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### ED Is Ground Zero for Medical Necessity Documentation; Docs Must Connect Dots

To typical emergency department (ED) physicians, it may seem obvious that a patient who’s not responding to anti-nausea drugs needs to be admitted. But often they document only “not responding to anti-emetics” in the medical record, when they also need to write “intractable vomiting.”

Medicare auditors don’t take anything for granted, so whatever rationale ED physicians have should appear in the chart if hospitals expect an inpatient stay to be deemed medically necessary. Intractable vomiting despite the administration of anti-emetics warrants an inpatient admission, according to Milliman, a screening tool used by many hospitals, recovery audit contractors and Medicare medical reviewers. But ED physicians need to connect the dots between anti-emetics and vomiting, since auditors won’t do it for them.

This kind of documentation disconnect is not uncommon in the emergency department. Though the ED is ground zero for most patients, physician documentation there has gotten less attention in the quest to improve documentation for medical necessity and quality of care. “It’s becoming clear this whole medical-necessity thing starts in the emergency department,” says Justin Chang, M.D., medical director of Exempla St. Joseph Hospital in Denver and chief of emergency services for Kaiser Permanente Colorado. “When Medicare audits charts, they go all the way back to the beginning of the hospital encounter, which is the ED. What happens there is part of the whole spectrum of the acuity level, so it’s hard to justify a status that’s radically different from what the ED chart reflected.” As CMS states in its Medicare Benefit Policy Manual, “All practitioners involved with and responsible for the patient’s care are expected to have knowledge of the patient’s hospital course, medical plan of care, condition, and current status.”

### Judge Grants Feds Second False-Claims Shot at South Carolina Health System

Tuomey Healthcare System had only two months to savor its False Claims Act victory over the Department of Justice before the federal judge who presided over the landmark trial said he would grant the government a second bite at the false-claims apple.

Not only will Tuomey have to repay CMS almost $45 million because a jury declared on March 29 that some of its physician employment deals violated the Stark self-referral law (RMC 04/12/10, p. 3), but the South Carolina health system will again have to face the government over allegations that the Stark violations caused the submission of false Medicare claims.

Senior U.S. District Judge Matthew Perry Jr. on June 4 granted DOJ a new trial on the false claims allegations against Sumter-based Tuomey. The judge said he made a mistake in excluding certain evidence from the trial. The jury’s Stark law findings stand,
and Perry will require Tuomey to pay $44.8 million in Medicare reimbursement that was collected in violation of the Stark law.

Pittsburgh attorney Dan Mulholland, who represents Tuomey, says “no orders have been formally entered by the court as of now. When and if such orders are entered, then Tuomey will determine what to do.” Motions filed by Mulholland object to the new trial but ask the judge to require the government to retry the entire case.

It was unusual the case ever went to trial because most hospitals settle false claims cases to avoid the risk of treble damages. The U.S. attorney’s office in Columbia, which tried the case, alleged that Tuomey’s part-time employment contracts with specialists were designed to lock in their patient referrals (RMC 12/7/09, p. 1). Compensation allegedly exceeded fair-market value and, therefore, violated the Stark law. As a result, the feds alleged, hospital claims for services referred by these physicians were false claims.

The false claims lawsuit was initially filed by orthopedic surgeon Michael Drakeford, one of the physicians offered an employment contract. After consulting with two attorneys who raised Stark concerns, Drakeford refused to sign the contract, according to the false claims complaint. Eventually he became a whistleblower, and the U.S. attorney’s office ultimately took over the case.

According to the lawsuit, increased competition for outpatient surgery in Sumter County environs prompted Tuomey to offer employment agreements to 18 community physicians. Under the 10-year employment contracts, the physicians were required to perform all their outpatient procedures at Tuomey.

Two compensation models were offered, the lawsuit alleged. Both called for base salary plus bonuses based on either the dollar value of the receipts that Tuomey received in connection with a physician’s services or the number of procedures performed by that physician.

The lawsuit alleged the gastroenterologists were paid a base salary of $120,000. To earn that salary, they had to perform at least 615 covered outpatient procedures during the previous year. If they didn’t, their base salaries drop to $60,000. However, Tuomey also pays the gastroenterologists 80% of their cash collections as a productivity bonus and another 5.4% as a quality incentive.

**MD Pay Was Allegedly 131% of Earnings**

The base salary that Tuomey paid the surgeons, obstetrician-gynecologists and the lone ophthalmologist was based on the cash collections they generated for their respective Tuomey specialty group during the previous year for covered outpatient services.

“Tuomey represented to the physicians that the bonuses would result in, on average, the physicians receiving approximately 131% of the actual amount of payments received in connection with the physicians’ services,” the complaint states. That compensation exceeded fair-market value and was not commercially reasonable, as Stark requires, the government alleged.

Tuomey adamantly denied its contracts were problematic and had one law firm opinion to back it up. After a three-week trial, the jury announced a split verdict: The hospital violated the Stark law but not the False Claims Act. The two sides then began to agree over whether the jury’s decision meant the hospital had to repay the $44.8 million the government alleged the hospital collected for services stemming from referrals by physicians who had the employment agreements that violated Stark.

The legal landscape may be different during the second trial. The judge agreed with Assistant U.S. Attorney Norm Acker, who is litigating the Tuomey matter, that it...
was a mistake to exclude a deposition given by Tuomey Chief Operating Officer-Senior Vice President Gregg Martin, according to a lawyer with inside knowledge of the case. In the deposition, Martin was asked how much he knew about an independent opinion on the employment deals. The formal opinion came from Kevin McAnaney, former chief of the HHS Office of Inspector General’s industry guidance branch. McAnaney had expressed Stark compliance concerns to both Tuomey and Drakeford, who jointly requested the advice. “When Mr. Martin was asked in his deposition how much detail Mr. Hewson [Tuomey’s lawyer] had told him about the conference call with Mr. McAnaney, he said that there had been ‘a good bit of discussion,’” according to the government’s motion. “This portion of the deposition would have been crucial to show the jury” that Hewson and Martin “knew about these warnings, and yet failed to heed them or even explore them further with Mr. McAnaney.”

At the hearing, Cam Lewis, an attorney for Tuomey, argued to the judge that “Mr. Martin’s testimony is...a little cumulative and...makes no difference,” according to a transcript. And in a motion, Mulholland said that “unfortunately, the government mischaracterized the contents of the deposition designation.”

But the judge, who had barred Martin’s deposition as hearsay for technical reasons, will allow the evidence the second time around.

Knowledge and Intent Are Key

The excluded evidence may be a game-changer because it gets at whether Tuomey knew it was violating the Stark law when it submitted Medicare claims for services, says Macon, Ga., attorney Alan Rumph.

“The issue of whether the False Claims Act was violated comes down to the hospital’s knowledge and intent,” says Rumph, with Smith, Hawkins, Hollingsworth & Reeves. “For false claims liability, you have to have known that the claim was false or fraudulent. In addition to actual knowledge, ‘knowing’ under the FCA includes reckless disregard for truth or falsity of the claim. It’s a standard that requires presumably more than ordinary negligence but certainly less than actual knowledge.” He says the government doesn’t have to prove Tuomey actually knew it was filing claims in violation of Stark; just that it recklessly disregarded whether Stark was violated.

If the government gets a false claims settlement or victory at trial, the whistleblower will get a piece of the action. That hasn’t been the case so far because the jury found the hospital to be liable only for Stark violations and there is no whistleblower reward in the Stark law.

Contact Rumph at alan@shhrlaw.com.

CMS Gives ‘Mixed Signals’ in New Physician Supervision Guidance

CMS has again put its pen to paper on the outpatient supervision requirement, this time fleshing out its expectations for supervising physicians’ competence and availability. In Medicare transmittal 128, which updates the outpatient prospective payment system (OPPS), CMS adds a fair amount of new language on the physician and nonphysician practitioner (NPP) supervision requirement.

Some lawyers think the transmittal contradicts April guidance posted on the CMS website, muddying the waters of a mandate already perceived as unreasonable.

“CMS is giving mixed signals,” says Portland, Ore., attorney Bernie Thurber, with Davis Wright Tremaine. The physician supervision requirement “is like a giant pendulum swinging back and forth and CMS can’t make up its mind.”

The 2010 OPPS regulation, which took effect in January 2010, requires physician supervision of outpatient diagnostic and therapeutic services and allows NPPs to supervise outpatient therapeutic services. Outpatient therapeutic services require direct supervision, which means the physician must be on campus and immediately available the whole time services are provided. CMS has defined “immediately available” as meaning “without interval of time.” Lawyers have interpreted this to mean supervising physicians can’t be performing another procedure that can’t be interrupted and shouldn’t have to sprint to prevent harm from coming to the patient in need of intervention.

Three Levels of Supervision Exist

There are three levels of supervision for outpatient diagnostic tests, according to the Medicare physician fee schedule: direct; general (which means the physician’s presence is not required when services are performed); and personal (which means the physician has to be in the same room).

The straightforward part of the transmittal emphasizes the limits of NPP supervision. NPPs can supervise only outpatient therapeutic services. CMS states that “diagnostic X-ray and other diagnostic tests must be furnished under the appropriate level of supervision by a physician.” While some types of NPPs may order and perform diagnostic tests without supervision, they can’t supervise diagnostic tests when performed by other hospital staff, CMS asserts.

Then CMS takes a stab at explaining the meaning of “immediately available” for purposes of satisfying the direct supervision requirement for outpatient therapeutic services. “CMS has not specifically defined the