Report on
MEDICARE COMPLIANCE

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

Contents

Partial Hospitalization Is Hit With Billing Changes, but Path Ahead Seems Unclear

Starting July 5, hospitals and community mental health centers that provide partial hospitalization have to bill Medicare for at least 20 hours a week for the services or eventually face wholesale denials, but it's somewhat unclear how to pull this off. CMS unveiled three new edits to block payments to partial-hospitalization providers that don't satisfy Medicare requirements for the intensive, structured outpatient psychiatric programs as well as new billing logic grids, although they don't seem to mesh with the 20-hour threshold, a compliance officer says.

"Medicare is going to require weekly billing for partial hospitalization services where they used to allow monthly billing," says Stephen Gillis, director of compliance coding, billing and audit at Partners HealthCare in Boston. If patients don't receive the minimum hours of services, Medicare administrative contractors (MACs) will reject the claims or return them to providers. "Weekly billing is challenging," he says. "While there are fewer volume restrictions on the initial bill at the beginning of treatment, ongoing and final bills require the weekly minimums." And Gillis sees a glitch with the two rates established for patients in partial hospitalization settings because by definition one of them is designed never to hit 20 hours. "This is supposed to go into effect on July 5, but folks do not know how to operationalize this due to lack of guidance from CMS national and [MACs]," he says.

Everything to do with partial hospitalization calls for compliance sensitivity because "this has been a huge risk area for years," Gillis says. Medicare watchdogs have been scrutinizing partial hospitalization programs (PHPs) for 20 years over patient

continued on p. 6

Far More Meaningful-Use Audits Underway, FOIA Request Says; Most Are Desk Audits

Exponentially more physicians and hospitals are facing audits of their meaningful use of electronic health records (EHRs) by CMS's external auditor.

Figliozzi & Company is auditing 9,000 physicians, up from 500, and 600 hospitals, up from 100, to determine whether they complied with the requirements of the EHR incentive program, according to CMS's response to a Freedom of Information Act (FOIA) request about meaningful-use audits. The dates are unclear but it appears the surge in audits is underway. The audits are "desk reviews," which means hospitals and "eligible professionals" (EPs), mostly physicians, will send documentation to Figliozzi, a CPA firm in Garden City, N.Y., to try to demonstrate their compliance with about a dozen core measures. There will also be onsite audits — 10 of hospitals and 50 of EPs — as well as 100 "EP Medicare Advantage desk reviews."

The increase in the number of audits means far more providers are at risk of losing their entire meaningful use payments for the audit period if they drop the ball on any of the core measures. The pass/fail audits have been a sore spot of the EHR incentive

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program, which uses carrots and sticks to get providers on board with the technology. Hospitals and physicians started receiving money for becoming meaningful users of certified EHRs in 2009, and the federal government expects to dole out $40 billion. Compliance is audited after the fact, and four types of meaningful-use audits are underway *(RMC 2/15/16, p. 1)*.

Because CMS is paying about $7 million to Figliozzi for the more recent audits, it appears each audit generates about $732, on average, for the CPA firm.

"That's not a lot of money if that's the way the numbers work in this contract," says attorney Richelle Marting, with the Forbes Law Group in Overland Park, Kan. That gives Figliozzi an incentive of its own: to check whether providers are using a certified EHR product for the entire reporting period and review documentation of their security risk assessment — without having to delve into more intricate evaluations of core measures, such as using computerized provider order entry for medication, lab and radiology orders. "If you can't produce certification for that year's [meaningful-use] standards and if you can't produce the security risk assessment, the audit is done," Marting says. "They tend to focus on a straightforward yes or no measure." CMS will then recoup the incentive payment.

The FOIA request was submitted to CMS by Wyoming surgeon Razi Saydjari, who shared the results with *RMC*. Saydjari sought information on meaningful-use audits after failing his audit solely because of the security risk assessment. That might have meant an end to his $18,000 EHR incentive payment, but the surgeon overturned the audit findings in an appeal to CMS *(RMC 4/18/16, p. 1)*. Saydjari told CMS he believed his EHR vendor, Allscripts Healthcare Solutions, performed and documented the security risk assessment, and he wasn't alone. A class-action lawsuit against Allscripts over its alleged meaningful-use practices was settled in late March, with Allscripts forking over almost $10 million. Saydjari's share was $1,200, and he and other physicians are using Allscripts' replacement platform.

The whole experience left a bad taste in his mouth. "There was just a visceral anger at having a CPA firm conduct an audit of my private practice," Saydjari says. "They had contacted me via email to notify me that I had been selected for the audit. The whole process was so bizarre that I thought it was fraudulent and called CMS to verify that the CPA firm was contracted with CMS. It was stunning to me that the government would give me $18,000, not tell me what the recordkeeping expectations were to determine compliance, and then audit me three years later. That is what prompted the FOIA request."

Auditors Are Not Rewarded for Recoveries

However, in a letter to Sen. John Barrasso, M.D. (R-Wyo.) on meaningful-use audits, Sherri McQueen, director of CMS's Financial Services Group, said core measure 15, security risk assessments, isn't causing much of an audit black mark. "The percentage of physicians failing to meet this measure is in the single digits," she wrote in response to Barrasso's inquiry about Saydjari's audit.

McQueen also said that Figliozzi doesn't receive a percentage of any audit recovery. The CPA firm's "full and total compensation is completely independent from the audit determinations they render," she wrote. "There is no financial incentive on their part for adverse audit decisions."

But Marting doesn't think it's that black and white. CMS's contract with Figliozzi has expectations about Medicare's "satisfaction." It states that CMS will evaluate contractor performance based on feedback from hospitals, EPs and CMS's regional and central offices. And the audit program has to be budget neutral, which presumably means Figliozzi has to find at least $7 million in meaningful use payments that can be recouped, she says. "Do they have a financial incentive to deny audits? Not in the same way recovery audit contractors do, but

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the nature of this program is if they don't deny audits, Medicare isn't happy and they may not maintain the contract with Medicare, so they do have an incentive to deny audits."

That being said, Marting finds the Figliozzi auditors reasonable. They call her back, and will grant extensions when providers need more time to gather documentation to prove their compliance with core measures. And there sometimes is flexibility when it comes to meaningful use of EHRs. For example, one of Marting's clients attested it met core measures from March to June, but its software was upgraded in April. That meant the client wasn't using a certified product for part of the 90-day period. "They thought it was certified to that year's standards, but it wasn't," she says. "They met the requirements for meaningful use even though it didn't match the attestation." Marting asked Figliozzi if it would audit a different 90-day timeframe, and Figliozzi obliged. This can happen with other core measures, where CMS changes the numerators and denominators and providers don't catch up fast enough in the reporting period. "Providers often just accept denials, and maybe they wouldn't think to talk to Figliozzi about a different reporting period," she says. But with 9,000 EP desk reviews, it's worth a try.

For more information, contact Marting at rmarting@forbeslawgroup.com. ✧

Political Activities May Need Policy Update as Fall Elections Loom

As political campaigns heat up across the country, the cool heads in compliance may want to review the laws and regulations governing political activities by corporations and employees. There are federal, state and local laws and IRS restrictions on lobbying, gifts and political advocacy, and some of the finer points may come as a surprise.

"Compliance and the political law area is not necessarily intuitive," Minneapolis attorney John Knapp said at a June 14 webinar sponsored by the Health Care Compliance Association. "You can't look at an activity and say it doesn't seem like it should be a violation." He recommends revising corporate policy manuals to set forth policies on employee and corporate political activity so employees are clear on where the lines are drawn.

"It's important to articulate what the company's objectives are, what its policies are and what the direction of political engagement the company intends to take both for employees and the public impacted by your policies," Knapp said. "It's much better to do that before an issue arises rather than in the midst of an election."

There are three general areas of political activity and they may require monitoring by compliance: interaction with elected officials (e.g., lobbying, gifts); corporate political activity (e.g., communicating with employees); and election activity by employees, said Knapp, who is with Winthrop and Weinstine. "It's a complex environment," added Tammera Diehm, who's also with Winthrop and Weinstine. She suggests compliance officers understand "the tools available for political participation."

In terms of interaction with elected officials, the federal Lobbying Disclosure Act / Honest Leadership and Open Government Act defines a lobbyist as "any person who (a) makes, or is expected to make, at least two lobbying contacts and (b) spends at least 20% of his or her time engaged in lobbying activities on behalf of a client or employer." There are also state lobbying laws. (Federal election campaign laws are at 14 US Code Sec 441b.)

Most hospitals probably have registered lobbyists and don't have to fret about executives or board members crossing that threshold, Knapp said. But state gift laws apply to both. "They can't give a gift to a public official and try to get the hospital to reimburse them," Knapp said. For example, the CEO might take a state legislator or executive agency official out to dinner. Depending on the state law, the wining and dining may be prohibited, but if the CEO seeks reimbursement from the hospital, it's "probably a violation of state law," he said.

State laws on gifts vary, and hospitals must understand the definition of gifts in their jurisdiction, Diehm said. "Who is prohibited from giving or receiving gifts? Are there exceptions? What are interpretations of gift rules? Definitions will vary greatly depending on where you are working," she said. For example, Alabama's definition of "gift" includes favor, service, gratuity, tickets to sporting or entertainment events, honoraria, promise of future employment and "any other item of monetary value." In Delaware, no state employee, officer or honorary state official is allowed to receive gifts, and "our general advice is to consider all gifts prohibited unless specifically allowed," she said.

Laws on gifts have exceptions, such as legal campaign contributions and items worth less than $5 or $10. "But even when you get your arms around the exceptions and variations, you have to take one more step to

see if there have been interpretations of the laws that may affect you," Diehm said. In Minnesota, for example, a state campaign finance and public disclosure board advisory opinion declared that permitting an elected official to buy tickets at full price to an event could violate the gift rule because the event would probably be sold out. "It was a surprise because fair-market value was not good enough," she said.

The second major activity for compliance officers to consider is political activity. "Assume any political activity by the corporation is prohibited," Diehm said. There is flexibility to discuss political views with a "restricted class," which generally means management, but politics are mostly off limits, Knapp and Diehm said. Federal and many state laws bar corporate spending to promote the election or defeat of candidates, and can trigger criminal penalties.

Political substance is a different story. Knapp and Diehm drew a distinction between "issue advocacy" and "independent expenditures." Issue advocacy refers to radio, television or print advertising to discuss issues, and it's not regulated by the Federal Election Commission, Diehm said. "The magic words to avoid to stay within issue advocacy are 'vote for,' 'elect,' 'defeat' or 'support.'"

Independent expenditures are all about supporting candidates. Since the 2010 U.S. Supreme Court decision in *Citizens United*, there is no limit on corporate funding of independent political broadcasts. But that's not the same thing as supporting or opposing an individual candidate, Knapp explained. Corporations can't coordinate or contribute directly to candidates, he noted.

Also, corporations may be asked if political candidates or public officials can use their offices to hold meetings or events, Knapp said. It's OK for campaigns and political parties to rent meeting rooms if they pay the usual charge within a commercially reasonable period of time. One exception: The corporation can offer the room to the candidate or political party for free or at a discount if that's ordinarily done for civil, community or other groups and other candidates have the same terms.

In all these areas, nonprofit hospitals have to tread lightly because of their tax exemptions, Knapp said. "There are restrictions in the Internal Revenue code on engaging in political activities if you are a nonprofit, so issues for hospitals are greater than for other businesses," he said. "They can't spend hospital money for partisan political activity."

Employees Can't Campaign at Work

Election activity by employees is a third major consideration. Employees generally can't campaign on company time or property. "It can subject the company to penalties and fines," Diehm said. For the most part, employees can't use corporate email or cell phones for political activity or forward Internet items at work that support or oppose candidates. But there are ways to channel communications about politics, Knapp said. "Some companies have brown bag lunches where they get employees to talk about public policy issues," he said. "Or they bring in candidates for lunch and create the opportunity for employees to ask about public policy issues that affect the company." Just be careful to remain neutral about the candidates, Knapp said. "The closer the activity gets to the election, the more problematic and sensitive this will be," he said.

Violations of political laws can result in civil and criminal liability and personal liability for executives, Knapp says. There's also the risk of reputational damage for companies that enter the political fray. He recommends periodic audits in this area and said "a visible and active endorsement [of compliance with political laws] by leadership is absolutely necessary."

Contact Diehm at tdiehm@winthrop.com and Knapp at jknapp@winthrop.com. ✧

CMS Transmittals and *Federal Register* Regulations
June 17 – June 23

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. 100-04, Medicare Claims Processing Manual

- October Quarterly Update to 2016 Annual Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement, Trans. 3546CP, CR 9688 (June 17; eff. Oct. 1; impl. Oct. 3, 2016)

Pub. 100-08, Medicare Program Integrity Manual

- Medical Review of Skilled Nursing Facility Prospective Payment System Bills (R), Trans. 656PI, CR 9571 (June 16; eff./impl. June 28, 2016)

Pub. 100-20, One-Time Notification

- System Changes to Implement Section 231 of the Consolidated Appropriations Act, 2016, Temporary Exception for Certain Severe Wound Discharges From Certain Long-Term Care Hospitals (R), Trans. 16750TN, CR 9599 (June 16; eff. April 21; impl. Oct. 3, 2016)

Federal Register Regulations

Final Rule

- Medicare Clinical Diagnostic Laboratory Tests Payment System, 81 Fed. Reg. 41035 (June 23, 2016)

Proposed Rule

- Medicaid Program and Children's Health Insurance Program; Changes to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs in Response to the Affordable Care Act, 81 Fed. Reg. 40596 (June 22, 2016)

Size of Compliance Staff is Stable; Structure May Be All Over the Map

Compliance departments may look very different from one organization to the next — if you've seen one compliance department, you've seen one compliance department — but their size seems to be a constant regardless of the number of employees in the organization, according to new data.

A benchmarking survey by the Health Care Compliance Association, which was released June 20, found that a significant number of health care companies has about one compliance professional for every 1,300 to 1,500 employees in the part of the organization he or she serves (e.g., the hospital). That holds true at companies with 3,000 to 4,999 employees, where 54.6% have two to five compliance professionals, and at companies with 10,000 to 14,999 employees, where 38.9% have six to 10 compliance professionals (see table, below).

Compliance officers can use the data to argue for more staff, says Roy Snell, CEO of HCCA. If you're operating as a one-person department, the survey provides some ammunition that it's understaffed. But Snell cautions it's hard to make apples-to-apples comparisons among departments. "There's no saying a big compliance department that has everything under one manager is more effective than a smaller team delegating tasks to other departments. The real question is how many hours a year does every employee in the organization spend on compliance program activity," Snell says. "It depends on your style." His preference is for operational departments to train their people on risks in their areas, while leaving compliance-related training to the compliance office. "I would delegate but not give them control — I would verify by looking at educational materials, I may sit in on a session, maybe do some testing to see if people understood what was said," he explains. The same thing goes for audits. Let the internal audit department run the show, and monitor the results. If internal audit only completes seven audits, finish the other three. If auditors identify a problem but don't follow through with corrective action, take the reins.

continued

HCCA Survey Data: Compliance Employees by Organization Size

To help compliance officers benchmark the size of their departments, the Health Care Compliance Association collected data on the size of compliance departments and broke it down by the number of employees and revenue. To ensure a more meaningful comparison, this table reports on the number of compliance professionals in the facility they serve (e.g., the hospital) rather than the parent organization. View the complete survey results at http://tinyurl.com/jbfrg65.

Members of Compliance & Ethics Group By Employees In Portion of Organization Compliance Group Serves

	Employees in compliance and ethics group								
	1	2 to 5	6 to 10	11 to 15	16 to 20	21 to 30	31 to 40	41 to 50	> 50
Healthcare									
Less than 100	18.8%	41.4%	15.5%	6.6%	5.0%	3.9%	3.3%	2.2%	3.3%
100-249	50.0%	33.0%	8.9%	2.7%	1.8%				3.6%
250-499	32.2%	53.9%	7.8%	1.7%	.9%	.9%			2.6%
500-999	43.0%	50.5%	4.3%	1.1%					1.1%
1,000-1,999	26.2%	50.0%	11.0%	5.5%	4.9%		.6%		1.8%
2,000-2,999	14.7%	52.0%	20.6%	4.9%	4.9%	2.0%	1.0%		
3,000-4,999	10.2%	54.6%	23.1%	7.4%	3.7%	.9%			
5,000-7,499	4.3%	37.1%	34.5%	8.6%	8.6%	.9%	3.4%	.9%	1.7%
7,500-9,999	4.4%	31.1%	17.8%	22.2%	8.9%	8.9%			6.7%
10,000-14,999	2.8%	13.9%	38.9%	11.1%	13.9%	13.9%	2.8%		2.8%
15,000-19,999		8.3%	36.1%	16.7%	25.0%	8.3%	5.6%		
20,000-29,999	4.2%	8.3%	10.4%	18.8%	31.3%	12.5%	8.3%	2.1%	4.2%
30,000-49,999		7.4%	7.4%	14.8%	22.2%	14.8%	18.5%	7.4%	7.4%
50,000-74,999		11.1%	11.1%		33.3%	22.2%	5.6%	5.6%	11.1%
75,000-99,999			20.0%		20.0%				60.0%
100,000 or more	7.1%				7.1%	7.1%		21.4%	57.1%

"You empower and delegate and involve as many people as you can to run a really effective compliance program," Snell says. It may make your budget or department smaller, but it could be more effective this way. "I would rather have everyone in the whole building committed to compliance." He recently got a call from a compliance officer seeking advice on how to keep the legal counsel and audit director off "her turf." Instead of driving them away, Snell suggested, let them do the work — with an asterisk. If internal counsel investigates an executive, finds a compliance problem and documents it but doesn't take action, then the compliance officer must step in. "You say, 'you almost got the job done. You documented a conflict of interest, but you didn't fix it. I can help with that,'" Snell says. Enlisting the help of legal, audit, risk management and quality doesn't mean giving up ultimate oversight responsibility. Let them know they are expected to report the conclusion of investigations and audits. "They can't just say 'I've got this' and go away," Snell says.

The benchmarking survey also showed that at the largest companies, the number of compliance professionals in a division dropped off. Snell attributes this to economies of scale. For example, "you still have to do the whole Stark training, whether you have 100 or 10,000 employees," he says.

Contact Snell at roy.snell@corporatecompliance.org. Read the survey at http://tinyurl.com/jbfrg65. ✧

PHPs Face New Billing Rules

continued from p. 1

eligibility and the medical necessity of their services. There have also been fraud settlements, including a Texas hospital's recent $2.474 million civil monetary penalty settlement to resolve allegations that its partial hospitalization services weren't supported by certifications, recertifications and individualized treatment plans *(RMC 5/11/15, p. 5)*.

Partial hospitalization is already a complicated billing experience in Medicare because it doesn't have its own billing designation. Hospitals (and community mental health centers) bill CPT and HCPCS codes for the services they provide, including psychotherapy and occupational therapy, and then add condition code 41 to tell Medicare the services were provided in a PHP. That triggers a bundling of the services into an APC.

There are two payment rates for patients in a PHP: full day (level II) and half day (level I), which is also known as an intensive outpatient program (IOP). An IOP is typically three hours a day on four or five days a week, while a full-day program is four hours or more every day, five to seven days a week, he says. In light of the 20-hour-a-week requirement, "it's not clear how one would get paid for the IOP since it is not intended to be as intensive as the full-day program," Gillis says.

There also are three different bill types. Gillis says most services are billed on type of bill (TOB) 133, which is called an interim claim. Partial hospitalization providers must meet the 20-hour requirement on TOB 133. There's more PHP flexibility in the beginning and end of care, when patients might receive fewer than 20 hours of services because they entered the program on a Thursday, for example, or wrapped up on a Monday. Services provided at the beginning of the PHP are billed on TOB 132 — the initial claim — and services provided at the end are billed on TOB 134 — the final bill. "On an initial or a final bill, it's OK if you're not meeting the 20 hours," Gillis says. The interim bill type is held to a higher standard.

CMS will be watching compliance with the 20-hour requirement through its new edits, which were announced in April. According to *MLN Matters* SE1607, the edits are:

◆ ***95:*** "Partial hospitalization claim span is equal to or more than 4 days with insufficient number of hours of service."

◆ ***96:*** "Partial hospitalization interim claim from and through dates must span more than 4 days."

◆ ***97:*** "Partial hospitalization services are required to be billed weekly."

For the three months after the edits take effect on July 5, MACs will return claims to providers so they can fix them. "Hospitals will have a bunch of claims that will come back and you'll have to figure out how to get paid," he says. Starting Oct. 1, "you won't get paid or you'll change them to get paid, but it won't be consistent with the services you provided, so it's creating risk."

And hospitals may be in a jam because of CMS claim editing logic for partial hospitalization added to the July update to the integrated outpatient code editor, Gillis says. The outpatient code editor has partial hospitalization flow charts with editing logic that tells Medicare how to process claims now that they must be submitted on a daily or weekly basis rather than monthly (see box, p. 7) .

The weekly logic, Gillis says, requires PHPs to submit a week's worth of care. "What they are looking for is 20 hours billed. That's four days of services with five units billed per day or five days with four units," he says. That's all well and good, because it fulfills the Medicare requirement for billing level II partial hospitalization. But the daily logic says Medicare will pay at the lower rate if the patient received three services, five times a week, which is only 15 hours. Again, that might qualify as level

I (IOP), but it doesn't cross the 20-hour threshold, and therefore is supposed to be rejected as a PHP. "One set of logic says they will reject that claim but the other logic says they will pay at the lower APC rate," Gillis says. "It doesn't seem to make sense."

He discussed the conflict with his MAC and was told "it's an interesting question." Here's what it boils down to: When hospitals provide less than four partial-hospitalization services a day, can they bill for the lower APC rate (IOP)? And if the answer is yes, how do you get around the edits? "They didn't have an answer to how it would work," Gillis says.

His advice: Hospitals must ensure they bill Medicare for PHPs weekly, which means "getting your bill types in order" and staying on top of the system's ability to process bill types appropriately — as interim or final bills. Compliance also depends on coordination between the clinical and billing departments, Gillis notes. For example, clinicians have to monitor whether patients disappear for two or three days. That affects the billing. Maybe the patient was admitted as an inpatient or changed to an outpatient. If so, close the PHP account and open an inpatient or outpatient account. "The billing department needs to manage the billing processes and get the right type of billing associated with each weekly claim," Gillis says.

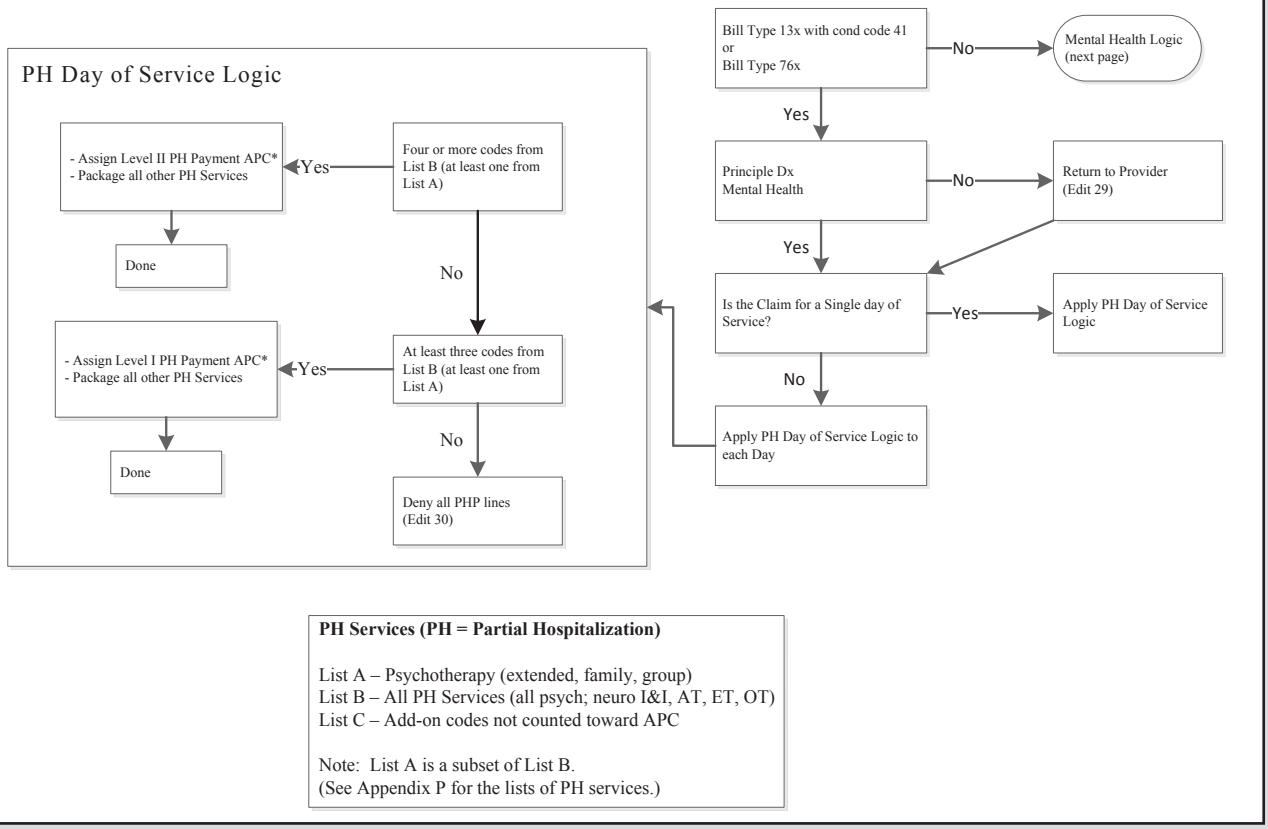
Visit Gillis at sjgillis@partners.org. Read about the new edits at http://tinyurl.com/jxk8zsx.

View the outpatient code editor billing logic at http://tinyurl.com/hbkgpse. ✧

New Claim Billing Logic for Partial Hospitalization

When CMS updated the outpatient code editor for July, it included flowcharts for processing Medicare claims for partial hospitalization. They seem to inject ambiguity into Medicare's new requirement for billing partial hospitalization on a weekly basis, and could lead to inappropriate rejections of claims for partial hospitalization, says Stephen Gillis, director of compliance coding, billing and audit at Partners HealthCare in Boston. Contact Gillis at sjgillis@partners.org. View the flow charts at http://tinyurl.com/hbkgpse.

Daily Partial Hospitalization Logic (effective v10.0)



NEWS BRIEFS

◆ **Federal law enforcers filed criminal and civil charges against 301 people, including 30 physicians, in the largest "takedown" in history, the Department of Justice and HHS said at a June 22 press conference.** Defendants in 36 federal districts were charged with alleged health fraud schemes that cost Medicare almost $900 million. They were variously accused of providing medically unnecessary services or no services in the areas of home health, psychotherapy, physical and occupational therapy, durable medical equipment and prescription drugs, according to DOJ, CMS and the HHS Office of Inspector General. Charges stemming from the Medicare fraud strike force operation include conspiracy to commit health care fraud, violations of the anti-kickback statute, money laundering and aggravated identity theft. More than 60 of the people arrested stand accused of fraud stemming from Medicare Part D. Visit http://tinyurl.com/hc5tr9x.

◆ **Even one free meal can influence a physician's prescriptions to Medicare patients,** according to a new study posted online June 20 in *JAMA Internal Medicine*. Researchers from the University of California, San Francisco, and elsewhere linked data from the CMS open payments program to Medicare Part D "to examine the association between industry payments and prescribing rates of the brand-name medications that were being promoted. We focused on meals sponsored by the pharmaceutical industry, which constitute nearly 80% of the total number of payments by drug and device manufacturers to physicians." The researchers looked at physicians who wrote prescriptions for Medicare patients in four drug classes — statins, cardioselective beta-blockers, angiotensin-converting enzyme inhibitors and angiotensin-receptor blockers, and selective serotonin and serotonin-norepinephrine reuptake inhibitors — and identified physicians who accepted "industry-sponsored meals promoting the most-prescribed brand-name drug in each class (rosuvastatin, nebivolol, olmesartan, and desvenlafaxine, respectively)." The findings, in a nutshell: "Receipt of industry-sponsored meals was associated with an increased rate of prescribing the promoted brand-name medication to Medicare patients," the paper states. Visit http://tinyurl.com/h5gmrsg.

◆ **Medicare overpaid hospitals $19.6 million over two years for 96 or more consecutive hours of mechanical ventilation, the HHS Office of Inspector General says in a new report.** OIG reviewed 200 claims and found that hospitals incorrectly used procedure code 96.72 on 63 claims when patients "had not received 96 or more consecutive hours of mechanical ventilation," the report states. CMS has an edit to detect mechanical ventilation errors, but it is limited to lengths-of-stay of four days or fewer, and some of the stays were longer, OIG says. Visit http://go.usa.gov/chepP.

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