Report on
MEDICARE COMPLIANCE

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

Contents

PUBLISHER'S NOTE: ***RMC*** *will not be published for the next two weeks. The next issue will be dated Jan. 9.*

HCCA
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In Latest Challenge, Broward Health Tells OIG It May Have Violated Kickback Law

Broward Health in South Florida, which has had its share of compliance woes, told the federal government Dec. 7 that it probably violated the anti-kickback law by giving certain physicians preferential treatment on an orthopedic and trauma call panel. The public hospital district plans to refund money for services that were tainted by the conduct.

That was a "reportable event" under Broward Health's corporate integrity agreement (CIA), according to the law firm hired by the hospital to conduct an independent investigation of allegations that were initially presented to the compliance officer.

"We have concluded that Broward Health's former interim president and chief executive officer Pauline Grant did, during her tenure as the CEO of [Broward Health], engage in conduct that constitutes a probable violation of the anti-kickback statute," Nashville attorney Richard Westling of Waller Lansden wrote in the letter, which was publicly available because of Florida's Sunshine Law. The hospital's orthopedic trauma call coverage contracts "did not comply with longstanding OIG guidance in this area in that it failed to treat physicians equally and, instead, favored physicians who were able to bring additional referrals" to the hospital.

There has been turmoil at Broward Health, which was formerly called North Broward Hospital District, going on two years. In September 2015, the hospital settled a

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Getting Ahead of Risks Helps Providers Prepare for MACRA; Mistakes Shed Light

Whether health care organizations decide to walk or run to the Medicare Access and CHIP Reauthorization Act (MACRA) — a choice made available in the final regulation — they are also facing the considerable compliance implications of this transformational method for paying physicians, which unfolds Jan. 1.

Although MACRA replaced the hated ritual of the annual congressional "doc fix," its elaborate pay-for-performance system brings new revenue and compliance challenges *(RMC 3/7/16, p. 1)*. Physicians and other clinicians (e.g., nonphysician practitioners) will continue to receive fee-for-service payments plus 0.5% annual updates through 2018, but there will be strings attached in 2019 and beyond. Physicians will be assigned points based on their performance on cost and quality measures, and some of their Medicare reimbursement will depend on their scores, says Atlanta attorney Sidney Welch, with Polsinelli. The scores for 2019 payments are based on their 2017 performance on cost and quality measures, which will be conveyed through claims data, qualified clinical data registries, attestations and other methods, she notes. Physicians stand to gain or lose four percent of their Medicare income the first year.

"MACRA is clearly tying payment to performance with a specific focus on key areas, such as quality, clinical integration and cost reduction," says Robert Jagielski,

compliance director for clinical integration at Dignity Health, a California-based health system. The law raises a number of compliance challenges, from protecting the integrity of the clinical data extracted and reported for quality measures to ensuring the accuracy of attestations submitted to CMS. "Compliance is more integrated on the operational side because of the nature of reporting under MACRA."

The walls will have to come tumbling down in light of MACRA's mind-boggling complexity. "You want to build on the integration that's already started between quality of care, compliance and clinical documentation improvement, and set up audit plans that are specific to MACRA," he says. Audit plans can be based on historical data and reporting experiences, as well as industry trends and CMS outreach efforts, including *Lessons Learned from the Performance Year 2015 Quality Measures Validation Audit*, which contains "actionable data highlighting areas needing improvement and identifying best practices," Jagielski says.

It's a lot to process, but CMS gave physicians a one-year transition period in the Oct. 14 final rule, Welch said. They have the option of less pain but less gain if they are willing to sacrifice dollars in exchange for less reporting, she says (see box, p. 3).

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There are two tracks in MACRA's Quality Payment Program (QPP) — the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) — and physicians can go either way. In MIPS, physicians are scored in four areas, and their payment correlates to their scores in these areas, Welch says. They are:

◆ ***Quality.*** This element replaces the Physician Quality Reporting System (PQRS) and includes numerous measures published in an appendix to the final rule, Welch says. For example, for patients with chronic stable coronary artery disease, the percentage of patients 18 years and older who were seen in a 12-month period and prescribed aspirin or clopidogrel.

◆ ***Cost*** (e.g., Medicare spending per beneficiary). This element replaces value-based modifiers

◆ ***Improvement activities,*** such as care coordination, population management, patient safety, expanded access and integrated behavioral and mental health.

◆ ***Advancing care information,*** which replaces the electronic health record (EHR) incentive program (also known as meaningful use).

"Doctors will have to be super careful from a compliance standpoint because they will be submitting information around four criteria," Welch says. She thinks cost measures will be the killer because it may be hard for them to achieve as shown on past demonstration projects, although physicians have a pass on that for a year.

MACRA Awareness Is Spotty

Physicians can skip MIPs and elect to participate in APMs. They include:

◆ ***Models that come out of CMS's Center for Medicare and Medicaid Innovation.***

◆ ***Medicare Shared Savings Program*** (MSSP) accountable care organizations (Track 2 and 3 only).

◆ ***Oncology Care Model.***

◆ ***Comprehensive Primary Care Plus.***

◆ ***Other demonstration programs.***

At least physicians get to decide whether to "crawl, walk or run" to MACRA the first year because their awareness is all over the map, Jagielski says. "Fifty percent of physicians don't know what MACRA is or the compliance requirements," he says, according to a survey conducted by Deloitte. MACRA is "disruptive by design" — giving hospitals and physician groups the opportunity to leverage MACRA's risk/reward model to improve the coordination and quality of care — but the stakes are very high. "Reporting on the quality measures is a real concern," Jagielski says. How do you know you're reporting the quality measures correctly? Do you have the documentation to back it up?

For MACRA, Dignity Health is building on its "integrated compliance program," Jagielski says. Because relevant departments, including IT, quality assurance, care coordination and population health management, already work together, they have absorbed MACRA. The compliance efforts focus on five areas:

(1) Strategic planning: In monthly operational and strategic planning sessions, "we are able to ensure that compliance requirements are factored into the evaluation process for selecting measures," Jagielski says. For example, flu shots and diabetic eye exams seem like no-brainers because they should be easy to comply with. On closer inspection, however, "internal data and CMS guidance indicates that actually obtaining the medical records for these measures are difficult because patients may not have easy access to these records."

(2) Training: Clinicians and their office staffs have to understand the level of detail that's necessary to meet a measure and learn how to abstract the data. For example, for some measures, the results of a test — not just the fact the patient had the test — must be documented in the medical record, he says.

(3) Audit: Dignity Health will periodically audit the measures to ensure the collection of data required by MACRA, Jagielski says. "We are designing audit plans based on required data elements, historical compliance with a standard, and known documentation issues that have been reported by CMS."

(4) Data extraction and integrity: Identifying qualifying patients and pulling detailed requirements from medical records is a big MACRA challenge, he says. For example, when reporting on a certain measure, physicians may have to identify patients within a given age range who have a specific condition, which requires extracting test scores and other detailed data. "Larger systems that have experience reporting PQRS should already have systems in place for extracting the required data from a medical record," he says. "For employed physicians that operate through a medical foundation, the process is easier because you are focused on one or two key electronic health care record systems. However, for clinically integrated networks with diverse participants, the process becomes more complicated because you are required to extract data from a multitude of record types."

(5) Patient compliance: Because it already has clinically integrated networks, Dignity Health will "leverage existing processes for tracking compliance with required testing and follow-up orders as well as ensuring that data is collected and properly reported." The expertise of a clinically integrated network is helpful even if it doesn't qualify for the advanced APM option because it's only participating in programs with non-downside risk (ACO Pioneer, MSSP Track 1), Jagielski says.

And there's always HIPAA. Dignity Health is ensuring its data warehouse — which contains patient demographics, and claims, enrollment and other data — is HIPAA compliant, Jagielski says. For example, the IT department attests to compliance with the security rule and the compliance department oversees role-based user access. "We plan to audit the data flow into and out of the data warehouse to ensure compliance with these measures," he says.

Although MACRA was a bipartisan law and the regulation was finalized, it could face some changes in light of concerns raised in October by Rep. Tom Price (R-Ga), who is President-elect Donald Trump's choice for HHS secretary. "MIPS is too complex," he wrote in an Oct. 6 letter to CMS acting Administrator Andy Slavitt.

Contact Jagielski at Robert.Jagielski@DignityHealth.org and Welch at SWelch@Polsinelli.com. View the Deloitte survey at http://tinyurl.com/hn7jy9f. ✧

Physicians Have More Flexibility in MACRA Transition Period

In the final rule implementing the Medicare Access and CHIP Reauthorization Act (MACRA), CMS gave physicians different paths for moving into the new pay-for-performance system, says Atlanta attorney Sidney Welch, with Polsinelli. The path they choose affects the size of potential rewards and penalties. Contact Welch at SWelch@Polsinelli.com

2017 Participation Strategy	MACRA Payment Implications for 2019
• Report all required MIPS measures • For full 90-day performance period and up to the full year	• Avoid up to the -4% MIPS payment adjustment • Qualify to receive up to +4% payment adjustment • Eligible for additional "exceptional performance" adjustment
• Report for 90-day period (but less than full year) • Report more than one quality measure, more than one improvement activity, or more than the required measures in the advancing care information (ACI) performance category	• Avoid up to the maximum -4% MIPS payment adjustment • Become eligible to receive up to the maximum +4% adjustment
• Report one measure in each of the quality and improvement performance categories, or report the required measures of the ACI performance category	• Avoid up to the maximum -4% MIPS payment adjustment (but not eligible for +4% adjustment)
• Fail to report one MIPS measure or activity	• Maximum -4% MIPS payment adjustment in 2019

Assessing the Effectiveness of Your Compliance Program

Brian Kozik, chief compliance officer at Lawrence General Hospital in Massachusetts, developed this tool for evaluating whether the compliance program is accomplishing its goals. The tool also has a comment section for more feedback (not included here). For example, a board member suggested in the comment area that Kozik include more compliance education at every meeting. "We can't always assume a board member will know what we mean by the two-midnight rule," he says. Contact him at Brian.Kozik@ lawrencegeneral.org.

	Yes	No	N/A
Compliance Officer and Compliance Committee			
Does the Compliance Officer participate in senior leadership team and have direct access to the CEO?			
Does the Compliance Officer make regular reports to the CEO?			
Does the entity have a local Compliance Committee? If so, how often does it meet?			
What departments and level of management is represented on the Compliance Committee, if one exists?			
Provide copies of the Compliance Committee meeting schedule and minutes (including handouts/attachments) - current year and prior year.			
List of external counsel and consultants used by the compliance department in recent years.			
Policies & Procedures - Code of Conduct			
Is the LGH Code of Conduct communicated during Orientation?			
Is the Code of Conduct acknowledgement form signed by all participants at Orientation and is the form kept in employee files?			
Is the LGH Code of Conduct distributed by the Medical Staff Office to all Privileged Physicians?			
Are there compliance related policies and procedures at the entity level? If so, provide copies of all.			
Are the Compliance policies and procedures available to workforce members at the entity? If yes, please describe how employees may access.			
Have the requirements of the Compliance policies and procedures been communicated to employees?			
Has the LGH Code of Conduct been distributed to the (A) board, (B) all officers, (C) all managers, (D) employees, (F) contractors, (G) vendors and (H) medical staff?			
Communication			
Is the compliance support line information publicized throughout the entity?			
Is the Compliance website accessible through the entities intranet? If yes, print screen demonstrating. If there are any other compliance sites, print screens.			
Has the COO received a copy of the annual work plan and compliance program documents?			
Education & Training			
Do new employees receive training regarding compliance program within 90 days of employment?			
Is orientation education provided to other (A) covered individuals, (B) contract employees, (C) contractors, (D) students, (E) volunteers)?			
Is failure to fulfill compliance training grounds for a covered individuals discipline up to and including termination? Does the organization ensure that employee completed required compliance training and take appropriate steps where employees to not?			
Is there documentation showing disciplinary action for covered individuals who do not complete compliance training?			
Are there compliance-related materials included in the new employee or on-boarding education packet? If yes, provide materials for new hires, existing employees, physicians and board members.			
Does the Medical Office Staff provide compliance related materials to privileged physicians? If yes, provide materials. Frequency?			
Internal Auditing & Monitoring			
Is regular auditing/monitoring conducted at the entity?			
Is there a process to review findings, identify weaknesses and deficiencies, and create corrective action plans if necessary?			
Are major findings communicated to senior management in a timely manner?			
Is there a mechanism to ensure identified overpayments and/or documentation not supporting services rendered, after identification and quantification, refunded within 60 days as required?			
Are corrective action plans followed up on? For Internal Reviews? By Whom? For External Reviews? By Whom?			
Has the entity received any RAC automated and/or complex letters? Does the facility receive RAC audits results/ outcomes? If yes, are the results being reviewed?			

Some Appeals Won't Disqualify Hospitals From Settlement Process

Hospitals won't always have to choose between a favorable administrative law judge (ALJ) decision and the partial payment that CMS is offering in the second round of the hospital appeals settlement process, which started Dec. 1 *(RMC 11/21/16, p. 1)*. If they win their ALJ patient-status appeal while their settlement process is in the works, hospitals can enjoy the fruits of both, an official from the Office of Medicare Hearings and Appeals (OMHA) said Dec. 12 during a national CMS call.

There's a caveat, however. "The ALJ decision needs to be written. It can't just be oral," the OMHA official said. "But if you received a favorable decision before the administrative agreement is signed by CMS, then the decision will be effectuated and you will get full payment for that appeal, so it is a matter of timing."

That was one of the clarifications to come out of CMS's follow-up call on the second, revised round of the hospital appeals settlement process, which requires participating hospitals to withdraw all appeals of denied patient-status claims in exchange for 66% of the net allowable amount of the claims. CMS also pointed out a

Assessing the Effectiveness of Your Compliance Program (continued)

	Yes	No	N/A
Investigation/Response and Prevention			
Is a process in place for investigating reports of non compliance?			
Are matters thoroughly and promptly investigated?			
Are corrective action plans developed that takes into account the cause(s) of each potential violation?			
Are findings, status and outcomes of investigations reported regularly to appropriate oversight bodies?			
Do written policies and procedures exist for responding to government investigations?			
Do monitoring efforts indicate that preventative measures taken in response to non compliance are effective in eliminating future instances of similar non compliance?			
Is there a contract in place with a credit monitoring agency to be used when necessary for validated HIPAA/security breaches?			
Enforcement of Disciplinary Actions			
Does the Hospital have a disciplinary policy? If yes, provide copy.			
Are disciplinary standards well publicized, communicated and readily available to all staff?			
Do disciplinary standards include actions for compliance-related items?			
Is each instance involving the enforcement of disciplinary standards thoroughly documented?			
Are covered individuals screened before hire/contract to assure they are not excluded by the OIG or GSA?			
Is compliance an element of performance review and incentive compensation decisions?			
Who handles disciplinary actions at the entity, regional or local HR rep?			
HIPAA			
Has HIPAA privacy walkthrough, HIPAA/physical security walkthrough been conducted?			
Are there privacy program communications such as newsletters, announcements etc. or opportunities to include privacy related content into existing communications?			
Is there an annual privacy program work plan for the system addressing entity based education and audits?			
Provide privacy materials distributed to (A) new hires, (B) existing employees, (C) physicians, (D) privileged physicians and (E) board members.			
Are staff provided additional training in response to incidents?			
Are there entity level privacy related policies or procedures in place?			
Is there documentation to show that privacy policies and procedures have been distributed to all covered individuals?			
Have reviews been conducted to assess compliance with privacy policies and procedures? If so, please provide access and/or copies of any reports.			
Are routine access audits being performed?			
Do compliance policies exist requiring employees to receive annual training regarding the privacy program and/or changes to the privacy policies or procedures made at the department level?			
Do employees in high risk (psyche and substance abuse) roles receive annual specialized privacy education/training?			
Is the Notice of Privacy Practices (NoPP) posted all required locations? Provide a copy of the currently posted NoPP.			
Who is handling Business Associate Agreements and where are they currently stored?			

couple of problems that have emerged as it implements the 2016 version of the settlement process and explained how to fix them.

Like the 2014 version, the hospital appeals settlement process is available for denied claims that have a date of admission before Oct. 1, 2013, if the appeal is pending before an ALJ or the Medicare Appeals Council, or if the hospital has not yet exhausted all of its appeal rights *(RMC 9/15/14, p. 1)*. Only fee-for-service claims that were denied because they weren't considered medically necessary for inpatient admission are eligible. There's no cherry picking; if hospitals sign up for the settlement process, they accept 66% payment for all eligible claims and withdraw the appeals.

For the most part, hospitals that participated in the 2014 version of the hospital appeals settlement process, which paid 68%, are not eligible for this version, which makes sense because they shouldn't have any denied claims left to resolve. However, if some pre-Oct. 1, 2013, patient status claim denials are out there — one person on the call said the Comprehensive Error Rate Testing (CERT) contractor was still auditing them — a "provider may participate in the settlement" again, a CMS official said.

CMS Transmittals and *Federal Register* Regulations
Dec. 9 – Dec. 15

Live links to the following documents are included on *RMC*'s subscriber-only Web page at www.AISHealth.com. Please click on "CMS Transmittals and Regulations" in the right column.

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-02, Medicare Benefit Policy Manual

- Rural Health Clinic and Federally Qualified Health Center Updates, Trans. 230BP, CR 9864 (Dec. 9; eff./impl. March 9, 2017)

Pub. 100-04, Medicare Claims Processing Manual

- Revisions to Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals and Swing-Beds in CAHs, Trans. 165SOMA (Dec. 14; eff./impl. Dec. 16, 2016)
- January 2017 Integrated Outpatient Code Editor Specifications Version 18.0, Trans. 3674CP, CR 9892 (Dec. 9; eff. Jan. 1; impl. Jan. 3, 2017)

Pub. 100-08, Medicare Program Integrity Manual

- Clarification of Certification Statement Signature and Contact Person Requirements, Trans. 689PI, CR 9776 (Dec. 9; eff./impl. Jan. 9, 2017)

Federal Register Regulations

Final Rule

- Conditions for Coverage for End-Stage Renal Disease Facilities-Third Party Payment, 81 Fed. Reg. 90211 (Dec. 14, 2016)

The settlement process is available through Jan. 31. To get started, hospitals email an "expression of interest" to CMS at MedicareAppealsSettlement@cms.hhs.gov. The subject line should include the provider's name and number (the six-digit PTAN) and state "expression of interest." That "helps CMS work your request more quickly," said Casey Welzant, a health insurance specialist in the CMS Financial Services Group. In response, CMS will send hospitals an administrative agreement and a spreadsheet of eligible claims that it believes qualify for partial payment. She urged hospitals to put the settlement process email address in their security filters to avoid CMS emails going to their spam folder.

"We expect to provide the listing of potentially eligible claims within 10 days of receiving the expression of interest from the provider," said Amanda Burd, a special assistant in the Financial Services Group. Hospitals that need more time are encouraged to email CMS.

If hospitals agree with the claims, they should sign the administrative agreement and return it to CMS within 15 days. "Please make sure you attach the administrative agreement when responding to the email. We have seen providers reply, but forget to attach the administrative agreement," Welzant said. Seven to 10 days after receiving the hospital's response, CMS will sign the administrative agreement, and within 180 days of the signature, hospitals get paid. Medicare administrative contractors will cut the check. There's one payment per provider number.

There Have Been Some Glitches

There's been a glitch in the list of eligible claims, however. Some hospitals received spreadsheets with multiple claims that had the same number, Welzant said. "Hospitals alerted us," she said. "We have fixed it and sent revised spreadsheets with multiple claim numbers and appeals numbers, and are moving forward."

Hospitals that find a discrepancy on the list of eligible claims — some claims either are missing or shouldn't be there — have 15 days to file an eligibility determination request. "Once CMS receives the eligibility determination request, it will work with the hospital and the MAC to reach a consensus on the spreadsheet," she said. Then the hospital either signs the administrative agreement on all eligible claims or on the consensus claims or it doesn't join the settlement process.

"A provider that is not responsive during the 15-day time frame will be considered to have abandoned the process," Burd noted.

After everything is wrapped up and they receive the money, the claims are still considered denied, which has cost report implications.

Visit go.cms.gov/HASP2016. ✧

Broward Health Reveals Kickbacks

continued from p. 1

Stark-based false claims case for $69.5 million *(RMC 9/21/15, p. 1)* and entered into the CIA. The following January, its CEO committed suicide, and Pauline Grant took over as interim CEO, only to be fired earlier this month "in an effort to remedy the unlawful conduct," the letter said. The compliance officer at the time, Donna Lewis, described to *RMC* Broward Health's implementation of its CIA and efforts to improve its corporate culture, as well as the tensions it faced after board members allegedly tried to identify the author of an anonymous email rather than address its substance, which targeted the integrity of an outside auditor and the behavior of general counsel *(RMC 6/6/16, p. 1; 3/28/16, p. 1)*.

And now there's the on-call coverage debacle. The story of the reportable event appears to be about favoritism for orthopedic surgeons in a position to generate business for the hospital and how it possibly led to a kickback violation, even though the hospital is under a CIA because of a Stark violation. Grant denies wrongdoing, according to the *SunSentinel*, a Florida newspaper.

It Began With a Hotline Call

According to the letter, an orthopedic surgeon called Broward Health's compliance hotline on Nov. 16, 2015, to complain that Grant was mismanaging the Physician Payment for Uncompensated Care (PPUC) orthopedic trauma call panel "in that call was not being dispersed equally among the physicians on the panel." Orthopedic surgeons vied for spots on the PPUC call panel because they were paid a per diem by the hospital.

The compliance officer investigated the complaint from the orthopedic surgeon, who is dubbed Dr. A in the letter, but not in a "meaningful" way until six months later, the letter says. When the compliance officer met with Dr. A, he alleged kickback violations, saying certain physicians were "on the call schedule more frequently and consequently receiving more PPUC program payments due to their status as significant referral sources of elective cases at North," the letter states. He had documents to support his allegations, but the compliance officer never really pursued them, the letter said. The general counsel, however, ordered Waller Lansden "to conduct a thorough and independent investigation."

It found no formal process existed for adding doctors to the PPUC orthopedic trauma call panel. Between six and nine orthopedic surgeons took call per month, and Grant decided who was in or out in consultation with the trauma medical director and medical director of orthopedic trauma.

Dr. A first came knocking in March 2008 and asked three more times in writing. In 2009, he got a letter from Grant stating there were enough orthopedic surgeons taking call. But then two new physicians were added. "These new physicians were associates in the practice of an established orthopedic surgeon who, although not an active participant in the call rotation, was a referral source of elective orthopedic cases at North," the letter states.

Dr. A continued to complain to Grant and eventually he received a PPUC contract, effective December 2012. But it still wasn't all roses. The call slots were not distributed evenly among the orthopedic surgeons on the panel. Dr. A usually got one or two days of PPUC call coverage a month, while other orthopedic surgeons got four, according to the letter. "Based on our review of the call schedules, North's process for assigning PPUC orthopedic trauma call coverage did not ensure equitable distribution," Westling said in the letter.

Dr. A pleaded his case to Grant and other people at Broward Health, but nothing changed. The reason: fear of upsetting other orthopedic surgeons who had been on the panel longer. Dr. A never had an equal number of days on the call panel. "Significantly, approximately one year after Dr. A was added to the schedule, another surgeon joined an established orthopedic practice that referred a large number of elective cases to North. The new surgeon, also a spine surgeon like Dr. A, was immediately added to the PPUC orthopedic trauma call schedule and was given equal call opportunity by taking over the slot occupied by his new employers," the letter said.

Dr. A was kicked off the call schedule in December 2014.

OIG: Call Payments 'Could Be Misused'

Westling and his colleagues interviewed Grant about the on-call schedule, and she said before 2012, Dr. A was excluded because he was "not believed to be qualified for the trauma service" on the grounds he was primarily a spine surgeon. But he was later added to be "fair" because another spine surgeon was on the call panel. In reality, the letter states, Dr. A's contract had been in place for over a year before the other spine surgeon came on the scene.

Based on that and other statements, "we concluded that Ms. Grant was less than forthcoming in our interview," Westling wrote. However, there was no evidence she got any direct payments from the call service, although she was eligible for a bonus if certain hospital financial targets were met, the letter said.

Call panels are a kickback risk because hospitals are paying referral sources, and "payments by hospitals for on-call coverage could be misused to entice physicians to

join or remain on the hospital's staff or to generate additional business for the hospital," as OIG noted in a 2012 advisory opinion (12-15). But OIG "acknowledges" that that on-call payments can be structured to minimize that risk, Westling wrote.

It would reduce risk for hospitals to offer the arrangement to all physicians in the same specialty regardless of referrals and to evenly distribute call obligations among them to avoid using call coverage to reward the biggest referral sources, according to the advisory opinion.

Westling wrote that the lawyers are calculating how much the hospital owes the government for the reportable event. The amount will be an estimate of "federal health care program reimbursement received by North during the relevant period for the services referred to the hospital by orthopedic surgeons other than Dr. A who participated on the PPUC trauma call panel," the letter says.

It's unusual to see the general counsel step in when there's a perception that the compliance officer is not vetting a compliance issue, says attorney Bob Wade, with Krieg DeVault in Mishawaka, Ind. "Typically, there should be close collaboration between the general counsel's office and the compliance office, but clearly this general counsel felt the compliance function did not completely review or make adequate recommendations to the board, so she felt she needed to go to a third party law firm," he says. If anything, it tends to be the other way around, with compliance officers seeking help on an investigation from outside counsel.

Wade advises hospitals to tread carefully with call panels. Some physicians avoid serving on them, but when there is competition for the slots, make sure you divide them equally among all physicians in the same specialty, no matter the size of their group, he says. If there are two practices — one with 25 physicians and the other with two — put them in a pool and rotate them through. Wade is also wary of hospitals denying call slots based on the physician's alleged poor quality of care. "If there are quality issues, they need to be brought forward to the medical executive committee," he says. "If you don't want to give doctors call slots based on quality indicators, you better have adequate documentation to support that reason for denial."

The case also sends a message about how much compliance and CIAs demand. "Providers uniformly underestimate the time, cost and complexity of CIA compliance," says Denver attorney Jeff Fitzgerald, with Polsinelli. "Fraud and abuse compliance is an ongoing activity. It does not end at the settlement of a whistleblower case."

Contact Westling at richard.westling@wallerlaw.com, Wade at rwade@kdlegal.com and Fitzgerald at JFitzgerald@polsinelli.com. ✧

NEWS BRIEFS

◆ **The Department of Justice (DOJ) said Dec. 14 that it obtained more than $4.7 billion in civil fraud and false claims cases in fiscal year 2016, which ended Sept. 30.** Of that amount, $2.5 billion came from cases in the health care industry, and 2016 was the seventh year in a row that civil health fraud recoveries exceeded $2 billion, DOJ said. The biggest recovery came from the pharmaceutical manufacturer Wyeth, which paid $784.6 million to settle federal and state allegations that it reported fraudulent prices on two acid reflux drugs. The feds said the alleged conduct occurred before Wyeth was acquired by Pfizer. Another $360 million in recoveries came from hospitals and outpatient clinics. Tenet Healthcare Corp. shelled out $513 million to settle allegations that four of its hospitals paid maternity clinics kickbacks for referrals *(RMC 10/17/16, p. 1)*. Visit http://tinyurl.com/j3jobgb.

◆ **CMS has posted the new statement of work (SOW) for the next round of the recovery audit contractors (RACs).** There are separate SOWs for Parts A and B and for the new hospice/home health RAC. The phrases "diagnosis validation" and "clinical validation" audits *(RMC 11/14/16, p. 3)* don't appear in the documents, even though clinical validation audits were in the previous RAC SOW. The SOW instead refers to "complex coding validations." But Denise Wilson, vice president of clinical audit and appeal services at AppealMasters in Lutherville, Md., thinks RACs will continue to perform clinical validation audits. "I believe CMS sees clinical validation denials as coding denials," she says. "I'm beginning to separate these audits into three categories: medical necessity, coding and clinical validation." Contact Wilson at dwilson@intersecthealthcare.com. View the RAC statements of work at http://tinyurl.com/jztek8r (for regions one to four) and http://tinyurl.com/zdrxe6p (for region five).

◆ **CORRECTION:** The U.S. District Court for the District of Columbia ordered the Office of Medicare Hearings and Appeals to clear the appeals backlog by Dec. 31, 2020, not 2010, as was stated in the Dec. 12 *RMC*.