Report on
MEDICARE COMPLIANCE

Volume 18, Number 21 • June 15, 2009

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

Contents

Managing Editor
Nina Youngstrom

Associate Editor
Eve Collins

Lab Tests Denied Despite Signed Orders; Reliance on MDs Can Be Costly for Hospitals

Orders for lab tests are the source of ongoing tension for hospitals, which continue to face claims denials for lab work and diagnostic tests when physicians lack supporting documentation in their files. It's similar to the admission necessity issue on the inpatient side, where hospitals are at the mercy of decisions made by physicians who have no financial horse in the race.

The experiences of two hospitals on opposite coasts exemplify the problem. Olympic Medical Center in Port Angeles, Wash., is undergoing an audit of a very common lab test — complete blood count (CBC) — by its fiscal intermediary (FI), Noridian Administrative Services *(RMC 3/23/09, p. 1)*. Though Olympic had physician requisitions with diagnosis codes to justify the medical necessity of the tests, Noridian denied 16 of 41 claims, says Compliance Officer Mic Sager. The requisitions were signed by the physicians, but Noridian went back to the physicians' medical records to examine the supporting documentation for the CBCs (CPT code 85025). Ultimately, the FI was not satisfied with the physicians' reasons for ordering the tests and/or couldn't locate adequate documentation for more than a third of the tests, he says. So now the hospital, which performs tests whenever physicians order them, loses its reimbursement even

continued on p. 7

Six Steps that Can Be Taken to Reduce Serious New False Claims Risks Under Stark

Hospitals play with fire if they fail to perform Stark reviews, especially if it turns out financial arrangements with physicians are noncompliant and they owe money to CMS. Hospital payments to physicians that fall outside a Stark exception snowball over time because CMS contends that all reimbursement stemming from that physician referral to the hospital must be returned.

The new Fraud Enforcement and Recovery Act (FERA) compound these problems, since hospitals are at greater risk of a False Claims Act lawsuit for knowingly and improperly retaining money that belongs to the government *(RMC 5/25/09, p. 1)*

"People may want to skip a review and avoid telling the board [about potential Stark problems], but with the False Claims Act I and II, deciding not to investigate your Stark compliance could be to your detriment," says South Bend, Ind., attorney Bob Wade, with Baker & Daniels. "In a typical hospital, you will find 200 to 500 financial relationships and nonmonetary compensation relationships that must meet Stark and it is a paper chase trying to determine when they begin, end and are modified. If you believe violations occurred, you need to figure out how so you can put in process changes to prevent violations from occurring again."

The Stark self-referral law bans Medicare payments for "designated health services" (DHS) referred by physicians who have a compensation or investment relationship with an entity providing DHS, unless an exception applies. When a physician refers patients for

services to such an entity without meeting an exception — which is known as a self-referral — the DHS entity may face fines and penalties in addition to repaying reimbursement from the referrals.

Wade cautions hospitals to avoid old patterns of thinking that a Stark review is strictly the domain of the legal and compliance departments; it's more a "marriage" of legal, compliance and finance. "In hospitals, it is challenging to make sure payroll or financial departments are in lockstep with legal departments," he says. "You will find financial arrangements where payments being made are not consistent with written agreements." For example, management might end an administrative relationship with a physician, but no one tells payroll, so checks keep rolling out to the physician. "Convince people in finance they need to be part of this even if it is perceived as more of a legal and compliance review," Wade says.

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

Copyright © 2009 by Atlantic Information Services, Inc. All rights reserved. No part of this publication may be reproduced or transmitted by any means, electronic or mechanical, including photocopy, FAX or electronic delivery without the prior written permission of the publisher.

Report on Medicare Compliance is published with the understanding that the publisher is not engaged in rendering legal, accounting or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought.

Managing Editor, Nina Youngstrom; Associate Editor, Eve Collins; 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.

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

To order **Report on Medicare Compliance:**

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

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

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

	Introductory Discount Price:
Payment Enclosed*	❑ $468
Bill Me	❑ $498

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

Subscribers to *RMC* are eligible to receive up to 12 Continuing Education Credits per year, which count toward certification by the Compliance Certification Board. For more information, contact CCB at 888-580-8373.

Call 800-521-4323 (or visit the Marketplace at www.AISHealth.com) to order ***Report on Medicare Compliance on CD***, a searchable CD with all issues of the newsletter published from January 2007 through December 2008. ($89 for subscribers; $389 for non-subscribers.)

Also, the earlier violations are caught, the better, since "a small financial Stark violation can result in a significant overpayment return," he says. Suppose a hospital pays a cardiovascular surgeon an hourly rate to serve as medical director, with a cap of $10,000 a year. The compensation maxed out three years ago, so all referrals received from that physician starting when the cap was exceeded are subject to repayment by the hospital.

Conducting Effective Stark Reviews

Here are Wade's tips for conducting a Stark review:

(1) Get information from the finance department on all hospital payments to and from physicians. Then find the contracts that support payments for all your arrangements.

(2) Review each contract to determine whether Stark applies. Not every contract triggers Stark. If Stark is implicated, audit the contract to determine whether each component is consistent with a Stark exception. "A primary issue is to determine that payments made to the physician are consistent with the contract," Wade says. For example, did the hospital pay Dr. Smith $100,000 last year for serving as a medical director even though on paper the payment was set at $50,000?

(3) Audit for documentation of fair-market value, the magic words in Stark compliance. If the payment is questionable, redo the fair-market analysis. "It's inevitable you'll find some financial arrangements that don't conform to fair-market value," Wade says. If that's the case, consider returning the overpayment stemming from the Stark noncompliance to your fiscal intermediary — "or the U.S. attorney if you have a friendly relationship."

(4) Don't neglect to audit nonmonetary compensation to physicians, such as gifts and benefits (e.g., football tickets). Stark caps the amount a DHS entity can give a referring physician annually (the current amount is $355). This is a big challenge and probably "where you will see the most violations," Wade says. The reason: Most hospitals don't have a "regimented way" to track gifts and benefits to physicians. "It's not a big issue in their eyes," he says. "It's cumbersome to make people aware of these, and it's counterintuitive to have to document and track them. Only people who are very Stark sensitive will appreciate this."

(5) Calculate potential repayments carefully so they only include DHS services. For example, if a hospital owns a nursing home and the physician self-refers patients for nursing home services, the hospital doesn't have to repay Medicare for these services because they are not on the DHS list.

(6) Share the findings of the Stark review with the compliance committee and board of directors.

EDITORIAL ADVISORY BOARD: ***TONY CAPULLO***, Professional Provider Services, ***PAUL R. DeMURO***, Esq., CPA, MBA, Latham & Watkins, ***EDWARD GAINES***, Esq., Healthcare Business Resources, ***DEBI HINSON***, Corporate VP and Chief Compliance Officer for Regency Hospital Company in Alpharetta, GA, ***MARION KRUSE,*** FTI Healthcare, ***WALTER METZ***, CPA, MS, JD, Brookhaven Memorial Hospital Medical Center, ***DAVID B. ORBUCH***, Allina Hospitals & Clinics, Minneapolis, ***MARK PASTIN***, PhD, Council of Ethical Organizations, ***ANDREW RUSKIN***, Esq., Morgan, Lewis & Bockius LLP, ***L. STEPHAN VINCZE***, TAP Pharmaceutical Products Inc., ***BOB WADE***, Esq., Baker & Daniels, ***D. McCARTY THORNTON***, Esq., Sonnenschein Nath & Rosenthal, ***JULIE E. CHICOINE***, JD, RN, CPC, Compliance Director, Ohio State University Medical Center, ***WENDY TROUT***, CPA, Director Corporate Compliance, WellSpan Health

Wade has provided *RMC* readers with two useful Stark compliance tools, which appear below and on p. 4.

Contact Wade at bob.wade@bakerd.com. ✧

ICD-10 Will Reduce Payment Errors And Denials, but Help Feds Also

Payment errors should be reduced significantly under ICD-10 diagnosis and procedure codes, which must be implemented by Oct. 1, 2013. Experts say that improvements over ICD-9 — including less ambiguity, more specificity, standardized terminology and combination codes — will help hospitals improve their compliance. But at the same time, fraud investigators may also benefit from ICD-10 when it's deployed with electronic anti-fraud tools.

"This is a boon for compliance," said Rita Scichilone, director of practice leadership at the American Health Information Management Assn. (AHIMA). With 35% of overpayments identified during the recovery audit contractor (RAC) pilot related to coding errors, the new system could have a huge ripple effect, Scichilone said at a June 9 audioconference sponsored by the Health Care Compliance Assn.

The effective date of ICD-10 — which includes ICD-10-CM diagnosis codes for all settings and ICD-10-PCS procedure codes for hospital inpatients — can't come soon enough, said Sue Bowman, director of coding policy and compliance at AHIMA, who also spoke at the audioconference. ICD-9 is running out of space for codes, its terminology is obsolete and it's unable to keep up with advances in technology, she said.

According to Bowman and Scichilone, the many benefits of ICD-10 include:

- ***Preventing and detecting health fraud and abuse;***
- ***Measuring quality and effectiveness;***
- ***Monitoring resource use;*** and
- ***Improving clinical, financial and administrative performance*** and systems for payment and claims processing.

"This mandate affects all facets of health care and provides the greatest opportunity for a new compliance environment," Bowman says.

To ensure ICD-10 can accommodate the current, more complex needs of the contemporary and future health care environments, its codes have three to seven alphanumeric characters, in place of ICD-9's three to five, according to Bowman. But the transition to ICD-10 won't spell an end to CPT and HCPCS codes, which will still be necessary.

Bowman described four ways that hospitals should be able to improve their coding selections with ICD-10, which means more accurate claims submissions and fewer claims denials:

(1) ICD-10 eases the reimbursement and compliance problems of combination codes. When patients now pres-

Contract Review for Stark Compliance

When reviewing hospital-physician contracts, it is important to determine whether they contain the elements that qualify them for a Stark exception. Meeting a Stark exception is essential for Stark compliance, says South Bend, Ind., attorney Bob Wade, with Baker & Daniels. Contact him at bob.wade@bakerd.com.

Contract Type:	4-Employment (Clinical)	8-Independent Contractor (Teaching)
1-Lease in medical office building	5-Employment (Teaching)	9-Hospital Based Group
2-Lease other than medical office building	6-Independent Contractor (Medical Administration)	10-Physician Recruitment
3-Employment (Medical Administration)	7-Independent Contractor (Clinical)	11-Other (Please Specify)

Contracting parties: [Name] Hospital & _____, M.D.

Issue	File Complete	Reviewer Comments
Executed copy and all amendments		***Agreement Name:*** ***Term:***
Fair-market value (FMV) documentation supporting arrangement		***Compensation:*** ***Time:*** ***FMV Justification:***
Meeting minutes with discussion and approval		***Committee minutes:***
List of payments to and from party		***Aggregate Amounts:*** ***2007:*** ***2008:***
Legal review		
Timesheets submitted		
Productivity data		
Additional comments		

Go to www.AISHealth.com to sign up for FREE e-mail newsletters —
AIS's Health Business Daily *and* Government News of the Week.

ent at the hospital, the physician has to determine the chief complaint that occasioned the admission (known as the principal diagnosis), and the coder codes accordingly. The principal diagnosis drives the MS-DRG assignment. But it's often unclear which of multiple conditions is principal and which should be coded as secondary diagnoses; there is often temptation to select the condition that will group to the highest-paying DRG, which is a compliance hazard.

Combination codes are used in ICD-10-CM to represent multiple conditions in a single code, whereas ICD-9-CM would provide separate codes for each condition, Bowman says. "It eliminates the need to wrestle with sequencing," which is the term for putting codes in order of importance (i.e., principal, secondary), Bowman says. With combination codes under ICD-10, "there's no judgment call on what is the principal diagnosis." Suppose the patient has angina, artherosclotic heart disease and surgery for a heart condition. At present, both conditions would be treated and it would normally be a struggle to figure out which is the principal diagnosis that occasioned the admission. But with ICD-10, artherosclotic heart disease with angina is a single code.

(2) ICD-10-CM provides clearer instructional notes than ICD-9-CM, thereby improving coding accuracy. For example, standard definitions have been added for two types of "excludes notes," she says. A note under a code that is identified as Excludes 1 means the code being excluded should never appear with the code it is excluded from. "A note identified as Excludes 2 means that the excluded condition is not part of the condition represented by the code where the note appears, but it is acceptable to report both codes together if the patient happens to have both conditions," Bowman says. In contrast, ICD-9-CM doesn't distinguish different types of excludes notes, so it's often hard to determine how the note should be interpreted, which can lead to coding errors.

(3) ICD-9 is vague and nonspecific compared to ICD-10, according to Bowman, leaving too much room for error in describing what procedures were performed.

Stark Document Review Checklist

These are the types of contracts that must be subjected to Stark review and the elements that must be reviewed, according to Bob Wade, an attorney with Baker & Daniels in South Bend, Ind. Contact Wade at bob.wade.bakerd.com.

The following is a list of documents that are required to be copied and assembled in the order as they appear on this checklist. The documents will be reviewed by _____, the law firm serving as the Independent Review Organization for [Name] Hospital. If the document is located and copied, place a "✓" before the description of the document. If the document is either not applicable, or could not be located, insert "N/A" in the space before the document description.

Contract Party: _____

Contract Type:

__ Leases in medical office building (MOB)
__ Employment — Medical Administration
__ Employment — Teaching
__ Independent Contractor — Clinical
__ Physician Recruitment
__ Other
__ Leases — other than MOB
__ Employment — Clinical
__ Independent Contractor — Medical Administration
__ Independent Contractor — Teaching
__ Hospital-Based Group

	List and Description of Documents
	Executed copy of contract and all amendments.
	Fair-market value documentation supporting the financial arrangement in the contract.
	Minutes of meeting where contract was discussed and approved.
	List of all payments made to and from contract party related to the contract.
	Legal review of contract (both internal and external).
	Time sheets submitted by contract party.
	Productivity data if any portion of compensation is based upon productivity.
	The following documents apply only to recruitment arrangements:
	Community need analysis
	For income guarantees, financial documentation relied upon for payment of income guarantee, including incremental expenses.
	Documentation relied upon supporting the reasonableness of amount of income guarantee or forgivable loan.
	If contract does not specify, state where physician moved from, and when: Relocated from: _____ City State Date physician relocated: _____

If you have any questions or comments regarding the assembly of the documentation, contact _____.

Visit www.AISHealth.com/conflist.html to review a free, regularly updated six-month calendar with dozens of *Upcoming Health Business Meetings*.

ICD-10 codes are much more specific. For example, ICD-9 was implemented in 1979, when a scalpel was the only way to perform surgery. ICD-10 codes are written to reflect whether the procedure required a scalpel, needle or scope. Because the code itself tells the story, there is little room for error, Bowman says.

(4) Because ICD-10-CM diagnosis codes contain so much detail, there should be less room for queries, which are the forms hospital coders use to get clarification and additional information from physicians (usually when coding MS-DRGs). The fewer queries used, the less chance a mistake will be made when translating physician documentation into a DRG assignment.

ICD-10 to Help the Feds and Coders Alike

The government also will become more powerful in its anti-fraud efforts. In a new report, the Office of the National Coordinator for Health Information Technology (ONCHIT) says that shifting to ICD-10, which is essential to adoption of electronic medical records, will help promote the use of information technology that has become a core part of health fraud "management programs."

ICD-10 also allows coders to be more productive without sacrificing integrity and accuracy. Consider the different approaches to coding the same procedure:

◆ ***ICD-10-PCD code 0270346 is dilation of coronary artery***, one site, bifurcation, with drug-eluting intraluminal device, percutaneous approach.

◆ ***To arrive at the same procedure using ICD-9-CM takes five codes:*** 00.66 (percutaneous transluminal coronary angioplasty or coronary atherectomy); 00.40 (procedure on single vessel); 00.45 (insertion of one vascular stent); 36.07 (insertion of drug-eluting coronary artery stent (2); and 00.44 (procedure on vessel bifurcation).

Bowman also dispelled two myths about ICD-10:

(1) It's a myth that ICD-10 implementation can wait until electronic medical records (EMRs) are in place. "Everyone is focused on electronic medical records and health reform and they [think they] don't have time for ICD-10. The message we are trying to convey is that ICD-10 is not a separate project. It is part of these other projects," Bowman says. "You won't have better data coming out of EMR if you're still using ICD-9." The longer the wait, the higher the price tag. It's more expensive to implement a new coding system in an EMR system because of the need for systems and application upgrades, she says.

(2) Another myth is that ICD-10 demands more medical-record documentation. On the contrary, Bowman says. Though specificity is a hallmark of ICD-10, it still has unspecified codes available when documentation doesn't support a more specific code.

Contact Bowman at sue.bowman@ahima.org. ✧

With Fewer Errors in Reported Data, P4P Programs Are 'Wave of Future'

Errors in reporting data to CMS have hampered the Physician Quality Reporting Initiative (PQRI), which pays bonuses to physicians for reporting certain quality measures. But CMS has worked out the kinks and it's now running more smoothly, the top PQRI official tells *RMC*.

"There is a learning curve for CMS because it's a new system and there are some things we didn't anticipate," says Michael Rapp, M.D., director of the quality measurement and health assessment group in the CMS Office of Clinical Standards and Quality.

CMS kicked off PQRI, a voluntary program, in 2007, and has expanded the number of quality measures every year. Physicians in hospitals and private practices are eligible for a maximum 2% bonus of all their Medicare fee-for-service reimbursement for every year they report on the quality criteria for 80% or more of their patients in compliance with CMS criteria.

Adapting to P4P Is Essential

Adapting to pay-for-performance programs like PQRI is essential because they are the wave of the future, says Susan Theuns, administrative director of physician practices at Union Memorial Hospital in Baltimore. CMS has multiple versions of pay-for-performance in place and under consideration, including PQRI, the Hospital Quality Initiative, and the National Coverage Determination for three (surgical) never events and hospital-acquired conditions. And value-based purchasing is not too far down the road. All link payment to quality and compliance. "It's inevitable because CMS keeps looking at cutting reimbursement," says Theuns, who implemented PQRI for physicians at Union Memorial Hospital in 2007 and paved the way for others throughout her parent company, MedStar Health. Union Memorial earned 16% above the national average for groups with their PQRI bonus in 2007.

For the 2009 version of PQRI, physicians report on 153 quality measures and seven measure groups. For example, they report on diabetic patients' hemoglobin A1c test scores (which monitor blood glucose) and the number of patients that received aspirin when presenting with a heart attack at an emergency room. Other measures include screening for osteoporosis, mammography and colorectal cancer; advising smokers to quit; and flu and pneumonia vaccinations.

When CMS first set up the program, it instructed physicians to use claims to report their findings (e.g., whether the patient has osteoporosis). "We fashioned G codes for this context," Rapp says. AMA also developed CPT II

Post your *Health Business Job Openings* at no charge at www.AISHealth.com/HealthJobsList.html.

codes, which mirror G codes, for quality data. "They are treated like billing codes and put on the claims, but they only tell about the quality process," he says. Then physicians submit claims with quality data codes in addition to procedure and diagnosis codes.

An unforeseen problem occurred, however, Rapp says. Sometimes physicians or their employers used claims-processing vendors to prepare claims, and some of them would split the claims and put billing data on one claim and quality data code on another. "We had a requirement saying you have to report quality data code with the

Consolidated Worksheet for Physician Quality Reporting Initiative

Susan Theuns, administrative director of physician practices at Union Memorial Hospital (part of MedStar Health) in Baltimore, developed this encounter form for services for the Physician Quality Reporting Initiative (PQRI). She condensed 24 CMS worksheets into one concise form, thus making participation in PQRI more appealing and user-friendly. Contact Theuns at susan.theuns@medstar.net.

Patient Name: _____Date of Birth: _____ Date of Service: _____

(110) Influenza vaccine for patients ≥ 50 years old during flu season (September – February)
- ☐ **G8482:** Flu vaccine ordered or administered; or
- ☐ **G8483:** Flu vaccine not ordered or administered for reasons not documented by clinician; or
- ☐ **G8484:** Flu vaccine not ordered or administered, reason not specified.

(111) Patients 65 YO+ who have ever received a Pneumonia Vaccine
- ☐ **4040F:** Pneumonia vaccine administered or previously received.

Check any modifier that applies to the above codes (measure not performed):
- __ **1P:** Not performed for medical reasons.
- __ **8P:** Not performed, reason not specified.

(112) Screening mammography within the last 24 months in women aged 40-69
- ☐ **3014F:** screening mammogram results documented and reviewed.

Check any modifier that applies to the above codes (measure not performed):
- __ **1P:** Not performed for medical reasons, e.g., bilateral mastectomies.
- __ **8P:** Not documented and reviewed, reason not otherwise specified.

(113) Colorectal cancer screening: (1) FOBT during reporting period, (2) flexible sigmoidoscopy within four years, (3) double contrast BE within four years, or (4) colonoscopy within nine years.
- ☐ **3017F:** Colorectal cancer screen results documented and reviewed.

Check any modifier that applies to the above codes (measure not performed):
- __ **1P:** Not performed for medical reasons.
- __ **8P:** Not performed, not o/w specified.

(39) Screening or Tx for Osteoporosis, women 65+

Choose one:
- ☐ **G8399:** Dual-energy X-ray absorptiometry (DXA) results documented, DXA ordered or pharmaceutical prescribed;
- ☐ **G8401:** Not eligible; or
- ☐ **G8400:** DXA not ordered, not performed and/or no pharmaceutical prescribed.

(114) Inquiry Regarding Tobacco Use age 18+
- ☐ **1000F:** Tobacco use assessed; AND
- ☐ **1034F:** Current tobacco smoker;
- ☐ **1035F:** Smokeless user;
- ☐ **1036F:** Non-user; or
- ☐ **1000F & 8P:** Tobacco use not assessed.

(115) Advising Tobacco Smokers to Quit age 18+
- ☐ **G8455:** Current tobacco smoker; AND
- ☐ **4000F:** Use cessation intervention/counseling**;**
- ☐ **4001F:** Use cessation intervention/pharmaceutical therapy.

(128) Body Mass Index (BMI) Screening & Follow-Up Plan Documented age 18+
- ☐ **G8420:** Normal BMI;
- ☐ **G8417:** Upper parameter BMI;
- ☐ **G8418:** Below normal;
- ☐ **G8422:** Not eligible (refuses, terminal illness etc.);
- ☐ **G8421:** BMI not performed; or
- ☐ **G8419:** +/- normal with no follow-up plan documented.

Subscribers to *RMC* are eligible to receive up to 12 Continuing Education Credits per year, which count toward certification by the Compliance Certification Board. For more information, contact CCB at 888-580-8373.

billing code," Rapp says. To remedy this, CMS has put in place a mechanism to rejoin split claims.

Another snag arose, he says. Normally, when physicians bill for a procedure, they must identify the diagnosis prompting the procedure. CMS dubs this a "diagnosis pointer," and it's required for quality data codes as well. "Some measures have more than one diagnosis so you can't point to just one diagnosis" Rapp says. CMS has now fixed this data analysis problem, by considering all diagnoses on the claim, not just the one pointed to for the particular G code or CPT code.

"But the biggest reason for quality data not being submitted accurately was that the codes reported did not apply to the patients in terms of the measure," Rapp says. For example, physicians would report a diabetes measure for patients with no diabetes diagnosis. Or physicians would report measures for patients older than 75 when the age limit is 75. Physicians didn't get credit for these errors. "The main point we had to get across was that the measures apply by age, gender and correct diagnosis, and through that education and modified analytics, the percentage of valid quality data codes has gone up substantially," Rapp says.

To improve reporting, CMS in 2009 has since added a registry method, which allows physicians and their hospital-employers to engage registries to organize and submit the data on their behalf. There are 31 registries doing this work, organized by medical specialty, Rapp says. Down the road, CMS may get the data directly from electronic health records.

To ensure reporting is accurate, MedStar's corporate compliance department includes PQRI codes in its chart reviews. Auditors assess documentation that supports the PQRI codes to confirm and hold "feedback sessions" to discuss whether the codes are a good choice for CMS reporting, Theuns says.

Consistency Is Essential

When physicians decide to participate in PQRI, they must do it whole hog. "They need to be consistent and continue to report through the reporting period," Theuns says. It's useless to report diligently for four months and then slack off for two months because no money will be forthcoming. Similarly, physicians must report at least three measures in a particular cluster in order to get credit. Again, CMS will void the reporting if only two out of three requirements of diabetes measures, for example, are reported.

But Theuns says there have been some frustrations. For one thing, CMS's quality reporting measure sheets have been burdensome. Expecting physicians to wade through so much material is unrealistic, she says. To

Lab Test Denials Can Be Costly

continued from p. 1

though the requisition met Medicare requirements. "We are being penalized for a physician's behavior even though we followed a signed order with good diagnoses," Sager says. "Hospitals should be able to rely on signed physician orders that have appropriate diagnoses on them."

Noridian denied one of the claims because the patient was asymptomatic. While Medicare clearly doesn't cover CBCs for asymptomatic patients, the hospital didn't know from the physician order that the patient was asymptomatic, Sager says. Again, there is a disconnect between the actions of the physician and the financial consequences for the hospital, he says. "I would like Medicare to tell us how we are to determine the symptomology in conflict with a physician's order." In this case, there were no clues the patient was asymptomatic. She has coronary artery disease, hyperlipidemia, hypertension, memory dysfunction with a history of cerebrovascular accident and a history of atrial fibrillation and peripheral artery disease. However, at the moment the physician ordered the CBC, Sager later learned, the patient was "doing fine." Because the physician didn't mention on the order that the patient was asymptomatic, the hospital billed for the test. If it had known she lacked symptoms, the hospital would have given the patient an advance beneficiary notice (ABN), which explains that Medicare doesn't consider the service medically necessary and therefore the buck literally stops with her.

Hospital Gets Mixed Messages from Contractors

"Noridian is technically correct" in denying payment for the asymptomatic patient's test, "but what I think is wrong in the way CMS runs the show is that the hospital loses money in a case like this where we follow what's in the outpatient order," Sager says.

Noridian has put Olympic on "provider on review" status for 3% of its CBCs. That means Olympic won't be paid for the blood tests until it submits corroborating documentation so Noridian can audit the claims. Sager says this prepayment condition will eat up 10 to 12 hours of hospital staff time per week.

In Florida, the compliance manager of a hospital has been going back-and-forth with its FI and the CMS Comprehensive Error Rate Testing (CERT) contractor, a major program-integrity player, over the use of its requisitions. The CERT contractor found a high error rate for outpatient diagnostic and lab tests, says the hospital's compliance manager, who declined to be identified.

The FI and CERT told the hospital that its requisitions are not adequate as physician orders. The compliance manager finds this odd. For one thing, "requisitions are time-honored," she says. They contain all the necessary information — patient name, tests requested and diag-

Call 800-521-4323 or visit the MarketPlace at www.AISHealth.com for more information on AIS's comprehensive services,
High-Risk Areas in Medicare Billing *and* **A Guide to Complying With Stark Physician Self-Referral Rules.**

nosis codes. The hospital lab director told the compliance manager that Medicare has never before had a problem with the requisition. "Only recently has she gotten a letter saying [the FI] has to have the order from the physician, including the prescription pad with the code or narrative," the compliance manager says. Essentially, the FI is demanding a signed order, though Medicare says orders don't have to be signed. Once again, the burden is falling on the hospital to prove to Medicare the test is medically necessary beyond the information provided on a requisition from the physician.

But the FI and CERT are still being vague about their intentions. "We're waiting for clarification of exactly what documentation the CERT wants," she says.

Unsigned requisitions might be the cause of problems for some hospitals, says San Francisco attorney Judy Waltz, with the law firm Foley & Lardner LLP. "A lot of people interchange requisitions and orders, but somewhere you need a physician's signature or [electronic] equivalent to qualify it as an order and show medical necessity," she says. "My question is: Is the requisition a physician order? There doesn't have to be a formal order — you can take it from the physician's office notes as long as the physician intended the test to be ordered and [it says] why," she explains. "If the physician states 'get a CBC for anemia' and scrawls his name at the bottom, that would count as an order. But if you just have a requisition with no signature," there must be other backup — a signed order or progress notes or something "to prove the physician did it personally," Waltz says.

Contact Sager at msager@olympicmedical.org and Waltz at jwaltz@foley.com. ✧

NEWS BRIEFS

◆ **The HHS Office of Inspector General expects recoveries from fighting fraud, waste and abuse to total more than $2.4 billion for the first half of fiscal year (FY) 2009,** OIG says in its Semiannual Report to Congress. Funds recovered between October 2008 and March 2009 include $274.8 million in audit-related receivables and $2.2 billion from investigations (including about $552 million that goes to the states), OIG says. More than 1,400 individuals and organizations were excluded in the first half of FY 2009 for fraud and abuse involving federal health care programs. There were 293 criminal actions against individuals or organizations and 243 civil actions (including False Claims Act suits, Civil Monetary Penalty Law settlements and administrative recoveries from self-disclosures). Read the report at http://oig.hhs.gov/publications/docs/semiannual/2009/semiannual_spring2009.pdf.

◆ **A physician with ownership interests in several orthopedic practices has agreed to pay $3.5 million to settle allegations that he and others submitted false claims to Medicare and other federal programs,** the U.S. Attorney's Office for the Western District of Oklahoma said June 8. The feds allege that Houshang Seradge, M.D., five practices in which he had an ownership stake and five employees (including another physician) billed for procedures that (1) were not performed, (2) were not performed by a doctor, or (3) were not performed with the required physician oversight, among other things. The case was originally filed by three former employees of the practices, and the government intervened in March 2007, court documents show. The feds allege that the defendants were all notified by other employees that false or fraudulent billings were taking place, but no action to correct or stop the conduct was taken. "Settling the case was a business decision and in the best interest of the practice and the patients," an attorney for one of the practices says in a statement. Contact the U.S. Attorney's Office at (405) 553-8700.

◆ **The University of Medicine and Dentistry of New Jersey (UMDNJ) will pay $2 million to resolve civil fraud allegations that the hospital it owns double billed Medicaid,** the Department of Justice (DOJ) said June 9. University Hospital allegedly submitted Medicaid claims for outpatient services that also were billed by doctors working in outpatient centers, DOJ says. The case originated as a whistleblower lawsuit filed in 2005 by a physician. The feds filed a criminal complaint against UMDNJ in late 2005, but then entered a "deferred prosecution agreement" under which the school allowed a federal monitor to enforce and secure compliance there for 24 to 36 months *(RMC 1/9/06, p. 8)*. The criminal complaint was dismissed in December 2007. UMDNJ previously paid $4.9 million to New Jersey and the federal government. The additional $2 million will cover outstanding civil False Claims Act allegations, DOJ explains. "This settlement agreement relates to inappropriate actions and poor management decisions made during a period between 1993 and 2004," UMDNJ says in a statement. "Our new leadership team has diligently implemented numerous reforms that reflect the university's full commitment to exemplary corporate citizenship, corporate governance and the highest principles of integrity and professionalism," it adds. Visit www.usdoj.gov.

Call Bailey Sterrett at 202-775-9008, ext. 3034 for rates on bulk subscriptions or site licenses, electronic delivery to multiple readers, and customized feeds of selective news and data…daily, weekly or whenever you need it.

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

1. Return to any Web page that linked you to this issue

2. Go to the MarketPlace at **www.AISHealth.com** and click on "newsletters."

3. Call Customer Service at 800-521-4323

If You Are a Subscriber And Want to Routinely Forward this PDF Edition of the Newsletter to Others in Your Organization:

Call Customer Service at **800-521-4323** to discuss AIS's very reasonable rates for your on-site distribution of each issue. (Please don't forward these PDF editions without prior authorization from AIS, since strict copyright restrictions apply.)