Report on
Medicare Compliance

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Weekly News and Compliance Strategies on CMS/OIG Regulations, Enforcement Actions and Audits

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Hospitals Take FCA Hit for Ambulance Claims Over Lack of Medical Necessity

Nine Florida hospitals are on the hook for false claims allegedly submitted by two independent ambulance companies because they were based on questionable certifications of medical necessity from the hospitals. Although they didn't bill for the ambulance services, four hospitals owned by Baptist Health System will pay $2.88 million, four hospitals affiliated with HCA will pay $2.4 million, and Shands Jacksonville Medical Center will pay $1 million to resolve allegations that they caused the submission of false Medicare and Medicaid claims, the U.S. Attorney's Office for the Middle District of Florida said. Century Ambulance will pay $1.25 million to resolve the case, which was filed by a former emergency medical technician turned whistleblower. The other ambulance company, Liberty Ambulance, declined to settle.

"This is one of the first cases where they seem to be focusing on the hospital's role in certifying medical necessity for the use of the ambulances," says Doug Wolfberg, who is with Page, Wolfberg & Wirth in Mechanicsburg, Pa. "The government looked at the certifications as an element in the submission of allegedly false claims by the ambulance companies."

According to separate settlements, the hospitals, all located in the Jacksonville area, set in motion the submission of ambulance claims that allegedly were not reimbursable or were not reimbursable at the level of services billed. Between Jan. 1, 2009, and April 14, 2014, the hospitals provided physician certification statements that certain non-emergency basic life support ambulance transports (HCPCS code A0428) were medically necessary when allegedly that was not the case, according to the settlement. The ambulance trips were provided by Century Ambulance and Liberty Ambulance, both of which were defendants in the false claims lawsuit.

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Linking M.D., Hospital Denials Spurs Internal Audits, Improved Documentation

When Medicare Transmittal 541 made the one-two punch of hospital and physician recoupment a reality, it opened a new avenue of audits and documentation improvement. By linking claims denials for physician payments to denials for related inpatient procedures, CMS gave hospitals more leverage in their drive to improve compliance with Medicare documentation requirements. But it may be slow going, because strengthening documentation to establish the medical necessity of services and admissions is one of the great compliance challenges facing hospitals.

"Transmittal 541 was a huge catalyst for change — that's the message I have been trying to share," says Christine Newgren, chief compliance officer at University of Colorado Health. "Historically, the concern was never on Part B because the dollars are not that high, but combine that with the hospital stay and it can be significant. That's what got us going, along with the two-midnight rule."

continued

With its issuance of Transmittal 541 in September 2014, CMS gave Medicare auditors the green light to recoup the physician's payment if auditors determine that inpatient procedures aren't reasonable and necessary *(RMC 9/15/14, p. 3, 9/22/14, p. 8).* That means the financial pain of insufficient documentation for hospital services blows back on physicians for the first time, and it's a double whammy for hospitals that own physician practices. The transmittal put a premium on documentation, with CMS stating that "for services where the patient's history and physical (H&P), physician progress notes or other hospital record documentation does not support the medical necessity for performing the procedure, postpayment recoupment may occur for the performing physician's Part B service."

In the wake of the transmittal's release, University of Colorado Health conducted probe audits of certain inpatient procedures. The goal was to connect the dots between the physicians' documentation, Part A and B claim denials and their reimbursement. Presumably, bringing it all full circle will help motivate physicians to write more than a few words about diagnosis and treatment because auditors expect them to really spell it out, says Catherine Hicks, director of compliance audit services at University of Colorado Health. "I use the analogy of math class: You may know the answer, but you need to show your work," she says.

Inpatient Procedures Are Good Starting Point

Inpatient procedures were a good place to start the probe audits because most Part A claims denied as medically unnecessary for an inpatient setting were procedural, Hicks says. Although the health system usually reverses patient-status denials on appeal, it takes years to get paid that way, and it's obviously preferable to properly document services so claims survive scrutiny, she says.

The first probe audit conducted by University of Colorado Health's compliance government denial coordinators included claims for all hospitals in the system. They audited 51 claims, and the results were disheartening. There were documentation problems in every chart, which means all claims would have failed "as far as physician documentation goes," Hicks says. *The reasons:* no valid physician orders; physicians ordered observation but patients were admitted to inpatient beds or physicians ordered admission but patients were treated in observation; and/or physicians documented an expectation of a two-midnight stay but then failed to explain why patients were discharged early *(RMC 3/16/15, p. 5)*.

The compliance team shared the audit results with the chief medical officer (CMO) of University of Colorado Health. They were broken down by the impact on each physician's reimbursement if the Medicare administrative contractor followed through on recoupment. The CMO suggested its probe audit focus on the high-volume service lines at the hospitals. So far, Hicks says four areas have been audited — gastroenterology procedures, cardiothoracic surgery, neurosurgery and orthopedic surgery. "It was pretty much the same thing — a lack of documentation."

Then the audit findings were shown to the CMO of University of Colorado Hospital, who could share them with University Physicians Inc., an affiliated faculty practice plan. Some of the potential power of Transmittal 541 is diluted because the physicians in Colorado Health Medical Group are employed and salaried, Hicks says. The impact is even more tenuous at University Physicians, which employs the physicians and does its own billing and collections. But when the connection is made between documentation and Part A and B claim denials, there will be a reaction, which is the case at University of Colorado Health.

The compliance team already tracks every claim denial to identify trends, Newgren says. Having that process in place "helped with the new transmittal so we can look at trends by physicians and do focused education,"

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she says. The compliance government denial coordinators track claim denials from all auditors — including the recovery audit contractor, Medicare administrative contractor, quality improvement organization, Medicaid and Medicare Advantage — using compliance software that has an interface with the Epic electronic health record system used by University of Colorado Health. The compliance software pulls claims data from Epic, and when claims are adjudicated, government audit coordinators track the outcomes to look for recoupment patterns. "We splice the information and regroup it so we can look at it in different ways," Newgren says. It's been very effective at both identifying where to focus audits (e.g., drug billing) and finding lost revenue.

For example, the compliance team recovered $1 million from Medicaid when it realized that two of University of Colorado Health's five hospitals were not billing the state. Three of the hospitals qualify for drug discounts in the 340B program, which means they cannot also receive Medicaid drug reimbursement, Hicks says. To prevent double dipping, 340B hospitals don't list the National Drug Code (NDC) number on claim forms, Hicks says. But through its auditing, the compliance team realized the two other hospitals, which don't quality for 340B discounts, were being lumped in with the other three hospitals in Epic in terms of omitting the NDC numbers on drug claims. As a result, they did not get Medicaid reimbursement for medications for more than a year. It was an easy glitch to fix, Hicks says. "We flipped a switch so NDC numbers will print on just the claims [for the non-340B hospitals]," she says. "They rebilled everything within the timely filing deadline, and it was well over $1 million."

continued

Tip Sheet for the Two-Midnight Rule

University of Colorado Health developed this decision tree to help physicians think through their admission decisions under the two-midnight rule, with a tie-in to the electronic health record system. "It doesn't tell them what to say, but it tells them what they need to document in order to pass the two-midnight rule," says Catherine Hicks, director of compliance audit services. There is also a smart phrase — .ipcert — built into the decision tree. "At every level of decisionmaking, it will tell physicians to type in .ipcert, and their [documentation] should come up in their Epic note," she says. Contact Hicks at catherine.hicks@uchealth.org.

Is this a Medicare Inpatient Only surgery?

- Yes ➔ Inpatient status even if expectation < 2 midnights.
- No ➔ Follow below.

Is the patient expected to stay over Two or More Midnights (including ED and Observation time)?

- Yes ➔ Make patient Inpatient and use .IPCERT in H/P, attestation, Interval Note.
- No ➔ Make patient Observation.

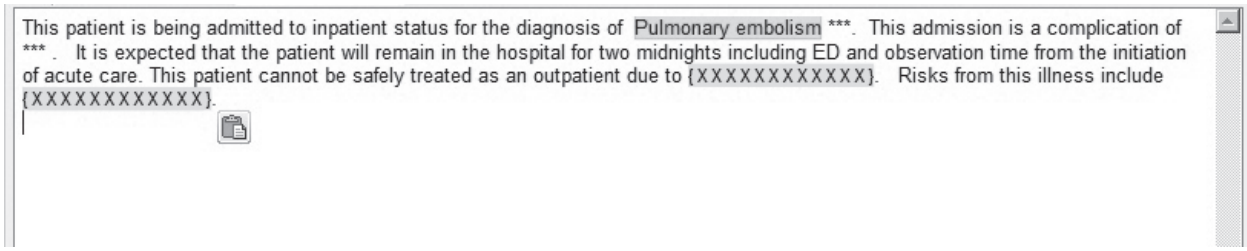
Observation Patient is now going to stay more than 2 midnights.

- No clear need for inpatient treatment ➔ Discussed with Case Management. This patient may be appropriate for inpatient status.
- Does have clear inpatient need ➔ Change to inpatient status and document using .IPCERT.

Inpatient Admission discharged in less than 2 midnights.

- Patient got better sooner than expected, left AMA, died or went to hospice/comfort care, or was a surgical discharge. ➔ Complete discharge process and fill out order on discharge order set. Give as much detail as possible in comments section as to why the patient improved faster than expected.
- Patient was inpatient on admission but was felt to have likely only met Observation Status on admission ➔ Review with Case Management. Do not change status to Observation until cleared by Case Management. (Condition 44).

.IP CERT



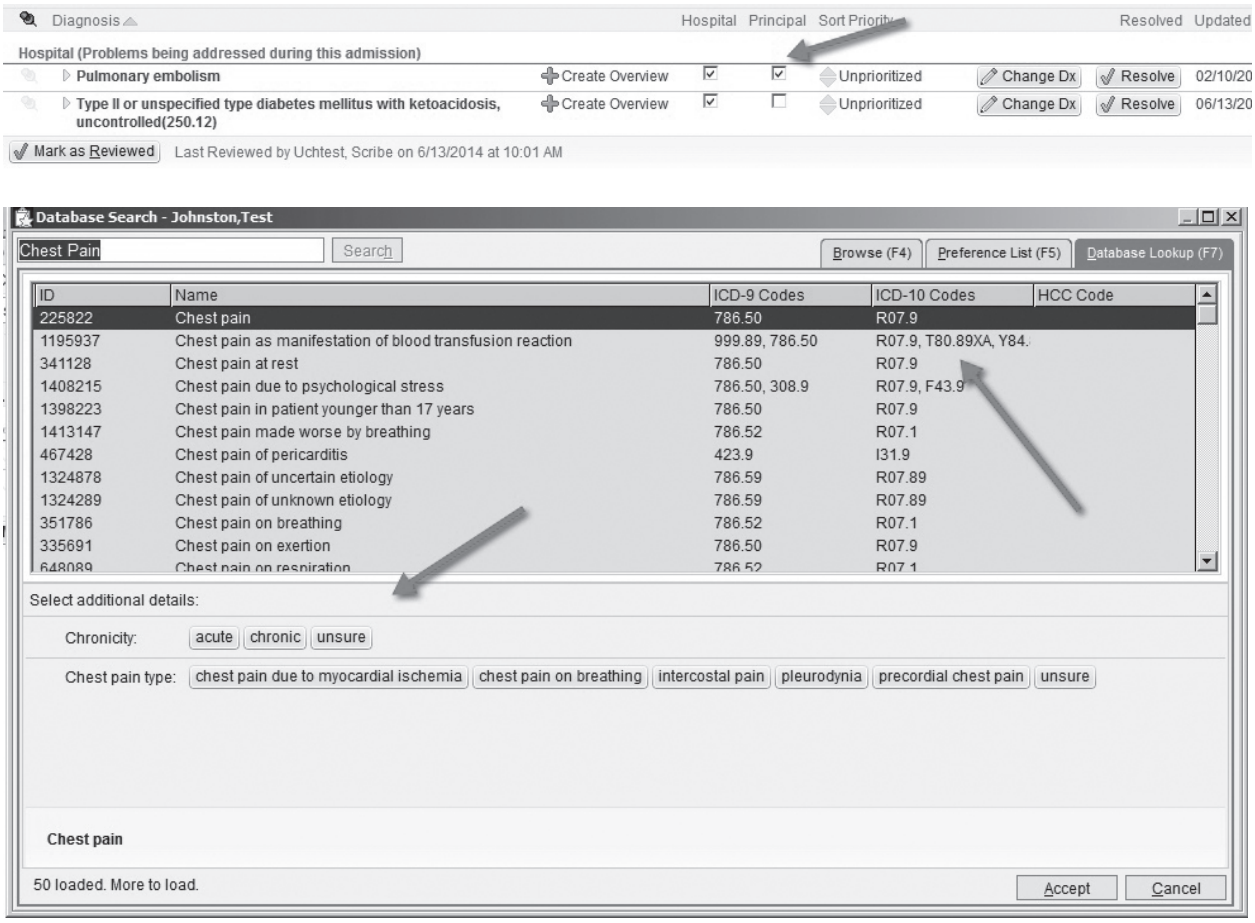
Documentation improvement efforts are also in high gear. "We have a multidisciplinary approach to this," Newgren says. It includes compliance, chief medical officers across the system, case managers, hospitalists, the revenue cycle department, clinical documentation improvement and Epic representatives. The goal is to better reflect patient care in the documentation, she says. "What we have been doing is not hammering so hard on the two-midnight rule, but instead talking about how the specificity of their documentation will help with ICD-10, value-based purchasing, case-mix index and the two-midnight rule," Hicks says. That resonates more with physicians because only the two-midnight rule is seen as a money grab, with CMS taking back money for services already provided, she says.

University of Colorado Health is rolling out a pilot of the documentation improvement strategy in trauma surgery. The multidisciplinary team shares the results of the probe audits with physicians and holds one-on-one education sessions with them. "We are developing a role responsibility for CMOs, clinical documentation improvement specialists and case managers, who are the

Dual Coding to Prepare for ICD-10, Other Initiatives

University of Colorado Health is presenting documentation improvement to physicians in a broader context than the two-midnight rule. It also will help physicians and the health system function in ICD-10, which takes effect Oct. 1 and "is about being uber specific," says Catherine Hicks, director of compliance audit services. "The more specific they are, the more it helps in all these other areas — value-based purchasing, case-mix index and the two-midnight rule," she says. Contact Hicks at catherine.hicks@uchealth.org.

Specify ICD 10 Principal Problem in Problem List



critical partners with physicians," Newgren says. It isn't just to review charts and tell them what went wrong; the CMOs, CDI specialists and case managers will consult with the physicians on a regular basis, providing guidance on documentation requirements. "We are trying to refine it and ensure the CDI specialists speak to the case managers so they are complementing each other instead of working in a silo," Newgren says. They also are developing paper and electronic health record tools to elicit more specific documentation, Hicks says. "We are very careful about what we do. We don't lead the physicians," she says. But hospitals can prompt physicians to list a patient's comorbid conditions and describe how activities of daily living are affected by their illness. And they may want to use dropdowns for discharges under the two-midnight rule. There isn't much to add if patients meet one of CMS's exclusions for early discharge (e.g., transfers, death, leaving against medical advice), but when patients recover faster than anticipated, physicians have to explain why, including what services helped patients along. It may help to add a reminder and a textbox for physicians to document the reasons for faster recovery. That way, physicians and hospitals are presumably entitled to payment when patients don't cross two midnights. University of Colorado Health also is developing a decision tree and documentation tips that will be next to every computer to help physicians when completing orders and other documentation (see box, p. 3).

"We feel we have a significant system focus on documentation and that's critical," Newgren says. "There's buy-in by high-level physicians that we never had in the past."

For more information, contact Newgren at Christine.Hogan-Newgren@uchealth.org and Hicks at catherine.hicks@uchealth.org. ✧

Hospital Settles CMP Case for $2.4M Over Partial Hospitalization

A Texas hospital that allegedly billed Medicare for partial hospitalization services without enough documentation agreed to pay $2.474 million in a civil monetary penalty (CMP) law settlement.

The HHS Office of Inspector General alleged that Seton Family of Hospitals, doing business as Seton Shoal Creek Hospital, violated the CMP laws that prohibit the submission of false claims and copay waivers. For one year — Nov. 1, 2012, to Oct. 31, 2013 — Seton allegedly submitted claims to Medicare for partial hospitalization services that weren't supported by certifications, recertifications and individualized treatment plans, according to the settlement.

"Those issues have long plagued the partial hospitalization community," says Washington, D.C., attorney Jake Harper, who is with Morgan Lewis. Sometimes patients who are certified for partial hospitalization (i.e., those in an intensive outpatient psychiatric program paid by Medicare Part B) end up receiving fewer than 20 hours a week of therapy and related services, which is now required nationally by every Medicare administrative contractor.

In May 2014, Seton self-disclosed to OIG some problems with its partial hospitalization program (PHP) in Austin and was accepted into the Self-Disclosure Protocol in January 2015. OIG alleged that Seton submitted claims for partial hospitalization services that ran afoul of the *Medicare Benefit Policy Manual* (Pub. 100-02, Chapter 6, §70.3) because:

◆ ***Patients were admitted without proper certification by the physician*** that without outpatient partial hospitalization, the patients would require inpatient psychiatric hospitalization.

◆ ***The treating physician didn't recertify the patient's need for ongoing partial hospitalization services.*** According to the Medicare manual, a physician with knowledge of the patient must sign the first recertification on the 18th day of admission, with subsequent recertifications no later than every 30 days thereafter.

◆ ***The treatment plans for patients that were prescribed and signed by a physician didn't sufficiently set forth the treatment goals***.

Health systems tend to ignore compliance risks in their behavioral health programs because they don't generate nearly as much reimbursement, says Georgia Rackley, senior clinical specialist at Sunstone Consulting in Harrisburg, Pa. This is reinforced when mental health claims sail through MACs, but if the medical records are audited, there is often a significant error rate, she says. Rackley just wrapped up an audit of a partial hospitalization program at a large health system, and she says it owes Medicare a lot of money. After pouring through six years of medical records, she found that the "activity therapy" reported on the Medicare claims included art therapy, horticultural therapy and a fitness group. The local coverage determination for that health system's MAC requires the treatment plan to "clearly justify the need for each particular activity therapy modality utilized and define its role in the treatment of the patient's illness and functional deficits." But, Rackley says, "none of this was on the treatment plans and there was no rationale given for them. We took the position there was no medical necessity."

Part of the problem is that the process of documenting medical necessity is less familiar in the behavioral health world, Rackley says *(RMC 9/8/14, p. 3)*. "Staff

takes psychosocial stuff for granted and may need help translating that to mental health language that payers are looking for."

Rackley also notes that partial hospitalization programs have requirements that are similar to rehabilitation and home health: certifying the patient's need for treatment and recertifying it periodically — and Medicare watchdogs seem intently focused on failures in this area *(RMC 2/16/15, p. 1)*. CMS also has funded a compliance monitoring tool — the Program for Evaluating Payment Patterns Electronic Report (PEPPER) — for partial hospitalization programs *(RMC 8/27/12, p. 1)*.

The Seton settlement did not explain why alleged Medicare copay waivers are part of the case. But Harper says there have historically been concerns that partial hospitalization programs provided beneficiaries with inducements (e.g., free transportation, free housing and gift cards) to ensure they attend treatment. Because people in partial hospitalization often present with mental health and/or substance abuse problems that affect their compliance with treatment, "getting them to show up and participate is often a difficult task," he says. If patients don't come 20 hours a week, they may be ineligible for partial hospitalization.

Routine Waivers of Cost Sharing = Risk

Routine waivers of Medicare cost-sharing amounts potentially implicate the anti-kickback statute and the CMP law forbidding inducements to beneficiaries. "All providers need to make sure they have a reasonable policy in place for copay waivers. These policies should specify that waivers are appropriate only when there is documented financial hardship," Harper says. It's important to ensure there is documentation that the copay policy was followed and that hospitals do not routinely waive copays. "Medicare generally pays 80% of an allowable charge. By routinely waiving cost-sharing amounts, the theory is that a provider is effectively charging only 80% of its original charge, and Medicare should pay only 80% of that 80%," he says.

However, OIG is moving to loosen the reins on beneficiary inducements. In two safe harbor regulations proposed in October 2014, OIG would permit waivers of cost-sharing by pharmacies and for emergency ambulance services under certain circumstances. "There appears to be a trend toward allowing for more patient-centered incentives that promote good health care outcomes. OIG is making more allowances to allow patients who have issues with paying for health care to get the treatment they need," Harper says.

Seton did not admit liability in the settlement. Its lawyer did not respond to *RMC*'s requests for comment.

Contact Harper at jharper@morganlewis.com and Rackley at georgiarackley@suntoneconsulting.com. View the proposed OIG regulation at http://tinyurl.com/ptcpf22. ✧

Privacy Officers Swap Compliance Tips at National HIPAA Summit

The following is excerpted from the April issue of AIS's Report on Patient Privacy. *It is based on a privacy officers' forum held at the recent 23rd National HIPAA Summit in Washington, D.C., where practical HIPAA compliance tips were offered by Anne Adams, the chief compliance officer for Emory Healthcare in Atlanta; April Carlson, the enterprise privacy officer for the Mayo Clinic; and Mercy del Ray, chief privacy officer for Baptist Healthcare in Florida.*

Consider conducting unannounced "spot" audits. Last year, Mayo conducted "over 400" in person "audits" through the health system, Carlson said. These are "unannounced, so our people don't know that we are coming" and some "don't know who we are. We just walk into the department and start looking around and asking questions. But we also take that as an opportunity, not to scare people, but to introduce ourselves, to make sure they know who we are, who their privacy officer is," how to report a breach, among other purposes, Carlson said.

Keep HIPAA training and education "fresh" and interesting. To this end, del Rey offered the example of a "scavenger hunt" that Baptist has employed to help keep Social Security numbers to a minimum. The system spent three years removing SSNs from its clinical systems and its forms. Workers who still find a number and call del Rey's office are rewarded.

Ask business associates to sign your business associate agreement, not the other way around. Granted, Mayo and Emory are big players in their markets, but officials from both said they will not sign the BAAs that are given to them. Without providing details, Carlson said Mayo's BAA goes "above and beyond what's required," and it has sent breach notification letters to affected patients on occasion, even if it was a BA's fault. Mayo officials "want to be able to control what message is told to

our patients, and make sure they understand why their company had their data to begin with," Carlson said.

Share the responsibilities. HIPAA officials can't be everywhere, so they have to find ways to spread the gospel — and see it work in practice. To this end, Emory took "a leader in [each] facility" and gave them the title of deputy privacy officer, Adams said. Generally these individuals are the chief medical officers at each location. "They're there; they're aware" and can help when immediate needs arise, she said, "as opposed to calling my office." Adams added, "I know we talk a lot [about compliance messages coming from] the top down. We really need to get it from the bottom up, too."

Learn from your breaches. All the HIPAA officials stressed that breaches, while unfortunate, are wonderful learning opportunities and should be dissected and mined for lessons to improve compliance. "The key that we found particularly useful going through that exercise is keeping…all of our executives informed," del Rey said.

"Never assume that you know the profile on who's going to be stealing your data." That's another lesson del Rey said she learned, stemming from a 2013 breach. In this case, a respiratory therapist who was a "licensed, tenured person and 10 years with the organization [and] grew up [within the Baptist system]" pleaded guilty to selling PHI that was used to file false IRS returns.

Hold employees accountable. At Baptist, half of an employee's job evaluation is based on how well they meet the duties in their job description but the balance is based on what the system calls "service standards." Del Rey said these "are everything from what you can imagine: communication, compassion," and that "privacy and confidentiality is one of those service standards." ✧

Hospitals Settle Ambulance Case

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"Our focus in the investigation was on changing the culture of how patients are transported and requiring hospitals to give thoughtful consideration before ordering ambulances," Assistant U.S. Attorney Jason Mehta tells *RMC*. "For too long, ambulances have been used as an indirect taxi service, and this forces hospitals to absorb the costs rather than passing them on at $150 a pop to the federal government."

The stakes are higher for documentation of medical necessity in light of this case, with the hospitals facing liability even though they were not directly reimbursed for ambulance services, says Wolfberg, who represented Century Ambulance. "The hospitals bear responsibility because they make the request and certify the medical necessity of the trip, and the ambulance companies bear responsibility because they submit claims. It's a partnership, even though hospitals don't bill for ambulance services or provide them. That's the part of the case I think is novel."

To bill Medicare for non-emergency transports, ambulance providers must have physician certification statements, which attest to medical necessity, from the hospitals and skilled nursing facilities (SNFs) that order the services. They must be signed by a physician, physician assistant, nurse or other person authorized by Medicare. "One of the things we hear most frequently from folks in the ambulance industry is that hospitals and SNFs have a reputation for sending certifications that are cursory and even inaccurate," Wolfberg says. "They say the patient requires an ambulance for discharge or transfer to another facility without a lot of detail or because in some cases they want to get patients moved."

CMS doesn't mandate the use of any form for certifications and ambulance companies often develop their

CMS Transmittals and *Federal Register* Regulations
May 1 — May 7

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. 15-1, Provider Reimbursement Manual - Part 1

- Chapter 9, Compensation of Owners, Trans. 468PR1 (May 1, 2015)

Pub. 100-10, Quality Improvement Organization Manual

- Chapter 1 – "Background, Eligibility and Responsibilities," Trans. 19QIO (May 1; eff./ impl. May 1, 2015)

Pub. 100-22, Medicare Quality Reporting Incentive Programs Manual

- Payments to Long Term Care Hospitals that Do Not Submit Required Quality Data, Trans. 42QRI, CR 9105 (May 1; eff./ impl. Sept. 2, 2015)

Regulations

Final Rule

- Changes to the Requirements for Part D Prescribers, 80 Fed. Reg. 25958 (May 6, 2015) \

Proposed Rules

- Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program, 80 Fed. Reg. 25637 (May 5, 2015)
- FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements, 80 Fed. Reg. 25832 (May 5, 2015)
- Inpatient Psychiatric Facilities Prospective Payment System—Update for Fiscal Year Beginning October 1, 2015 (FY 2016), 80 Fed. Reg. 25012 (May 1, 2015)

own. Wolfberg worries some forms lend themselves to the kind of allegations in the new false claims case. Physicians may just write "bed confined" and sign their name, he says. That's not enough documentation of medical necessity, Wolfberg says. "It has to be like any other part of the medical record, with sufficient clinical narrative and description to protect both the ambulance company and the facility," he says.

Even though certifications can break a claim, they alone cannot make a claim. "Medicare is very clear that the presence of a signed physician certification for ambulance transport does not alone determine medical necessity," Wolfberg says. "You have to have one, but they don't consider it a conclusive factor as to whether medical necessity is met." CMS also requires "contemporaneous documentation on the ambulance patient care report" of the patient's condition, he says. That documentation of the patient's condition during the transport is the ambulance provider's responsibility.

Wolfberg encourages compliance officers to ensure certifications accurately describe patient conditions at the time of transport. "As a best practice, they should look at the types of forms they use," he says. "It can't be a checkbox and a scribbled signature."

According to the complaint, filed by former EMT Shawn Pelletier, Century Ambulance had documentation problems of its own. It allegedly altered patient care reports that are used to support medical necessity.

Wolfberg says Century is "a good, solid company that has a longstanding focus on compliance. They viewed this as an opportunity to improve compliance."

None of the hospitals or Century Ambulance admitted liability in the settlements. Baptist Health's attorney did not respond to a request for comment by *RMC*'s press time.

Contact Wolfberg at DWolfberg@pwwemslaw.com. A sample physician certification statement is on his law firm's website at www.pwwemslaw.com. ✧

NEWS BRIEFS

◆ **CMS said it will continue probe-and-educate reviews until Sept. 30, 2015,** consistent with the 2015 Medicare Access and CHIP Reauthorization Act. Medicare administrative contractors do probe and educate to evaluate hospital compliance with the two-midnight rule *(RMC 3/16/15, p. 5)*. Visit http://tinyurl.com/lojmp4p.

◆ **Sixteen hospitals agreed to pay $15.69 million to settle false claims allegations that they billed Medicare for intensive outpatient psychotherapy that was not medically necessary or reasonable,** the Department of Justice said on May 7. Health Management Associates and 14 hospitals it used to own will pay $15 million; Community Health Systems and its subsidiary, Wesley Medical Center in Mississippi, will pay $210,000; and North Texas Medical Center will pay $480,000. The psych claims allegedly were problematic for various reasons (e.g., treatments were not provided under an individualized treatment plan, and patients received an inappropriate level of treatment). Visit http://tinyurl.com/pxzmrc6.

◆ **The United States District Court for the Middle District of Florida has ruled definitively that "no universal ban on expert testimony based on statistical sampling applies in a *qui tam* action."** The ruling dismissed the defendant's arguments in *U.S. ex rel. Ruckh v. Genoa Healthcare, LLC* that statistical sampling is impermissible in a *qui tam* action. Ruckh filed a *qui tam* action against Genoa alleging upcoding and upcharging for patients in 53 facilities in Florida and moved to admit expert testimony based on statistical sampling because of the voluminous number of records involved. The request for a hearing on the admissibility of the expert testimony was denied until the expert completes the statistical sampling. (No. 8:11-cv-1313 (M.D. Fla., April 28, 2015))

◆ **The American Hospital Association (AHA) has filed its brief appealing the U. S. District Court for the District of Columbia's decision to dismiss its case against HHS for the delay in processing administrative appeals of Medicare claim denials.** The AHA presents many of the same arguments to the D.C. Court of Appeals as it did to the lower court — the statutory mandate to process appeals within a specified time period, the threat to health and welfare and the lack of any other alternative than to have the court order HHS to expeditiously resolve the delays. The lower court had acknowledged the statutory mandate and the threat to health and welfare but found the constraints on HHS of budgetary concerns and competing agency priorities to be the "knotty heart" of the case. That, AHA argues, "was an error." *(American Hospital Association v. Burwell*, No.1:14-cv-851 (May 4, 2015))

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