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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*PUBLISHER'S NOTE: **RMC** will not be published next week. The next issue will be dated April 11.*

Amid Hospital Chaos, Compliance Reports Rise; Governor Removes Two From Board

The chaos at Broward Health in Fort Lauderdale, Fla. — where the governor suspended two board members on March 18, the CEO committed suicide in January, and a false claims case was settled for $69.5 million in September 2015 — is showing up in the compliance program. It's not unlike conversion disorder, when stress is expressed as physical illness.

The former CEO, Nabil El Sanadi, M.D., "has been gone for 59 days, and over the past 59 days, I have seen an overall increase in the number of reported concerns," says Donna Lewis, chief compliance and privacy officer for Broward Health. "I have also seen an increase in reports where individuals have indicated they are fearful of retaliation." That, she tells *RMC*, is a hallmark of a damaged corporate culture. "Lately the cohesiveness is no longer there, and the organization has become extremely siloed," with many departments losing trust in corporate leadership and general counsel's advice, Lewis says. Still, the compliance and ethics program moves ahead, with Lewis' chief responsibility overseeing implementation of the corporate integrity agreement (CIA) that Broward Health entered into as part of its false claims settlement for alleged Stark violations *(RMC 9/21/15, p. 1)*. "It's important that compliance has a presence in all of our regions" — there are 30 facilities in Broward Health — and she continues to promote compliance through training, posters and the intranet.

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Psych Cases Test EMTALA Mettle; Hospital Settles Case Over Patient Sent to Jail

Floyd Medical Center in Rome, Ga., agreed to accept the transfer of a psychiatric patient, and yet the hospital wound up paying $50,000 to settle a civil money penalty case over an alleged violation of the Emergency Medical Treatment and Labor Act (EMTALA). Things went south when the patient arrived for involuntary commitment; he became agitated, and there was a scuffle with security guards, according to the settlement. The hospital never contacted its on-call psychiatrist, and ultimately the patient, who was injured in the process, got carted off to jail.

The case illustrates the challenges hospitals face at the intersection of mental health and EMTALA compliance. "It's a constant source of alleged violations in cases we have seen," Sandra Sands, a senior counsel in the HHS Office of Inspector General, tells *RMC*. Psychiatric emergencies are unique because patients also may have medical problems, pose a risk of harm to themselves or others and raise questions about involuntary commitment. "Psychiatric issues are inherently more complicated" with respect to EMTALA, Sands explains.

Having a dedicated pod in the emergency unit for psych patients, which one hospital set up, may reduce EMTALA risk, although that's not its reason for being.

continued

EMTALA requires hospitals to give "medical screening exams" to all patients who show up in the emergency room regardless of ability to pay and to stabilize them if they have "emergency medical conditions." Patients may be transferred if hospitals lack the capacity to treat them, and "receiving hospitals must say yes unless they lack the capacity to treat" them, Sands says.

Floyd Medical Center had the capacity to treat the psychiatric patient in this case and accepted him for inpatient care, she says. "But then something else happened." According to the settlement, the hospital didn't evaluate and treat the 32-year-old patient, who was "aggressive and combative" on arrival at the emergency room. The patient "moved his body in an aggressive manner toward a nurse" when in an exam room, so the nurse called security. Three security officers entered the room — including one police officer who was moonlighting — and the nurse went to get medication to calm the patient and soft restraints, the settlement says. The patient then tried to hit one of the security officers, who hit back, striking the patient in the head with his fist and pushing the patient until he fell on the bed. "A security guard and the officer then wrestled [the patient] to the ground and handcuffed him, causing several injuries to [the patient]," the settlement says. "When the nurse returned, the security personnel informed her that they had determined that [the patient's] behavior was 'beyond what the facility could safely control.'"

Other than treating the minor cut on the patient's forehead, the ER physician cleared the patient without psychiatric or medical intervention, and he was taken to jail, the settlement says. Even though Floyd Medical Center had an on-call psychiatrist and the ability to treat the patient, he wasn't evaluated or treated at any point by a mental health professional.

For its part, Floyd Medical Center did not agree in the settlement that the findings by OIG "were wholly accurate." The hospital CEO did not return *RMC*'s phone call.

"Here I think what happened was a confluence of things that might be described as a perfect storm, and that's why this person wasn't served," Sands says. Floyd Medical Center "wasn't trying to shirk its responsibility for psych patients. It appears some of the hospital's policies and procedures were not followed, and the chain of events was started by the security officer who was a police officer in his primary job and may have responded to the behavior of the patient, so there was a training issue for the hospital in terms of hiring current or retired police officers because it's a different environment."

There May Be Contrary Information

Psych patients require hospitals to think EMTALA through at another level. "It is a more complex area of medicine," Sands notes. To properly treat patients, both medical and psychiatric conditions must be considered by decision makers, but communication can be a stumbling block, she says. "If a doctor is the appropriate person to decide if someone has a psychiatric emergency and is speaking with the patient who denies homicidal or suicidal thoughts, but other family members in the emergency room who had been interviewed by other staff say contrary things and the doctor is unaware, the doctor may make a different decision about an appropriate disposition," Sands says. "So there are communication decisions related to psychiatric dumping cases." Hospitals can address in their policies how to proceed when the head of the ER recommends discharging a patient but other staff who had contact with the patient or family believe that's a bad idea.

Sometimes there's tension over psych evaluations in the ER. Suppose the on-call psychiatrist refuses the ER physician's request to come in to evaluate a patient. "A lot of hospitals have protocols to be notified of that so they potentially can call the on-call specialists to get them to change their mind," Sands says.

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Georgia Rackley, a senior clinical specialist with SunStone Consulting in Enola, Pa., conducted an EMTALA compliance review at a hospital and says "we saw mostly issues with patients who on paper didn't appear stable but were discharged or going on to the next level of care with transportation that didn't match the level of care" — particularly with psychiatric and substance-abuse patients, she says.

"If they're physically ill, you use more objective measures like vital signs and lab work, while [with] psychiatric patents it's maybe based on conversations with patients, and severely ill psych patients are consistently inconsistent," says Rackley. If they are substance abusers, it complicates the medical screening exam.

During the EMTALA review, Rackley found problems with the way the hospital handled two substance-abuse patients at the ER. Both appeared to be in withdrawal. One had an order for a withdrawal protocol, and the other was transferred to rehab. They were discharged but didn't appear to be stable, according to the documentation, says Rackley, who is a nurse.

"It's dangerous because without a medically monitored withdrawal, patients are at risk of complications, ranging from restlessness or nausea to elevated blood pressure and pulse, seizures, stroke and even heart attack," Rackley explains.

Withdrawing Patient Left Hospital in Taxi

The patient with the withdrawal-protocol order had been accepted for a medically monitored detox at a rehab facility. "The patient was showing signs of withdrawal and was going to the most intense level of care for substance abuse, yet he was released with a friend," who planned to drive him there, she says. The hospital let the other patient transfer to rehab by leaving with a friend in a taxi. "Patients are supposed to be stable before transfer," Rackley notes. Ambulance transport was necessary, she adds.

EMTALA requires hospitals to ensure patients are transferred consistent with the patient's needs. According to Sec. §489.24 (e)(2)(iv), "It is the treating physician at the transferring hospital who decides how the individual is transported to the recipient hospital and what transport service will be used, since this physician has assessed the individual personally. The transferring hospital is required to arrange transport that minimizes the risk to the individual who is being transferred, in accordance with the requirements of §489.24(e)(2)(B)(iv)."

Like many general acute-care hospitals, this hospital doesn't have an inpatient psych unit, and Rackley identified patients with suicidal ideation who were referred to other facilities — but allowed to leave with family members who promised to drive them there. The documentation said something to the effect of "patient deemed stable for transport," which didn't jibe with notes about suicidal ideation. "We saw a disconnect with what was clinically written about patients," Rackley says. "While the patients were in the ER, a personal sitter was with them, and then you release them to family members? The rationale wasn't there." She says certain psych and substance-abuse patients need a clinician in the ambulance, especially if they are in withdrawal.

EMTALA compliance isn't the reason that PinnacleHealth System in Harrisburg, Pa., has a designated area in its ER for mental health care, but it's a secondary gain, says ER chairman Craig Skurcenski, M.D. The secure behavioral area in its ER is staffed by ER physicians and technicians who have additional training in managing psychiatric patients.

"Patients presenting with complaints related to behavioral health issues go through the same initial medical screening evaluation that all patients receive as outlined by EMTALA. In addition, there are safety measures, such as the separate secure area and screening for potentially hazardous materials, including metal detectors, that are performed," Skurcenski tells *RMC*.

After the medical screening exam rules out a medical condition, case managers, who are social workers from the crisis intervention unit, consult with the ER physician. "If it's determined the patient needs inpatient psychiatric care, we do a voluntary or involuntary petition and then get them placed in an inpatient psych facility. We transfer all those patients with EMTALA-compliant procedures," he says, because PinnacleHealth System doesn't have an inpatient psychiatric unit.

Sometimes the level of stability of a presenting complaint is hard to determine, so the goal is to get patients to the most appropriate level of care for their conditions, Skurcenski says. It's not unlike hospitals needing to transfer trauma patients for whom they can't provide all of the care required. "It's not a violation because you are sending them to a necessary higher level of care."

He adds that because all the ER psych patients are screened and treated in the behavioral health pod, it's easier to ensure they are kept safe.

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Despite what people think, EMTALA violations often have nothing to do with reimbursement, Sands says. The Floyd Medical Center case, for example, was not about avoiding the treatment of an uninsured patient. "A lot of people think it's only about money," she says, and that isn't necessarily true. "While in a certain number of cases it appears [lack of insurance] might have affected decision making, in many we don't have knowledge it was a factor."

Contact Sands through OIG spokesman Donald White at Donald.white@oig.hhs.gov, Rackley at georgiarackley@sunstoneconsulting.com and Skurcenski at cskurcenski@pinnaclehealth.org. ✧

Less Is More for Rule-Fatigued MDs; Two-Midnight App Helps

To compliance officers, it may not seem like a big deal for physicians to document that a heart attack is the reason a patient is expected to stay two midnights in the hospital, but physicians are dumbfounded they have to go through these regulatory motions when it's so obvious. "The physicians will say, 'the patient is having a heart attack, and I need to treat him,' and underlying that is the need to have access to everything the hospital has," says Paul Simmons, M.D., assistant chief medical officer and physician advisor to case management at Massachusetts General Hospital in Boston. "No clinicians really think in terms of justifying inpatient vs. outpatient." Their attitude, he says, is "call it whatever you want as long as I can treat the patient."

The two-midnight rule is one example of the challenges that hospitals face when the linchpin of compliance with a new regulation or payment model is busy, sometimes-exasperated physicians. Simmons says physicians are experiencing "new-regulation fatigue and intense skepticism" about regulations because of the perception they are "just going to change," he says. They're also frustrated with "mixed messages" from CMS, which on the one hand is promoting "the noble goal" of ensuring "attending physicians are dictating and planning care," but on the other hand is pushing medical homes and team-based care, which relies on allied professionals, Simmons says. "It's a little weird."

Against this backdrop, hospitals are finding ways to overcome the physicians' resistance and encourage them to respond to regulatory requirements. One strategy is to focus on the most paramount messages and let the others go, Simmons tells *RMC*. "Everyone thinks they have this great little message to tell the doctors, but there are 1,000 people saying that every day," he says. "Someone needs to prioritize what's important and work with the medical staff office and chief medical officer to decide. If you can come up with a solution that doesn't involve the doctors, that's a far better way to go."

For example, with the two-midnight rule, it helps to take a lot of the burden off attending physicians, he says. Mass General, which is a teaching hospital, modified a module in its electronic health records (EHRs) to serve as the admission order and supporting documentation. It requires residents and/or attending physicians to choose an in-hospital status when patients were in a bed and check off why (e.g., "expected care will cross two midnights" or "patient has been observed for 24 hours and continues to need hospital care"). The *pièce de résistance*: An app created by an in-house programmer makes it easy for attending physicians to co-sign the admission order when it's written by a resident.

App Improved Compliance

The app, which is called "iCertify," sends a link to attending physicians. If they're at a hospital workstation, attending physicians open the link and hit "agree," Simmons says. If they're outside the hospital, attending physicians co-sign on a tablet or smartphone. "The system also generates pages after 24 hours to people who haven't done it," he says. "Our response rate is very good" — although not 100%, because there are always a handful of people who ignore the requirement and the pages. "Never underestimate a physician's ability to see something as unimportant because it has zero impact on the clinical care provided," he observes.

Even though Mass General has made it easy for physicians to comply with the two-midnight rule, it's still essential for the compliance officer and physician advisor to explain why it matters (i.e., noncompliance translates into loss of reimbursement for treating patients, who often require expensive care). Physicians will respond to data and thoughtfulness, says Simmons. The hospital needs to say to the physicians, "here is the situation, here is what the government is asking for, this is our analysis, and these are the conclusions we have come to," he says. And then invite people to comment. "It's a diplomatic process."

When conveying the impact of audits and enforcement actions, it's more effective to build a coalition than for the compliance officer to go it alone. "Billing compliance officers can feed up to the CFO's office and figure out the potential impact — Medicare is the only insurance that can put you in jail — and if the CFO sees the lack of compliance as an existential threat to the hospital and partners with the chief medical officer, it seems like they should be able to make a compelling case to the medical staff," Simmons says. But if compliance officers fly solo, they may sound more like "gadflies," he says. "For whatever reason, physicians tend to respond better

hearing things from other physicians." So he recommends building a coalition that presents the problem to physicians, using data to support it and analysis to explain it. "That moves people," Simmons says. "Physicians respond to data" and to knowing an issue has been examined very seriously.

For more information, contact Simmons at psimmons1@mgh.harvard.edu. ✧

OCR to Start Next HIPAA Audits; Business Associates Are Added

The HHS Office for Civil Rights (OCR) said March 21 it is moving ahead with its next round of HIPAA audits, which will hit both covered entities and business associates. More than 200 will face audits in Phase 2 of the HIPAA Audit Program, which will be a combination of desk and on-site audits, with an emphasis on the former.

Phase 2 is a follow up to Phase 1 of the HIPAA audits, when OCR audited 115 covered entities for potential violations of the privacy, security and breach notification rules. This time, OCR will also evaluate business associates' compliance, since the HITECH Act made them directly accountable for compliance.

This will be a paperless audit, according to OCR. First the agency will send an email to covered entities and business associates to nail down the name of the privacy officer or other appropriate contact person. "OCR will then transmit a pre-audit questionnaire to gather data about the size, type, and operations of potential auditees; this data will be used with other information to create potential audit subject pools," the agency says.

Blowing off OCR won't do covered entities and business associates any good because OCR will use public information to create an audit subject pool, and they may still be chosen for the audit. If covered entities and business associates are chosen for an audit, they will be asked for policies and procedures and evidence of their risk assessments, which they will send through a secure portal.

OCR calls the audits mainly "a compliance improvement activity." The results will be used to develop technical assistance for the industry and tools to help covered entities and business associates evaluate themselves and avoid breaches. However, if an audit detects a significant compliance problem, OCR may do a compliance review.

Nickie Braxton, privacy officer for Boston Medical Center, encourages covered entities and business associates to be as "responsive and collaborative" as possible. "Demonstrate you have a real privacy program," she says. "Don't miss the opportunity to talk about everything you do." For example, with education, show how many ways you train employees — in classrooms, online and through newsletters, email blasts and department staff meetings.

During these early days, Braxton suggests getting the word out to people to make sure they forward OCR emails to the privacy officer so he or she doesn't miss the audit notification. Also, she adds, covered entities and business associates already under investigation for a breach will be spared an audit.

The Phase II HIPAA Audit was announced in the wake of two major OCR settlements for potential HIPAA violations.

On March 17, OCR said Feinstein Institute for Medical Research in Manhasset, N.Y., agreed to pay $3.9 million to settle potential HIPAA violations and "will undertake a substantial corrective action plan to bring its operations into compliance." In September 2012, Feinstein, a biomedical research institute sponsored by Northwell Health, Inc., filed a breach report with OCR indicating a laptop was stolen from an employee's car. The laptop contained the electronic protected health information (ePHI) of about 13,000 patients and research

CMS Transmittals and *Federal Register* Regulations

March 18 – March 23

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. 100-04, Medicare Claims Processing Manual

- April 2016 Integrated Outpatient Code Editor Specifications Version 17.1 (R), Trans. 3484CP, CR 9553 (March 22; eff. April 1; impl. April 4, 2016)
- New Waived Test, Trans. 3479CP, CR 9563 (March 18; eff. July 1; impl. July 5, 2016)
- Updates to Chapters 3, 6, 7 and 15 to Correct Remittance Advice Messages, Trans. 3481CP, CR 9562 (March 18; eff./impl. June 20, 2016)

Pub. 15-2, The Provider Reimbursement Manual — Part 2

- Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS-2552-10, Trans. 9P240 (March 18; various eff./impl. dates)

Pub. 100-20, One-Time Notification

- Reclassification of Certain Durable Medical Equipment HCPCS Codes Included in Competitive Bidding Programs from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category (R), Trans. 1638OTN, CR 8822 (March 23; eff. July 1; impl. July 5/Oct. 3, 2016)
- Required Billing Updates for Rural Health Clinics (R), Trans. 1637OTN, CR 9269 (March 23; eff. April 1; impl. April 4, 2016)

Federal Register Regulations

- None published.

participants, including names, dates of birth, diagnoses and medications, OCR said.

"OCR's investigation discovered that Feinstein's security management process was limited in scope, incomplete, and insufficient to address potential risks and vulnerabilities to the confidentiality, integrity, and availability of ePHI held by the entity," said OCR. "Further, Feinstein lacked policies and procedures for authorizing access to ePHI by its workforce members, failed to implement safeguards to restrict access to unauthorized users, and lacked policies and procedures to govern the receipt and removal of laptops that contained ePHI into and out of its facilities. For electronic equipment procured outside of Feinstein's standard acquisition process, Feinstein failed to implement proper mechanisms for safeguarding ePHI as required by the Security Rule."

An unrelated settlement was announced the day before. North Memorial Health Care of Minnesota agreed to pay $1.55 million to resolve allegations that it potentially violated HIPAA's privacy and security rules. OCR alleged the health system lacked a business associate agreement with a major contractor and didn't do an organizationwide risk analysis to identify the vulnerabilities of its patient information. OCR investigated North Memorial Health Care after it reported a breach in 2011. An unencrypted, password-protected laptop was stolen from the locked vehicle of a workforce member of a business associate. The theft affected the ePHI of 9,497 people, OCR said. As part of the settlement, North Memorial Health Care must implement a corrective action plan.

The findings from Phase 1 of OCR's HIPAA Audit were released in 2013. Auditors made a total of 979 "findings and observations."

Contact Braxton at Nickie.Braxton@bmc.org. For information on the audits, visit http://tinyurl.com/gq-maovc. For information on Feinstein, visit http://tinyurl.com/hurpm8c. For information on North Memorial, visit http://tinyurl.com/zlnhclt. ✧

Compliance Reports Up Amid Chaos

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Broward Health is a cauldron at the moment. The FBI is conducting an investigation, says hospital spokeswoman Daniella Aird. She doesn't know the exact subject of the investigation, but it's unrelated to the false claims settlement. In that case, the Department of Justice (DOJ) alleged Broward Health paid nine employed physicians above fair-market value and at rates that weren't commercially reasonable and that took into account the volume or value of patient referrals. This is one of several cases where DOJ sees Stark violations in the fact that hospitals lose money on practices but pay physicians handsomely anyway because of their referrals *(RMC 9/28/15, p. 1; 3/16/15, p. 1)*. Broward Health did not admit liability.

Now Florida Attorney General (AG) Pam Bondi (R) wants back from Broward Health money she says Medicaid lost because of the allegedly illegal contracts that were the target of the federal false claims lawsuit. In a March 10 letter, Bondi demanded $5.325 million. "This settlement demand amount represents damages recoverable under the Florida False Claims Act," she wrote to the health system. If the hospital doesn't settle the case, the state "may pursue Florida False Claims Act litigation," seeking treble damages plus $11,000 per claim.

Governor Removed Two Board Members

Then there's Gov. Rick Scott's (R) suspension of the chairman of Broward Health's board and the head of the board's audit committee. The move was recommended by the Florida Office of the Chief Inspector General (IG), which is reviewing the board members, known as the "board of commissioners." The board is appointed by the governor because Broward Health — legally known as North Broward Hospital District — receives tax dollars, so members also can be removed by the governor. The IG is reviewing certain contracts approved by the board, and, according to a March 18 letter, the chief IG's "concerns from the outset" are "whether the board is operating as a whole body and not through the actions of any individual commissioner; whether any board member has operated in a management role while also performing charter oversight duties; and whether any board member has given direction to or interfered with any district employees, agents, and officers who are supervised, directly or indirectly, by the President/CEO."

Aird tells *RMC* the suspended board members "have not been replaced at this time."

As all this gets sorted out, Lewis focuses on the day-to-day operations of the compliance and ethics program and the CIA. "In the midst of the chaos, we have to remain calm and let our work speak for itself," she says. That includes "closing the loop" with employees who report compliance concerns. Lately a common complaint is that "I have been asked to do X, Y and Z, and it deviates from the process," says Lewis. "It reflects a lack of trust" but also indicates the employees' desire to do the right thing.

Her top priority is ensuring Broward Health's adherence to its CIA because failure in that regard puts participation in federal health care programs in jeopardy. Lewis continues to develop her relationship with the monitor from the HHS Office of Inspector General assigned to oversee Broward Health's CIA. Lewis has been working on implementation of the five-year CIA, which focuses on physician arrangements, since August 2015.

Because it's a trying time, Lewis says she relies on her faith to get through. Professionally, she recommends to compliance officers who wind up in a similar boat to document like crazy. "Document everything — every meeting and every conversation in case you are questioned on it at a later time," she says. Write down the time, location, what was talked about and what actions were taken.

Ultimately, Lewis takes heart in the fact that Broward Health's drama can't go on forever. "There is a beginning and an end to everything," she says. "It will resolve. I just don't know when."

At health systems everywhere, boards need to up their oversight game, says former DOJ attorney Peter Anderson. There is a question of whether boards truly know what's going on behind the scenes, says Anderson, with Beveridge & Diamond in Washington, D.C. "That's an understandable frustration. Unfortunately, it's unwise to simply rely on the management's assessment of their own performance," he says. "Board oversight has to mean something more than rubber stamping what management says."

Anderson urges boards to require more affirmative periodic reports from managers so the board members don't discover significant problems only after they're dropped in their lap. "Without such an expectation or obligation, management is left to decide on its own what reporting threshold to use when deciding when to report problems up the chain," he says. This is analogous to parents thinking their work is done by telling their teenagers to come to them when there's a problem. "The board can reset the expectations and shift the presumption by requiring periodic reports that include both strengths and weaknesses," he says.

Board members may need training on questioning managers and recognizing red flags. Anderson suggests that board members rotate responsibilities in "respectfully scrutinizing the information they receive from management" — similar to the role that defense lawyers play in the criminal justice arena. That means asking questions that are designed to mimic the adversarial nature of the criminal justice system, which is designed to get at the truth, and to promote better decision making. "They can trust management, but they need to verify what they're told," he says. "Sometimes management comes clean about problems, and sometimes they don't."

Boards gain additional protection from periodically hiring a third party to review the risks, the compliance program's effectiveness or other information. It's necessary because of the challenges of dealing with "fallible and greedy human beings," says Anderson. "Whenever you put human beings around a lot of money," a fraction of them will try to commit fraud, he says. "That's why the board and management need to set up effective and transparent systems to prevent, detect, respond and correct wrongdoing."

In a statement about Bondi's pursuit of Medicaid money, Broward Health said, "Although we are unable to discuss specifics, Broward Health employees and Broward County residents should know that we are looking into the merits of the claim and will evaluate available options to resolve the matter in the best interest of the North Broward Hospital District. We take patient care very seriously, including Medicare and Medicaid patients. Neither the federal nor state governments have questioned the quality of that care — nor have they questioned medical necessity. The federal settlement and this state claim are focused entirely on employment contracts with a small number of physicians. The North Broward Hospital District continues to monitor the compliance of complex Stark Laws."

Contact Lewis at Dllewis@browardhealth.org and Anderson at PAnderson@bdlaw.com. ✧

NEWS BRIEFS

◆ **Forged documentation figures into the case of the former CEO of a home health provider who pleaded guilty to two federal criminal charges and was sentenced March 24 to eight months in federal prison,** said the U.S. Attorney's Office for the Western District of Virginia. Amanda Moye Randolph also must pay $136,574 in restitution. She pleaded guilty last October to one count of theft of public money and one count of falsification of records in relation to a federal investigation. Randolph was the CEO of Medicaid home health care provider Karlisle In-Home Care from April 2008 to June 2014. She "knowingly concealed her employment" when she applied for and received disability and supplement security income benefits totaling more than $80,000. In addition, when the Medicaid Fraud Control Unit in Virginia began a criminal investigation of the company in response to a complaint that Randolph had dummied documentation missing from patient files, before turning over the requested files, she forged missing information. Those claims caused a loss of more than $55,000 to Medicaid. Randolph

NEWS BRIEFS

was also sentenced to three years of supervised release after prison. Visit http://tinyurl.com/zvlfba3.

◆ **Almost all of the claims for hospital outpatient dental services paid by one Medicare administrative contractor (MAC) were improper,** according to a March 24 HHS Office of Inspector General report (A-06-15-00034). OIG audited 100 claims submitted by hospitals in 2013 and 2014 to Wisconsin Physician Services (WPS) for jurisdictions five and eight and concluded that 95 didn't comply with Medicare requirements. That caused an overpayment of $1,298,794. Medicare doesn't cover outpatient dental services care for the most part, unless they're "performed as incident to and as an integral part of a procedure or service covered by Medicare," OIG said. The bulk of the noncovered services that hospitals billed the MAC for was tooth socket repairs and unallowable X-rays. The MAC also paid for noncovered tooth extractions and periodontics. Visit http://oig.hhs.gov/oas/reports/region6/61500034.pdf.

◆ **A Houston physician is headed to prison for 42 months and was ordered to pay $389,285 in restitution after being convicted of health care fraud and conspiracy,** the U.S. Attorney's Office for the Southern District of Texas said March 24. Between about 2006 and 2010, Enyibuaku Rita Uzoaga and others falsely billed Medicare and Medicaid for unnecessary vestibular diagnostic tests, which are used to diagnose vertigo and dizziness. The vestibular diagnostic tests were not performed at all, weren't done by licensed individuals or weren't medically necessary, the U.S. attorney's office said. Uzoaga was convicted by a federal jury in November after a six-day trial. Her co-defendant, Charles Harris, pleaded guilty prior to trial. Earlier this month, Harris was sentenced to 33 months in prison and three years of post-prison supervised release in connection with the Uzoaga case and two other vestibular indictments. Between the three indictments, Harris has been directed to pay $1.2 million in Medicare restitution and $103,268.64 in Medicaid restitution, the U.S. attorney's office says. Visit www.justice.gov/usao-sdtx.

◆ **An owner of home health care and hospice companies in the Detroit area pleaded guilty to health fraud and wire fraud,** the Department of Justice and U.S. Attorney's Office for the Eastern District of Michigan said March 24. Muhammad Tariq of West Bloomfield was involved in a scheme to pay physicians, marketers and recruiters to induce referrals to companies he co-owned, A Plus Hospice and Palliative Care, At Home Hospice and At Home Network Inc. Tariq is the last of five defendants to plead guilty in the case. The rest copped to the Medicare fraud scheme a week earlier. Two of the others were co-owners and pleaded guilty to one count of conspiracy to commit health care fraud and wire fraud, DOJ said, and two were physicians. All five were indicted in June 2015. Visit http://tinyurl.com/h8elg3u.

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