Report on
MEDICARE COMPLIANCE

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

Contents

Claims for Physical, Speech, Occupational Therapy Face Scrutiny for Proof of Progress

Hospitals will face an increasing number of denials for outpatient physical, speech and occupational therapy claims unless they can prove medical necessity in a way that moves beyond traditional notions of impairment, experts say. Therapists should succinctly document the progress and outcome of therapy (e.g., dressing, bathing, communicating, eating, home management), not just incremental accomplishments (range of motion, muscle strength). New methods for documenting medical necessity have gained traction and may prevent denials by recovery audit contractors (RACs) and other auditors.

"We have seen a lot of what Medicare considers abuse of the Medicare benefit: too many therapy sessions with no associated practical improvement within a reasonable period of time," says Becky Cornett, director of fiscal integrity at Ohio State University Medical Center and its former director of inpatient rehabilitation. "The number of therapy treatmentts keeps going up while the Medicare Trust Fund is going down, and the purpose of the RACs is to recover some of that." It's a good time to audit these services (see checklist, p. 7).

Therapy compliance hinges on demonstrating why people are coming to therapy (i.e., the physician's diagnosis), what therapists will do for them (i.e., a plan of care signed by a physician), how long it will take and what it will cost, says physical therapist Tim Richardson, owner of Medical Arts Rehabilitation in Palmetto, Fla. But medical necessity is probably the trickiest part. According to Medicare Transmittal 88, issued in May 2008, "services are medically necessary if the documentation indicates they meet the

continued on p. 6

How to Challenge Claims That Are Denied By CMS for Insufficient Documentation

CMS's program-integrity mantra — "if a service wasn't documented, it wasn't performed" — is not grounded in Medicare laws or regulations, so hospitals should consider appealing claims denied for insufficient documentation if they believe the services were provided, one lawyer advises.

That's not merely an abstract idea. Minneapolis attorney David Glaser is making headway with administrative law judges (ALJs) by submitting evidence that services were provided even though they were not documented according to Medicare's evaluation and management (E/M) documentation guidelines, which is the gold standard.

Glaser has prevailed in a number of E/M payment appeals when claims were denied because Medicare contractors said they didn't pass muster with documentation guidelines. For example, Glaser had an oncologist-client whose Medicare carrier denied $3 million worth of the oncologist's claims after an audit of 90 patients treated during a four-year period. The claims were rejected mostly because the oncologist didn't sign the chemotherapy records. Without the oncologist's signature, the carrier said, how could it

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be sure the oncologist was present when the chemo was provided? In response, Glaser says, "we gave the carrier an affidavit from the nurses that the doctor was always there, plus his appointment book showing his schedule." That should have put the matter to rest, he says, but "the carrier kept after him." However, when the oncologist got to the ALJ, the overpayment was reversed.

"I'm not saying 'ignore the documentation guidelines,' because I think the burden is on the provider to demonstrate they did the work. If it's not in the documentation, it will be a harder burden to meet," Glaser says. "But if you have a physician who has poor documentation, I don't think you have a duty to refund the money unless you think they billed for services they didn't do. When documentation is lacking, you should make an effort to determine whether the services were provided as billed (underdocumented) or coded at a level higher than billed (overcoded). Medicare only requires a refund if it has overpaid based on what was inaccurately billed."

As Glaser argued before an ALJ this month, the fact that in-person hearings before an ALJ exist is, by definition, support for the idea that providers should be able to supply alternate forms of support for their services (e.g., testimony, appointment books). "The reason for a hearing is to gather evidence, to say whether the work was done," he says. "If it were all a question of looking at medical records, why would HHS have an ALJ?"

Glaser's strategy could be valuable as recovery audit contractors and Medicaid integrity contractors launch audits nationally, and Medicare administrative contractors and fiscal intermediaries ramp up medical review. These entities are under pressure to recoup money for the cash-strapped federal government, especially with President Obama's pledge to help fund health reform with fraud-and-abuse recoveries. Document-related payment errors account for a significant percentage of claims denials, according to the RAC pilot and the annual Medicare fee-for-service improper payment report.

Glaser has been able to fend off a Department of Justice (DOJ) investigation by resisting the government's premise that an absence of conventional documentation is tantamount to no service being performed. "I had a fraud investigation where the government's initial position was that 'it was not written so [the service] was not done.' They were going to use that standard" in pursuing the false claims case against his client, Glaser says. A whistle-blower had filed the lawsuit, and the government, after a preliminary investigation, contended that documentation was insufficient and therefore the provider should cut the government a check. "We said 'no' and the case went away," Glaser says. DOJ refused to intervene in the whistle-blower's case, and ultimately it was dismissed.

Repeating It Doesn't Make It Law

"I haven't heard CMS use the argument of 'if it's not documented, it's not done' in court. It's not policy, it's not a rule, and it shouldn't be. It's a dumb rule. But it's been repeated so often that people start to live by it," says Glaser, who is with the law firm of Fredrikson & Byron PA. "If it's the law, [the government] should be able to point to it." The closest dictate is the Social Security Act, which, in essence, states that no payments should be made to providers unless they furnish information to Medicare that enables it to determine the amount of reimbursement owed. But that key phrase — "furnish information" — does not specify medical records, Glaser says. And it's fine that E/M documentation guidelines are *de rigeur* — and serve as a safe harbor, which means compliance with the documentation guidelines is a sure-

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fire way to get paid. But not falling perfectly inside them should not necessarily mean providers lose all reimbursement, Glaser says.

He says the "compliance oath" that providers should live by is to bill Medicare only for the services they perform, and if they really did the work, the payment should be forthcoming — even if documentation has to be provided by alternate means (e.g., nurse affidavits).

Pay Attention to Documentation Requirements

While many in the health law bar would agree with Glaser, some lawyers also strike a note of caution. "If the actual regulation, rather than subregulatory guidance, requires that there be certain items in the medical record, failure to have those items means that there is no basis for the claim, unless the provider or physician is planning on challenging the validity of the regulation," says Washington, D.C., attorney Andy Ruskin, with the law firm of Morgan Lewis & Bockius. Ruskin adds that this has important implications for self-audits as well. "If the provider determines there's evidence that the service was furnished, even if not in accordance with CMS's subregulatory guidance, then perhaps the entity gathers that evidence in a file as an indication of its good-faith belief that it does not have any overpayment liability," he says. However, make sure there's no regulation on point that requires specific items in the medical record.

If the entity disagrees with the regulation, it can always file a claim under protest, knowing that it will be denied but preserving its appeal rights, Ruskin says. Of course, that's not the ideal position to be in, he says. "You'd rather just have your money and not have to fight for it," he notes. Where documentation problems are found, Ruskin says that, in his experience, additional training of staff and periodic auditing have had a salutary effect, meaning that often the same problem doesn't come up twice.

San Francisco attorney Judy Waltz agrees that, when providers lack the types of documentation that CMS or its contractors usually see for a particular type of item or service, they should look for alternative documentation to establish an equivalency. "For example, I have argued that lab tests lacking a physician order to establish the reason for the test can demonstrate medical necessity by looking at how the physicians altered treatment in response to a lab test," she says. "Or allegations of inadequate supervision of staff can sometimes be refuted by physician calendar entries. It's certainly more difficult than having great documentation. If an item is specifically required as a condition of payment, then it needs to be there. But providers need to be creative in figuring out what they have to work with when challenged with deficiencies."

Part of the problem is the government has long contended that "a documentation defect relieves the government from paying for services that were actually rendered, even in instances where quality and medical necessity are not at issue," says New York City attorney Mark Thomas, who represents the Healthcare Assn. of New York. But he sees little basis for this, other than what he calls a rigid application of general rules and payment certifications that condition payment on 100% compliance with all applicable regulations. "This perspective, however, conveniently ignores the obligation of any payer, including the government, to pay for services it covers and does not question," Thomas says. "It would be immensely productive to have a candid exchange of views on the propriety and basic fairness of the all-or-nothing system we now have."

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Surprises Arise as Hospitals Struggle With FTC Red Flags Rule

As hospitals and health systems implement the FTC Red Flags Rule *(RMC 10/20/08, p. 5)*, they are confronting unanticipated challenges. These challenges include unforeseen compliance angles involving post-acute care and the National Patient Safety Goals, and patient misrepresentation that can set off alarm bells but isn't necessarily what it seems.

The Red Flags Rule, which the FTC will start enforcing Aug. 1, requires certain organizations to have an identity theft mitigation and detection program. It's been well-established that many health care entities are subject to compliance with the rule because of their billing and collection practices. Failure to comply can mean civil monetary penalties, but not criminal penalties, for violations.

According to the FTC, a red flag is "a pattern, practice, or specific account activity that indicates the possibility of identity theft." Red flags include:

- Alerts or warnings from a consumer reporting agency;
- Suspicious documents and/or personal identifying information (e.g., an inconsistent address or nonexistent Social Security number);
- Unusual use of, or suspicious activity concerning, a patient account; and
- Notices of possible identity theft from patients, identity-theft victims or law enforcement agencies.

Employees at Ohio State University Medical Center (OSUMC) have apparently been paying close attention to its identity theft and medical identity theft education

and mitigation program *(RMC 5/4/09, p. 1)*. In the months following the multi-faceted training program, which is required by the FTC to help organizations identify and mitigate identity theft, employees have become aware of red flags that may indicate identity theft. "We have lots of different red flags rolling in," Privacy Officer Jennifer Cironi tells *RMC*. "We are trying to triage." That means separating potential identity theft, which will be investigated by OSUMC's "red flag response team," from minor clerical errors (two patients with the same names), which can easily be resolved by the medical information department.

One incident in particular has confirmed both the peculiar turns that identity theft can take and the effectiveness of OSUMC's program in terms of identifying abuses of identities and uncovering the reasons behind it for purposes of mitigation.

Here's the story: A man called the hospital to complain that he was getting bills for hospital care he never received. OSUMC checks out these stories carefully because one side effect of the publicity about identity theft is that unscrupulous people sometimes use it as a ploy to try to evade paying their medical bills. But this case was immediately suspicious because the computer indicated that the man on the phone was at that moment an inpatient at OSUMC. Either a flagrant case of medical identity theft was in progress, or something else was afoot. The latter turned out to be true, Cironi says.

When the red flag response team started poking around, it couldn't understand what the inpatient's motive was. He had insurance coverage, so he didn't need to steal the caller's insurance. The nurses thought the patient was malingering; hospital staff at one point speculated that the caller was actually one and the same as the inpatient. They thought maybe he snuck downstairs and used his cell phone to call patient accounting from inside the hospital. Finally, however, the caller figured out that his own cousin was the imposter, checking into the hospital under the caller's name. But the reasons were inexplicable. As the hospital's investigation unfolded over the course of a week, it became clear that the inpatient actually believed he was his cousin.

It turned out the inpatient had a number of illnesses, and they had some effect on his perception. "Ultimately, we think he really believes he is someone else. We don't think he had any criminal intent," Cironi says. "His health issues likely affected his perception." This conclusion was bolstered by the fact that the inpatient has been treated at the hospital a number of times, and had used his cousin's identity those times as well — again, for no apparent reason because both have insurance. Given the findings, there were no consequences for the inpatient.

The next step: The hospital focused on cleaning up the medical-records mess that was created by one cousin thinking he was the other. The cousin who was not hospitalized is healthy and has received few services, so the hospital had to make sure all the treatment information related to the sick cousin's treatment was stripped from the healthy cousin's records and placed where it belonged. That way, if and when the healthy cousin presents at the hospital, the medical records will be accurate. Insurance claims were also rectified so the healthy cousin's insurance company was refunded for claims it paid on his behalf, and the sick cousin's insurance company was billed instead.

The lesson learned was never to take potential identity theft at face value. "Our team spoke to staff and told them not to get jaded. You have to keep an open mind and consider the entire picture," Cironi said.

Post-Acute Care Raised Red-Flag Questions

As Catholic Healthcare Partners (CHP) approached Red Flags Rule compliance, it realized it "faced a unique set of challenges" with post-acute care, including home health, long-term care and skilled nursing facilities and durable medical equipment suppliers, says Cheryl Rice, interim corporate responsibility officer at the Ohio-based health system. With these entities, patients don't walk off the street; they are referred by hospitals and physicians, where they have already been through an extensive registration process. But the post-acute care entity may have minimal information on the patient at the first encounter or assessment session. "One of the questions that came up is, can we assume hospitals and doctors did all the

proper screening for identity theft since they were referred to us?" Rice says. Because the Red Flags Rule holds each provider responsible for compliance, post-acute care entities must have their own Red Flags policies and procedures.

Rice explains that each post-acute care entity will typically have a separate provider number from the hospital or physician office. Post-acute care entities can use information provided in the referral to supplement their efforts, but they should not automatically assume that the referral source did the identity check. "Although post-acute care providers would be considered a low-risk organization for identity theft, they still need to demonstrate a good-faith effort to comply with the FTC requirements in terms of having safeguards and mitigation efforts in place," she says. "CHP affiliates are looking to network with their referral sources for post-acute care to see what information can be shared in the transfer and referral process to further both parties' compliance efforts with the Red Flag Rule."

Consider Other Demands for Identifiers

But there's a twist that complicates compliance. The Joint Commission requires health care organizations to meet National Patient Safety Goals (NPSGs) to improve patient safety. Among other things, health care organizations, including acute-care and post-acute-care entities, must "reliably identify the individual as the person for whom the service or treatment is intended" and "to match the service or treatment to that individual." In other words, is Mr. Smith, who is about to have his leg amputated, the correct Mr. Smith who is scheduled for an amputation? To confirm that, the Joint Commission requires health care organizations to obtain two patient-specific identifiers.

"All post-acute settings rendering treatment are subject to the Red Flags Rule and have to abide by the two-identifier National Patient Safety requirements," Rice notes.

It's burdensome for patients and health care organizations alike to deal with repetitive identification. So Rice said CHP sought to figure out which kinds of identification would fulfill both the Red Flags Rule and the National Patient Safety Goals. A utility bill may ease concerns about identity theft, but isn't sufficient for NPSGs. A driver's license with photo, eye color, birth date and address would cover both bases, she says. If patients lack a driver's license, "caregivers may have to ask for a combination of identifiers to meet both requirements," Rice notes. For example, a utility bill provides the name and address to meet the Red Flags Rule and one identifier under NPSG, while a verbal birth date covers the second NPSG identifier.

In another Red Flags Rule challenge, CHP's affiliates have realized there are certain populations, such as the Amish, who lack mainstream methods of identification. Amish people don't have Social Security numbers, she says. "They won't let you take their picture," and they don't use electricity, so forget relying on utility or cable bills, Rice adds. The closest thing to insurance is the Amish Society, which helps pay for treatment, but it doesn't use conventional identifying information. Their lives are modest so it's unlikely someone is trying to co-opt their financial identity, but someone could pretend to be Amish to get care under one of their names, Rice says. "The hospital would be at risk if you rendered care for someone not Amish or if the Amish Society paid for care for someone not Amish," she says. So CHP still tries to get at some identifiers — names of patients, when they were last treated at the hospital, their birthdays, where they live and names of their private physicians. It's often enough information to detect identity theft.

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Four Medical Device Makers Get Subpoenas From Feds in FCA Case

Four medical device manufacturers have been served with subpoenas by the Department of Justice in relation to a whistleblower lawsuit alleging False Claims Act violations, according to public filings by the companies and court documents.

Orthofix International, Biomet Inc., and DJO Inc. all say in recent financial filings with the Securities and Exchange Commission that they were served with subpoenas by the feds seeking documents dating back to the 1990s. Smith & Nephew, Inc. also is named in the suit, but a review of the company's financial filings did not turn up a mention of the subpoena. A spokesperson for the company could not be reached for comment.

The suit — originally filed in 2005, but just unsealed in March — alleges that the companies and some of their subsidiaries bill federal health care programs for devices called bone growth stimulators as purchase items when they should be billed as rental items. The suit also alleges that the companies claim the devices are necessary for periods that were "far in excess" of the time patients actually needed them. According to the complaint filed in U.S. District Court in Massachusetts, the improper billings began in 1993 and continue today.

The companies received at least $300 million from Medicare alone between 1998 and the time of the suit's filing, according to the complaint. Medicare purchased more than 70,000 new stimulators on behalf of patients during that time. "The vast majority of these devices cur-

rently are sitting idle in the homes of those patients, have been thrown out or otherwise disposed of," the complaint says. "Osteogenesis stimulators are routinely listed for sale on eBay for as little as $50. Medicare, on the other hand, paid approximately $3,600 for each new device, many of which were used by patients for no more than a few months."

The whistleblower, Jeffrey Bierman, is the co-owner of a small company in Missouri that provides non-coding medical billing services and compliance programs to doctors, hospitals, nursing homes and other providers. The government has not yet intervened in the case, but has asked for at least one extension on the deadline to do so. The companies say they were given the subpoenas in April, which indicates that the feds are still investigating the case.

The companies say they will cooperate with the government's requests. DJO adds that it "believes that its marketing practices in the bone growth stimulation business are in compliance with applicable legal standards and intends to defend this case vigorously."

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Prove Progress on Therapy Claims

continued from p. 1

requirements for medical necessity, including that they are skilled, rehabilitative services, provided by clinicians (or qualified professionals when appropriate) with the approval of a physician/NPP, safe, and effective (i.e., progress indicates that the care is effective in rehabilitation of function)."

That means Medicare won't cover therapy unless patients have a problem "of such a level of complexity that it requires the services of a skilled therapist," Cornett says. Reimbursement stops after therapists have taught patients the skills necessary to regain lost function or mobility. After that, she says, it becomes a matter of practice and repetition, which are tasks that can be handled by the patient or the patient's family or friends. For example, with stroke patients, speech-language pathologists work toward restoring communication skills, says Cornett, who has a doctorate in communication sciences and disorders. "At some point, when can the spouse or nursing home aide pick up on the repetition of conversational skills or writing or reading or listening to news and talking about retaining what was heard?" she says. "You don't need the services of a professional for that" at $50 a pop.

Similarly, with the aquatic form of physical therapy, there is some point at which patients can shift from the physical therapist's skills and transition from a water environment to land-based treatment, Cornett says. "To be covered by Medicare, aquatic therapy must be used for patients who are unable to tolerate land-based exercises for rehabilitation and should facilitate progression to land-based therapy and measurable increased function," she says.

Minimal Progress Not Enough for Medicare

Medicare states that it doesn't pay for aquatic exercise when it consists of "exercises in the water environment to promote overall fitness, flexibility, improved endurance, aerobic conditioning, weight reduction or for maintenance purposes," she says. Aquatic therapy (CPT code 97113) also can't be billed to Medicare in situations when no exercise is performed (e.g., debridement). The same is true for a water modality (whirlpool, CPT code 97022) when billed in addition to 97113. National Government Services (NGS), the Medicare fiscal intermediary for 12 states, cautions in a local coverage decision that "these exercises become repetitive quickly. Once a patient can demonstrate an exercise safely, you may no longer bill Medicare for the time it takes to perform this now-independent exercise."

Cornett says Medicare auditors also want to see concise documentation that gets to the heart of the matter. Therapists often put too much subjective information into medical records. "They document reams of data, but it's often not the right information," she says. "In this new world, nothing is wrong with saying that the knee was extended, but that shouldn't be the end of it." Therapists have new tools for establishing objective criteria for showing activities and improvements in functional independence, including the American Speech-Language Hearing Assn.'s National Outcomes Measurement System; the American Occupational Therapy Assn.'s Focus on Therapeutic Outcomes and the American Physical Therapy Assn.'s OPTIMAL scale.

"Medicare doesn't want to cover therapy endlessly if the patients aren't making significant progress, and minute progress is not enough," she notes. "Medicare wants to see significant, practical improvement in a predictable period of time." Yet some therapists still focus their documentation on impairment, when it should emphasize activities and participation.

Evidence-Based Tools Show Medical Necessity

Between 40% and 60% of Medicare audit denials for physical therapy are due to a lack of (perceived) medical necessity, Richardson says. "The reason is because of soft data," he notes. There are no CT scans or X-rays to show objective findings. "We rely on func-

tion scores, range of motion, strength." But now the physical therapy community has developed objective tools to measure them. "The challenge for compliance is getting physical therapists to use these tools," he says, which would help demonstrate the medical necessity of therapy and the larger issues of whether patients would be safer in a more protective environment (e.g., skilled nursing facility, nursing home) because they are at high risk of injury from falling.

There are four tools that physical therapists can use to demonstrate, in concrete terms, medical-necessity progress and skill decision making, Richardson says:

(1) Self-report measures: Using tools like the Optimal scale, patients describe the state of their functional impairment. This includes the extent of their pain and how body parts are affected (e.g., they can't lift their arm or leg, can't walk or run, or have trouble turning their head). These tools are "validated, public-domain questionnaires," he notes.

(2) Performance measures: Therapists evaluate patient status in a clinic, work or sport setting. For example, patients sitting in a chair are asked to stand up, walk three meters and then turn around and walk back. "We have valid data that indicate that patients that can't do that in fewer than 11½ seconds are at higher risk of falls," Richardson says. "That's valuable data and helps give physical therapists a prognosis [for the patient]."

(3) Impairment measures: The old-school notion of impairment was range of motion, strength and girth, but he says "they don't have very good predictive powers" alone for the patient's vulnerability to continued back problems or falls. While impairment measures are helpful, they must be combined with these other tools.

(4) Classification measures: This is a more recent tool used to identify the kind of physical therapy that

Speech Therapy Audit Checklist

WellSpan Health in York, Pa., uses this checklist in its speech therapy audits. Each of the columns below can be used to report the findings of one patient's chart audit. Contact Compliance Officer Wendy Trout at wtrout@wellspan.org.

Medical record number		
Referral for therapy		
Reason for therapy		
Initial evaluation completed		
Initial evaluation should have reason for treatment*		
Plan of care outlined		
Attendance log completed		
Re-evaluated every 30 days		
Recertify every 90 days		
Documentation of HEP		
Short-term goals		
Goals evaluated each visit		
Long-term goals		
Progress note written, signed, dated		
Start and stop time documentation		
Estimated treatment plan		
Billable units mentioned in chart		
Is the chart organized?		
Handwriting readable?		
Visit signed off by therapist		
Family involved in care		
Re-evaluation is needed if changes occur (improvement or declining progress)		
Comments		

* Initial assessment should include the patient condition will improve in period of time, or the services must be necessary to establishment of a safe and effective maintenance program. Initial visit should include diagnosis and description of problem, specific body area evaluated; include all conditions and complexity that may impact the treatment. A description also includes date of onset and current function. Evaluation of disorders also requires description of speech, articulation, fluency and voice, language skills and cognitive aspects of communication.

will have the best outcome and avoid negative outcomes, Richardson says. "Classification is the most evidence-based, well-researched method that physical therapists use," he says. Therapists identify baseline characteristics of patients when they walk in the door to determine whether the best treatment for lower back pain, for example, would be manipulation, traction or stabilization (which involves training the patient to avoid using particular muscles when doing certain activities, such as bending or lifting, to minimize, for example, back pain).

If, for example, the physical therapist were to perform five tests, with three of them coming up positive, then manipulation of the spine would be an effective method. Richardson just evaluated and treated a back-pain patient who presented with a prescription from his physician for a hot pack, ultrasound and massage. But first he applied the classification measure for low-back pain, which has five "predictor variables": how long the patient suffered from the pain; the extent of leg pain from the back pain radiating down the leg; the results of a Fear Avoidance Beliefs Questionnaire (FABQ), which means how much the patient is avoiding exercise and other activities for fear of causing himself pain; hip range of motion asymmetry (unequal hip internal rotation); and lumbar hypomobility (stiff backbone). The patient registered on three out of the five manipulation predictor variables, which means the patient needed manipulation instead of a hot pack, ultrasound and massage. "He responded well after one session," Richardson says. So far, there are classification measurements for the low back, shoulder, neck and ankle, he says.

Richardson says medical-necessity denials would drop significantly if physical therapists used these tools to assess and treat patients. "We need to show the services we provide are unique, and that we are making decisions based on data — examining the patient, determining what's wrong, designing interventions to improve patients and making measurable progress," Richardson says.

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NEWS BRIEFS

◆ **Medical device manufacturer Norian Corp., its parent company Synthes, Inc. and four Synthes executives have been charged with conducting clinical trials without the authorization of the FDA,** the U.S. Attorney's Office for the Eastern District of Pennsylvania said June 16. The defendants allegedly conspired to conduct trials of devices that are used in surgeries to treat vertebral compression fractures in the spine. The feds say the two products were not approved by the FDA for use in the spine because of serious medical concerns. Pilot studies showed that the bone cement reacted chemically with human blood in a test tube to cause blood clots, the feds say. Three patients died during procedures, but the company did not stop marketing the products, the government alleges. The defendants are charged with making false statements to the FDA and shipping adulterated and misbranded products in interstate commerce with intent to defraud. Synthes says in a prepared statement that it fully cooperated with the investigation and believes its marketing practices were proper. It adds that it will vigorously defend itself against the charges. Visit www.usdoj.gov/usao/pae and www.synthes.com.

◆ **Inaccurate data in the Provider Enrollment, Chain and Ownership System (PECOS) Individual Global Extract File "limits [the] usefulness" of the system,** Office of Inspector General (OIG) says in a memo to CMS posted June 12. Medicare contractors use PECOS, which is considered a program integrity tool, to maintain information on providers. OIG discovered during a separate audit that there were some discrepancies in the number of active Medicare reassignments and in some reassignment effective dates. CMS staff told OIG that this was because it retained records of terminated reassignments (when only active ones should have been retained) as well as inaccurate effective dates. CMS staff said they would investigate the cause of the discrepancies. OIG had no recommendations. Read the memo at http://oig.hhs.gov/oei/reports/oei-07-08-00181.pdf.

◆ **HHS's Health Information Technology Policy Committee began the process of defining "meaningful use" of electronic health records (EHRs) with draft recommendations released June 16.** The American Recovery and Reinvestment Act of 2009 (ARRA) included incentive payments for Medicare and Medicaid providers who adopt EHRs. But to receive the payments, providers must show "meaningful use" of EHRs. CMS and the Office of the National Coordinator for Health Information Technology will develop a proposed rule that includes a definition of "meaningful use," which CMS expects to issue in late 2009. Public comment on the draft recommendations is open until June 26. Visit http://healthit.hhs.gov

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