Teaching Hospital Settles FCA Allegations Around Overlapping Neurosurgery, PA Use

Medical College of Wisconsin agreed to pay $840,000 to settle false claims allegations that two of its teaching physicians charged Medicare for performing more than one neurosurgery at the same time, the U.S. Attorney’s Office for the Eastern District of Wisconsin said on Jan. 9. The case underscores the cluster of risks associated with billing by teaching physicians in connection with residents, which can send Medicare reimbursement on a downward spiral to overpayment recoupment and in some instances potentially put patients in harm’s way.

The false claims lawsuit was initially filed by Ganesh Elangovan, M.D., a resident at Medical College of Wisconsin who became a whistleblower after he allegedly was put in the position of operating on patients without the presence of the teaching physician. Prosecutors eventually took over the case, and the settlement alleges they believe fraudulent Medicare claims were submitted for two neurosurgeons “in performing neurosurgeries that involved residents at Froedtert Memorial Lutheran Hospital,” according to the settlement. The alleged false claims, which were submitted from April 16, 2006, to March 31, 2013, violated Medicare and TRICARE teaching physician billing rules, the settlement states. Medical College of Wisconsin, a Milwaukee-based academic medical center, employs its teaching physicians and is affiliated with several hospitals, including Froedtert Memorial.

ASC Terminated from Medicare, Medicaid For Deficiencies in Conditions of Coverage

CMS says it has thrown an ambulatory surgery center out of Medicare for not complying with some of the conditions for coverage even after it got a second chance. Yorkville Endoscopy, LLC, the Manhattan ASC where comedienne Joan Rivers suffered cardiac arrest, will no longer be able to bill Medicare or Medicaid for services provided to patients starting Jan. 31.

CMS “has determined that Yorkville Endoscopy LLC no longer meets the Conditions for Coverage for a supplier of Ambulatory Surgical Services,” Associate Regional Director J. William Roberson wrote in a Jan. 9 letter. The ASC may appeal the decision to an administrative law judge, he noted.

Generally, when there’s a will, there’s a way to prevent the devastating consequence of Medicare and Medicaid termination, says an attorney who has worked on similar actions proposed by CMS but is not involved in this matter. “It usually doesn’t get to this stage,” she says. “Usually if there are deficiencies, the entity does a plan of correction, which is accepted or tweaked by CMS. Then there is a follow-up survey demonstrating the facility is in substantial compliance with the conditions and the plan of correction, and everyone moves on. This termination action is out of the ordinary.” If providers find themselves in this unfortunate position, she recommends they...
The state identified a number of deficiencies during the initial survey at Yorkville Endoscopy, CMS says. It sent the ASC a statement of deficiencies — the dreaded 2567 form — that means it’s on the verge of termination but can salvage its Medicare participation with a “plan of correction.” In response, the ASC submitted the plan of correction, “which was determined to be acceptable by CMS on Dec. 15,” a CMS spokeswoman says. In essence, by that acceptance, CMS found that the plan of correction, if implemented as proposed, would result in the ASC being in substantial compliance with the conditions for coverage, the lawyer explains. However, a three-day follow-up survey in December concluded otherwise.

“Based on the findings of the survey completed on December 17, 18 and 19, 2014, Yorkville Endoscopy no longer meets the requirements for participation as a supplier of services in the Medicare program. Accordingly, CMS has determined that the Medicare Agreement between Yorkville Endoscopy and the Secretary will be terminated on January 31, 2015, which means that the facility will no longer be eligible to receive federal funds for services provided to Medicare and Medicaid beneficiaries,” the spokeswoman says.

### Four Areas of Deficiencies Cited by CMS

According to the CMS letter, there are deficiencies in four areas: governing body and management; surgical services; quality assessment and performance improvement; and environment.

On the CMS statement of deficiencies, surveyors contend that Yorkville Endoscopy did not satisfy the conditions for coverage requiring it to provide surgical services in a “safe manner by qualified physicians who have been granted clinical privileges by the governing body of the ASC in accordance with approved policies and procedures of the ASC.” For example, in a Dec. 17 interview, a staff nurse said nurses are partly responsible for completing the pre-discharge anesthesia evaluation form. “Nurses would document a patient’s mental status, vital signs, ambulation status, presence of nausea, pain assessment, and the severity of bleeding, and would indicate if the patient has met discharge criteria. She also stated the anesthesiologist would sign off on this form after evaluating the procedure,” CMS contends. This practice disregards the anesthesiologist who would sign off on this form after evaluating the patient.”

Yorkville Endoscopy also failed to assess the effectiveness of its quality assurance program, including the collection, analysis, and reporting of data, CMS says. For example, “Review of the facility’s Quality Assessment and Performance Improvement (QAPI) Committee meeting minutes dated March 17, 2014, and September 24, 2014, showed no data was collected or analyzed. There

---


Copyright © 2015 by Atlantic Information Services, Inc. All rights reserved. On an occasional basis, it is okay to copy, fax or email an article or two from RMC. But unless you have AIS’s permission, it violates federal law to make copies of, fax or email an entire issue, share your AISHealth.com subscriber password, or post newsletter content on any website or network. To obtain our quick permission to transmit or make a few copies, or post a few stories of RMC at no charge, please contact Eric Reckner (800-521-4323, ext. 3042, or erreckner@aishealth.com). Contact Bailey Streets (800-521-4323, ext. 3034, or bstreet@aishealth.com) if you’d like to review our very reasonable rates for bulk or site licenses that will permit weekly redistributions of entire issues. Contact Customer Service at 800-521-4323 or customerserv@aishealth.com.

Report on Medicare Compliance is published with the understanding that the publisher is not engaged in rendering legal, accounting or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought.

Managing Editor, Nina Youngstrom; Contributing Editor, Francie Femald; Executive Editor, Jill Brown; Publisher, Richard Biehl; Managing Editor, Nina Youngstrom; Contributing Editor, Francie Femald; Executive Editor, Jill Brown; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Tracey Filar Atwood; Production Editor, Carrie Epps.

Subscriptions to RMC include free electronic delivery in addition to the print copy, e-Alerts when timely news breaks, and extensive subscriber-only services at www.AISHealth.com that include a searchable database of RMC content and archives of past issues.

To order an annual subscription to Report on Medicare Compliance ($728 bill me; $628 prepaid), call 800-521- 4323 (major credit cards accepted) or order online at www.AISHealth.com.

Subscribers to RMC can receive 12 Continuing Education Credits per year, toward certification by the Compliance Certification Board. Contact CCB at 888-580-8373.

---

EDITORS ADVISORY BOARD: JEFFREY FITZGERALD, Polsinelli Shughart, EDWARD GAINES, Esq., Zotec-MMP, DEBI HINSON, Chief Research and Privacy Compliance Officer, Catholic Health Partners in Cincinnati, OH; MARION KRUSE, FPI Healthcare, RICHARD KUSSEROW, President, Strategic Management Systems, Alexandria, VA; WALTER METZ, CPA, MS, JD, Brookhaven Memorial Hospital Medical Center, MARK PASTIN, PhD, Council of Ethical Organizations, CHERYL RICE, Corporate Responsibility Officer for Catholic Health Partners in Cincinnati, OH; ANDREW RUSKIN, Esq., Morgan, Lewis & Bockius LLP; BOB WADE, Esq., Krieg DeVault, D. McCARTY THORNTON, Esq., Sonnenschein Nath & Rosenthal, JULIE E. CHICOINE, JD, RN, CPC, Compliance Director, Ohio State University Medical Center, WENDY TROUT, CPA, Director Corporate Compliance, WelfSpan Health, AMI ZUMKHAWALA-COOK, Chief Compliance Officer for Holy Spirit Health System
was no documented quality assurance data or analysis to monitor performance and effectiveness of the Ambulatory Surgery Center’s (ASC’s) services. Specifically, reports from the monitoring logs, Infection Control, Patient Satisfaction Surveys, Incident Reports, Medical Record Audits, Pharmacy, and Nursing Services showed no documented data collection and or analysis. The facility did not follow its QAPI plan.”

To move forward with a termination, CMS generally must be convinced that the ASC will not be able to sustain substantial compliance with the conditions for coverage, the lawyer says. She maintains that the progress of each case will depend upon the underlying circumstances. “Sometimes, there is still room to alter CMS’s view with some additional information and discussions. My first effort would be to get one more survey and get it right, to CMS’s satisfaction,” she says. Even when the situation seems dire, CMS also may be open to settling an appeal before the formality of an ALJ hearing at the Departmental Appeals Board. She says that the appeal process is costly to pursue for both the ASC and the government, and the process can take a period of time in which the facility is not paid. “In addition, CMS has an excellent track record winning its appeals. At the end of the day, there’s a lot of deference to their judgment. It’s like beauty is in the eye of the beholder.”

ASC Says It Has Low Hospital Transfer Rate

In a statement posted on its website in November in response to CMS’s first findings of noncompliance with the conditions of coverage, Yorkville Endoscopy said: “From the outset of the August 28th incident described in the CMS Report, Yorkville has been fully cooperative and collaborative with all regulatory and accreditation agencies. In response to the statement of deficiencies, Yorkville immediately submitted and implemented a plan of correction that addressed all issues raised. The regulatory agencies are currently reviewing the corrective plan of action and have been in regular contact with Yorkville. In addition, the physicians involved in the direct care and treatment referenced in the report no longer practice or provide services at Yorkville. The staff and providers are focused on providing the highest quality and most advanced care possible to its patients.” The ASC notes “its hospital transfer rate is 1/4,000, four times better than the national average.”

Yorkville Endoscopy did not respond to RMC’s request for comment. A company official told The New York Times it will appeal the Medicare termination.

State survey agencies that survey providers and suppliers on behalf of CMS follow procedures in Chapter Three of the state operations manual at http://tinyurl.com/pq6h8kw. Information about the enforcement process is available at http://tinyurl.com/lq2gegte. The appeal process for Medicare terminations is described at http://tinyurl.com/o2vnj6t.

IRS Final Rule on Charity Care Raises Concerns About Inducements

To preserve their tax exemptions, nonprofit hospitals have to implement or update charity care policies, according to a final regulation published by the IRS and Treasury Department on Dec. 31. While the final regulation goes easier on hospitals than the proposed version, it creates uncertainty in areas where it intersects with Medicare, an attorney says.

The regulation interprets Sec. 501(r) of the Affordable Care Act, which requires nonprofit hospitals to have a well-publicized “financial assistance policy” (FAP) for emergency and medically necessary care and to limit charges to what insurers generally pay. The goal is to avoid having uninsured patients at the mercy of the sometimes exorbitant prices listed on hospital chargemasters, which means they typically pay more than patients covered by Medicare, Medicaid and private insurers. Hospitals also must do their best to qualify patients for the FAP before engaging in “extraordinary collection actions.” And every three years, tax-exempt hospitals will have to perform a community needs assessment to identify and prioritize the community’s health care needs. If hospitals fail to comply with the rule, they could lose their tax exemptions, although they are permitted to remedy minor omissions and violations.

The IRS initially spelled out these provisions in two proposed regulations — on June 22, 2012, and April 5, 2013 — but they were finalized together in the Federal Register, and are now in effect. “Although IRS relaxed some of their standards from the proposed rules, providers still need to be aware there are logistical hurdles to remain in compliance with Medicare and IRS rules,” says Washington, D.C., attorney Andy Ruskin, who is with Morgan Lewis.

continued

Report on Patient Privacy

The Industry’s #1 Source of News and Strategies on HIPAA Compliance

Go to the “Marketplace” at www.AISHealth.com and click on “newsletters” for details and samples.

Call Bailey Sterrett at 202-775-9008, ext. 3034 for rates on bulk subscriptions or site licenses, electronic delivery to multiple readers, and customized feeds of selective news and data...daily, weekly or whenever you need it.
The FAP is, essentially, a charity care policy, which many hospitals already have. If they don’t, they need to get an FAP, and if they do, they have to conform it to the new IRS rule. The proposed rules required hospitals to have written FAPs that include “eligibility criteria for financial assistance and whether such assistance includes free or discounted care.” The final rules lighten up a little, and “only require the FAP to describe discounts ‘available under the FAP’ rather than all discounts offered by the hospital facility.”

Hospitals must widely publicize the FAP in their community. The policies have to be posted on their websites with paper versions made available free, if requested. However, the final rule eases up the notification requirement somewhat. While the proposed rule required billing statements to include the entire FAP, the final regulations say they “require only that a hospital facility’s billing statement include a conspicuous written notice that notifies and informs the recipient about the availability of financial assistance under the hospital facility’s FAP and includes the telephone number of the hospital facility office or department that can provide information about the FAP. . . .”

Also, instead of requiring hospitals to present the policy during the visit, they have to offer it to patients between intake and discharge. Many patients know they are not eligible and won’t be interested, so hospitals won’t have to waste their breath.

Although the final rule doesn’t require hospitals to shout out their FAPs from the rooftops, they still must be widely publicized, and that could spell trouble under the fraud-and-abuse statutes. Ruskin says. Waiving copays and deductibles violates the anti-kickback law and providers may face civil monetary penalties from the HHS Office of Inspector General, unless the waivers are not routine and not advertised, he says.

“The requirements are you have to widely publicize the FAP, and there’s zero reference to OIG standards to the contrary,” he says. “OIG says you can’t widely publicize. It results in exposure under the beneficiary inducement statute, and the IRS and Treasury Department don’t answer questions about how you balance those two laws.” The only comfort zone for hospitals is the fact that the regulation now says it’s good enough to inform patients of the FAP at discharge, focusing on patients who may need it rather than blanketeting everyone, Ruskin says. And while hospitals have to put it on their websites, Ruskin says, “hospitals can mitigate risk by not using the website to proclaim, ‘hey everyone, come to us because we have a great FAP.’ It shouldn’t be a distinguisher,” he says, which OIG could perceive as an illegal beneficiary inducement with the potential to influence the choice of provider. But Ruskin is disturbed that the IRS/Treasury Department rule set forth FAP requirements with indifference to Medicare beneficiary inducement restrictions. “You are not going to get a free pass any longer unless you are a for-profit hospital that doesn’t have to concern itself with the IRS rules,” he warns. “You are now between a rock and a hard place. IRS people do IRS stuff and people tasked with responding to this are not people who advise on fraud-and-abuse issues.”

There Are Limits on Charges for FAP Patients

When patients qualify for the FAP, there are limits on how much they can be charged for emergency and medically necessary care, the regulation states. Hospitals can’t charge FAP patients more than the “amount generally billed” (AGB) to patients with insurance. In the proposed regulation, the IRS gave hospitals two mutually exclusive options for calculating the AGB:

1. The retrospective method is “based on actual past claims paid to the hospital facility by either Medicare fee-for-service only or Medicare fee-for-service together with all private health insurers paying claims to the hospital facility,” including the money the patient chipped in.

2. The prospective method requires the hospital to estimate the amount it would get paid for the FAP patient if he or she were a Medicare fee-for-service beneficiary.

The final rule generally stuck with these formulas, but gives hospitals more options for implementing them.
What’s new is the IRS allowing hospitals to include all charges in the calculation — not just charges for emergency and medically necessary care — and to either base the calculations on Medicare alone, Medicare and Medicaid only, or Medicare, Medicaid and all commercial payers, Ruskin says. And hospitals can consider all allowable charges, not just paid charges. “There is flexibility,” he says, noting this process can now look much more similar to the cost-report submission process, “meaning the need for arduous, parallel processes may be less necessary.”

And hospitals aren’t stuck with one method forever. The final regulation says they can change the way they calculate the AGB anytime, as long as they update the FAP to explain their plans to change their method before doing it.

But there’s a wrinkle, Ruskin says. Hospitals have only 120 days to come up with AGB calculations for uninsured and indigent patients, a month less than the five months they have to submit their cost reports from the beginning of the year. “It will be tricky from a compliance perspective because cost-report staff typically work all the way up to that last day before the deadline,” Ruskin says.

**Bad Debt Rules Can Create Complexities**

Another compliance challenge is the disparity between bad debt and the time hospitals must allow patients to apply for discounts under the FAP. The final rule still gives patients 240 days to activate the FAP, but Medicare requires hospitals to try to collect payment only for 120 days before they can report it as bad debt and write off the charges on their cost report, Ruskin says. “That’s kind of strange,” he says. “They could have made the two standards more similar. It calls into question whether nonprofit hospitals have to extend it out before they write off bad debt. That’s now an open question.”

The final rule reflects comments from stakeholders on all sides, including the American Hospital Association and groups like Community Catalyst, which advocates for the underserved, says Washington, D.C., attorney T.J. Sullivan, former special assistant to the IRS assistant commissioner for employee plans and exempt organizations. “So I think you have a balanced perspective in these regulations,” he says. While the IRS and Treasury Department generally eased some of the administrative burdens on hospitals, there are a handful of more stringent requirements, says Sullivan, who is with Drinker Biddle. For example, the proposed rule required nonprofit hospitals to translate FAPs into another language if people in the community with limited-English proficiency (LEP) made up more than 10% of the residents. The final rule mandates FAP translations “in the language spoken by each LEP language group that constitutes the lesser of 1,000 individuals or 5 percent of the community served by the hospital facility or the population likely to be affected or encountered by the hospital facility.” The reason for the change, which the final rule says may require more translations, is to conform it to an existing HHS mandate. “It’s probably a good thing,” Sullivan says. “It shows coordination between IRS and HHS.”

Contact Ruskin at aruskin@morganlewis.com and Sullivan at tj.sullivan@dbr.com. View the final rule at http://tinyurl.com/o3h5mal.

**Walgreens: Is an Employer Liable for An Employee’s HIPAA Violations?**

When the Indiana Court of Appeals released its decision in mid-November upholding the $1.44 million jury verdict against Walgreens for privacy violations by an employee pharmacist, the press and blogosphere started buzzing about the precedent it was setting — an employer could be held liable for the HIPAA violations of an employee. This was the view espoused by the plaintiff’s attorney, Neal F. Eggeson, in a statement he made to The Indianapolis Star.

The plaintiff, Abigail Hinchy, had sued Walgreens and its pharmacist, Audra Withers, for viewing her prescription records without authorization and then disclosing the information to her husband, who was a former boyfriend of Hinchy’s and the father of her child, and threatened to use the information in a paternity lawsuit. After contacting the company, Walgreens acknowledged the HIPAA violation to Hinchy and said that it had given Withers a written warning and required her to retake a HIPAA computer training program.

Hinchy sued both Walgreens and the pharmacist. In her complaint, Hinchy alleged negligence and professional malpractice, invasion of privacy and public disclosure of private facts, and invasion of privacy/intrusion against Withers. She alleged the same causes of action against Walgreens, citing the theory of “respondeat superior,” under which an employer is held responsible for the actions of employees performed within the scope of their employment. Walgreens argued that an employer should not be held liable for acts of an employee who knowingly violated company policy, in this case, HIPAA policies and procedures.

In its decision, the court of appeals cited a number of Indiana cases to explain the concept of respondeat superior. In particular, it focused on when an employee is “acting within the scope of employment when performing work assigned by the employer or engaging in a course of conduct subject to the employer’s control.” After reviewing the case law, the court concluded that
“Withers’s actions were of the same general nature as those authorized, or incident to the actions that were authorized, by Walgreens...Hinchy belonged to the same general category of individuals to whom Withers owed a duty of privacy protection by virtue of her employment as a pharmacist.”

The court also explained that for respondeat superior liability to attach “there must also be underlying liability of the acting party,” in this case, Withers. Hinchy sued Withers on two theories of direct liability — professional malpractice and public disclosure of private facts. The court did not express an opinion on whether Indiana recognized the tort of public disclosure of private facts, which could encompass a HIPAA violation, because Walgreens had not appealed the trial court’s denial of summary judgment on the claim of privacy invasion. Instead, it considered whether Withers committed “the tort of negligence by virtue of professional malpractice of a pharmacist.” It found that under Indiana law, Withers had a duty of confidentiality to Hinchy and that she had breached that duty when she examined Hinchy’s prescription records without authorization and subsequently disclosed the information. “Under these circumstances,” the court said, “we find that the jury verdict can be affirmed based upon the respondeat superior liability of Walgreens, which attaches via the liability of Withers for her negligence/professional malpractice.”

**Employer Liability for Employees Is Not New**

According to Jeff Drummond, a partner in the Dallas office of Jackson Walker LLP, employer liability for employee actions when acting within the scope of employment has been around forever, and to conclude that the appeal confirmed that privacy breach victims may hold employers responsible is an “overreach.” The issue in the Walgreens case was whether the employee was acting in the scope of her employment when she breached HIPAA and violated company policy. In this case, the jury decided that the employee was, and the appellate court declined to overturn that decision. But, according to Drummond, “in this particular case, the appellate court gave too much credence to the fact that the employee’s wrongdoing (looking at medical records she shouldn’t have looked at) was very similar to activities the employee would take in the performance of her legitimate duties (looking at medical records she should look at); if that’s the case, a waiter stealing a customer’s credit card number would be attributable to the restaurant owner, which doesn’t seem fair.”

Walgreens also argued that the $1.44 million jury verdict was excessive and based on improper factors. The court cited evidence admitted at trial regarding the damages and dismissed Walgreens’ arguments because they amounted to a request to reweigh the evidence, which, the court said, it does not do when evaluating a damages award. It found the evidence presented sufficient to support the award.

Privacy attorney Adam Greene of the law firm of Davis Wright Tremaine points out, “Even if a plaintiff can demonstrate a violation of HIPAA, a challenge has been showing damages. What remains to be seen is whether the $1.4 million verdict in the Walgreens case leads to similar findings of harm in other state cases, or whether this was a particularly unique fact pattern.”

Drummond points out that “while the pharmacist definitely ‘used’ PHI improperly by accessing PHI she should not have accessed, the plaintiff’s damages came not from that use, but from a further ‘disclosure’ of the data” to Withers’ husband, the father of Hinchy’s child. While the pharmacist’s improper use of the PHI closely tracked the pharmacist’s proper uses of PHI, any disclosure (which would be required for the damages to occur) would not be within the pharmacist’s normal employment activities and might provide a good argument that the actions of the pharmacist were outside the scope of employment.”

Walgreens plans to appeal the court of appeal’s decision.

**What Is the Impact on Other State Cases?**

So how much impact will this decision have on other state cases alleging privacy violations using HIPAA as the standard of care? Are employers now more likely to be held liable for employees who violate HIPAA while on the job?

According to Drummond, “I don’t think there were too many plaintiffs sitting on the sidelines, not making legitimate state-law claims because they know there’s no private cause of action under HIPAA. I’ve thought all along that, while clearly you can’t sue for a HIPAA violation, you could still sue for a state law violation. These cases may make plaintiffs’ lawyers more interested in bringing marginal cases, where there’s no clear state law allowing a breach of confidentiality claim. But where there’s a clear state law right to sue, I don’t think HIPAA’s ‘no private cause of action’ standard has been much of an impediment,” even before the Walgreens case.

Covered entities, Drummond says, should “have strong, consistent, and enforced policies and procedures. Draft clear data use and disclosure rules and information pathways, and constantly remind your employees of their duties and obligations. Regularly audit your employees and their data access/use/disclosure activities, and encourage your employees to keep tabs on each other (to positively reinforce data rules, but also to report suspicious activities). Promptly correct errors and mis-
teaches, and punish employees who willfully or carelessly violate policies and procedures. Covered entity employers must take visible steps to place HIPAA-violating activities outside the ‘scope of duties’ of their employees in any way they can.”

The case is Walgreen Co. v. Hinchy, No. 49A02-1311-CT-950 (Ind. Ct. of Appeals, Nov. 14, 2014).

Contact Drummond at jdrummond@jw.com and Greene at AdamGreene@dwt.com. ✧

This article was reprinted from the December issue of AIS’s Report on Patient Privacy. For more information, please visit the Marketplace at www.AISHealth.com and click on “Newsletters.”

Teaching Hospital Settles for $840k
continued from p. 1

The complaint invokes the risks first raised in the national Physicians at Teaching Hospitals (PATH) audits more than 15 years ago, but goes beyond with the overlapping surgery issue. “While the main wave of enforcement activity was in the late 1990s, the rules are still in place and are enforced,” says Nina Tarnuzzer, assistant dean of physician billing compliance at the University of Florida in Gainesville, who wasn’t involved in the case.

At its core, the Medicare teaching physician billing rule allows separate billing only if the teaching physician personally performs the service or is physically present for at least the key portions of the service and immediately available when the resident performs the service. In the surgery arena, Medicare pays for overlapping surgeries by the same surgeon, with the residents pitching in, but the practice is governed by strict Medicare regulations designed to protect patient safety (RMC 6/20/11, p. 1).

The surgeon must be in the operating room for the “key and critical portions” of two concurrent surgeries, and personally document his or her presence. Surgeons define the “key portions” for each type of procedure, which may differ by the surgeon or surgery. What matters is the key portion of the surgery in Room A can’t take place at the same time as the key portion of the surgery in Room B, and a third overlapping procedure is not permitted. The surgeon also must be immediately available in case something goes wrong or arrange for a back-up surgeon.

PATH Rules Create a ‘Bright Line’

“The rules governing Medicare billing for teaching physicians set forth a bright line rule, in plain and unmistakable language: a single teaching physician cannot be responsible for two simultaneous surgeries,” the complaint states. It alleges Medical College of Wisconsin violated these rules by scheduling two neurosurgery patients at the same time and billing Medicare and TRICARE as if teaching physicians performed the surgeries and were immediately available during them. “This money grab put patients’ lives at risks,” the complaint alleged.

The resident-turned-whistleblower found himself in the middle of the alleged misconduct, the complaint says. “[Elangovan] personally witnessed the routine occurrence of simultaneous surgeries and was forced to participate in the fraud — frequently performing one of those surgeries without any back-up,” the complaint alleged. He also cited 10 examples of two surgeries scheduled simultaneously by neurosurgeons who were named in the complaint, but are not part of the settlement.

Sometimes, if the surgery was scheduled to start but the neurosurgeon hadn’t arrived at the hospital yet, or was in another surgery, he allegedly told Elangovan to go it alone. If Elangovan had a question or problem, he had no recourse except to page the neurosurgeon, “often leading to substantial delays,” the complaint alleged.

The neurosurgeons then billed Medicare for the procedures, even though they allegedly weren’t there for the key and critical portions, the complaint contends. Two hospitals that are part of Medical College of Wisconsin billed the facility fee for the procedures as well, the complaint alleged, and residents were expected to play ball. “All of the residents were trained to include in their operative reports a statement that the teaching physician was present for all key and critical parts of the surgery and otherwise immediately available throughout the surgery. Indeed, in the event that the operative report did not expressly state the ‘key and critical’ and ‘immediately available’ magic language, a billing specialist who prepares bills for the College and/or [Medical College of Wisconsin Affiliated Hospitals] would send an email to the resident demanding that the language be added,” the complaint alleged.

Residents Were Available but PAs Were Used

Medical College of Wisconsin also allegedly used physician assistants to assist with surgeries even when residents were available, which is a violation of Medicare rules, according to the complaint. There’s no separate reimbursement for physician assistants when residents are around because Medicare already pays teaching hospitals for training residents through direct and indirect graduate medical education. But if teaching physicians certify that a qualified resident is not available, they may use PAs and bill Medicare separately for their services. On most days, there were more residents at Medical College of Wisconsin than there were surgeries to assist, but PAs were used anyway, the complaint alleged. Not only did that waste Medicare money, it undermined “the educational experience of the residents,” the complaint contended.

continued
Elangovan alleged he raised concerns to his superiors about the conduct detailed in the complaint, around May 2009 and again twice about a year later. He was terminated in July 2010, the complaint alleged.

Part of what makes teaching physician billing a risk area is that Medicare reimbursement is all or nothing, Tarnuzzer says. If the teaching physician isn’t physically present for the key and critical portion of the procedure or it wasn’t documented, “you don’t bill,” she says. Many institutions promote compliance by adding a documentation block in their electronic health records. It prompts the teaching physicians to chart their physical presence at the key and critical portions of the service, but must be specific to the episode of care and not pre-populated, Tarnuzzer notes.

Residents are aware of the teaching physician billing rule; “they are smart and are observers of behavior,” Tarnuzzer says. But the key and critical portions are “a matter of the medical judgment of the attending physician,” she says. And the residents’ skill sets evolve as they progress through their training, and surgeons are able to cede more of the surgery to residents.

A spokesperson for Medical College of Wisconsin did not respond to RMC’s request for comment.

Contact Tarnuzzer at nwt@ufl.edu. Read the press release at http://tinyurl.com/ojxesuj.

---

**NEWS BRIEFS**

**◆ CMS said Jan. 14 that work by its new national recovery audit contractor (RAC), which will audit claims for home health, hospice and durable medical equipment, prosthetic and orthotic supplies, has been delayed because of a protest to the Dec. 30 award.** Performant, an existing RAC, filed a post-award protest with the Government Accountability Office (GAO), objecting to CMS’s selection of Connolly, LLC as the new Region 5 RAC. This is the latest setback in CMS’s efforts to get the second five-year round of the RAC program under way. CMS is in a court battle with another RAC, CGI Federal, over the terms of the future RAC contracts, so the contracts of the incumbent RACs have been extended through Dec. 31, 2015, but only for limited reviews (RMC 1/12/15, p. 1). “I would be very surprised if Performant prevailed,” Emily Evans, a partner in Obsidian Research in Nashville, said at a RACmonitor.com webcast. Visit http://tinyurl.com/mcgzo3.

**◆ An analysis of all Medicare hospice claims from 2007 to 2012 found that payments for hospice services provided in assisted living facilities (ALFs) doubled, reaching $2.1 billion, according to the HHS Office of Inspector General.** In a new report, OIG said that hospices got much higher Medicare payments for hospice patients in ALFs compared to other settings and provided care for longer periods, even though hospice patients in ALFs “often had diagnoses that usually require less complex care.” In fact, hospices usually visited ALF patients for fewer than five hours a week. And for-profit hospices got much higher Medicare payments per patient than nonprofits, OIG found. “This report raises concerns about the financial incentives created by the current payment system and the potential for hospices to target beneficiaries in ALFs because they may offer the hospices the greatest financial gain,” OIG said. The Affordable Care Act requires reform of the hospice payment system. Visit http://go.usa.gov/zEM3.

**◆ CMS overpaid hospital outpatient clinics $4.6 million in 2012 for new patients who were actually established patients, the HHS Office of Inspector General said in a new audit report.** Until 2014, Medicare paid hospitals more for evaluation and management visits to clinics when patients were new instead of established, which is defined as a registered hospital inpatient or outpatient within the previous three years. For its audit, OIG randomly sampled 110 line items for outpatient clinic visits (HCPCS codes 99203 to 99205). For 72 line items, hospitals used the new patient HCPCS codes incorrectly; for 21 line items, hospitals billed the wrong level of service. OIG suggests CMS recover the overpayments. Visit http://go.usa.gov/z8vA.

**◆ Pharmaceutical company Daiichi Sankyo Inc. agreed to pay $39 million to settle false claims allegations in connection with kickbacks it paid to physicians to prescribe some of its drugs, the Department of Justice said Jan. 9.** Daiichi Sankyo, which has its U.S. headquarters in New Jersey, allegedly paid kickbacks to encourage physicians to prescribe Azor, Benicar, Tribenzor and Welchol, among other meds, DOJ contends. The alleged kickbacks were paid as speaker fees through Daiichi’s “Physician Organization and Discussion Programs,” which operated from Jan. 1, 2005, to March 31, 2011, and other speaker programs than ran from Jan. 1, 2004, to Feb. 4, 2011, according to DOJ. Visit http://tinyurl.com/1vqo5s.

---

Call Bailey Sterrett at 202-775-9008, ext. 3034 for rates on bulk subscriptions or site licenses, electronic delivery to multiple readers, and customized feeds of selective news and data...daily, weekly or whenever you need it.
If You Don’t Already Subscribe to the Newsletter, Here Are Three Easy Ways to Sign Up:

1. Return to any Web page that linked you to this issue

2. Go to the MarketPlace at www.AISHealth.com and click on “Newsletters.”

3. Call Customer Service at 800-521-4323

If you are a subscriber and want to provide regular access to the newsletter — and other subscriber-only resources at AISHealth.com — to others in your organization:

Call Customer Service at 800-521-4323 to discuss AIS’s very reasonable rates for your on-site distribution of each issue. (Please don’t forward these PDF editions without prior authorization from AIS, since strict copyright restrictions apply.)