Report on
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Contents

Health System Settles Case Over Assistants at Surgery; Certifications Magnify the Risk

University of Miami Health System has agreed to pay $289,573 in a settlement with the HHS Office of Inspector General (OIG) over payments for assistants at surgery. This area rarely bubbles to the surface, but it's lurking because assistants at surgery in teaching hospitals are required to certify their services were medically necessary and no resident was available to perform them, or report a modifier to that effect, an attorney said. Alleged noncompliance with Medicare regulations on assistants at surgery also is at the heart of an unrelated False Claims Act (FCA) lawsuit.

"This is another great example of a rule buried at the end of a Code of Federal Regulations subpart, but if you mess it up, it can get you in serious trouble," said attorney David Vernon, with Hooper Lundy & Bookman in Washington, D.C. It involves a judgment call by the attending surgeon that another attending physician should be the assistant at surgery instead of an available resident, said attorney Asher Funk, with Troutman Pepper in Chicago. "The assistant at surgery rules and the use of attending physicians supporting the primary attending in a teaching hospital is a compliance issue that providers need to be aware of. It's a risk area."

According to the civil monetary penalty settlement, obtained through the Freedom of Information Act, OIG alleged that University of Miami Health System submitted claims to Medicare, Medicaid and TRICARE for items or services it knew or should have known were fraudulent. Between July 1, 2011, and June 30, 2017,

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Compliant Query Update: 'No Set Number of Clinical Indicators;' Leading Queries Are a Risk

Even when they use technology, hospitals are responsible for ensuring their queries are compliant, according to a 2022 practice brief from the American Health Information Management Association (AHIMA) and the Association of Clinical Documentation Integrity Specialists (ACDIS) that was released Oct. 10.[1] Compliant queries are an industry standard, and CMS has echoed the concerns about "leading" queries that point physicians to diagnoses that may generate higher reimbursement.

The purpose of a compliant query is to clarify information about diagnoses and procedures and help providers create thorough and complete documentation in the medical record (see box, p. 3).[2] Coders and clinical documentation specialists (CDSs) typically submit queries to physicians to get a fix on the patient's diagnosis for coding and documentation integrity purposes.

"Even if you're doing a technology solution, it has to meet query requirements," said Erica Remer, M.D., co-host of Talk Ten Tuesday, a weekly podcast. "If your artificial intelligence is saying these clinical indicators indicate this one specific condition, that is not compliant because it is leading. Technology is only as good as the people who designed it." If she developed technology-driven queries, "In addition

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to offering all appropriate choices which matched the clinical indicators, I would have a disclaimer to say, 'You always have the option of declining our suggested diagnosis,' or always have a choice of 'other.'"

The practice brief has significant additions and more explicit discussions of definitions. It addresses query templates, problem lists and who and when to query, among other things, said Melissa Potts, a CDI practitioner at AHIMA, at the Oct. 11 Talk Ten Tuesday. There's a two-week comment period on the practice brief before it's finalized, she said.

Hospitals should guard against queries leading a physician to a particular diagnosis, especially if it generates more reimbursement or a more favorable score in a quality improvement/value-based performance program. "There's no rule or law specifically prohibiting leading queries, but it's industry standard," Remer said. Leading queries may "be construed as fraud" because they could cause upcoding. And compliance is not just about following laws and regulations or corporate policies, Remer said. "One of the hardest things I had to do as a physician adviser was wrap my head around compliance," she said. Sometimes it's about ethics and industry standards.

CMS Expects a Second Look at Leading Queries

There are times when Remer, as a physician and clinical documentation improvement expert, doesn't feel like "leading should be unkosher." For example, if the patient's blood count dropped from 12 to 7 and they had a transfusion, it doesn't seem like a leading query to confirm with the provider that the diagnosis is acute blood loss anemia. "But it's a slippery slope," she said. It may be obvious in that case, but sometimes CDSs think they know the answer and are wrong or the physician might be inclined to deviate from a legitimate urinary tract infection MS-DRG to a higher-paying sepsis MS-DRG just because they're asked.

Remer also noted that CMS addressed leading queries in a 2014 Medicare transmittal (18).[3] "The purpose of DRG validation is to ensure that diagnostic and procedural information and the discharge status of the patient, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the patient's medical record. Refer the case for a physician review if medical judgment is needed when changing the narrative diagnosis that the codes were based upon. Your reviewer must use his or her professional judgment and discretion in considering the information contained on a hospital's physician query form along with the rest of the medical record. If the physician query form is leading in nature or if it introduces new information, the nonphysician reviewer must refer the case to the physician reviewer."

The transmittal doesn't flat-out forbid leading queries, she said, but it "established the precedent of needing a physician reviewer to interpret the validity of the elicited diagnosis."

Remer said hospitals must decide whether to maintain queries as part of their medical/legal record or their business record. "If queries are asked and answered in the medical legal record, they are visible to any reader," she said. That may increase the likelihood that a diagnosis will get pulled into subsequent notes. "If queries are sequestered in the business record, they are allowed to be coded, but there is a greater chance that the diagnosis will be isolated, creating risk for denial. It is always recommended for diagnoses to appear more than once in the documentation. And whether in the medical legal or business record, queries are always discoverable."

Practice Brief: Clinical Indicators Are Required

The practice brief covers a lot of ground, including when to query providers. The list of reasons includes "to support documentation of medical diagnoses or conditions that are clinically evident and meet the Uniform Hospital Discharge Data Set (UHDDS) requirements but without the corresponding diagnoses or conditions stated" and to resolve conflicting documentation between providers.

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Queries may have different formats. They include open-ended queries, multiple-choice queries and yes/no queries.

Clinical indicators are required on queries. "There is no set number of clinical indicators to have a compliant query," Potts said. But they must fit the clinical scenario and should be removed if that's not the case. There also are no set minimum or maximum diagnosis options, Remer said. "You have to give choices that match the clinical indicators. If a query asks if there is acute hypoxic respiratory failure and the physician picks it but the patient doesn't have hypoxia, it sets up a clinical validation issue. If you generate a query, you need to remove query options that don't fit that clinical scenario," she noted.

That doesn't prohibit a CDS or coder from introducing a diagnosis, however. If they put in a diagnosis that matches the clinical indicators, "that's not considered new information," she explained.

To clear up confusion around an option often included in multiple-choice queries—"unable to be

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Checklist for Compliant Queries

This checklist was developed by Erica Remer, M.D. It's designed to help with compliant queries, which are the subject of an updated practice brief from the American Health Information Management Association and the Association of Clinical Documentation Integrity Specialists (see story, p. 1).[1] Contact Remer at eremer@icd10md.com.

Dr. Remer's Checklist for Effective, Compliant Queries

- ❒ Be sure you are clear on what needs to be clarified. Be sure your query is going to answer that question.
- ❒ Only provide choices which match the clinical indicators (e.g., don't offer "acute hypoxic respiratory failure" if the oxygen level is normal – if they choose that, it will set up a clinical validation issue).
- ❒ You may use prior encounter data as clinical indicators if the condition you are seeking to clarify is a valid secondary diagnosis in the current admission.
- ❒ Present all relevant choices which correspond to the clinical indicators (e.g., don't cherry-pick only risk-adjusting choices).
- ❒ There are no obligatory minimum or maximum number of choices (although at least two [suitable response and "other"] is recommended by Dr. Remer, if the query is not in an open-ended format).
- ❒ Always give an option for the provider to give an alternate explanation for the clinical indicators (e.g., "other _____").
- ❒ Don't coerce or give the appearance that you are trying to force the provider into choosing a specific diagnosis (i.e., leading).
- ❒ Your query/template should not have a specific diagnosis as a title (e.g., *Acute respiratory failure* for a query to clarify hypoxemia).
- ❒ Never provide quality or reimbursement implications in a query (you may present them AFTER the encounter has been closed out, as an educational tool). Don't have risk adjustment indicators associated with diagnoses in your EHR (e.g., [HCC] notated after the diagnosis in the problem list or impression).
- ❒ You must anticipate what will be left after the provider chooses an option. If you are left with a lack of clarity or nothing to code and will need another query to further clarify, the design of the current query is suboptimal (e.g., "unable to determine" can leave you in this predicament).
- ❒ Use "unable to determine" as a choice only when appropriate. Be sure providers understand this means undeterminable and not "I don't feel like making a decision or declaring an opinion."
- ❒ Know what constitutes a query. As soon as you pose a question (e.g., verbally, during education, by technological alert, as a result of a committee referral), it is a query and must be compliant.
- ❒ Make your queries understandable, concise, and easy to answer. If a query is convoluted and crowded, the provider will get confused and frustrated.

Endnotes

1. Nina Youngstrom, "Compliant Query Update: 'No Set Number of Clinical Indicators;' Leading Queries Are a Risk," *Report on Medicare Compliance* 31, no. 38 (Oct. 17, 2022).

determined"—the practice brief explains that the "options of 'unable to determine,' 'possible,' and 'unable to rule out' are NOT synonymous terms." Unable to be determined "is defined as the provider being clinically unable to determine if a diagnosis or further clarity can be provided in the documentation."

'Unable to Determine' Is Clarified

Remer calls "unable to be determined" one of her "personal bugaboos." It gives physicians a way out of thoughtfully answering a query, she said. "What it really is intended to mean is, 'I have investigated it and I can't determine whether the condition was present or not,' but doctors read it as, 'I don't have time for this.'" She sees a lot of this with COVID-19 queries. Coders or CDSs query the physician about whether the patient has COVID-related pneumonia or whether a COVID-19 diagnosis has been ruled out. If "unable to determine" is on the query, physicians often pick it as the path of least resistance, she said. "You may be stuck with nothing to code." It rarely affects the physician's professional fee to go that route, but "accurate documentation is for a lot of things"—medical/legal, compliance and quality of care, among them.

The practice brief also states for the first time that coders and CDSs may need to query to "clarify a diagnosis on an ancillary note that has been signed by a provider." The brief is signaling that a signature may not be enough to indicate a valid secondary diagnosis. Remer said this is important because some hospitals may try to design a technology solution to minimize documentation burden for the provider. The nutrition note is channeled to the physician for signature "and they think they're done," she explained. But there must be documentation of services provided to the patient, such as further clinical evaluation, treatment, or increasing nursing care. "Just having a signature without attestation or follow-up action doesn't demonstrate that the condition is a legitimate secondary diagnosis. Best practice is to weave the diagnosis into the subsequent medical record."

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Endnotes

1. American Health Information Management Association and the Association of Clinical Documentation Integrity Specialists, *Guidelines for Achieving a Compliant Query Practice*, October 10, 2022, update, https://bit.ly/3TeLOCj.
2. Nina Youngstrom, "Checklist for Compliant Queries," *Report on Medicare Compliance* 31, no. 38 (Oct. 17, 2022).
3. Centers for Medicare & Medicaid Services, "Update to Pub. 100-10, Chapters 04 and 07 to Provide Language-Only Changes for Updating ICD-10," October 10, 2014, https://bit.ly/3SapSaI.

Feds Discourage Ransom Payments, but 'the Answer Is Not That Simple'

The government discourages paying ransom to cybercriminals and in some cases prohibits it, but health care organizations may decide it's worth making a dubious deal with the devil to try to get back their data or keep it off the dark web, attorneys say. If they go that route, organizations run the risk of sanctions from the Treasury Department and will soon face new reporting requirements. They should look to the HIPAA security rule for cybersecurity preparedness, especially with the new Department of Justice (DOJ) civil cyber-fraud initiative, although HIPAA faces criticism for not keeping up with technology advances.

The FBI, the Cybersecurity and Infrastructure Security Agency (CISA) and the Treasury Department "all discourage paying ransom with the understanding by doing so there is no guarantee you will get files back and there can be sanctions risk in some situations," said attorney Kate Driscoll, with Morrison Foerster, at a Sept. 20 webinar sponsored by the Health Care Compliance Association. Treasury's Office of Foreign Assets Control (OFAC) issued an updated advisory in September 2021 on "sanctions risks associated with ransomware payments in connection with malicious cyber-enabled activities and the proactive steps companies can take to mitigate such risks."[1] It's a carrot-stick approach, she noted. As OFAC explained, "U.S. persons are generally prohibited from engaging in transactions, directly or indirectly, with individuals or entities ('persons') on OFAC's Specially Designated Nationals and Blocked Persons List (SDN List), other blocked persons, and those covered by comprehensive country or region embargoes."

States also are moving aggressively against ransomware attacks. So far, two have banned ransom payments to hackers by public institutions, Driscoll said.

The activity on this front reflects the ongoing threat of cyberattacks. Ransomware is "uniquely disruptive," and health care organizations are targeted because "criminal groups believe they are more likely to pay" in light of the time-sensitive services they provide, said attorney Alex Iftimie, with Morrison Foerster. In the second quarter of 2022, ransomware attacks in health care were estimated to have grown 90% after a slowdown in the first quarter, according to the attorneys. Last year, two-thirds of health care organizations reported ransomware attacks.

But the picture is mixed in terms of how much they pay and whether it gets the desired result. Driscoll said the proportion of health care organizations that recover

their data after forking over the ransom is about 61%. Whether to pay depends heavily on the organization's risk tolerance.

"To law enforcement's credit, there are a number of risks in paying ransom," Driscoll said. "You don't know what you're paying for, and you are in effect funding the next ransomware attack." But health care organizations often aren't "resilient" enough to "respond to attacks without making ransomware payments and to entities, the answer is not that simple," she noted. "If they refuse to pay, they could lose access to health care information that helps save people's lives. It's a difficult balance to strike. Our cyber resilience will never be so low that we never make ransom payments."

There's also "a bit of tension" because the victims of a ransomware attack (e.g., hospitals) "are victims of criminal conduct," said Nathan Reilly, an attorney with Morrison Foerster. They "want to communicate with state and federal law enforcement about what happened, but they have to think about their own risk, whether in civil litigation or regulatory or reputational risk."

When they make ransom payments, health care organizations will soon have to report them to CISA under the Cyber Incident Reporting for Critical Infrastructure Act of 2022 (in addition to breach reporting obligations under HIPAA).[2] The law, which was part of the 2022 Consolidated Appropriations Act, creates two reporting obligations for owners and operators of critical infrastructure: The first is an obligation to report ransomware payments within 24 hours and the second is an obligation to report significant cybersecurity incidents within 72 hours, Driscoll said. Incidents are considered significant if there's unlawful system access, malicious code found in systems and phishing attempts, among other things. The reports must include the incident date and time, number of people affected, a narrative of the events and other details.

"These are pretty strict requirements," Driscoll noted. "During ransomware attacks, there is a lot going on with hospitals where they are trying to regain access to critical lifesaving information." At the same time, they have to keep in mind reporting requirements and their various deadlines. "It places a burden on companies," she said, but there are enforcement mechanisms for the law, which won't be in effect until CISA implements final rules.

Two Settlements From Cyber-Fraud Initiative

Meanwhile DOJ is deploying the False Claims Act (FCA) against cyber-related fraud, Driscoll said. DOJ's civil division launched the civil cyber-fraud initiative last year and so far has announced two settlements, she said. In one of them, Comprehensive Health Services LLS (CHS) in Cape Canaveral, Florida, which is contracted to provide medical support at government-run facilities in Iraq and Afghanistan, agreed to pay $930,000 to settle FCA allegations, DOJ said.[3] "Under one of the contracts, CHS submitted claims to the State Department for the cost of a secure electronic medical record (EMR) system to store all patients' medical records, including the confidential identifying information of United States service members, diplomats, officials and contractors working and receiving medical care in Iraq," DOJ said. From 2012 to 2019, CHS allegedly didn't disclose to the State Department "that it had not consistently stored patients' medical records on a secure EMR system."

'A New Territory of Potential Exposure'

The use of the FCA to pursue cybersecurity failures "opens up a new territory of potential exposure" for government contractors, grant recipients and others who participate in government programs, Driscoll said.

With the heightened threat of ransomware attacks and pressure from the government not to pay threat actors, the stakes are high for investment in prevention. The HIPAA security rule advances that protection, said Melissa Crespo, an attorney at Morrison Foerster. "HIPAA is often criticized as not being sufficiently prescriptive and it is criticized because it isn't keeping up with the times and advances in technology" and whether that's accurate is a debate for another time. "But looking to the HIPAA security rule can help establish a baseline for preparedness and readiness and protecting your organization from ransomware arracks," Crespo said. A security risk analysis and incident response plan are two of the requirements. "What are the threats and vulnerabilities? Ransomware is one of the biggest threats."

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1. U.S. Department of the Treasury, "Updated Advisory on Potential Sanctions Risks for Facilitating Ransomware Payment," September 21, 2021, https://bit.ly/3ewb0Wd.
2. Consolidated Appropriations Act, H.R. 2471 (2022), https://bit.ly/3KQWh2K.
3. U.S. Department of Justice, Office of Public Affairs, "Medical Services Contractor Pays $930,000 to Settle False Claims Act Allegations Relating to Medical Services Contracts at State Department and Air Force Facilities in Iraq and Afghanistan," news release, March 8, 2022, https://bit.ly/3rTEsIH.

Recent Guideline May Keep Chest-Pain Patients Out of Observation

Although the inpatient versus observation narrative usually grabs all the attention, a recent guideline from the American College of Cardiology (ACC) on chest pain adds emergency room versus observation into the mix.[1] The guideline "recommends a dramatic change in disposition of some chest pain patients," said William Rifkin, M.D., associate vice president and managing editor of MCG Health, in a white paper.[2] As a practical matter, it should help send low-risk patients home from the emergency department (ED) in a few hours and prevent medically unnecessary observation stays.

"I'm not sure this is fully appreciated," Rifkin told *RMC*.

The ACC changed its guidelines for chest-pain patients who are identified in the ED as low risk, which he said are patients who are very unlikely to have a heart attack or major adverse cardiac event in the next 30 days. "Usually, the friction point is observation versus inpatient," he said. "For this population, it's ED treatment and release versus observation because not much testing needs to be done."

The reason this is possible is a new high-sensitivity troponin test along with clinical evaluation and EKG analysis, Rifkin said. If all these things look good, patients have less than a 1% chance of a major cardiac event over the next 30 days. "Nothing in medicine is perfect, but this is a pretty good evaluation." He said in the white paper that "designation as low risk was associated" with a negative predictive value (NPV) for myocardial infarction or death within 30 days that was over 99%.

In response to the evidence-based guidance from ACC, in February the MCG guidelines on the care of patients presenting to the ED with possible acute coronary syndrome (ACS)—the Chest Pain guidelines for Observation Care and Inpatient Care—have undergone change.

Using patient history and physical exam alone usually doesn't reduce the likelihood to 1% or less, the white paper stated. To get to that degree of certainty, the standard practice has been to rule out ACS over six or more hours with troponin tests that were not high-sensitivity and to send patients for hospital-based, noninvasive testing, such as coronary computed tomography angiography, according to the white paper. "Patients cared for in this manner were usually admitted to observation care, as the duration of care went beyond that routinely provided in the ED."

Now, according to the ACC guideline, "a significant portion (20% to 50% of chest-pain patients) can be labeled as low-risk within 3 or fewer hours of presentation, without need for observation care," he wrote in the white paper.

The guideline could affect a lot of people. About 20% to 40% of Medicare patients would fall into this group because chest pain is a top reason that fee-for-service and commercial patients present to the ED and wind up in observation, Rifkin said.

Guidelines May Lead to Payer Denials

One purpose of the guidelines is to reduce variation in diagnosis and treatment of patients, Rifkin said. "If you checked emergency departments in 50 EDs and asked how do they treat this patient, you would get many different answers." With evidence like this, MCG distills the ACC guidelines, which in this case are about 100 pages, into a list-logic format and walks providers through them. "After incorporating the changes due to the new ACC guidance, the Chest Pain Observation Care guideline indicates that patients identified as low risk do not need evaluation in observation care, that is to say, they can be evaluated and discharged directly from the emergency department," he said.

Keep in mind the ACC guidelines may lead to payer denials if hospitals put patients in observation or admit them despite the low risk of a cardiac event, said Ronald Hirsch, M.D., vice president of R1 RCM. Payers may question whether patients should have been hospitalized "and whether they should pay for hospitalization if the NPV suggests they have very little chance of adverse effects" without observation or admission. "Why would an insurance company be obligated to cover costs simply because the doctor recommended hospitalization?"

It's also safer for patients to avoid unnecessary tests. "More testing can lead to a cascade of over testing," Hirsch said. For example, if a patient with low-risk chest pain is hospitalized for an angiogram, during the angiogram an artery is accidentally punctured and they have to have emergency surgery, but the arteries were normal, "that's not an outcome you ever want."

Rifkin noted MCG is neutral and licensed to payers and providers. "One of our central tenets is we go with the evidence and whether something is good or bad for the patient," he said. "Our purpose is to help identify the right level of care for the patient."

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Endnotes

1. David S. Bach, "2021 AHA/ACC Chest Pain Guideline Perspectives," American College of Cardiology, October 28, 2021, https://bit.ly/3SXxTRp.
2. William Rifkin, *New Paradigm for Patients Evaluated for Acute Coronary Syndrome*, MCG Health, April 2022, https://bit.ly/3CTeefG.

Assistants at Surgery Case is Settled

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University of Miami Health System submitted claims for the services of an assistant at surgery in a teaching hospital for two employed physicians who didn't comply with the conditions of payment under 42 C.F.R. §415.190. Medicare pays extra when the assistant at surgery is not the resident and bills Part B separately.

The settlement stemmed from the health system's self-disclosure to OIG. It was accepted into OIG's Self-Disclosure Protocol on Dec. 18, 2017. That's a long time for a self-disclosure to sit unresolved, but in the intervening years, University of Miami was embroiled in an FCA lawsuit, and ultimately paid $22 million in May 2021.[1] University of Miami didn't admit liability in either settlement.

CMS keeps a tight lid on billing for assistants at surgery at teaching hospitals with graduate medical education (GME) programs when the program is related to the medical specialty required for the surgical procedure and a resident in the training program related to the specialty required for the surgery is available. The regulation defines assistants at surgery as physicians who actively assist the other physician in charge of the surgery. The reason for the limit, imposed by Congress, is that residents are already available at teaching hospitals to assist at surgery, and Medicare makes GME payments to teaching hospitals for training residents so teaching hospitals shouldn't be paid above and beyond for services that residents might be able to provide, Vernon said. "Medicare subsidizes residents at teaching hospitals and if you have residents to assist at surgery, that's what you should do," he explained. But CMS also recognized "teaching hospitals can't throw residents in every situation and there should be some circumstances where it would be appropriate to pay assistants at surgery something. Residents are busy and not always available or qualified."

Payment under the Medicare physician fee schedule is only available for assistants at surgery in teaching hospitals if they meet one of the conditions below, according to 42 C.F.R § 415.190:[2]

- "Are required as a result of exceptional medical circumstances." Vernon said an assistant at surgery might be required for certain life-threatening situations or multiple traumatic injuries, for example.
- "Are complex medical procedures performed by a team of physicians, each performing a discrete, unique function integral to the performance of a complex medical procedure that requires the special skills of more than one physician." Vernon explained this is a realization there will be complex procedures performed by a team of specialists and "it's not the type of procedure where only a resident could assist."
- "Constitute concurrent medical care relating to a medical condition that requires the presence of, and active care by, a physician of another specialty during surgery." For example, if a patient with a cardiac condition is undergoing abdominal surgery, a cardiologist might be present for the surgery, Vernon said.
- "Are medically required and are furnished by a physician who is primarily engaged in the field of surgery, and the primary surgeon does not use interns and residents in the surgical procedures that the surgeon performs (including preoperative and postoperative care)." Some physicians rarely use interns and residents, and won't be dinged for it if they have an across-the-board policy of never involving residents in their surgical procedures, Vernon said.
- "Are not related to a surgical procedure for which CMS determines that assistants are used less than 5 percent of the time." This is an across-the-board payment limitation for procedures that rarely use assistants at surgery, Vernon said. In other words, if assistants at surgery are used in

CMS Transmittals and *Federal Register* Regulations, October 7-13

Transmittals

Pub. 100-04, Medicare Claims Processing

- Home Health Claims - New Grouper Return Code Edits and Informational Unsolicited Response, Trans. 11644 (October 13, 2022)
- Ambulance Inflation Factor (AIF) for Calendar Year (CY) 2023 and Productivity Adjustment, Trans. 11642 (October 13, 2022)
- Calendar Year (CY) 2023 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures, Trans. 11640 (October 13, 2022)
- Provider Specific File (PSF) changes for Direct Medical Education (DME), Direct Graduate Medical Education (DGME), Organ Acquisition Cost (OAC) and Kidney Acquisition Costs (KAC), Trans. 11639 (October 7, 2022)

Pub. 100-08, Medicare Program Integrity

- Provider Enrollment Appeals and Rebuttals - Revised Instructions and Model Letters, Trans. 11637 (October 7, 2022)

Pub. 100-01, Medicare General Information, Eligibility and Entitlement

- Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2023, Trans. 11641 (October 13, 2022)

Pub. 100-06, Medicare Financial Management

- Notice of New Interest Rate for Medicare Overpayments and Underpayments -1st Qtr Notification for FY 2023, Trans. 11643 (October 13, 2022)

fewer than 5% of a type of surgical procedure across the nation, CMS doesn't pay for their services, Vernon said.

Assistant at Surgery Use is Transparent

The use of assistants at surgery is transparent to CMS and its Medicare administrative contractors (MACs). According to the "Medicare Claims Processing Manual," MACs process claims for services provided by assistants at surgery in teaching hospitals based on their certification that a qualified resident surgeon was unavailable or through the use of modifier 82.[3] The certification requires the assistant at surgery to agree to the following:

"I understand that §1842(b)(7)(D) of the Act (follow the link and select the applicable title) generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the A/B MAC (B)."

MACs keep the certifications for four years and do post-payment reviews as necessary, the manual explains.

The assistants at surgery rule is "not just a live body standard," Funk said. Attending physicians have a "lot of latitude to exclude fellows or residents" because "the primary obligation of the attending physician is to keep the patient safe." But the attending physician must make a judgment that a specific resident isn't qualified for a procedure "and that's subjective," Funk explained. Ideally, there would be a way to memorialize a physician's assessment that, for example, they grabbed another attending for a cardiac bypass because the available resident had never assisted on one. "You need to be able to explain that two, three, five years down the road," he said. "A subjective judgment is OK, but you need to be able to back that up when push comes to shove."

Brushing residents aside in favor of another attending physician has its own perils. It can help turn residents into whistleblowers, whether or not the allegations have merit, Funk said. But there may not be a lot of money at stake because assistants at surgery are paid by Medicare Part B, which reimburses at a much lower rate than Part A, and there's a payment reduction for assistants at surgery.

CMS, the MACs and whistleblower attorneys are paying attention to this area, Vernon noted. In 2017, an FCA lawsuit was filed against Advocate Christ Medical Center in Illinois, Cardiothoracic & Vascular Surgical Associates SC, and several physicians over Medicare payments for assistants at surgery when residents allegedly were available. The case was set in motion by a resident turned whistleblower. The judge dismissed the claims against Advocate Christ Medical Center with prejudice in 2018.[4]

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Endnotes

1. Nina Youngstrom, "Prosecutor: Provider-Based Notice Noncompliance Is 'Easy to Assess'," Report on Medicare Compliance 30, no. 34 (September 27, 2021), https://bit.ly/3j1Roby.
2. 42 C.F.R. § 415.190, https://bit.ly/3Mr7uJl.
3. Centers for Medicare & Medicaid Services, "Chapter 12 - Physicians/Nonphysician Practitioners," Medicare Claims Processing Manual, Pub. 100-04, revised March 4, 2022, https://go.cms.gov/2XXxnb5.
4. United States ex rel. v. Advocate Christ Medical Center, No. 13-cv-1826 (N.D. Ill. July 3, 2018) https://bit.ly/3VnBKJ2.

NEWS BRIEFS

◆ **HHS on Oct. 13 extended the COVID-19 public health emergency for another 90 days.**[1] That means the waivers and flexibilities that flow from it will continue.

◆ **In an Oct. 13 MLN Connects,**[2] **CMS said it will reprocess claims for 340B drugs paid on or after Sept. 28, 2022, "using the default rate,"** generally average sales price (ASP) plus 6%, in response to a Sept. 18 federal court decision.[3] CMS said it is vacating the "differential payment rate for 340B-acquired drugs" in the 2022 outpatient prospective payment system and uploading revised OPPS drug files for the rest of the year. This is the latest chapter of the ongoing skirmishes over the 340B drug-discount program. A decisive win for hospitals came down with the Supreme Court's June 15 decision that massive cuts to 340B drug payments are "unlawful."[4]

Endnotes

1. U.S. Department of Health and Human Services, "Declarations of a Public Health Emergency," October 13, 2022, https://bit.ly/3Vsz257.
2. Center for Medicare & Medicaid Services, "Vacating Differential Payment Rate for 340B-Acquired Drugs in 2022 Outpatient Prospective Payment System Final Rule with Comment Period," MLN Connects, October 13, 2022, https://go.cms.gov/3MytfH8.
3. Nina Youngstrom, "Hospitals Win Another 340B Decision, but Dollars May Not Come Fast," Report on Medicare Compliance," Report on Medicare Compliance 31, no. 36 (October 3, 2022), https://bit.ly/3T4vHaD.
4. American Hospital Association et al. v. Becerra, Secretary of Health and Human Services, et. al, No. 20-1114, U.S. (2022), https://bit.ly/3E1VsE3.