletins from the fiscal intermediary and evidence of seminars attended by LFM personnel on incident-to billing. To read the opinion, go to www.ca11.uscourts.gov, click "Opinions," click "Published Opinions," and search for No. 04-15283.

◆ **Mohammad Khera, M.D., and Winsted Pediatrics in Winsted, Conn., have agreed to a settlement to resolve allegations that they violated the federal False Claims Act by submitting false claims to Medicaid,** says the U.S. Attorney's Office for the District of Connecticut. The feds say that Khera and the clinic billed for vaccine doses that the practice received for free from the Vaccines for Children program, among other charges. The defendants agreed to pay more than $200,000 to the federal and Connecticut governments, and $27,000 to private insurance companies. They have also entered an integrity agreement with HHS. The defendants did not admit liability in the agreement, according to the feds. The attorney representing Khera and the clinic did not respond to a request for comment. Contact the U.S. attorney's office at (203) 821-3722.

◆ **CORRECTION:** Medicare does not have an actual policy that allows hospitals to upgrade patients from observation to DRG after discharge. Rather, Medicare does not forbid hospitals from changing a patient from observation to DRG after discharge, provided the status change meets InterQual criteria. An article in the Jan. 9 issue of *RMC* incorrectly stated that such a policy exists.

Subscribers to *RMC* are eligible to receive 1.0 Continuing Education Credit for each issue of the newsletter, in order to be certified in healthcare compliance by the Healthcare Compliance Certification Board. For more information, contact HCCB at 888-580-8373.

If You Don't Already Subscribe to the Newsletter, Here Are Three Easy Ways to Sign Up:

(1) Call us at **800-521-4323**

(2) Fax the order form on page 2 to **202-331-9542**

(3) Visit **www.AISHealth.com** and click on "Shop at the AIS MarketPlace"

If You Are a Subscriber And Want to Routinely Forward this E-mail Edition 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 e-mail editions without prior authorization from AIS, since strict copyright restrictions apply.)