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

By Nina Youngstrom

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.

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.

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 relator'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.

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.