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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Prosecutor: Expect More 60-Day Rule Cases in Wake of Final Rule, Court Decision

The prosecutor who filed the first False Claims Act case for violations of the Medicare 60-day rule expects to see a lot more cases like it because the path has been cleared for them. The case ended last month when Continuum Health Partners and three New York City hospitals agreed to pay $2.95 million, and the settlement may mark the beginning of a long line of reverse false claims lawsuits around the rule, which requires health care organizations to return Medicare overpayments within 60 days of identifying and quantifying them.

"I expect there to be more 60-day cases," says Becky Martin, the longtime co-chair of the civil frauds unit in the U.S. Attorney's Office for the Southern District of New York, who recently left to join McDermott, Will & Emery in New York City. She gives two reasons for her prediction. First, "it's been given judicial gloss," she tells *RMC*. "There is judicial guidance."

The federal judge presiding over the Continuum case last year denied motions to dismiss the false claims lawsuit, which alleged Continuum and the three hospitals retained Medicaid overpayments long after learning about them, and that Robert Kane, the technical director of revenue cycle operations, was fired after bringing the overpayments to management's attention. In siding with the government, the judge noted that legislative history "indicates that Congress intended for FCA liability to attach in circumstances where, as here, there is an established duty to pay money to the government, even if the precise amount due has yet to be determined" *(RMC 8/10/15, p. 1)*. The hospitals are now part of Mount Sinai Health System.

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Board Chair, Senior VP Pay out of Their Own Pockets in NAHC False Claims Settlement

The chairman of the board of North American Health Care Inc. (NAHC) will dig into his own pocket to pay $1 million of the $30 million that the post-acute care company agreed to pay to settle false claims allegations, the Department of Justice (DOJ) said Sept. 19. A similar fate befell NAHC's senior vice president of reimbursement analysis, who paid $500,000 of the settlement amount because DOJ alleged she was an architect of the Medicare and TRICARE fraud scheme.

"This is an example of the Yates memo coming to life," says attorney Bob Wade, with Krieg DeVault in Mishawaka, Ind. The Yates memo is DOJ's 2015 blueprint for nailing "culpable" individuals as part of corporate fraud cases. DOJ requires corporations to disclose the names of culpable individuals if they want to settle civil or criminal cases or get cooperation credit *(RMC 9/14/15, p. 1; 12/14/15, p. 1)*.

NAHC, which manages 35 skilled nursing facilities (SNFs), resolved allegations that it caused the submission of false claims to Medicare and TRICARE for medically unnecessary physical, speech and occupational therapy. NAHC is a private, for-profit

company headquartered in Orange County, Calif. The SNFs provide the rehab services and NAHC bills for them, according to the settlement.

Medicare Part A and TRICARE allegedly were squeezed for additional reimbursement in different ways, DOJ said. The SNF stays of patients were extended unnecessarily and they received ultra high and very high levels of therapy when they didn't need therapy at that intensive level, DOJ alleged.

Medicare pays SNFs under a prospective payment system based on resource utilization groups (RUGs). RUG assignment is largely driven by therapy and there are five levels of therapy RUGs. The most lucrative is "rehabilitation ultra high," which means patients receive at least 720 minutes of at least two kinds of therapy over five days every week. Next is "rehabilitation very high," which is 500 minutes over five days. The minutes, and reimbursement, decline from there. Enforcers have been hot on the trail of SNFs that allegedly play games with reimbursement. There have been a number of high-dollar settlements, with therapy at the heart of most of them *(RMC 9/22/14, p. 1; 10/20/14, p. 5; 1/18/16, p. 3).*

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What's remarkable about the NAHC case is that two top officials were held accountable for what the government alleged was false claims. The chairman of the board, John Sorenson, agreed to fork over $1 million, and the senior VP of reimbursement analysis, Margaret Gelvezon, agreed to pay $500,000, DOJ said.

"The United States contends that Ms. Gelvezon, in her capacity as an officer of NAHC, contributed to this conduct by creating the RUG scheme…while Mr. Sorensen, in his capacity as an officer of NAHC, contributed to this conduct by reinforcing the RUG scheme," the settlement states.

Details are sketchy because there is no complaint in the NAHC case. There's no whistleblower and the U.S. attorney's office didn't file its own lawsuit or respond to *RMC*'s questions. Three different attorneys representing the defendants also didn't respond to *RMC*'s requests for comment. "The NAHC parties deny" the allegations, according to the settlement.

Medical Necessity May Be Yates Memo Trigger

One thing seems obvious. The U.S. attorney's pursuit of the board chair and the senior VP personally for their roles in the alleged false claims submissions "is evidence of what DOJ and the HHS Office of Inspector General have been saying: they are looking at individual accountability," says attorney Paula Sanders, with Post & Schell in Harrisburg, Pa. That's what DOJ said it would do when it issued the Yates memo, which revised the Principles of Corporate Prosecution (see story, p. 1). "This is not just a company settlement. They're holding people accountable." The Yates memo also said DOJ would not resolve a civil or criminal fraud case with a corporation unless it turned over "culpable individuals."

Wade says people have been wondering if DOJ would really pursue individuals in settlements and he thinks the time has come — "especially if they influence medical necessity determinations. The Yates memo really has teeth" if executives interfere with physician judgments and other clinical decision making.

Wade says he serves on the board of a SNF. "As a member of a SNF board, from a personal perspective, this makes me want to pause and make sure we have processes in place to ensure we don't influence the medical determinations of doctors," he says. Generally, he says, board members should be crystal clear that medical-necessity determinations are the province of physicians and, depending on the type of facility and service, Medicare coverage policies.

Contact Sanders at psanders@postschell.com and Wade at rwade@kdlegal.com.com. Visit http://tinyurl.com/j2p5mt5 for the DOJ statement. ✧

Preparing for Peer-to-Peer Discussions to Prevent Denials

Maria Johar, M.D., system physician adviser for ProMedica Health System in Ohio, developed this form to prepare attending physicians for peer-to-peer reviews with medical directors of commercial payers and Medicare Advantage plans. "This is our opportunity to prevent a denial," she says. If the outcome is favorable, no formal appeal is necessary. The completed form is also shared at monthly physician meetings as an educational tool. Contact Johar at Maria.Johar@ProMedica.org.

Promedica Peer to Peer Form

To be completed by UR Nurse:

Hospital: _____ Tax ID: _____ NPI: _____

Name: _____ Age _____ DOB: _____

Insurance Plan: _____ Policy ID: _____ Ref no: _____

Admission: ( ) Emergency ( ) Elective Admission Date: _____

Level Of Care: ( ) Med Surg ( ) Intermediate ( ) ICU Pt Notified of final decision: ( ) Yes ( ) No

Diagnosis: _____

Reason for Denial: _____

Length Of Stay	Anticipated DC Date	No of Denied Days

UR Comments: _____

Ins P2P Ph no: _____ Timeframe for P2P: ( ) 24 Hrs ( ) 48 Hrs

UR Nurse: _____ Date: _____

To be completed by Physician	YES	NO
1. Does the patient's condition require an inpatient stay?	( )	( )
2. Are treatments and services being rendered that can only be provided in an INPT setting?	( )	( )
3. Is discharge planning in progress?	( )	( )
4. Could services be provided more efficiently as suggested by the payor?	( )	( )
5. Can Physician documentation justify an INPT stay?	( )	( )
6. Are you willing to do a P2P to get the Inpt stay approved?	( )	( )

7. Reason to Appeal: _____

_____

8. Called at: _____ Am/Pm Call returned at _____ Am/Pm Spoke to: Dr _____

9. INPT STAY: ( ) APPROVED ( ) Denied

10. Reasons for Denial/ Approval: _____

_____

_____

11. If Denied, which options will you select?

( ) Accept OBS and facilitate DC Asap ( ) Consider a written Appeal ( ) Refer to Physician Advisor

12. Reviewing Physician: _____ Date: _____

UR Nurse: Please fill the top half with all pertinent information.

MDs Should Brace for Audits as Freeze Ends, HCCs Gain Traction

The one-year audit moratorium that physician practices enjoyed under ICD-10 ends on Oct. 1, and that means they must be conversant with 3,600 new codes and 487 revisions in code descriptions.

"The freeze is [almost] over," said Christine Lee, a manager of provider practice audit services for CIOX Health in Alpharetta, Ga., at an Aug. 18 webinar sponsored by the Health Care Compliance Association. It's one of the many things being thrown into the path of physician practices, including new payment models, greater scrutiny of physician billing and the different documentation demands of electronic health records (EHRs).

"How do we adapt to the multitude of compliance challenges facing those who work in physician offices?" she asked. For starters, the end of the ICD-10 audit reprieve is a big wake-up call, Lee said. When ICD-10 was looming, CMS agreed to give physicians and other practitioners a break the first year it took effect. In July 2015, CMS announced that auditors would not deny Medicare claims billed under the Medicare physician fee schedule "through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a valid code from the right family of codes." It wasn't a free pass, however. CMS added that it was still possible that "a claim could be chosen for review for reasons other than the specificity of the ICD-10 code" *(RMC 7/13/15, p. 8)*. CMS later elaborated on this and other ICD-10 issues, noting that auditors would go easy only on post-payment reviews. "ICD-10 codes with the correct level of specificity will be required for prepayment reviews and prior authorization requests."

A related challenge is the phasing out of unspecified codes under ICD-10, Lee said. Unspecified diagnosis codes are used when hospitals don't have enough clinical information or documentation to assign a more specific diagnosis code. Their use is discouraged because unspecified codes are a little vague about a patient's diagnosis and the reason why a procedure is medically necessary. With so much detail baked into ICD-10, there is less call

Preparing for Peer-to-Peer Discussions Before Formal Appeals (continued)

Please inform the Physician why the denial occurred, and what documented options can be considered to justify the inpt stay.

The physician may need a little assistance for the first few calls. Contact your Physician Advisor or Manager if you need any support.

***** Pt should be notified of denial and all the efforts you and the Physician are doing to overturn the Denial. Pt satisfaction is an important strategic initiative as is transparency to cost.**

Physicians: You are seeking **INPATIENT CARE!** You know their clinical issues the best!

Inpatient status covers them financially and it is up to **YOU to Fight For Your Patient's Best Interests!**

*** Before Calling the Payor, discuss the case with the UM nurse to prep for the call, understand the reason, and prepare your clinical justification.

*** Here are some tips we have gathered to optimize your experience.

1. **Be cordial.** (The Dr on the other end is just doing his job)
2. **Know**/ask for the specialty of the Dr you are speaking with.
3. **Know** your case, why they are denying and have a clinical justification ready.
4. **Have** all the facts and reasons handy.
5. **Ask** them what information they have regarding your pt, fill in the gaps. (Usually this will be enough to overturn your case)
6. **Share** any outpatient failed treatments and why observation is not appropriate.
7. **Ask for potential options to keep the pt safe and decrease readmissions and morbidity.**
8. **Do Not Discuss** different kinds of criteria, only individual clinical care!
9. **Always remain Professional and Calm.**
10. **Any** contractual issues should be referred back to the Physician Advisor or UM nurse.
11. **Please end with a clear decision. Inpt or not inpt?**
12. **You** will not win all, however we learn from all!
13. **Please contact you UM nurse and she will help you fill out the other side of the form.**

for unspecified codes than there was in ICD-9. However, CMS said "they have acceptable, even necessary uses" and will live on in ICD-10, according to an *MLN Matters* article (SE1518), dated Oct. 15, 2015, the same date the new coding system took effect. There has been confusion with ICD-10 and unspecified codes, as CMS deleted many unspecified codes prematurely and has been putting some back *(RMC 5/23/16, p. 1)*.

"It's the one area where providers may no longer be allowed flexibility," Lee said. The use of unspecified codes should be the exception. There may be more valid codes available, but everything hinges on the documentation. "You must assign the most granular ICD-10." For example, it should include "laterality" — the specific location of the fracture, tumor, injury or mass. Sometimes it's an uphill battle to convince physicians that this is necessary to achieve the most precise ICD-10 code and avoid using unspecified codes, Lee said. She said she worked with an oncologist who resisted documenting the quadrant of the breast where a lesion was located. "He thought it would make him look unintelligent to his peers because the location didn't affect how he would treat the patient," Lee said. "He felt it was unnecessary. So be aware of these types of challenges and potential resistance for change when you look at your ICD-10 documentation."

'Note Bloat' Is a Problem

Lee also cautions physician practices to expect scrutiny of claims submitted for new patients vs. established patients. CMS pays physicians more for evaluation and management (E/M) services provided to new patients because they require more resources up front. "If a physician is a member of a large physician group and a colleague is seeing the patient, the patient is not a new patient. We often see this in large metropolitan areas with multiple locations," Lee said. "If they have same tax ID, it's not a new patient."

In the EHR environment, "poor documentation of the patient encounter is probably the biggest vulnerability," Lee said. One problem is copy and paste, where a patient's notes are carried forward from one encounter to the next without editing or updating. "I can buy the social and family history being identical" or having the same past family medical history from a July visit to an October visit, for example. "But nothing changed in the October assessment and plan?" It's doubtful, she says, and calls the integrity of the documentation and therefore the claim into question.

Another EHR problem is "note bloat," where there is too much documentation to wade through, she says. That wastes the physician's time and can lead to repetitive testing. Lee told of auditing the charts of a neurologist who treated a patient who got out of his car to grab a drink of water at a fountain and had an epileptic seizure, collapsing on the sidewalk. A stranger stopped to help, but she left her car without putting it in park and it rolled back into a delivery truck. When Lee was auditing the neurologist's charts, she found all this background in there, and was surprised she hadn't heard about the story because it was a small town. As it turned out, the seizure had occurred three years earlier, but the neurologist insisted on carrying forward all information in the patient's record to his subsequent encounters. At the same time, the neurologist complained to Lee that she disliked seeing new patients because it was terribly time-consuming to review past medical records.

continued

CMS Transmittals and *Federal Register* Regulations
Sept. 16 – Sept. 22

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. 100-01, Medicare General Information, Eligibility and Entitlement Manual

- Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions, Trans. 101GI, CR 9748 (Sept. 16; eff./impl. Oct. 18, 2016)

Pub. 100-02, Medicare Benefit Policy Manual

- Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions, Trans. 227BP, CR 9748 (Sept. 16; eff./impl. Oct. 18, 2016)

Pub. 100-04, Medicare Claims Processing Manual

- Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions, Trans. 3612CP, CR 9748 (Sept. 16; eff./impl. Oct. 18, 2016)

Pub. 100-08, Medicare Program Integrity Manual

- Clarification of Certain Policies in Chapter 15 Regarding the Processing of Form CMS-855R Applications, Trans. 676PI, CR 9552 (Sept. 16; eff./impl. Dec. 19, 2016)

Pub. 100-20, One-Time Notification

- Updates to the 72X Type of Bill for Home and Self-Dialysis Training, Retraining, and Nocturnal Hemodialysis, Trans. 17150TN, CR 9609 (Sept. 16; eff. Jan. 1/impl. Jan. 3, 2017)
- Affordable Care Act - Operating Rules - Requirements for Phase II and Phase III Compliance for Batch Processing, Trans. 17160TN, CR 9358 (Sept. 16; eff. April 1; impl. April 3, 2017)

Federal Register Regulations

Final Rule

- Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 81 Fed. Reg. 63859 (Sept. 16, 2016)

Proposed Rule

- Revisions to State Medicaid Fraud Control Unit Rules, 81 Fed. Reg. 64383 (Sept. 20, 2016)

"That's not a case of 'a little is good, more is better,'" Lee said. "How favorably will a payer or outside entity reviewing for quality review this type of information?"

Another "wake-up alarm" for physicians is hierarchical condition categories (HCCs), Lee said. They are risk-adjusted payment models first implemented in 2004 in managed care models to reimburse at higher rates for sicker patients. "Risk-adjusted payment models are gaining in popularity," she noted. If any diagnoses that are part of HCCs are left off of claims, there's a possibility that physicians will lose reimbursement. "The correlation between high quality documentation and diagnosis codes assigned from documentation is very clear."

Contact Lee at christine.lee@cioxhealth.com. ✧

Kindred Pays $3 Million Fine for Violating CIA It Inherited in Purchase

Kindred Health Care, Inc. has paid a $3.073 million penalty for violating its corporate integrity agreement (CIA), the HHS Office of Inspector General said Sept. 20. It's the largest fine ever for running afoul of CIA obligations, OIG says.

There's a winded path from the origins of the CIA to the alleged violations. The five-year CIA began in 2012 with Odyssey Healthcare Inc., a national hospice provider. In March 2012, Odyssey agreed to pay $25 million to settle false claims allegations that it submitted claims to Medicare for continuous care services "that were unnecessary because the patients were not experiencing a crisis or that were not performed in accordance with Medicare requirements," according to the settlement.

Odyssey was later bought by Gentiva Healthcare, and in 2015, Kindred, the nation's largest post-acute care provider, acquired Gentiva and inherited the CIA obligations. But according to OIG, things went awry. After making several unannounced site visits to Kindred facilities, OIG said it found ongoing violations. Kindred allegedly failed to fix improper billing practices in the fourth year and didn't carry out policies and procedures mandated by the CIA. "Poor claims submission practices had led to significant error rates and overpayments by Medicare," OIG said.

According to OIG, Kindred was charging Medicare for hospice care for patients who either weren't eligible at all or who weren't eligible for the highest level of services.

"This stipulated penalty amount is shocking," says Tony Maida, former OIG deputy chief of the administrative and civil remedies branch. That's especially true considering the fact that Kindred didn't own Odyssey at the time it entered the CIA, he notes. "It's not clear whether this is a one-off or whether this signals a change in the way OIG monitors corporate integrity agreements."

Meanwhile, Louisville, Ky .-based Kindred has shuttered 18 "underperforming" sites since March 2015 because of findings from audits required by the CIA, OIG said. Also, in 2016, Kindred took "significant corrective actions, including upgrading internal audits and investigations and tracking resolutions of identified issues."

Kindred also operates under another CIA. This one stems from a 2016 false claims settlement with RehabCare Group Inc., RehabCare Group East Inc. — collectively known as RehabCare — and parent Kindred. They agreed to pay $125 million to settle allegations they caused skilled nursing facilities to submit false claims to Medicare for rehab that wasn't necessary or skilled or never happened *(RMC 1/18/16, p. 3)*.

Thomas Herrmann, former chief of the OIG Administrative Litigation Branch, says the fine shows that OIG is enforcing the terms of CIAs and making sure "they are not just window dressing." That's a reminder to providers operating under CIAs to watch their backs. "Any company that is subject to a CIA needs to put in place an operational process for ensuring full compliance with the terms," says Herrmann, senior vice president of Strategic Management in Alexandria, Va.

Contact Maida at tmaida@mwe.com and Herrmann at therrmann@strategicm.com. ✧

Expect More 60-Day Cases

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Second, Martin noted that Medicare overpayment refund rules are in place for all four parts of the program — A, B, C and D — "and CMS has made it clear they should be implemented by all providers and plans." In other words, there's no regulatory or judicial place to run or hide. In the A/B rules, CMS requires health care organizations to execute a proactive compliance program for overpayments and make a reasonable inquiry into potential overpayments when they receive credible information about them *(RMC 2/15/16, p. 1)*.

But alleged violations of the rule won't be shoved into every FCA lawsuit. "The 60-day rule is not supposed to be a stand-in for every violation. If it's pled as a mere redundancy to any other False Claims Act violation, it probably won't survive the pleading state," Martin says. "It will be its own freestanding claim that should have met its own particularized pleading requirements."

In addition to focusing on the 60-day rule, hospitals and other health care organizations should put their risk assessment and defense audit resources into the usual suspects. "While there will always be a flavor of the month, the great majority of cases that fall under

the False Claims Act are brought by whistleblowers, and whistleblowers are typically employees sitting in an office who think they see something that's wrong," she says. "These are not people who are in tune with the latest enforcement trends." Allegations in whistleblower cases continue to be "about pretty obvious stuff," including anti-kickback and Stark law violations, upcoding, medically unnecessary procedures and lack of documentation, Martin says. "These are the bread and butter of the False Claims Act and that won't change."

DOJ's Approach Is Evolving

But the DOJ's approach to civil and criminal enforcement is evolving. The Yates memo changed the way prosecutors in the main Department of Justice and its 92 federal districts pursue corporate fraud cases, and the U.S. Supreme Court decision in the *Escobar* implied certification case will reshape the false claims enforcement landscape, she says.

According to DOJ's September 2015 Individual Accountability Policy — better known as the Yates memo — corporations won't be able to settle fraud cases or get "cooperation credit" unless they reveal the names of "culpable" individuals *(RMC 9/14/15, p. 1; 12/14/15, p. 1)*. Prosecutors are expected to pursue them right off the bat — in both civil and criminal investigations — and they only get a pass on the attorney general's say-so.

Martin sees the Yates memo bearing fruit. False claims settlements no longer have a release of liability for individuals, which was standard language in the past "except in extraordinary circumstances," she says. "You will see in settlements going forward a carve-out of individuals for release." And more settlements have cooperation clauses, which put in writing the pledge the company makes to continue to produce information about individuals who may have been involved in the allegedly fraudulent scheme, Martin says.

Also, because assistant U.S. attorneys (AUSAs) will have to explain why they aren't accusing individuals of submitting false claims or other frauds, "many investigations will be more in depth and there will be more requests for substantial amounts of email focusing on higher level individuals," she says.

Another game-changer is the U.S. Supreme Court's June 16 decision in *Universal Health Services v. United States ex rel. Escobar (RMC 6/20/16, p. 1)*. The decision lent support to the theory of implied certification as a basis for a false claims case. Implied certification means the submission of a claim for payment carries with it the assurance that providers have complied with all conditions of payment, even if they haven't expressly certified compliance.

But the Supreme Court didn't make it too easy to connect the dots to a False Claims Act violation. The decision set forth two conditions under which the implied certification theory can be a basis for liability: (1) "The claim does not merely request payment, but also makes specific representations about the goods or services provided"; and (2) "The defendant's failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths."

The jury is out on whether providers can rely on the two-part test for determining false claims liability under the implied certification theory. In a Sept. 20 decision, *Rose et al vs. Stephens Institute* (09-cv-05966-PJH), the U.S. District Court for the Northern District of California ruled that the two-part test is not the only way to determine that a valid implied certification claim is being asserted, Martin says. "The court, here, adopted the government's argument, but the decision ultimately may be an outlier," she notes. "Other courts have adopted the *Escobar* two-part test in a definitive way and have dismissed claims on that basis. But we are only three months out from the *Escobar* decision, so it's hard to tell."

The *Escobar* decision will translate into more false claims cases that involve challenges to the "materiality of regulations," Martin says. The Supreme Court made it clear that every regulatory violation does not amount to a condition of payment and therefore a potential false claim. "In the world of reimbursement, there is a lot of gray area. Whether something is material will be very fact intensive." Because of *Escobar*, false claims cases built on regulatory violations will turn more on whether the government would have paid the claim if it had known about that particular instance of noncompliance, she says. In other words, was it material enough to have affected payment? Or was it some "immaterial violation"? Parsing this may lead to depositions of a lot more CMS policy and payment people than typically seen in false claims cases before *Escobar*, Martin notes.

In her 15 years with the U.S. attorney's office, Martin says she has found that organizations reduce their risks by having "very strong compliance people who are respected and know how to hold their ground." But they need support. "Hospitals exist to serve patients and give the best health care that can be provided, and compliance people are there to help hospitals fulfill their mission

within the lines of the law," she says. "It's very important to listen to those people — to listen to their legal advice and understand its limits — and be cognizant of the risks of crossing those boundaries." A theme in false claims cases is that compliance officers' or counsels' concerns about billing or financial arrangements were "overridden," Martin says, and/or they "couldn't get access to appropriate people" or legal advice was "stretched."

If the U.S. attorney's office is on the fence about a whistleblower case, it could be pushed toward intervention by this type of environment, she says. "There are scores and scores of qui tams filed every month," Martin notes. "There is a triage aspect to cases and there are things providers can do to be less appealing targets because there is a government resource issue. There's always a judgment that every assistant U.S. attorney handling these cases has to consider. The AUSA will always go where the facts support a clearer case."

Contact Martin at Rcmartin@mwe.com. ✧

NEWS BRIEFS

◆ **The U.S. District Court for the District of Columbia denied HHS's motion to delay until Sept. 30, 2017, proceedings in the case over the backlog of Medicare appeals,** but noted the court "does not possess a magic wand that, when waved, will eliminate the backlog." In 2014, the American Hospital Association asked the court to issue a *writ of mandamus*, which would require HHS to meet statutory deadlines for resolving appeals of claim denials before the Office of Medicare Hearings and Appeals. The court denied AHA's request, instead finding that resolution was best left to the administrative process. On appeal, the U.S. Court of Appeals for the District of Columbia reversed the lower court holding and sent it back to the lower court to "determine whether 'compelling equitable grounds' now exist to issue a *writ of mandamus*." The district court's decision ultimately turned on its assessment of "whether the administrative and legislative fixes offered in [HHS's] briefing constitute progress sufficient to warrant pausing this litigation until September 30, 2017." U.S. District Judge James Boasberg reviewed the two categories of actions presented by HHS: (1) administrative actions including estimates of the effect on the backlog; and (2) legislation to reform the appeals process and provide the agency with additional funding. According to Boasberg, HHS's proposed administrative fixes would result in 50% fewer backlogged OMHA appeals in fiscal year 2020. As impressive as that sounds, the court observed, "the OMHA backlog will still grow every year between FY 2016 and FY 2020 — from 757,090 to 1,003,444 appeals.… 'Significant progress toward a solution' cannot simply mean that things get worse more slowly than they would otherwise." He also brushed aside HHS's assertion that Congress would step in with increased budget support, stating "it must draw the conclusion that Congress is unlikely to play the role of the cavalry here, riding to the rescue of the Secretary's besieged program." Boasberg, however, reminded the parties that this ruling addresses only whether to grant a stay; it does not address the *mandamus* issue. Visit http://tinyurl.com/hz42lol.

◆ **CMS is suspending the pre-claim review demonstration for home health services.** CMS announced in the June 10 *Federal Register* that it would do home health prepayment reviews in Illinois, Florida, Texas, Michigan and Massachusetts. They were the responsibility of Medicare administrative contractors (MACs). CMS said on its website that the pre-claim reviews began in Illinois on Aug. 3, but because more education is necessary, it will not move forward in Florida. There is no word on when reviews will start in other states. Ronald Hirsch, M.D., vice president of Education and Regulations at Accretive Physician Advisory Services, figured the prepayment demonstration "would not run as smoothly as CMS anticipated." There has been a lot of confusion in the Medicare home health program around who documents the patient's homebound status and skilled needs. Contact Hirsch at rhirsch@accretivehealth.com. Visit http://tinyurl.com/hekrgqj.

◆ **North Carolina Baptist Hospital in Winston-Salem received overpayments of $1.48 million, according to a Medicare compliance review.** OIG audited 246 claims submitted by the 885-bed hospital between Jan. 1, 2013, and Aug. 31, 2014, and found errors in 209 of them that resulted in net overpayments of $221,481. "On the basis of our sample results, we estimated that the Hospital received overpayments of at least $1,488,468 for the audit period," OIG contends. The hospital disagreed with some of OIG's findings and its sampling and extrapolation methods, and plans to appeal some denials. Visit http://go.usa.gov/xKeQC.

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