Guided by Pocket Card, Doctors Are Coaxed To Keep it Simple With Two-Midnight Rule

To comply with the two-midnight rule, Todd Butz, physician adviser at WellSpan Health in York, Pa., is trying to get physicians on the same page, free of considerations that are beside the point. That means placing patients in observation or admitting them as inpatients because that’s the appropriate level of care, regardless of the impact on copays or skilled nursing facility admissions, or the hospital’s worries about revenue, patient-satisfaction scores or readmission penalties.

It’s not easy because patient status is artificial to physicians, who take care of patients the same way whether they’re labeled “inpatients” or “outpatients,” Butz says. His strategy is for physicians to let the chips fall where they may, inpatient or outpatient, with guidance from a pocket card he developed (see box, pps. 3-4).

“If we’re all on the same page, that’s where the power is. Otherwise, we work against each other,” Butz tells RMC. “There are too many variables that work in differ-
ent directions that it pays to stay the course. The pocket card is the first step. It’s an attempt to better define for our system how we are looking at the two-midnight rule.”

As it turns out, patients with chest pain, transient ischemic attacks (TIA) and syncope are almost always placed in observation, despite what InterQual says, which is why WellSpan also is developing its own admission screening process for those conditions. Conversely, some conditions are “slam dunk” inpatient admissions, such as pneumonia with sepsis, he says. That’s explained in the pocket card, which covers medical admissions. Butz has plans to develop a surgical version, which would include information on inpatient-only procedures, outpatient procedures and admissions after surgery.

One reason he developed the pocket card is that physicians have trouble applying the two-midnight rule despite its apparent clarity. “To me, it’s simple. If there’s no reason to admit a patient for outpatient procedures and admissions after surgery, it’s observation,” he says. That’s the definition of inpatient admittance. Physicians may be reluctant to risk an observation placement for those conditions, he says.

Also complicating matters is that InterQual doesn’t perfectly align with the two-midnight rule, he says. There are cases where patients satisfy InterQual admission criteria but not the two-midnight rule. TIA is a perfect example. “Time and time again, TIA will meet inpatient on InterQual, but patients usually won’t be in the hospital a second midnight with just a TIA,” he says.

Here’s how it plays out: the physician orders an echocardiogram, carotid ultrasound and MRI, and the results are normal. But when the case manager runs TIA through InterQual, it often comes back as inpatient, and the case manager tells the physician he or she can change the observation order to admission. The physician says, “I thought TIA was observation,” and because there’s a conflict, the case is sent to Butz. The physician is correct. Unless patients have further symptoms indicating a stroke, TIA is a classic observation placement. “For certain diagnoses, I see a mismatch between InterQual and the two-midnight rule,” he says.

Another one is syncope. InterQual may give the green light to admit patients with syncope, but they should be treated in observation unless there is suspicion of rhythm-related cardiac syncope, such as ventricular tachycardia or a significant heart block, Butz says. Chest pain presents similar problems with InterQual. That’s why WellSpan is working on an internal protocol for TIA, syncope and chest pain to replace InterQual. “You have to create your own policy [for some conditions] so you don’t just find out on Medicare audits” they didn’t meet the two-midnight rule, he says. A new protocol will help physicians who are questioning why WellSpan’s education on the two-midnight rule doesn’t mesh with InterQual (which otherwise is “very helpful”), he says.

That inconsistency is partly what drove Butz to develop the pocket card.

Everything that confounds physicians is laid out in the pocket card — the definitions of inpatient and outpatient admissions, asynchronous conditions, hospitalization outcomes, and more. The pocket cards allow for quick reference to a doctor’s office or in the field. "It’s something to refer to quickly," Butz says. But it may be hard to find a match for every condition. Patients may require hospitalization, they should be inpatients. Physicians also get tripped up by the word “observation,” which Butz calls “a misnomer” because “you’re not just observing the patient. You are actively treating them. It’s not intuitive.”

And then there’s the impression that observation leads to increased out-of-pocket costs for patients, which may or may not be the case. “That’s a real hurdle in the emergency department, when patients and their families are demanding to be made inpatients because they don’t want increased out-of-pocket costs,” Butz says. “I’m not sure it’s truly that way, but it’s definitely the perception. We are trying to get a handle on that. It depends on your insurance and whether you have secondary insurance.”

‘Mismatch’ Is Seen With InterQual

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That inconsistency is partly what drove Butz to develop the pocket card.

Everything that confounds physicians is laid out in the pocket card — the definitions of inpatient and out-
patient status/observation, along with diagnoses that usually fall into each level of care and diagnoses that could be either. The pocket card also gives examples of documentation for common illnesses.

It’s only meant to be “training wheels” because physicians won’t need the pocket card after they internalize the thinking behind the two-midnight rule, Butz says. “The crux of the matter is the thought process,” he says. If at day one the physician has a sepsis patient who needs IV antibiotics, “make them inpatient right out of the gate” because they probably won’t be ready for discharge before two midnights, he says. Critically ill diabetic ketoacidosis patients should also be admitted, Butz says. “They can be near death and sometimes turn around after one midnight,” but CMS allows Part A payment when inpatients leave before two midnights, he says. Physicians won’t need the pocket card after they internalize the thinking behind the two-midnight rule, Butz says. “Just follow the card system how we are looking at the two-midnight rule,” he tells RMC. Butz has distributed the pocket card to physicians, residents, case managers, billers and coders at the four-hospital system. Contact him at tbutz@wellspan.org.

**Physician Education Tool on Two-Midnight Rule**

Todd Butz, physician adviser at WellSpan Health in York, Pa., devised this pocket card to help physicians turn shortness of breath but don’t have fever or elevated white blood cell count or infiltrate on a chest X-ray should be treated in observation. “It’s a question-mark analysis,” he says. It could turn out to be pneumonia, but that’s what observation is for.

### Pocket Cards Were Distributed Widely

Butz rolled out pocket cards to case managers and physicians at WellSpan’s four hospitals, specifically to hospitalists, ED physicians, family physicians and residents. They were also handed out to the billing and health information management departments and to leading physicians at WellSpan medical groups, who will distribute them to physicians. He plans to distribute them during grand rounds. “Community doctors get the cards as well,” he says. “I hand them out as I walk the halls. Anyone can have these cards.”

He also instructs physicians (and nonphysician practitioners) not to lean toward inpatient or outpatient for any reason other than medical necessity and their time in the hospital. Forget about targets, such as 25% of patients should be placed in observation. “Just follow the card

### Inpatient Level of Care

| If at the time of hospitalization you expect the patient will require medically necessary hospital services for 2 or more midnights (MIN) | Order Inpatient LOC. |

**Implied in this statement:**
1. Most admitting providers would agree with you (i.e., it is a reasonable assessment and you are not an outlier)
2. You documented your thought process and plan including the service(s) you expect to provide crossing the 2nd MN
All other hospitalizations should begin as Observation status.

### Outpatient Status/Observation (OBS)

**If you are unsure of the underlying cause of the presenting issue, or are sure of the cause but uncertain that the patient will require two midnights of necessary inpatient services, begin the hospitalization as Observation status.**

If it becomes clear on day 2 that the patient will require continued medically necessary hospital services that will cross the 2nd midnight, order Inpatient LOC at that time.

### Diagnoses that are usually Inpatient Status/Observation

#### Symptomatic diagnoses:
- Chest pain
- Shortness of breath
- Abdominal pain
- Epigastric pain
- NVUICD
- Wetness
- Diarrhea
- Headache
- Back pain
- Ambulatory dysfunction

#### Specific diagnoses:
- Fall without fracture
- Fall with non-surgical fracture
- DVT
- Syncope
- Secondary to vasovagal
- Gastroenteritis
- Renal colic
- Drug OD with stable VS
- Dehydration
- Hypertension with mild or no acidosis
- HTN urgency
- Infected without sepsis

### Many Diagnoses Can Be Either Inpatient LOC or Outpatient Status/Observation

- COPD & Asthma — inpatient LOC if severe resp distress (tachypnea and/or new or worsened O2 need) — expect IV Sustanevel VI-IV Ate greater than 2 midnights; OBS if mild exacerbation with quick switch to PO Prednisone anticipated.
- Syncope — inpatient LOC only if evidence suggests/supports a serious cardiac etiology (V or tech...)
- CHF — inpatient LOC if plan BID IV diuretics > 2 midnights; OBS if BID IV diuretics then back to PO.
- Rhabdomyolysis — inpatient LOC when CK level significantly elevated and saline and bicarb expected to be given > 2 MN.
- Pancreatitis — inpatient LOC when severe where prolonged NPO and IV support is expected.

### Less Than 2-Midnight Stays That Are Inpatient LOC

Some patients can be in-house less than 2 midnights and still be legitimately leveled Inpatient LOC if there was an “unforeseen circumstance” and this was documented in the progress notes.

**Examples:**
- Unforeseen death
- Unforeseen transfer to another hospital
- Unforeseen departure against medical advice (AMA)
- Unforeseen election of Hospice
- Unforeseen recovery (e.g. very sick DKA patient who has rapid recovery)

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and the observation will fall where it may,” Butz tells physicians.

Hand in hand with education on the two-midnight rule is the documentation messaging. “One of the last messages I leave with providers I talk to is ‘write what you are thinking in the progress note,’” he says. Why is the patient here tonight? Why isn’t he going home? If the answer is because there’s no placement in a nursing home yet, he tells physicians to write it down. That’s not a medically necessary reason to be in the hospital — “we call them avoidable days” — they should still be documented, like social admissions. “We keep track of these things,” Butz says. “There’s no reason to be vague.”

Good Documentation Is Key

Also, it’s no longer good enough to imply patients are sick because of lab-test results. Physicians should summarize the results and explain their connection to the expectation of a two-midnight stay. “There are some cases where I know the patient is sick, but I have trouble in peer-to-peer reviews because the documentation is so poor,” he says. He urges physicians “to document their thoughts because it gives me ammunition when I am talking to medical directors.”

Contact Butz at tbutz@wellspan.org.

Short Stay Reviews Resume; QIO to Request Records Immediately

Reviews of short hospital stays by the Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations (QIOs) are back. On Sept. 12, CMS announced the resumption of short-stay audits under the two-midnight rule four months after they were paused because of problems encountered with their execution (RMC 6/13/16, p. 1).

The QIOs, Livanta and KEPRO, will pick up where they left off, auditing 50 medical records from larger hospitals and 20 from smaller hospitals every year. In the interim, CMS said it “successfully completed education” of the QIOs to ensure they will apply the two-midnight rule accurately and consistently.

Hospitals should prepare for audit activity sooner rather than later. “We are selecting a new sample to restart the review process and some providers will see requests for medical records next week,” Pam Applegate, senior program manager at Livanta, tells RMC. As always, “good documentation of the physician’s thought process to support the admission helps the reviewer understand why the claim should be approved,” she says.

Physician Education Tool on Two-Midnight Rule (continued)

| Greater Than 2-Midnight Stays Are Not Automatically Inpatient LOC |

| Documentation: |

| “If it ain’t on the page, it ain’t on the stage.” |

That is, “It isn’t documented, you didn’t do it or even consider it.”

If ordering inpatient LOC, be clear in the H&P as to what service/treatment you expect to be providing through the 2nd MN:

- 1. CVA – “Patient has suffered CVA and is 12 pounds above his usual weight – I plan to discontinue with BD IV Lasix over the next several days.”
- 2. Sepsis – “Patient has sepsis – I expect she will need IV antibiotics for the next several days.”
- 3. PE – “Patient has a PE and has hemodynamic instability with tachycardia and borderline low BP. I am placing him on IV Heparin and have consulted the Internist.”
- 4. Aortic Dissection – “At the time it is unclear whether the patient will need surgery, but she will require intensive blood pressure control. I expect she will require two midnights of treatment to stabilize her present condition.”
- 5. GI bleed – “I anticipate stabilization will take greater than 2-midnights given the severe acidosis manifested with a pH of 7.10, bicarb of 14 and anion gap of 21.”
- 6. DKA – “I expect treatment and stabilization to require greater than 2 midnights given the severe acidosis manifested with a pH of 7.10, bicarb of 14 and anion gap of 21.”
- 7. CVA – “Patient has suffered a CVA causing significant deficits. I expect treatment and stabilization to require at least 2 midnights in the hospital.”

Avoid “incongruent” documentation such as:

- “I am making this patient a full inpatient admission because he is having such a severe exacerbation… expected length of stay is 1 to 2 days”
Audits of short stays have had a rocky road. They used to be reviewed routinely by recovery audit contractors (RACs), which set in motion the enormous backlog of appeals in the Office of Medicare Hearings and Appeals (RMC 7/4/16, p. 3). After the advent of the two-midnight rule, CMS shifted scrutiny to Medicare administrative contractors (MACs) for the probe and educate reviews. “The MACs were teaching it incorrectly,” says Ronald Hirsch, M.D., vice president of regulations and education at Accretive Physician Advisory Services. Then CMS handed the reins to the QIOs, but that didn’t go smoothly either. For example, hospitals said that QIOs were not counting the time that patients spent in observation or the emergency room toward the two-midnight benchmark when they were later admitted as inpatients.

Some of the audit problems are a function of the subjectivity of some patient-status decision making, Hirsch says. “Two physicians looking at the same patient may have a different expectation about how much time the patient will require in the hospital,” he says. “One of the most bewildering parts for physicians is how Medicare can possibly expect a patient in the ICU not to be considered inpatient even if the stay is not expected to last two midnights. On its face it makes no sense. I explain it’s a payment issue — it doesn’t matter what you call the patient as long as you provide all the care they need.”

**QIO: ‘This Will Be a Fresh Start’**

Going forward, hospitals have to understand how InterQual and MCG (formerly called Milliman) admission screening guidelines play into the two-midnight rule, Hirsch says. Although Medicare doesn’t mandate the use of commercial tools and remains neutral about the top vendors, the QIOs use them. But these criteria should serve only as a guide to the need for hospital care and not be used to determine the correct level of care, Hirsch says. If hospitals don’t perform well on short-stay audits, they may find themselves back in the laps of the RACs. CMS has directed QIOs to send repeat offenders to RACs for audits (RMC 8/24/15, p. 5).

As they return to work, QIOs won’t go back farther than six months from the date of admission when selecting claims for audit at acute-care hospitals, long-term care hospitals and inpatient psychiatric hospitals under the two-midnight rule.

“For the cases that were in process at the time of the pause, hospitals can expect to see re-review results for those previously formally denied, as well as notices of sample drops due to the age of the cases,” Applegate says. “The new selection will be a fresh start.”

CMS said it will keep an eye on QIOs with monthly re-reviews of cases the QIOs have audited. The agency also said the QIOs did provider outreach “on claims affected by the temporary suspension” and provided education on the two-midnight rule.

If the older claims were already reviewed and denied, the money will not be recouped, CMS said July 28 (RMC 8/1/16, p. 4).

For more information, contact Hirsch at rhirsch@accretivehealth.com. View the CMS announcement at http://tinyurl.com/p9ha9qh.

**LEP Notices Must Be Posted Soon**

patients who will be served by their health programs, according to HHS. That includes providing a qualified interpreter and posting notices and taglines in various places and publications. The notices state that covered entities don’t discriminate, and “the taglines notify people that language assistance services are available free,” Stevens said at a Sept. 13 HCCA webinar.

Covered entities must post taglines in the 15 top languages spoken in the states where they are located, Stevens said. OCR has provided 64 translations on its website, which has a sample tagline — “If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx)” — and a notice and statement of non-discrimination. Small providers only have to post a shorter tagline in the top two languages.

The notices and taglines have to be posted in physical locations where the public will see them, as well as on the website and in “significant” publications and communications, which can include other hospital notices “as long as they’re conspicuous and inform [people] of their rights under 1557,” Stevens said. Other Sec. 1557 provisions went into effect July 18. For example, an employee must take charge of compliance at covered entities with 15 or more employees, and covered entities have to adopt grievance procedures, Stevens said.

Obligations to LEP patients don’t end with notices, taglines and the provision of an interpreter. As the Sec. 1557 regulation notes, hospitals and other providers are

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required by Title VI to translate “vital medical documents” and the Joint Commission has the same expectations, Mead said.

Translation is important because both patients and the medical staff “must be heard and understood,” she said. “When we look at the potential consequences of ineffective communication, it is very dangerous. Translation helps with the process.” It can be overwhelming because a lot of documents seem vital, and there are at least 400 languages, Mead said. But there’s guidance for sorting it out.

In its roadmap for hospitals, the Joint Commission suggests considering whether written documents have “clinical, legal or other important consequences.” And HHS in 2003 published a four-factor analysis (68 Fed. Reg. 47311): “(1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the [facility]; (2) the frequency with which LEP individuals come in contact with the [facility]; (3) the nature and importance of the program, activity, or service provided by the [facility] to people’s lives; and (4) the resources available to the [facility].”

Hospitals can put documents through the four-factor analysis, but informed consents, discharge instructions and information about language assistance make the cut, and the list gets longer (see box, below). Nonvital documents may include enrollment handbooks, third-party documents, general informational material and maybe menus. It depends on what’s “vital” in your facility, Mead said.

She thinks menus might be vital and therefore require translation for LEP patients. Hospitals may want to put them through the Joint Commission analysis. For example, there are clinical consequences, such as patients who have food allergies or are on a low-sodium diet. There also could be legal consequences because Title VI prohibits religious discrimination and several religions have dietary restrictions (e.g., kosher and Halal). Menus are important — patients see them three times a day unless they’re in surgery or unconscious, Mead noted. It

### List of Medical Documents to Consider for Translation

Although it’s up to hospitals to decide which documents to translate for limited English proficiency (LEP) patients, here is a list to consider, says Jill Mead, compliance counsel with Vocalink Language Services. Longstanding language-assistance requirements for LEP patients were beefed up by Sec. 1557 of the Affordable Care Act (see story, p. 1). Some of them take effect Oct. 16. Contact Mead at jillm@vocalink.net.

- After-hours instruction sheet
- Authorization for disclosure of health information (release of medical records from previous provider)
- Authorized representative form
- Cholesterol test results form
- Client behavior contract (written notice of violation of policy)
- Congratulations on birth of baby/instructions to apply for Medicaid
- Consent to sterilization
- Cover letter
- Dental checkup reminder
- Depo Provera factsheet
- Health history
- Health screen
- Healthy Kids application
- Information and resource card
- Information sheet on transportation resources
- Informed consent for counseling
- Instructions to prepare for a flexible sigmoidoscopy
- Lab/diagnostic test results form
- Medical instruction sheet (in 10 languages; all other forms in two primary limited English proficient languages)
- Missed appointment/moving letter
- Missed appointment/no-show letter
- New patient registration packet
- Ninth month of pregnancy information sheet
- Notice of appointment change
- Parental consent form to provide care to a minor
- Patient bill of rights
- Patient contract for care
- Patient information sheet (about clinic services and hours)
- Prescription pickup permission form
- Procedure consent form
- Referral confirmation
- Refusal for procedure form
- Transfer of care questionnaire
- Violation of policies letter

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seems like they should be on the vital list, but “there’s no hard and fast rule.”

To determine what to include on your vital documents list, the HHS Office of Minority Health suggests asking LEP patients what would be most helpful, Mead said. Question them during visits, conduct surveys or talk to community organizations that serve LEP populations. “Prioritize based on important content and frequency of use,” such as intake forms and the notice of privacy practices, she said. The list should be revised (e.g., a travel form may be added to the vital documents list if the Zika virus becomes a greater concern).

The informed consent is “probably where you see the most litigation,” Mead said. One hospital paid almost $100,000 to the family of a 59-year-old LEP patient who died during surgery to remove her kidney, Mead said. The patient had signed an informed consent that was written in English and didn’t mention a possible nephrectomy. No qualified medical interpreter was used.

HHS Helps With Which Languages to Use

Hospitals have to decide which languages they will translate vital medical records into. HHS provides a formula, and Mead said the agency considers its use “strong evidence of compliance with Title VI.” According to HHS, vital medical documents should be translated into any language spoken by 5% of the people served by your facility or 1,000 of them — whichever is less. For example, at a hospital with 1 million patients per year and 156,937 LEP encounters, the magic number is 1,882. Because 1,000 is less than 1,882, the hospital must translate vital medical records into languages when the number of LEP patients who spoke those languages was 1,000 or above. A small physician practice has to make the same calculations but may come up with the need for translating documents into one or two languages.

The math is simple, but figuring out your numbers can be tough, Mead explained. If you don’t have good records of LEP encounters, you may have to rely on demographic data. However, it’s often outdated.

Hospitals also have to protect the integrity of translation. Machine translation, such as Google Translate, “does its best to translate written materials without application of human eyes and human brains,” she said. But machine translation as the “sole means of translating medical information is not a good idea.” One study found serious errors in Google Translate’s version of medical phrases, Mead said. Two top errors: “Your wife is stable” was translated to “Your wife cannot fall over” and “your husband had a cardiac arrest” was translated to “your husband was imprisoned.”

Mead’s other tips:

- Use multiple choice questions and checklists (e.g., How would you describe your pain in English and Spanish)?
- Only use qualified interpreters. The Sec. 1557 regulation defines “qualified” and states that covered entities cannot require patients to bring their own interpreter or rely on a friend, family member, or minor child to interpret unless it’s an emergency.
- Give patients graphics whenever possible (e.g., faces to indicate the level of pain).

Mead also suggested using “wayfaring” and signage. Wayfaring refers to signs, symbols and words to help people find their way. Hospitals should use “clear and recognizable symbols,” such as a heart to indicate the cardiology department. Also decide which signs need to be in multiple languages. Signs directing patients to the emergency room? Signs about hazardous materials?

Contact Mead at jillm@vocalink.net and Stevens at drew.stevens@AGG.com. Visit http://tinyurl.com/j7zotaw for HHS “translated resources” to comply with Sec. 1557 requirements. Read the FAQs at http://tinyurl.com/znfnp7s and the Sec. 1557 final rule at http://tinyurl.com/jq3anm4.

CMS Transmittals and Federal Register Regulations

Sept. 9 – Sept. 15

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. 100-02, Medicare Benefit Policy Manual

Pub. 100-04, Medicare Claims Processing Manual
• Influenza Vaccine Payment Allowances – Annual Update for 2016-2017 Season, Trans. 3611CP CR 9758 (Sept. 9; eff. Aug. 1; impl. Nov. 1, 2016)

Pub. 100-07, State Operations Manual
• Revisions to Appendix J, Part II – Interpretive Guidelines – Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities and Exhibit 355, Probes and Procedures for Appendix J, Trans. 158SOMA, (Sept. 9; eff./impl. Sept. 9, 2016)
• Revisions to Appendix I – Survey Procedures for Life Safety Code Surveys, Trans. 159SOMA, (Sept. 9; eff./impl. Sept. 9, 2016)

Federal Register Regulations
• None published.
The University of Connecticut Health Center agreed to pay $184,984 to settle allegations that it overbilled Medicare for wound closure procedures, the U.S. Attorney’s Office for the District of Connecticut said on Sept. 15. Farmington-based UConn Health allegedly submitted claims for higher-paying adjacent tissue transfer or rearrangement codes (CPT codes 14020, 14021, 14040, 14041, 14060, and 14061) instead of codes for the lower-paying complex repairs that were performed, according to the settlement. The alleged overbilling took place from Jan. 1, 2011, to June 2, 2016. Providers may make billing errors for wound care and other procedures if they’re unfamiliar with the long descriptor of CPT codes, says Toni Turner, owner of InRich Advisors in The Woodlands, Tex. There can be one word at the end of the long descriptor, such as “bilateral,” that changes the code and therefore the payment, she says. Coders should ensure the documentation in the medical records is consistent with the requirements in local coverage determinations, Turner says. While coders may “hyperfocus” on abstracting for the diagnosis, “they don’t always look for documentation to substantiate the procedure,” she says. UConn Health didn’t admit liability in the settlement. “Following an extensive review, UConn Health is confident that there is no wrongdoing, and that the safety and best outcomes of our patients were and remain its top priority,” according to its attorney, Joan Feldman, with Shipman & Goodwin in Hartford. “However, anticipating that additional time, effort and resources would be expended to defend the matter, UConn Health agreed to the settlement to best steward its resources and time.” For more information, contact Turner at toni@inrichadvisors.com and Feldman at JFeldman@goodwin.com.

The owner of a large Illinois home health and hospice company has pleaded guilty to paying kickbacks to approximately 20 medical directors in exchange for patient referrals, the U.S. Attorney’s Office for the District of Illinois said on Sept. 14. Romy Macasaet Jr., who owned Home Bound Healthcare Inc., in Lemont, “acknowledged in a plea agreement that he retained and paid medical directors a monthly fee solely for the purpose of obtaining patient referrals, and not for medical services,” the U.S. attorney’s office said, and hid the kickbacks in the medical directorships. He paid the medical directors $789,327 between December 2006 and September 2014, according to the U.S. attorney’s office. He pleaded guilty to one count of violating the anti-kickback law. In a civil settlement, Macasaet agreed to quit Home Bound and divest his ownership interest in 120 days. For more information, visit http://tinyurl.com/za5238.

The HHS Office of Inspector found problems on hospice election statements, according to a new report. OIG reviewed election statements and certifications of terminal illness from a stratified random sample of 565 general inpatient care (GIP) stays in 2012. One third of them were missing required information or “had other vulnerabilities,” the report stated. To be eligible for the hospice benefit, Medicare requires beneficiaries to sign election statements and physicians to certify that beneficiaries are terminally ill. But OIG found that in 19% of GIP stays, election statements didn’t specify the beneficiary was electing hospice care; “in 12% of stays, the election statements did not mention — as required — that the beneficiary was waiving coverage of certain Medicare services by electing hospice care, or inaccurately stated what Medicare benefits were waived.” Also, election statements didn’t say that hospice care is palliative instead of curative in 9% of stays. OIG recommended that CMS draft and circulate model text for election statements and educate hospices about them. For more information, visit http://go.usa.gov/xKj25.

A Kansas physical therapy (PT) practice received $134,967 in Medicare overpayments, mostly because it billed for medically unnecessary services, the HHS Office of Inspector General said in a new report. The practice has two PT offices and employs four licensed physical therapists and one physical therapy assistant. OIG looked at a random sample of Part B claims submitted by the PT practice, which wasn’t identified, in 2012 and 2013. Of the 100 beneficiary days in the sample, the PT practice “improperly claimed Medicare reimbursement” for 29 of the 71 beneficiary days, OIG said. All but one of the billing errors stemmed from lack of medical necessity; there was also one error related to a HCPCS code. “These deficiencies occurred because the Therapy Practice did not have adequate policies and procedures in place to ensure that it billed for services that complied with Medicare requirements,” the report stated. For more information, visit http://go.usa.gov/xKjZk.
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