Report on
Medicare Compliance

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

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Congress Moves to Delay RAC Two-Midnight Audits; CMS Cuts Slack on MD Orders

Congress stepped into the fray of the two-midnight rule for inpatient admissions in a bill approved by the U.S. House of Representatives (H.R. 4302) on March 27 that is now moving through the Senate. If the House language survives, as expected, the measure would postpone recovery audit contractor (RAC) reviews of inpatient admissions until March 31, 2015, unless they suspect fraud or abuse, while extending spot checks of hospital compliance by Medicare administrative contractors (MACs) in their "probe and educate" program.

Although hospitals are on the verge of a reprieve, it's not all wine and roses for them. RACs are free to review the coding and medical necessity of services, such as stent insertions and joint replacements, and MACs would be able to recoup overpayments under the two-midnight rule.

If adopted, the Protecting Access to Medicare Act of 2014, which addresses the sustainable growth rate (SGR), would also delay ICD-10 implementation until Oct. 1, 2015. Senate action on the bill is expected on Monday. Congress is scrambling to get the bill on President Obama's desk for signature before April 1 to prevent a 24% drop in Medicare payments for physician services, congressional sources say.

Meanwhile, a top CMS official indicated there is some flexibility with admission orders under the two-midnight rule. Marc Hartstein, director of the CMS Hospital and Ambulatory Payment Group, said that when it's painfully obvious hospital stays crossed two midnights, a lack of physician order is not necessarily fatal to Part A claims.

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Despite Layers of Compliance, Duke Health System Ran Into Trouble, Settles for $1M

A three-tiered coding compliance system allegedly didn't prevent errors at Duke University Health System, which agreed to pay $1 million to settle a False Claims Act case, the U.S. Attorney's Office for the Eastern District of North Carolina said March 21. The academic health system was accused of overcharging Medicare for surgical assistants and unbundling cardiac and other procedures.

According to the complaint, from 2006 to 2013 Duke University Health System billed Medicare, TRICARE and Medicaid separately for "assistant at surgery" services provided by nonphysician practitioners even though residents were available at no extra charge, and misused modifier -59. Both errors should have been averted by the health system's thorough coding-compliance process, but something went wrong, the government alleges.

"Having good processes is not a panacea," says Denver attorney Jeff Fitzgerald, with Polsinelli. "At the end of the day, there is always a human factor to this." It's the people in any organization — including coders, case managers and compliance officers and managers — who may make bad decisions as they juggle rules from multiple

payers that may conflict or confuse, says Fitzgerald, who was not involved in the case.

Like many false claims cases, Duke's originated with a whistleblower — Leslie Johnson, a former Duke coding auditor. After her warnings to colleagues and bosses about Duke's alleged violations fell on deaf ears, Johnson filed the false claims lawsuit on the last day of 2012. The U.S. attorney later intervened in some of the allegations and filed an amended suit against Duke, which operates three hospitals — Duke University Hospital, Duke Regional Hospital and Duke Raleigh Hospital — as well as other entities, including Duke Patient Revenue Management Organization (PRMO).

The complaint describes Duke's layered coding compliance procedure. The first tier of coders simply coded all services on claim forms with CPT codes. They were told not to worry about bundling edits, the complaint alleged, because Duke didn't want "to train its coders specific to the coding rules of each payer." Instead, Duke relied on its computer system to scrub codes to prevent the submission of inappropriate claims.

The second tier of coders reviewed "problematic" claims spit out by the scrubber, the complaint said, and the third tier reviewed claims denied by government payers. Then the second and third tier coders reviewed claims to determine if they should be changed and resubmitted. They allegedly had the latitude to change CPT codes or append modifiers in the hopes claims would be paid.

Sometimes the alleged trouble at Duke began with first-tier coders. "The first tier coders included CPT codes for surgical assistants when residents were present at surgeries," the complaint alleged. "Duke submitted and was paid for surgical assistant services performed by medical personnel, specifically physician assistants, when residents were present in violation of the applicable billing guidelines."

Assistants at surgery include surgeons, residents and nonphysician practitioners (e.g., physician assistants, nurse practitioners and clinical nurse specialists) who help the primary surgeon during the procedure. Generally, Medicare doesn't pay for the services of assistants at surgery at teaching hospitals that have a training program related to the medical specialty required for the surgical procedure and a qualified resident available to perform the service, according to Chapter 12 of the *Medicare Claims Processing Manual*. Medicare is already footing the bill for residents through graduate medical education (GME) payments to hospitals, so it seems redundant to pay NPPs to do a job residents are paid to do.

There Are Exceptions to the Rules

But there are exceptions. For example, teaching hospitals may use NPPs even when residents are available if there are "exceptional circumstances" (e.g., multiple traumatic injuries that require immediate treatment). And Medicare may pay for NPPs "if the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients. Generally, this exception is applied to community physicians who have no involvement in the hospital's GME program," the manual states.

In 2009, the complaint alleged, Duke's scrubber started to inappropriately send government payers claims for surgical assistants. Coders and coding auditors tipped off the compliance office at the faculty practice plan as well as management, but Duke didn't investigate, the complaint alleged. "Instead, Duke trusted that its system worked as designed, even in light of complaints from the auditor team. Because Duke failed to investigate the complaints, it billed government payors for physician assistants in violation of the government payor guidelines," the complaint alleged.

Interestingly, Medicare's allowed amount for assistants at surgery is only 16% of the surgeon's fee. And it's even less — 12% — when NPPs are used because they

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are billed at 85% of the physician's Medicare fee schedule rate, says Vermont-based consultant and certified coder Betsy Nicoletti. "But if you do anything, even that small, and you do it hundreds of times over many years, it can come to a lot of money," she says, although she has no direct knowledge of Duke's conduct and is not commenting on it.

Surgical assistants allegedly weren't the only problem. Duke got itself into hot water with modifier -59, which is appended to claims to bypass National Correct Coding Initiative (NCCI) edits that prevent providers from billing Medicare for two procedures performed on the same patient on the same day. It's OK to use modifier -59 when two procedures are performed at separate patient encounters or on different anatomic sites, but unless a procedure or service is "distinct or independent from other services performed on the same day," as the CPT manual puts it, modifier -59 should not be used.

The complaint alleged that, in some cases, Duke's second- and third-tier coders appended modifier -59 "to lesser-included claims to override Government Payor denials or to prevent a Government Payor from denying the claim, although the lesser-included service was not separate and distinct from the bundled claim." Specifically, Duke allegedly submitted claims that charged separately for cardiac services and peripheral vascular access procedures (CPT 36000) or IV push injection (CPT 96374). The codes for insertion of flow-directed catheters (CPT 93505) and insertion of central venous access lines (CPT 36556), which should be bundled, were billed separately. Also, CPT 36000, which is part and parcel of preparing patients for general anesthesia, was unbundled from some services, the complaint alleged.

The whistleblower raised her concerns about the alleged improper use of modifier -59 with management, "but Duke continued to use modifier -59 as an override code for the lesser-included claims," the complaint alleged.

Coder Savvy Can Backfire

Nicoletti says coder savvy can backfire. "Beware of the coder who knows how to get a claim paid," she says. "We want of course to get claims paid, but sometimes coders say 'just put modifier -59 or -25 on it' without understanding when they are permitted or not permitted to use them." Hospitals and physicians should keep modifier -59 "on the short list," Fitzgerald notes, because it is prone to error and faces audit scrutiny. Other high-risk modifiers include -24, -25 and -57, Nicoletti says.

What stands out about this case is the fact Duke had compliance fail-safes and was still investigated, says Fitzgerald, who wasn't involved in the case. "It's unclear from the complaint what the government got hot and bothered about and why this is a False Claims Act case," he says. "That's troubling because while DOJ says it doesn't sanction billing errors, nothing in the complaint tells us why this was something more than mistakes."

There are a few dynamics at work here. For one thing, establishing upfront compliance procedures are critical, but no moat around the hospital castle is impenetrable. "Once individual decisions are made by humans on a case-by-case basis, then you can have payment errors," he says. "The theory you will remove any possibility of mistakes from the billing process is foolish. People make mistakes." That's why hospitals establish auditing and monitoring procedures. "Part of the way you address human errors is to audit and then you avoid future mistakes through education," Fitzgerald says. "But if the process doesn't work perfectly, there is inherent risk."

Hospital compliance programs also are up against regulations and manual provisions that aren't always easy to follow, Fitzgerald says. "The government always tries to portray the rules as more black-and-white than they really are," he contends. Rules also may vary among

CMS Transmittals and *Federal Register* Regulations
March 21 – March 27

Live links to the following documents are included on *RMC*'s subscriber-only Web page at http://aishealth.com/newsletters/reportonmedicarecompliance. Please click on "CMS Transmittals and Regulations" in the right column.

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-02, Medicare Benefit Policy Manual

- Implementing the Part B Inpatient Payment Policies from CMS-1599-F, Trans. 182BP, CR 8666 (March 21; eff. Oct. 1, 2013; impl. April 21, 2014)

Pub. 100-04, Medicare Claims Processing Manual

- Health Professional Shortage Area Post-payment Review Process (R), Trans. 2914CP, CR 8608 (March 25; eff./impl. March 31, 2014)

Pub. 100-07, State Operations Manual

- Revised Appendix A, Interpretive Guidelines for Hospitals, Condition of Participation: Quality Assessment and Performance Improvement, Trans. 105SOMA (March 21; eff./impl. March 21, 2014)

Pub. 100-20, One-Time Notification

- Implementation of NACHA Operating Rules for Health Care Electronic Funds Transfers (R), Trans. 13610TN, CR 8629 (March 25; eff. July 1; impl. July 7, 2014)
- Rescind and Replace of CR 8409: Reclassification of Certain Durable Medical Equipment from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category (R), Trans. 13620TN, CR 8566 (March 25; eff. April 1; impl. April 7, 2014)

Federal Register Regulations

- None published.

commercial payers and Medicare Advantage, and it's hard to bill them all compliantly on the one hand and defend against the growing number of audits from all sides. For example, Fitzgerald says, "Medicare may not pay for an assistant at surgery if a resident is available, but other payers might."

An attorney who represented Duke in the settlement did not respond to *RMC*'s request for comment. However, Doug Stokke, vice president of marketing and communications for Duke Medicine, said in a statement that "Duke had no intent to submit inaccurate claims, and denies that it violated the False Claims Act. For settlement purposes only, we have agreed to pay back to the Medicare, Medicaid and TRICARE programs payments received over a six-year period for claims that resulted from an undetected software problem and through possible misapplication of certain technical billing requirements. We are pleased to have reached a settlement of the matters raised in the Amended Complaint, and note that at no point did any of the allegations involve questions about the quality of care provided to patients at DUHS facilities. DUHS has a robust corporate compliance program and is committed to the highest standards of ethics and integrity in all of our interactions with governmental healthcare programs."

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OIG: If Deal Feels Wrong, Don't Get Lost in the Stark, Kickback Weeds

Hospitals and their attorneys may be so deep in the weeds when analyzing financial relationships that they don't realize the fundamental flaws, said a top official from the HHS Office of Inspector General.

Sometimes there's a failure to see "the flashing yellow warning signs on the anti-kickback and Stark roads" because people get tunnel vision about whether compensation arrangements with physicians can be shoved into an exception to the Stark self-referral law or a safe harbor under the anti-kickback statute, Kevin Barry, senior counsel in the OIG Office of Counsel, said March 26 at the Institute on Medicare and Medicaid Payment Issues sponsored by the American Health Lawyers Association. "Before you do an analysis of whether they fit into a safe harbor or exception, [ask yourself], 'does the thing seems like a big deal?' In my experience, a big-picture analysis on the front end may save a whole lot of grief on the back end," he said. "The one thing we see a lot of is the failure to see things at the outset."

Barry also gave a heads-up about the "30-second rule." If a government official can summarize the problems with a financial arrangement in half a minute — including what happened and what's wrong with it — it's vulnerable to a false claims case or other enforcement action.

He cited examples of "snake-bit deals" that show up repeatedly in false claims settlements, self-disclosures and the OIG Medicare fraud reporting hotline at (800) 447-8477:

◆ ***Payments to referral sources for referral streams.*** The arrangements may look good on paper, but the hospital pays for no-show contracts or "make work" (e.g., medical directors earning money without doing anything). Or there may be multiple contracts with different physicians for certain tasks when one would suffice.

◆ ***Forgiving rent for sustained periods or paying above or below fair-market value.***

◆ ***Physician compensation formulas that credit physicians for their ancillaries and other designated health services they don't personally perform.*** That's part of what led to Halifax Hospital Medical Center's $85 million false claims settlement with the Department of Justice *(RMC 3/10/14, p. 1)*. "In general, it's not a good idea to pay doctors for DHS referrals they don't do," Barry said.

◆ ***Certain joint ventures, including joint ventures between physician groups or between a physician group and a hospital, "where it looks good — 50/50 — but on implementation that's not the way it works,"*** Barry said. If there is a "skewed cost allocation," where the hospital shoulders more of the joint-venture costs, the players are asking for trouble.

To file a False Claims Act case based on Stark or kickback liability or other alleged misdeeds, the Department of Justice doesn't necessarily have to prove Medicare claims were false on their face (e.g., services not performed), said Washington, D.C., attorney Laura Laemmle-Weidenfeld, who also spoke at the AHLA conference. The other "predicate" for false claims liability is for claims that "violated a separate statute, regulation or contractual term with which compliance was a condition of payments." In other words, the services were performed, but the "underlying violation" makes the claim false or fraudulent. That's the basis for false claims cases built on Stark and kickback violations, said Laemmle-Weidenfeld, a former DOJ trial attorney who is now with Patton Boggs.

She listed the hot spots for civil False Claims Act enforcement, including inpatient/outpatient hospital billing; devices; hospital-physician financial relationships; hospice care, especially patient medical eligibility; and individuals embroiled in alleged fraud cases. Although Medicare watchdogs tend to target the deeper pockets of organizations, "there is an increasing appreciation within

the government of the need to go after individuals as well as entities," Laemmle-Weidenfeld said.

Case in point: the U.S. Attorney for the District of Maryland on March 13 said an ophthalmologist settled a false claims case for $1.4 million and was excluded from Medicare for 20 years. John Arthur Kiely, M.D., of Lutherville, Md., allegedly submitted and caused the submission of false Medicare claims by Bon Secours Hospital in Baltimore "for laser eye procedures that fell outside the medical standard of care," the U.S. attorney says. They include argon laser trabeculoplasties performed from Oct. 29, 2002, to Sept. 11, 2007; lysis of adhesions performed between Oct. 29, 2002, and April 14, 2009; and laser peripheral iridotomies performed between Nov. 12, 2002, and Sept. 26, 2006. Kiely denies the allegations.

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Billing Under the Wrong Medicare Number or NPI Is a Sleeper Risk

Consumed by billing audits and medical necessity compliance, hospitals and physician groups may overlook the perils of billing Medicare for services under the wrong national provider identifier and Medicare number, which is linked to the NPI. Medicare pays for services provided by physicians only when they are billed under their own NPI, and CMS may revoke their privileges if providers use another clinician's billing number.

"Sometimes our fear of risk is based on whether it's a level two or level three evaluation and management visit, but we should be worried about whether we are using the correct NPI and whether we are using the *locum tenens* rules correctly," says Vermont consultant Betsy Nicoletti. In fact, one of the largest civil monetary penalty settlements with a hospital involved alleged misrepresentation of the provider of the service. University of North Texas Health Science Center paid $859,500 to settle allegations that it billed Medicare, Medicaid and TRICARE for services under the provider identification numbers of 103 physicians who didn't provide or supervise the service. Other physicians performed the services, but their enrollment applications were still pending so they lacked billing numbers *(RMC 8/1/11, p. 1)*.

Providers Are Now at Greater Risk

Providers are at greater risk because Medicare tightened up enrollment policy several years ago. Payers generally used to allow physicians to start accumulating charges for their services as soon as they sent in a complete enrollment form, although they couldn't actually drop the bills until they got provider numbers. The services were typically considered reimbursable from the time the enrollment form was filed and completed (and received by the payer, since it's usually electronic and therefore simultaneous), says San Francisco attorney Judy Waltz, who is with Foley & Lardner. In fact, Medicare at the time allowed providers to bill 27 months after the fact, Nicoletti says. But CMS cracked down with a 2009 CMS regulation, she says. "A practice may retroactively bill 30 days from either the date the physician began seeing patients or the date the enrollment application was received by the Medicare administrative contractor — whichever is later," she says (assuming the application is approved at all).

It's not hard to run afoul of the rules, Waltz and Nicoletti say. Sometimes physician services have been billed

Enforcement Actions by the HHS Office of Inspector General

Updated figures from the Medicare watchdog show billions of dollars in alleged overpayments and fraud identified and a steady drumbeat of exclusions from federal health care programs.

Recent OIG Statistics

OIG Mission – To protect the integrity of Department of Health & Human Services (HHS) programs, as well as the health and welfare of program beneficiaries.

OIG Action	FY09	FY10	FY11	FY12	FY13	Total
Criminal Actions	671	647	723	778	960	3,779
Civil Actions	394	378	382	367	472	1,993
Exclusions	2,556	3,340	2,662	3,131	3,214	14,903
HHS Investigative Receivables	$3.0 billion	$3.2 billion	$3.6 billion	$4.3 billion	$4.0 billion	$18.2 billion
Non-HHS Investigative Receivables	$1.0 billion	$576.9 million	$952.8 million	$1.7 billion	$1.03 billion	$5.2 billion
Total Investigative Receivables	$4.0 billion	$3.8 billion	$4.6 billion	$6.0 billion	$5.0 billion	$23.5 billion

SOURCE: HHS

under the billing number of the medical director when for some reason the actual provider of the service does not have a viable billing number. "Then it looks like the medical director did 100 services that day," Waltz says. "It will kick out on someone's radar screen, and then the medical director will have some explaining to do. It's possible the medical director will not even know that his or her number is being used."

Or practices bill *locum tenens* physicians — temps — under the NPIs of the physicians they replaced, Nicoletti says. *Locum tenens* rules allow a physician to bill for services provided by a substitute physician when the regular physician is unavailable, subject to limitations imposed by CMS, Waltz says. But there may be abuses. Some doctors may not fit the rules for *locum tenens* billing as their tenure is not expected to be temporary or they are not in fact a substitute for the regular physician who may never be expected to return, Waltz says.

If provider number shenanigans occur, hospitals and physician groups may have collected an overpayment that has to be returned to Medicare, Waltz says. And now, under Sec. 424.535(a)(7), CMS may revoke a provider's or supplier's Medicare billing privileges for misuse of a billing number, Waltz says. That includes when "the provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers who enter into a valid reassignment of benefits as specified in §424.80 or a change of ownership as outlined in §489.18 of this chapter."

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Congress Shuffles Hospital Cards

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"If the patient is a train wreck and in the hospital for 45 days and did not have an order, they clearly wouldn't be treated except as an inpatient," Hartstein said March 26 at the Institute on Medicare and Medicaid Payment Issues sponsored by the American Health Lawyers Association. "If there is no doubt the patient could be treated [as an inpatient], the lack of order should not preclude payment [under Part A]." Orders are one of the four components of the certifications required by the 2014 inpatient prospective payment system regulation and its two-midnight rule, which says CMS generally will assume admissions that cross two midnights are medically necessary unless they are delayed on purpose *(RMC 8/12/13, p. 1)*.

Although Hartstein conveyed flexibility, the IPPS regulation turned orders into a condition of Medicare payment, said Mark Polston, former CMS deputy associate general counsel for litigation. If hospitals bill Medicare for MS-DRGs despite missing or defective inpatient admission orders, they open themselves up to false claims lawsuits, says Polston, who is now with King & Spalding in Washington, D.C.

Hartstein also addressed co-signatures on admission orders, which must be written before the patient is discharged. Originally, CMS said residents, nonphysician practitioners (NPPs) and emergency-room physicians without admitting privileges could not write admission orders without first conferring with attending physicians. Then CMS backed off in Jan. 30 guidance, allowing

residents, NPPs and others to sign orders unilaterally as long as attending physicians authenticated them before discharge. "The ordering practitioner may allow these individuals to write inpatient admission orders on his or her behalf, if the ordering practitioner approves and accepts responsibility for the admission decision by counter-signing the order prior to discharge," CMS said *(RMC 2/10/14, p. 1)*.

Hartstein seemed to go a step further. He said that "no co-signature is necessary if the hospital gives admitting privileges to the resident or nurse practitioner." However, they can't complete certifications, which are the province of attending physicians. Certifications have four parts: admission orders, the expectation of a two-midnight stay, the reason for inpatient services and the plan for post-hospital care.

A Patient's Time in Hospital Is Key

CMS emphasizes that the time patients spend in the hospital is the determinant of Part A vs. Part B billing, assuming patients need hospital care and the services are medically necessary *(RMC 12/23/13, p. 1)*. So far, CMS is sticking to its guns, although it has recognized there are "rare and unusual circumstances" where patients who don't cross the magic threshold have "sufficient acuity" for an inpatient admission, Hartstein says. So far, CMS has recognized only one rare and unusual circumstance: mechanical ventilation initiated during the present visit. But there is a push for CMS to create a short-stay DRG for high-acuity patients who tend to consume a lot of resources. Hartstein, however, shrugged off the idea. Still, a bipartisan bill was recently introduced in the U.S. Senate to create a short-stay DRG *(RMC 3/10/14, p. 8)*.

As hospitals work through the two-midnight rule, their compliance will be evaluated for an additional year by the MAC probe-and-educate program, assuming the legislation is finalized, as expected. The MACs will continue to conduct prepayment audits of small samples of inpatient admissions (10 to 25 claims per hospital, and more if errors are identified). The probe-and-educate program is the main vehicle for assessing adherence to the two-midnight rule, although CMS recently told MACs to re-review the claims out of concern the two-midnight rule was misapplied *(RMC 3/3/14, p. 1)*.

Although some lawyers and compliance experts think the two-midnight rule brings simplicity, others think it burdens hospitals, and aren't bowled over by the new legislation. "This is a positive step for the hospital industry, but only a small one," Polston says. "Hospitals' experience thus far is that the two-midnight rule requires massive retraining and ultimately doesn't promote the clarity on inpatient admission that CMS promised." He thinks it would've been better to ditch the rule. However, keeping the RACs at bay is welcome, Polston says.

ICD-10 May Be Delayed Yet Again

The pending legislation also would give hospitals another year to comply with ICD-10. This is the third delay, says Julie Chicoine, senior assistant general counsel at Wexner Medical Center at the Ohio State University Medical Center in Columbus. The delay is unwelcome in some quarters.

"ICD-9 is based on 1970s medicine and patient population. I often hear physicians talk about the increasing time and effort it takes to manage today's average patient, who has more than one chronic co-comorbid condition. The granularity and detail in ICD-10 will show the payer a patient's complete level of health. ICD-10 will show the payer what the physician deals with in terms of chronic medical management and patient noncompliance," she says. "Such information will be key to physician compensation as the industry shifts from volume-based compensation to value-based compensation."

And of course hospitals and physicians have made a significant investment of time and money to prepare for ICD-10, says William Malm, senior data projects manager at Craneware and a physician assistant. "Additionally, a delay will not rectify the physicians' response as they attempt to continually delay in hopes of lack of enactment. We must remember that all ICD-10 work began in 1995, almost 20 years ago, and to be successful for the Affordable Care Act and population management, this is necessary."

The legislation would also extend the therapy cap exceptions process, which allows outpatient therapy providers, including hospitals, to exceed the Medicare therapy cap if it's medically necessary, subject to manual medical review *(RMC 3/17/14, p. 4)*. The extension would last through March 31, 2015.

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NEWS BRIEFS

◆ **Medicare compliance reviews are being expanded to home health agencies,** said Greg Demske, the chief counsel to the HHS Inspector General, at the Institute on Medicare and Medicaid Payment Issues in Baltimore March 26. So far, Medicare compliance reviews, which are comprehensive audits of multiple types of payment errors simultaneously, have targeted hospitals only.

◆ **Valley Heart Consultants in Texas and its physician owners agreed to pay $3.9 million to settle allegations they submitted false claims to Medicare for substandard and/or medically unnecessary nuclear stress tests from Jan. 1, 2004, to September 2010,** according to the U.S. Attorney's Office for the Southern District of Texas. Valley Heart Consultants and Carlos Mego, M.D., and Subbarao Yarra, M.D., also allegedly billed Medicare for some medically unnecessary coronary angiographies, echocardiograms and carotid doppler studies. "The United States also alleged that the nuclear medicine used in the tests was injected by personnel who lacked the requisite license," according to the U.S. attorney. The physicians, who denied liability and did not admit guilt in the settlement, entered into a three-year corporate integrity agreement with OIG. Two former employees of Valley Heart Consultants initiated the lawsuit as whistleblowers. Visit www.justice.gov/usao/txs.

◆ **In its first consolidated Medicare compliance review, OIG unveiled audit findings at three CHRISTUS Health System hospitals** — CHRISTUS Santa Rosa Hospital, CHRISTUS St. Frances Cabrini Hospital, and CHRISTUS Hospital–St. Elizabeth — in a report unveiled March 27. OIG says there were three types of errors: inpatient services that could have been provided in an outpatient setting, medical records without a signed and dated physician order, and MS-DRG codes not supported by the medical records. "As a result of these errors, the Hospitals received overpayments of $1,321,644," the report states. "Based on the results of the three separate samples, we estimated that the Hospitals received at least $3,326,589 in overpayments from Medicare." However, OIG says, the hospitals did not concede they made the errors and therefore didn't explain them. OIG still suggests the hospitals return the overpayments to Medicare and improve their controls to ensure Medicare compliance. View http://go.usa.gov/Kswk.

◆ **CMS submitted its most recent report to Congress on the recovery audit contractors (RACs).** The report covers RAC activities in Medicare and Medicaid in fiscal year 2012. Visit http://tinyurl.com/m9gtaas.

◆ **A new study indicates that most hospitals participating in the 340B discount drug program provided less charity care than the national average, says the Alliance for Integrity and Reform of 340B.** Even though the 340B program is open only to entities that serve vulnerable patient populations, a small number provide the bulk of charity care delivered by 340B hospitals, according to the study, which was conducted by Avalere Health. "Charity care in about a quarter of all 340B hospitals represents 1% or less of total patient costs," the study contends. Under federal law, drug manufacturers give drug discounts to about 3,200 organizations that are in the 340B program, including critical access hospitals, disproportionate share hospitals and sole community hospitals. Because the 340B program has been criticized for lax oversight and overly broad rules, participants face more audits and a slew of new regulations, which are expected to be issued in June *(RMC 3/17/14, p. 1)*. View http://tinyurl.com/mslzmxd.

◆ **A Long Island, N.Y., physician was arrested for allegedly billing Medicare for surgeries he never performed, the U.S. Attorney for the Eastern District of New York said March 25.** Syed Imran Ahmed, M.D., was charged with one count of health care fraud in federal court in Brooklyn and the feds moved to seize millions of dollars of his "alleged ill-gotten gains, including the contents of seven bank accounts," the feds alleged. They also are pursuing forfeiture of the physician's $4 million home in Muttontown, N.Y. The criminal complaint alleges Ahmed billed Medicare for procedures that patients said they never had or that lack corresponding hospital medical records. "From January 2011 through mid-December 2013, Medicare was billed at least $85 million for surgical procedures purportedly performed by Ahmed," the U.S. attorney's office said. Visit www.justice.gov.

◆ **University Hospitals Case Medical Center in Cleveland did not comply with Medicare rules for any of the 95 claims reviewed,** OIG says in the latest in a series of reports on kwashiorkor billing *(RMC 3/17/14, p. 1)*. Visit http://go.usa.gov/KswG.

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