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Weekly News and Compliance Strategies on Federal Regulations, Enforcement Actions and Audits

Contents

UPMC Settles FCA Case on Overlapping Surgeries, Agrees to External Audit but Not CIA

In a false claims settlement that includes an unusual audit requirement, University of Pittsburgh Medical Center (UPMC), University of Pittsburgh Physicians (UPP) and James L. Luketich, M.D., agreed to pay $8.5 million over allegations they billed for overlapping surgeries in a way that violated Medicare regulations, the U.S. Attorney's Office for the Western District of Pennsylvania said Feb. 27.[1] Luketich, a cardiothoracic surgeon employed by UPMC, allegedly performed up to three surgeries at the same time without always being present for the "critical or key" portions and left some patients under anesthesia for hours while he attended "to other matters," according to the False Claims Act (FCA) complaint filed by the Department of Justice (DOJ).[2]

The defendants declined to enter into a corporate integrity agreement (CIA) as part of the FCA settlement, however, and therefore were added to the HHS Office of Inspector General's (OIG) high-risk category, which subjects them to "heightened scrutiny," according to OIG's Fraud Risk Indicator.[3]

UPMC, UPP and Luketich deny the allegations.

Something helpful for all teaching hospitals and physicians may come out of the settlement. It includes a unique provision allowing UPMC—on its own or with other health systems or teaching hospitals—to send a letter to CMS asking for guidance and/or an advisory opinion on the teaching physician regulation, the parts of the Medicare Claims Processing Manual related to the teaching physician regulation and/or "the application of those provisions to the types of surgeries at issue in this Civil Action," according to the settlement.[4] CMS must respond to the letter, if it materializes, as soon as possible or by a date that CMS and UPMC agree on.

"That provision could be viewed as an admission on the part of the government that teaching physician regulations and manual guidance are not entirely clear," said attorney Lauren Gennett, with King & Spalding in Atlanta, Georgia.

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Hospitals Find Ways to Bill for Custodial Patients, 'Compassionately' Coax Discharge

When the parents of a patient at a skilled nursing facility (SNF) became disenchanted with her care, they brought her back to the hospital. Although the young woman has no acute medical needs and dissatisfaction with the SNF isn't a legitimate reason for admission, at the parent's insistence, she joined the ranks of patients who are in the hospital for custodial care—which isn't covered by Medicare, takes up beds needed by acutely ill patients and exposes them to risks.

The woman is now one of 30 custodial patients on the med-surg unit at University of Vermont Medical Center (UVMMC) in Burlington, which has 400 med-surg beds, said Steven Grant, M.D., associate chief medical officer of care coordination and patient transitions. Typically, 10% to 15% of the beds are non-acute care (custodial and skilled-level care), which he understands is comparable to

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other hospitals. Grant is seeing more patients who are custodial from the start. They are awaiting placement elsewhere—usually in SNFs or nursing facilities, often because their families are unable or unwilling to take care of them in the meantime or they don't have homes or families at all. One patient has been at UVMMC for 600 days. The problem will intensify on May 11 with the end of the COVID-19 public health emergency, when the waiver of the three-day inpatient hospital qualifying stay for SNF admission expires.

UVMMC admits them as inpatients and delivers the Hospital-Issued Notice of Noncoverage (HINN). Depending on the version of the HINN, it informs Medicare patients that the services they're about to receive or are receiving aren't covered because they're not medically necessary, not delivered in the most appropriate setting or custodial, which means they pay for the stay.

"We make all our custodials inpatients," Grant said. "The only lever we have in the Medicare population is the HINN."

But he doesn't like using money to coax them out of the hospital. Although UVMMC gives patients or their families a weekly statement with their mounting charges, it doesn't necessarily move the discharge needle, he said. "I haven't found it super effective. I would rather have compassionate conversations with families about why remaining hospitalized indefinitely isn't the best answer for their loved one or the many patients in need of our acute-care beds."

To that end, Grant developed a script for the case management team. They talk to families about how patients who live in the hospital typically don't get better; "it's a hard place to recuperate," he said. And with their family member taking up an inpatient bed they don't need, some acutely ill patients are stuck boarding in the emergency room (ER). It would be better for the patient to be out of the hospital and if it can't find a facility, can the hospital come up with a plan to help them recuperate at home?

"Most people are totally reasonable," Grant said. In the past week, four custodial patients left the hospital: two went home to their families and two went to long-term care facilities.

Billing for Custodial, Courtesy Care in Observation

Custodial care patients may also wind up in observation, but hospitals shouldn't bill Medicare for observation hours with the G0378 code, said Ronald Hirsch, M.D., vice president of R1 RCM. It doesn't square with CMS's definition of observation, which requires observation services to be "clinically appropriate," according to the Medicare Benefit Policy Manual.

"This is the crux of a lot of what we do in the hospital," Hirsch said at a Feb. 2 webinar sponsored by Racmonitor.com. "Every day on every single patient, you should be asking this question: do they need to remain in the hospital to receive services or reduce risk or can they go anywhere else to receive services, whether it's home, home with home care, or a skilled nursing facility? Hospitals are expensive and need to make sure patients who are there need to be there."

Hospitals have billing options for services provided to custodial care patients in observation, who are still monitored by nurses and fed, Hirsch said. They can report HCPCS code A9270—a generic code for noncovered services—with revenue center code 0760, when observation isn't clinically appropriate. "You can define under the chargemaster an hourly charge for custodial care," Hirsch noted. He added that modifier GY should be used because it's for items or services that are statutorily excluded from Medicare coverage like custodial care.

When it's less a question of custodial care, hospitals have other decisions to make. Suppose a patient comes to the ER for chest pain on Monday, is placed in observation at 7 p.m. and has a normal stress test and labs, with the physician ordering discharge Tuesday at 3 p.m. By the time the patient is picked up by her spouse, it's 7 p.m. Does the hospital bill for 24 hours of observation? What about the four hours the patient waited for a ride and the

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three hours she spent having the stress test? "Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure," according to Chapter 4 of the *Medicare Claims Processing Manual*.

Some hospitals may think it doesn't really matter how they report the hours because Medicare pays a comprehensive APC (C-APC) for observation when the patient has been there for eight or more hours, Hirsch said. They figure they don't get more money so they might as well report 21 hours with the G0738 code after subtracting three hours for the stress test. But "the truly compliant thing" would be to bill 17 hours with G0378 and four hours with A9270 (except in Maryland, which has a unique payment system that compensates for every hour of observation).

Active monitoring may trip up the observation count. Although Medicare requires hospitals to subtract the time patients spend in services that require active monitoring, it told hospitals to decide what services qualify, Hirsch said. One large health system uses this definition: "The basis for determining a 'monitored procedure' on this carve out list is when clinical assessment or monitoring is required to assess the effects of the therapy or procedure including vital signs, pulse oximetry, cardiac rhythm, and/or skin color." Services that require active monitoring include ablation, blood transfusion, bronchoscopy, cardiac catheterization, central line placement and chemotherapy. Not on the list? CT scans, echocardiograms, EEGs, MRIs, nuclear medicine, PICC line placement, physical/occupational/speech therapy and ultrasounds.

The A9270 code also is useful for billing custodial patients who cross a second midnight after receiving observation services but aren't admitted as inpatients, Hirsch said. "There may be 18 hours of courtesy time," he noted. "It's an occupied room, there's food service, nursing care and medications and we should bill that."

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Changes in Waiver Fact Sheets, Rules May Have Big Implications

Although the fate of the COVID-19 waivers and flexibilities is somewhat of a moving target, with CMS and other federal agencies tweaking them over time, many will be gone May 12 now that the Biden administration announced an end to the public health emergency (PHE) May 11. But there are some surprises in the pages of CMS's provider-specific waiver fact sheets and proposed regulations and perhaps more to come in forthcoming rules, experts say.

Case in point: the Feb. 1 version of the fact sheet on waivers for hospitals and critical access hospitals had different information about billing for telehealth services provided to patients who are at home but treated as hospital outpatients (i.e., patients at provider-based departments) than the Feb. 24 fact sheet.[1] The earlier fact sheet stated that "After the PHE ends, this flexibility, to bill the telehealth service provided in the patient's home as if it was provided at the hospital, will end." That statement is gone now, said Martie Ross, a consulting principal with PYA, and its absence may speak volumes. It implies hospitals will be able to continue billing Medicare an originating site facility fee for telehealth services delivered to patients in their homes by a physician or practitioner with code Q3014, which pays $28.64, after the PHE is over, she said.

But it's not something hospitals can take to the bank yet. "Let's hope CMS clarifies that," Ross said at a March 1 webinar sponsored by PYA. A definitive answer may come during the open-door forums CMS said it will be holding to answer questions about the expiration of waivers.

The end of the PHE doesn't mean saying goodbye to all the waivers and flexibilities. As CMS noted in a Feb. 27 press release, "There are significant flexibilities

CMS Transmittals and *Federal Register* Regulations, February 24-March 2

Transmittals

Pub. 100-04, Medicare Claims Processing

- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update, Trans. 11,886 (March 2, 2023)
- Claim Status Category and Claim Status Codes Update, Trans. 11,885 (March 2, 2023)
- April 2023 Healthcare Common Procedure Coding System (HCPCS) Quarterly Update Reminder, Trans. 11,883 (March 1, 2023)
- Calendar Year (CY) 2023 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment, Trans. 11,881 (March 1, 2023)

Pub. 100-20, One-Time Notification

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)--July 2023 Update, Trans. 11,884 (March 1, 2023)

Federal Register

Proposed rules

- Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule, 88 Fed. Reg. 11,865 (Feb. 24, 2023)
- Medicare Program; Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated With Section 1115 Demonstrations in the Medicaid Fraction, 88 Fed. Reg. 12,623 (Feb. 28, 2023)
- Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Medical Evaluation, 88 Fed. Reg. 12,875 (March 1, 2023)

and actions that will not be affected as we transition from the current phase of our response."[2] Congress made changes in the 2022 and 2023 Consolidated Appropriations Act (CAA) and CMS did the same in regulations, with an emphasis on telehealth services.

OPPS Rule Retains Part of Waiver

For example, in the hospital-without-walls waiver, CMS gave hospitals the flexibility to temporarily relocate provider-based departments to patient homes for the purpose of providing certain hospital outpatient services—counseling, therapy, education (e.g., diabetes self-management) and partial hospitalization services—by hospital clinical staff via telehealth and bill the Outpatient Prospective Payment System (OPPS) for the services.

Although that must stop when the sun goes down May 11, there's a big carve-out, thanks to a provision in the 2023 OPPS rule. Remote behavioral health services furnished by clinical staff of hospital outpatient departments and critical access hospitals to patients in their homes will be covered outpatient services paid under the OPPS. Audio-only is OK. But patients must have an initial in-person visit with the provider six months before the first telebehavioral health visit and annual in-person visits. Ross noted that remote services are not considered partial hospitalization.

In terms of other telehealth services, the picture is more complex. The 2023 CAA again removed rural-area requirements and expanded originating sites, which means Medicare will continue to pay for certain covered telehealth services everywhere in the country and in patient homes and other locations, such as retail clinics and schools, through Dec. 31, 2024. The law also continues reimbursement for certain audio-only telehealth services and physical, occupational and speech therapy services and audiology delivered by telehealth, as well as telehealth services at federally qualified health centers and rural health centers. The use of telehealth to recertify hospice eligibility, and for home health face-to-face encounters, also will continue.

But the fate of telehealth codes that came to life during the pandemic hangs in the balance and will be revealed in the proposed 2024 MPFS rule, which is due this summer. These include category 3 codes, which are in a holding pattern while CMS determines whether they merit a permanent spot (category 1 or 2), and interim codes for telehealth services that would have gone away when the PHE ended except the 2023 MPFS rule continued them for 151 days. Other telehealth flexibilities are ending, Ross said. For example, the use of telehealth for subsequent inpatient hospital visits again will be limited to once every three days (see box, p. 4). Saying there's a lot to keep track of is a wild understatement.

As for Medicaid telehealth services, Ross recommends looking to the Center for Connected Health Policy—which keeps an inventory of state Medicaid programs' telehealth coverage policy and payment parity laws (https://www.cchpca.org).

Another federal agency with an interest in telehealth, the Drug Enforcement Administration (DEA), proposed a rule on telehealth prescriptions for controlled substances with an eye on finalizing it before the PHE expires, Ross said. It pertains to the Ryan Haight Online Pharmacy Consumer Protection Act, which requires practitioners to

Highlights of Telehealth Flexibilities That Vanish With the End of PHE May 11

Here's a brief summary of how things will look after the COVID-19 public health emergency, according to Martie Ross and Kathy Reep of PYA (see story, p. 3). Contact Ross at mross@pyapc.com and Reep at kreep@pyapc.com.

Other Telehealth Flexibilities Ending May 11

- ✓ For subsequent inpatient visits, use of telehealth limited to once every three days
- ✓ For subsequent skilled nursing facility visits, use of telehealth limited to once every 14 days
- ✓ For critical care consults, use of telehealth limited to once per day
- ✓ For home dialysis, required face-to-face visits cannot be performed via telehealth
- ✓ For inpatient rehab stays, required face-to-face visits cannot be performed via telehealth
- ✓ To the extent national coverage determination or local coverage determination requires face-to-face visit for evaluations and assessments, these visits no longer can be performed via telehealth
- ✓ Opioid treatment programs no longer can furnish periodic assessments by telephone (two-way, interactive audio-video communication still permitted)
- ✓ Only teaching physicians in non-metropolitan statistical area residency training sites may use telehealth to meet presence for key portion requirement (but not for complex procedures, endoscopy and anesthesia services)
- ✓ Hospitals and critical access hospitals must comply with conditions of participation regarding provision of telemedicine services to patients under contract with distant-site hospital or distant-site telemedicine entity

do one in-person medical evaluation before prescribing controlled substances. That requirement has been waived during the PHE but will be back after May 11. In a proposed rule published in the *Federal Register* March 1, however, the DEA would allow physicians and other practitioners to prescribe a 30-day supply of a Schedule III, IV or V non-narcotic controlled substance by telehealth without an in-person visit but they couldn't prescribe narcotic controlled substances by telehealth without an initial in-person visit.[3]

Administrative Requirements Are Coming Back

The flexibilities that are uniformly evaporating May 11 are the ones that were granted under Sec. 1135, which allows HHS to waive or modify certain Medicare, Medicaid/Children's Health Insurance Program (CHIP) and HIPAA requirements, Ross explained. HHS waived almost 200 federal regulatory requirements during the PHE and made changes to Medicaid and CHIP requirements under a separate statutory authority. CMS fact sheets walk you through them.

For example, during the PHE, hospitals are permitted to use other locations, such as distinct part units, to deliver inpatient care (the hospitals-without-walls waiver). "All that ends May 11," Ross said.

Here are a few other waivers ending May 11:

- Screening patients under the Emergency Medical Treatment and Labor Act outside the emergency room.
- Adding swing beds in acute-care hospitals to provide skilled nursing facility services.
- Creating new or relocating existing provider-based departments.
- Allowing critical access hospitals to exceed the 25-bed count maximum and the 96-hour length of stay.

Administrative burdens also will return when certain waivers expire, Ross said. For example, at discharge planning, hospitals will resume providing patients with data on quality measures and resource use about post-acute providers. Also, the full array of utilization review (UR) requirements will be back May 12. During the PHE, CMS waived the entire UR condition of participation, which requires hospitals to have a UR plan and committee to review services provided to Medicare and Medicaid patients to assess the medical necessity of admissions and services.

Reimbursement Takes a Hit

In terms of vaccines, testing and treatment, Medicare will continue to cover COVID-19 vaccines without cost sharing, said Kathy Reep, a senior manager with PYA, at the webinar. Medicaid programs are required to keep covering vaccines without cost sharing through the end of September 2024. After that, coverage varies by state. Most commercial payers will continue covering vaccines provided by in-network providers without cost sharing, but uninsured people are on their own.

After the PHE, providers won't be able to bill Medicare with CPT 99211 when clinical staff assesses patients and collects specimens for COVID-19 tests and there won't be a separate payment anymore for hospital outpatient departments for symptom assessment and specimen collection using HCPCS C9803, Reep said. Medicare also will stop paying extra for COVID-19 testing using high throughput technologies.

The 20% add-on payment for COVID-19-related MS-DRGs ends May 11 but there's uncertainty about how this will play out, Reep said. If the patient with a COVID-19 diagnosis is admitted before May 11 but discharged after, will the bonus attach? Also, enhanced payments for new COVID-19 treatments administered to patients in hospital outpatient departments will continue through the end of the year and after that will be wrapped into comprehensive APC payments.

Contact Ross at mross@pyapc.com and Reep at kreep@pyapc.com. ✧

Endnotes

1. Center for Medicare & Medicaid Services, "Hospitals and CAHs (including Swing Beds, DPUs), ASCs and CMHCs: CMS Flexibilities to Fight COVID-19," fact sheet, February 24, 2023, https://bit.ly/3ESs5nd.
2. Centers for Medicare & Medicaid Services, "CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency," news release, February 27, 2023, http://bit.ly/3SOoVXy.
3. Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Medical Evaluation, 88 Fed. Reg. 12,875 (March 1, 2023), https://bit.ly/3kPSOd9.

UPMC Settles FCA Case

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The settlement is the latest in a series about overlapping surgeries. Last year, Massachusetts General Hospital agreed to pay $14.6 million to settle false claims allegations about overlapping surgeries and add language to its informed consent for patients that "my surgeon has informed me that my surgery is scheduled to overlap with another procedure she/he is scheduled to perform," according to its settlement with DOJ, the Massachusetts attorney general and the whistleblower.[5] In 2021, Neurosurgical Associates LTD and St. Joseph's Hospital in Phoenix, which is part of Dignity Health, agreed to pay $10 million to settle false claims allegations over billing Medicare for certain concurrent and overlapping surgeries.[6]

"A lot of organizations may have some degree of potential risk here," Gennett said. With cases piling up, overlapping surgeries may be ripe for a compliance

check-up, although it's not an easy area to get your arms around. "Auditing overlapping surgeries can be challenging," Gennett said. "There are so many layers of information you need to piece together."

The UPMC case was initiated in 2019 by former UPMC cardiothoracic surgeon Jonathan D'Cunha, and two years later, DOJ filed an FCA complaint in partial intervention. According to the DOJ complaint, Luketich allegedly continued to bill concurrent surgeries even after receiving a memo from the UPMC compliance department about teaching physician documentation and billing rules for procedures.

Surgeons Must Be Present for 'Critical or Key' Portions

In the teaching hospital context, Medicare allows surgeons to bill professional fees for two overlapping surgeries if their "critical or key portions" aren't simultaneous. "When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure," according to Chapter 12 of the *Medicare Claims Processing Manual*.[7] "The teaching surgeon must personally document in the medical record that he/she was physically present during the critical or key portion(s) of both procedures." Three surgeries are another matter. The role of the teaching physician is classified as a supervisory service to the hospital instead of a physician service to the patient that's payable under the physician fee schedule.

DOJ alleged that UPMC created a "unique surgical 'suite'" for Luketich with interconnected operating rooms (ORs) at its Presbyterian Hospital so he could perform overlapping surgeries. He typically scheduled two complex surgeries around the same time. Because a teaching physician can't bill for three overlapping surgeries, the third usually was booked under another physician's name. "Luketich initiates the first two operations, in OR 26 and OR 27, and progresses them each to a point; but before the key and critical portions of those operations are complete, and while the patients in OR 26 and OR 27 are still under general anesthesia, Luketich leaves OR 26 and OR 27, and enters a *third* operating room, where he participates in a third, non-emergent, pre-scheduled procedure. Only after Luketich completes his portion(s) of that third procedure does he return to his customized surgical suite, and attend to the patients he left behind in ORs 26 and 27. He then regularly bills *all three* patients' insurance providers for his services—usually, as the 'primary surgeon' or 'co-surgeon,'" the complaint alleged.

When Luketich performed three overlapping surgeries or two complex procedures at the same time, the surgical and anesthesia time allegedly is often "artificially" lengthened because he generally doesn't let residents, fellows and junior attendings "substantively" advance procedures when he's not there, according to the complaint. That increases the risk to patients and in some cases "caused significant patient harm," with one patient losing a lower leg, DOJ alleged.

Claims Review Report Will Go to U.S. Attorney

As for the integrity provisions, the settlement requires UPMC to submit a corrective action plan to CMS and the U.S. attorney's office 30 days after the settlement takes effect. UPMC also must hire an auditor to review, for a year, all Medicare fee-for-service claims for surgeries performed by Luketich to determine their compliance with the relevant teaching physician regulations (TPR) and Medicare manual guidance and the corrective action plan.

At the end of the year, the auditor will submit a claims review report to UPP and the U.S. attorney's office. The report will have descriptions of the auditor's objectives, methodology, sources of data, review protocol and findings, including "a narrative explanation of the Auditor's review process and any errors identified in UPP's coding or documentation of the Claims Sample, and overpayments associated with the Claims Sample." The auditor will also suggest ways to improve UPP's billing and coding system(s) or controls for Medicare billing.

The settlement requires the claims review report to include a spreadsheet with this information for every paid claim in the claims sample:

"i. Federal health care program billed;
ii. Beneficiary health insurance claim number;
iii. Date of service;
iv. Code submitted (e.g., DRG, CPT code, etc.);
v. Code reimbursed;
vi. Allowed amount reimbursed by payor;
vii. Correct code (as determined by the Auditor);
viii. Correct allowed amount (as determined by the Auditor);
ix. Whether the item or service was appropriately documented; and
x. The dollar difference between allowed amount reimbursed by Medicare and the correct allowed amount."

No more than 60 days after getting the claims review report, UPP is required to repay CMS any overpayments identified by the auditor and provide evidence of the overpayment refund to the U.S. attorney's office.

"You don't typically see integrity provisions incorporated into a settlement agreement and it's also noteworthy the U.S. attorney's office is responsible for overseeing the audit," Gennett said.

Checklist of Core Competencies for Internal Investigators

This tool appears in the *Complete Compliance and Ethics Manual 2023*.[1]

When appointing an internal employee, likely one who already has other full-time responsibilities, to serve as an investigator for a potential compliance issue, here are some core competencies to keep in mind as you make your selection. While it is unlikely you will find a single employee who has all of these competencies, the more of these competencies they do have, the more qualified they are, and the better the investigation is likely to be.

Core Internal Investigator Competencies

- ☐ Absence of any actual or perceived conflicts of interest (organizational reporting structure or personal relationship)
- ☐ Ability to understand the business purpose of the investigation and the potential issues that may arise (i.e., the big picture)
- ☐ Understanding of the organization's applicable policies, procedures, and practices
- ☐ Interviewing skills, both verbal and nonverbal, including the ability to ask the tough questions
- ☐ Experience and training in investigation techniques and procedures
- ☐ Ability to speak the native language of witnesses to be interviewed
- ☐ Ability to be an impartial and neutral fact finder
- ☐ Ability to spot key issues and problem-solve
- ☐ Flexibility and good judgment
- ☐ Being well respected and trusted in the organization
- ☐ Supporting strong ethics and compliance culture, with a spotless integrity record
- ☐ Ability to establish boundaries and maintain rapport with witnesses
- ☐ Ability and willingness to maintain confidentiality
- ☐ Ability to appropriately document findings/write a good report
- ☐ Expertise in specific subject matter area at issue (e.g., discrimination, fraud, theft)
- ☐ Availability for anticipated time frame of investigation
- ☐ Relevant demographics (e.g., race, age, gender) that could affect the investigation (e.g., appointing an older employee to investigate a claim of age discrimination may result in a perception of bias in the investigation)
- ☐ Ability to serve as a witness if called to testify in litigation.

Endnotes

1. Society of Corporate Compliance & Ethics, "Checklist of Core Internal Investigator Competencies," *Complete Compliance and Ethics Manual 2023* (Eden Prairie: Society of Corporate Compliance & Ethics, 2023), http://bit.ly/3y5am8b.

Desk Audits May Not Get the Job Done

With overlapping surgeries under scrutiny, Gennett suggests that teaching hospitals consider reviewing their compliance with Medicare regulations for professional fee billing. Because overlapping surgeries also take place at nonteaching hospitals, they should consider comparing their practices against 2016 guidance from the American College of Surgeons (ACS), which considers concurrent surgeries on multiple patients in multiple operating rooms inappropriate. ACS says concurrent surgeries occur "when the critical and key components of the procedures for which the primary attending surgeon is responsible are occurring all or in part at the same time." Gennett said it's also a good idea to factor in informed consent practices, policies and training when thinking about overlapping surgeries.

Auditing overlapping surgeries "should be very thoughtful," Gennett said. For one thing, "doing a desk audit of claims isn't necessarily going to get you to the heart of what you're looking for. You have to piece together the medical record documentation, surgery schedule and electronic medical records data and often go further and talk to people about their practices." Some electronic medical records (EMRs) automatically generate in and out times and therefore may not accurately reflect when providers come in and out of the room. Also, manually entered times may not be precise. That's why it's important to consider how documentation entries are generated to confirm whether times are reliable, Gennett said.

"Sometimes we also see missing or potentially conflicting documentation that needs to be unpacked," she said (e.g., documentation for the first surgery says the surgeon was present "skin to skin" while the documentation for the overlapping surgery says the surgeon was present for the key and critical portions).

In terms of strengthening compliance, there are opportunities to build out controls that can be tailored to each institution's practices and risk tolerance, Gennett noted. Some EMR systems have controls related to the documentation of the attending physician's presence or absence. For example, Cerner has a tapping function that allows clinicians to tap into the chart during surgery. Also, hospitals can use their scheduling system to identify possible patterns and risk areas that help target reviews.

In a statement, Paul Wood, vice president and chief communications officer at UPMC, said that "While UPMC continues to believe Dr. Luketich's surgical practice complies with CMS's requirements, it has agreed to pay $8.5 million to the government to avoid the distraction and expense of further litigation. UPMC has also reserved the right to challenge the realtor's share of the settlement."

Efrem Grail, the attorney for Luketich, said, "We're pleased this settlement puts an end to the Government's case. Medical schools and their hospitals have sought clarity about the billing regulation for teaching physicians at issue here for years, and the United States has never provided it. This settlement provides a mechanism we hope will lead to authoritative guidance so that universally respected surgeons like Dr. Luketich can return their focus to training young doctors to save lives without having to put up with baseless claims of fraud."

Contact Gennett at lgennett@kslaw.com. ✧

Endnotes

1. U.S. Department of Justice, U.S. Attorney's Office for the Western District of Pennsylvania, "James L. Luketich, M.D., University of Pittsburgh Medical Center, and University of Pittsburgh Physicians Agree to Pay $8.5 Million and Implement Monitoring Actions to Resolve False Claims Allegations," news release, February 27, 2023, http://bit.ly/3SNIOhd.
2. United States of America ex rel. Jonathan D'Cunha, M.D. v. James Luketich. et al., No. 19-cv-495 (W.D. Pa., September 2, 2021), https://bit.ly/2VMFYjz.
3. U.S. Department of Health & Human Services, Office of Inspector General, "High Risk - Heightened Scrutiny," last accessed March 2, 2023, http://bit.ly/3XIqQhw.
4. Settlement agreement, United States v. University of Pittsburgh Medical Center and University of Pittsburgh Physicians, http://bit.ly/3IM96fh.
5. Nina Youngstrom, "Mass General Hospital Pays $14M in FCA Case on Overlapping Surgeries, Changes Informed Consent," *Report on Medicare Compliance* 31, no. 8 (February 28, 2022), http://bit.ly/3KOMjC7.
6. U.S. Department of Justice, U.S. Attorney's Office for the District of Arizona, "Neurosurgical Associates, LTD and Dignity Health, D/B/A St. Joseph's Hospital, Paid $10 Million to Resolve False Claims Allegations," news release, May 5, 2021, https://bit.ly/36qk3U7.
7. Center for Medicare & Medicaid Services, "Chapter 12 - Physicians/Nonphysician Practitioners," *Medicare Claims Processing Manual*, Pub. 100-04, revised December 8, 2022, https://go.cms.gov/2XXxnb5.

NEWS BRIEFS

◆ **Texas physician Ashok Jain and his three companies—Psychiatric Solutions P.C., Longview Psychiatric Center PLLC and Longview Psychiatric Center LP—have agreed to pay $3 million to settle false claims allegations, the U.S. Attorney's Office for the Southern District of Texas said March 3.**[1] "The allegations included intentionally pressuring patients to accept unnecessary medical treatments and billing for those treatments, falsifying treatment records and billing Medicare for worthless services and services they did not provide," the U.S. attorney's office said. Jain and the clinics allegedly billed Medicare for Transcranial Magnetic Stimulation (TMS) procedures that weren't performed and routinely administered TMS without a valid medical purpose. The case was set in motion by two whistleblowers who had worked at Psychiatric Solutions Longview. The business was sold in 2022.

◆ **Javery Pain Institute PC, in Grand Rapids, Michigan, has agreed to pay $215,000 to settle false claims allegations over medically unnecessary moderate sedation services and falsifying medical records to support the claims, the U.S. Attorney's Office for the Western District of Michigan said Feb. 27.**[2] The government alleged Javery Pain Institute charged Medicare for moderate sedation services provided with certain pain injection procedures when the sedation services didn't satisfy Medicare's medical necessity requirements. After this was uncovered in a Medicaid audit, the practice allegedly crafted template language in its electronic medical records to support medical necessity for the sedation services and used the templated language for some Medicare patients getting moderate sedation services "to create medical records that contained statements that were not true," the U.S. attorney alleged. "Additionally, on some occasions, the practice billed Medicare for moderate sedation services when the intraservice time for those procedures was less than the ten minutes required to bill for the service." The pain institute didn't admit liability in the settlement.

Endnotes

1. U.S. Department of Justice, U.S. Attorney's Office for the Southern District of Texas, "Psychiatrist settles claims for unnecessary brain stimulation treatments," news release, Friday, March 3, 2023, http://bit.ly/3kNU00L.
2. U.S. Department of Justice, U.S. Attorney's Office for the Western District of Michigan, "Grand Rapids Pain Management Practice Pays $215,000 To Resolve Allegations Of Falsified Medical Records," news release, Monday, February 27, 2023, http://bit.ly/41GfJZd.