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**Auditors Sharpen Focus in Physician Audits; Prepayment Reviews Put Revenue at Risk**

The hunt is on for physician billing that falls outside the norm, as Medicare audits seem to move toward the services — and the physicians — identified as outliers and away from the others. Compliance officers say internal audits and education should follow suit so they don’t waste resources on physicians who follow coding and medical necessity guidelines, a form of triage that’s invaluable as hospitals employ more physicians. They are also showing up in a steady stream of enforcement actions, including American Family Care’s $1.2 million false claims settlement (see story, p. 4).

Physician audits — internal and external — are a complex area for patient accounting departments that handle technical and professional billing. Claim for claim, evaluation and management services don’t have the price tag of MS-DRGs or surgical APCs, so the emphasis is on the latter, says Stephen Gillis, director of compliance coding, billing and audit for Partners HealthCare in Boston. “This is a huge challenge,” he says. “The volume is high but the payments are low.” Prepayment probe reviews of physician services may fly under the radar because Medicare administrative contractors (MACs) request documentation as a matter of course. When the claim is downcoded, the billers might not notice. “The claim gets paid, so it doesn’t throw up a red flag,” Gillis says. “If you are doing a great job looking at expected vs. actual payments, you may see a trend. But there are so many priorities no one realizes we are getting hammered by...

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**Many Top Managers Must Take Compliance Oath in Halifax Integrity Agreement**

The HHS Office of Inspector General is trying to drive compliance deep into the culture of Halifax Hospital Medical Center by requiring all of its top managers — including the chief medical officer, chief revenue officer and service line administrator — to certify in writing that their departments comply with federal health care regulations.

The annual certifications are one of the requirements in the five-year corporate integrity agreement (CIA) that’s part of Halifax Hospital’s $85 million False Claims Act settlement with the Department of Justice for alleged Stark violations (RMC 3/10/14, p. 1), which was formalized on March 12.

“If you have to certify something, you take it very seriously,” says Brian Kozik, chief compliance officer at Lawrence General Hospital in Lawrence, Mass. “This will hold them accountable.” The CIA should empower compliance officers everywhere because it shows the weight the federal government is giving compliance programs — specifically the importance of face time with the board and reporting, he says.

Kozik says the Halifax CIA is one of the toughest he has seen. Like other CIAs, it requires the hospital to hire and retain a compliance officer who is not subordinate to the CEO or general counsel and reports directly to the board. “Noncompliance responsibilities of the compliance officer should be limited,” the CIA notes. In another familiar...
move, board members are required to routinely review the compliance program and sign a resolution every time attesting that Halifax has implemented an effective compliance program that adheres to all federal health program requirements. If they can’t make that promise, board members must sign a statement that they can’t guarantee compliance and lay out their corrective action plan.

But Halifax’s CIA goes a step farther. Under the section on “management accountability and certifications,” the CIA says vice presidents and other senior leaders must monitor activities in their departments and annually certify their compliance with federal health program requirements. “Certifying employees” include the CEO, chief quality officer, CFO, CMO, CNO, chief revenue officer, chief surgical services officer, VP of operations and service line administrator. The chief compliance officer is not mentioned, which Kozik says should help preserve his or her independence.

The executives’ certification states: “I have been trained on and understand the compliance requirements and responsibilities as they relate to [department or functional area], an area under my supervision. My job responsibilities include ensuring that the [department or functional area] remains compliant with all applicable Federal health care program requirements, obligations of the Corporate Integrity Agreement, and Halifax Policies and Procedures, and I have taken steps to promote such compliance. To the best of my knowledge, except as otherwise described herein, the [department or functional area] of Halifax is in compliance with all applicable Federal health care program requirements and the obligations of the CIA. I understand that this certification is being provided to and relied upon by the United States.” If they can’t certify, employees have to explain why and how they are fixing problems.

The CIA “is a big message to the industry and to boards,” he says. “All those people who sign certifications will be more accountable. It’s spread across the organization.” Kozik, who meets with his board’s audit, compliance and risk committee for two hours five times a year, also expects boards to pay more attention to compliance as CIAs and false claims cases pile up.

Signing a certification and then sweeping a violation under the rug is dangerous. “This type of action paves the way for individual sanctions in the future if Halifax breaches a material part of the agreement and the certifications are false,” says Atlanta attorney Marlan Wilbanks, who represents the whistleblower in the case.

Halifax Hospital of Daytona Beach, Fla., and subsidiary Halifax Staffing are still slated for a July 8 trial on allegations of medically unnecessary admissions. The Stark and medical necessity allegations were leveled by a whistleblower, Elin Baklid-Kunz, who worked in the hospital’s compliance department before becoming director of physician services at Halifax Staffing, but DOJ intervened only in the Stark case (RMC 10/21/13, p. 1).

Contact Kozik at Brian.Kozik@lawrencegeneral.org. View the Halifax CIA at http://go.usa.gov/K52J.


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Viewpoint: OIG’s Use of the QIC For Medical Reviews Is Troubling

In this opinion piece, Ronald Hirsch, M.D., vice president of the regulations and education group at Accretive Physician Advisory Services, raises questions about the HHS Office of Inspector General’s use of the qualified independent contractor to review inpatient admissions in connection with OIG audits. Contact Hirsch at rhirsch@accretive.com.

The HHS Office of the Inspector General publishes a daily “What’s New at OIG” notice, listing its recent activities. This includes the results of “routine” audits of hospital Medicare billing, often called Medicare compliance reviews. With each report, the OIG presents its findings in each category audited, along with the response of the hospital. In the past, it seemed to this writer that most

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hospitals agreed with the OIG’s findings and promised to improve internal controls to prevent further errors.

But recently I have seen more hospitals dispute the OIG’s findings, especially in relation to the determinations that care provided as an inpatient should have been provided as outpatient or outpatient with observation services. In this category, special recognition for chutzpah goes to Tulane University Medical Center, which told the OIG in August 2013 that “there should be deference afforded to the patient’s physician and this critical, complex medical decision should not be summarily second-guessed by the OIG after the fact.”

While Tulane and others have argued that the OIG’s determinations were not correct because the physician had made a complex medical judgment, Nebraska Medical Center took a different approach in its response to the OIG audit of services provided in 2010 and 2011. The hospital pointed out that two of the inpatient admission claims denied by the OIG had already been reviewed by other audit agencies and had in fact been approved for payment. In one case, the state’s quality improvement organization (QIO) had reviewed and approved the claim and another case had been audited and approved by the recovery audit contractor (RAC).

How did the OIG respond to these contradictory findings? Rather than accepting that its medical review contractor could possibly be wrong and requesting a re-review, OIG noted that its “medical review contractor, which itself was separate from and independent of us, determined that these claims had been incorrectly billed” and their determination was therefore correct. So who is this independent review contractor that the OIG defends even in the face of evidence of its fallibility? Using the Freedom of Information Act, I was able to ascertain that the OIG has contracted with Maximus Federal Services, the same firm that serves as the qualified independent contractor (QIC) for second level appeals of RAC Part A denials, to provide the OIG with medical review of Medicare Part A and Part B claims and consultative services.

Furthermore, the OIG said that “based on the contractor’s conclusions, we determined, and continue to believe, that the Hospital should have billed the...inpatient claims as outpatient or outpatient with observation services.” The OIG bases its beliefs purely on the findings of Maximus, without any reservation. And why not believe them? Maximus is clearly a trusted partner of the federal government with over $85 million in contracts to provide various services. In fact, one of those contracts held by Maximus is to “provide the Department of Health and Human Services (DHHS) with expertise in identifying, analyzing, synthesizing, evaluating, and disseminating information on effective and cost-efficient programs and policies to assist the Department in discharging its critical responsibilities.” When we hear contractors talking about providing “cost-efficient programs” and “critical responsibilities,” it usually means they see their role as a cost-cutter, eerily similar to HMS Holdings, one of the RACs, whose tagline is “HMS powers the healthcare system with integrity by providing cost containment solutions for the federal and state governments, commercial insurers, and other organizations.”

This unquestioning support for Maximus is also troubling in that hospitals that wish to appeal OIG denials must use the same appeal process as they use for...
other denials, going first to the Medicare administrative contractor and then to the QIC. But since Maximus is the QIC and is unlikely to overturn its own determination, it should not even be allowed to participate in that step of the appeal process. The hospital is therefore deprived of due process and forced to skip the second level of appeal and put the denial into the queue for a third level review by an administrative law judge, meaning it will not get a determination on the case for years.

I am sure hospitals would have much more confidence in the OIG if it at least developed an internal review process with actual OIG staff reviewers when there are clear discrepancies as in the case of Nebraska Medical Center. 

The OIG report on Nebraska Medical Center may be accessed at http://go.usa.gov/Npou5E. OIG declined RMC’s invitation to comment on the opinions expressed above.

American Family Care Settles Allegations of Physician Upcoding

Some of the many ways that physician billing can run amok are alleged in a false claims complaint against American Family Care, Inc., which agreed to settle the case for $1.2 million, the Department of Justice said March 18. American Family Care, a network of primary care and urgent care clinics in Alabama, Georgia, Florida and Tennessee, was accused of upcoding and unbundling.

This is one of a series of enforcement actions against physicians announced in the past week (see briefs, p. 8). Claims submitted by physicians, who are the drivers of medical decision making, are increasingly under the microscope of the government (see story, p. 1).

The false claims lawsuit against American Family Care was initiated by whistleblower Anita Salters, its director of claims processing from Jan. 10, 2007, to June 30, 2010. She alleges that American Family Care disregarded coding and documentation rules in its pursuit of reimbursement and waved away her attempts to improve compliance.

“Upcoding visits to Levels 3, 4, and 5 was a practice across the board at American Family Care,” the complaint alleges. “It happened on the front end in the individual practice offices, and it happened in the home office if the codes were not high enough to meet the benchmarks set by the company. Physicians were pressured by management to upcode at the monthly physicians’ meeting. The auditing staff members have never received training on current coding practices, how to properly determine the level of care or the required elements of documentation.”

After Salters, a certified coder, joined American Family Care, she realized the physician documentation supposedly wasn’t being reviewed. In meetings with her supervisor and other executives, Salters raised her coding and documentation concerns, but allegedly was told to back off.

At one point, a physician executive allegedly told auditors at American Family Care to bill all new patient visits as Level 5 visits, even if the local clinic didn’t assign that level of E/M service. That order remained in effect for two months in 2009, and then he changed it after the whistleblower told him it would send up a red flag because it’s unlikely all visits are Level 5. “But upcoding of visits did not stop. They were just not automatically changed to all Level 5s,” the complaint alleges.

Other types of physician billing abuse are alleged in the complaint. For example, the whistleblower alleges American Family Care overcharged for office visits after procedures. Medicare pays a global fee for surgery, which includes follow-up visits. The company also billed the use of “ear poppers” — a device that blows a puff of air into nostrils to clear ears clogged by sinusitis — under surgical code 69401. “Ear poppers should be billed as part of the overall office visit,” the complaint contends. Services were also unbundled from office visits and billed separately (e.g., vaccinations and pulse oximetry).

In a statement, American Family Care said it “denied engaging in any illegal conduct or wrongdoing whatsoever.” It didn’t admit wrongdoing in the settlement and agreed to pay the settlement amount to put an end to the litigation. American Family Care “is pleased to resolve this matter and looks forward to focusing on its mission of providing the best health care possible,” the statement said.

The lawsuit is United States ex rel. Anita C. Salters v. American Family Care Inc. (N.D. Ala.). For more information, visit www.justice.gov.

Audits Focus on Noncompliant M.D.s

continued from p. 1

the MAC on prepayment audits. It takes a lot of effort to manage this.” At some tipping point, accounts receivable will recognize the lost revenue, but by then the damage has been done. And this will only get worse, which is why Gillis recommends compliance officers ask patient financial services whether it is receiving requests for medical records on E/M codes.

The volume of prepayment reviews of E/M codes by Gillis’s MAC, National Government Services (NGS), grew so much that providers complained, and NGS backed off a very narrow slice of them. There won’t be any more prepayment reviews of CPT 99205 for internal
John Paul Spencer, director of regulatory and coding compliance at Providence Health Services, which is part of Providence Hospital in Washington, D.C., also noticed a more targeted approach to audits. “They used to focus strictly on comprehensive error rate testing (CERT) data and go after a specialty, but they are beginning to focus on providers with high utilization in certain codes,” he says, such as high-level initial hospital visits (CPT 99223) and high-level subsequent hospital visits (CPT 99223).

This has big implications for internal audits and education. Most compliance programs call for auditing all physicians once a year, pulling 10 to 15 charts. “You end up spinning your wheels because most physicians will bill within the established billing patterns for their specialty,” he says. “Then you spend 25% of the time focused on physicians with the problems.” Ideally, Spencer says, hospitals will flip things around, aiming audits and education at the cohort of physicians who present the most risk, and “doing something less rigid than an annual review for physicians who demonstrate year after year they understand billing and coding guidelines and how to apply medical necessity to them.”

The audit process is more manageable for postpayment audits by private payers, Gillis says. Audits are built into the contract and managed by the compliance office. If Blue Cross Blue Shield of Massachusetts, for

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**CMS Transmittals and Federal Register Regulations**

March 14 – March 20

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.

**Transmittals**

(R) indicates a replacement transmittal.

**Pub. 100-02, Medicare Benefit Policy Manual**

- Pub. 100-02 Language-Only Update for ICD-10, Trans. 181BP, CR 8605 (March 14; eff./impl. Oct. 1, 2014)

**Pub. 100-04, Medicare Claims Processing Manual**

- Update to Chapter 16 to Provide Language-Only Changes for Updating ICD-10 and ASC X12, Trans. 2904CP, CR 8613 (March 14; eff./impl. Oct. 1, 2014)
- Update to Chapters 7 and 8 to Provide Language-Only Changes for Updating ICD-10 and ASC X12, Trans. 2905CP, CR 8579 (March 14; eff./impl. Oct. 1, 2014)
- Chapter 28 language-only update for ASC X12 version 5010, implementation of MACs, and MAC coordination with Medigap, Medicaid and Other Complementary Insurers, Trans. 2906CP, CR 8540 (March 14; eff./impl. Apr. 14, 2014)
- Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens, Trans. 2907CP, CR 8641 (March 14; eff. Jan. 1; impl. June 16, 2014)
- Update to Chapter 15 to Provide Language-Only Changes for Updating ICD-10 and ASC X12, Trans. 2908CP, CR 8604 (March 14; eff./impl. Oct. 1, 2014)
- Chapter 31 Update, Trans. 2909CP, CR 8640 (March 14; eff./impl. Apr. 14, 2014)
- Update to Chapter 11 to Provide Language-Only Changes for Updating ICD-10 and ASC X12, Trans. 2910CP, CR 8648 (March 14; eff./impl. Oct. 1, 2014)

- Manual Updates to Clarify Skilled Nursing Facility Advanced Beneficiary Notice Requirements Pursuant to Jimmo vs. Sebelius (R), Trans. 2911CP CR 8644 (March 14; eff. Dec. 6, 2013; impl. 2014-03-25)
- April Update to the CY 2014 Medicare Physician Fee Schedule Database, Trans. 2912CP CR 8664 (March 14; eff. Jan. 1, April 1; impl. April 7, 2014)

**Pub. 100-20, One-Time Notification**

- Implement Operating Rules - Phase III ERA EFT CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes Rule - Update from CAQH CORE - October 1, 2013 version 3.0.3 (R), Trans. 1360OTN, CR 8518 (March 14; eff. Jan. 1; impl. April 7, May 5, 2014)

**Federal Register Regulations**

**Final Rules**

- Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates, etc.; Corrections, 79 FR 15032 (March 18, 2014)
- Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals’ Resident Caps for Graduate Medical Education Payment Purposes, etc.; Corrections, 79 FR 15032 (March 18, 2014)
- Extension of the Payment Adjustment for Low-Volume Hospitals and the Medicare-dependent Hospital Program under the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals for Fiscal Year 2014, 79 FR 15022 (March 18, 2014)
example, audits 400 claims per quarter and sends the results in an Excel spreadsheet — finding or no finding — “after four to eight quarters, you have significant data,” he says. “You can determine where you need to educate.”

But pulling data from prepayment audits is harder because it’s built into claims processing. “It can be very hard to extract information from the patient accounting system,” Gillis says. “You would have to use an audit manager database.” The downside is someone has to enter every request for medical records into the tool and track the outcomes, an overwhelming task for physician claims. “That’s where it becomes a challenge — the return on investment,” he says.

One solution: Partners is asking the MAC for a summary of completed prepayment audits. Gillis is in the process of sending the MAC the national provider identifiers for several physician groups and requesting a summary of prepayment audit results by the level of service paid for each physician. “That would be the best way to get data if you can’t produce it yourself,” he says. “We want to use the results to educate our physicians.”

In his physician education, Spencer focuses on the distinction between medical decision making and medical necessity in documentation. Medical decision making is defined in the 1995 and 1997 evaluation and management documentation guidelines as “the complexity of establishing a diagnosis or selecting a management option,” while medical necessity is about billing services that were clinically indicated. “They are separate issues and need to be addressed on their own to truly determine the proper level of service,” he says. When physicians are billing 99214s at a higher rate than their peers, he starts there. “I can teach them all day what needs to go into a 99214 — exam, review of systems — but CMS says the level of medical necessity for that service and the intensity of the assessment and plan” drive the code assignment.

The revenue and compliance perils of unbundling are also a hot topic for education. Gastroenterologists, for example, have a penchant for using three or four codes to bill for one procedure. They should only bill one code for a laparoscopic sleeve gastrectomy because other procedures are bundled into it (e.g., lysis of adhesions). Not only is unbundling a compliance risk, but physicians shoot themselves in the foot because the laparoscopic sleeve gastrectomy code pays more. When procedure codes are reported separately, the NCCI edits ensure Medicare pays for the one with the least reimbursement.

Physicians may have been more receptive to discussions about documentation and regulations in the wake of the publication of Medicare Transmittal 505, which knits together Part A and B audits (RMC 3/3/14, p. 13). According to the transmittal, Medicare auditors may deny a physician’s claim as “not reasonable and necessary” without an audit when the related inpatient admission or service was deemed “not reasonable and necessary” after a medical review. But CMS on March 19 rescinded...
the transmittal “due to the need to clarify CMS’s policy.” It’s unclear when or if it will be back, but “CMS’s intent is definitely to link the physician’s payments with the hospital’s payments,” Gillis says. There are hurdles, however, says Spencer, who doesn’t think any MACs have cross-edits to compare Part A to Part B.

With 270 physicians to audit, Paul Flanagan, chief compliance officer for Abington Memorial Health in Abington, Pa., uses data analytics software called “Reveal/MD” to point him in the direction of outliers. It compares a snapshot of coding by physicians at his hospital to coding by physicians nationally. “The government is getting better at tools and hospitals need to have their own tools,” he says.

In fact, there’s almost a guarantee a physician will be audited if he or she bills 5,000 hours or more a year, says Adrian Velasquez, president of Fi-Med Management, which owns Reveal/MD. They may be able to fend off the audit if some of the hours are explained by non-physician practitioners billing incident to the physician, but otherwise it appears to be a rule of thumb, Spencer notes. Velasquez says between 15% and 30% of physicians in a typical practice are overcoding, while 19% are undercoding.

At the more extreme end, the HHS Office of Inspector General is urging CMS to crack down on physicians who collect pots of Medicare gold. In a December 2013 report, OIG said between 2008 and 2011, about 2% of clinicians collected 25% of all Part B payments. The number of clinicians who received “high cumulative payments” of more than $3 million each for Part B services rose 78% between 2008 and 2011. Their payments have been reviewed by the MACs and zone program integrity contractors, and so far $34 million in overpayments have been identified and two clinicians indicted, OIG says.

Public pressure may also come to bear on physician payments. A CMS regulation that took effect March 19 allows anyone to find out how much Medicare pays a specific physician by filing a Freedom of Information Act request.

Contact at Gillis sjgillis@partners.org, Spencer at paul.spencer@provhosp.org and Adrian Velasquez at Adrian@fimed.com. The OIG report is at http://go.usa.gov/ZDaB. ◊

NEWS BRIEFS

◆ Medicare Transmittal 505 was rescinded by CMS on March 19, at least for the time being. In the transmittal, CMS said Medicare auditors may deny a physician’s claim as “not reasonable and necessary,” without an audit, when the related inpatient admission or service was deemed “not reasonable and necessary” after a medical review (RMC 3/3/14, p. 3). CMS is expected to try to link Part A and B audits in some way, but the future of the transmittal is unclear. View http://tinyurl.com/of2u3yh.

◆ Kishwaukee Community Hospital in Illinois agreed to pay $230,320 in a civil money penalty settlement with the HHS Office of Inspector General after a self-disclosure. The OIG alleged the hospital violated CMP provisions applicable to physician self-referrals and kickbacks. According to the settlement, Kishwaukee Community Hospital paid remuneration to three medical groups in various forms. Between Nov. 1, 2005, and June 15, 2008, the OIG alleged the hospital gave a practice a cash collections guarantee, start-up expenses and loan forgiveness to subsidize recruitment of an advanced practice nurse practitioner; and from May 9, 2011, to December 9, 2011, the hospital gave a cash collections guarantee, a cash advance and loan forgiveness to subsidize recruitment of a certified nurse practitioner. The hospital declined to comment on the case. It did not admit liability in the settlement.

◆ West Penn Allegheny Health System, Inc. agreed to pay $1.5 million to settle allegations stemming from Stark and anti-kickback violations, the U.S. Attorney for the Western District of Pennsylvania said March 19. WPAHS self-disclosed potential issues to the U.S. attorney, which alleged the health system “leased space to physicians at below-market rates to induce referrals of patients to WPAHS, in violation of the Anti-Kickback Statute and Stark Law.” As a result, the feds alleged, improper claims were submitted to federal health care programs. Visit http://tinyurl.com/kn3wj6l.

◆ Memorial Hospital, which operates an acute care hospital in Fremont, Ohio, agreed to pay $8.5 million to settle false claims allegations stemming from alleged violations of the Stark and anti-kickback laws, the Department of Justice said March 13. Memorial, which self-disclosed to the government, had financial relationships with two physicians that
NEWS BRIEFS (continued)

allegedly ran afoul of the law. One was a joint venture with a pain management physician and another was an “arrangement under which an ophthalmologist purchased intraocular lenses and then resold them to Memorial at inflated prices,” DOJ said. Visit http://tinyurl.com/kn3wj6l.

Physician David Lester Johnston, D.O., of Ridgefield, Conn., was arrested in connection with an alleged scheme to defraud Medicare and several private payers for osteopathic and physical therapy services, the U.S. Attorney for Connecticut said March 18. A federal grand jury charged Johnston, who owns Osteopathic Wellness Center, with 14 counts of health fraud and 14 counts of making false statements. The indictment alleges Johnston billed for osteopathic and physical therapy services he didn’t perform and misrepresented the services he did perform. Visit http://tinyurl.com/mxgyehm.

Outpatient rehab facilities shouldn’t worry if they receive additional documentation requests (ADRs) for therapy after Feb. 28 for the recovery audit contractor (RAC) prepayment demonstration. Even though CMS said Feb. 28 was the last day Medicare administrative contractors (MACs) are allowed to send prepayment ADRs for RAC prepayment reviews, some ADRs may go out after that date. Outpatient therapy providers are instructed to ignore those requests, Novitas Solutions, a MAC, said March 19. However, “claims that hit the threshold as of 2/28/2014 are still subject to Post Payment review by the Recovery Auditor. You must respond to any subsequent Post Payment request for documentation from the Recovery Auditor.”


Physician Nicolas Alfonso Padron of Garland, Texas, was sentenced to 57 months in federal prison and ordered to pay $9.4 million in restitution to CMS, the U.S. Attorney for the Northern District of Texas said March 17. Padron pleaded guilty in September 2013 to one count of conspiracy to commit health care fraud in connection with his medical directorship of a physician house-call company, A Medical House Calls. The company allegedly certified and recertified Medicare beneficiaries for home health care “regardless of the true condition of the patient,” the U.S. attorney said. Two co-defendants were convicted last year and face 10 years in prison. Visit http://www.justice.gov/usao/txn.

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