First Telehealth FCA Case Comes Down Over MD Billing; Beware Related Risks

Telehealth services are at the heart of a false claims settlement with a provider — perhaps for the first time — and the whistleblowers are, surprisingly, a former patient and a “medical bill advocate.”

Connecticut psychiatrist Anton Fry and his Danbury-based mental health practice, CPC Associates, Inc., agreed to pay $36,704 to resolve allegations that they billed Medicare for services provided over the phone from Jan. 1, 2008, to June 1, 2015, the U.S. Attorney’s Office for the District of Connecticut said July 27. Fry allegedly didn’t meet the patients or treat them in person, and the services didn’t qualify as telehealth.

Medicare covers 37 services delivered by telehealth, including emergency department or initial inpatient telehealth consultations, office or other outpatient visits and individual psychotherapy (RMC 6/20/16, p. 3) when they are provided in a rural area, which includes counties outside of Metropolitan Statistical Areas (MSAs) or in health professional shortage areas either outside of an MSA or in a rural census tract. Telehealth services have to be delivered in an “originating site,” such as hospitals and physician practices; skyping from home doesn’t cut it. “Distant-site” providers deliver telehealth services and bill Medicare using CPT codes.

Providers also must use face-to-face, interactive audio and video telecommunications systems that enable real-time communication between the distant-site provider and the patient at the originating site. “Talking on the phone to a patient is never separately billable to Medicare and does not amount to a billable patient visit,” the complaint filed in the telehealth case states.

continued on p. 6

Varying Ideas on Compliance Programs May Spur Larger Role for CCO, or Backfire

Some compliance officers feel they’re not adequately valued by senior leaders and the board, who may view the job as limited to responding to government mandates, including regulations and audits.

“They feel like they are seen as cops and naysayers, and left out of executive meetings,” says Margaret Hambleton, vice president and chief compliance officer at Dignity Health in California. “They may put blinders on — ‘management only thinks of me as a requirement.’” But that’s not really been her experience. “I’ve found that managers believe a compliance program helps meet organizational and strategic goals as much or more than the regulatory environment. They appreciate the compliance officer’s perspective and value compliance officer participation in strategic decision making,” she says.

Which experience is more common? And does a compliance officer’s perception about the confines of his or her job turn into a self-fulfilling prophesy? These questions were sparked by the results of a survey conducted by the Health Care Compliance

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Association (HCCA) and the Society of Corporate Compliance and Ethics (SCCE) on the primary objective of compliance and ethics programs. Whatever the answers to the questions, compliance officers may want to think about the role they play in their organizations and consider how to maximize their value in measurable terms.

HCCA and SCCE surveyed 328 compliance officers during the second quarter of 2016. They found a big gap between what compliance officers consider the primary objective of their compliance program and what compliance officers think their senior leadership and board members consider the primary objective of their compliance program. Almost half of compliance officers surveyed believe that promoting an ethical culture is the main goal, while 35.4% said preventing and detecting misconduct is the primary purpose. The rest of the respondents gave various reasons, such as meeting a regulatory requirement (8.6%) and protecting the corporate reputation (2.8%).

But the compliance officers don’t think senior leaders and board members share their vision. According to compliance officers surveyed, “42.6% thought management saw regulatory requirements as the primary objective of the program.” Next was 29% for preventing and detecting misconduct and then 13.3% for promoting an ethical culture. Something similar happened with board members, although not entirely: 27.9% of compliance officers said board members think the primary objective of a compliance program is to prevent and detect misconduct, while 24.2% said it’s to meet a regulatory requirement, 19.3% said to protect corporate reputation and 15.6% to promote an ethical culture.

Letting CCOs Off the Hook?

Compliance officers who believe their leaders see the role of the compliance program as confined to helping their organization comply with regulations may make that “self-fulfilling in some cases,” Hambleton says. “It lets the compliance officer off the hook — ‘this is my role so I won’t go beyond that.’” But compliance officers are far more effective when engaged in operations and strategy, which demand more of them. This includes understanding the future of health care delivery and how the organization will grow, its financial viability, how it envisions delivering care and who its partners should be. “It’s important for compliance officers to be a part of those discussions,” she says.

Suppose the health system decides to deliver care in patients’ homes. Compliance officers have to consider the implications of this plan because it will require the use of telemedicine, partnering with physicians and entering joint ventures with entities the health system hasn’t worked with before. What are the privacy risks with telemedicine and what is the reimbursement picture? Are there conflicts of interest in terms of the physicians? That’s just for starters. “Compliance officers can assist in how we deliver a strategy and what tactics we will use and what risks will look like as we move forward,” says Hambleton, noting it’s a hypothetical.

Hambleton doesn’t necessarily think that promoting an ethical culture is the primary objective of a compliance program because that’s the responsibility of management and the board. “It’s the old thing that compliance is not responsible for compliance — it’s responsible for developing the framework to help the organization comply [with laws and regulations] and to understand its ethical obligations.” She suggests compliance officers partner with operations “so they understand where the burdens and pressures are.”

Even when compliance programs have expansive goals with direct and indirect economic benefits, senior leaders and boards may be interested only in the regulatory compliance part, says former Department of Justice attorney Peter Anderson, with Beveridge & Diamond in Washington, D.C. Benchmarking the benefits from compliance programs is challenging, but easier than measur-
ing progress in ethics, he says. For example, compliance officers can compare the $25,000 in overpayments the organization repaid last year vs. the $2 million overpayment repaid two years earlier. In contrast, measuring the return on investments in the ethical culture is harder, and most executives and boards are all about results. “How do you measure improved employee morale or better ethical decision making? It doesn’t really translate,” he says, at least on its face. In an ideal world, the “primary objective of both management and the board would be to create or improve an ethical culture because that is the underpinning of the success of the whole compliance program. But they don’t know how to translate that criteria into data points.”

There’s tension here: “Compliance officers want to focus on ethics and compliance — doing the right thing — while senior leaders focus on avoiding fines, indictments, losing their reputations or heightened regulatory scrutiny from being viewed as a ‘bad actor,’” Anderson says. It’s a tug of war that’s been going on for 20 years, he says.

**Investing in More Risk Assessments**

There also may be tension when compliance officers ask for more money to improve the effectiveness of a compliance program from a B+ to an A- or an A to an A+. “The mantra of compliance officers is often ‘let’s keep getting better,’” but executives may push back, saying, ‘we have other risks and corporate objectives and for now, our compliance program is good enough.’” Many boards will ask how additional investment in compliance will further the company’s plans. How much is too much? Is it necessary to make a good program extraordinary? “A lot of executives aren’t willing to do that,” Anderson says. “This is a true reflection of the culture and level of commitment. It is not necessarily a bad culture, but it’s not as committed to an ethical culture.” As far as he’s concerned, “a company’s commitment to ethics and compliance can be measured by what improvements they make long before a scandal hits, and when no one is scrutinizing them.”

Larger companies usually grasp the need for additional compliance risk assessments in light of high-profile incidents (e.g., ICD-10, cybersecurity). Does it mean compliance will get more resources from the board, or rob Peter to pay Paul? The answer lies partly in whether management and the board understand that the government is looking at how the organization “exercises self-governance and whether it makes reasonable and responsible compliance investments in response to changing risks,” Anderson says. “When it comes to the exercise of broad enforcement discretion, the government’s perception is reality. If they concluded a company was unreasonable or deceptive, the government will teach it a lesson in decision making with the benefit of 20/20 hindsight.”

If there’s a whistleblower lawsuit, for example, the Department of Justice will give your organization a break if the alleged violation “was a one-off and you couldn’t see it coming,” Anderson says. “But if the violations were foreseeable or repeat violations within your company or the industry, and you didn’t reassess your risks, that’s irresponsible. It’s a failure to reboot risk calculations and it will come back to haunt you,” he says. One example: cyberattacks.

Anderson is an advocate of both minimizing risks and increasing value, and part of that is “gaining market share by doing good.” He points to companies that have increased market share by going green. Even without a single regulation, companies are committing to sustainable practices, which include “environmental, social, and governance performance indicators, including waste productivity, CEO-to-average-worker pay ratio, leadership diversity and employee turnover,” according to Forbes.

Similarly, Anderson says that adding a “value component” is attracting more attention in health care. “It’s next generation compliance. How do we increase market share by being a good actor?” Government agencies are trying to use the carrot, not just the stick, with rewards for self-disclosure and cooperation credit (RMC 5/23/16, p. 5). CMS also recently said recovery audit contractors (RACs) in the next five-year round of contacts will have the option of demanding fewer medical records from hospitals that have lower claim denial rates (RMC 5/23/16, p. 6).

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**CMS Transmittals and Federal Register Regulations**

**July 22 – July 28**

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**

- Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program Additional Instructions for the Implementation of Round 2 Recompete of the DMEPOS CBP and National Mail Order Recompete (R), Trans. 3565CR CR 9579 (July 20; eff. Oct. 1; impl. Oct. 3, 2016)

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


**Federal Register Regulations**

- None published.

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It’s preferable not to ask board members what their expectations are for compliance, says Brian Kozik, chief compliance officer at Lawrence General Hospital in Massachusetts. “I want them to think independently,” he says. “I don’t think we do that enough in the compliance world. In regional meetings in New England, compliance officers have grappled with this topic.” Some say the board understands the objectives of the compliance program, which Kozik believes should be consistent with the perceptions of management and the compliance officer, and cover the main areas mentioned in the survey, including preventing and detecting misconduct, promoting ethics and complying with regulations. That’s how it is at Lawrence General Hospital, he notes.

Other compliance officers say they never get a chance to report to the board and some have the chance, but only through written reports. There is clearly still a gap between what the HHS Office of Inspector General’s compliance-program guidance says about how compliance programs should operate and how they run in the real world.

Contact Hambleton at Margaret.Hambleton@DignityHealth.org, Anderson at PAnderson@bdlaw.com and Kozik at Brian.Kozik@lawrencegeneral.org. Read the survey at http://tinyurl.com/zu2d8vd.

### CMS Will Cap Look-Back Period for QIO Reviews When They Resume

Audits of short inpatient stays by the Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs) are not resuming yet, but CMS has tweaked them. On July 28, CMS said on its website that the QIO reviews will undergo two changes before they start up again sometime soon. QIOs won’t go back farther than six months in selecting claims for audit under the two-midnight rule. If the older claims were already reviewed, they will be paid. For claims reviewed within the two-midnight policy in effect at the time of the hospital admission, “CMS says. It states that “formally denied” means “the provider was sent an initial results letter by the BFCC-QIO; the BFCC-QIO conducted and completed provider-specific education on claims in question; or the BFCC-QIO sent the provider a final results letter and the denial was sent to the MAC for effectuation.”

Visit http://tinyurl.com/p9ha9qh.

### Solving Complex Riddles About SNF Admissions and the Three-Day Rule

It may drive hospitals, physicians and patients to distraction, but Medicare won’t pay for stays in skilled nursing facilities (SNFs) unless patients were just discharged from a three-day medically necessary stay in an acute-care hospital. It doesn’t count when patients spend three days in observation or were there for social/custodial reasons.

CMS makes no bones about this, yet hospitals face claim denials because of misconceptions about Medicare rules on “qualifying stays” in SNFs, says Ronald Hirsch, M.D., vice president of education and regulations at Accretive Physician Advisory Services.

For example, some physicians are adamant that Medicare allows them to admit patients as inpatients when family members can’t take care of them at home anymore, including patients with worsening dementia, as long as the doctor labels it failure to thrive. The doctors stated “we have always done this and never had a problem and the family expects me to admit them.” But that’s not compliant with the two-midnight rule, which allows Part A reimbursement only for patients who have a medically necessary reason to cross two midnights in the hospital, at least one as an inpatient. After hearing...
a lot of misconceptions about hospital stays and SNF admissions, Hirsch figured it was time to clear some of them up. What follows is information provided to RMC by Hirsch. Contact him at rhirsch@accretivehealth.com.

Who qualifies for Part A skilled nursing facility care?

Part A SNF care is health care given when the patient needs skilled nursing or therapy staff to manage, observe, and evaluate their care. Examples of skilled care include intravenous injections and physical therapy. Medicare certifies these facilities if they have the staff and equipment to give skilled nursing care, therapy services, and/or other related health services.

Medicare does not cover custodial care if it’s the only kind of care the patient needs. Custodial care is care that helps the patient with daily activities like getting in and out of bed, eating, bathing, dressing, and using the bathroom. It may also include care that most people do themselves, like using eye drops or oxygen, and taking care of colostomy or bladder catheters. Custodial care is often given in a nursing or long term care facility.

The patient must get the required skilled care on a daily basis and the services must be ones that can be provided only in a SNF on an inpatient basis. Medicare covers up to 100 days for Part A SNF care, but coverage may end prior to that point if the need for skilled services ends. There must be a preceding inpatient admission of three or more days that’s medically necessary, meaning the admission was required to receive services or reduce risk and that care could not have been safely provided at any other level of care.

What do we do when families want their loved one admitted to qualify for transfer to a SNF?

If the patient has a condition that warrants hospital care that is expected to require two or more midnights, the patient should be admitted as an inpatient. If that stay lasts over three days, the patient can be evaluated for transfer to a SNF under Part A. If the patient does not require hospital care, the patient should not be admitted to the hospital as an inpatient solely to accumulate the three needed inpatient days. First, the patient is unlikely to have a condition that requires skilled care on a daily basis. It is more likely that they require custodial care that the family is no longer able to provide and custodial care is not a covered Medicare benefit.

When a patient or family member insists on inpatient admission, the physician has the option of admitting the patient and then notifying the care management staff who will issue a Pre-Admission Hospital-Issued Notice of Non-Coverage (HINN).

That will notify the patient and family that the hospital feels the admission is for non-medical reasons (a social admission) and will be billing the patient for the hospital stay. Furthermore, an admission accompanied by a Pre-Admission HINN will not be considered a qualifying stay for SNF coverage.

The family will have the option of taking the patient home, agreeing to transfer to a long term care facility and pay out of pocket, or allowing the patient to be admitted and accepting financial responsibility (without accruing the needed days for SNF qualification). The hospital will assist the family in arranging transfer to a long term care facility for the needed custodial care or arranging needed home assistance.

What if I diagnose the patient with failure to thrive?

Failure to thrive is not a diagnosis that requires acute hospital care. Patients with failure to thrive need assistance with eating, bathing and using the bathroom; those are not skilled services.

We used to always admit these patients and send to SNFs; why is this happening now?

As the Medicare Trust Fund drops, Medicare has started looking more closely for areas where they have been paying for services that were not a Medicare benefit. This is one area where billions have been paid improperly to SNFs for patients who did not require skilled care and they are now targeting this area for strict compliance with the rules.

Why three days?

The three day requirement dates back to 1967 and is obsolete today, but despite lobbying by many organizations, it remains in place. This harms beneficiaries who would benefit from SNF skilled care after an acute illness or injury, such as a pelvic fracture with difficulty ambulating and need for therapy, but until the rule is changed, we must work with it as is.

Medicare has allowed some accountable care organizations (ACOs) to waive the three day requirement for cases such as this, but those ACOs are financially accountable for the SNF costs so they use it wisely. It is hoped that Medicare will adopt some form of this waiver for all hospitals soon.

A Guide to Complying With Stark Physician Self-Referral Rules

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The false claims complaint was filed by two whistleblowers: former patient Jodie Cohen and Medical Bill Consultants, LLC, which is a “medical bill advocate,” according to Raphael Katz, an attorney for the whistleblowers. The U.S. attorney’s office later intervened in the case. The complaint alleges that Fry and CPC Associates billed Medicare for treating patients he never examined in person; instead, he briefly spoke to them on the phone.

“The patients treated over the phone by Dr. Fry and CPC Associates were not located in rural health professional shortage areas and Dr. Fry and CPC Associates did not use interactive audio and video communications,” the U.S. attorney’s office says. “They simply treated certain Medicare patients by phone.”

Here are the allegations:

◆ Fry spoke to Cohen by phone for about five minutes on Oct. 2, 2012, and allegedly billed Medicare twice for a psychiatric diagnostic interview examination (CPT code 90801). He was paid $255.

◆ Although Fry allegedly didn’t see Cohen in person on Dec. 18, 2012, and spoke to her by phone for no longer than five minutes, the psychiatrist charged Medicare for pharmacologic management, including prescription use and review of medication with no more than minimal medical psychotherapy (CPT 90862). He was paid $37.05, the complaint alleged.

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**Checklist: Legal Matters to Consider When Providing Telehealth**

Before submitting claims for telehealth services, providers should review the constellation of laws and regulations they may implicate, says Atlanta attorney Sidney Welch, who is with Polsinelli. Here are many of them. Contact her at SWelch@Polsinelli.com.

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Prior to providing and/or submitting claims for reimbursement of telehealth/telemedicine services, the following general laws, regulations, and other guidance (collectively “Laws”) should be reviewed and considered:

**Delivery of Telehealth/Telemedicine Services**

- State Telemedicine Laws including:
  - Medical Practice Act
  - Medical Board Policies\(^1\) or other Guidance
  - Attorney General Opinions
  - Standard of Care Law
  - Informed Consent Law
  - Federal and State Case Law
- State Licensure Laws\(^2\) including:
  - Medical Practice Act (Physicians)
  - Nursing Practice Act (e.g., Advanced Practice Registered Nurses, Clinical Nurse Specialists, Nurse Midwives)
  - Physician Assistant Practice Act (Physician Assistants)
  - State Psychology Practice Act (Psychologists)
- Federal and State Laws Related to Prescribing including:
  - Medical Practice Act (or other applicable act depending on type of provider)

- Pharmacy Practice Act
- Medical (or other applicable professional board depending on type of provider) Board Policies or other Guidance
- State Attorney General Opinions
- Controlled Substance Act\(^3\)
- Ryan Haight Online Pharmacy Consumer Protection Act of 2008\(^4\)
- Drug Enforcement and Administration Enforcement Actions
- Federal and State Case Law
- Federal (e.g., HIPAA/HITECH)\(^5\) and State Medical Record Retention Requirements
- Federal and State Privacy and Security Laws including:
  - HIPAA/HITECH
  - Federal Trade Commission Laws\(^6\)

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\(^1\) See e.g., Federation of State Medical Boards’ Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine, available at [https://www.fsmb.org/Media/Default/PDF/FSMBAdvocacy/FSMB_Telemedicine_Policy.pdf](https://www.fsmb.org/Media/Default/PDF/FSMBAdvocacy/FSMB_Telemedicine_Policy.pdf)


\(^3\) 21 U.S.C. §§801 et seq.

\(^4\) 21 U.S.C. §829(e).


Medicare paid Fry $49.86 on June 18, 2013, for an established patient office or other outpatient visit typically 25 minutes (CPT 99214) for services to Cohen, although allegedly Fry never set eyes on her and only spoke to her by phone for about five minutes. He billed again for CPT 99214 on Nov. 4, 2013, this time receiving $73. In similar fashion, Fry charged Medicare for an established patient office or other outpatient visit typically 15 minutes (CPT 99213) on Aug. 13, 2013. Fry was paid $73 although allegedly he never saw Cohen and only spoke to her by phone for five minutes, the complaint said.

Atlanta attorney Sidney Welch figured it was just a matter of time before telehealth services and the False Claims Act collided, and that time has come — although the settlement amount is tiny. “It seems to indicate this was not part of a grand scheme to defraud but perhaps more ignorance or a need for provider education on Medicare requirements as they relate to the telehealth world,” says Welch, who is with Polsinelli. She cautions, however, that “although CPT codes exist for phone consultations (99441 to 99444), Medicare doesn’t recognize reimbursement for them.”

Telehealth services fall into two buckets: (1) asynchronous monitoring, which is real-time, face-to-face communication, and includes telepsychology and monitoring of patients with cardiac conditions and continuous positive airway pressure (CPAP) machines for sleep apnea; and (2) “store and forward,” which refers to information that is gathered and forwarded to providers for review, such as radiology images. Medicare reimbursement, however, is limited, even with the expansion contemplated in the proposed 2017 Medicare physician fee schedule regulation, Welch says. Assuming the telehealth proposals are finalized, starting Jan. 1, Medicare would pay for telehealth versions of end-stage renal disease-related services for all ages; two more advanced care planning services (HCPCS code G0438 and HCPCS code G0439); and two new G codes for critical care consultations (GTTT1 and GTTT2).

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**Checklist: Legal Matters to Consider When Providing Telehealth (continued)**

- Federal (Medicare), State, or Accreditation Agency (e.g., The Joint Commission) Credentialing Requirements
- Federal Food and Drug Administration Requirements and Guidance (if mobile app constitutes a “device”)
- Federal Communications Commission Laws
- Federal and State Children’s Online Privacy Protection Laws (if services are provided to minors)
- Federal and State Fraud and Abuse Laws

**Reimbursement of Telehealth/Telemedicine Services**

7 CMS-3227-F: 42 C.F.R. §482.22(a)(3).
8 The Joint Commission, Standard LD.04.03.09, available at http://www.jointcommission.org/assets/1/6/Pre_Pub_Telemedicine_HAP.pdf.
11 Children’s Online Privacy Protection Act of 1998, 15 U.S.C. §§6501-6506 (applies to operators of commercial websites and online services, including mobile apps, directed to children under 13 that collect, use, or disclose personal information (e.g., first and last name, address) from children.
12 Federal Medicare Telehealth Reimbursement Laws
13 Federal Medicare Site of Service Laws (e.g., Rural Health Clinics located in a qualifying area)
14 Federal Medicare Laws Regarding Charges to Beneficiaries
15 State Medicaid Telehealth/Telemedicine Reimbursement Laws including:
   - State Medicaid Statutes and Regulations
   - State Insurance Statutes and Regulations
16 Private Payor Agreements, Policies, Manuals, and other Guidance related to Telehealth/Telemedicine
17 Foreign and State Tax Laws

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12 42 U.S.C. 1834(m); 42 C.F.R. §410.78; Medicare Benefit Policy Manual, CMS Pub. 100-02, Chap. 15 § 270(Rev. 221, Eff. 4-11-16); Medicare Claims Processing Manual, CMS Pub. 100-04, Chap. 12 § 190 (Rev. 3476, 03-11-16); CY2016 Physician Fee Schedule Final Rule & List of Medicare Telehealth Services, 80 Fed. Reg. 70886 (Nov. 16, 2015).
13 See Medicare Claims Processing Manual, CMS Pub. 100-04, Chap. 12 § 190.2 (Rev. 3476, 03-11-16).
14 See 42 U.S.C. §1395u(h); Medicare Claims Processing Manual, CMS Pub. 100-04, Chap. 1, §30.1.1 (Rev. 3398, 11-06-15)(beneficiaries may be billed for: (a) Part A deductible; (b) Part B deductible; (c) blood deductible; (d) Part B coinsurance; (e) Part A coinsurance; or (f) services not Medicare covered services.)
The American Medical Association’s CPT advisory panel is looking to add codes for telehealth, and reimbursement probably will follow, but for now, “the technology has outpaced regulations,” Welch says. Partly it’s a function of the fact that telehealth is viewed with some skepticism. “It’s an area that could be ripe for abuse. How do we know the services are legitimately provided and beneficial?”

Reimbursement, however, “is only the tip of the iceberg,” she says. There are many other compliance considerations, including state licensure laws and privacy regulations (see box, pp. 6-7).

As for the Fry case, Washington, D.C., attorney Jacob Harper found it remarkable that the U.S. attorney’s office intervened in a false claims case where so little money was at stake. “In a lot of ways, because the amount at issue was relatively small, this could signal an increasing focus on providers engaging in telemedicine services,” says Harper, with Morgan Lewis. He also questions why the government presented Fry’s behavior as telehealth fraud without mentioning the GT modifier, which is the modifier that distant site practitioners (e.g., hospitals, physician practices) must append to their claims when billing to signal they are in compliance with Medicare telehealth coverage requirements. The complaint simply mentions billing for services provided by phone without the benefit of seeing patients in person, as required by Medicare, except in very limited circumstances.

Fry and CPC Associates didn’t admit liability in the settlement. A statement from Richard Tynan, an attorney for Fry and CPC Associates, pointed out that the number of patient encounters at issue in the settlement was “exceedingly small.” Although CPC has a policy on seeing patients face to face, it made an exception “from time to time” for patients who couldn’t come to the office because of bad weather, health problems or their departure from the Danbury, Conn., area, without realizing it violated the law, according to the statement.

Contact Welch at swelch@polsinelli.com, Harper at jacob.harper@morganlewis.com, Katz at rkatz@sadowskikatz.com and Tynan at tynan@halloransage.com. View the press release at http://tinyurl.com/joc3fvb.

**NEWS BRIEFS**

◆ University of Pittsburgh Medical Center, University of Pittsburgh Physicians, UPMC Community Medicine, Inc., and Tri-State Neurosurgical Associates-UPMC, Inc. agreed to pay $2.52 million to settle false claims allegations, the U.S. Attorney’s Office for the Western District of New York said on July 27. The complaint, which originated with a whistleblower, alleged that certain neurosurgeons employed by University of Pittsburgh Medical Center billed Medicare for helping with or supervising surgeries that were performed by other surgeons, residents, fellows or physician assistants “when those neurosurgeons did not participate in the relevant surgeries to the degree required.” Also, one neurosurgeon who did multi-level spinal decompression allegedly billed Medicare for more levels than were performed. Visit http://tinyurl.com/zal7utx.

◆ Lexington Medical Center in West Columbia, S.C., agreed to pay $17 million to resolve false claims allegations, the Department of Justice (DOJ) and U.S. Attorney’s Office for the District of South Carolina said on July 28. Lexington Medical Center allegedly had compensation deals “in the form of asset purchase agreements and employment arrangements with certain physicians, and such arrangements did not satisfy all of the requirements” of any Stark exception, according to the settlement. The arrangements with 28 physicians in five medical groups allegedly violated the Stark Law “because they took into account the volume or value of physician referrals, were not commercially reasonable or provided compensation in excess of fair market value,” DOJ said. Visit http://tinyurl.com/gvcsu4q.

◆ The manager of an Illinois home health company is headed to prison for six years and two months after being convicted for health fraud and making false statements in a health matter, the U.S. Attorney’s Office for the Northern District of Illinois said on July 26. Diana Jocelyn Gumila, manager of Suburban Home Physicians in Schaumburg, which did business as Doctor at Home, told employees to provide home visits to patients who were physically capable of leaving their homes. She also billed Medicare at a higher level of service than necessary because the visits were usually for routine services, the U.S. attorney’s office said. On a recording presented at her trial, “Gumila can be heard telling a new doctor to ‘paint the picture’ of patients so as to make them appear confined to their homes,” according to the U.S. attorney’s office (RMC 5/16/16, p. 8). Visit http://tinyurl.com/hpb2j63.

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