Hospital Settles Stent False Claims Case; More Audits Predicted as Standards Evolve

In a medical-necessity case, an Ohio hospital and a medical group have settled false claims allegations that they billed Medicare for implanting stents in patients whose arteries weren’t blocked enough to need them, the Department of Justice announced Jan. 7.

EMH Regional Medical Center (EMH), a nonprofit health system in Lorain County, has agreed to pay $3,863,857 and North Ohio Heart Center Inc. (NOHC), an independent physician group, will pay $541,870. The defendants did not admit wrongdoing in the settlement and there is no corporate integrity agreement.

Challenging the medical necessity of treatment is the next frontier of audits and enforcement, experts say. The cardiac arena is ripe for it in light of recent guidance from specialty societies that is reshaping the calculus of diagnosis and intervention. “In certain cases, the literature doesn’t show people do any better with stents than medication,” but physicians and hospitals often reap financial rewards for implanting stents, says Evan Pollack, M.D., national medical director for Medical Audit & Review Solutions in West Chester, Pa. In light of the tension between money, medicine and audits, “now is the time for increased vigilance by cardiology leadership on a hospital-by-hospital level. If cardiologists and hospital compliance staff don’t take a proactive role to ensure the clinical appropriateness of their practices through robust quality monitoring and peer review, it seems inevitable that external audits and enforcement authorities will be intervening,” adds Michael Taylor, M.D., president of Medical Audit & Review Solutions.

continued on p. 5

New Overpayment Provision in Fiscal Law May Cause Providers to Jump Off the Cliff

Attorneys may need secret decoder rings to translate the overpayment return provision in the American Taxpayer Relief Act of 2012, but that might not even be enough. Sec. 638 of the so-called “fiscal-cliff” law has a provision on “removing obstacles to collection of overpayments” that gives Medicare contractors more time — five years instead of three years — to recover overpayments under Sec. 1870 of the Social Security Act (RMC 1/7/13, p. 1).

That sounds simple, but the interplay between the new provision and Medicare’s 48-month period for reopening paid claims is gumming up the works. “It makes your hair hurt,” says Minneapolis attorney David Glaser, with Fredrikson & Byron.

After a period of time, CMS essentially gives providers a pass on overpayments based on the “staleness” of the claim. Section 1870 of the Social Security Act allows for limited waivers of recovery when a provider was “without fault” in causing the overpayment and recovery would be “against equity and good conscience,” says San Francisco attorney Judy Waltz, with Foley & Lardner LLP. Because of the new fiscal-cliff law,
the hospital will be considered liable for repayment of an erroneously paid claim five years following the year in which payment was made, not three, even if the hospital was without fault in causing the overpayment.

“It’s a little change that potentially has a big effect,” says Washington, D.C., attorney Robert Roth, with Hooper, Lundy & Bookman. “It could lead to a change in the reopening regulations. Right now, providers figure once there is a violation, four years is arguably as far back as it would go, in the absence of an allegation of fraud.”

That’s because CMS regulations (42 CFR Sec. 405.980) and related manual provisions allow Medicare administrative contractors to reopen claims for only up to 48 months (unless “there is reliable evidence...that the initial determination was procured by fraud or similar fault”).

Medicare contractors, qualified independent contractors, administrative law judges and providers may reopen claims. According to chapter 34 of the Medicare Claims Processing Manual, “a contractor may reopen and revise its initial determination or redetermination on its own motion” within one year for any reason and within four years “for good cause” (e.g., new and material evidence has come to light). The manual also states that providers can ask contractors to reopen claims along the same lines. There’s no time limit in cases of fraud or clerical errors.

So which overpayment standard governs? And when providers identify errors and refund Medicare overpayments under the 60-day repayment mandate, should they abide by the fiscal-cliff law or the 48-month standard, at least until CMS finalizes a regulation on the 60-day rule?

**Lots of Dates, Lots of Confusion**

“I used to tell people the easy one is 48 months and the hard one is three years after the year you received payment” before the fiscal-cliff law changed it to five years, Glaser says. “It was legally defensible and more favorable” to go with 48 months because of the hassle in figuring out the latter. Depending on when the overpayment determination is made, Sec. 1870 could stretch to four years under the old law and six years under the new law, he says.

Here’s why: the pre-fiscal-cliff statute limited recoupment to “three years after the year in which payment was made.” Suppose Medicare paid the provider on Jan. 1, 2010. The first “year following the year” of payment is 2011, and the “third year” is 2013, which means the recovery can be done anytime through Dec. 31, 2013, Glaser says. “Functionally, that is four years,” he says.

But if payment were made on July 1, 2010, recovery can still occur any time until Dec. 31, 2013, because the first year is 2011, the second is 2012, and the third year is 2013, he says. That’s three years and six months.

The recoupment deadline drops to three years when payment was made on Dec. 31, 2010, because the first year is 2011, the second is 2012 and the third is 2013.

What a difference a day makes. “A payment received January 1 can be recouped for four years, and one received December 31 can be recouped for three,’ Glaser says. “To convert this to the new statute, just add two years to each example.”

Now Glaser is trying to figure out whether there is a way to still use the 48 months. “It isn’t clear.”

The grab bag of recoupment and “without fault” timelines — there are more, including the cost-report reopening deadlines — leave providers in limbo, says Washington, D.C., attorney Linda Baumann, with Arent Fox. Even before the fiscal-cliff law, providers sometimes struggled to determine the appropriate look-back period when returning overpayments. But now it feels different. “Be prepared for the government to ask for the five-year look-back period,” she says. The five-year period may also be formalized when the 60-day repayment rules are finalized, Baumann says, because she thinks CMS’s ambivalence about proposing a 10-year period was evi...
dent between the lines of the proposed rule’s preamble. Meanwhile, providers should cling to the notion that repayments already in the works (e.g., sent to MACs or the HHS Office of Inspector General) probably escape the new five-year provision of the fiscal-cliff law and fall under the three-year version, Baumann says.

There are really two fundamental questions presented by the fiscal-cliff provision, Glaser says. What does the change in the law mean if there are no changes to the reopening rules? And will the revision in the law be followed by a change in the regulations? “The first question is a challenging legal puzzle. The second question may be the bigger question, but answering it requires a fortune teller,” Glaser says. “One thing is clear: providers should complain to their members of Congress about the notion that there might be a six-year window to recover overpayments. The practical challenges to finding data that old are formidable.”

Contact Baumann at baumann.linda@arentfox.com, Glaser at dglaser@fredlaw.com, Roth at rroth@healthlaw.com, and Waltz at jwaltz@foley.com.

Opportunity, Risk Are Two Sides of The Coin With Transitional Care

Another piece of the pay-for-performance puzzle was put into place Jan. 1, when Medicare started paying primary care physicians for transitional care management. The two new codes for transitional care management are designed to encourage primary care physicians to arrange a visit with patients almost immediately after their discharge from the hospital with an eye toward improving quality of care, which should have the ripple effect of reducing readmissions. But there are some hoops to jump through and a few compliance risks.

“It will require a lot of coordination to get it right,” says Stephen Gillis, director of billing compliance for Massachusetts General Hospital and Massachusetts General Hospital Physicians Organization in Boston. “There are a lot of logistical challenges.”

The two new codes, which debuted in the 2013 Medicare physician fee schedule regulation, promote the physician’s role as “the focal point of accountable care,” he says. The services described by the new codes are similar to the physician oversight required for home health and hospice (i.e., the face-to-face requirement) and apply to patient discharges home from hospitals (patient or observation), skilled nursing facilities, inpatient rehab or long-term care hospitals, Gillis says. Payment is enhanced if physicians make contact within two days of discharge (not necessarily in person) and then see the patient face-to-face within seven or 14 days, depending on which of the two codes are appropriate to the intensity of services.

The two new codes are:

- **CPT code 99495**: transitional care management including communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision making of at least moderate complexity; and a face-to-face visit within 14 days of discharge.

- **CPT code 99496**: communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision making of high complexity; and a face-to-face visit within seven days of discharge.

Medicare pays about $130.08 for CPT code 99495 and $183.96 for CPT code 99496 for the initial face-to-face visit and all non-face-to-face work over the 30-day period after discharge, Gillis says. If the patient is not seen within 7 or 14 days, the face-to-face visit should be billed with conventional codes and Medicare will not pay for the non-face-to-face time, he notes.

Transitional care management requires coordination between hospitals and physician practices. For one thing, primary care physicians need to be informed that their patients have been admitted and that they’re being discharged or have been discharged, and they should receive the patient’s discharge summary pronto, Gillis says. Unless they have a concise discharge summary with salient information, primary care physicians won’t be able to provide meaningful oversight within two days and then again in seven or 14 days. “It could be a major dissatisfier to primary care physicians if they still have
to do care management but can’t bill for it because the hospital didn’t notify them that the patient was in the hospital or the hospital did a terrible job on the discharge instructions,” Gillis says.

Instead of missing this window of opportunity, Gillis says hospitals can use transitional care management to justify improving their discharge summaries and their procedure for communicating them to physician practices. They have a stake in it too, because of the potential to improve quality of care, which also reduces readmissions and the Medicare penalties associated with them.

But be wary of the compliance risks with transitional care management. Medicare auditors may declare an overpayment if physicians fail to document that they contacted patients within two days of discharge and that face-to-face visits took place within seven or 14 days.

The transitional care management codes may cause other kinds of problems. Suppose the patient schedules a post-discharge visit with a cardiologist but then is reminded by the primary care physician to come in for a follow-up. It only lasts five minutes because the cardiologist will address most of the medical issues. This irritates the patient and perhaps doesn’t accomplish much, Gillis says.

There are also some coverage limitations, he says. For example, when patients are hospitalized for certain procedures, the surgeon can’t bill for transitional care management for the follow-up services provided during the 10-, 30- or 90-day period after the procedure. Those services are already bundled into the global surgery. “But primary care physicians could potentially bill for assistance in managing the patient back into the community,” he says.

In some circumstances, attending physicians in the hospital are also the primary care physicians and will complete the discharge service on the patient and bill with a discharge day management code (99238 or 99239). In these cases, the primary care physician can also bill for transitional care management if he or she also provides

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**Blog Posting Draws Spirited Response**

On Nov. 20, AIS senior editor Francie Fernald posted a blog on AISHealth.com summarizing a page 1 story in the Nov. 19 RMC on the problems many hospitals are having with MAC appeals, entitled “Hospitals Say They Spin Wheels With MAC Appeals; Better Odds With ALJs May Change.” A few days later, Robert Weiss, M.S., a Lymphedema Patient Advocate from Porter Ranch, Calif., responded with the posting reprinted below.

I am a patient advocate who helps lymphedema patients file appeals of denials of the compression bandage systems and compression garments they must use every day and night to control their chronic lymphedema. I have been doing this for ten years and have assisted beneficiaries in scores of cases using the Medicare appeal system. I am becoming more and more frustrated with the blatant disregard by Medicare contractors of the regulations governing appeals, by their twisting the intent of title XVIII in their LCDs, by ignoring the evidence and the arguments submitted with appeals, and their arrogance in sending prepared responses which are not even close to addressing the issues. ALJs are somewhat better in reviewing appeals decisions to help identify policies concerning treatment of lymphedema. But there are still some ALJs who do not read the evidence and side automatically with the MAC or QIC citing LCDs which are not relevant to the benefit category at issue. One ALJ quoted a reference from Wikipedia (clearly marked needing verification and evidence citation) for compression garments used to treat a diagnosis of venous insufficiency where the diagnosis in the case was lymphedema (a different condition). The testimony of a leading lymphedema physician was available in the case record and the evidence package cited a dozen medical journal articles supporting the appellant. Clearly this is a system which needs fixing.

RMC contacted CMS officials to respond to the above comments by Mr. Weiss, and an agency spokesman said: “CMS expects its contractors to provide beneficiaries with fair, thorough and timely reviews for all appeals, and we continually look for ways to improve the administration of the Medicare program, including work performed by our contractors.” CMS will search for ways “to help ensure that all contractors are evaluating the outcomes of their appeals at the ALJ level and appropriately considering the applicable ALJ reversal rates in developing any future strategies for reviewing Medicare policies,” the spokesman says. “We will continue evaluating appeals decisions to help identify policies that are being interpreted inconsistently by ALJs and Medicare’s contractors, and use this information to develop future appeals training programs.”

Rick Biehl, Publisher, RMC

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Web addresses cited in this issue are live links in the PDF version, which is accessible at RMC’s subscriber-only page at http://aishealth.com/newsletters/reportonmedicarecompliance.
the follow-up care seven or 14 days later. The visit on
the last day in the hospital doesn’t count. “It would be
considered double dipping to bill for transitional care
management unless they have an outpatient visit in
seven to 14 days, which may not be realistic or medically
necessary even though the patient will benefit from the
non-face-to-face work by the physician over the 30-day
period,” Gillis says.

Contact Gillis at sjgillis@partners.org.

More Stent Audits Are Expected

continued from p. 1

In the Ohio settlement, the government alleges that
EMH and NOHC billed Medicare “for coronary angioplasty and stent placement procedures that were not
reasonable and necessary for the diagnosis or treatment
of illness from January 1, 2001, through November 24,
2006.” DOJ added in a press release that the patients had
heart disease but their blood vessels “were not sufficient-
ly occluded” to require the procedures.

Cleveland attorney Stephen Sozio, who represents
EMH, tells RMC that the settlement reflects a relatively
small percentage of the Part A dollars received by the
hospital for stent placements, which were ordered by the
physicians. “The hospital is not the entity making medi-
cal necessity determinations,” says Sozio, who is with
Jones Day. At the time, he notes, stenting was more pop-
ular than it is today. The hospital, which now employs
many of the NOHC physicians, took steps to ensure
quality of care, Sozio says. For example, it does regular
external peer review in addition to internal peer review,
he says. “An external interventional cardiologist will do
an overread on a sample of cases to ensure quality stan-
ards are being met,” he says.

The complaint was initially filed by a whistleblower,
who alleged more complex misdeeds, although Sozio
says the government did not intervene in those allega-
tions. The whistleblower, Kenny Loughner, was formerly
the manager of EMH’s catheterization and electrophys-
ology lab. Patients came to the lab for angiograms, which
use X-rays to identify blockages in the blood vessels serv-
ing the heart (arteries), and angioplasties, a procedure to
clear them and restore blood flow by inflating a balloon
and/or implanting stents. Both procedures require anes-
thesia and are performed by cardiologists. Cardiologists
generally approach angiograms prepared to do an angi-
oplasty if necessary, because the patient is already sedated
and a cardiac catheter is in place.

The complaint alleged that the hospital and cardiol-
ogy group scheduled angiograms without planning to
perform angioplasties. As a result, patients with block-
ages came back for the angioplasties. In some cases, the
providers allegedly would “insert fewer than the neces-
sary number of stents, leaving blocked or occluded blood
vessels to be stented at a later date. This practice led the
defendants to routinely schedule serial angioplasties, the
usual frequency between procedures being one to three
weeks later,” the complaint said. As a result, the defen-
dants overcharged Medicare, the complaint alleged.

Cardiac Cases Are Big Bucks for Hospitals

Cardiac cases are “bread and butter” for many hos-
pitals, and any pattern of questionable procedures makes
them vulnerable to false claims lawsuits, says Washing-
ton, D.C., attorney Andy Ruskin, with Morgan Lewis and
Bockius LLP. Cardiology is also the centerpiece of Medi-
care pay-for-performance programs, he says. Two of the
three conditions that trigger payment denials for read-
missions are heart related — acute myocardial infarction
and congestive heart failure. And CMS’s value-based
purchasing program, which links Medicare payments
to performance, puts a premium on cardiac measures,
Ruskin says. Two of the 12 clinical process-of-care mea-
ures address treatment for acute myocardial infarction.

Against the backdrop of payment for outcomes, au-
ditors are focusing on the medical necessity of implant-
ing automatic implantable cardiac defibrillators (RMC
10/15/12, p. 1), stents and pacemakers and performing
diagnostic procedures.

Taylor breaks down the “problem areas” of cardiac
procedures into fraud and waste/abuse:
◆ Fraud: One of the first warning signs may be a cardi-
ologist, cardiology group or hospital with practice pat-
terns far outside their peers, he says. This is reflected in
the data, such as the total number of interventions per-
formed per patient and “patterns of appropriateness” —
whether a different intervention, such as a bypass, would
have been preferable, or whether the procedure was
superior to medication. In the process, auditors should
consider the context (e.g., the geographic area and the
demographics of the patient population). “If you see a
pattern of behavior in the data that suggests highly un-
usual billing practices, that is often a compelling reason
to investigate further with review of medical records and
images by a qualified cardiologist,” Pollack says.

A Guide to Complying With Stark
Physician Self-Referral Rules

The industry’s #1 resource for avoiding
potentially enormous fines and penalties
(looseleaf/CD combo with quarterly updates)
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Whether there has been fraud doesn’t turn on “legitimate differences of opinion among cardiologists but rather patterns of intentional misrepresentation,” Taylor adds, such as angiograms that don’t support the need for stents because minimal disease is consistently interpreted as high-grade stenosis (abnormal narrowing in blood vessels).

**Waste and abuse:** “This is a far bigger realm than fraud in terms of dollars,” Taylor says. He notes there is somewhat of a divergence between physician practice patterns and the medical society consensus statements about what benefits patients. “In the past 18 months, the number of consensus statements on coronary artery disease and intervention is impressive,” says Mark Miani, M.D., chief medical officer for Medical Audit & Review Solutions. They are redefining which patients should undergo catheterization, when patients with blockages would benefit from immediate intervention, and when it’s valuable to perform angioplasty to make a diagnosis, Miani says. He cites a November 2012 report by the Society for Cardiovascular Angiography and Interventions in the journal *Catheterization and Cardiovascular Interventions*; a May 2012 report by the American College of Cardiology Foundation Appropriate Use Criteria Task Force on diagnostic catheterization in the *Journal of the American College of Cardiology*; and 2011 practice guidelines on percutaneous coronary intervention from the American Heart Association and American College of Cardiology Foundation Task Force.

“Cardiologists have a number of authoritative references guiding their choices,” Miani says. Because of the recent consensus in the field, Taylor suggests that hospitals and cardiologists seize the opportunity to exercise authority over peer review. “If not, you will see more aggressive auditing and audits moving from clear cases of fraud to waste and abuse,” Taylor says.

**Peer Review Has Its Demons**

But peer review has its own demons. When competing cardiology groups practice at the same hospital, there may be problems with perceptions of fairness, Taylor says. It’s up to compliance, legal and cardiology leadership to “put business rivalries aside,” he says. “This is about ensuring patient safety and appropriateness of care. Hospitals that don’t take steps to police standards of care will be hospitals that rank poorly in measures of quality and cost effectiveness, and as the literature and practice standards become more sophisticated, they will find themselves falling behind in these measures.”

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**Worksheet for Auditing Compliance with Incident-to Rules**

Noncompliance with Medicare rules for billing services provided incident-to a physician’s professional services is apparently common and a vulnerability for physician practices and hospital-owned clinics (*RMC* 7/2/12, p. 1). Olympic Medical Center in Port Angeles, Wash., developed this worksheet to monitor incident-to billing, says Compliance Officer Mic Sager. It is based on guidance from Noridian Administrative Services, a Medicare administrative contractor. The guidance may be accessed at [http://tinyurl.com/af5fqhr](http://tinyurl.com/af5fqhr).

Patient Number: _______________________________________ APC: ______________________________

Name of incident-to physician: ___________________________________________________________________________

Date of visit to establish plan of care: ________________________________________________________________

Date of incident-to visit: _____________________________________________________________________________

Plan of care: _____________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Does it include subsequent services by auxiliary staff (e.g., nurse practitioner)? Yes No

Did physician inform patient of APC follow-up? Yes No

Did APC stay within plan of care? Yes No

Was a qualified physician on site? Yes No

How documented: _______________________________________________________________________________

Which physician’s NPI is on claim? __________________________________________________________________

Is physician reviewing APC chart notes? Yes No

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And with the myriad acquisitions under way, it’s a good idea for hospitals to consider case reviews “to ensure the practice they are buying has been practicing a defensible standard of care.”

In a statement, John Schaeffer, M.D., president of North Ohio Heart Center, said it settled only to move on. “It’s very important to note that this settlement is only about whether or not Medicare covered some procedures we did six to ten years ago that were considered cutting edge at the time,” he said. “As the physicians on the ground when these decisions were made and the procedures were performed, we felt confident we were making the correct choices for our patients,” adding it has “passed every Medicare audit ever done — whether regarding stent procedures, or any other service.” Schaeffer notes that EMH for three years has received the Health-Grades Cardiac Care Excellence Award and is ranked in the top 5% nationally for cardiac care.

**Cardiac Care Triggers Many Settlements**

The Ohio settlement is at least the fourth one with a hospital over unnecessary cardiac care. In 2003, Redding Medical Center in California paid the Department of Justice $54 million to settle a false claims lawsuit over allegations that two cardiac surgeons performed medically unnecessary cardiac catheterizations and bypass surgeries. Redding’s then-parent, Tenet Healthcare Corp., made a deal with OIG to prevent the hospital’s Medicare exclusion by selling Redding.

In 2011, Peninsula Regional Medical Center in Salisbury, Md., agreed to pay $1.8 million to resolve allegations “that it was aware of, but failed to take action to prevent medically unnecessary cardiac stent procedures by John R. McLean, formerly a cardiologist with privileges at PRMC,” the U.S. Attorney’s Office said (RMC 8/15/11, p. 1). A jury convicted McLean of one count of health care fraud and five counts of making false statements relating to health care fraud matters in connection with the medically unnecessary stents he implanted in patients at Peninsula Regional Medical Center (RMC 8/1/11, p. 3). He was sentenced to eight years in prison and ordered to pay fines and restitution of about $1.1 million.

In 2010, St. Joseph Medical Center in Towson, Md., paid $22 million to settle a false claims case over alleged Stark violations and medically unnecessary stent implant surgery (RMC 11/15/10, p. 1). In that case, the Maryland Board of Physicians yanked the license of the surgeon, Mark Midei, M.D., who played a pivotal role in the case.

**NEWS BRIEFS**

- The HHS Office of Inspector General (OIG) gave the thumbs up to a federally qualified health center’s plan to offer grocery store gift cards to certain patients in capitated Medicaid managed care plans as an incentive to receive health screenings or other clinical services, according to an advisory opinion (12-21) posted on Jan. 3. Under the proposed arrangement, the health center would send letters to enrollees of the managed care plans who either: (1) were newly assigned to the center as their contracted provider, or (2) were assigned to it as their contracted provider at least one year before and have not been seen by the center in the past 12 months. The health center said the letters would offer the eligible enrollee the opportunity to claim an incentive gift card redeemable for $20 in groceries from a major supermarket chain in exchange for a visit to the health center for a screening or any other clinical service performed on behalf of the eligible enrollee. The center stressed that the award of the gift card would not depend on the eligible enrollee’s selection of any particular screening or other clinical service.

- OIG concluded that the proposed arrangement would not implicate the anti-kickback statute and won’t face sanctions because, among other reasons, the proposed arrangement would not be advertised or marketed to the general public and is consistent with the health center’s not-for-profit mission. Visit http://go.usa.gov/gtAB.

- Medicare inappropriately paid five home health agencies (HHAs) that had suspended or revoked billing privileges, the OIG said in a report (OEI-04-11-00220) released Dec. 20. In fact, CMS did not act on OIG’s revocation recommendations. The report also contends that four of the zone program integrity contractors (ZPICs) did not identify any HHA vulnerabilities and varied substantially in their efforts to detect and deter fraud. However, two Medicare administrative contractors (MACs) prevented $275 million in improper payments to HHAs and referred 14 instances of potential fraud to the feds in 2011. To improve HHA program integrity, OIG recommends that CMS: (1) establish additional contractor perfor-
NEWS BRIEFS (continued)

mance standards for high-risk providers in fraud-prone areas, (2) develop a system to track revocation recommendations and respond to them in a timely manner, and (3) follow up on and prevent inappropriate payments made to HHAs with suspended or revoked billing privileges. CMS concurred with all three recommendations. OIG also posted a podcast on HHA oversight. To listen to the podcast, visit http://go.usa.gov/gGUV. To view the report, visit http://go.usa.gov/gGU.

♦ Florida-based American Sleep Medicine LLC has agreed to pay $15.3 million to settle allegations it billed Medicare, TRICARE and the Railroad Retirement Medicare Program for sleep diagnostic services that were not eligible for payment, according to the Department of Justice. Under federal program requirements for the reimbursement of claims submitted for sleep disorder testing, initial sleep studies must be conducted by technicians who are licensed or certified by a state or national credentialing body as sleep test technicians. The feds contend that Medicare and TRICARE claims submitted by American Sleep between Jan. 1, 2004, and Dec. 31, 2011, were false because the diagnostic testing services were allegedly performed by technicians who lacked the required credentials or certifications, according to the settlement. The lawsuit was initiated by whistleblower Daniel Purnell, who will receive $2.6 million as part of the settlement. OIG also imposed a corporate integrity agreement on American Sleep Medicine that requires enhanced accountability and wide-ranging monitoring activities conducted by both internal and independent external reviewers. A company spokesman could not be reached for comment. Sleep clinics have a target on their back. In June, Arete Sleep agreed to pay $650,000 to settle allegations that its Arizona and Texas locations billed Medicare for tests that were not performed by licensed and/or certified sleep technicians (RMC 6/6/12, p. 1). Visit www.justice.gov.

♦ Only 193 of 2,105 line items for the oral form of Emend paid by Medicare contractors in 2010 were correct, OIG said in a report (A-07-11-04181). The remaining 1,912 line payment amounts were incorrect because providers did not bill for all of the required drugs in the regimen on the same claim as required, resulting in overpayments totaling $530,769, according to OIG. Emend is an anti-nausea medication for chemotherapy patients and is now an OIG audit target (RMC 11/14/11, p. 1). The providers said they billed incorrectly because they were not aware of the federal requirements for the three-drug oral antiemetic regimen until OIG made them aware. Visit http://go.usa.gov/g7VB.

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