Report on
MEDICARE COMPLIANCE

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

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Changes in Pressure-Ulcer World Present Compliance Challenges on Multiple Fronts

Decubitus ulcers are rapidly climbing the compliance and quality risk-area ladder now that coding has become more complex. They are also about a month away from Medicare payment restrictions if they're hospital acquired. These are just two reasons decubitus ulcers will be an attractive target for recovery audit contractors (RACs). And new coding guidance reiterated in the final inpatient prospective payment system (IPPS) regulation adds a wrinkle.

"Compliance officers need to be aware of traps and bumps in the road for decubitus ulcers," also known as pressure ulcers, contends Marion Kruse, a director with FTI Consulting in Atlanta.

2008 ushered in big changes for pressure ulcers. For one thing, their status as a hospital-acquired condition (HAC) means that starting Oct. 1, Medicare won't pay hospitals the heightened payment for treating pressure ulcers that are not present on admission (POA). As part of the process of determining whether a condition is hospital acquired, hospitals have to assign POA indicators to every principal and secondary diagnosis. The indications are "Y" for yes, the condition was present on admission; "N" for no, it wasn't present on admission; "U" for unknown because documentation was insufficient to determine if the condition was POA; "W" for when the provider is

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Hospital Settles CMP Case Over Physician Admissions, Shows Compliance Overhaul

When a coder at Sparks Health Systems noticed something was amiss with a physician's inpatient records in 2001, she didn't bother to notify the then-compliance officer. That's apparently how little the compliance officer — whose main focus was HIPAA privacy — registered with employees of the Arkansas health system. So the coder conveyed to the peer-review committee concerns about potentially unnecessary hospitalizations by this particular physician. That set in motion a series of intriguing events that culminated in Sparks' self-disclosure to the HHS Office of Inspector General and a $1.14 million civil monetary penalty settlement, which was posted on the OIG Web site this summer. "The issue was discovered twice" — once by the coder and later when the hospital was called for a reference about the physician — says Wendy Dunlap, the new compliance officer at Sparks. The health system entered the OIG Self-Disclosure Protocol immediately following the second discovery when it was determined that overpayments had not been returned.

There's now new top management and an eight-person compliance team at Sparks. But at the time, compliance auditing wasn't done at the health system, which employs 100 physicians in 36 clinics and includes a hospital licensed for 476 beds and a short-

Managing Editor
Nina Youngstrom

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James Gutman

term skilled nursing unit, says Dunlap, who joined Sparks in 2006. "We did not have a mature compliance program at the time," she maintains.

But the health system did identify its own billing error. "A coder pulled the trigger," Dunlap tells *RMC*. The coder recognized that the employed physician, internist Wajih Istanbouli, M.D., seemed to hospitalize a lot more patients than his peers, she explains. For example, patients who could have taken oral antibiotics were admitted for intravenous antibiotics, she says.

His patients were largely elderly, so it was normal to have a lot of referrals. There was no smoking gun in any of the medical records individually, but taken in their entirety, the volume was striking, Dunlap says. The peer-review committee analyzed the numbers and types of patient visits reported by Istanbouli. His numbers were compared to his peers, a standard program-integrity method. "There were an extraordinarily high number of visits made," she says. "When you looked at individual medical records, it was hard to see anything. But when they did a total number of hospital admissions and compared physician to physician, he was way off the chart. The rest of the physicians were at the same level [as each other], but he was way off the chart."

It wasn't that patients didn't get services after admission. Rather, it was a question of allegedly medically unnecessary services, says Dunlap. "We questioned the amount of time he could spend with patients based on sheer volume," she says. During peer review, one physician put it in a nutshell when he said, "You can work twice as hard as me or twice as long, but you can't do both."

The hospital suspended Istanbouli's privileges and reported him to the state medical board. Ultimately, the physician resigned from the hospital in November 2003, Dunlap says. "To them it was a behavior issue," she says. Sparks prepared the paperwork to report Istanbouli to the National Practitioner Data Bank. But the hospital did not think about the overpayments, she says. "A bell didn't go off in the hospital's mind that if the physician couldn't see the patients at the level charged, there were overpayments. They were only thinking about quality of care. They were thinking they had done everything they needed to do."

Hospital Failed to Report Physician

Things were about to improve vastly on the compliance front. But not before the other shoe dropped. When another hospital called for a reference on Istanbouli, the new Sparks chief medical officer (CMO) looked in the files. To his dismay, says Dunlap, the CMO realized that while Sparks made preparations to report Istanbouli to the National Practitioner Data Bank, it never followed through. Reporting in this circumstance was mandatory, she explains. (Hospitals have to report when physicians quit or resign while under peer review, she says.)

This time, Sparks filed the report in 2007. Istanbouli disputed the health system's claims about his allegedly unnecessary hospitalizations and asked HHS to look into the matter, which is a physician's right under the National Practitioner Data Bank process, Dunlap says. "We never heard back," she notes. By this time, Sparks decided to resolve the overpayments through the OIG Self-Disclosure Protocol.

Sparks also reported Istanbouli to the Arkansas State Medical Board, citing its belief that, among other things, some records lacked adequate documentation, and sometimes antibiotics were used improperly, Dunlap tells *RMC*. "But the medical board didn't find violations of the Arkansas Medical Practices Act," she says. Istanbouli has active medical licenses in Arkansas and Tennessee. A

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woman who answered his phone said he was overseas and couldn't be reached for comment. The attorney who represented him during peer review had no comment, citing attorney-client privilege.

By now, Sparks had transformed its compliance program. That was recommended by Quorum Health Resources, a hospital management company that had entered the picture. Quorum furnished a new CEO and chief financial officer, and Sparks hired a new compliance officer and funded seven additional staffers, Dunlap says. This was not driven by a corporate integrity agreement or any outside mandate. The board of trustees, she says, "wanted to get the [compliance] book off the shelf" and bring it to life.

A lawyer, a specialist in health care, guided Sparks through the protocol. "The key to having a successful outcome is having a team of people who understand how the Self-Disclosure Protocol works and having them guide you through it," Dunlap says. The audit performed during the protocol by an outside consulting firm was tricky business because the situation wasn't a black-and-white issue, like obvious upcoding. "You couldn't see it on a claim-by-claim basis. The documentation was there. But when you looked at the volume — we calculated inpatient and outpatient volume because they are employed physicians, and, because they are employed physicians, we calculated anything billed on the UB [hospital billing form] and HCFA 1500," she says.

Sparks Now Has Tough Audit Plan

The OIG Self-Disclosure Protocol is not to be entered into lightly. "It's incredibly demanding and requires tremendous time," maintains Dunlap. It's critical to be open and honest and not hide anything from OIG, she notes. "If you know there is a problem, you have an obligation to report it," she says. However, she adds, "You have an obligation to investigate before you report it. You need legal counsel to help work through the facts." If it weren't for the protocol, Sparks wouldn't have learned some important lessons. *One big lesson:* Compliance pays off. When you look at the amount of repayment involved in a typical error, plus treble damages and per-claim fines, it becomes immediately clear that identifying problems and resolving them early — the compliance mantra — is worth its weight in gold, Dunlap says.

The Sparks board and new management had seen the compliance light even before the Istanbouli affair blew up. The health system had gone from having only a compliance officer to an eight-person compliance team. "In my first conversation with the current CEO, I said, 'We might have this self-report issue. I will let you know,' and he gave me free access to the board chairman. He understood the importance of compliance and never tried to stop anything from being reported to the board," Dunlap says.

Dunlap also now has "an aggressive audit schedule," from recovery audit contractor preparedness to the OIG Work Plan. The compliance officer has put together an education and audit program for physician clinics, which she considers the biggest vulnerability at Sparks given the fact that it owns dozens of clinics and employs 100 physicians.

Generally, she says about compliance, "We turned up the heat." The compliance staff intensely educated the board about compliance and what the board needed to do in terms of its fiduciary duty and oversight for the compliance program. Sparks developed a compliance subcommittee of the board that includes representatives from the physician practices, she says.

Hospitals must monitor physician admission orders to justify inpatient billing, says Judy Waltz, an attorney with Foley & Lardner LLP in San Francisco. For example, the Medicare Conditions of Participation require that medical records contain information to justify admissions and length of stay, and that hospitals have a utilization-review plan to ensure this.

Similarly, the payment regulations require that hospitals have a process for review of the medical necessity, reasonableness and appropriateness of hospital admissions and discharges, she notes. "At the end of the day,

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the physician's opinion may override other indicators as to the level of care necessary for a particular patient, but the hospital must be able to show medical justification in the form of documentation as to medical necessity and reasonableness for the services provided," Waltz says.

Moreover, a hospital may have liability for more than just the services it bills as the provider of services, if the hospital also bills on behalf of the physician. Claims for physician services include an attestation from the physician that the services for which payment is claimed were medically necessary (this statement appears on the back of the CMS Form 1500). Under the reassignment of payment rules, a physician's reassignment of the right to Medicare payment to an entity under an employer-employee relationship or under a contractual arrangement results in joint and several responsibility for any Medicare overpayment for the hospital and the physician.

Contact Dunlap at wdunlap@sparks.org and Waltz at jwaltz@foley.com. ✧

Hospitals Urged to Start Training Now on Proposed ICD-10 Codes

Hospitals should start getting ready for the next round of diagnosis and inpatient hospital procedure codes now that HHS proposed a regulation on Aug. 15 to replace the ICD-9-CM code sets with the ICD-10 code sets.

ICD-10 is urgently needed to capture the diagnoses and procedures in the current health care environment. ICD-9 has 17,000 codes and is fast running out of new codes. ICD-10 is much more expansive, with 155,000 codes that can "accommodate a host of new diagnoses and procedures," CMS said in a press release. "The additional codes will help to enable the implementation of electronic health records because they will provide more detail in the electronic transactions."

ICD-10 is scheduled to take effect in 2011.

Sue Bowman, director of coding policy and compliance at the American Health Information Management Assn. (AHIMA), says hospitals should do an impact assessment to determine what specific steps they need to take (e.g., work with software vendors) to make the transition from ICD-9 to ICD-10. Training is a big issue, she says. Everyone who uses coded data in the hospital will need training on ICD-10. That includes coders and staffers from clinical, registration, quality management and utilization review departments, Bowman notes. Hospitals should also start budgeting for the implementation of ICD-10, she says. AHIMA has developed a preparation checklist to help hospitals with this significant undertaking. The coding systems are on the Web sites of CMS and the National Center for Web Statistics.

Meanwhile, in a separate move, HHS proposed adopting the updated X12 standard, Version 5010, and the National Council for Prescription Drug Programs standard, Version D.0, for electronic transactions, such as health care claims. Version 5010 is essential to use of the ICD-10 codes.

View both regulations at www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage. Contact Bowman at sue.bowman@ahima.org. ✧

CMS Abandons EMTALA Expansion, Crafts On-Call Coverage Solution

In response to complaints from hospitals, CMS has backed off a plan to expand Emergency Medical Treatment and Labor Act (EMTALA) responsibility to hospitals that receive transferred patients. The final inpatient prospective payment regulation (IPPS), published in the Aug. 19 *Federal Register*, clarifies that recipient hospital obligations under EMTALA do not extend to transfers of inpatients. That near-mandate appeared in the proposed IPPS rule, but CMS changed its mind when it recognized some unintended consequences.

"Once an individual is admitted in good faith by the admitting hospital, the admitting hospital has satisfied its EMTALA obligation with respect to that individual even if the individual remains unstabilized and a hospital with specialized capabilities does not have an EMTALA obligation to accept an appropriate transfer of that individual," according to the final rule, which takes effect Oct. 1.

The origin of this issue is a 2003 regulation. CMS said then that hospitals' EMTALA responsibilities — to screen and stabilize patients for emergency medical conditions — ended when patients were admitted (as long as they were already screened and stabilized without regard to their financial status), says Houston attorney Nancy LeGros, who is with the law firm King & Spaulding. Hospitals welcomed this ETMALA bright line, with one glaring exception: CMS didn't explicitly address when EMTALA duties ended for recipient hospitals that received requests for transfers of inpatients.

So in the proposed IPPS rule for fiscal year 2009, CMS said it would expand the recipient hospitals' obligations when inpatients were transferred. Although EMTALA obligations ended when the original hospital admitted the patient as an inpatient, EMTALA obligations would rise again for the recipient hospital that was asked to accept transfer of the inpatient.

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The problem, LeGros says, was the potential risk that some hospitals would try to shift their inpatients to hospitals with the full spectrum of specialty capabilities as an end run around EMTALA. Considering the battle these hospitals already face since they serve as a safety net, the CMS provision could blow up in their faces.

Now the final IPPS rule abandons the plan.

The IPPS rule also set forth a plan to help hospitals improve their physician coverage of emergency departments. On-call coverage is a major challenge for hospitals, now that specialists — faced with declining reimbursements and other stressors — no longer consider it a routine (unpaid) part of the job. LeGros says more physicians are serving on call panels less often, and far more physicians will do it only if paid.

EMTALA requires hospitals to provide physician on-call coverage without specifying the details. A 2003 regulation told hospitals to implement a plan that addressed physician coverage if the on-call physician were otherwise occupied (e.g., in surgery at another hospital).

The new plan in the IPPS rule envisions hospitals in the community working together to achieve more comprehensive call on-coverage. This must be a formal plan, CMS says, though it doesn't need CMS preapproval. According to CMS, the community call plan would:

◆ ***"Include a clear delineation of on-call coverage responsibilities***, that is, when each hospital participating in the plan is responsible for on-call coverage."

◆ ***"Define the specific geographic area to which the plan applies."***

◆ ***"Be signed by an appropriate representative of each hospital*** participating in the plan."

◆ ***"Ensure that any local and regional EMS [i.e., emergency medical services] system protocol formally includes*** information on community on-call arrangements."

◆ ***Require participating hospitals to "engage in an analysis of the specialty on-call needs*** of the community for which the plan is effective."

◆ ***"Include a statement specifying that even if an individual arrives at the hospital that is not designated*** as the on-call hospital, that hospital still" must meet EMTALA obligations.

LeGros says community call plans should lessen the burden on hospitals that are struggling to maintain call panels, but the effectiveness will turn on the details (e.g., whether all or most hospitals in a community participate).

"Everyone has to step up to the plate," she says.

Contact LeGros at nlegro@kslaw.com. ✧

Tools for Improving Compliance With Inpatient-Only Rule

These tools can help hospitals comply with the inpatient-only rule, which can trip people up when there is a lack of communication among registration and clinical departments. According to this rule, Medicare pays hospitals for certain procedures only if they are performed on an inpatient basis, unless certain conditions are present. CMS publishes the list, code by code, each year as an addendum to the outpatient prospective payment system (OPPS) regulation. For more information, visit www.medicareriskareas.com

Worksheet to Monitor Billing of Inpatient-Only Procedures

Review date:	Time period under review:
Reviewer:	Inpatient-only code:

Conditions. To bill Medicare for an inpatient-only procedure performed in an outpatient setting, all the following circumstances must be present. (Y/N)

	Rec. #	Rec. #	Rec. #	Rec. #	Rec. #	Rec. #	Rec. #
The patient was an outpatient and had an emergent, life-threatening condition.							
A procedure on the inpatient-only list (Status indicator "C") was performed on an emergency basis to resuscitate or stabilize the patient.							
The patient is admitted for inpatient services after the procedure or is admitted and transferred.							
The patient dies during or immediately following the operation without being admitted as an inpatient. See Worksheet for Modifier -CA.							
Documentation. The medical record must contain the following information. Indicate whether the patient's medical record contains the information listed in (1) – (4) (Y/N):							
(1) Either of the following: (a) Orders to admit to the hospital written by the physician responsible for the patient's care at the hospital to which the patient was to be admitted following the procedure for the purpose of receiving inpatient hospital services and occupying an inpatient bed, or							
(b) Written orders to admit and transfer the patient to another hospital following the procedure							
(2) Documentation that the reported HCPCS code for the surgical procedure with OPPS payment status indicator "C" was actually performed.							
(3) Documentation that the reported surgical procedure with status indicator "C" was medically necessary.							

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Tools for Improving Compliance With Inpatient-Only Rule ***(continued)***							
(4) For patients transferred to another facility, documentation that the transfer was medically necessary.							
Check claim for the following:							
Claim is type of bill (TOB) inpatient (12X).							
Status of Claim: Paid (Pd) Pending (P) Return to Provider (RTP) Denied (D)							
Was claim billed and paid correctly? (Y/N)							
Corrective Action and Recommendations:							

Worksheet to Monitor Assignment of Modifier -CA							
Review date:					Time period under review:		
Reviewer:					Inpatient-only code under review:		
To bill the modifier -CA, all of the following circumstances must be met. For each record reviewed, indicate whether the record supported the circumstance. Indicate Yes or No.							
	Rec. #	Rec. #	Rec. #	Rec. #	Rec. #	Rec. #	Rec. #
The patient was an outpatient.							
The patient had an emergent, life-threatening condition.							
A procedure on the inpatient-only list (Status indicator "C") was performed on an emergency basis to resuscitate or stabilize the patient.							
The patient dies during or immediately following the operation without being admitted as an inpatient.							
Indicate whether the patient's medical record contains the information listed in (1) – (3) (Y/N):							
	Rec. #	Rec. #	Rec. #	Rec. #	Rec. #	Rec. #	Rec. #
(1) Either of the following: (a) Orders to admit written by the physician responsible for the patient's care at the hospital to which the patient was to be admitted following the procedure to receive inpatient hospital services in an inpatient bed, or							
(b) Written orders to admit and transfer the patient to another hospital following the procedure.							
(2) Documentation that the reported HCPCS code for the surgical procedure with OPPS payment status indicator "C" was actually performed.							
(3) Documentation that the reported surgical procedure with status indicator "C" was medically necessary.							
Are all circumstances and all information in the record to assign modifier -CA?							
Check claim for the following:							
	Rec. #	Rec. #	Rec. #	Rec. #	Rec. #	Rec. #	Rec. #
Code is on inpatient-only list.							
Claim is TOB 13X.							
Patient status code is 20.							
Claim reports only one code with modifier -CA.							
Status of Claim: Paid (Pd) Pending (P) Return to Provider (RTP) Denied (D)							
Was claim billed and paid correctly? (Y/N)							
Corrective Action and Recommendations:							
SOURCE: Reprinted from *High Risk Areas in Medicare Billing*, a comprehensive new Web-based service from AIS and Strategic Management Systems, Inc. For a demo of this powerful new service, go to www.medicareriskareas.com.							

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Pressure Ulcers Are Growing Risk

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unable to clinically determine whether the condition was POA; and "1" to indicate an exemption from POA reporting.

Also, the coding rules were changed in the ICD-9-CM diagnosis coding manual. Until recently, all that mattered for coding purposes was the location of pressure ulcers. But in 2008, the emphasis shifted to the stage of the ulcer (there are four stages plus a category for ulcers that can't be staged because of tissue loss).

That triggered new guidance from the *ICD-9-CM Official Guidelines for Coding and Reporting*. Kruse says the guidelines explain that "two codes are necessary to completely describe a pressure ulcer." Coders need to assign a code from subcategory 707.0 (pressure ulcer, to identify the site of the pressure ulcer) and a code from subcategory 707.2 (pressure ulcer stages). "The codes in subcategory 707.2 are to be used as an additional diagnosis with a code from subcategory 707.0," Kruse says. Codes from 707.2 may not be assigned as a principal or first-listed diagnosis. The pressure ulcer stage codes should be used only with pressure ulcers and not with other types.

Only Certain Documentation May Be Used

That seems straightforward enough until you start thinking about other Medicare requirements, says Kruse. The final IPPS rule in the Aug. 19 *Federal Register* states that "code assignments for pressure ulcer stages may be based on medical record documentation from clinicians who are not the patient's provider." (CMS attributes this to recent guidance from the Centers for Disease Control and Prevention, which maintains the ICD-9-CM guidelines.) Kruse says that based on this, it appears that CMS believes coders may use the documentation of nonproviders when determining how to code a pressure ulcer, its stage and whether it is POA.

"People who read the new IPPS rule will think hospitals can code from anyone's documentation, but I didn't find anything in the official coding guidelines to support that," she says. "You will be in trouble if you do that." The 2008 coding guidelines continue to maintain that diagnoses and POA may be coded only when documented by a person who is legally accountable for diagnosing illnesses, Kruse says. Staging may be coded only from clinicians who are not the patient's provider.

Perhaps the most vexing of the pressure ulcer issues from a compliance perspective is reverse staging. If the patient is admitted with a healing pressure ulcer, how does that fit in with POA and the HAC issue? The coding guidelines state that "pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record. If the documentation does not provide information about the stage of the healing pressure ulcer, assign code 707.20, Pressure ulcer stage, unspecified. If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider."

Notwithstanding the coding guidelines, some disagreement exists in the clinical literature about the appropriateness of staging a healing pressure ulcer (known as reverse staging), so this may be an ongoing source of tension between coders and clinicians. "Reverse staging is not supported by the National Pressure Ulcer Advisory Panel," Kruse notes.

Compliance Officers May Be Caught in Middle

Against this backdrop, coders and compliance officers have to deal with the Medicare severity DRGs and POA. There are various complications here. For one thing, pressure ulcers used to automatically be a complication and comorbidity or major CC (MCC). But with the advent of staging, not all pressure ulcers are MCCs, Kruse says. Only stage-three and -four pressure ulcers are MCCs, she says. So hospitals have to be careful about coding MCCs that may evaporate when a pressure ulcer starts healing, moving from stage three to stage two, as noted in the nurse's documentation. And they can't decide this on their own — coders must query clinicians, who may be irritated by the question, Kruse says. "We don't reverse stage ulcers," physicians might say. Coders don't enjoy getting their heads bitten off. And RACs may pursue hospitals that reported an MCC when it later improved to a stage two.

"Compliance officers may be caught in the middle of competing forces within the hospital — coders, physicians, finance, quality," Kruse says. "You have coders who need to query under coding guidelines, physicians who say, 'We don't reverse stage pressure ulcers,' quality people who may not be savvy in the details of POA rules and combination codes, and financial people who will be irritated because the hospital is not being reimbursed for the care it provided for the pressure ulcer." And then the RACs will be waiting in the wings, emboldened by the official coding guidelines.

Her advice: Meet with your wound care team and/or plastic surgeons and discuss the new ICD-9 codes and official coding guidelines for their use. Based on this clinical advice, create coding policy to guide coders regarding querying for healing skin ulcers. Assure that your clinical documentation specialists understand the coding guidelines and your internal coding policy for pressure ulcers, and incorporate the associated documentation issues into their query process. Provide education for bedside nurses

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regarding pressure ulcer documentation in their nursing history and physical examinations (H&Ps). Even though coders cannot code from their documentation, it may be a cue to query the physician.

On the flip side of reverse staging is the worsening pressure ulcer. This can be bad news for hospitals from a quality and financial perspective because pressure ulcers may get worse in hospitals even when they've done the right clinical thing, Kruse says.

When pressure ulcers get worse (i.e., progress from stage two to three), they can't be classified as POA, says Sharalyn Milliken, a nurse-attorney who is a managing consultant at FTI Consulting. *The reason:* The pressure ulcer did not remain at the same level of severity. Milliken bases this on the official coding guidelines' section on combination codes. Appendix I, she says, addresses POA indicator assignment for combination codes:

◆ ***Assign "N" if any part of the combination code was not POA*** (e.g., obstructive chronic bronchitis with acute exacerbation, and the exacerbation was not present on admission; gastric ulcer that does not start bleeding until after admission; asthma patient develops status asthmaticus after admission).

◆ ***Assign "Y" if all parts of the combination code were POA*** (e.g., patient with diabetic nephropathy is admitted with uncontrolled diabetes).

◆ ***If the final diagnosis includes comparative or contrasting diagnoses***, and both were present, or suspected, at the time of admission, assign "Y."

"As the stage-three part of the combination codes was not present at the time of admission, an 'N' must be assigned to both parts of the combination code," says Kruse. She says the notion that patients arriving at the hospital with deteriorating pressure ulcers always must have those ulcers deemed hospital acquired will be unpopular with hospitals. It's hard to stabilize a pressure ulcer when a patient is gravely ill, she notes. Even when the hospital is diligent in helping a patient who is admitted with various problems, including a pressure ulcer, worsening of the pressure ulcer may be inevitable, she says. "Not only will the hospital not receive additional payment to cover this expense, from a quality perspective it will appear as if the hospital was solely responsible for the stage-three pressure ulcer," she says.

Contact Kruse at marion.kruse@ftihealthcare.com. ✧

NEWS BRIEFS

◆ **CMS's assertions in 2006 that it reduced the number of fraudulent and improper claims, saving billions, were "misleading,"** according to a draft OIG report obtained by *The New York Times*. "In calculating the agency's rate of improper payments, Medicare officials told outside auditors to ignore government policies that would have accurately measured fraud," The Times reported Aug. 21. More than a third of spending on medical equipment — or about $2.8 billion — was improper, says the newspaper, citing other Medicare reports. CMS officials told The Times that they agree with OIG's findings, but that the $2.8 billion figure is "unsupportable." The report is expected to be made public this week. Visit www.nytimes.com.

◆ **Cherry Hospital in North Carolina could lose federal funding if CMS does not accept its corrective action plan (CAP) after one patient died and another allegedly was struck by a staff member,** according to an Aug. 9 report by CMS. Officials with the North Carolina Department of Health and Human Services (DHHS) are assisting Cherry with the CAP, which was due Aug. 23. A CMS survey found deficiencies in nursing services, patient rights and governing body. If CMS rejects the CAP, funds will be cut off Sept. 1. Cherry is a state-run, 274-bed inpatient psychiatric hospital. Dempsey Benton, the secretary of DHHS, says disciplinary actions have already been taken. Read CMS's inspection report at www.ncdhhs.gov/mhfacilities/cherry/index.htm.

◆ **BlueCross BlueShield of Tennessee, Inc. (BCBST) will pay $2.1 million to resolve false claims allegations,** the Department of Justice (DOJ) said Aug. 11. DOJ alleged that BCBST subsidiary Riverbend Government Benefit Administrators, the primary Medicare fiscal intermediary for New Jersey, did not adjust cost-to-charge ratios for many New Jersey hospitals between 2000 and 2002. The result: excessive Medicare outlier payments. "DOJ has not alleged that [BCBST] committed any fraud and BCBST has denied liability and any intentional misconduct in connection with the administrative delays," the payer says in a statement. Visit www.usdoj.gov.

◆ **CLARIFICATION:** OIG definitely will not impose sanctions on the gainsharing arrangement between an academic medical center and surgeons, despite the potential for fraud, according to Advisory Opinion 08-09. A brief in the Aug. 11 issue of *RMC* said that OIG "probably won't impose sanctions."

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