Compliance Programs That Demonstrate Strong Savings Will Be on Stronger Footing

With hospital revenue eroding, it’s important for the return on investment in compliance programs to be crystal clear to management and the board, and there are some surprising ways to accomplish this.

“Compliance will get harder, and it’s not just dealing with new rules. We will be faced with significant fiscal pressure from business development and finance,” said former federal prosecutor Robert Trusiak, chief compliance officer and associate general counsel at Kaleida Health in Buffalo, N.Y. The loss of Medicare payments from sequestration and the Affordable Care Act, the decline in inpatient services and the shift to outpatient settings are taking a bite out of hospital income, which will squeeze departments perceived as cost centers. “As compliance officers, try to identify ways you can say ‘yes’ to compliant growth and not just be the person who has two thoughts: either ‘no’ or ‘we must [refund an overpayment].’ You want to be the compliance officer who can achieve cost savings on behalf of your institution.”

That may be easier than you think. For nonprofits that operate on a 1% profit margin, $5,000 in cost savings equals $500,000 in new revenue, according to Trusiak. Compliance officers that find that kind of cost savings “will be the object of more people seeking more information from you,” Trusiak said at the Fraud and Compliance Forum co-sponsored by the American Health Lawyers Association and Health Care Compliance Association in Baltimore on Oct. 1.

continued on p. 5

IPPS Rule: One-Day Stays, Resident ‘Discussion’ Requirement Vex Hospitals

Admission orders and one-day stays are very much on the minds of hospitals as they parse the language in the 2014 inpatient prospective payment system (IPPS) regulation and the related Sept. 5 guidance. There is concern because the guidance says that residents in teaching hospitals are required to contact attending physicians before admitting patients. At the same time, hospitals are worried that Medicare auditors will never see a short stay claim they like, no matter how acutely ill the patient is.

The “subregulatory” guidance on inpatient orders and certification allows residents to order hospital admissions “but only after discussion with the attending physician because residents don’t have admitting privileges,” says Ronald Hirsch, M.D., vice president of the regulation and accreditation group at Physician Advisory Services. Some teaching hospitals “are freaking out” because typically residents admit patients to the attending’s service, with the attending physicians learning of the admission when they arrive at the hospital for rounds or are notified the next morning by phone call.

The IPPS rule throws a wrench into the works, Hirsch says. “CMS wants the force of law behind admissions to the hospital because physicians are the only ones legally allowed to admit,” he says.

continued
Forcing residents to contact attending physicians before admitting patients will make them very unhappy—if CMS enforces the language, which appears only in the guidance, not the regulation. There is some indication it may back off a literal application of the provision. If not, teaching hospitals have to loosen interpret it to be able to go about their business, some observers say.

The subregulatory guidance states that “following discussion with and at the direction of the ordering practitioner, the order (including a verbal order) may be documented by an individual who does not possess these qualifications (such as a physician assistant, resident, or registered nurse), as long as that documentation (transcription) of the order is in accordance with State law including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.” Attending physicians also must authenticate verbal orders before discharge.

Ivy Baer, senior director and regulatory counsel for the Association of American Medical Colleges, doesn’t think CMS intended for residents to call attending physicians all through the night. “I believe CMS thought it was allowing residents to admit” and that it was closing a loophole, she says. AAMC is urging CMS to clarify this and other aspects of the IPPS rule and to extend the audit reprieve past Jan. 1. Meanwhile, “compliance officers are trying to do their best to comply” with the language on residents, Baer says. She doubts teaching hospitals are following the strictest interpretation, but “I think attendings are well aware of the admissions. They are somehow signing or confirming or doing whatever they need to do.”

**Is This Much Ado About Nothing?**

This is much ado about nothing, says Jeffrey Farber, M.D., chief medical officer at Mount Sinai Care and associate professor at Mount Sinai Medical Center in New York City. “I don’t think CMS is trying to be unreasonable and shake up the order of things,” he says. “We have hundreds of residents admitting patients and they can do this under the supervision of the attending physician. They don’t have to be physically or verbally communicating 24/7 about admissions.” Because the attending physicians are required to authenticate orders when they arrive at the hospital for rounds or on the phone, they can always reverse the resident’s order if they disagree with it, Farber says.

The fact is, the resident confers with the emergency room physician, who knows the patient best at that juncture, he says. “I don’t think you need to wake up the attending physician,” Farber says. To adhere to the certification requirements in the IPPS rule, Mount Sinai set up a system where the inpatient order is routed to the attending physician for co-signature. “That’s the part that matters,” he says.

Hospitals also worry about the fate of claims for resource-intensive patients who stay a day or so. Under the two-midnight rule in the 2014 IPPS, which took effect Oct. 1, CMS generally will assume inpatient admissions that cross two midnights are medically necessary unless they are delayed on purpose (RMC 8/12/13, p. 1, 9/2/13, p. 1). The clock starts ticking toward two midnights when patients begin receiving care in any setting, including observation or the emergency room. That means auditors will turn their attention to shorter stays except for procedures on the inpatient-only list, although CMS delayed RAC and most MAC audits of inpatient admissions with dates of service from Oct. 1 to Dec. 31, 2013, except for MAC probe reviews of short stays (RMC 9/30/13, p. 1).

But short stays are sometimes medically necessary, compliance experts say. In a Sept. 13 letter, AAMC urged CMS to change its new policy and cover short inpatient procedures on the inpatient-only list, although CMS delayed MAC probe reviews of short stays (RMC 9/30/13, p. 1).
this type of outpatient surgery takes 30 minutes. However, in her case it unexpectedly requires 90 minutes and is complicated by difficulty in mobilizing the gallbladder, requiring another surgeon with laparoscopic expertise to join the primary surgeon to avoid having to convert to an open procedure. There is intra-operative low blood pressure requiring medications and fluids, and she is sent to the ICU overnight for close monitoring and repeat blood testing. The expectation is that she will be discharged the following day. To treat this stay as an outpatient stay is unfair to the Medicare beneficiary who will shoulder a much higher financial liability for the care, and to the hospital that provided medically necessary services for which they will be inadequately compensated.”

Strategies Are Needed for Short Stays

There will always be some patients who fall into this category, says Larry Hegland, M.D., chief medical officer and system medical director for recovery audit and appeal services at Ministry Health Care in Weston, Wis. CMS’s own data on average and geometric mean lengths of stay shows “quite a few DRGs are less than two days,” he says. While Hegland doesn’t expect short inpatient stays to pop up that often, they will have a target on their back. In response, he has developed a process for addressing them:

1. **Review short-stay cases** and either use condition code 44 to recast them as outpatients or, if it’s after discharge, rebill the stays to Part B pursuant to the hospital’s utilization review processes.

2. **Set up an early warning system in case management** to identify short stay cases that are medically necessary. If the admission qualifies as an inpatient according to admission screening criteria (e.g., InterQual), that triggers a physician adviser process. “We will look at that case and make an assessment of the physician’s complex medical judgment,” Hegland says.

Hirsch points out that CMS addressed short stays on page 50947 of the IPPS rule. “In this rule, we have not identified any circumstances where the two-midnight benchmark restricts the physician to a specific pattern of care, as we have specified that the two-midnight benchmark, like the previous 24-hour benchmark, does not prevent the physician from providing any service at any hospital regardless of the expected duration of the service.”

Physician training on the two-midnight rule is another challenge of the IPPS rule. “I have great difficulty getting them to understand this. They view this as a clinical decision, but Medicare just wants to know which way the bill will go,” Hegland says. If it’s inpatient, it’s Part A, and if it’s outpatient, it’s Part B. And now the decision to admit is time-based “unless there’s a compelling reason to go outside the rules,” he says. But doctors just want to take care of patients and a bed is just a bed — resources vary by the unit (ICU, med-surg, telemetry), not observation vs. inpatient. Location matters to beneficiaries, however, in terms of lower copays, so that’s another factor. “If observation is not appropriate, you saddle patients with a much larger bill,” Hegland notes.

With the implementation of the two-midnight rule, CMS threw out the severity of illness and intensity of service model for determining site of service, Farber notes. “CMS is saying ‘if patients need to be in the hospital, that’s what counts. If you think they will get better and go home tomorrow, put them in observation. If they need to stay in the hospital another night, write the admission order and keep them there,’” he says. “We spent all our time trying to demonstrate severity of illness and intensity of services to justify admission, and now Medicare says ‘we don’t care.’ It’s all irrelevant.”

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In New Stark Advisory Opinions, CMS Says ‘Yes,’ ‘No’ to Free Devices

In its first advisory opinions on the Stark law since 2011, CMS came to opposite conclusions about two arrangements between physicians and clinical labs that on the surface seem similar.

In the first opinion (CMS-AO-2013-01), CMS said a clinical lab could provide free Pap smear specimen collection kits to referring physicians without running afoul of the Stark law. The kits are not surgical devices and therefore don’t create a compensation arrangement that triggers Stark.

In the second opinion (CMS-AO-2013-02), CMS said a clinical lab would invite Stark problems by giving referring physicians free disposable biopsy brushes used to excise visible exocervical lesions. The brushes are a surgical device and therefore a form of remuneration, which creates a compensation relationship with physicians and implicates the Stark law, CMS said.

“This sends a message to labs that they need to closely monitor the items and devices they are providing to physicians to make sure they fit in the exception to the definition of remuneration. They have to be used solely to collect and transport specimens, and items or devices given to physician can’t be used as part of a billable service,” says attorney Bob Wade, with Krieg DeVault in Mishawaka, Ind. Stark aside, physicians who accept free goodies from entities they refer business to are playing with fire under the anti-kickback and civil monetary penalty laws, he says.

continued
The Stark law bars Medicare payments to entities that provide “designated health services” (e.g., lab work, inpatient and outpatient hospital services) when they are provided to patients referred by physicians who have a financial relationship with the DHS entity, unless an exception applies. That includes compensation arrangements, which refers to arrangements involving “remuneration” between DHS entities and referring physicians. However, CMS carved out an exception for “items, devices, or supplies that are used solely to...collect, transport, process, or store specimens for the entity providing the item, device, or supply.”

CMS’s analysis of the two lab arrangements turned largely on whether the devices provided free to physicians could take refuge in this exception.

The clinical lab that got the green light from CMS gives physicians liquid-based Pap smear specimen collection kits for obtaining cells to screen for abnormal growth of cervical cells. The kits — which are patented, FDA cleared and disposable — are classified as cervical, cytological spatulas.

CMS started by evaluating whether they are surgical devices. FDA defines a “manual surgical instrument for general use” in surgical procedures as a non-powered, hand-held, or hand-manipulated device, either reusable or disposable, according to the opinion. FDA lists about 50 kinds of devices, including a spatula. But the FDA is not “dispositive” under Stark, says CMS, which also consulted its medical officers and the CPT manual. Ultimately, it concluded the kits are used for a screening exam and therefore are not surgical.

The next question was whether the kits are used solely to collect or transport specimens or have some other value to referring physicians. The lab confirmed the devices are disposable and have no application beyond the collection of cervical cells. The lab keeps track of the number of devices it gives physicians to ensure it approximates the number of specimens they send to the lab for analysis. Therefore, CMS concluded there was no remuneration for referring physicians and no Stark violation.

But CMS did not have the same good news for the other clinical lab arrangement. The lab wants to give referring physicians free biopsy devices that are an alternative to traditional punch biopsies. Biopsies with the single-use devices are billed with the same CPT code as punch biopsies — CPT 57454 (colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage).

The biopsy devices are a surgical device, item or supply, CMS said. They are used for biopsies, which are surgical procedures that “go well beyond the mere scraping of surface cells seen in a Pap smear.” Therefore, free devices would be remuneration to referring physicians and could trigger the Stark law.

But Wade notes that labs could still supply the devices to referring physicians if they meet a Stark exception. The lab and physicians could sign a sales agreement in which the physicians agree to pay a fair-market value price for the device. But there shouldn’t be any tying of referrals to the purchase of the devices, Wade says.

Contact Wade at rwade@kdlegal.com. Read the advisory opinions at http://www.cms.gov/Medicare/Fraud- and-Abuse/PhysicianSelfReferral/advisory_opinions. html.

**Health Plan Settles CMP Case Over Payments for Patient Referrals**

Molina Healthcare of Florida, Inc. agreed to pay $257,111 to settle allegations it violated the civil monetary penalty laws. The HHS Office of Inspector General alleged the health plan violated the CMPLs that impose fines for violations of the anti-kickback statute.

According to OIG, Molina allegedly offered to raise the capitation rates paid to four physicians in return for their patient referrals and followed through with two of the physicians. Some of the patients were covered by Medicaid. The health plan applied to the OIG Self-Disclosure Protocol and was accepted in April 2012.

“It is significant because it demonstrates that, in the managed care context, kickbacks can take a variety of forms, including increasing capitation rates for enrollment, or even favoring the provider with assigning more patients in exchange for recommending enrollment,” says Washington, D.C., attorney Carrie Valiant, with Epstein, Becker & Green, which wasn’t involved in the case. She says “white-coast marketing” has always been sensitive in the managed-care arena, but it isn’t flat-out forbidden, and it’s unclear where the line is drawn.

“Since this was a self-disclosure, it is interesting that the MCO itself thought this practice was a violation. MCOs don’t always realize that their conduct can implicate the anti-kickback statute. They think it is just about
provider payment for referrals, when it is really much broader than that,” Valiant says.

Molina did not admit liability in the settlement.

Contact Valiant at cvaliant@ebglaw.com.

Show Compliance Saves Money
continued from p. 1

One strategy to reduce costs, which sounds counterintuitive, is a self-disclosure to the U.S. attorney’s office for short stays that may be medically unnecessary. Assuming your hospital has potential liability for certain MS-DRGs based on RAC audits of earlier claims, self-disclosure to the U.S. attorney is a money saver. For one thing, it will shut down the RAC audits of the short stays. “Before you self-disclose, make sure your U.S. attorney’s office has the ability to suppress all RAC activity,” Trusiak said. “They all have it. Some have desktop ability; some need to coordinate with CMS.” Then contact the U.S. attorney’s office, perhaps using outside counsel. But hospitals shouldn’t go any further until the U.S. attorney has given its blessing to audit parameters. “The key is this: When you make the self-disclosure, you won’t get letters from the RAC every 45 days saying ‘give us 435 medical records for all the DRGs we are reviewing,’” he said. And you may be spared the RAC or Medicare administrative contractor’s (MAC) interpretation of medical necessity. Trusiak said that NGS, the MAC in his region, uses a “simplistic method of evaluating whether DRGs are inpatient or outpatient.” If physicians are treating a symptom, the patient should be an outpatient. If physicians are treating a diagnosis, the patient should be an inpatient. But there’s no support for this method in CMS definitions of an “inpatient,” he said. By self-disclosing, hospitals may apply InterQual or Milliman admission screening criteria, which will identify a smaller subset of medically unnecessary short stays. “Plus you give yourself the benefit of a netting analysis,” Trusiak said, allowing hospitals to subtract outpatient reimbursement from the inpatient overpayment.

Compliance officers also could save their institutions a boatload of money by tackling “abandoned property” before the state beats a path to their door, Trusiak said. “This is the stuff that used to be called compliance before we had compliance,” he said. Cash-strapped states are paying private companies a contingency fee to track down unclaimed property from corporations, partnerships and limited liability companies. Abandoned property generally isn’t real estate; it includes checks on patients within 24 hours of discharge. His hospital checks on patients within 24 hours of discharge. His hospital also downloads a load of abandoned property, which it then begins to process. “In the state audit office, which is waiving penalties and interest, Trusiak said. “This is an area of significant exposure, but it’s something we’ve forgotten to do because we are so caught up doing everything for HHS and OIG.”

Readmissions, which trigger Medicare penalties, are another area where compliance officers can show they are more than a cost center. So far, two-thirds of hospitals had their readmission rates reviewed and 2,213 hospitals were penalized. According to articles in the New England Journal of Medicine, patients are most at risk for readmissions in the four to seven days after discharge. “We are keying in on the discharge planning process and the post-discharge process,” Trusiak said. The hospital checks on patients within 24 hours of discharge. His hospital also works with private payers on this problem. Some send home health aides to patients’ homes within four days of discharge to ensure they are recovering. “It

CMS Transmittals and Federal Register Regulations
Oct. 18 — Oct. 24

Live links to the following documents are included on RMC’s subscriber-only Web page at www.AISHealth.com. Please click on “CMS Transmittals and Regulations” in the right column. This list also contains earlier transmittals just posted due to the government shutdown.

Transmittals
(R) indicates a replacement transmittal.

Pub. 100-02, Medicare Benefit Policy Manual

Pub. 100-04, Medicare Claims Processing Manual
• Medicare Remit Easy Print Annual Enhancement, Trans. 2795CR, CR 8467 (Sept. 27; eff. Jan. 1; impl. Jan. 6, 2014)

Pub. 100-07, State Operations Manual
• Chapter 2 Policy and Nomenclature Revisions for Intermediate Care Facilities for Individuals with Intellectual Disabilities, Trans. 915OMA, (Sept. 27; eff./impl. Sept. 27, 2013)

Pub. 100-08, Medicare Program Integrity
• 100% Prepayment Review and Random Review Instructions, Trans. 489P, CR 8427 (Oct. 18; eff./impl. Nov. 19, 2013)

Pub. 100-20, One-Time Notification
• OWF Editing for Vaccines Furnished at Hospice (R), Trans. 1298OTN, CR 8098 (Sept. 30; eff. Oct. 1; impl. Oct. 7, 2013)
is that critical time post-discharge where we will beat or lose on readmissions,” he said (RMC 6/10/13, p. 1).

Reducing the risks of a fraud enforcement action is one of the most critical cost-saving roles compliance officers play. Enforcement shows no signs of letting up, especially since health care spending is expected to reach $4.64 trillion in 2020, with 3% to 10% lost to fraud, said John Kelly, former assistant chief for health fraud in the Department of Justice criminal division.

But compliance programs won’t do much good unless “they are critically reviewed on a regular basis,” Trusiak said. They should be revised to reflect changes in laws, regulations and reporting requirements. If the auditing component is still stuck on 72-hour window unbundling, it’s probably stale. “That made sense about 15 years ago,” he said.

Reverse false claims have raised the stakes for the compliance program. The Affordable Care Act and the Fraud Enforcement and Recovery Act turned knowledge of an unreturned overpayment into a False Claims Act violation. Suppose the compliance officer arrives at work Monday to find an email thread by well-meaning employees with words like “fraud” and “intentional wrongdoing.” First, shut the email exchange down, Trusiak said. “Telephone is still an outstanding method of communication,” he said. “And the first information is always wrong or at least incomplete.” The employees want to audit immediately, but as soon as they fix on an

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**Decision Tree for Using Outside Counsel/Consultants vs. Handling Compliance Matters Internally**

This decision tree was developed by Danette Leigh Slevinski, vice president and corporate responsibility officer at Bon Secours Charity Hospital System in Suffern, N.Y.; John Kelly, an attorney with Bass Berry & Sims in Washington, D.C., and Robert Trusiak, chief compliance officer and senior associate general counsel at Kaleida Health in Buffalo, N.Y. It’s designed to help compliance officers choose between internal and external experts for particular challenges, Slevinski says. “There is no perfect decision. There are risks and benefits to either choice,” she notes. Contact Trusiak at rtrusiak@kaleidahealth.org, Slevinski at danette_slevinski@bshsi.org and Kelly at jkelly@bassberry.com.
overpayment, the hospital has 60 days to return it. For now, maybe let the whole thing unwind a couple days. “Do pre-claim audits on the front end” to determine whether the hospital is, in fact, billing incorrectly instead of a retrospective audit because that creates knowledge. “Under the reverse false claims act provisions, once you have knowledge, you must repay even if the conduct was inadvertent. You have transformed a billing mistake into a treble-damage mistake,” Trusiak said. And consider using outside counsel to cloak the exercise in attorney-client privilege.

There’s “tremendous value” in cloaking the information in attorney-client privilege, added Kelly, now with Bass, Berry & Sims. It lets hospitals control how information is shared with the government while establishing credibility in the event they self-disclose a violation, he said.

No matter how hard compliance officers work, at some point their institutions will face regulatory or law enforcement actions, Trusiak said. When that happens, compliance officers should educate law enforcers on the depth of the compliance initiatives and why their hospitals should not face double or treble damages. The assistant U.S. attorney is handed a tidy whistleblower complaint that makes the allegations seem so obvious — “why couldn’t the hospital figure this out? — so you need to show them all of the other things in the compliance program."

With reimbursement dropping and costs climbing, compliance will have to leverage its resources more effectively. “Hospitals are shrinking. Overhead has to go down,” said Danette Leigh Slevinski, vice president and corporate responsibility officer for Bon Secours Charity Hospital System in Suffern, N.Y. If they all work in silos, hospitals won’t be able to afford highly paid compliance officers, auditors, legal counsel, HIPAA privacy and security officers. “What you will see is a reduction in overlap and the need for collaboration,” Slevinski says. “There have to be experts in all these areas, but if these folks are duplicating efforts, it will be too costly.” She predicts greater leveraging of internal expertise, such as revenue cycle, as well as external experts (see box, p. 6). For example, hospitals may consider giving patients free glucometers after consulting with outside counsel because of the potential for kickback or civil monetary penalty liability.

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**NEWS BRIEFS**

- In a footnote to its third-quarter financial statements filed with the Securities and Exchange Commission, Omnicare, the largest dispenser of prescription drugs to nursing homes, says it has agreed to pay $120 million to settle false claims allegations in a whistleblower lawsuit. Omnicare emphasizes that the settlement is not an admission of wrongdoing. The lawsuit alleged that the Cincinnati, Ohio, company gave discounts to nursing facilities in return for referrals of patients with drug costs reimbursed by Medicare. Despite the fact that the government did not intervene in the case, it will get between 65% and 70% of the settlement, with the rest going to the whistleblower, a former Omnicare pharmacist. The settlement still must be approved by the court and the Department of Justice. The case is U.S. ex rel. Gale v. Omnicare Inc., 10-cv-00127, N.D. Ohio. Visit http://tinyurl.com/12cv9ts.

- The latest issue of the Medicare Quarterly Provider Compliance Newsletter features seven findings identified by the CERT contractor and recovery auditors. The CERT addressed clinic end-stage renal disease services and immunosuppressive drugs, and for both issues the problem was insufficient documentation to meet Medicare requirements. The RAC finding, inappropriate outpatient payment for vertebral augmentation procedures, focused on diagnosis codes that did not match those in the local coverage determination. A second outpatient issue was an incorrect source of admission code when a patient was transferred within the same facility to its inpatient psychiatric distinct part unit. Hospitals also were incorrectly reporting the principal diagnosis for patients admitted with conditions such as dehydration or anemia, but who also had a documented neoplasm (metastasis as secondary diagnosis, MS-DRGs 820-825, 840-842). Two physician issues included office visits billed for hospital inpatients and evaluation and management services with allergy services. Visit http://tinyurl.com/ljdm8l.

- OIG has released its findings on the impact physician-owned distributorships have on the cost and volume of spinal infusion surgeries in hospitals. OIG investigated the issue at the request of Congress. While it did not find any significant cost difference between surgeries using the POD-purchased spinal infusion devices and those that did not, OIG did find an increase in the number of
surgery performed using them. PODs supplied almost 20% of these devices in spinal surgeries billed to Medicare, according to the report. OIG also found that approximately one-third of the hospitals in the study of 1,000 purchased the devices from PODs, and, of these, two-thirds purchased from PODs owned by their surgeons. Once hospitals began purchasing from the POD, their rates of spinal surgery grew faster than the rate for hospitals overall. Based on these factors, OIG concluded that PODs, which are a significant presence in the spinal device market, may increase the cost of spinal surgery to Medicare over time. OIG also found a great variation in hospital policies on disclosure of a physician’s ownership interest in a POD, which compromises the ability of hospitals and patients to identify potential conflicts of interest. Visit http://tinyurl.com/mwtpkco.

◆ Eugene Goldman, who was convicted in June of conspiring to violate the anti-kickback statute and violating the statute, was sentenced on Oct. 23 to 51 months in prison and fined $300,000. According to the press release from the U.S. Attorney for the Eastern District of Pennsylvania, for more than 10 years Goldman was the medical director for Home Care Hospice Inc., which provided hospice services for patients in a variety of settings. Goldman regularly referred Medicare and Medicaid patients to HCH and entered into a contract with the company that reportedly paid Goldman for his medical director services. However, evidence at trial supported the conclusion that a large majority of payments from HCH to Goldman were illegal payments for the referral to HCH of Medicare and/or Medicaid patients. Visit http://tinyurl.com/ntsaaaww.

◆ A former Rhode Island physician will pay the government $1.2 million, which is twice the amount he allegedly overbilled Medicare and Medicaid. In an Oct. 17 press release from the U.S. Attorney for the District of Rhode Island, the government alleged that Dr. Hafeez Kahn overbilled government health programs for some services and also submitted claims for services never performed. Visit http://tinyurl.com/mwtpkco.

◆ The HHS OIG gave the thumbs up to a plan by a community health services organization to bill Medicaid for dental services, while continuing to provide free dental services to uninsured and underinsured financially needy children. The organization asked whether its Medicaid billings would be “substantially in excess” of its “usual charges” in violation of Section 1128(b)(6)(A) of the Social Security Act. In AO 13-13, OIG explained that when calculating their usual charges, providers and suppliers do not need to consider free or substantially reduced charges to uninsured or underinsured patients who are responsible for the charges for items or services furnished to them. Because the organization would not provide free services to Medicaid beneficiaries or bill other federal health care programs, no remuneration would be provided to patients who would receive items and services payable by federal health care programs, and thus there are no violations. OIG also issued Advisory Opinion 13-14, which concerns a county that would not bill residents for cost-sharing amounts for emergency ambulance services, but instead would use tax revenues to cover the unpaid cost-sharing amounts. Visit http://go.usa.gov/DhvV.

◆ A Corpus Christi, Tex., physician was indicted on Oct. 9 for nine counts of health care fraud, three counts of mail fraud and two counts of aggravated identity theft. According to a press release from the U.S. Attorney for the Southern District of Texas, Dr. Roque Joel Ramirez allegedly submitted claims to Medicare totaling more than $1.4 million for services he did not perform. He allegedly billed for services provided to patients who died before the date of service; billed for services on days when he was out of the country or in another state; and billed for services that would have required him to have personally worked more than 24 hours in a single day. The aggravated identity theft charges related to using the Medicare identification numbers of the deceased patients. Ramirez was arrested on Oct. 11. Visit http://tinyurl.com/n65g9nz.

◆ Many compliance program budgets continue to increase, according to new survey results from the Society of Corporate Compliance and Ethics and Health Care Compliance Association. This year, 38% of survey respondents report greater spending on compliance programs. Half said budgets stayed the same and 12% reported a decline. Budget increases were not uniform. “While 35% of health care companies reported an increase, a much higher 41% of non-health care companies saw positive growth,” the survey says. Visit http://tinyurl.com/l8q3sfv.
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