Hospitals and Other 340B Entities Should Brace for Audits and Major New Rules

More audits and a slew of new regulations are at the doorstep of hospitals and other entities that receive deep drug discounts through the 340B program. Their compliance with the 340B program is under scrutiny, and hospitals will get more insight into the government’s expectations when it releases the 340B “mega-reg” and three related regulations, probably in June.

About 3,200 organizations participate in the 340B program, including critical access hospitals, sole community hospitals, disproportionate share hospitals, freestanding cancer hospitals, children’s hospitals, rural referral centers and hemophilia clinics. Administered by the HHS Health Resources and Services Administration’s Office of Pharmacy Affairs (OPA), the 340B program requires pharmaceutical manufacturers to provide discounts on outpatient drugs purchased by certain entities that serve the nation’s most vulnerable patients.

Things are heating up in the wake of Government Accountability Office findings that HRSA guidance and oversight of the 340B program are inadequate. For one thing, OPA — which had its budget doubled to $10 million — is ramping up audits, said Karolyn Woo-Miles, a senior manager with Deloitte & Touche in Costa Mesa, Calif. “It’s not a question of if you will be audited, it’s more a matter of when,” she said at a recent

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Health Care Compliance Association webinar. Pharmaceutical manufacturers that demonstrate “reasonable cause” also can audit a hospital’s 340B compliance with HRSA permission and are building their own cases for audits, she said.

When hospitals get it wrong, they pay back the pharmaceutical manufacturer the difference between the 340B discounted price and the retail price of the drugs, Woo-Miles said. That’s painful because a typical 340B hospital can save between 25% and 35% off the group purchasing organization (GPO) cost of outpatient drugs — and sometimes 50% off for some brand-name drugs, she says.

What Is a Material Event?

Hospitals may identify a “material event” themselves and repay the manufacturer. “But the definition of a ‘material event’ is open to interpretation,” she said. “It depends on the organization’s compliance culture.” More details on how 340B violations should be handled are expected in the June regulation.

The 340B program is also the subject of two audits on the 2014 HHS Office of Inspector General Work Plan: (1) whether drugmakers are overcharging 340B entities and the steps HRSA has taken to “provide 340B covered entities with access to 340B ceiling prices”; and (2) how much Medicare Part B spending could be cut if it shared in 340B savings.

The 340B program is governed by 1994, 1996 and 2010 regulations and additional policy releases and answers to frequently asked questions issued by HRSA since the program’s inception, Woo-Miles said. She described 340B compliance challenges, some of which stem from four regulatory “prohibitions”:

(1) **Duplicate discounts:** Hospitals can’t accept 340B discounted prices on drugs that also generate Medicaid rebates. In other words, drug manufacturers should not lose money twice. But applying this prohibition is tricky because the precise billing and reimbursement methodology is determined on a state-by-state basis. It’s the hospitals’ responsibility to inform the manufacturer of its participation to prevent duplicate discounts. Hospitals must decide if they will “carve-in” Medicaid patients for 340B discounted drugs or “carve-out” Medicaid patients from the program, Woo-Miles said. “HRSA recommends [hospitals] work directly with their Medicaid agencies to determine the applicable billing requirements.”

(2) **Diversion:** Hospitals can’t sell 340B drugs to people who don’t meet the definition of a patient of the entity. Reselling 340B drugs or providing them to ineligible patients is known as “diversion” and is prohibited. “This happens typically with inadequate internal controls and processes around patient and provider eligibility definitions,” Woo-Miles said.

(3) **GPO exclusions:** Disproportionate-share hospitals, children’s hospitals and freestanding cancer hospitals in the 340B program can’t get covered outpatient drugs through a GPO for any of their clinics/departments within the four walls of the hospital (i.e., the same physical address). “However, certain off-site outpatient facilities of the hospital may use a GPO for covered outpatient drugs if they meet certain requirements,” Woo-Miles said.

(4) **Orphan drugs:** Effective Oct. 1, 2013, freestanding cancer center hospitals, rural referral centers, sole community hospitals and critical access hospitals subject to the 340B program’s orphan drug exclusion may buy FDA-approved orphan drugs at 340B prices as long as the drugs are used for an indication other than the one for which the orphan designation was granted.

Other compliance issues revolve around definitions of “eligible physicians” and “patients,” Woo-Miles said. “The existing guidance is not black and white.” For example, the regulation states that physicians must be employed by participating hospitals or have some other formal relationship with them and hospitals must have an established relationship with the patient and maintain a established relationship with the patient and maintain a
their medical records. This can get dicey, she says. Suppose a physician sees a patient at the emergency room and refers the patient to a specialist who is not affiliated with the hospital. The specialist writes a prescription, and the patient fills the prescription at the hospital’s contract pharmacy. Some hospitals may not treat the prescription as 340B-eligible if the hospital uses a list of all credentialed prescribers to determine provider eligibility, and the specialist would not be on this list. However, some hospitals may treat the prescription as 340B-eligible because, even though it originated outside the hospital, the medical records indicate the patient was referred by a physician of the hospital, Woo-Miles said.

The Industry Needs More Clarity

The industry hopes for more clarity on these off-site relationships; definitions of “eligible patients,” “physicians” and “hospitals”; and compliance requirements for community pharmacies under 340B. Hospitals fill most 340B prescriptions in-house, but the Affordable Care Act expanded the number of community pharmacies each hospital is allowed to contract with in a bid to expand access to care, Tony Lesser, a manager with Deloitte & Touche in Chicago, said at the webinar. A side effect has been noncompliance in the form of drug diversion and duplicate discounts; and compliance requirements for eligible prescribers.

More 340B Audits Are on the Way

Meanwhile, hospitals are facing more 340B audits. OPA completed 51 audits in fiscal year (FY) 2012, and 16 resulted in repayments, according to its website, where the results were posted in January. Errors included diversion, duplicate discounts, and drugs dispensed by ineligible sites or not supported by medical records. In nine more cases, sanctions are still to be determined. OPA did 94 audits in FY 2013 and an unpublicized number have been scheduled for FY 2014.

Hospital 340B compliance may be hobbled by the complexity of the program, Lesser said. On top of the regulatory fuzziness, hospitals have to deal with convoluted billing rules, such as converting drug units to billing units, he says. They often don’t invest in auditing and monitoring 340B compliance, and only one person may be well-versed on the program.

Here are Lesser’s tips for improving compliance:

◆ “Start with people,” he said. Identify a 340B project team with executive support, give responsibilities to each member and use a project management tool.

◆ Establish a “global policy” for 340B compliance, Lesser said. “How are you abiding by the GPO exclusion on a day-to-day basis? How do you review records to ensure compliance? How do you maintain the database for eligible prescribers?”

◆ Consider making 340B someone’s full-time job because the program can be worth millions of dollars to hospitals.

◆ Ensure that employees involved in 340B, such as pharmacists, are properly trained. “HRSA doesn’t expect every person to know everything about 340B, but they should be able to answer basic questions,” Lesser said.

◆ Take certification and recertification seriously, he said. Eligible hospitals and other entities must register to participate in 340B online and attest their compliance annually. “I would encourage hospitals to not just click through the recertification each year. Take the process very seriously. You are putting your name on the bottom line for 340 compliance,” Lesser said. “If noncompliant, they may be liable to drug manufacturers for repayment or risk getting kicked out of the program.”

◆ Establish procedures for monitoring and validating 340B compliance. “You can’t just trust the 340B administration software is operating correctly behind the scenes,” he said. “Look at your encounter and utilization data used to justify prescriptions captured for 340B.” Do a variety of audits — on patient and physician eligibility, inventory, duplicate discounts, compliance with Medicare billing guidelines, price changes and purchasing patterns.

◆ “Maintain a complete audit trail from prescription to pick-up by the patient to replenishment,” Lesser said.

Contact Woo-Miles at kwoo@deloitte.com and Lesser at aless@deloitte.com. View OPA audit findings at http://tinyurl.com/m2bfjsr.

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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Outpatient Therapy Cap With No Exceptions Takes Effect April 1

The world of outpatient therapy will turn upside-down on April 1, when the Medicare benefit is capped in most rehabilitation settings with no exceptions allowed while audits will linger for years. Only acute-care hospitals will be spared any dollar limits on outpatient therapy, although, as always, they must demonstrate its medical necessity.

Without congressional intervention, there will be a “hard therapy cap” per beneficiary of $1,920 for physical and speech therapy combined and $1,920 for occupational therapy, says Nancy Beckley, president of Nancy Beckley & Associates in Milwaukee. “That means it’s a statutorily excluded benefit,” with no exceptions. Other than acute-care hospitals, the hard cap applies to all outpatient therapy providers, including critical access hospitals, comprehensive outpatient rehabilitation facilities, skilled nursing facilities, home health agencies’ Part B type of bill (TOB) 34X and physical therapists in private practice.

Congress often adds language on outpatient therapy to legislation addressing the sustainable growth rate (SGR). But it’s not mentioned in the SGR Repeal and Medicare Provider Payment Modernization Act of 2014 (H.R. 4015/S. 2000), which has bipartisan support. That means “all outpatient therapy rules extended by SGR legislation through March 31 come to an end,” Beckley says. However, the “doc-fix” legislation, which would overhaul the Medicare physician payment methodology instead of cutting reimbursement 24% for all physician services, is now in flux. Senate Majority Leader Harry Reid (D-Nev.) added a revised version of the Senate bill, the Medicare SGR Repeal and Beneficiary Access Improvement Act (S. 2110), to the Senate calendar, and it includes the $3,700 therapy threshold and medical review process. “That bill will likely be considered on the Senate floor during the last week of March, after Congress returns from a scheduled recess the week of March 17,” according to the American Medical Association.

Critical Access Hospitals Were ‘Blindsided’

If no SGR measure is passed or it’s passed without addressing therapy, the hard cap takes effect for all providers except acute-care hospitals, with no exceptions process, Beckley says. “This is very major,” she says. “If there is a hard therapy cap of $1,920, there will be no more therapy than that even if beneficiaries can’t walk or talk. They would have to sign an ABN and pay for the therapy themselves” or receive it at an acute-care hospital outpatient department. And a hard cap means there is no exceptions process. After March 31, rehab providers can’t use the KX modifier to bill above the $1,920 therapy cap, which subjects them to automated review, or above the $3,700 threshold, which requires recovery audit contractors (RACs) to do prepayment or postpayment manual medical reviews. “It all expires,” Beckley says. “Critical access hospitals were simply blindsided by this at the beginning of the year.”

RAC Therapy Audits Will Continue

But, according to Beckley, audits are not over for pre-April 1 outpatient therapy claims that crossed the threshold and were submitted by acute-care hospitals and other rehab providers (RMC 4/8/13, p. 4). In the 11 states where RACs do prepayment therapy audits and the 39 states where they do postpayment therapy audits, RACs will continue their work. But it won’t be under the existing contracts, Beckley says. “Those claims will be reviewed when [CMS] has new RAC contracts in place,” she says. “It’s a 100% medical review.” For some reason, the usual RAC rules don’t apply, she says. There is no discussion period, there is no limit on the number of medical records that can be requested, rehab providers can’t be reimbursed for the cost of producing and mailing medical records “and this likely will carry over to the next five years of the new contracts,” she says.

Beckley is worried about adjustment by critical access hospitals to the cap. She recommends they listen to a webinar provided by a Medicare administrative contractor, WPS (http://www.wpsmedicare.com/j5macparta/training/on_demand/therapy-od.shtml).

It’s possible Congress will act in time to allow a higher cap with an automated exceptions process and/or medical review process, but Beckley worries providers didn’t pay attention because they got used to it being fixed every year. “The industry may have been lulled into complacency despite the work of the therapy lobby,” she says. Also, the Medicare Payment Advisory Commission (MedPAC) has advocated reducing the therapy cap to $1,270.

Two Areas Where Improvement Is Needed

Beckley says most therapy providers do good work, but it may not show up in their documentation. Her audits show that they need to focus improvement in two areas:

(1) Compliance with the regulations that drive the plan of care and how it is certified, and

(2) Ensuring the daily note is comprised of “everything that will support the codes that are billed,” she says. “Daily notes support what you billed for the date of service, while the plan of care supports the structure for your entire episode of care.”

Contact Beckley at nancy@nancybeckley.com.
OIG Auditors Are Human, Too
continued from p. 1

States. As a result, OIG is doing a national review, and WellSpan’s report is one of five audit reports released in the past month. All the reports say every Medicare inpatient claim with kwashiorkor (ICD-9-CM diagnosis code 260) reviewed was billed wrong (see briefs, p. 8). In the case of WellSpan York Hospital, it repaid $204,226 for 48 MS-DRGs where kwashiorkor was the only major complication and comorbidity (MCC) and therefore triggered higher payments in 2010 and 2011. OIG said kwashiorkor was incorrectly billed another 59 times, but it didn’t affect DRG reimbursement.

Verify Claims on Auditors’ Lists

If WellSpan’s experience is typical, that cut-and-dried finding doesn’t convey the complexities of the audit or the nuances of kwashiorkor, which is also a recovery audit contractor (RAC) target. For example, “we started with a list of claims they provided, but ultimately found some claims that didn’t make sense,” Trout says. “So we pulled the claims out of our own system. Then we compared our lists and came up with a good list of claims.”

For starters, OIG’s original list of kwashiorkor claims included one that was already denied by the RAC even though Medicare watchdogs are not allowed to double up on the same claims because it’s a burden on hospitals. Anyway, WellSpan had reversed the denial during the RAC discussion period, Trout says. “We provided the supporting documentation that the RAC already reviewed the case” and OIG dropped it from the audit, she notes. “People make mistakes, including OIG.”

OIG also included Medicare HMO claims where WellSpan received a Medicare indirect medical education payment. They were ultimately removed from the audit list because they’re usually billed through Medicare Advantage plans.

The audit was eye-opening in terms of OIG’s documentation expectations. “OIG was telling us that kwashiorkor had to be specifically documented in the medical records so first we looked to see if that was documented, but it never was,” says Colleen Dailey, clinical coordinator of defense audits at WellSpan. Physicians typically don’t use that term; the documentation instead said “protein malnutrition,” which codes to kwashiorkor in the ICD-9 coding book. WellSpan made that clear to OIG auditors so they didn’t overlook “protein malnutrition” in the medical records. OIG gave the hospital an alternative in the absence of the word “kwashiorkor”: if clinical documentation supported severe protein malnutrition, the hospital could code it as ICD-9-CM 262, which is other severe protein-calorie malnutrition. “From a pure technical standpoint in reading the codes, that doesn’t make sense,” Trout says. “What if the patient is just severely protein malnourished and not calorie malnourished?”

OIG originally planned to review claims from 2009 as well as 2010 and 2011, but WellSpan got the 2009 claims dropped from the audit. Dailey and Trout believe it’s because the claims were submitted in good faith based on advice from the American Hospital Association. When WellSpan implemented a clinical documentation improvement program, one coder asked how she should handle documentation for protein malnutrition. “It says kwashiorkor, but there was a lack of clarity in the code book,” Dailey says. So the coder sought guidance from AHA’s central office on ICD-9-CM, and in early 2009 it wrote back to WellSpan, saying that it’s appropriate to code “kwashiorkor” if the physician says “protein malnutrition.” This was superseded later that year by industry-wide guidance from Coding Clinic, which directed hospitals to code 263 if physician documentation corresponds to moderate protein malnutrition, she says. WellSpan, however, did not want to apply that standard after the fact, and OIG appeared to agree, Dailey says.

During the audit, WellSpan nurses and coders examined every medical record on the hit list to determine whether there was documentation to support kwashiorkor or other severe malnutrition, both of which are MCCs and upgrade MS-DRG reimbursement, Trout and Dailey say (see audit tool, p. 7). For example, was body mass index (BMI) less than 16? Did a nutrition consult find weight loss of 25% or more? What were the patient’s albumin scores? Was there hyperalimentation? Did the patient have cancer, Crohn’s disease or any explanation for extreme malnourishment? “It was a long process,” Dailey says. “We separated the charts between five people and determined which were coded correctly and which were not.” And if they found other major complications and comorbidities, the hospital’s reimbursement would be unaffected. This was an object lesson in the necessity of “identifying all these things yourself. Be sure the auditors don’t miss them,” Trout says.

It Can Help to Highlight Records for Auditors

In fact, she suggests highlighting records for auditors. WellSpan gave OIG access to charts through a secure electronic portal, and also showed on a spreadsheet where the auditors could find something noteworthy, including a case that had “protein malnutrition” documented in the physician’s progress notes. When OIG returned the audit results to WellSpan, it said in reference to this case that “the physician never mentioned protein malnutrition in the discharge summary, history and physical or in physician notes.” Trout asked OIG about this and was told the electronic access must have timed...
out and auditors couldn’t locate it in the pages they had printed out from their review. “We had to reproduce those important pages,” she says. “If I had to do it over again, I would have sent copies and highlighted those.”

As it turned out, the glitches didn’t end with the audit findings. Rebilling had its snags as well. OIG told WellSpan it could rebill the kwashiorkor cases as severe protein-calorie malnutrition if documentation supported it. But the Medicare administrative contractor (MAC) denied the claims because they were submitted beyond the one-year timely filing requirement. That’s not supposed to happen when claims are rebilled after OIG audits, Trout says. WellSpan had added a “remark” in the comment field per the OIG’s instructions, which was supposed to prevent denials for billing outside timely filing deadlines, Trout says. But the remark — OIG Review Report A-03-13-000115 — didn’t work until the OIG intervened. Ultimately, the claims were corrected but not without WellSpan’s bird-dogging them. “Make sure your billers know to watch those claims and don’t write them off because they’re rejected for being outside timely filing,” Trout advises.

The Lesson: Review Everything for Yourself

What is the message for hospitals? They should validate the data submitted by OIG and the details of corresponding medical records, Trout says. “Review everything with a fine-tooth comb,” she advises. “Then work with the auditor to make sure everything is correct on both sides.” And if claims are rebilled after audits, compliance officers should keep an eye on them. “Make sure in the end your organization is paid what it is due,” Trout says. “You have to be extremely detail oriented.”

WellSpan has implemented compliance reforms for kwashiorkor documentation and billing. It has a two-fold review process. Clinical documentation improvement specialists look at the entire picture for malnutrition cases, and when documentation is not specified, they query clinicians. Coders have been instructed to not assign 260 unless the word “kwashiorkor” is documented by physicians. If they use the terms “protein malnutrition” or “protein deficiency,” coders query for the severity, asking for mild, moderate, severe, Kwashiorkor, other or unspecified. “If the physician won’t specify the severity and documents only protein malnutrition or protein deficiency, despite where the code book takes us, we have been instructed to use code 263.9 — unspecified protein-calorie malnutrition,” WellSpan told OIG.

Trout is still bothered by OIG’s comfort level with protein-calorie malnutrition because sometimes it is off base. Patients may be protein deprived but stuffed full of empty calories, such as junk food. And notwithstanding Coding Clinic’s insistence that kwashiorkor is exceedingly rare in America, she says there are cases of it in nursing homes. But physician documentation doesn’t capture this. If it doesn’t state dyspigmentation of skin and hair and nutritional edema, for example, hospitals can’t make the case for kwashiorkor. “It’s still a confusing area.”

Contact Trout at wtrout@wellspan.org and Dailey at cdaily2@wellspan.org. View the audit at http://go.usa.gov/BSyj.

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CMS Transmittals and Federal Register Regulations
March 7 — March 13

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**Transmittals**
(R) indicates a replacement transmittal.

**Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual**
- Update to Pub. 100-01, Chapter 7 for Language-Only Changes for ICD-10, Trans. 83GI, CR 8639 (March 7; eff./impl. Oct. 1, 2014)

**Pub. 100-04, Medicare Claims Processing Manual**
- Update to Pub. 100-04, Chapter 19 to Provide Language-Only Changes for ICD-10 and ASC X12, Trans. 2895CP, CR 8646 (March 7; eff./impl. Oct. 1, 2014)
- Indirect Payment Procedure – Payment to Entities that Provide Coverage Complementary to Medicare Part B, Trans. 2896CR CR 8638 (March 7; eff./impl. June 6, 2014)
- April 2014 Update of the Ambulatory Surgical Center Payment System, Trans. 2901CP CR 8675 (March 7; eff. April 1; impl. April 7, 2014)
- April Quarterly Update for 2014 DMEPOS Fee Schedule (R), Trans. 2902CP CR 8645 (March 11; eff. April 1; impl. April 7, 2014)
- April 2014 Update of the Hospital Outpatient Prospective Payment System (R), Trans. 2903CP CR 8653 (March 11; eff. April 1; impl. April 7, 2014)
- **Pub. 100-07, State Operations Manual**
  - State Operations Manual Appendix M Revisions for Intermediate Care Facilities for Individuals with Intellectual Disabilities, Trans. 104SOMA (March 7; eff./impl. March 7, 2014)
  - Pub. 100-08, Medicare Program Integrity Manual Supplemental Medical Review Contractor, Trans. 508PI, CR 8578 (March 7; eff./impl. April 8, 2014)
  - Pub. 100-20, One-Time Notification
  - Modifying the Daily Common Working File to Medicare Beneficiary Database File to Include Diagnosis Codes on the HIPAA Eligibility Transaction System 270/271 Transactions (R), Trans. 1356OTN, CR 8456 (March 6; eff. Oct. 1; impl. Oct. 6, 2014)

**Federal Register Regulations**
- None published.
The HHS Office of Inspector General is doing a series of audits of MS-DRG claims that include coding for kwashiorkor and finding pervasive errors (RMC 2/24/14, p. 1). However, as WellSpan Health in York, Pa., learned, OIG’s data may not always be correct and hospitals may have to hash over the MS-DRGs and major complications and comorbidities (MCCs) under scrutiny (see story, p. 1), according to Wendy Trout, director of corporate compliance, and Colleen Dailey, clinical coordinator of defense audits. Both as an audit defense strategy and in the event OIG comes knocking, hospitals may want to conduct an internal audit of kwashiorkor, a severe form of protein malnutrition that Coding Clinic says is very rare in the United States. Contact Trout at wtrout@wellspan.org and Dailey at cdailey2@wellspan.org.

### Spreadsheet for Malnutrition/Kwashiorkor Audits

| Sample # | Kwashiorkor Specificity Documented Y/N? | Kwashiorkor Documented Y/N? | Physician Documentation Noted in Record | Location in Record | Nutrition Consult Y/N | Documented BMI < 16 Y/N | List Any Malnutrition Treatments - Tube Feedings, TPN, Hyperal, Supplements, etc. | Pre-albumin < 5 Y/N (N/A - lab not done) | Albumin < 2.1 Y/N (N/A - lab not done) | Documented Weight Loss of 25% or more Y/N? | List Comorbid conditions - i.e. Cancer, Protein Malabsorption, Crohn’s, etc. | List Other MCCs Documented | DRG Documented | DRG billed | Audited DRG? | Error Y/N |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | |
CMS on March 12 posted new guidance on the two-midnight rule and its “probe and educate” program. In its answers to frequently asked questions (A4.10), CMS explains how Medicare administrative contractors will review cases when surgeries are cancelled after the patient has been admitted. CMS says MACs will judge the claims under the two-midnight rule. “In other words, if the physician reasonably expects the beneficiary to require a hospital stay for 2 or more midnights at the time of the inpatient order and formal admission, and this expectation is documented in the medical record, the inpatient admission is generally appropriate for Medicare Part A payment,” CMS says. In another FAQ (A1.3), CMS says if the probe and educate program turns up no errors or only one error at a hospital, it will not face any more prepayment reviews under the two-midnight rule for claims with dates of service of October 2013 through September 2014. MACs are auditing 10 to 25 inpatient admissions at every hospital under the probe and educate program. Other than these reviews, hospitals are free of most other audits for the medical necessity of their admissions in terms of site of service until Oct. 1 (RMC 3/3/14, p. 4; 2/10/14, p. 1). Visit http://tinyurl.com/km93mqm.

Joseph A. Raia, M.D., will be excluded from Medicare and other federal health care programs for 15 years and pay $1.5 million in connection with his civil money penalty settlement with the HHS Office of Inspector General. Raia, a physical medicine and rehab physician licensed in New Jersey and New York, agreed to resolve CMP liability arising from allegations that he submitted false and fraudulent Medicare claims, OIG said on March 12. Raia, who denied liability in the settlement, owned and operated Grafton Medical Center, PC, and Joseph A. Raia, M.D., P.C., which are physical medicine and rehabilitation practices in Newark and Brooklyn. OIG alleged that from January 2006 to November 2011 Raia submitted or caused to be submitted thousands of Medicare claims for physical therapy and physical medicine and rehab services that were never provided or were otherwise false. For example, OIG alleged Raia billed Medicare for providing or supervising physician therapy when he wasn’t in the state where services were provided; billed for services performed at the same time in five locations in two states; and “improperly used chiropractors to provide physical therapy services incident to his professional services.” Visit http://go.usa.gov/KKAQ.

In the latest Medicare compliance review, OIG said Nebraska Medical Center did not bill correctly for 34 claims of the 185 inpatient and outpatient claims reviewed. The result was a $319,731 overpayment for claims. The hospital agreed with most audit findings, except for six cases where OIG contends inpatient admissions should have been billed as outpatient services. Visit http://go.usa.gov/KDdW.

Butler Memorial Hospital in Butler, Pa. did not bill properly for kwashiorkor on any of the 91 claims reviewed, OIG contends. In a new audit report, OIG says the hospital used ICD-9-CM diagnosis 260 for kwashiorkor when it should have used codes for other kinds of malnutrition. The errors increased reimbursement for 43 claims, resulting in an overpayment of $130,000. For more information, visit http://go.usa.gov/KDdC.

Halifax Hospital Medical Center and Halifax Staffing formally settled allegations it violated Stark-related False Claims Act violations and will pay $85 million, the Department of Justice said March 12. The government, intervening in a case brought by a whistleblower, alleged the hospital’s compensation relationships with nine employed physicians ran afoul of Stark. A tentative settlement was announced last week (RMC 3/10/14, p. 1). Halifax Hospital also agreed to a five-year corporate integrity agreement. Visit www.justice.gov.

Two recovery audit contractors have filed “pre-award” protests with the Government Accountability Office (GAO) over CMS’s planned changes to the next set of RAC contracts, Emily Evans, a partner in Obsidian Research Group in Nashville, said March 10 at a Monitor Mondays webinar sponsored by RACMonitor.com. The protests have to be ruled on before CMS can award the new RAC contracts. CGI Federal and HMS Holdings (which owns HealthDataInsights) object to CMS’s changes to the next RAC installment, Evans says. Existing RACs are winding down, with RACs precluded from seeking “additional documentation requests” after Feb. 21. For future RAC contracts, CMS said it would, among other things, withhold RAC contingency fees for identifying overpayments until it was clear they would survive the second level of appeal. Currently, RACs receive their contingency fees after the first level of appeal. For more information, contact Evans at emily@obsidianresearchgroup.com.
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