

# MEDICARE COMPLIANCE

Weekly News and Analysis on New Enforcement Initiatives and Billing/Documentation Strategies

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## Health Systems Strive to Identify, Eliminate Compliance Gaps at Joint Ventures

As hospitals extend their compliance oversight to joint ventures, they may find one hand tied behind their backs. As part owners, hospitals don't necessarily have the power to ensure that joint ventures embrace compliance policies and procedures to reduce the risk of overpayment returns or fraud settlements. But that ownership interest — no matter how small — may confer a portion of the liability. Caught between their risks and their limitations, some hospitals and health systems are brainstorming ways to implement, strengthen and oversee compliance programs in joint ventures. The timing is good, considering the slew of Medicare audits and investigations, the health reform law's compliance program mandate, and the proliferation of joint ventures that could occur soon with accountable care organizations.

"If we have a joint venture with a compliance issue, who will they turn to? If the government wants to see the compliance program, what will they show them? Will they show them our compliance program or their own?" asks Michael Holper, senior vice president of organizational integrity for Michigan-based Trinity Health, which has 46 hospitals, 379 outpatient centers and 1,400 employed physicians. "I don't want to be in the position where the joint venture says they are part of the Trinity compliance program when the joint venture is not actively in our compliance program."

*continued on p. 5*

## CMS Nearly Doubles Investment in RACs, Has Method to Win More Provider Appeals

CMS funding for recovery audit contractors (RACs) will almost double in fiscal year 2012, which starts Oct. 1. The investment in RACs will rise from \$259 million in 2011 to \$500 million, a sign they will recoup more of the green stuff from providers because RACs are paid only when they identify Medicare errors that survive provider appeals, according to former RAC executive Vickie Axsom-Brown.

And RACs — which CMS now calls "recovery auditors" — are not the only Medicare auditors armed with generous budgets and new overpayment-recovery strategies.

"Each year the amount spent on recovery audit activities is going to increase because they will find more improper payments and as improper payments go up, the value of the findings will go up," Axsom-Brown said at a Sept. 8 webinar sponsored by RACMonitor.com. Also on CMS's 2012 agenda: better success fending off provider appeals of RAC claims denials. One of the agency's "performance targets" for 2011-2012 is a reduction of RAC overpayment determinations thrown out on appeal, said Axsom-Brown, former regional vice president of HealthDataInsights, the RAC for Region D. As of March 9, 2010, providers won 64.4% of the appeals they filed — although they only challenged 76,073 of the RACs' 598,238 overpayment determinations. Now RACs may get a boost in fending off provider appeals from the validation contractor, which CMS

hired as a check and balance when the national RAC program got underway. Every month, the validation contractor reviews 100 RAC claims denials (per recovery auditor) for accuracy and outcomes. Results from the validation contractor can be used to support RAC defenses when providers appeal overpayment determinations, she noted. But the overriding goal is to improve RAC performance over time, which is in everyone's best interest, said Axsom-Brown, who is now president of Audits & Recovery Solutions in Henderson, Nev.

Connie Leonard, director of the CMS Division of Recovery Audit Operations, tells *RMC* that CMS is pleased with the results of the validation contractor's findings. The accuracy rates are high, she says, although she couldn't be more specific. Results will be released soon in a report to Congress.

Recovery auditors also may pile on audit targets faster than ever. CMS is required to approve "issues" (e.g., DRG validations, short stays) before RACs can audit providers in these areas, and they must persuade CMS with preliminary reviews that the audits won't be a waste of hospital resources. But because the process can be slow, in June "CMS asked the four RACs to collaborate on com-

mon issues so approval could be expedited," according to Axsom-Brown. That went well, she said, and as a result "CMS will ask them to collaborate on more issues."

RACs are far from the only type of auditor intensifying scrutiny of hospitals and other providers. Axsom-Brown listed six others: the medical review units at Medicare administrative contractors (MACs); zone program integrity contractors, known as ZPICs (*RMC* 8/22/11, p. 1); Medicaid RACs; Medicaid integrity contractors (MICs); quality improvement organizations (QIOs); and the HHS Office of Inspector General.

### Review Materials Posted by RACs

It is important to keep an eye on the material posted by MACs, because they are major program-integrity players and they produce reports for CMS that are good sources of compliance monitoring, she says.

For example, Noridian Administrative Services, the MAC for six states on the West Coast, on Sept. 1 started a review of surgical claims for percutaneous vertebroplasty and percutaneous vertebral augmentation (kyphoplasty) involving CPT codes 22520 to 22525. "They are receiving claims that lack documentation to support the necessity and appropriateness of surgery. These claims will now be stopped and audited," Axsom-Brown said.

There's no secrecy about these kinds of medical reviews, which are based on data from OIG, RACs and the Comprehensive Error Rate Testing (CERT) contractor, she said. They are announced on MAC websites.

Also, two quarterly reports that MACs submit to CMS may be useful tools for compliance monitoring. One type of report addresses overpayments and how they were discovered. Every quarter, MACs have to trot out the number of claims attributed to overpayments according to their cause and break it down by dollar amount and means of discovery. The overpayment causes are:

- ◆ Beneficiary not entitled.
  - ◆ Services not covered.
  - ◆ Charge exceeded reasonable charge.
  - ◆ Payment made to wrong payee.
  - ◆ Duplicate payment.
  - ◆ Medically unnecessary services.
  - ◆ Services not rendered.
  - ◆ Medicare secondary payer.
  - ◆ Documentation/coding/data entry.
  - ◆ Other.
- MACs also report how overpayments were discovered:
- ◆ Reported by beneficiary or supplier.

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- ◆ CMS's carrier quality control program.
- ◆ Carrier internal audit or review.
- ◆ Government agency.
- ◆ Other methods of discovery.

Another MAC report concerns beneficiary overpayments. Axsom-Brown said MACs are required to report details of beneficiary overpayments. If providers are overpaid, then beneficiaries are paid more than their fair share (e.g., a 20% copay of a \$1,000 claim is obviously more than 20% of a \$500 claim).

"CMS is collecting all this data and using it to give feedback on where improper payments are coming from and how they can be stopped," Axsom-Brown said. "Hospitals need to look at these sites to figure out what is in the pipeline and what is being executed now. This is proactive," and it's much more effective to audit for overpayment risks early than to wait for OIG auditors or ZPIC investigators to appear at your door.

### QIOs Are a Major Force

QIOs are also a force to be reckoned with. Their latest CMS contract with QIOs — April's statement of work — includes more improper payment activities. In addition to quality reviews, QIOs review potential EMTALA violations, adverse events, DRG upcoding, higher-weighted DRGs, short stays and readmissions, among other things, she said.

Because the odds are high that some of your claims will be targeted by these auditors at one time or another, preparing for claims-denial disputes is essential, Axsom-Brown said.

She provided guidelines to help providers develop their own checklist for complex audits for "any kind of audit you might get" (e.g., RAC, MAC). Hospitals should tailor their checklists to the topic. If it's a short-stay audit, for example, look at how OIG and other Medicare agencies approach short stays. And checklists should be developed keeping in mind the people in your organization who will actually carry out the audit, she said.

Here are key audit steps:

(1) *Nail down the purpose of the audit* based on the external auditor's medical record requests.

(2) *Gather information on the audit topic.* Check websites — including those for CMS, the RACs, OIG, the CERT and specialty associations — for updates on the target.

(3) *Document information about the audit topic.* Use the information gathered as a foundation for your internal medical-record review, but make sure it's sourced so the veracity can be evaluated. Look for common factors in the information.

(4) *Pull requested medical records* and start an internal audit.

(5) *Contact industry peers and evaluate their experience* with the audit topic (e.g., audit preparations, results and resources).

(6) *Use the information to audit requested medical records and identify any problems.* "Managed care/billing teams should review both billing and medical record documentation for completeness, accuracy, medical-necessity support, documentation/billing errors (dates of services, place of service, providers), data matching and quality of care indicators," Axsom-Brown said. Incorporate items from MAC medical-review checklists.

(7) *Identify issues.* Figure out whether there's a problem. Will claims be denied? If so, how many? Will they be full or partial denials? Have you opened a can of worms with the internal audit, and found far more serious problems? If you were unable to locate complete medical records during the internal audit, attach a letter with other supporting documentation that shows medical necessity and appropriateness of the health care delivery when the medical records are submitted to the external auditor, she said.

(8) *Review medical-record submissions.* "Make sure all relevant documentation is included with the medical records" when they are submitted to the external auditor," she says. Double check this by having a colleague review the document production and ask questions about it. Axsom-Brown advises knowing the status of every medical record requested "so you know the likelihood of denials," and the resulting cost of repayment, especially if the external auditor extrapolates the error rate based on a smaller sample. "That report is used to keep [your] manager and my board of directors apprised of the repercussions of the audit activity," she said.

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## Feds Say Billing Company Used Formula to Inflate Level of Services

A California-based medical billing company has agreed to pay \$4.6 million to settle allegations that it caused the submission of false claims to Medicare and Louisiana's Medicaid program, the Department of Justice (DOJ) said Sept. 1. The feds say the company used a billing formula that pushed claims for evaluation and management (E/M) services to a higher level, an allegation that has surfaced in other cases, an industry expert tells RMC.

Janzen, Johnston & Rockwell Emergency Medicine Management Services Inc. (JJ&R) of El Segundo, Calif., provides billing services for physicians and hospitals. The feds allege that the firm inflated claims it prepared

on behalf of emergency department physicians in Louisiana and California between 2000 and 2007. A coding formula that JJ&R used allegedly generated claims for a higher level of evaluation and management (E/M) service than physicians had actually provided. The feds also allege that JJ&R added charges to the E/M claim for other minor services (e.g., pulse oximetry) that were provided by nursing staff or other physicians.

The allegations should ring bells with compliance officers and attorneys. There were many settlements in the mid- and late-1990s that stemmed from similar allegations, says Ed Gaines, chief compliance officer at Medical Management Professionals, Inc. in Greensboro, N.C. "In one case, there was a software tool where the coder would enter the chief complaint and diagnosis and it would tell you what the visit level was. So that's a common thread in these cases." The use of a coding formula, guide or other methodology can cause coders to default or choose a higher level of service when in doubt, explains Gaines, who was not involved in the JJ&R case.

A billing company that uses a formula or other tool as an aid in coding is a red flag for providers, says Gaines. "If you have some methodology that takes cases of judgment — and E/M coding is a good bit of judgment — and you steer the decision making a particular way based on some criteria, one of the lessons you have to seriously consider is whether or not that tool...is correct or is leading to an unintended consequence."

Gaines uses the example of a man who presents at the emergency department complaining of belly pain.

The difference between a Level Three and Level Four E/M service is going to depend on various factors, such as urgency of presentation. If the man simply says "my belly hurts," that may be less urgent than if he comes in describing sharp pains in a specific area. "That's the kind of concept it's difficult to arrange a formula for," Gaines says. Coders and physicians seem to want a tool to make it easier: Belly pain + Demerol = [code]. "If you code them all to Level Four, are you willing to say that 100 out of 100 were an urgent presentation just because they got some pain meds?"

The government further alleges that JJ&R did not comply with Medicare rules on the submission of separate Part B claims for teaching physicians during the same time period. "While these coding practices had a relatively small impact on the reimbursement of any particular claim, over time they generated significant overpayments from Medicare and Medicaid," DOJ says in a Sept. 1 statement.

Gaines says this allegation also has a history with similar settlements dating back to the 1990s for problems involving compliance with the Physicians at Teaching Hospitals (PATH) program. Medicare pays teaching hospitals for training residents, and their supervising (teaching) physicians can bill Medicare separately for services performed by residents only if they are physically present when residents perform the services. "This has been one place that has been clear for decades — what the teaching physician must do to document" services, he says. "OIG has been clear that PATH has been

### *New Rankings in PEPPER Are Due Out in November*

Compliance monitoring at short-term acute care hospitals will get a boost from a new report coming out in November from the PEPPER people. On one sheet of paper, the "National High Outlier Ranking Report" ranks the nation's 3,500 short-term acute care hospitals by the total number of high outliers in 29 risk areas for the previous 12 quarters. It's being produced by TMF Health Quality Institute, which generates the Program for Evaluating Payment Errors Electronic Report (PEPPER) for CMS. The free report will show every hospital how it stacks up compared with every other hospital in the country in the same 29 admission-necessity and coding risk areas reported in the quarterly PEPPERS (*RMC 5/9/11, p. 5*), says Kim Hrehor, project director for TMF Health Quality Institute.

PEPPERS flag when a hospital is at or above the 80th percentile in any risk area, which means it sub-

mits a higher percentage of claims for that target than 80% or more of the hospitals in the Medicare administrative contractor/fiscal intermediary (MAC/FI) jurisdiction. PEPPERS also alert hospitals when their percent of claims for a coding-related risk area is lower than all but 20% of the hospitals in the MAC/FI jurisdiction, which could mean underbilling. Condensing the data onto one page allows hospitals to identify consistent outliers in particular risk areas, Hrehor says. "This report is our attempt to boil it down," she says. "How many times were you a high outlier as compared to all hospitals in the nation for all these target areas for 12 quarters, and how does your total number of high outliers compare to that of all other hospitals in the nation?"

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a major priority. It kind of fell off the radar after OIG did its PATH audits...but we continue to see settlements in some form."

There's a lesson in that, Gaines warns. "What's old is new. Just when we thought PATH was long gone, we have another settlement. And this is in the ED context where a lot of residents are used," he points out.

Former JJ&R employee Le Jeanne Harris filed the lawsuit that led to the feds' investigation. As a whistleblower, she will receive \$774,450 from the settlement.

A JJ&R representative could not be reached for comment.

Contact Gaines at [egaines@cbizmmp.com](mailto:egaines@cbizmmp.com). ✧

## Reform Law Creates New Incentives, Protections for Whistleblowers

Whistleblowers were already driving the bulk of health-related False Claims Act lawsuits when they got another boost from the health reform law. Some of the changes are well-known, such as the new opportunities for whistleblowers when providers don't return overpayments 60 days after identifying them. Others may be less obvious, such as the "Elder Justice Act," which requires reports of possible crimes affecting long-term care facility residents.

"The environment is increasingly accepting of whistleblower claims," says New York City attorney Allen Roberts, with Epstein Becker & Green.

The reform law made it easier to file a false-claims case. It's clearer now that a case isn't DOA if whistleblowers aren't the original source of information about overpayments, says Washington, D.C., attorney George Breen, also with Epstein, Becker & Green.

Specifically, the reform law amends False Claims Act language that bars courts from hearing whistleblower cases based on publicly disclosed allegations or transactions. Congress added the words "unless opposed by the Government, if substantially the same allegations were publicly disclosed," which means that unless the Department of Justice stands in the way, whistleblowers can proceed even if their allegations have been made public.

However, the U.S. Supreme Court has partly closed this door. Its decision in the May 2011 Schindler Elevator case "limits opportunities for whistleblowers who seek to trade on" publicly available reports, such as those obtained through a Freedom of Information Act request (*RMC 5/23/11, p. 5*), Roberts says.

Another way the reform law has altered the whistleblower climate is through an amendment to the Fair Labor Standards Act, says Jeffrey Landes, also with Epstein Becker & Green. The amendment gives employees

the right — and protection when he or she exercises it — to challenge the action of employers relating to the implementation of the reform law in certain areas (e.g., mandated employer coverage and receipt of premium-tax credits).

The reform law also protects employees who are about to provide information to the government in these areas, Landes says. Fired employees could challenge the termination on grounds that it occurred because they were about to provide information, and the definition in the reform law is so broad that the protection also could apply to any other employer conduct that could be construed as retaliation.

There also are other provisions in the reform law designed to encourage reporting related to whistleblowers. Landes points to the law's Elder Justice Act, which imposes an obligation to report "reasonable suspicion" (which is not defined) of a crime affecting recipients of care at a long-term care facility, and which bars retaliation against reporters. In addition to nursing homes, the covered institutions might include hospices and assisted-living facilities that receive at least \$10,000 annually in federal funds under the reform law.

It takes broad compliance policies to limit the risks that health care organizations face under the strengthened whistleblower-related provisions. "The biggest challenge is to recognize you have this array of laws enhancing and protecting whistleblowers," so policies geared to just one of the laws aren't likely to be effective, Roberts says.

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## Joint Ventures = Compliance Risks

*continued from p. 1*

Hospitals and health systems enter into joint ventures of all sorts, typically with physicians, for ambulatory surgery centers, imaging centers, clinics and other services. Hospitals may be majority or minority owners. Either way, joint ventures fall outside the main operations of a hospital or health system, and that leaves hospitals trying to find the best way to handle compliance programs and problems, Holper says.

"One of the struggles that hospitals and health systems have in general with joint ventures is, there are two parties at play and getting them integrated into a structured compliance program is a mindset change and a culture change," says Cheryl Rice, vice president and chief

corporate responsibility officer at Catholic Health Partners, an Ohio-based nonprofit system with 31 hospitals.

Solving this problem isn't necessarily a matter of extending your hospital compliance program to the joint venture. If the hospital is not a majority owner, the joint venture's board of directors may resist compliance-program overtures. Even if the board is receptive or the hospital is a majority owner, it's possible the hospital's compliance officer is too overwhelmed to take on compliance oversight of joint ventures scattered around a large geographic area.

Or sometimes it's not feasible for every joint venture to have a dedicated compliance officer, and even if it is, in some regions the pool of compliance talent is shallow, Rice says.

### Minority Owners Have Little Clout

"If you are a minority holder, you have little say. You may have a member on a joint-venture board or board committee and that is the only representation you have," Rice says. "If you are a majority owner, you really have to work on these joint ventures to integrate them into your compliance program. Joint ventures can be more challenging to bring into compliance than other institutional providers, such as home health or hospice, because they involve multiple parties who have interests both legally and operationally."

Integrating joint ventures into your compliance program is complicated by three factors, Rice says: (1) the overall process of joint-venture development is primarily focused on the upfront legal arrangement itself and making sure it fits within the Stark self-referral rules, with less emphasis on how it will function after the arrangement takes effect; (2) joint ventures are typically sought in service lines not furnished by the hospital, so staff may not be savvy about compliance issues germane to the joint venture; and (3) operational and legal staffers drafting the joint-venture arrangement may not communicate with compliance during the development process in order to identify compliance risks, Rice says. As a result, there may be compliant, legal arrangements on paper but not compliant operations. And that spells trouble for hospitals because "you are now legally associated with them," Rice says.

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Ideally, compliance programs will be addressed at the time the joint ventures are established, Holper says. "We have come a long way," he says. "We are making sure that it's discussed up front as part of joint-venture negotiations." For example, Trinity pushes for right-to-audit clauses. Without these clauses, the hospital might get pushback from joint-venture partners when the hospital wants to perform an audit.

Recently, Trinity encountered a compliance issue with one of its joint ventures that caused it to question the joint venture's compliance program. Holper wanted to know who the joint venture considered its compliance officer because he was concerned about the joint venture claiming the hospital's as its own. "The hospital compliance officer was not walking the halls of the [joint venture entity]," Holper says, and "the joint-venture folks probably didn't even know who the compliance officer of the hospital was." That prompted Holper to take the bull by the horns, and he is developing tools to help Trinity hospitals address joint-venture compliance programs and promote monitoring of joint-venture activities.

"There probably is not one set of hard and fast rules," he says. The Trinity compliance office will put together some resources so hospitals in the system can meet with their joint ventures and determine how to customize the Trinity code of conduct to reflect their needs. "This is all new," Holper says.

### Two Different Scenarios Are Described

Rice has seen joint ventures play out in two ways:

(1) Hospitals reach out to partner with established experts in the field to meet a community need, and compliance is integrated from the beginning; or

(2) Physicians jump the hospital ship and set up competing businesses, realize they have to comply with Medicare conditions of participation quality, safety and reporting standards, "which are getting more strict as the government weeds out fraud and abuse," and recognize they can't make a profit and be compliant on their own. The physicians ask the hospital to buy into them, but they lack a true commitment to compliance, she says.

"Doing upfront diligence of your partners is crucial before entering joint ventures," Rice says. Ask upfront whether they have a compliance officer and what they do if they identify problems, and be wary when you are met with silence. "If you enter joint ventures and then find out they are a mess and you are the majority owner, you bear all the risk."

Rice thinks it usually makes more sense for the joint venture's compliance program to be integrated into the hospital or health system's compliance program. "Most problems are interconnected," she says. Patients are moved, for example, from the hospital to the joint-

venture ASC or to be referred for imaging at the imaging joint venture or receive cancer treatment at the oncology joint venture.

The same way hospitals don't have separate compliance officers for post-acute care or the skilled nursing facility wing, it probably doesn't make sense to have

separate compliance officers for the joint venture, she says. But it will depend on the level of integration, and the compliance officer may have to learn an entirely new set of regulations.

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## NEWS BRIEFS

◆ **The University of Texas Southwestern Health Systems (UTSW) has agreed to pay \$1.4 million to resolve allegations that one of its teaching hospitals upcoded claims for teaching physician-related services**, the feds say in a Sept. 1 statement. Teaching physicians can submit Medicare and Medicaid claims for resident supervision if the teaching physician is present for critical portions of the service. UTSW allegedly submitted improper claims because its teaching physicians' supervision of the residents was inadequate during key portions of surgeries performed at Parkland Health and Hospital System, according to the U.S. Attorney's Office for the Northern District of Texas. The feds say UTSW improperly submitted claims with the GC modifier even though there sometimes was no documentation by the physicians that they were present for critical portions of the surgery. The settlement stems from a whistleblower suit filed in 2007 by Larry Gentilello, M.D., who was chair of the burns, trauma and critical care unit at UTSW Medical Center at Dallas. UTSW says in a statement it "vigorously denies any lapse in the supervision of physicians-in-training, inappropriate billing, wrongdoing or liability." Visit [www.justice.gov/usao/txn](http://www.justice.gov/usao/txn).

◆ **A health system's proposal to provide consultations with stroke neurologists to community hospitals through telemedicine could violate the anti-kickback statute, but OIG will not impose sanctions**, it says in Advisory Opinion 11-12. Hospitals often transfer potential stroke patients to facilities that have comprehensive stroke centers, but since time is of the essence, treatment may be more effective if patients stay at the emergency department. Many stroke centers make stroke neurologists available to other facilities, but the consultations usually take place over the phone, which limits the quality of the information exchanged. The requestor of the advisory opinion is a "nationally-ranked neuroscience care" provider and wants to offer the following items specific to neuro emergencies: telemedicine technology; clinical consultations; acceptance of transfers; and clinical protocols, training, and medical education.

OIG says the arrangement is at low risk of improper payments for referrals for several reasons, including the fact that the community hospitals would not be required to refer patients to the requestor as a condition of participation. Also, the proposal is unlikely to result in increased costs to the government because few of the consultations would be billable to Medicare. Read the opinion at <http://oig.hhs.gov/fraud/docs/advisoryopinions/2011/AdvOpn11-12.pdf>.

◆ **Certain MS-DRGs have been added to the post-acute care transfer (PACT) rule under the 2012 inpatient prospective payment, while others have been dropped**, CMS says in a recent *MLN Matters* article. The PACT rule pays per diem instead of MS-DRG payments when certain patients are discharged to home health, skilled nursing, rehab or psychiatric care (*RMC 8/8/11, p. 1*). CMS has dropped MS-DRG 228 (other cardiothoracic procedures with MCC), MS-DRG 229 (other cardiothoracic procedures with CC); and MS-DRG 230 (other cardiothoracic procedures without CC/MCC). Read MM7508 at [www.cms.gov/MLN MattersArticles/downloads/MM7508.pdf](http://www.cms.gov/MLN MattersArticles/downloads/MM7508.pdf).

◆ **The government has amended a complaint against a home health agency (HHA) to add allegations that the provider bribed physicians to refer patients**, the United States Attorney for the Eastern District of Kentucky said Sept. 6. The feds intervened in a whistleblower lawsuit against Nurses' Registry and Home Health Corp. in July (*RMC 8/1/11, p. 8*). Two former employees of the Nurses' Registry alleged that the HHA submitted false Medicare claims for services that were medically unnecessary by exaggerating the medical conditions and needs of patients so it could obtain higher reimbursements. In their amended complaint, the feds add that the company and its owners offered cash and goodies (e.g., tickets to concerts and college basketball games) to induce physicians and their staff members to refer patients to the HHA. The feds allege that these gifts amount to illegal remuneration under the anti-kickback statute, so any claims submitted as a result of the physicians' referrals vio-

## NEWS BRIEFS

late the False Claims Act. Nurses' Registry says in a statement that it "flatly denies" the allegations. The company adds that, at the time the conduct is alleged to have occurred, it was operating under a corporate integrity agreement and was filing annual reports on its business activities, so its billing practices were being monitored by the government. Visit [www.justice.gov/usao/kye](http://www.justice.gov/usao/kye).

◆ **A Miami-area registered nurse pleaded guilty on Aug. 31 for her part in a scheme to defraud Medicare of nearly \$25 million**, according to the Department of Justice. Farah Maria Perez pleaded guilty to one count of conspiracy to commit health care fraud. She was indicted in February 2011 along with co-defendants who operated Florida Home Health Care Providers Inc., a home health agency. The feds say the defendants allegedly billed for physical therapy and home health services that were medically unnecessary or were never provided. Four other defendants in the case have pleaded guilty. Perez faces 10 years in prison, plus fines, when she is sentenced on Nov. 14.

◆ **TrailBlazer Health Enterprises, LLC should recover \$81,971 from providers that billed for procedures involving the insertion of multiple units of the same type of medical device**, OIG said in audit report (A-01-10-00515) released Aug. 19. OIG reviewed \$551,979 in outlier payments to facilities on 101 claims showing insertion of more than one type of the same medical device during 2008 and 2009. Seventy-three of the audited claims were paid correctly, but the other 28 were paid incorrectly because hospitals overstated the number of units and related charges (25 claims) or hospitals understated the units and charges (three claims). The hospitals had inadequate controls to ensure that billings were accurate, according to the report. OIG says TrailBlazer should recover the overpayments and educate hospitals on the importance of coding claims with the correct number of units. OIG also says the company should work with CMS to strengthen prepayment edits by reviewing the unit amount thresholds for certain devices. TrailBlazer concurred. Read the report at <http://go.usa.gov/kDu>.

◆ **Judith Negron, the co-owner of a Miami-area mental health care company, was found guilty on Aug. 23 of 24 counts, including health care fraud and conspiracy to pay and receive kickbacks**, according to the Department of Justice. Negron's company, American Therapeutic Corp. (ATC), submitted

more than \$205 million in fraudulent claims to Medicare between 2002 and October 2010. The indictment against her was unsealed Feb. 15, 2011. The two other owners of the company pleaded guilty to all the charges against them in April 2011. The feds say ATC purported to operate partial hospitalization programs in seven locations, but that the owners paid bribes and kickbacks to assisted living facilities and halfway houses to deliver ineligible patients to them. A sentencing date for Negron has not yet been scheduled. An attorney representing her declines to comment. Visit [www.justice.gov](http://www.justice.gov) and click on "News."

◆ **The Medicare Learning Network's (MLN) "Medicare Enrollment Guidelines for Ordering/Referring Providers" has been revised and reissued to delete chiropractors from the list of eligible providers**. CMS erroneously included chiropractors on the list in recent announcements and materials but began correcting the errors in an Aug. 12 technical direction. Read the updated MLN fact sheet at [www.CMS.gov/MLNProducts/downloads/MedEnroll\\_OrderReferProv\\_FactSheet\\_ICN906223.pdf](http://www.CMS.gov/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf).

◆ **The Medicare Fraud Strike Force arrested and charged 91 people in eight cities for their alleged participation in Medicare fraud schemes that resulted in \$295 million in false claims submissions**, HHS and the Department of Justice said Sept. 7. Some of the defendants are doctors, nurses and other medical professionals in the home health care, physical and occupational therapy, mental health services, psychotherapy and durable medical equipment industries. Their alleged crimes include conspiracy to defraud Medicare, health care fraud and violations of the anti-kickback statute, the feds say. The schemes involved submitting claims for treatments that were medically unnecessary or were never provided and paying kickbacks to patient recruiters and beneficiaries. This coordinated effort involves the highest amount of alleged false Medicare billings in a single takedown in the strike force's history, the feds note. "Today's Strike Force operations should serve as a wake-up call to would-be fraudsters nationwide," said Assistant Attorney General Lanny Breuer. "With Strike Force teams now in nine cities across the country, and employing sophisticated, data-driven law enforcement methods, we are determined to hold criminally responsible those who defraud Medicare." Read more at [www.justice.gov](http://www.justice.gov) and [www.hhs.gov](http://www.hhs.gov).

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