

MEDICARE COMPLIANCE

Weekly News and Compliance Strategies on CMS/OIG Regulations, Enforcement Actions and Audits

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CCOs Evaluate Compliance From Many Angles; 'Everything Old Is New Again'

Before Dignity Health in California implemented secure texting for physicians to use with their clinical teams, the application was evaluated by the privacy officer and passed through other security checkpoints. Then Margaret Hambleton, vice president and chief compliance officer, reminded her department to consider the free texting program from a Stark law perspective. "If we're offering them something in private practice, it is nonmonetary compensation," she says, which means the hospital is limited to \$392 per physician, per year. "We did a fair-market-value analysis and determined the annual value of the secure texting application was \$60 per physician." That amount was attributed to every physician who received secure texting on the Dignity Health nonmonetary compensation log, Hambleton says. All were safely within the cap. But the compliance questions did not end there. For example, how would Dignity Health ensure secure texting did not substitute for appropriate documentation?

The many compliance dimensions of decisions that health systems make illustrate the challenges of the environment, for both the compliance team and the people in operations who are responsible for carrying them out. Thinking them through and training employees to recognize them can be demanding because there is so much ground to cover.

"It's hard for people to look at things with a broader lens," says Hambleton.

With all the compliance tentacles, she advises her team to walk through five "considerations" when looking at a problem or proposal:

(1) "Are we providing anything of value to a physician, a physician's family member or other potential referral source?"

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Some Hospitals Lose Big Bucks to Revenue Code 270 Adjustments by Private Payers

Money may be slipping through hospital hands when commercial payers adjust payments for certain room and board charges, consultants say. Payers are denying charges for "minor medical and surgical supplies" — which are included in room and board charges — even when they don't actually fall into that category. With losses piling up, hospitals may want to nip this practice in the bud instead of accepting the fraction of money they get back years later at mediation, the consultants advise.

"You need to vigorously defend your charges" in this area, which centers on revenue code 270, said Chris Baggott, president of Medlinks Inc., at a Finally Friday webinar sponsored by the Appeal Academy Sept. 18.

He is seeing commercial payers go after an aspect of room and board charges in a way he finds disconcerting. Medicare addresses room and board charges — a colloquialism for routine inpatient services — in its *Provider Reimbursement Manual*. Sec. 2202.6 states that "Inpatient routine services in a hospital or skilled nursing facility generally

are those services included by the provider in a daily service charge — sometimes referred to as the ‘room and board’ charge. Routine services are composed of two board components; (1) general routine services, and (2) special care units (SCU’s), including coronary care units (CCU’s) and intensive care Units (ICU’s). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.”

Baggott contended that commercial payers — which he said use Medicare rules as guidelines — have seized on the concept of “minor medical and surgical supplies” to deny hospitals millions of dollars of reimbursement. The vehicle for this is revenue code 270, which is used to report medical/surgical supplies on Medicare and other claims. Private payers “are sweeping that entire revenue code and subcategories into a pile and saying these are all part of room and board,” which means they should not be charged separately, Baggott said. “It’s a revenue code 270 issue at its heart.”

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Suppose a diabetic patient is admitted to the hospital for a foot wound that won’t heal. The patient is taken to the operating room for a debridement, and in the days after, the wound is repeatedly cleaned and dressings changed. The commercial payer reimburses the hospital for the IV antibiotics, but it refuses to pay for IV supplies and bandages. “They are defining this as minor medical supplies that are bundled into room and board,” said Baggott. The payers are relying on the *Provider Reimbursement Manual’s* reference to minor medical supplies, but “IVs and associated IV supplies are not ‘minor’ medical supplies. Bandages are not ‘minor’ medical supplies.” Of course Band-Aids are minor medical supplies, and hospitals should not charge payers for them. But to roll the other items into room and board “is ridiculous,” Baggott said.

He called that a “gross misinterpretation” of the rule. “It’s meant to suck you into mediation two years from now,” where the hospital’s contracting and legal teams will sit across from the payer representatives, negotiating for much less money than the hospital is entitled to, he contended.

There are several payers sweeping charges for medical supplies into routine room and board, Baggott said. “We have seen this done *en masse*.” He called it a contracting issue and cautioned hospitals that the longer they let it go, “the harder it will be to unravel.”

Strategies to Minimize Losses

Here are Baggott’s strategies for preventing revenue code 270 payment adjustments and similar problems with commercial payers:

◆ **“Unsilence” your facility.** The 270 sweep “will come up as a denial, and your business folks will see it,” he said. “This department should not sit alone” and deal with the payers as if sweeping in medical supplies to room and board charges was a routine payment adjustment. “Suggest to people up the chain [that] it would be great to have the audit committee meet quarterly and talk about denials and what’s going on in contracting,” Baggott said. People from the C-suite should be there; “bring issues forthrightly onto the table and bring out a plan of action,” he suggested. “It’s a rare facility that, at contract negotiation time, asks its auditing department, ‘is there anything you want to add? Can we listen to issues that might be important to you?’”

◆ **Break down the walls between the people who manage denials from recovery audit contractors and the people who handle commercial-payer denials,** Baggott suggested. “Anything that is a review of medical records and results in a refund is an audit,” he said. “Are you talking at all? Are you tracking, doing data analytics and coming together as a facility and saying, ‘what are my audit

losses, what are my denials, my coding — [both] my DRGs and my commercial? Are you vigorously trying to protect your money? The way to do that is to bring your losses under one umbrella and talk about how those losses are occurring.”

◆ *Set parameters on commercial payer audit practices if possible.* When payers request medical records, hospitals tend to produce them at their own expense, he said. But Baggott recommended a different approach. “If it could result in recoupment, it is an audit. I think you can say, ‘if you want to review medical records, come to the facility and review them on site,’” he said. Payers are cooperating with this pushback; “it probably sounds out of the box for folks, but it is happening on a large scale,” Baggott said. “Maybe give them your audit policy that says, ‘we don’t release medical records. We will be happy to let you review the medical records, and here is how we do that.’”

◆ *Ensure the coding department stays on top of changes to revenue codes and connects them to different hospital departments,* Robert Chacon, a Medlinks project manager, said at the webinar. “Contracts may need to be revised depending on what revenue codes encompass.”

◆ *Anticipate the potential to lose money through medical supplies at the time you negotiate your contract,* said Sharon Easterling, president of Recovery Analytics in Charlotte, N.C. “This is something you should be thinking about at the time you write your contract...so you never have to face the argument [that] you should have to pay for these things because it’s rare the payer will give in on appeal,” she said.

Downside to Taking on Payers?

Challenging payers on specific claims is worth a shot, but the more money that’s at stake, the more resistance hospitals will face, said Ernie de los Santos, president of the Appeal Academy. “If they let you ‘win’ on any substantial volume of dollars in a year, watch for the payer to try to cut that much and more from your overall contract in the next round of negotiations. Your contracting team should at least be aware of this, whether they can fight it or not,” he said.

De los Santos has heard some hospitals fold supplies into room and board charges rather than argue with payers. “While that might seem easier and expedient, it is improper, as it inflates general costs for everyone, not just the cases that in fact needed those supplies, such as anesthesia,” he noted.

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Hospice Settles FCA Case; Help From Compliance Is Brief Respite

A Georgia hospice company agreed to pay \$3 million to settle allegations it submitted false claims for services provided to patients who were not terminally ill, the U.S. Attorney’s Office for the Northern District of Georgia said Oct. 2. The settlement with Guardian Hospice of Georgia, LLC; Guardian Home Care Holdings, Inc.; and AccentCare, Inc. — collectively, Guardian — is the latest in a hospice crackdown by the Department of Justice (*RMC 9/14/15, p. 8; 9/7/15, p. 8; 2/16/15, p. 8*).

In an interesting twist to the situation, one of the whistleblowers who set the lawsuit in motion got the corporate compliance office to audit the allegedly improper charges, but the victory was short lived, according to the whistleblowers.

Medicare covers hospice for patients who are certified as terminally ill, which means they have a life expectancy of six months or less. Patients receive palliative, not curative, care for 90 days, and, if medically necessary, are recertified for 90 more days. Beyond that, they must be recertified as terminally ill every 60 days. Medicare pays a daily rate for hospice care at one of four levels: routine care, general inpatient care, continuous home care and inpatient respite care. Initially, patients must be certified as eligible for hospice care by the hospice medical director or a physician-member of its interdisciplinary treatment team and by the patient’s own physician, if they have one. After that, just one physician has to recertify eligibility.

According to the complaint (No. 12:CV-0412), Guardian management called the shots on admissions. “Management regularly ignores the nurses’ notes, patient records, and lab work, and instead fabricates information on the admission and recertification documents so that the medical director will admit or recertify ineligible patients,” the complaint alleged. As a result, “Guardian regularly admits patients who do not medically qualify for hospice care and that it knows or should know do not medically qualify for hospice care,” including patients with a diagnosis of adult failure to thrive.

continued

A Guide to Complying With Stark Physician Self-Referral Rules

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Guardian did not admit liability in the settlement, which addresses allegations it overcharged Medicare between Dec. 1, 2009, and March 31, 2012.

This and other false claims cases in recent years have hammered hospices for allegedly admitting and keeping hospice patients who didn't qualify for the benefit or for related services, such as inpatient care, while in hospice. But there is other trouble on the horizon for hospices, says attorney Paula Sanders, with Post & Schell in Harrisburg, Pa.

"They may be addressing the 180-day issue, but the next big hurdle for hospices is making sure they are in compliance with requirements about who is paying for medications and whether the medication is related to the patient's terminal condition," Sanders says. "We are starting to see new audit activity in this area."

The case against Guardian was filed by two former case managers turned whistleblowers, Jennifer Williams and Rose Betts. They describe how summaries of interdisciplinary team (IDT) meetings, which normally are penned by case managers, allegedly were written by Guardian management, "who often fabricates whatever information is needed to make the patients eligible for hospice care," the complaint alleged.

Auditor Allegedly Found Problems

Consequently, there allegedly were disparities between the patients' conditions as documented by the nurses who treat them and the IDT summaries used to support certifications. A number of the patients showed no decline, as required for hospice recertification. The whistleblowers mentioned the patients should be discharged, but a Guardian executive responded that the hospice needed to keep its census high, the complaint alleged.

For example, a lot of patients were admitted to Guardian with adult failure to thrive or debility, the complaint said. If they were properly diagnosed with debility, they wouldn't survive for more than a few weeks, but "numerous patients diagnosed with debility by Guardian have received well over a year of hospice care without any decline in health," alleged the complaint. One patient was admitted to Guardian with adult failure to thrive even though she was able to care for herself, was ambulatory and had a serum albumin level of 3.6 gm/dl, well above the 2.5 or less associated with adult failure to thrive. Guardian billed Medicare for hospice services provided to the patient from July 31, 2010, through March 27, 2011, which it shouldn't have done after the first month without a more specific diagnosis, according to the complaint.

Williams complained about the alleged fraud to the Guardian corporate compliance office in October

2011, and in response, the hospice company dispatched an independent auditor to review patient records and Medicare billing, the complaint said. The auditor allegedly concluded some Guardian patients were ineligible for Medicare hospice reimbursement and recommended their "live" discharge. When the auditor left, billing for hospice care of ineligible patients allegedly resumed.

Hospices Have Unique Compliance Challenges

Hospices have some unusual compliance challenges, Sanders notes. Eligibility is one of them. "It is not always scientifically possible to predict someone's life is going to end," she says. "The problem as a hospice operator is you think their disease is progressing, but what happens if they are still alive at the end of six months? What's troubling is the government's statements suggest that anyone who lives beyond a second benefit period is immediately suspect as being improper for hospice." Yet Medicare covers unlimited 60-day periods beyond 180 days, she notes.

To protect themselves, assuming patients truly qualify for hospice care, hospice providers have to double down on documentation of clinical conditions, Sanders says. There are two ways to accomplish this: (1) Document appropriately, and (2) document in accordance with the plan of care. For example, a progress note that simply says, "patient has no complaint of pain" does not necessarily distinguish between patients who are pain-free and patients who have no pain because their medication regimen is effective, she says. Ensure clinicians paint a picture of the services being provided, how they fit into the plan of care and what changes are recommended. "A lot of hospices are looking more carefully at educating physicians and nurses about the Medicare requirements because the scrutiny is greater," she says.

Drugs Are New Hospice Focus

Recognizing hospice is a target area, Sanders recommends providers review patients who have been receiving services for more than 180 days. Look at the average length of stay, but account for outliers, she suggests. Most patients die early in their hospice stays, and that can skew a hospice's average length of stay when, in fact, it has a lot of patients exceeding 180 days.

"It may look like you have an average of 45 days, so you need to break it out and really look at service patterns," says Sanders. Hospices can drill down with the Program for Evaluating Payment Patterns Electronic Report (PEPPER), CMS's free compliance monitoring tool, which recently became available for hospices (*RMC 2/9/15, p. 1*).

Looking ahead, Sanders says hospices have to focus on the way they bill for medication. "We are seeing increased intensity under Medicare and Medicaid.

Medicaid wants to make sure it's not being billed for medications" that hospices are already paid for as part of their daily payment. The same goes for Medicare. In March 2014, CMS issued final guidance on Part D payment for drugs for beneficiaries enrolled in hospice. CMS reiterates that "the hospice is responsible for covering all drugs or biologicals for the palliation and management of the terminal and related conditions." Part D covers certain drugs for hospice patients that are unrelated to the terminal illness, but only in "unusual and exceptional circumstances," the guidance notes. There's a prior-authorization process to sort all this out.

Cleveland attorney Alan Schabes, who represents Guardian, says that "we disagree with the assertions that were made, and we do not believe that, had this gone to a conclusion, the government would have been able to prove its case. But it was settled. We feel the whistleblower allegations are without basis in fact."

Contact Sanders at psanders@postschell.com. View the press release at <http://tinyurl.com/nm2xubh> and the CMS guidance at <http://tinyurl.com/opeg3xn>. ✧

OIG Says 'Information Blocking' Would Void EHR Safe Harbor

Health care organizations that interfere with the free flow of information through electronic health record (EHR) technology they donated to physicians risk losing the protection of a safe harbor that confers immunity from the anti-kickback law, the HHS Office of Inspector General (OIG) said in an Oct. 7 alert.

The alert warns the industry against "information blocking," which OIG said can defeat the advantages of EHRs. "If a donor, or someone on the donor's behalf, takes any action to limit or restrict the use, compatibility, or interoperability of the donated items or services with other electronic prescribing or EHR systems, the donation arrangement would not receive safe harbor protection and would be suspect under the Federal anti-kickback statute," IG Daniel Levinson said in a statement accompanying the alert.

Under the EHR safe harbor, hospitals and other donors are allowed to give physicians up to 85% of the cost of software and related information technology and training. Donated items must be necessary and used mostly to create, maintain, transmit or receive EHRs. Hospitals may donate EHR software, interface and translation software, secure messaging and patient portal software, and software with billing, patient administration and scheduling functions. Hardware is not protected by the safe harbor.

In the alert, OIG notes that it wants to promote the use of interoperable EHRs without their being an in-

strument to reward referrals for federal health program business. That's why the EHR safe harbor stipulates that donors, such as hospitals, don't make any moves that "limit or restrict the use, compatibility, or interoperability of the items or services with other electronic prescribing or [EHR] systems (including, but not limited to, health information technology applications, products, or services)" (42 CFR § 1001.952(y)(3)). If donors make it hard for physicians to use their EHRs to communicate with products from other vendors, the donors jeopardize their safe-harbor protection, and "the arrangement would be subject to case-by-case review under the Federal anti-kickback statute," the alert notes.

How could this play out? Maybe the hospital strikes a deal with the physicians not to use EHRs to interact with other hospitals. Also, the alert said, if there are arrangements where donors and EHR vendors agree that the vendors will charge high interface fees to physicians who didn't get EHR donations or to competitors, they may be out of safe-harbor luck.

For more information, read Levinson's statement at <http://go.usa.gov/3uHZx> and the OIG alert at <http://go.usa.gov/3uHWQ>. ✧

Assessing All Compliance Angles

continued from p. 1

- (2) "Does this require an exchange of protected health information (PHI)?"
- (3) "Are there any potential conflicts of interest among the parties?"
- (4) "Will this change how information is documented in the medical record, coded, billed or require a change to the charge description master?"
- (5) "Do we need to engage others in our evaluation (human resources, revenue cycle, patient safety, legal, etc.)?"

"It is a very simple checklist to make sure my compliance staff thinks more broadly about any issue that comes to them," Hambleton says.

There is some frustration among compliance experts about the gap between the legal and regulatory expectations of health care organizations and the limits on how much information compliance officers can impart/how much employees can absorb and put to use. There is also tension between the need to emphasize conventional compliance risk areas, such as coding and EMTALA, and to manage risk areas that emerge from innovative and sometimes aggressive business practices as health systems adapt to transformations in the industry. Some compliance officers still contend with business leaders who want to forge ahead with questionable practices, undeterred by the prospect of a whistleblower or FBI agent.

continued

“Everybody is busy and looking at new technologies and having to get there before the other person, and a lot of the philosophy has been, ‘I’ll get there and figure it out when I get there. If I make mistakes, I will ask [for] forgiveness,’” says one compliance officer who did not want to be identified. Maybe they could slip by a decade ago, before the government ramped up its data mining and prepayment audits. “But there’s no luxury of error now. Time is not on your side anymore,” she notes. Money

from errors must be refunded within 60 days under the Medicare overpayment rule, or “it goes from repayment to reverse false claims” (*RMC 10/5/15, p. 4; 8/10/15, p. 1*).

Even as hospitals and physician groups turn their attention to emerging perils, the long-time risk areas stick in their craw, and compliance officers have to hammer away at them. “Everything old is new again,” says Ed Gaines, chief compliance officer of the emergency medicine division of Zotec Partners, LLC. “The laws may have gotten more onerous and more exacting than they were 20 years ago,” but many of the issues and challenges remain.

This drives the anonymous compliance officer a little crazy. It’s partly a function of the constant employee turnover, with some newbies unfamiliar with regulatory requirements. Whatever the reason, she is amazed she still has to tell people that no, they can’t use the expensive new equipment to unbundle lab tests, about 20 years after the national enforcement project to recover funds from hospitals that were accused of improperly billing lab tests separately.

The same goes for reminding observation nurses to note their start and stop times to ensure time is deducted from the observation-hour count when patients are taken to and from diagnostic tests and treatments.

“Every day there are six things I am back to square one on,” she says. “You have to constantly fight old battles, which detract from moving into new territory and new compliance matters. There’s less and less time to be proactive versus reactive.”

Leave Training Details to Managers

Resistance by certain providers to authenticating signatures of supervising physicians, attending physicians, residents and non-physician practitioners continues, Gaines says. “It never ceases to amaze me how often we deal with it: ‘I am a busy physician, and you expect me to sign the medical record for there to be a reimbursable encounter?’ Some want a shortcut — a code and a name with automatic entry — but may not provide the required authentication statement, something that says, ‘I read it; I own it; this is my provider documentation.’” And the same old coding, billing and modifier (particularly -25 and -59) risk areas persist. “That blocking and tackling has not fundamentally changed. Physicians either are not documenting completely, or coders are not coding it correctly or misinterpreting provider documentation,” says Gaines. “There’s a continual improvement, quality assurance loop we engage in to check coding and documentation accuracy.” The difference now is “we have more tools and can do more analytics and technology to help doctors.” For example, it’s easier to make addenda in electronic health records, and generally EHRs

CMS Transmittals and Federal Register Regulations

Oct. 2 – Oct. 8

Live links to the following documents are included on *RMC*’s subscriber-only Web page at www.AISHealth.com. Please click on “CMS Transmittals and Regulations” in the right column.

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- Changes to the Laboratory National Coverage Determination Edit Software for January 2016, Trans. 3366CP, CR 9352 (Oct. 2, 2015; eff. Jan. 1; impl. Jan. 4, 2016)
- Applying Therapy Caps to Maryland Hospitals (R), Trans. 3367CP, CR 9223 (Oct. 7; eff. Jan. 1; impl. Jan. 4, 2016)
- 2016 Healthcare Common Procedure Coding System Annual Update Reminder, Trans. 3365CP, CR 9353 (Oct. 2; eff. Jan. 1; impl. Jan. 4, 2016)

Pub. 100-07, State Operations Manual

- Revisions to State Operation Manual, Appendix C — Survey Procedures and Interpretive Guidelines for Laboratories and Laboratory Services, Trans. 147SOMA (Oct. 6; eff./impl. Jan. 4, 2016)

Pub. 100-08, Medicare Program Integrity Manual

- Signature Requirements, Trans. 615PI, CR 9332 (Oct. 2; eff. Oct. 1; impl. Nov. 2, 2015)

Pub. 100-20, One-Time Notification

- ICD-10 Conversion/Coding Infrastructure Revisions to National Coverage Determinations — 3rd Maintenance CR (R), Trans. 1547OTN, CR 9252 (Oct. 5; eff. Oct. 1, 2015; impl. Jan. 4, 2016)

Federal Register Regulations

Final Rules: Corrections

- Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, including Changes Related to the Electronic Health Record Incentive Program; Extensions of the Medicare-Dependent, Small Rural Hospital Program and the Low-Volume Payment Adjustment for Hospitals, 80 Fed. Reg. 60055 (Oct. 5, 2015)
- Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2016, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and Staffing Data Collection, 80 Fed. Reg. 60070 (Oct. 5, 2015)
- FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements, 80 Fed. Reg. 60069 (Oct. 5, 2015)

have improved documentation clarity and legibility, he says, while issues with EHR macros, cut and paste, and prompting are new issues.

The list goes on, and then compliance officers have to grapple with newer challenges, from meaningful use and pay for performance to hospital experiments with physician compensation models and partnering with other providers and/or insurers.

Against this backdrop, compliance training somehow has to get the job done, telling employees what they need to know without overwhelming them. The best way to do it, compliance experts agree, is to get across some core information and then leave the details to the managers in the departments where the employees work, which is where they face most of the risks unique to their department.

"You need to have a picture of where the compliance risk is in your organization, or the training task is infinite," says Mark Pastin, president of the Council of Ethical Organizations in Alexandria, Va. "You have to have reasonable expectations of your general training, and then you need to let risks guide the rest of your training agenda."

Training May Not Sink In for a While

Hambleton says she doubts it's possible to do training well, but her approach is to limit initial training to three "key messages" that employees must get. "For brand-new employees, I want them to know our commitment to compliance, where they can find policies and procedures, and where to report concerns and ask questions," she says. Over the course of the 90-day orientation, employees will learn more about the substance of policies, but "it becomes an operations issue rather than a compliance function to make sure they know the basic rules related to their position. We need to hold managers accountable."

In terms of training incoming compliance team members, Hambleton ensures they understand the framework of compliance programs (i.e., the seven elements) and know how to evaluate risks associated with a compliance concern, as well as the basics of the "big four": the Stark law, anti-kickback statute, False Claims Act and HIPAA. Usually, new arrivals to the Dignity Health compliance department have experience; "we are not seeing as many people come into compliance through the 'tag, you're it' methodology," she says. "We are seeing more people prepared to enter the compliance field," although they may be moving from HIPAA to other compliance areas.

It may take time for compliance to really sink in. Years ago, after he did on-site compliance training, Gaines was approached by an employee, who said, "This

is the fifth or sixth time I heard it, and I am really starting to understand it." Gaines took that to heart. It means "you have to keep repeating the high-risk areas, why they are important and what people can do about them," he says. Encourage people to look at what they are doing from a coding and quality assurance standpoint and provider documentation, for example, and emphasize it's safe for them to raise questions and point out errors. "No one should lose their job because we misfiled 25 claims due to this compliance issue," Gaines says. "Doctors can handle bad news as it is part of their profession. What they can't handle is the lack of candor and lack of attention to the detail once you have identified the problem."

Pastin says compliance officers have to weigh how much training should be done by the compliance department vs. how much should be done by people working in operations. "In large organizations, there are so many potential compliance violations that if you try to cover all of them in one-size-fits-all training, you will sink," he says. Instead, he suggests customizing education to the "risk profile" of each area or department. Pastin describes a risk profile as a "map of the main risks," with organizations generally rating risks based on the "probability of a risk occurring and the consequences of that risk if it does occur."

Checking a Box Isn't Good Enough

Compliance training doesn't need to begin and end with the compliance department, Pastin contends. "Compliance has to maintain a wall to make sure someone doesn't advocate violating the rules or maximizing revenue inappropriately," he says. But there's no way the compliance function can be an expert on all the laws, regulations and guidance. For example, many community-based health systems have hospice services, and "compliance-wise, they are like nothing else."

Most general compliance training is pretty bad, Pastin says. "It's generic stuff, just thrown together," he says. When developing content for a basic education program, don't even bother with the seven elements. "They have nothing to do with what employees are dealing with," he says. "How bad would it be if you had an employee who was perfectly honest, able to document and recognize appropriate codes, but thought there were six elements instead of seven? If you're going to use this time, have a goal. Have something be different as a result of training. If you don't have goals, you aren't going to accomplish anything, and you won't impress the government because you checked the box. It has been a long time since that was impressive."

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NEWS BRIEFS

◆ **In a dramatic case, West Chester Hospital in Cincinnati and its parent company, UC Health, agreed to pay \$4.1 million to settle false claims allegations that the hospital billed Medicare and Medicaid for medically unnecessary spine surgeries,** the Department of Justice (DOJ) said Oct. 9. The false claims lawsuit alleged that West Chester Hospital charged for spine surgeries performed from 2009 to 2013 by Mason, Ohio, surgeon Abubakar Atiq Durrani, M.D., who had privileges there. He was arrested for health fraud in connection with medically unnecessary spine procedures he provided to Ohio and Kentucky patients, but after his arraignment, Durrani allegedly fled the country and is still a fugitive, DOJ said. Now the hospital is resolving the false claims case, which began with a whistleblower complaint. The press release about the surgeon's indictment is available at <http://tinyurl.com/oxwev3y>.

◆ **A Stamford, Conn., podiatrist pleaded guilty to making a false statement to Medicare,** the U.S. Attorney's Office for the District of Connecticut said Oct. 6. Amira Mantoura, DPM, admitted she submitted false claims to Medicare, Medicaid and private payers for nail avulsions from January 2009 to August 2013, the U.S. attorney's office said. A nail avulsion is a procedure to treat ingrown toenails. Mantoura billed for avulsions when she "had merely provided her patients with routine foot care including clipping the patients' toenails," the U.S. attorney's office said. She faces up to five years in prison and a maximum fine of more than \$380,000 when sentenced in December. Mantoura has been excluded from federal health programs and settled a related false claims case for \$288,538, the U.S. attorney's office said. Visit <http://tinyurl.com/qj9wqur>.

◆ **CMS is expected to update the statement of work for the next round of recovery audit contractors (RACs) "shortly" and release the new "request for quotes" soon,** CMS spokesman Tony Salters tells *RMC*. Those are necessary steps for CMS to get the next permanent RAC contracts in place. Meanwhile, the incumbent RACs "will continue active recovery auditing through at least Dec. 31, 2015," Salters says. The first five-year RAC contracts expired last year, but efforts to award the second set of five-year contracts were slowed by a successful court challenge by CGI Federal, a RAC, which objected to CMS's new payment terms (*RMC* 3/16/15, p. 1).

◆ **PharMerica Corp., the second-largest nursing home pharmacy in the country, agreed to pay \$9.25 million to settle false claims allegations that it got kickbacks for promoting the prescription drug Depakote,** DOJ said Oct. 7. The lawsuit centered on allegations that some pharmacists employed by PharMerica recommended that physicians prescribe Depakote, an anti-epileptic drug manufactured by Abbott Laboratories, to nursing home residents. In exchange, Louisville, Ky.-based PharMerica allegedly sought and received kickbacks disguised as rebates, educational grants and other financial support from Abbott, the lawsuit alleged. Two false claims lawsuits filed by two former Abbott employees who became whistleblowers got the ball rolling against PharMerica and Abbott. The drug manufacturer in 2012 agreed to a \$1.5 billion civil and criminal resolution in connection with alleged kickbacks to nursing home pharmacies, including PharMerica (No. 10-cv-00006 and No. 07-cv-00081), DOJ said. Visit <http://tinyurl.com/pdsga85>.

◆ **Physicians can now use their initials to sign addenda to paper medical records,** CMS said in Medicare Transmittal 615, issued Oct. 2. "Amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record. Amendments or delayed entries to paper records may be initialed and dated if the medical record contains evidence associating the provider's initials with their name," CMS said. Although most health systems have electronic health records, many still have paper progress notes, says Ronald Hirsch, M.D., vice president of Accretive Physician Advisory Services. Contact Hirsch at rhirsch@accretivehealth.com and view the transmittal at <http://tinyurl.com/pvu4h3r>.

◆ **Office for Civil Rights (OCR) audits of covered entities and business associates will begin in early 2016.** In her response to recommendations from the HHS Office of Inspector General (OIG), OCR Director Jocelyn Samuels, in an attachment to a Sept. 23 letter to IG Daniel Levinson, said that "OCR is moving forward with planning for a permanent audit program. We will launch Phase 2 of our audit program in early 2016. This phase will test the efficacy of the combination of desk reviews of policies as well as on-site reviews; it will target specific common areas of noncompliance; and it will include HIPAA business associates." Visit <http://go.usa.gov/3z8wJ>.

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