Report on
Medicare Compliance

Volume 26, Number 16 • May 8, 2017

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

Contents

After Extrapolation, Mount Sinai Is Hit With $41M Overpayment in Compliance Review

The HHS Office of Inspector General says Mount Sinai Hospital in New York City was overpaid $41.9 million—an amount extrapolated from an overpayment of $1.37 million, according to a Medicare compliance review posted on May 3.

That's probably the largest finding in a Medicare compliance review. Medicare paid Mount Sinai, a 1,171-bed teaching hospital, about $842.4 million during the audit period, 2012 and 2013. After auditing a stratified random sample of 261 claims and concluding there were errors on 110 of them, OIG extrapolated from there. OIG asserts that Mount Sinai has to refund claims for six years, citing the look-back period under the Medicare 60-day overpayment return rule from the Affordable Care Act, which requires providers to report and return overpayments within 60 days of identifying them. The hospital has asserted, however, that claims more than 48 months old may not be reopened by Medicare and therefore are not overpayments under the 60-day rule.

Almost $42 million "is a really big number," says Minneapolis attorney David Glaser, with Fredrikson & Byron. "Audits can be significant, just like other government investigations and whistleblower cases." But it's not a done deal, he says. Because part

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MOON Explanation for Patients Is Easier Said Than Done; Checkboxes Seem Inevitable

As hospitals continue to train physicians on documenting the medical necessity of inpatient admissions in regulatory and audit-proof language, they also are refining their delivery of the Medicare Outpatient Observation Notice (MOON). Explaining to patients why they are outpatients receiving observation services, not inpatients, in specific clinical terms without lapsing into medical jargon or taking too much of a clinician's time is almost as daunting as documenting the expectation of a two-midnight stay, and hospitals face consequences for noncompliance in both areas, a compliance officer says.

"It's operationally a huge challenge to ask clinicians to clearly identify when a patient meets inpatient criteria," says Stephen Gillis, director of compliance coding, billing and audit at Partners HealthCare in Boston. "And if a patient needs to be in observation, we need to provide a level of detail that's understandable to patients."

All this is in service to complying with the MOON, which hospitals have been required to deliver to patients since March 8. The MOON informs them they are outpatients receiving observation services, not inpatients, and that it affects how much they will pay out of pocket for their hospital care (*RMC 12/12/16, p. 1*). Patients who receive 24 hours or more of observation must be informed they are not inpatients within 36 hours after physicians have written the observation order. The MOON tells patients that "You're a hospital outpatient receiving observation services. You are not an inpatient because:" followed by a blank space, where physicians or other hospital personnel will have to explain why. In instructions posted with the MOON, CMS said, "Fill in the specific reason the patient is in an outpatient, rather than an inpatient stay."

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In late February, CMS said hospitals have to put a specific clinical reason on the MOON for why patients are in observation instead of admitted as inpatients. CMS also said hospitals may use checkboxes on the form (*RMC 3/3/2017, p. 4*).

Although the MOON is a tall order—be specific, but make it understandable to patients—Partners HealthCare is trying to strike a balance between being meaningful and being vague.

The case managers at its seven hospitals put their heads together and developed nine possible statements for the specific clinical reasons for being placed in observation, and then winnowed them down to four plus "other" (with room for an explanation). "We are piloting the language to evaluate if it provides adequate information to our observation patients," Gillis says. Clinicians may check one or more of the options:

1. ____You do not meet clinical criteria for inpatient admission at this time.

2. ____You are in observation to help your doctor decide if you need to be admitted as an inpatient or discharged;

3. ____Your physician(s) has/have determined that your condition does not require an inpatient admission. However, your condition requires further workup before the physician can make a determination whether to discharge you or whether an inpatient admission is necessary.

4. ____You require hospital care for treatment of _____ (fill in chief complaint).

5. ____ Other

This still feels like a work in progress because the statements more or less say the same thing, Gillis says. The Medicare administrative contractor (MAC) for Massachusetts, NGSMedicare, said in a recent call on the MOON that the statements couldn't be generic, but it didn't shed any light on "specific clinical reason." The MAC also told hospitals not to use templates even though CMS said checkboxes are acceptable, he says. But what choice do hospitals have? It's hard to cherry pick clinical information and put it in plain English. Should the hospital say on the MOON that the patient's blood sugar levels are high, but not high enough for admission, or that the patient's heart rate is significantly higher than normal, so discharge will have to wait? Additional medical information is labor intensive and goes beyond the purpose of the MOON, Gillis says. "I am going to document more than I would for inpatient admission but dummy it down so patients understand it? The translation to justify why I am not admitting a patient is ridiculous. How much effort do you go into?" he says. Without checkboxes and some generalities, "every patient that goes into observation status for 24 hours would have to get a written piece of information that would require custom notes specific to those needs." Anyway, he says, "the biggest point is you are notifying the patient they are not inpatients, they are considered observation patients, especially when patients have or will be spending the night in a unit."

Gillis also is bothered by the leeway that Medicare gives hospitals with the timing of the MOON's delivery. "It would make the most sense to deliver the MOON to patients before they spend the night on a medical unit as an observation patient in order to prevent the patients from being confused about their status," he says. However, Medicare only stipulates that patients receive the MOON based on the amount of time they spend in observation. "Medicare requires you to administer the MOON to patients who spend more than 24 hours in observation but no later than 36 hours after observation started. Technically, you could provide the MOON just prior to discharging the patient from the hospital. You'd be compliant with Medicare regulations, but how did that help the patient understand and be better informed about the care they have already received?"

Consider Spot Audits of MOON

Assuming hospitals make peace with their MOON, the next challenge is ensuring there's a process for uploading the forms in the electronic medical records

Report on Medicare Compliance (ISSN: 1094-3307) is published 45 times a year by the Health Care Compliance Association, 6500 Barrie Road, Suite 250, Minneapolis, MN 55435. 888.580.8373, www.hcca-info.org.

(EMRs). Gillis advises auditing to check whether they reside somewhere separate in the EMR. "Make sure they're retrievable in case surveyors ask for them," he says. "That means creating a new naming convention for the MOON so there is a specific administrative document type on your EMR system."

Hospitals will be on the hook for proof of MOON compliance. As NGS told hospitals on the call, "failure to provide the MOON to applicable beneficiaries when required is considered a violation of the hospital's Medicare provider agreement and may result in termination of the hospital's Medicare provider agreement."

The audit may open your eyes to other areas in need of improvement. Gillis came across a small sample of patients who received both the MOON and the Important Message from Medicare (IM), which informs inpatients of their discharge appeal rights. For the most part, that's contradictory because the MOON informs patients they are outpatients and the IM is reserved for inpatients, but procedures may take on a life of their own. "Sometimes staff pulls together packets for patients with five different forms and you have patients sign them all at once. Some institutions have certain processes that have been in place for so long that they don't even realize they've added the MOON to some piles," he says. But it will drive patients crazy and make the MOON meaningless unless hospitals audit the process and ensure they don't ask patients to sign mutually exclusive forms.

The MOON was created in response to the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act of 2015. CMS revised the form, which was approved by OMB on Dec. 7, 2016.

Contact Gillis at sjgillis@partners.org.✧

Hospitals May Lose Appeals If They Don't Keep Patients Informed

Appeals of Medicare claim denials may be dismissed if hospitals don't keep patients in the loop, even though they rarely have money on the line.

Administrative law judges (ALJs) are starting to enforce the requirement that hospitals and other appellants notify all parties to an appeal, including patients, attorneys say. The crackdown is apparently one way to reduce the Medicare appeals backlog by delaying or throwing out the appeal, they say. Hospitals are given time to "cure" the defect before the appeal is terminated, but if they don't prove they sent the appeal to patients and other parties, their request for a hearing will be tossed, according to the January 2017 regulation from the Office of Medicare Hearings and Appeals (OMHA). The regulation also clarified the requirement and eased it a bit, although informing patients about appeals is still a challenge for hospitals, partly because patients often are baffled or alarmed by the notification letters, attorneys say.

"It's being enforced," says attorney Jessica Gustafson, with The Health Law Partners in Southfield, Mich. Some of the ALJs have picked up on the beneficiary notification requirement and are threatening to throw out appeals unless they have proof it has been satisfied, she says. An ALJ in the Miami regional office recently informed a hospital that its request for a hearing would be dismissed because the ALJ saw no evidence that the beneficiary received a copy of the materials. "We sent back evidence [to the ALJ] of a shipping receipt," Gustafson says. "That's how we established" that the patient was, in fact, informed of the appeal. But it was eye-opening that ALJs really are willing to dismiss cases unless there is paperwork showing that patients know about them.

"I don't see that it's fatal to the appeal," says Richelle Marting, an attorney with the Forbes Law Group in Overland Park, Kan. Hospitals must be given time to inform patients about the appeal. But Marting sees the writing on the wall; if hospitals don't include patients on appeal paperwork or quickly correct their mistake, ALJs may start dismissing their appeals. Their authority comes from the Medicare Claims Processing Manual (100-04). According to Chap. 29, Sec. 330.1.A: "To receive an ALJ hearing, a party to the QIC's [Qualified Independent Contractor's] reconsideration must file a written request for an ALJ hearing with the entity specified in the QIC's reconsideration. The appellant must also send a copy of the request for hearing to the other parties. Failure to do so will toll the ALJ's 90-day adjudication deadline until all parties to the QIC reconsideration receive notice of the requested ALJ hearing." CMS defines a "party" as a "person and/or entity normally understood to have standing to appeal an initial determination and/or a subsequent administrative appeal determination or decision." The beneficiary's status in an appeal is also set forth at 42 CFR 405.906. It states that beneficiaries who file claims for Medicare Part A and B payment or who have claims filed on their behalf are parties to initial determinations, redeterminations, reconsiderations, hearings and reviews, which are the five levels of Medicare appeals.

This requirement is less than popular with hospitals and attorneys. "At the end of the day, it causes more confusion," Gustafson says. "I don't see a lot of value in copying the patient, especially when they don't have liability on the claim. It just creates questions. Patients ask, 'Why are you telling me this?'" They may think it's a collection agency and call the hospital with questions, Marting notes. "Someone has to be trained on explaining what the letter means," she says.

Sometimes the requirement is virtually impossible to comply with, Marting says. When she appeals claim

denials for 350 patients at the same time on behalf of one hospital, informing them would be a logistical nightmare. For HIPAA compliance purposes, she would have to redact the information for 349 patients and repeat the process again and again. Tracking down the patients is also difficult. Some have moved to nursing homes and some have died, but the Medicare manual requires hospitals to send the appeals information to their executor. Because that would be too expensive for her clients, she hasn't done it for the *en masse* appeals. So far, no appeals have been dismissed because patients were not on the distribution list. But that may change.

New Rule Speaks to Notification Requirement

Not all patients are indifferent to appeals. "We hear from beneficiaries a lot," Gustafson says, even though they rarely have a financial stake. Denials for joint replacement seem to provoke some ire. Patients can become frustrated when they see a copy of the hospital's appeal based on a Medicare denial because they supposedly didn't exhaust more conservative treatments, such as physical therapy. Patients will call us and say, "I did. I tried this and that," Gustafson says. "If the beneficiary is engaged, we can get statements from them. Even if the information of conservative treatments didn't make it into the chart, we can supplement our appeals directly with this information from patients. Anecdotally, people appreciated that they went to the hospital and got better. They don't think there's any reason why the hospital shouldn't get paid."

A comprehensive Jan. 17 regulation from the Office of Medicare Hearings and Appeals (OMHA), which was intended to reduce the appeals backlog (*RMC 1/23/17, p. 1*), also clarified some of the beneficiary-notification requirements.

For one thing, the OMHA regulation says with respect to postpayment audits, hospitals and other appellants only have to send patients a copy of the request for an ALJ hearing if they received a copy of the QIC

CMS Transmittals and *Federal Register* Regulations

April 28 to May 4

Live links to the following documents are included on *RMC's* subscriber-only webpage at www.hcca-info.org. Please click on "CMS Transmittals and Regulations."

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-08, Medicare Program Integrity Manual

- Scribe Services Signature Requirements, Trans. 713 (May 5, 2017)

Pub. 100-04, Medicare Claims Processing Manual

- July Quarterly Update for 2017 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule, Trans. 3760 (April 28, 2017)
- Screening for Hepatitis B Virus (HBV) Infection, Trans. 3761 (April 28, 2017)
- Payment for Moderate Sedation Services Furnished with Colorectal Cancer Screening Tests, Trans. 3763 (April 28, 2017)
- New Physician Specialty Code for Advanced Heart Failure and Transplant Cardiology, Medical Toxicology, and Hematopoietic Cell Transplantation and Cellular Therapy, Trans. 3762 (April 28, 2017)
- Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System, Trans. 3764 (April 28, 2017)

Pub. 100-03, Medicare National Coverage Determinations

- Screening for Hepatitis B Virus (HBV) Infection, Trans. 195 (April 28, 2017)

Pub. 100-20, One-Time Notification

- Implementing the remittance advice messaging for the 20-hour weekly minimum for Partial Hospitalization Program services, Trans. 1833 (April 28, 2017)
- Update FISS Editing to Include the Admitting Diagnosis Code Field, Trans. 1832 (April 28, 2017)

Pub. 100-06, Medicare Financial Management Manual

- New Physician Specialty Code for Advanced Heart Failure and Transplant Cardiology, Medical Toxicology, and Hematopoietic Cell Transplantation and Cellular Therapy, Trans. 283 (April 28, 2017)

Federal Register

Proposed Regulations

- Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities: Revisions to Case-Mix Methodology, 82 Fed. Reg. 20980 (May 4, 2017)
- Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, Survey Team Composition, and Proposal To Correct the Performance Period for the NHSN HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for PY 2020, 82 Fed. Reg. 21014 (May 4, 2017)
- Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2018, 82 Fed. Reg. 20690 (May 3, 2017)
- Medicare Program; FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements, 82 Fed Reg. 20750 (May 3, 2017)
- Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices, 82 Fed. Reg. 19796 (April 28, 2017)

decision, Gustafson says. Because QICs are not obliged to send patients their decisions—whether it's win or lose for hospitals—some patients never get them, and that means "in that scenario, beneficiaries won't have to be copied," she says.

OMHA also clarified what materials are part of the request for an ALJ hearing and therefore must be sent to patients. According to the regulation, "if additional materials submitted with a request are necessary to provide the information required for a complete request in accordance with proposed § 405.1014(b), copies of the materials must be sent to the parties as well (subject to authorities that apply to disclosing the personal information of other parties). That includes medical records, although "if you're sending medical records to support medical necessity, it's not necessary to provide them to the patient," Gustafson says. As OMHA said in the regulation, medical records "could instead be summarized and provided to the other parties at their request."

However, if the request for a hearing includes a position paper, such as a legal brief, that explains why the hospital disagrees with the QIC's denial, it has to be sent to the patient, the regulation states. "That's kind of new," Gustafson says, and it's unfortunate.

How to Prove Patients Were Kept in the Loop

There are a number of ways that hospitals may prove they informed beneficiaries of the appeals mounted on their behalf, according to the regulation:

(1) "Certifications that a copy of the request for hearing or request for review of a QIC dismissal is being sent to the other parties on the standard form for requesting a hearing or review of a QIC dismissal;

(2) an indication, such as a copy or "cc" line on a request for hearing or review, that a copy of the request and any applicable attachments or enclosures are being sent to the other parties, including the name and address of the recipients;

(3) an affidavit or certificate of service that identifies the name and address of the recipient and what was sent to the recipient; or

(4) a mailing or shipping receipt that identifies the name and address of the recipient and what was sent to the recipient."

As enforcement of the requirement increases, Marting advises hospitals to study the Medicare manual and ensure they're sending a copy of the request for a hearing and relevant materials when there are single patients in the appeal. For appeals of numerous claims simultaneously, make sure you designate a person in the hospital who can answer questions when patients call. Explain that nothing is required of patients and that they don't owe money and their presence isn't required at the hearing. "When appealing larger audits, you have to balance the risks," Marting says. Appellants risk having an appeal dismissed if they don't copy in the patients, but they also risk breaches of protected health information if they send medical records to the wrong address, she notes.

Contact Marting at rmarting@forbeslawgroup.com and Gustafson at jgustafson@thehlp.com. View the OMHA regulation at http://tinyurl.com/k395jof.✧

CCO: Reports Build Trust With Board Members; Less Isn't Always More

When Compliance Officer Cindy Matson first reported to the board, she was sure that brevity was the right way to go. The details about the compliance program went into the written presentations, but she kept the oral part short and to the point.

She sees things differently now. "Assuming they wanted less rather than more in the presentation was not correct," said Matson, senior executive director of compliance at Sanford Health in Sioux Falls, S.D. Matson now gives board members a full summary of significant risks, major settlements and new laws and guidance. "You can't give them a book every time, but in quarterly or monthly meetings, you can go in depth on some things." Although it depends on the culture of your organization and your board, Matson found that certain developments, such as the Yates memo (*RMC 5/1/17, p. 1*) require more than a brief mention.

The quality of the compliance officer's annual or semi-annual reports to board members may have a big impact on their oversight of the compliance program and the support it receives.

"It's sometimes your big chance to build trust at the highest levels of your organization and to solidify compliance as a tool for success at your company," Matson said March 27 at the Health Care Compliance Association's Compliance Institute. Board reports also help ensure board members have the information they need to fulfill their oversight responsibilities, which have been described in a series of documents over the years. They include the HHS Office of Inspector General's "Practical Guidance for Health Care Governing Boards on Compliance Oversight" (*RMC 4/27/15, p. 1*).

When reporting to board members, Matson suggested compliance officers tell stories and use examples from the news. "Sometimes reporting is less analytical and more subjective," she said. Because some board members aren't in the health care business, "just showing numbers and boiling things down" to cold hard facts won't resonate with them. "Tell stories about other industries and other compliance efforts and why risks went unchecked," she said. For example, the Volkswagen

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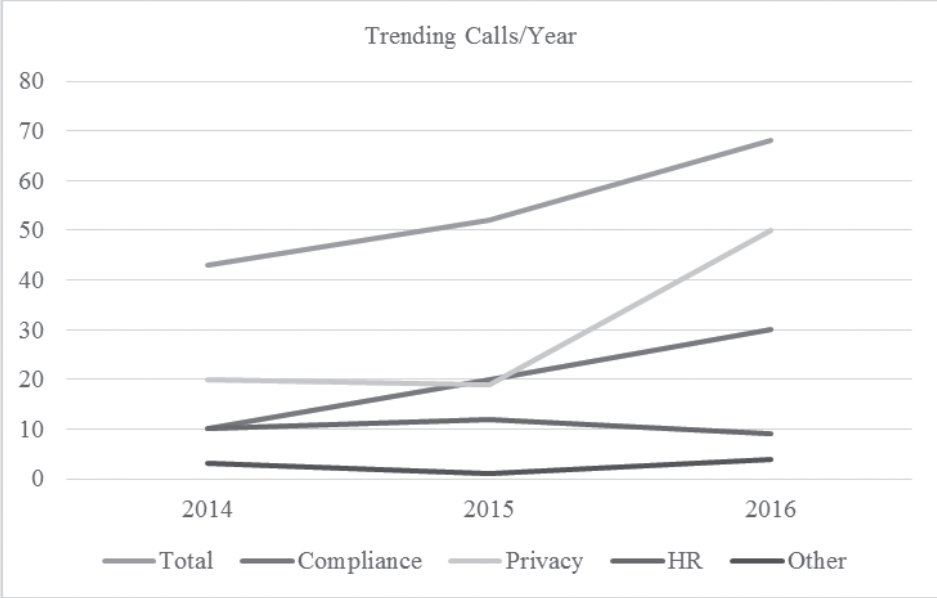
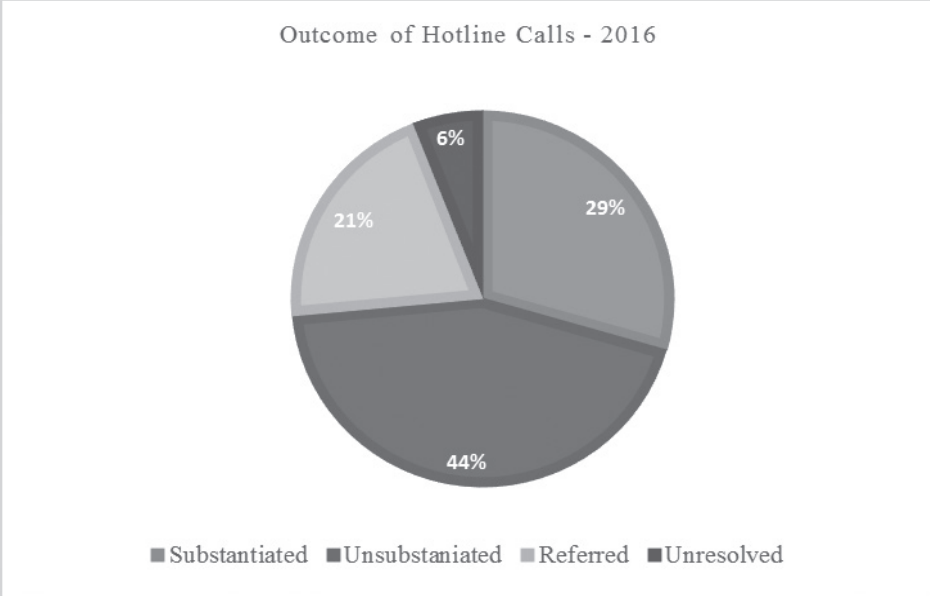
Examples of Compliance-Program Metrics for Board Updates

The dashboards below are designed to convey information succinctly to board members (although the data itself is fictional). The dashboards were developed by Sanford Health in Sioux Falls, S.D. Contact Cindy Matson, senior executive director of compliance, at cindy.matson@sanfordhealth.org.

Compliance Hotline Activity





continued on page 7

emissions debacle—the company pleaded guilty to three felonies and paid a $2.8 billion penalty—is a good example of the dangers of noncompliance. "Boards may not understand why something may go unchecked," she said. "You are giving an example and tying it to the hotline and the nonretaliation policy and training managers about how to deal with concerns when employees bring them. It gives them a chance to ask how we are preventing problems and ethical lapses."

Compliance officers should take their cue partly from the board. "You have to be open to what your board wants to hear about," she said. "They may be particularly concerned about certain parts of the operation based on the strategic plan." For example, Sanford plans to become more prominent in genetic testing and personalized care. "The compliance program has to make sure it has time to assess the risks around strategic initiatives at the right time instead of their being over in a silo," Matson said. Boards also may raise concerns—maybe they are very troubled by ransomware—and they have their own networks that feed them information. If you're not well-versed in a subject, get back to them.

Sanford Health's board reports always include metrics (see box, p. 6). "If you can't measure, you can't improve," Ruth Krueger, compliance program administrator, said at the Compliance Institute. Compliance reports include trends in the seven elements of the compliance program and data on the biggest risk areas and open investigations. The board is informed about challenges and successes. "Live up your successes," she said. "If all you ever share are your gaps, they will wonder how effective you are."

Contact Matson at cindy.matson@sanfordhealth.org and ruth.krueger@sanfordhealth.org.✧

OIG: Hospital Was Overpaid $41.9M

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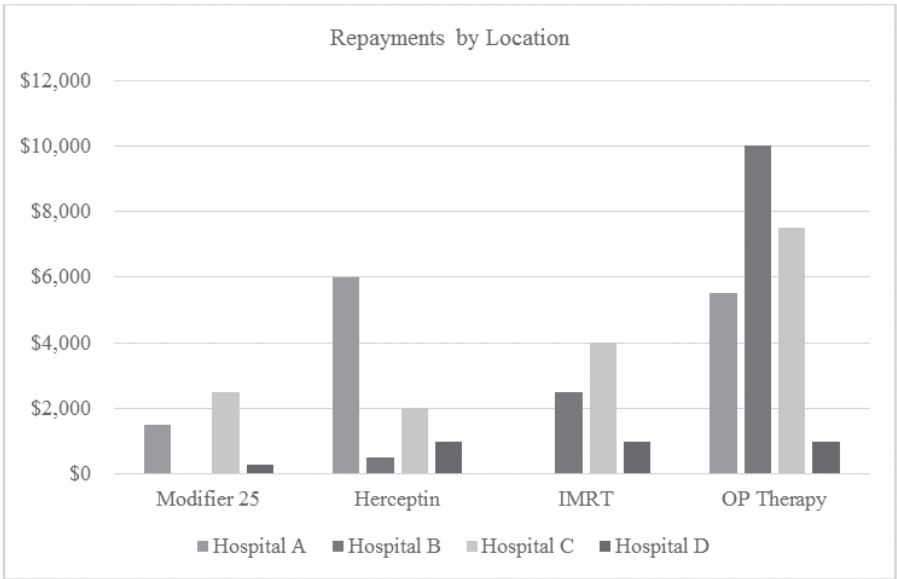
of the overpayment is based on the six-year look-back period, Mount Sinai has a good case on appeal that OIG can't reopen claims outside the four-year reopening period absent fraud or similar fault, he says. "The 60-day rule requires refund of an overpayment, defined as money to which the provider isn't entitled. If the government can't reopen a claim, the provider is entitled to the money and there is no overpayment. Section 1870 of the Social Security Act creates a presumption that the government cannot recover an overpayment five years after the year in which payment was made. When CMS issued the 60-day rule, it ignored Section 1870." He noted the Medicare compliance review "is a recommendation. There's no guarantee that amount of money will ever change hands."

Examples of Compliance-Program Metrics for Board Updates (continued)

Compliance Program Repayments



Mount Sinai told OIG it flat-out refuses to return money outside the four-year reopening period.

The errors identified by OIG are familiar, including inpatient admissions that should have been billed as outpatient or observation (mostly before the two-midnight rule took effect); manufacturer credits for replaced devices that were not passed to Medicare; DRG coding errors; and a case mix group (CMG) error at an inpatient rehab facility. The hospital disagreed with many of the findings. The net overpayment was $1,374,339, OIG contends, and "on the basis of our sample results, we estimated that the Hospital received overpayments totaling at least $41,869,783 for the audit period."

In Mount Sinai's written response, Frank Cino, senior vice president and chief risk officer, contested many of the overpayment findings as well as the extrapolation. On inpatient admissions and IRF services, for example, he said "a Mount Sinai physician appropriately determined and documented that the patient had medical conditions, symptoms, comorbidities and deficits that required the level of intensive treatment, rehabilitation and assessment that was only available on an inpatient basis," and they were compliant with Medicare rules. The hospital didn't have a single denial in its recent short-stay review by the quality improvement organization, Cino said.

OIG should limit its overpayment finding to four years in light of longstanding policies and practices on reopenings and appeals, Cino wrote. The hospital disputes the idea that claims outside the reopening and recovery period are overpayments. "Federal law imposes a specific statute of limitations on the reopening and recovery of alleged overpayments. Under these provisions, the Medicare contractor's initial claim determination is binding on all parties, unless the claim is properly reopened and adjusted within the prescribed timeframes. Once these timeframes have passed, the determination of payment becomes final and the Hospital is 'entitled' to the payment," he wrote. And the extrapolation was based "on a deeply flawed statistical methodology" and "drastically overstates Mount Sinai's potential repayment obligations to CMS," he said. It's also "premature" to extrapolate because Mount Sinai plans to appeal the claim denials.

Statistician: Extrapolation Seems OK

But statistician Bruce Truitt, faculty member of the Medicaid Integrity Institute and Government Audit Training Institute in Washington, D.C., said extrapolating from $1,374,339 to $41,869,783 isn't "unreasonable," assuming that random sampling and testing were properly carried out.

"Simply dividing the dollars paid in error ($1,374,339) by the dollars sampled ($4,375,619)—31.49%—and then multiplying by the total paid amount ($74,679,543) equals $23,456,112," he says. "True, this is not the $42 million asserted here, and likely uses a different method than OIG's. We would need the actual data and per-stratum overpayments, standard deviations, weights, etc., to recreate OIG's number. But this admittedly simple calculation shows that you can get from a small number to a pretty big one in a logical and appropriate way."

As for the question of whether extrapolation is premature, Truitt says it's not true. The Medicare compliance review was conducted according to the Generally Accepted Government Auditing Standards, which require auditors to report the results of their testing, he says. "When combined with the requirement to 'project the error results,' OIG must extrapolate and report those results now. Besides, it is not possible to consider future adjudications when reporting in the present tense. True, the extrapolation might change later, but this fact does not eliminate the requirement to report now."

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NEWS BRIEFS

◆ **The Alaska Medicaid Fraud Control Unit has charged a dentist, Seth Lookhart, and his office manager, Shauna Cranford, with felonies in connection with an alleged Medicaid fraud scheme involving IV sedation,** according to the Alaska Department of Law. A video showing Lookhart extracting a tooth from a sedated patient's mouth while riding a hoverboard was found on the dentist's phone by investigators, according to ABC News and other news reports. Visit http://tinyurl.com/kgv9jez.

◆ **A federal jury has convicted Florida ophthalmologist Salomon Melgen of 67 counts of health care fraud,** the U.S Attorney's Office for the Southern District of Florida said April 28. Melgen, who practiced with "Vitreo Retinal Consultants" and "The Melgen Retina Eye Center," falsely diagnosed Medicare patients with macular degeneration, and then performed medically unnecessary tests and procedures and billed for them, the U.S. attorney's office said. As a result, he collected more than $90 million from Medicare between January 2008 and December 2013. He was arrested in April 2015 and his practice closed. Melgen faces as much as 10 years in prison for each of 37 counts of health fraud and five years for each of 30 counts of false claims and false entry counts. Visit http://tinyurl.com/mjwr9d5.