In MD’s Plea, Feds Allege Link Between Medically Unnecessary Surgery and PODs

Medically unnecessary surgery and physician-owned distributorships (PODs) intersect in the May 22 health fraud conviction of a Michigan neurosurgeon. Aria Sabit, M.D., pleaded guilty and faces 108 to 135 months in prison in connection with his Medicare claims for spinal fusion that patients didn’t need or that were performed without the medical device that’s the backbone of the procedure, the Department of Justice said. Medicare, Medicaid and commercial insurers allegedly were cheated out of $11 million.

Sabit pleaded guilty to four counts of health care fraud, one count of conspiracy to commit health care fraud and one count of unlawful distribution of a controlled substance in the U.S. District Court for the Eastern District of Michigan, the Justice Department said. His sentencing is scheduled for Sept. 15.

Whether the case is more about one bad apple or the dangers of PODs is a matter of debate. Sabit’s plea agreement contends the ball got rolling on this “conspiracy” to perform medically unnecessary surgery when he was seduced by POD incentives. PODs sell medical devices to hospitals and ambulatory surgical centers, where they are often implanted by the surgeons who own the PODs, a situation the HHS Office of Inspector General called “inherently suspect” in a 2013 special fraud alert (RMC 4/8/13, p. 3). In fact, Sabit is embroiled in the first FCA lawsuit against a POD, which was filed in 2014 by the Department of Justice against Reliance Medical Systems, a spinal implant company, as well as two Reliance PODs — Apex Medical Technologies and Kronos Spinal Technologies — and their owners. The lawsuit alleges they paid physicians, including continued on p. 6

Hospitals Have More Angles Than Expected For Appeals; Use Medical-Necessity Map

Never say never when it comes to appealing certain denials of Medicare and commercial-payer claims because there is usually some room to maneuver, one expert says. But hospitals have to make a compelling case for why their claims should be paid, telling the patient’s story and supporting it with medical-necessity documentation and regulatory arguments.

“There’s always an exception to the rule and always a way to argue it,” says Denise Wilson, assistant vice president of clinical services for Denial Research Group/Appeal Masters in Lutherville, Md. For example, the gold standard for Medicare is national or local coverage determinations (NCDs and LCDs), and both Medicare and commercial payers use accepted standards of medical care in coverage decisions. But the American Association of Orthopedic Surgeons doesn’t have guidelines for knee or hip replacements, and there’s no NCD. Yet Medicare auditors often deny claims for joint replacement if physicians haven’t exhausted more conservative treatments, including physical
therapy (PT) and anti-inflammatory medication (RMC 9/24/12, p. 1). Several Medicare administrative contractors (MACs) have LCDs on joint replacement, but patients may not tolerate the meds or three months of PT. “You can argue that,” Wilson says, and an appeal may have more traction if the LCD in your jurisdiction requires more PT than LCDs published by other MACs.

Hospitals have a better shot at winning their appeals if they make it easy for medical reviewers and administrative law judges (ALJs) to find the documentation that will support the appeal and understand what it means, Wilson says. She sets forth the elements of an effective appeal and suggests that hospitals use templates to ensue consistency among appeals. The three elements are narratives, medical-necessity arguments and regulatory arguments.

Narratives must explain that patients were severely ill enough to warrant hospital care, were at high risk of death or disability, required intensive medical services and were expected to stay two midnights in the hospital.

But Wilson suggests telling the “patient’s story and why the patient needed that inpatient admission or procedure in a humanistic way.” It’s more likely to resonate with ALJs. For example, when listing comorbidities and complications, spell them out — e.g., congestive heart failure instead of CHF or atrial fibrillation rather than afib. But don’t report complications and comorbidities unless they genuinely affect the hospital stay.

And in the era of the two-midnight rule, it’s helpful to highlight “polypharmacy” patients, who are defined as patients on eight or more medications, Wilson says. It means they are sicker, are at greater risk of falls because their drugs could make them drowsy or forgetful and could suffer adverse events if released from the hospital prematurely, she says. “It’s something we like to include when we are writing appeals,” she says.

**Give ALJs a Roadmap**

Wilson walked through the example of “Mr. Farmer,” who was brought to the emergency room by ambulance because he felt dizzy and had chest pain, shortness of breath and a hard time breathing for four days. After the ER physician diagnosed acute exacerbation of chronic congestive heart failure secondary to hypertensive urgency, Mr. Farmer was admitted with a principal diagnosis of CHF and discharged the next day. Medicare denied the claim, and on appeal, the hospital used a narrative to explain why it believed the (pre-two-midnight rule) admission was medically necessary.

First, the appeal should make it easy for reviewers to understand the basic facts of the case, Wilson says. It lists Mr. Farmer’s name, dates of service, member ID, principal diagnosis, comorbidities (e.g., hypertension, hyperthyroidism) and social factors (e.g., polypharmacy, unsteady gait). Then she explains Mr. Farmer’s conditions in bold, how lab values are abnormal by giving the normal range and refers the medical reviewer or ALJ to the page in the medical record where this information can be found. After reporting blood pressure or lab results, Wilson uses the letters “H,” “L” or “C” to indicate high, low or critical and then states the normal range in parentheses, with the corresponding page in the medical record. It’s more likely to resonate with ALJs. For example, when listing comorbidities and complications, spell them out — e.g., congestive heart failure instead of CHF or atrial fibrillation rather than afib.

For example, “Mr. Farmer was extremely hypertensive with a blood pressure of 223/89 (H) [<119/79] (ED Record, p. 22) and bradycardic with a slow heart rate of 59 [60-100] (ED Record, p. 22). His chest X-ray revealed bilateral hazy consolidation in the lung bases consistent with pneumonia superimposed on vast chronic pulmonary interstitial changes and cardiomegaly (Radiology Report, p. 43). His BNP was high at 155 (H) [0-100]. His electrolytes were low as such, Sodium 129 (L) [136-144] and Chloride 91 (L) [101-111] (Lab Results, p. 104).”
Mounting a Convincing Medical-Necessity Appeal

Hospitals have a better chance of prevailing in their appeals of claim denials if they give administrative law judges and other HHS appeal tribunals a roadmap to the sections of the medical records that support their appeals, says Denise Wilson, assistant vice president of clinical services for Denial Research Group/AppealMasters in Lutherville, Md. Below are sample checklists of medical-necessity criteria of hospital care, before and after the two-midnight rule took effect on Oct. 1, 2013, with an “X” next to the criteria that are relevant to the appeal, she says. The samples are based on what appeal writers for the hospital determine are supported by physician documentation from that case. “They put an X where they think they can make an argument for this case,” she says. Wilson notes that hospitals may appeal if they satisfied one or two criteria (e.g., risk of adverse outcomes if the patient is discharged from the hospital).

For more information, contact Wilson at dwilson@intersecthealthcare.com.

### Appealing Denials of Claims Submitted Before the Two-Midnight Rule Took Effect Oct. 1, 2013: Justification of Treatment and Setting by CMS Guidelines

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Supportive Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The severity of the signs and symptoms exhibited by the patient warrant possible need for inpatient admission. CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A.</td>
<td>EMT Records, p. 10; Emergency Department Record, pp. 16, 20, 23, 24, 28; Admission Note, pp.31-32; Cardiology Consultation, p. 34; Pulmonary Consultation, pp. 36-38; Lab Results, p. 85; Portable Chest X-ray, p. 92,</td>
</tr>
<tr>
<td>The medical predictability of something adverse happening to the patient warrants possible need for inpatient admission. CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A.</td>
<td></td>
</tr>
<tr>
<td>The need for diagnostic studies warrants possible need for inpatient admission. CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A.</td>
<td></td>
</tr>
<tr>
<td>The availability of diagnostic procedures at the time when and at the location where the patient presents warrants possible need for inpatient admission. CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A.</td>
<td></td>
</tr>
<tr>
<td>This patient was expected to need hospital care for 24 hours or more. CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A.</td>
<td>Progress Note, p. 45; History and Physical, p. 36</td>
</tr>
<tr>
<td>The beneficiary’s medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. CMS Medicare Program Integrity Manual 100-08; Chapter 6; Section 6.5.2 - Medical Review of Acute Inpatient Prospective Payment System (IPPS) Hospital or Long-term Care Hospital (LTCH) Claims.</td>
<td>Progress Note, p. 45; Lab Results, p. 84</td>
</tr>
</tbody>
</table>

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when there are LCDs and NCDs that set coverage policy for tests, drugs and procedures, Wilson recommends citing them in appeals and explaining how they were satisfied. For example, Highmark Medicare Service's LCD on chemotherapeutic agents (A47797) sets forth the diagnosis codes that pave the way for coverage. Cite this in a chart, along with the page number of the medical record where it was documented (e.g., “Infliximab

Mounting a Convincing Medical-Necessity Appeal (continued)

<table>
<thead>
<tr>
<th>Justification of Treatment and Setting by CMS Guidelines Under the FY 2014 Hospital IPPS Final Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>For cases with Admission Dates on or after 10/1/2013 through 12/31/2014, after the two-midnight rule took effect</td>
</tr>
</tbody>
</table>

**ADMISSION ORDER:** A Medicare beneficiary is considered an inpatient of a hospital if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner. The order must specify admission for inpatient services. The order must be furnished at or before the time of the inpatient admission. Authentication of the order is required prior to discharge and may be performed and documented as part of the physician certification. CMS Hospital Inpatient Admission Order and Certification, 1/30/14.

Please cite title of document and page numbers that support this guideline (if applicable).

**CERTIFICATION:** The medical record documentation contains authentication of the practitioner order: The physician certifies that the inpatient services were ordered in accordance with the Medicare regulations governing the order. Hospital Inpatient Admission Order and Certification; 1/30/2014

Please cite title of document and page numbers that support this guideline (if applicable).

**CERTIFICATION:** The medical record documentation includes the reason for the inpatient admission: The reasons for either—(i) Hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study; or (ii) Special or unusual services for cost outlier cases under the inpatient prospective payment system (IPPS). Hospital Inpatient Admission Order and Certification; 1/30/2014

Please cite title of document and page numbers that support this guideline (if applicable).

**CERTIFICATION:** The medical record documentation includes the plans for posthospital care. Hospital Inpatient Admission Order and Certification; 1/30/2014

Please cite title of document and page numbers that support this guideline (if applicable).

**DECISION TO ADMIT:** The admission decision is supported through documentation by the admitting provider of consideration of complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event and consideration of various other factors, including the beneficiary’s age, disease processes, and the potential impact of sending the beneficiary home. FREQUENTLY ASKED QUESTIONS, 2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after Oct. 1, 2013

Please cite title of document and page numbers that support this guideline (if applicable).

**For cases with Admission Dates on or after 1/1/2015 (when CMS modified the certification requirement)**

| X | ADMISSION ORDER: A physician order is present in the medical record and supported by the physician admission and progress notes, and signed prior to discharge by a practitioner familiar with the case and authorized by the hospital to admit inpatients. Federal Register / Vol. 79, No. 217 / Nov. 10, 2014 / Rules and Regulations; XVI. Revision of the Requirements for Physician Certification of Hospital Inpatient Services Other Than Psychiatric Inpatient Services and 42 CFR 412.3
| Physician’s Orders, p. 112; History and Physical, p. 36 |

| X | 2 MIDNIGHT EXPECTATION: There is clear physician documentation in the medical record supporting the physician’s order and expectation that the beneficiary required medically necessary care spanning at least 2 midnights. Federal Register / Vol. 78, No. 160 / Aug. 19, 2013 / Rules and Regulations. Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A
| Progress Note, p. 45; History and Physical, p. 36 |

| X | DECISION TO ADMIT: The admission decision is supported through documentation by the admitting provider of consideration of complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event and consideration of various other factors, including the beneficiary’s age, disease processes, and the potential impact of sending the beneficiary home. FREQUENTLY ASKED QUESTIONS, 2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after Oct. 1, 2013
| History and Physical, p. 36; Physician’s Plan of Care, p. 38 |

Web addresses cited in this issue are live links in the PDF version, which is accessible at RMC's subscriber-only page at http://aishealth.com/newsletters/reportonmedicarecompliance.
Progress Note, 7/19/2011; p. 10 of the medical record; Clinic Note dated 3/15/2011; pp. 11-12 of the medical record”), and add relevant comments (e.g., “diagnosis of moderate to severely active ulcerative colitis, ICD 556.8”).

The third element of the appeal is regulatory arguments. One argument is limitation on liability. According to Sec. 1879 of the Social Security Act (42 U.S.C. 1395pp), providers cannot bill Medicare if they know the services they provide are not covered. One example is custodial care, also known as social admissions (RMC 2/16/15, p. 1). CMS says hospitals are expected to know what’s excluded from coverage because it publishes regulations, Medicare manuals and other guidance, and because hospitals are aware of acceptable standards of practice. That last item gives hospitals a way into an appeal, Wilson says. They may argue the services they provide are consistent with the standards of practice in the medical community.

She suggests hospitals embed medical society guidelines into their appeals of claim denials. They may want to focus on high-volume and/or high-dollar denials, such as syncope, transient ischemic attack and congestive heart failure. Appeal writers can use a truncated version of evidence-based guidelines from the Heart Failure Society of America or American College of Cardiology and check off the patient’s symptoms. For example, the Heart Failure Society of America in 2010 published guidelines on the evaluation and management of patients with acute decompensated heart failure (ADHF). It states that “hospitalization is appropriate in ADHF with:

- Hypotension,
- Worsening renal function,
- Altered mentation,
- Dyspnea at rest/resting tachypnea/oxygen saturation < 90%,
- Hemodynamically significant arrhythmia,
- New onset of rapid atrial fibrillation,
- Acute coronary syndromes,
- Worsened congestion even without dyspnea,
- Signs and symptoms of pulmonary or systemic congestion, even in the absence of weight gain,
- Major electrolyte disturbance,
- Associated comorbid conditions,
- Pneumonia,
- Pulmonary embolus,
- Diabetic ketoacidosis,
- Symptoms suggestive of transient ischemic accident or stroke,
- Repeated ICD firings, [and]

- Previously undiagnosed HF with signs and symptoms of systemic or pulmonary congestion.”

Wilson recommends putting the list in checklist form and then checking off the findings that apply to the patient whose claim is on appeal. This could apply to Medicare and commercial-payer appeals.

For more information, contact Wilson at dwilson@intersecthealthcare.com.

Time Limits for FCA Cases Stand Under Supreme Court Decision

Hospitals and other health care organizations no longer have to worry that False Claims Act (FCA) lawsuits will hit very old claims because the U.S. Supreme Court ruled on May 26 that the suspension of the statute of limitations for certain fraud laws doesn’t apply.

In the final word on the subject, the highest court in the land said the Wartime Suspension of Limitations Act (WSLA), which still is in effect, applies to only criminal statutes, not civil statutes such as the FCA. The WSLA suspends the statute of limitations for fraud perpetrated against the federal government, the court noted.

Washington, D.C., attorney Jesse Witten says the 9-0 Supreme Court decision restores “common sense” to the statute of limitations under the FCA. An FCA case may be brought (1) six years from the date of the violation, or (2) three years from the date of discovery of the violation, but not longer than a decade after the violation, he says. “Until this was decided, every other [lower] court agreed with the government that the WSLA applies to the FCA and suspends the running of the statute of limitations,” says Witten, with Drinker, Biddle & Reath. Hospitals in current and future settlement negotiations should get some relief because the government can’t argue that under the WSLA, FCA liability is indefinite. “The value of these older cases just became less to the government,” he says.

In the same decision, Kellogg Brown & Root Services, Inc., et al. vs. United States ex rel. Carter, the Supreme Court ruled that new claims filed against a defendant under the False Claims Act may proceed if the initial case is no longer pending. That means the “first-to-file bar,” which says the first whistleblower has dibs, goes out the window as soon as its case dies.

It’s probably obvious from the name, but the case decided by the Supreme Court did not involve health care. It applies, however, to false claims lawsuits against health care organizations. The decision stemmed from four false claims lawsuits filed on behalf of the government by a man who worked for a company that provided logistical services to the United States military in
Iraq. He alleged the company, which includes defense contractors and related entities, “had fraudulently billed the Government for water purification services that were not performed or not performed properly,” the court decision said. Before trial in 2010, the government told the parties that a false claims lawsuit with similar claims had already been filed. As a result, the U.S. District Court dismissed Carter’s complaint under the first-to-file bar. But apparently turnabout is fair play: The other lawsuit — the Thorpe case — was dismissed, so the first-to-file bar doesn’t apply, and the Carter case was remanded by the Supreme Court to the district court for further proceedings. “We hold that a qui tam suit under the FCA ceases to be ‘pending’ once it is dismissed,” the decision states.

Read the opinion at www.supremecourt.gov/opinions/14pdf/12-1497_2d8f.pdf. Contact Witten at Jesse.Witten@dbr.com. ♦

### CMS Transmittals and Federal Register Regulations

**May 22 – May 28**

Live links to the following documents are included on RMC’s subscriber-only Web page at www.AISHealth.com. Please click on “CMS Transmittals and Regulations” in the right column.

**Transmittals**

(R) indicates a replacement transmittal.

**Pub. 100-03, National Coverage Determinations**


**Pub. 100-04, Medicare Claims Processing Manual**

- Inpatient Prospective Payment System Hospital Extensions per the Medicare Access and CHIP Reauthorization Act of 2015, Trans. 3263CP, CR 9197 (May 22; eff. April 1; impl. July 6, 2015)

**Pub. 100-08, Medicare Program Integrity Manual**


**Pub. 100-20, One-Time Notification**


**Federal Register Regulations**

**Final Rule**


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### MD Pleads Guilty in Surgery Case

Continued from p. 1

Sabit, to induce them to use Reliance spinal implants in their surgeries (RMC 9/15/14, p. 1).

But it’s unclear how much light the Sabit conviction sheds on PODs. The overarching question is whether PODs are ever appropriate and under what circumstances, says Denver attorney Jeffrey Fitzgerald, with Polsinelli. The allegations in the Sabit prosecution may be too egregious to generalize to POD structures and their interactions with hospitals, he says. “The case is an over-the-top example of how these things can go wrong,” he says. When a physician is engaged in outright criminal behavior, “it’s no longer a discussion of whether PODs are legitimate.” The Sabit case has more to say about the importance of hospitals monitoring utilization and diving deeper into data on physicians who are outliers in terms of the volume of procedures they perform, says Fitzgerald. “The high utilizers are the ones the government will look at.”

The POD connection, however, is the river that runs through the Sabit case. When the POD arrangement began, Sabit practiced in California, but he ran into trouble with the state medical board, which alleged he performed unnecessary spinal procedures, according to the false claims lawsuit. Around March 2011, Sabit moved to Detroit and obtained temporary hospital privileges at Detroit Medical Center, Doctor’s Hospital of Michigan and McLaren Lapeer Regional Medical Center. Sabit, who operated the Michigan Brain and Spine Physicians Group, implanted Reliance devices in patients there until spring 2012. He was arrested in November 2014 (RMC 12/8/14, p. 1).

**Facet Screws Were Not Used**

The plea agreement describes how Sabit “derived significant profits” by persuading patients to have spinal fusion with instrumentation, which he didn’t perform as documented in the medical records. “This invasive surgery would cause serious bodily injury to the patient,” the plea agreement states. Here are some examples and how they connect to the POD, according to the plea agreement:

- **In a surgery at Doctor’s Hospital of Michigan in Pontiac in February 2012, Sabit wrote in an operative report that he performed a spinal fusion with instrumentation at L4, L5 and S1 levels and used Zimmer transfacet screws**. But subsequent diagnostic imaging showed this wasn’t true. Even though Sabit didn’t put screws in the patient or perform a posterolateral fusion, he billed Medicaid for $26,067.

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In a surgery at Detroit Medical Center in April 2012, Sabit’s operative report said the patient had spinal fusion with instrumentation at levels L4, L5 and S1, using transfacet screws. Instead, Sabit implanted a cortical bone dowel, which is made of tissue, but he billed Medicaid $28,604 for the fusion with screws.

In a surgery at Doctor’s Hospital in March 2012, Sabit documented he performed a spinal fusion with instrumentation at L4-L5 and placed two transfacet screws. Subsequent imaging of the patient’s spinal column showed there were no screws in the spinal column and that Sabit never performed a posterolateral fusion. He charged Blue Cross Blue Shield of Michigan $20,383 for the procedure.

In a surgery at McLaren Lapeer Regional Hospital in March 2012, Sabit documented he performed a fusion with instrumentation, using transfacet screws on L4-L5 and L5-S1, and billed Medicaid for $27,205. But imaging showed the patient never had a fusion and that Sabit implanted two cortical bone dowels instead of screws.

The plea agreement then alleges the connection to Sabit’s relationship with Apex. Every spine surgery he performed using Apex devices “was predicated on illegal kickback payments” he received from co-conspirators, the plea agreement alleges. “Moreover, incentivized by this illegal kickback arrangement and his involvement in the conspiracy, [Sabit] performed medically unnecessary surgeries that caused serious bodily injury to at least some of his patients.”

Sabit Allegedly Kept POD Secret

Sabit’s alleged relationship with the POD is fleshed out in the false claims complaint against Reliance and Apex, which also names him as a defendant. Sabit made an initial $5,000 capital contribution to Apex in May 2010 for a 20% share and received $20,000 from Reliance that same month, the complaint alleges. During an eight-month period, Sabit used Reliance implants in surgeries he performed at Community Memorial Hospital in Ventura, Calif., although he never had used the brand before, the complaint alleges. The hospital paid Apex $1.42 million, which in turn paid Sabit $264,967. “After April 16, 2010, Dr. Sabit used Reliance implants in more than 90% of his spinal fusion surgeries at Community Memorial,” the complaint contends. It also describes an increase in utilization. In the eight months Sabit practiced at the hospital but was not an Apex investor, he did 64 instrumented fusion surgeries, and in the eight-month period after he bought into Apex, that number jumped to 130, the complaint alleges.

The plea agreement alleges that Sabit knew his Apex “co-conspirators” expected him to persuade the hospitals to accept Apex as a spinal implant vendor and to buy the devices he used in procedures. That wouldn’t happen if he revealed his financial interest in Apex, so Sabit kept it secret, the plea agreement contends.

In April 2011, Sabit left for Michigan and got privileges at the three hospitals. He continued to use Apex devices in surgeries he performed there. Ultimately, the complaint alleges, Sabit was paid $438,570 because of his ownership in Apex, part of which stemmed from “the profits he generated for Apex by using Reliance implants in his surgeries on Medicare patients.”

Eventually, he reduced his use of Apex devices, and the Michigan hospitals slowed or stopped paying for them. Apex threw Sabit out of the company around August 2012.

The case probably will cause more scrutiny of PODs, says Minneapolis attorney Thomas Beimers, with Fager Baker Daniels. “While there are certainly different ways to structure PODs, the allegations call into question common assertions by proponents that PODs result in savings without impacting quality of care,” he says. It may be a good idea for hospitals to revisit controls that are designed to promote transparency around physician incentives to choose particular products, Beimers says.

Criminal cases against physicians and health care administrators are starting to pile up. For example, last week, the former assistant administrator of Riverside General Hospital in Houston was sentenced to 40 years in prison for his role in a $116 million Medicare fraud scheme (RMC 5/25/15, p. 7). In Chicago, the former CEO, chief financial officer and chief operating officer of Sacred Heart Hospital, which is now closed, were convicted in March of paying kickbacks for patient referrals (RMC 4/22/13, p. 1). And in New York City, the former CEO of the prestigious Hospital for Special Surgery was sentenced to 18 months in prison after his 2013 plea to wire fraud and making false statements to a law enforcement agent in connection with his demands for a share of an employee’s bonus for resolving a dispute with a vendor that specialized in joint replacement technology (RMC 11/11/13, p. 1). Some physicians also are being sent to jail after convictions for implanting medically unnecessary stents (RMC 6/17/13, p. 1; 8/1/11, p. 3). It’s not a shocker

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when criminals exploit Medicare, but “it gives me pause to read about health care people wandering off the ranch and doing crimes,” Fitzgerald says. “These are doctors and health care administrators. Doctors are in training for a long time, and you don’t get to be a health care administrator overnight. It’s a career path.”

The Sabit conviction is a cautionary tale about overutilization. Potential overutilization is on the radar of the federal and state governments, Fitzgerald says. They see it in their data mining and run statistical analyses to identify outliers — and then question hospitals and practices about them, he says. It’s better when providers identify anomalies themselves and, if they correlate to overpayments, return them before auditors or investigators initiate contact.

Fitzgerald worked with an anesthesia group that had one anesthesiologist whose billing was outside the norm. It raised a few eyebrows but wasn’t cause for concern until he went on vacation for two weeks. At the end of the month, the anesthesiologist reported more minutes — which is how Medicare pays for anesthesia — than other anesthesiologists in the group, even though he’d been on vacation for half the month, Fitzgerald says. “The other doctors thought that was troubling,” he says. So the anesthesiology group hired an outside expert to do a chart audit. The findings: The anesthesiologist was padding his charts by three to four minutes per case. When confronted, he admitted it. The anesthesiology group understood it was at risk because all claims were submitted under its provider number, Fitzgerald says. It returned the overpayment to Medicare.

“The compliance lesson is that people need to watch for doctors who are high utilizers,” he says. There may be good reasons why Dr. ABC performs more interventional cardiac procedures than her peers — maybe she treats sicker patients — “but a good compliance program understands and documents the reasons for concluding the physician is practicing properly,” Fitzgerald says. Like other risk areas, the goal is to have a ready answer of “we know Dr. ABC is a high utilizer, but we have reviewed her cases, and they are appropriate for the following reasons” in case the government comes knocking.

Contact Fitzgerald at jfitzgerald@polsinelli.com and Beimers at thomas.beimers@FaegreBD.com.
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