Report on
MEDICARE COMPLIANCE

Volume 18, Number 14 • April 27, 2009

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

Contents

Hospitals Use Screeners, Observation Units for Compliance as RACs Close In

Many hospitals are redoubling their compliance efforts in the area of admission medical necessity, using "screeners" and "rapid diagnostic units," among other strategies, to reduce errors in this area. The tension between observation and inpatient status has been a compliance risk area for years, since it was a target of the HHS Office of Inspector General (OIG) and the CMS Hospital Payment Monitoring Program. But now hospitals have made it a priority because recovery audit contractors (RACs) are turning up the heat on medical necessity.

"More hospitals are starting to use screeners," says Elaine Barry, vice president of clinical client relations at EDIMS, LLC, a New Jersey consulting firm. "That is a big thing because RACs will look at overuse and underuse of observation."

Like case managers, screeners apply admission criteria, such as InterQual or Milliman, to a patient's signs and symptoms for the purpose of determining whether he or she qualifies for an inpatient stay, Barry says. But unlike case managers, that determination is the screeners' only task. The information is passed to the physician, who has the ultimate say because InterQual and Milliman are tools, not mandates. Under the Medicare conditions of participation, only physicians have the authority to write admission orders pursuant to the hospital's utilization review plan.

Case managers are then available to work on more complex cases or focus on their many other functions. Since case managers have historically invested their time applying admission screening criteria to managed care patients, screeners may be deployed to

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Loss of Stark Access to OIG Protocol Spurs Rethinking of Deals, Payment Obligations

Now that OIG has shut the door on Stark-only self-disclosures, some lawyers say it's time to revisit whether providers really have an obligation to return Medicare payments for services when there has been a technical violation of the self-referral ban. Providers also may be too quick to assume a financial relationship is noncompliant when it may fit within some Stark exception.

HHS Inspector General Daniel Levinson on March 24 announced in an open letter to providers that the OIG Provider Self-Disclosure Protocol is no longer available to Stark-only violations *(RMC 3/30/09, p. 1)*. Providers can submit applications to the protocol, which offers potentially reduced penalties, for Stark violations only if they're paired with anti-kickback violations and if the anticipated settlement amount is $50,000 minimum.

Lawyers say that leaves providers between a rock and a hard place when it comes to self-disclosing Stark violations. The only apparent alternatives are CMS and its Medicare contractors or the local U.S. attorney's office, and lawyers see negatives about both options. "Without some guidance from the government as a whole, providers are in a

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

quandary about how to cope with these situations," says Washington, D.C., attorney Heidi Sorensen, former chief of the OIG administrative and civil remedies branch. As a result, fewer technical Stark violations are going to come to light, says Sorensen, now with Foley & Lardner LLP.

But maybe that's the way it should be, some experts say. Don Romano, the lawyer who headed up Stark regulation writing when he was director of the division of technical payment policy at CMS, tells *RMC* that "it's not clear providers have to report technical violations." The only language in the Stark law about repayments "applies to Medicare refunds of copays and deductibles to beneficiaries," Romano says. "If a provider self-discovers it had a Stark violation and was paid by Medicare for a claim and it was a technical violation, I don't think providers have to call up CMS or its contractor and say, 'I have discovered a bunch of claims we got paid on but we didn't have a signature by a physician [on a medical directorship, for example], so these claims are tainted. Where do I send the check?'" says Romano, now with the law firm Arent Fox LLP in Washington, D.C.

There are some criminal statutes that impose penalties on failing to return money, Romano says. But he believes that the statutes may apply only to situations where the payments were received with fraudulent intent.

Romano acknowledges that not disclosing could cause some anxiety. But "the overarching point is if people step back and think about it, I'm not sure they have to disclose Stark-only violations unless they are under a corporate integrity agreement," in which reporting material violations to OIG is mandatory.

Los Angeles attorney Charles Oppenheim says that "there is some legal back-up" for not self-reporting, but it's a gray area. "There are legal arguments that you don't have to return the money, but there are other legal arguments that you do," says Oppenheim, with Hooper, Lundy & Bookman Inc. It's true, he says, that the Stark statute itself doesn't address Medicare repayment of claims arising from illegal self-referrals. The statute says only that if a person collects money that was billed in violation of Stark, the person is liable to the individual and has to refund to the individual any money collected (42 USC 1395nn(g)(2)). "Arguably, that's about copays and deductibles," Oppenheim says. Of course, "CMS has taken a more expansive view." CMS has stated that entities that collect Medicare reimbursement for designated health services (DHS) in violation of Stark must return the money to Medicare.

Only Clear Violations Demand Self-Disclosure

Oppenheim says DHS entities might not have to worry whether self-disclosure is necessary in certain cases. Sometimes they jump to the conclusion that they violated Stark when it isn't true. "A lot of situations appear at first blush to be a Stark violation, but it may turn out there wasn't a Stark violation," he says. For example, a hospital may panic when it realizes it doesn't have a written agreement for a financial relationship with a physician who refers patients to the hospital. But if the physician is a hospital employee, no written agreement is required. Even if the hospital gave the physician a Form 1099, the physician may still qualify as an employee. "The 1099 is not necessarily definitive," Oppenheim says. "You do a case-by-case analysis under IRS rules. Maybe that doctor doesn't qualify as a 1099 independent contractor and really should be an employee."

Oppenheim contends that only clear-cut violations warrant self-disclosure. However, if there is ambiguity about an arrangement, change it to make sure that going forward it's unquestionably compliant. For example, an

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.

Managing Editor, Nina Youngstrom; Associate Editor, Eve Collins; Editor, Michael Carbine; Executive Editor, Angela Maas; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Gwen Arnold; Production Coordinator, Darren Jensen.

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

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unsigned agreement, such as a lease, may seem like an obvious violation — "CMS tends to see violations all over the place" — but Oppenheim says it depends on how the lease is written. Perhaps it's an automatically renewing lease as long as the parties continue to perform the same services under the same terms. Also, state law may provide that the lease has effectively renewed by the parties' course of conduct. And the Stark analysis is different depending on whether the lease is with one physician or the group.

Alternatives Worry Providers

Now that OIG has redrawn the parameters of the Self-Disclosure Protocol, providers have no predictable way to resolve technical (also known as procedural) violations, such as missing signatures on contracts or expired contracts. Lawyers are not thrilled with the alternatives.

The problem with disclosing to CMS/Medicare contractors is their mindset, which is recouping all overpayments, Chicago attorney Ryan Meade tells *RMC*. The recoupment will be based on the "period of disallowance," as the Stark regulation calls it. That refers to all the months or years the hospital received reimbursement for services referred by physicians if any aspect of Stark was violated in a way that involved payment to those physicians. And CMS and Medicare contractors "can't work out a settlement or a release [for false claims]," says Meade, with the law firm Meade & Roach LLP. The downside of self-disclosing to the U.S. attorney's office is that a penalty could be assessed, he says.

One lawyer is struggling to help a hospital client who paid physicians for on-call emergency department coverage four years after the contract for these services expired. It's intolerable for the hospital to have to repay Medicare for all inpatient and outpatient services provided to patients who were referred by these physicians just because the on-call coverage contract expired while the payments continued, says the lawyer, who asked not to be identified. The on-call payments were at fair-market value, but the hospital had a poor contract-management system. "I don't think payback is absolute in all cases," the lawyer says. On the one hand, he doesn't feel right advising his clients to return four years worth of reimbursement, and "it's not reasonable for the hospital to assume that scope of liability and culpability" given the nature of the violation. On the other hand, "there is no legal or regulatory authority" on which to base that advice, the lawyer says. He is still mulling over what to do.

The lawyer says that DOJ influenced OIG to exclude Stark-only violations from the Self-Disclosure Protocol. "OIG was accepting disclosures based on Stark violations and agreeing to damages which may have been putting them at odds with the Department of Justice, which also receives Stark disclosures, but may use different damage models," says the lawyer. "There may have been an interagency disagreement and DOJ may have pulled rank as the official legal representative of the United States."

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Multifaceted Scenarios Knock Boredom Out of Training

Because compliance might seem remote from employees' day-to-day experiences and boring when presented as a series of regulatory mandates, some compliance officers suggest using scenarios in compliance training. Scenarios engage employees, and if multiple compliance issues are embedded in the scenarios, teasing them out may sharpen employees' critical thinking.

"Training has to be interactive and entertaining. Otherwise, the message is lost," says Dean Jessup, an attorney and compliance officer for Ivinson Memorial Hospital, a 99-bed facility in Laramie, Wyo. "When you are going over regulations and laws, most people are not going to be wowed. If people get bored, their minds start wandering. You have to keep them hooked."

All Ivinson employees attend annual compliance training (as well as "re-orientation" every year, but that's now online). Jessup introduces employees to the compliance program, gives a short quiz (see p. 4), explains the code of conduct and then presents the scenarios. Each scenario includes multiple topics from the code of conduct (e.g., billing and coding, conflicts, marketing, quality of care). Jessup guides the discussion as employees brainstorm about the compliance issues raised by the scenarios. Generally, employees are able to identify all or most of the compliance issues in scenarios. "Sometimes they need a little help," Jessup notes.

Here are the scenarios Jessup developed and some of the issues they raise:

◆ ***Serenity works as the admissions clerk for the emergency department and it is a very slow midnight shift.*** Two individuals appear at the door, a man and a woman. It is obvious the woman is pregnant. At the same time, Serenity notices a doctor and nurse having a very loud and heated conversation. A doctor is telling a nurse that she is not going to explain anything to the patient or their family, and that they would not understand what she had to say anyway. The nurse storms off in the middle of the conversation and asks Serenity, "What are you looking at? Mind your own business or I'll have your job!" Stunned by his comment, Serenity turns back to see the pregnant woman on the ground in front of her office, rolling in pain, saying she "shouldn't be here because I

do not have insurance and have no way to pay for anything." At that point, Serenity notices the woman's water has broken. Meanwhile, Serenity hears another patient tell his companion, "See that pregnant lady? I know her. She was tested for HIV last week. My friend Squeaky works here and he's going to find out the results of her HIV test. He snoops in peoples' medical records all the time and has even sold stuff to telemarketers."

Comments: Jessup wants employees to know that patient safety/quality of care come first. The woman is going into labor and needs to be seen right away. Her insurance status is irrelevant and asking for it before screening and stabilizing her is a violation of the Emergency Medical Treatment and Labor Act. Also, loud arguments between hospital staffers fly in the face of Ivinson's standards of behavior. And it's inappropriate that the doctor refuses to speak to a patient about her medical condition because patients have rights. Finally, patient confidentiality (HIPAA) is violated when Serenity overhears that an employee regularly accesses patient files inappropriately.

◆ ***Max is a clinical engineer and is working in radiology troubleshooting on an issue connected with a new piece of equipment.*** He is talking to Sue Jones, a radiology technician, who tells him radiology is doing some really cool things these days. She says she is making a ton of extra money and "it's cool that patients don't have to pay for anything." She goes on to tell Max that one of his friends is in this research program and may not be able to have kids because of the amount of radiation he is exposed to. She also tells Max that she thinks someone may be leaving hazardous materials outside of their required storage area. When Max asks her how she knows all of this, she says, "Lou Sir, the guy who just lost his license, told me to leave them out so they are more accessible." As Max starts to walk away, she slaps him on his rear, winks, and says, "Nice seeing you again, Max!" Max could smell alcohol on Sue's breath, but he thought maybe it was just mouthwash, so he goes about his business. When Max walks by the radiology break room, he notices some unusual bottles and containers, some of which have warning labels.

Compliance Quiz: Are Employees Getting It?

Attorney Dean Jessup, compliance officer for Ivinson Memorial Hospital in Laramie, Wyo., asks employees to complete this quiz halfway through compliance orientation. Jessup uses multifaceted scenarios during training to keep employees engaged in the process (see story, p. 3). Contact Jessup at deanj@ivinsonhospital.org.

(1) What is the best way for IMH Team Members to handle their compliance questions or issues?

(a) Ask for a lifeline
(b) Write a letter to the editor of the Boomerang
(c) Complain to anybody who will listen
(d) Call the Compliance Hotline at 1-800-273-8452

(2) Who is the Chief Compliance Officer?

(a) Anne Alexander
(b) Carol Dozier
(c) Dean Jessup
(d) Jimmy Buffet

(3) Who is responsible for ensuring the Compliance Program is in place and effective?

(a) Board of Trustees
(b) Education Department
(c) IMH President/CEO
(d) Chief Compliance Officer

(4) Only IMH employees are required to abide by the Compliance Program.

❍ True
❍ False

(5) An effective Compliance Program has:

(a) Seven elements
(b) Open lines of communication
(c) Support and commitment from the Board of Trustees
(d) All of the above

(6) What is the greatest asset to the IMH Compliance Program?

(a) Spy equipment
(b) Lithium transmitters
(c) Team Members
(d) Video cameras

(7) In reporting any compliance issues, an IMH Team Member may request:

(a) To remain anonymous
(b) Paper or plastic
(c) The right to remain silent
(d) Fries or Onion Rings

(8) IMH Team Members can request guidance on compliance issues.

❍ True
❍ False

(9) IMH Team Members can report compliance issues to:

(a) Supervisors
(b) Department Heads
(c) Managers
(d) All of the above
(e) None of the above

(10) The Compliance Program provides IMH Team Members with guidance on:

(a) Laws, rules and regulations, and procedures
(b) Career choices
(c) Both a & b
(d) None of the above

ANSWERS: 1 D, 2 C, 3 A, 4 False, 5 D, 6 C, 7 A, 8 True, 9 D, 10 A.

Comments: The most important message for employees to take home from this scenario, Jessup says, is that Max must talk to his supervisor because he suspects Sue is drinking alcohol on the job, which means she could endanger patients. The scenario also "alerts people to consider that research may be occurring based on Sue's comments to Max," Jessup says. "We then discuss issues of appropriate channels to get approval for research on human subjects, patient safety issues as they relate to research projects and payment issues (inducement) related to research subjects." And there are environmental issues (e.g., hazardous materials outside the storage area), sexual harassment, and patient confidentiality/HIPAA problems (when Sue tells Max that his friend is part of ongoing research).

◆ ***Art Count works in Accounting and is cruising the Internet, trying to find gifts for his family on eBay***. While online, Art notices that his computer is generating a lot of e-mails, which he is not sending. He notices that John Hacker was on his computer and he knows that John has boasted about his computer skills in the past. Art and John have a strained working relationship, especially over the last few months. Art feels like he is having problems with John because the last time they went golfing he asked John where he got his new set of golf clubs. The golf bag was stamped with a local doctor's association name and logo, and John told Art that it was just a gift because he was steering so much business to them. Art told John he thought all of that was against the law, but never told anyone else about this conversation or John's gift.

Comments: For one thing, the hospital's IT people would have to be notified because a hacker (probably John) has messed with Art's e-mail. Also, there has been a violation of the hospital's vendor gift policy. Ivinson has a zero-tolerance policy for gifts from vendors and patients. In the past, Ivinson bought its physicians gifts, such as a small grill set. The price was well below the $355 annual Stark limit on hospital gifts to referral sources. But this year the hospital did something different: It held a food drive and donated the proceeds to charities on behalf of the physicians.

◆ ***Mary Trustee is a member of the Board.*** Mary and her husband, who is a physician, own one of three swimming pools in town. At a board meeting, two action items need to be voted on. The first involves giving employed doctors a raise. The second concerns a contract that needs to go out to bid, and it's for the hospital's new aquatic rehabilitation services. Should Mary participate in the discussions and vote on these two items?

Comments: Conflicts of interest are at the heart of this scenario. Though Mary's husband has privileges at the hospital, he isn't employed there, so she can vote on the salary increases. But she can't vote on the vendor contract for the aquatic rehab project unless she opts out of the bidding. "However, under Wyoming law, if she did submit a bid and was selected, the full board, minus Mary, would need a unanimous vote to extend a contract offer," Jessup says.

◆ ***Billy from the business office comes to you as his supervisor and asks about billing errors.*** He lets you know that the wrong code is being used for an outpatient procedure that makes it look like an inpatient procedure. He also tells you that one of his co-workers has been throwing away financial records he thinks are needed for the annual audit and cost report. Billy asks you if these two incidents are compliance issues. What do you tell him and how do you handle the situation from there?

Comments: Obviously this scenario addresses billing errors. Jessup emphasizes the importance of detailed documentation when discussing this scenario. It also raises issues of financial reporting and document retention. For example, as hospitals convert to electronic medical records, they eventually can dispose of paper records after scanning them in. But employees shouldn't destroy paper records until checking with their supervisors, Jessup says.

Contact Jessup at deanj@ivinsonhospital.org. ✧

Health Reform Update

OIG Chief Counsel: Fraud Fighting Is Essential to Health Reform Efforts

OIG's contribution to the battle against health care fraud will be essential to health care reform strategy. But OIG and its law enforcement partners will need new weapons and sufficient resources to continue the fight, OIG Chief Counsel Lewis Morris told the Senate Finance Committee at an April 21 Roundtable Discussion on Health Care Reform.

The anti-fraud measures and program safeguards of a reformed health care system will have to depend on the way that system's payments are structured, Morris explained. When "Medicare pays on a fee-for-service basis, providers have an incentive to increase the number and complexity of the services, even if those services are not medically necessary," he pointed out. "When the program pays on a capitated basis, the incentive is reversed. Patients may not receive the necessary services for which the program has paid the health care provider."

Morris said OIG has a five-principal strategy to combat fraud, waste and abuse:

(1) Individuals and entities that want to participate as providers and suppliers in federal health care programs must be scrutinized prior to their enrollment. "Screening measures should include requiring providers to meet accreditation standards; requiring proof of business integrity or surety bonds; periodic recertification and onsite verification that conditions of participation have been met;

and full disclosure of ownership and control interests," Morris said.

(2) "Establish payment methodologies that are reasonable and responsive to changes in the marketplace." OIG has determined based on many reviews that Medicare pays too much for certain items and services because its reimbursement methodologies have not responded to changes in the marketplace. "In addition, the health care system must anticipate that providers may alter their practices in response to program integrity efforts," Morris said.

(3) Assist health care providers and suppliers in adopting practices that promote compliance, including quality and safety standards. "Health care providers must be our partners in ensuring the integrity of health care programs and should adopt internal controls and other measures that promote compliance and prevent, detect and respond to health care fraud, waste and abuse," Morris told the roundtable.

(4) "Vigilantly" monitor the programs for fraud, waste and abuse. The "federal health care programs often fail effectively to use claim-processing edits and other information technology to identify improper claims before they are paid."

(5) "Respond swiftly to detected frauds, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities." Health care fraud has become a magnet for organized crime because the penalties are lower, there are low barriers to entry, the schemes are easily replicated and the criminals perceive a low risk of detection, Morris said. Part of OIG's strategy to combat this was to start a strike force in 2007 in south Florida, which is plagued by durable medical equipment and HIV infusion fraud. With the Department of Justice (DOJ), HHS has tried to decrease "the amount of time between the government's detection of a fraud scheme and the arrest and prosecution of the offenders," Morris said.

Read the testimony at www.oig.hhs.gov/testimony/docs/2009/HealthRefmSenFinanceLMorris.pdf. ✧

More Hospitals Are Using Screeners

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work on Medicare cases now that RACs are on the hunt for overpayments stemming from DRG payments for patients who should have been treated in observation.

"Screeners are becoming in vogue as hospitals put stop-gap measures in place" now that observation and inpatient admissions are under the RAC microscope, Vonda Moon, senior manager for Sunstone Consulting in Pennsylvania, tells *RMC*.

One trouble spot they can zero in on: presurgical status determinations. Physicians are making pre-surgery determinations about the level of care patients should receive after surgery, says Ann Kunkel, director of case management at WellSpan Health, a health system in York, Pa. "They can't do that in advance." Unless the procedure is on the Medicare inpatient-only list, the patient's post-surgical destination hinges on his or her condition. To justify an inpatient admission for a procedure that's not on the inpatient-only list, "the procedure must reflect clinical comorbidities and complications, why they are problematic and why inpatient status is needed," she explains. (The inpatient-only list refers to procedures that can only be performed on inpatients.) For example, kyphoplasty (a type of spinal surgery) and installing an automatic implantable

cardiac defibrillators (AICDs) are not on the inpatient-only list. That means case managers must work with physicians to evaluate whether patients undergoing these procedures warrant admission and to document thoroughly the co-morbidities and treatment plan supporting inpatient status so RACs (and other auditors) don't deny the claims.

Physician Advisers Are a Necessity

If they employ screeners or contract with a screening vendor, hospitals should assess the competency of the screeners, Moon advises. "Their knowledge of InterQual and how they interpret it can vary widely," she says. "We have seen case managers who were not properly trained tell doctors that 'InterQual says X, so you need to change the order.' Instead, the dialogue should hinge on the medical conditions or reasoning regarding level-of-care assignment." For example, Moon says, the case manager might ask the physician what's happening with the patient that led to the assignment of a particular level of care. "That question can draw out complications and comorbidities that, when presented to the physician advisor or utilization management committee, could support the hospital's criteria for level-of-care assignment," she says.

But screeners and case managers are not a panacea, Kunkel cautions. "You need physician advisers available because just having case managers or screeners does not meet the conditions of participation. Status determinations are a medical-staff responsibility, not a hospital responsibility," according to the conditions of participation, she says.

Whether it uses screeners or case managers, Kunkel says that a hospital's first step in driving down underuse and overuse of observation is working with physicians in an educational capacity on status determinations. "The difference between an inpatient admission and observation can be $800 to $4,000," she says. Get physicians to consider all the other implications of wrongly placing patients in observation when they should be admitted as inpatients and vice versa.

For one thing, if the level of care is wrong and the patient is discharged to post-acute care, the hospital takes a hit on transfer per-diem payments, Kunkel says. Suppose a congestive heart failure (CHF) patient is placed in observation until the physician realizes on day two that the patient needs to be admitted as an inpatient. If the geometric mean length of stay for CHF is four days, but the patient was there three days, the hospital will receive per diems only for the three days if the patient is discharged to post-acute care.

Also, with public reporting of readmissions, physicians and hospitals don't want payers and the public to think patients were prematurely discharged when they had complications and comorbidities. But that's what it will look like if patients are improperly placed in observation for a day or two before they are moved to their rightful place in an inpatient bed.

And suppose a patient is in observation for one day unnecessarily before being shifted to inpatient status, where he spends two days and then is discharged. The physician decides the patient needs skilled nursing facility care, but the misplaced day in observation sabotages the SNF placement because Medicare requires a three-day acute-care admission before SNF coverage kicks in, and observation days don't count. "Getting status right from the beginning is a really important issue for providers, and they are just now understanding the impact," Kunkel says.

Rapid Diagnostic Units Are Catching On

More hospitals are creating dedicated observation units with staff assigned exclusively to those areas, Barry says. Typically observation beds can be located anywhere, and patients often can't tell the difference between observation and inpatient status because they are tended to by the same nurses and receive many of the same tests and procedures. However, an observation unit — sometimes called a rapid diagnostic unit — has a separate location in the hospital and its own staff (e.g., physician, nurse, physician assistant), Barry explains. "They have more than doubled in volume in the past couple of years," she notes.

The reason hospitals are considering rapid diagnostic units is that they allow hospitals and physicians to interrupt their inpatient focus and hone the skills needed to improve observation compliance, Moon and Kunkel say.

"Most facilities are completely oriented toward inpatients in terms of their documentation, computer systems and clinical processes," Kunkel says. That's a problem when it comes to observation because Medicare rules for documenting and billing observation differ from the rules for documenting and billing inpatient care. Inpatient documentation and billing are case oriented. In contrast, Medicare's observation billing criteria is based on time. Observation is billable only if patients are placed there for a minimum of eight hours. But Medicare doesn't allow hospitals to count time spent away receiving diagnostic tests and therapeutic services, so nurses must document stop and start times whenever a patient leaves observation for this reason. If, however, hospitals have dedicated observation units, nurses (and others) become experts in observation documentation.

Also, dedicated observation units would give patients more clarity about their status. Hopefully, that will reduce patients' frustration when charged higher copays for observation (an outpatient service even though they may lay in a hospital bed for 24 to 48 hours) than inpatient care "People don't differentiate status for themselves," Kunkel says.

continued

Charge capture and coding are different for observation versus inpatient, Moon notes. "This is a great model, though some facilities have struggled with whether they have enough volume to support a separate unit."

WellSpan may have come up with a solution to that problem, Kunkel says. It is exploring the creation of a dedicated observation unit combined with an outpatient ambulatory surgery center on the grounds of its Gettysburg hospital.

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NEWS BRIEFS

◆ **A murder victim's estate can sue a hospital under EMTALA,** the U.S. Court of Appeals for the Sixth Circuit said in an April 6 opinion. The suit alleged that Providence Hospital and Medical Centers Inc. in Michigan and psychiatrist Paul Lessem violated EMTALA by releasing a patient even though he had an emergency medical condition. On Dec. 13, 2002, Marie Moses-Irons brought her husband to Providence's emergency department (ED) because he was demonstrating threatening behavior. The ED physicians admitted him for tests. Lessem determined that the patient should be transferred to the hospital's psychiatric unit. Instead, he was released on Dec. 19 and murdered his wife 10 days later, according to the opinion. He is serving a life sentence. Moses-Irons' estate filed the lawsuit in December 2004. The defendants filed a motion for summary judgment in May 2007, arguing that (1) the estate had no standing to sue because only the individual patient can do so, and (2) EMTALA imposes no further obligation on a hospital once a patient is admitted. The judge dismissed the EMTALA claim, and the plaintiffs appealed. In the opinion, the appeals court notes that EMTALA says "'any individual who suffers personal harm as a direct result' of a hospital's EMTALA violation may sue…. This language would seem to include [the] plaintiff." Also, a facility's obligations under EMTALA go beyond just admitting a patient and also must include treatment and stabilization, the court says. The appeals court says the claim against Lessem should be dismissed because EMTALA does not authorize a private right of action against individuals. The appeals court remanded the case to the district court for further proceedings. The hospital said it cannot comment on pending litigation. The case is *Moses v. Providence Hospital and Medical Ctrs.* Visit www.ca6.uscourts.gov.

◆ **HHS guidance released April 17 says that methods to render protected health information (PHI) "unusable, unreadable or indecipherable" — as required by the breach notification provisions passed as part of the stimulus law — include data encryption and destruction.** The guidance also solicits public comments by May 21 on other methods, and says feedback may be used in future rulemaking and guidance modifications. The law requires that HIPAA covered entities (CEs) notify affected individuals following a breach of unsecured PHI. The guidance notes that if PHI is already rendered unusable, then that PHI is not considered unsecured and notification is not required. For electronic PHI, the National Institute of Standards and Technology (NIST) offers valid encryption processes for data "at rest"and "in motion." PHI in paper, film or other hard-copy form should be shredded or destroyed so it cannot be read or reconstructed, and electronic media have to be cleared, purged or destroyed consistent with NIST standards. "HHS really did no more than point to the NIST standards," which are already considered the default, says Chris Apgar, president of Apgar and Associates. And HHS did not give specifics on level of encryption, he adds. "Also, regarding paper PHI, the guidance only addressed [destruction]….Given that the new statute did not differentiate between unsecured electronic versus non-electronic PHI, HHS failed to define what is required to secure paper documents (e.g., locked cabinets, storing in safes, storing in locked offices, etc.)," he says. Read the guidance at www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/hitechrfi.pdf.

◆ **Attorneys working for federal and state governments have told stories of "promising fraud prosecutions dying" under the procedural hurdles of the False Claims Act,** said Joseph White, president of Taxpayers Against Fraud, in testimony before the House Committee on the Judiciary April 1. The committee heard testimony on several fraud-fighting bills, including the False Claims Act Corrections Act of 2009 (H.R.1788). The legislation is needed to close loopholes in the False Claims Act, White contends. Other bills pending in the Senate now are the Fraud Enforcement and Recovery Act of 2009 (S. 386) and the False Claims Clarification Act of 2009 (S. 458), which is sponsored by Sen. Charles Grassley (R-Iowa). Grassley sponsored similar legislation in 2007. Read more at http://judiciary.house.gov/hearings/hear_090401.html and http://thomas.loc.gov/.

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