

# MEDICARE COMPLIANCE

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

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**Managing Editor**  
Nina Youngstrom  
[nyoungstrom@aishealth.com](mailto:nyoungstrom@aishealth.com)

**Associate Editor**  
Eve Collins

**Executive Editor**  
Jill Brown

## Use of Scribes, Related Compliance Risks Grow With Electronic Health Records Usage

The use of scribes has gained traction during the transition to electronic health records, but there are compliance and other risks related to their use. Scribes may make documentation errors that translate into billing errors or even step over the line into providing clinical care.

Scribes are human tape recorders who accompany physicians to patient encounters and document their descriptions of diagnoses and treatment. Physicians talk out loud as they interact with patients, and scribes enter the information in the EHR system in real time.

"Scribes have been used by some hospitals as a way to offset the productivity loss associated with electronic health records," says attorney Ed Gaines, chief compliance officer for Medical Management Professionals in Greensboro, N.C. "Scribes free up the doctor to be able to provide direct medical care, but care must be used in deploying scribes."

Gaines notes that scribes are viewed by some as not appropriate for all clinical settings and group practices, for several reasons.

For one thing, the productivity gains are questionable while the risks are real. "What you say may not be what they write down. It might be misconstrued," says James Taylor, M.D., medical director of the revenue cycle and a family physician at Kaiser Colorado, which includes 800 physicians at 18 facilities and is affiliated with two hospitals. "If you check what they wrote, it doesn't save that much time. Most doctors can finish a note in a minute or two." Voice-recognition software is more effective for physicians who are struggling to adapt to EHRs, Taylor says.

*continued on p. 6*

## Hospitals Try to Increase Interaction With Compliance Officers and Senior Leaders

In a sign that compliance has arrived, senior executives and board members are working more closely with compliance departments at hospitals and health systems.

Some compliance officers may still be marginalized by their management. But in 2011, compliance programs are increasingly a part of the fabric of many organizations. This gradual ascension of the compliance function may in part be a reflection of the government's warning that senior managers and board members will be held accountable for compliance failures in their organizations. It's one thing to stress the importance of setting the tone at the top; it's another for board members and top leaders to meet routinely with compliance officers and engage actively in oversight.

"I operate on the premise that compliance is not a trailer" hitched to the back of your organization, said Jackson Ellison, vice president of corporate compliance for Presbyterian Healthcare Services in Albuquerque, an integrated delivery system that includes eight hospitals, 40 provider-based clinics, a 600-member employed physician

group and a health plan with 350,000 enrollees. He conveys to people throughout his organization that “if you see compliance as something different from what you do every day, you have problems.”

Ellison has consistent interaction with management and governance. On the management side of the coin, all 15 senior leaders serve on the “ethical business practices committee,” Presbyterian’s name for the compliance committee. Ellison is chair, and members include the CEO, CFO, chief legal counsel, chief nursing officer, health plan president, chief operations officer for the quality program, administrator of the physician group and medical director of the employed physician group.

The ethical business practices committee meets monthly, with its major functions including to help the compliance officer implement and deploy the compliance program, resolve compliance issues and review the organization’s compliance effectiveness indicators. The committee tackles all sorts of issues, from specific compliance issues (Stark, one-day stays, physician supervision) to broader mandates like HIPAA/HITECH and ICD-10 implementation.

Items land on the agenda either because Ellison put them there, or because they meet established criteria. If an issue, such as appropriate supervision of physical therapists, can be handled by one of the facilities, so be it. But if an issue warrants the attention of the ethical business practices committee, then its formal process kicks in. First the issue is assigned to the appropriate manager. “There are never enough resources and I am not a subject matter expert in everything, so let’s use someone accountable,” Ellison said. For example, the CFO is accountable for billing issues but the audit itself would be delegated to the revenue cycle manager. The committee also draws expertise from Presbyterian’s provider-based oversight committee, the information security and privacy oversight team, its enterprisewide coding function and policy standards committee.

### Risk Areas Are ‘Sized and Scoped’

Once a risk area has been identified, the designated committee member has 30 days to “size and scope” it, Ellison said. That means determining whether it’s “a one-off incident or a systemic problem,” he said. While the issue is under review, it remains on the committee’s monthly agenda. “You keep the problems in front of senior leaders so they don’t languish,” he explained.

The goal is to close out all reviews in 180 days, but that can’t happen until the committee member in charge completes a “certificate of resolution” (see chart, p. 4), Ellison said. Whether the problem turns out to be trivial or serious, its story must be told in this document. Certificates are reviewed by the full committee at subsequent meetings and proposed corrective actions (e.g., a new policy, training, auditing) are put up for a vote. “Then we plug that into a follow-up plan and will come back unannounced to do a review,” he adds.

Ellison said he has been “blown away by the open attitude” of the senior leaders on the ethical business practices committee.

On the governance side of the coin, only the CEO and Ellison report directly to the compliance and audit committee, Ellison said at the Health Care Compliance Association’s annual Compliance Institute in April and in an interview with *RMC* (see box, p. 3). He also has an executive session with the full board afterward. “All the C-suite folks leave unless I ask them to stay,” he said. The chairman of the full board serves on the compliance committee.

The compliance and audit committee includes a compliance officer from a different health system (Suzie Draper from Intermountain Healthcare in Utah). “It’s very valuable to have another compliance officer on our committee,” he says. If the board is skeptical about El-

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lison's opinion, Draper can back his play. By the same token, she may disagree with his take on something. "It helps me do my best. If everything depends on my compliance expertise, it makes me nervous."

Ellison also meets once a year with each member of the compliance and audit committee. "It's a requirement of their being on the board," he says. "I make sure they are comfortable in their job of governance. They can ask me anything and I can ask them anything." He draws questions from the 2007 guidance published by the HHS

Office of Inspector General and American Health Lawyers Association, "Corporate Responsibility and Health Care Quality."

Management and governance is a two-way track. A member of the compliance and audit committee attends one ethical business practices committee meeting per year. "It shows that the board is engaged in what the committee is doing," he says. "They understand the importance. It's not a smokescreen. Senior people are rolling up their sleeves."

*continued*

## ***Persuasion in Small Doses: What to Highlight for the Board***

Board members don't want to become experts on the fraud-and-abuse statutes, but there is some essential information for compliance officers to convey in their periodic meetings. "My experience in talking to senior leadership is they don't want a lot of details. You only have limited time to make your point," says Washington, D.C., attorney Don Romano, former director of the CMS Division of Technical Payment Policy. "What can you tell them to emphasize what they need to know?"

Here are some key points to make in a short period of time, says Romano, who is now with Arent Fox:

◆ ***Compliance matters in health care.*** "The health care industry is different than other types of industries," he notes. Explain how what passes in other industries as good business practices or effective sales and marketing can land someone in jail, Romano said at the Health Care Compliance Association conference in April in Orlando.

◆ ***There are numerous state and federal statutes to be aware of.*** Among them: the False Claims Act (FCA), the Stark law, the criminal anti-kickback statute (which is now an automatic trigger for a FCA violation), the civil monetary penalty law, exclusion statute and HIPAA/HITECH. Many states have their own versions of the FCA, kickback and self-referral and privacy laws, and some are all-payer statutes.

◆ ***Even when the government loses a case, "it sometimes wins in the end,"*** Romano says. The reason? If the Department of Justice can't cross the burden-of-proof threshold of a criminal health fraud statute or a civil False Claims Act allegation, there's always the HHS Office of Inspector General's CMPL and exclusion authority, he says. A great example of this is the case of Alvarado Hospital Medical Center in California. After two failed attempts by DOJ to convict Alvarado of paying kickbacks to physicians — two

hung juries, two mistrials — OIG stepped in. OIG told Alvarado's then-owner, Tenet Healthcare Corp., in May 2006 that it intended to exclude Alvarado from Medicare for paying kickbacks to physicians. OIG used the threat of being kicked out of Medicare to force Tenet to sell Alvarado, which it did that month. Romano advises compliance officers to make sure the board understands the power that OIG has to penalize allegations of Stark, kickback, billing, and other violations with the CMPL, which includes fines and exclusions. "The stakes are really high when it comes to the threat of exclusion," he says.

◆ ***Effective compliance programs help the organization avoid a CIA,*** which usually means hiring an incredibly expensive independent review organization (IRO), he says. Compliance programs are cost effective, but IROs can break the bank. OIG mandates IROs, typically consulting or accounting firms, to conduct ongoing, independent reviews to keep an eye out for a recurrence of the billing, Stark or other activities that got the organization in hot water in the first place. Romano says IROs charge as much as \$1.5 million to \$2 million a year, and the typical CIA lasts five years.

◆ ***Even when it's not required, it's a good idea to put arrangements with referral sources in writing.*** All parties must sign the agreement, which must pay compensation that's fair-market value and not take into account the volume or value of referrals. In the Stark arena, "don't depend on physicians to keep you compliant," he says. "Liability generally falls on the entity, not the physicians."

◆ ***Keep your eye on HIPAA.*** Your organization is far more likely to run afoul of HIPAA and face the HHS breach-reporting requirements than it is to be caught in a kickback scheme, he says.

Contact Romano at [romano.donald@arentfox.com](mailto:romano.donald@arentfox.com).

At meetings and individually, Ellison gives board members written reports on Presbyterian’s compliance program in terms of the seven elements. But they question him about more intangibles. “What keeps you up at night? Do we have a culture of compliance? What do you leave out of your reports?” He answers at a very high level, and doesn’t criticize employees. “I don’t want to be viewed as a policeman,” he says. “I try not to be judgmental.” Ellison also questions the board about the compliance program and requests feedback about the ethical business practices committee, among other things.

**Health System Ups the Governance Ante**

Catholic Health Partners, a 30-hospital Cincinnati-based nonprofit health system, is reinforcing the relationship between executives, board members and regional compliance officers, says Cheryl Rice, vice president and chief corporate responsibility officer. CHW is taking its cue from two trends:

◆ *The revised Federal Sentencing Guidelines*, which expect direct compliance-officer reporting to the board,

among other things. The guidelines took effect in November.

◆ *Recent corporate integrity agreements (CIAs)*, which require boards to make sure that compliance-program engines are humming, says Rice, who notes that CHW has never been under a CIA. For example, an unrelated health system, The Christ Hospital, entered a false claims settlement with the Department of Justice (*RMC 5/31/10, p. 1*) and CIA with OIG in October 2010. It requires the board, among other things, to meet at least quarterly to “review and oversee” its compliance program and to make sure the hospital is implementing policies and procedures developed to promote compliance with CIA and federal health care program requirements.

This has opened eyes at many organizations. “There are areas where you can enhance and improve accountability and communication,” Rice says. “One way to improve your compliance program is to ensure that efforts at the corporate level carry through at the regional level.”

Here are some of the ways that health systems can promote better communication, Rice says:

**Documenting the Resolution of Compliance Concerns**

The ethical business practices committee at Presbyterian Healthcare Services in Albuquerque uses this form to certify that compliance issues were resolved and briefly describe how. Contact Jackson Ellison, vice president of corporate compliance, at [jellison2@phs.org](mailto:jellison2@phs.org).

**EBPC Certification of Log Item Resolution**

Log Item #:

Brief Summary of Issue:

Summary of Resolution:

Close Issue based on:

- \_\_\_\_\_ Not Found to be a compliance issue (please describe above)
- \_\_\_\_\_ Corrective action plan in place, see workplan document/line # \_\_\_\_\_
- \_\_\_\_\_ Following corrective Action taken: See above
- \_\_\_\_\_ Other

Describe audit or monitoring plan in place:

If a refund was required, please attach supporting documentation of all monies refunded. If communication with individual or entity external to PHS was required, please attach a copy of the communication for Compliance files.

As owner of the above issue, I certify that the above actions have been taken and that this Log item may be closed.

\_\_\_\_\_ Date \_\_\_\_\_  
 EBPC Member (signature)

\_\_\_\_\_ Date \_\_\_\_\_  
 EBPC Member (Print Name)

(1) At least once a year, regional compliance officers can meet in executive session with their board's audit committee without legal counsel or management. People are more candid in executive sessions, but there's no panic around the meeting because it is pre-arranged.

(2) Regional CEOs and other executives can set aside time to meet more often with their compliance officers and foster two-way conversations.

(3) The chief compliance officer would have more input on the roles and responsibilities of regional compliance officers and a say in their performance appraisals.

(4) The full board of regional facilities could meet at least once a year with regional compliance officers.

Contact Ellison at [jellison2@phs.org](mailto:jellison2@phs.org) and Rice at [clrice@health-partners.org](mailto:clrice@health-partners.org). ✧

## Greater Scrutiny, Use of PEPPER Data Will Reduce RAC Risks

With RAC recoupments skyrocketing in recent months, hospitals may want to drill down into billing data from CMS's Program to Evaluate Payment Patterns Electronic Report (PEPPER). CMS uses RAC findings when deciding the content of "PEPPERS," which are hospital-specific reports on billing for admission necessity and coding. While PEPPERS are free, the reports may wind up on the cutting-room floor before compliance officers get their hands on them. And even if compliance officers or auditors access PEPPERS, they may not make the most of them.

PEPPERS cover 29 target areas for short-term acute-care hospitals. Nearly every hospital receives PEPPERS, which show how their volume of billing in the target areas compares to other hospitals in their state, in their Medicare administrative contractor (MAC)/fiscal intermediary (FI) jurisdiction, and nationally. If there are billing outliers, it's up to the hospitals to determine whether they translate into over (or under) payments or there's some logical explanation.

### Compliance Officers Should Seize PEPPERS

PEPPERS are generated by TMF Health Quality Institute, a CMS contractor. The admission necessity target areas include syncope, two-day stays for cardiac arrhythmia and 30-day readmissions. The coding target areas include septicemia, ventilator support and unrelated operating room procedures; the latter two are the top issues for two RACs (*RMC 5/2/11, p. 1*).

"I suspect there are still people out there who know about PEPPER but don't use it. They may not realize what type of resource it might be," says Kim Hrehor, project director at TMF. The biggest challenge may be in compliance officers getting their hands on PEPPERS.

QualityNet — a secure CMS server used by hospitals to report data for Medicare's Internal Quality Reporting (IQR) program — is the only CMS-approved method to electronically distribute PEPPERS. Because all short-term acute care hospitals must participate in IQR, they all have a QualityNet administrator who is likely to be the person who sends in quality data to Medicare, Hrehor says. The problem is, when PEPPER data comes from TMF on QualityNet, the administrator may have no idea what it is. "These people get the report and don't know what it is and just dump it," she says. Compliance officers should get their own QualityNet account to ensure they receive PEPPERS. Hrehor suggests asking the QualityNet administrator at their hospital to set it up.

Although the comparisons in PEPPERS come in three flavors — state, MAC/FI jurisdiction and national — the national ranking is the most important in terms of compliance monitoring, Hrehor says. "While both the jurisdiction and national percentiles are important to consider, if you are an outlier compared to the nation, that is something you should sit up and look at because the nation is the largest comparison group," with 3,400 short-term acute-care hospitals.

PEPPERS flag when a hospital is at or above the 80th percentile in any risk area, which means it submits a higher percentage of claims for that target than 80% or more of the hospitals in that MAC/FI jurisdiction. PEPPERS also alert hospitals when their percent of claims for a coding-related risk area is lower than all but 20% of the hospitals in the MAC/FI jurisdiction, which could mean underbilling.

"We encourage hospitals to use the national [benchmark] as the highest priority," Hrehor says. As they prioritize internal reviews, hospitals should consider the reimbursement implications because program-integrity contractors tend to focus on high-value targets. "If you are in the top 20%, that is more an indication of being [an outlier] than if you are in the top 20% of, say, 300 hospitals in your MAC jurisdiction." Plus, the jurisdiction comparison group may reflect regional differences in practice patterns that are not pronounced in the national comparison group.

*continued*

### New from AIS

## Conducting Internal Investigations in Health Care Organizations: A Practical Guide on How to Resolve Allegations of Wrongdoing

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When hospitals get their PEPPERS, Hrehor recommends they look at the Compare worksheet first. "That's the heart of PEPPERS because it's the only place where hospitals can see at a glance all the target areas for the most recent quarter and whether they are an outlier in any of them," she says. The Compare worksheet also shows hospitals how many discharges occurred and how much money in total they received that quarter for each risk area.

### It's All in the Math

Understanding what the percents and percentiles mean is important. In calculating the percents, the numerator is the total number of claims your hospital submitted that quarter in a particular risk area, such as medical back problem MS-DRGs. The denominator is based on the same claims during the same period, but TMF uses a bigger piece of the hospital billing pie. "The denominator is a larger reference group we use to calculate a percent for the target area," Hrehor says.

Take the example of an admission-necessity target that's been a long-time risk area: one-day stays for chest pain and atherosclerosis. The numerator includes patients discharged in one day with MS-DRGs 313 (chest pain), 302 (atherosclerosis with MCC) and 303 (atherosclerosis without MCC). The denominator includes all patients discharged with any of these MS-DRGs regardless of their length of stay.

Then TMF divides the numerator by the denominator and multiplies that figure by 100. The result is a percentage that represents how many of your hospital's claims for MS-DRGs 313, 302 and 303 are one-day stays. On its face, that's not necessarily a bad thing. The next step, calculating percentiles, takes hospitals a lot closer to finding out whether they should audit the target area for overpayments. After TMF gets percentages for all 3,400 short-term acute care hospitals in this target (and the other 28 targets), it ranks them from smallest to largest in each comparison group (nation, jurisdiction, state). If 80% of the nation's hospitals have a lower percent than your hospital for one-day stays for chest pain and atherosclerosis (i.e., your hospital's percent is greater than 80% of all hospitals in the nation), consider pulling medical records and finding out why. There could be a physician with a penchant for admitting every chest-pain patient regardless of Medicare and InterQual guidelines, and that means potentially a lot of overpayments. But it's possible that for most of those patients there's a reasonable explanation, such as the opening of a nearby nursing home, which attracts many new patients with multiple serious conditions who may warrant admissions. PEPPERS just point you in the direction of questionable claims; they don't equate with overpayments.

The coding ratios work a little differently. With septicemia, for example, the numerator includes the number of discharges for MS-DRGs 870, 871 and 872. MS-DRG 870 is septicemia and severe sepsis with mechanical ventilation 96+ hours; 871 is septicemia and severe sepsis without the vent but with major complications and comorbidities (MCC); and 872 is septicemia and severe sepsis without vent or MCCs. Because a diagnosis of urinary tract infections (UTI) may have been upcoded to septicemia or severe sepsis, the denominator adds MS-DRG 689 (kidney and urinary tract infections with MCC) and 690 (kidney and urinary tract infections without MCC) to the septicemia and sepsis MS-DRGs.

Even though septicemia is a coding risk area, Hrehor encourages hospitals to contrast the patients' lengths of stay in the numerator and denominator. Patients in the numerator theoretically would have a longer length of stay than patients in the denominator because septicemia is more serious than UTI and kidney infections. Compliance officers can ask the health information management or information systems departments to run a list of patients who were discharged with 870, 871 or 872 and look at lengths of stay for those patients and do the same for DRGs 689 and 690. "You expect patients with septicemia to have a longer length of stay," especially if they are on a respirator for four or more days, she says.

Visit the PEPPER website at [www.pepperresources.org](http://www.pepperresources.org). Contact Hrehor at [khrehor@txqio.sdps.org](mailto:khrehor@txqio.sdps.org). ♦

## Scribes Are Risky Business

*continued from p. 1*

There's also a disconnect between the way physicians talk to patients, which is what scribes write down, and the kind of documentation that's expected in the medical records, Taylor says. Physicians explain medical conditions to patients in layperson's terms, but the purpose of the chart is clinical communication between physicians and support for reimbursement. With scribes, "it will be in layspeak versus doctor speak," and layspeak is unfamiliar to auditors who are used to deciphering clinical jargon. Taylor notes that it's harder to defend charts lacking familiar clinical phrases that establish certain services were provided.

If physicians and hospitals use scribes, Gaines cautions them to be wary of several compliance traps for the unwary:

♦ **Don't hire medical students or physician assistant and nurse practitioner students as scribes**, Gaines warns. In the emergency department, for example, medical students acting as scribes may be tempted to document elements of the patient history, exam or medical decision making that must be provided by the physician, or con-

tinue “treatment” of the patient if the physician is called away to respond to a trauma. Medicare won’t pay for evaluation and management (E/M) services that were performed or documented by a medical student, according to CMS Transmittal 1780.

◆ **Licensed physician assistants and nurse practitioners also should not be scribes.** As licensed clinicians, they should be able to provide patient care under the supervision rules and consistent with their state licenses. Medicare evaluation and management documentation guidelines allow ancillary personnel, such as nurses, to document the review of systems and the past social and family history, but only physicians may document the history of present illness and do medical decision making. Wisconsin Physician Services, a Medicare administrative contractor, reinforces this point in its scribe guidance. “Hospital or nursing facility E/M services documented by a Non-Physician Practitioner (NPP) for work that is independently performed by that NPP, with the physician later making rounds and reviewing and/or co-signing the notes, is not an example of a ‘scribe’ situation. Such a service cannot be billed under the physician’s National Provider Identifier (NPI), since it would not qualify as a split/shared visit. Neither would it qualify as ‘incident to,’ which is not applicable in a facility setting. In this case, the service should be billed under the NPP’s name and NPI.”

◆ **Pre-med students are good candidates for scribes because they may have some working knowledge of anatomy and physiology.** Scribes should be well-trained on their role and learn medical abbreviations. “They should be elbow to elbow with the doctor at all times,” Gaines

says. If the doctor steps away, it should be clear scribes do nothing.

◆ **Hospitals and physicians should establish a protocol for how scribes will be identified in the EHRs** (i.e., “Tim Jones, scribe for Dr. Sara Wong”). And hospital coders should be notified that scribes will be documenting in the chart. “Coders are trained to look for who is adding into the medical record,” he says. They may be concerned if there’s a new name in the chart or on templates without any credentials. Be prepared for the extra challenge from EHR systems. “Some EHRs are not good at identifying who is entering the information,” Gaines says. He has seen EHRs that close as soon as residents authenticate the information, which prevents teaching physicians from adding notes, as required by Medicare regulations for separate Part B billing.

When Kaiser Colorado went live with EHRs, it didn’t hire scribes. Instead, fewer patients were scheduled per physician and locum tenens were brought aboard during the transition. “All hands were on deck because we knew we couldn’t see as many patients while we had to learn the machines,” Taylor says. Once they get EHRs under control, however, they don’t interfere with productivity, he says. But when physicians have trouble, they use voice recognition rather than scribes. They speak into a microphone and watch as the words come up on the computer screen. There’s no risk of misinterpretation, which could translate into inaccurate claims. “Scribes are more expensive and you have to read their work,” he says. “It’s a short-term transitional phenomenon.”

Contact Gaines at [egaines@cbizmmp.com](mailto:egaines@cbizmmp.com) and Taylor at [james.m.taylor@kp.org](mailto:james.m.taylor@kp.org). Visit [WPSMedicare.com](http://WPSMedicare.com). ◆

## NEWS BRIEFS

◆ **Medicare contractors did not recover an estimated \$3.4 million in overpayments to durable medical equipment (DME) suppliers for non-routine supplies used by home health agencies (HHAs) that should have been subject to consolidated billing in 2007 and 2008,** OIG says in a report (A-01-10-00505) released May 3. Non-routine supplies (e.g., surgical dressings, ostomy supplies and catheters) are included in prospective payments to HHAs, so separate Medicare payments made to DME suppliers are overpayments, the report explains. For 107 sampled items, the contractor recovered overpayments for 49 items (four more were not used at HHAs). For 54 items, the contractor had not yet recovered more than \$24,000 in overpayments as of June 10, 2010. OIG estimates

that contractors have missed \$3.4 million in overpayments to DME suppliers in 2007 and 2008. Although a Medicare payment edit consistently identifies problems with non-routine supplies, the contractors are not processing and recovering the overpayments in a timely manner. OIG says CMS should tell the contractors to (1) recover the \$24,413 in overpayments found in the audit, (2) use OIG’s data to find and recover other potential overpayments, and (3) implement procedures to ensure “prompt and aggressive” action to recover overpayments. Visit <http://oig.hhs.gov/oas/reports/region1/11000505.asp>.

◆ **Two Miami-area health care corporations pleaded guilty May 3 to their parts in a scheme that involved**

**NEWS BRIEFS (continued)**

**the submission of more than \$200 million in fraudulent Medicare claims**, according to the Department of Justice. American Therapeutic Corp. operated partial hospitalization programs (PHPs), and Medlink Professional Management Group Inc. was a management company for health care businesses. But the feds say ATC and one other company were Medlink's only clients. From 2002 through 2010, employees at the companies altered patient files and therapist notes to make it look like patients were being treated by ATC and qualified for PHP services, the feds say. To read more, visit [www.justice.gov](http://www.justice.gov) and click on "Briefing Room."

◆ **A long-term care pharmacy company that wants to form a new firm for the purpose of contracting with more LTC providers could violate the anti-kickback statute and face administrative sanctions**, OIG says in Advisory Opinion 11-03, released April 14. The company provides pharmaceutical products and services to LTC facilities, plus support such as medication distribution systems and consultant pharmacist services, among other things. Under the proposed arrangement, the company's director of business integration would form a new LTC pharmacy firm "that he would own along with one or more LTC facility owners in the requestor's market area," according to OIG. The requestor would take care of the day-to-day operations of the new company and provide all personnel. Joint venture arrangements like this one have been a longstanding concern of OIG's, and many elements of the proposal appear in a Special Advisory Bulletin issued in April 2003, OIG says. Some of the elements are: (1) the LTC facility owners would be expanding into a related line of business that would be dependent on referrals from the facilities themselves, (2) the facility owners would not participate in the operation of the new firm, but would contract out the operations to the requestor, and (3) the facility owners' financial and business risks would be minimal since they would control referrals to the new company. Read the opinion at <http://oig.hhs.gov/fraud/docs/advisoryopinions/2011/AdvOpn11-03.pdf>.

◆ **Nineteen percent of Medicare claims for interpretation and reports on certain diagnostic radiology services provided by outpatient emergency departments in 2008 had insufficient documentation, resulting in \$29 million in erroneous claims**, OIG says in a report (OEI-07-09-00450) released April 19. OIG went through 9.6 million Medicare claims from 2008

in two simple random samples: claims for computed tomography (CT) and magnetic resonance imaging (MRI), and claims for X-rays. Claims were considered erroneous if they didn't contain sufficient documentation or physicians' orders. OIG found that physicians' orders were not found in 12% of the CT/MRI claims (\$18 million), and 9% of the X-ray claims (\$5 million). Also, Medicare paid for services after beneficiaries left the hospital for 16% of X-rays (\$10 million) and 12% of CTs/MRIs (\$19 million) in 2008. The agency says CMS should (1) educate providers on maintaining documentation for claims, (2) adopt a uniform policy for single and multiple claims for these services to require that they be contemporaneous or say why noncontemporaneous interpretations will contribute to the diagnosis and treatment, and (3) take action on the erroneous claims identified in the report. CMS agreed with the first and third suggestions, but said it does not believe a single-billed interpretation must be contemporaneous with a diagnosis and treatment. Read the report at <http://go.usa.gov/T70>.

◆ **Many of the payments one Medicare contractor paid for units of a service, procedure or drug for outpatient claims were incorrect, resulting in about \$6.2 million in overpayments over a three-year period**, OIG says in an audit (A-09-10-02019) released May 3. Noridian Administrative Services LLC processed 89.7 million items for outpatient services between Jan. 1, 2006, and June 30, 2009. OIG audited the claims that had (1) a Medicare payment amount exceeding the provider's charge by at least \$1,000, and (2) three or more units of service. More than 900 items contained overpayments of \$6.2 million, which included: (1) incorrect units of service for 656 items (\$5 million), (2) HCPCS codes that did not reflect the procedure performed for 148 items (\$587,165), (3) unallowable services for 97 items (\$295,619), (4) a combination of incorrect units of service and incorrect HCPCS codes for 17 items (\$136,686), and (5) no supporting documentation for 12 items (\$131,044). Overpayments were due to clerical errors or insufficient billing systems on the provider end. OIG says Noridian should recover overpayments, implement system edits to find payments that exceed billed charges and use OIG's audit to educate providers. Noridian concurred with OIG's recommendations. Read the report at <http://oig.hhs.gov/oas/reports/region9/91002019.pdf>.

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