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

Contents

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RACs Look Back Further in Reviews, Testing Hospital Documentation-Gathering Ability

When Katie Zeller, manager of government audit services for UCHealth in Colorado, opened a request for documentation from the new recovery audit contractor (RAC) earlier this month, she was in for a surprise. Some of the claims under review had dates of service going back three years. Although CMS allows RACs to look back three years, that hasn't been their M.O. in most of the audits in the past two years, Zeller says.

"That tells me the RACs are broadening their scope," she says. "They are starting to look back further than they have before. That's challenging from a release-of-information perspective."

As the second round of RAC reviews gets under way, compliance officials say they are seeing familiar territory with a few twists in the automated and complex reviews. The automated reviews on the RACs' approved issues list don't bode well for providers, so they're good areas to get a head start on internal reviews, says Stephen Gillis, director of compliance coding, billing and audits at Partners HealthCare in Boston. With automated reviews, "RACs are more or less sure you billed wrong," he says. "There's a 5% chance in automatic situations they are wrong."

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Hospital Settles HIPAA Privacy Case; Sensitive PHI Faxed to Patient's Employer

In a case that's a reminder not to overlook patient privacy requirements at a time when covered entities are facing ransomware and other security threats, St. Luke's-Roosevelt Hospital Center Inc. in New York City paid $387,200 to settle potential violations of the HIPAA privacy rule, the HHS Office for Civil Rights (OCR) said May 23.

St. Luke's, which is part of Mount Sinai Health System, runs the Institute for Advanced Medicine, formerly known as the Spencer Cox Center for Health. It treats people with HIV or AIDs and other chronic diseases. In 2014, OCR investigated a complaint that a Spencer Cox Center employee faxed a patient's protected health information (PHI) to the patient's employer. The PHI included information about HIV status, medical care, sexually transmitted diseases, medications, sexual orientation, mental health diagnosis and physical abuse, according to OCR. The patient had asked Spencer Cox Center to send the PHI to the patient's personal post office box.

OCR also found nine months earlier, Spencer Cox Center had another breach "but had not addressed the vulnerabilities in their compliance program to prevent impermissible disclosures."

The settlement is a departure from recent HIPAA resolution agreements, which have been focused on security rule violations (*RMC 5/1/17, p. 1*), says Minneapolis attorney Katie Ilten, with Fredrikson & Byron. But unencrypted laptops, electronic PHI and ransomware aren't the only risks that covered entities have to manage. "This is a totally different kind of HIPAA 101 privacy rule issue, which we haven't seen much of lately," she says. "Just because security is hot, it isn't the only thing to care about."

continued

The privacy rule allows patients to access their PHI, amend their PHI and request an accounting of disclosures (45 CFR 164.524). Generally, covered entities are required to provide patients, at their request, with access to a "designated record set," either to inspect it or get a copy or both.

"Directing communications to a particular address or by a particular method has been on the books since HIPAA came about," Ilten says. "You have to have controls specific to honoring patients' rights, like getting access to their information and being able to direct communications to a particular address or phone number and request alternative communication methods. Those rights are still there and just as robust as when they came to be. They're an oldie but a goodie. But it hasn't gotten as much press lately."

Covered entities should do a version of a risk assessment on the privacy side, Ilten says. How does information flow out of the organization and to the patient? Is there oversight of the processes to ensure PHI is sent to the right person? Is there a protocol for employees to check the release form to make sure PHI is released to the right person? Is there a reminder at the fax machine to double check the number and confirm the recipient's identity? Do you have a prompt in your e-mail when replying "all" that asks whether you're sure you want to send the e-mail to everyone? These seem like simple steps, but they can help prevent privacy breaches, Ilten says.

In a statement on the settlement, which includes a corrective action plan, Mount Sinai St. Luke's and Mount Sinai West said "patient privacy and security is a top priority at Mount Sinai St. Luke's and Mount Sinai West. We are working with HHS to meticulously review privacy and security protocols, ensuring all necessary safeguards are in place. Compliance with the Health Insurance Portability and Accountability Act is a core tenet of our work and we will continue to remain committed to attaining the highest levels of success in this regard."

Contact Ilten at kilten@fredlaw.com. View the resolution agreement at http://tinyurl.com/yboyo3am.✧

Hospital Uses OIG Resource Guide to Rate its Compliance Practices

Greater Hudson Valley Health System in Middletown, N.Y., has deepened its employee surveys in the wake of the March 27 release of the HHS Office of Inspector General's resource guide for measuring compliance program effectiveness (*RMC 4/3/17, p. 1*). It's one way the upstate New York health system has made use of the resource guide, which is a list of "ideas" to help providers measure the effectiveness of the seven elements of their compliance programs.

Before the debut of the resource guide, Greater Hudson Valley Health System asked more conventional questions on compliance surveys, says Stephen Sugrue, vice president of compliance, real estate and audit. For example, employees were asked if they knew about the hotline and could identify the compliance officer. But now the health system has expanded the scope of its employee-survey questions, and did it just in time for National Hospital Week, which was May 7 to 13. It used versions of questions from the resource guide, including:

◆ Do department policies and procedures assist you in doing your job effectively?

◆ Do you know the content of the code of conduct and how to access it?

◆ What's your perception of the compliance officer's role?

◆ Do you know who "the compliance team is, how to get to them and what to tell them?"

◆ Is the compliance staff approachable? Are the people in the compliance department "solution facilitators or looked at as the organizational police force?"

◆ "Does the compliance department have an impact on how you do your job?"

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Employees who answered the survey were entered into a raffle to win a $100 gift card, and 1,116 out of 3,000 employees responded, Sugrue says. While the health system is now analyzing the answers, preliminary results have been revealing. For example, there were requests for more training on protected health information and social media, and one employee expressed concern about hallway conversations. A number of people were positive about the compliance program.

Two months after its release, Sugrue has compared all the compliance practices at Greater Hudson Valley Health System against the OIG resource guide, which was developed with the Health Care Compliance Association. Although OIG and HCCA caution compliance officers that it's not a checklist and that using all the items or even a large number of them "is impractical," Sugrue felt a little rebellious. "I did the opposite," he says.

He went through the entire document, assigning ratings to Greater Hudson Valley Health System in every area (see box, p. 3). If the health system already engages in the ideas suggested by the resource guide, they're marked green. If there is room for improvement, that's indicated by the color yellow. Any problem areas show up as red.

"This tool is more useful if you do an honest self-assessment," he says. "We felt some were green and some were yellow. We had no red." The health system did a similar exercise when the New York State Office

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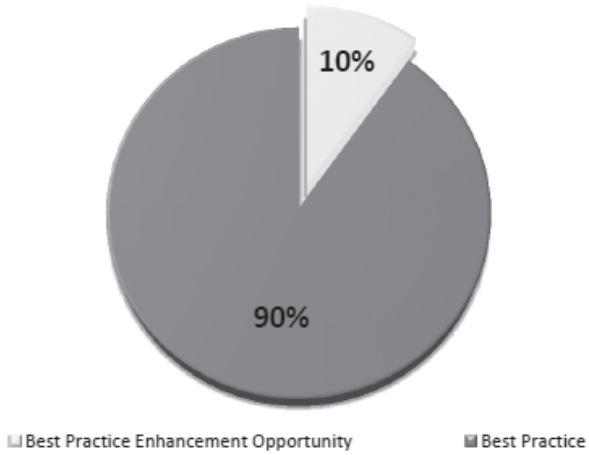
Applying the OIG Resource Guide for Measuring Compliance-Program Effectiveness

Greater Hudson Valley Health System in upstate New York rated its compliance practices against the HHS Office of Inspector General's resource guide for measuring compliance-program effectiveness, which was released March 27, says Stephen Sugrue, vice president of compliance, real estate and audit. If they were consistent, he gave them a green. If there is room for improvement, they're marked yellow. Anything way off gets a red. Contact Sugrue at ssugrue@ghvhs.org.



OIG Compliance Program Effectiveness	% Best Practice	% Best Practice Opportunities
Element 1: Standards, Policies, and Procedures	85%	15%
Element 2: Compliance Program Administration	95%	5%
Element 3: Screening and Evaluation of Employees, Physicians, Vendors and other Agents	73%	27%
Element 4: Communication, Education, and Training on Compliance Issues	76%	24%
Element 5: Monitoring, Auditing, and internal Reporting Systems	98%	2%
Element 6: Discipline for Non-Compliance	98%	2%
Element 7: Investigations and Remedial Measures	99%	1%

Tracking Reports to the Board Compliance Committee on Policy Updates

When it benchmarked its compliance practices against OIG's resource guide for measuring compliance-program effectiveness, Greater Hudson Valley Health System realized it wasn't informing the board's audit and compliance committee of the status of policy reviews, as suggested. That gap was immediately closed with a list of policies. Contact Sugrue at ssugrue@ghvhs.org.

Compliance & HIPAA Policies	Next Review Deadline	Review Status
GHVHS COMPLIANCE AUDITING AND MONITORING	2/2018	●
GHVHS COMPLIANCE INVESTIGATIONS	2/2018	●
GHVHS COMPLIANCE OFFICER	2/2018	●
GHVHS COMPLIANCE WITH FEDERAL AND STATE FALSE CLAIMS ACTS AND WHISTLEBLOWER PROTECTIONS	2/2018	●
GHVHS CONFLICT OF INTEREST	2/2018	●
GHVHS ETHICAL CODE OF BEHAVIOR: ORGANIZATIONAL	2/2018	●
GHVHS EXIT INTERVIEW	2/2018	●
GHVHS FEDERAL SUBPOENA	2/2018	●
GHVHS GIFTS, GRATUITIES, AND BUSINESS COURTESIES POLICY	2/2018	●
HIPAA VIOLATION, BREACH NOTIFICATION & DISCIPLINE POLICY	4/2019	●
GHVHS HIPAA BUSINESS ASSOCIATE AGREEMENT POLICY	2/2018	●
ORMC HIPAA NOTICE OF PRIVACY PRACTICES POLICY	2/2018	●
GHVHS HIPAA PRIVACY POLICY	2/2018	●
GHVHS HOTLINE OPERATIONS	2/2018	●
GHVHS JOINT VENTURE REVIEW AND APPROVAL	2/2018	●
GHVHS NON RETALIATION	2/2018	●
GHVHS OMIG AUDIT PROCESS	2/2018	●
GHVHS PHYSICIAN AND CLINICAL SERVICES CONTRACT MANAGEMENT	2/2018	●
GHVHS SANCTION SCREENING	2/2018	●
GHVHS HIPAA COMPLAINT FILING	2/2018	●
GHVHS DISCLOSING PHI TO PATIENT'S FAMILY/FRIENDS VIA TELEPHONE	3/2018	●
GHVHS Code of Conduct	2/2018	●
GHVHS Compliance Plan	2/2018	●
GHVHS HIPAA Privacy & Security Reference Tool	2/2018	●
GHVHS Policies with Compliance as a concurrence	**Review Date**	**Review Status**
GHVHS DISCOUNTS, "PROFESSIONAL COURTESIES," AND CO-PAYMENT WAIVERS	2/2018	●
GHVHS FUNDRAISING OPT-OUT POLICY	2/2018	●
GHVHS MARKETING OPT OUT POLICY	2/2018	●
GHVHS MEDICAID CREDIT BALANCES	2/2018	●
GHVHS EMPLOYMENT OF RELATIVES/ANTI-NEPOTISM POLICY	2/2018	●
QUALITY AND SAFETY ADVERSE EVENT-OCCURRENCE, NEVER EVENT, & HAC PROCESS	8/2018	●
NON-CLINICAL CONTRACTS (GOODS, SERVICES, MANAGED CARE, ETC.)	3/2018	●
GHVHS ACCESS TO PATIENT HEALTH INFORMATION AND BUSINESS INFORMATION	3/2018	●
GHVHS FAX TRANSMISSIONS POLICY	11/2017	●
GHVHS HIPAA SECURITY OFFICER POLICY	8/2018	●
GHVHS INFORMATION SYSTEM AUDIT LOGGING POLICY	5/2019	●
GHVHS IT SECURITY INCIDENT POLICY	6/2018	●
GHVHS MEDICAL RECORD ENTRIES CORRECTION AMMENDMENT LATE ENTRY	2/2018	●
GHVHS MEDICAL RECORD INFORMATION DISCLOSURE	2/2018	●
GHVHS PROTECTED HEALTH INFORMATION CONFIDENTIAL MATERIAL DESTRUCTION (PHI)	3/2018	●
GHVHS RECORD RETENTION AND DESTRUCTION	4/2018	●
HIPAA SPECIAL REQUEST	3/2018	●
ORMC FACILITY SECURITY POLICY	9/2018	●
GHVHS MEDIA-HARDWARE USE, RE-USE, DESTRUCTION AND DISPOSAL POLICY	6/2018	●
ADVANCED BENEFICIARY NOTICE/OUTPATIENT MEDICAL NECESSITY VALIDATION	2/2018	●
APPLYING MODIFIERS TO CLAIMS BEING BILLED	3/2018	●
COST REPORT PREPARATION, REVIEW & SUBMISSION	1/2018	●
GHVHS ELECTRONIC HEALTH RECORD AUDITING	6/2017	●
EMTALA POLICY	6/2018	●
GHVHS ENCRYPTION POLICY	6/2018	●
INFORMATION MANAGEMENT PLAN	10/2018	●
GHVHS PASSWORD MANAGEMENT POLICY	4/2018	●
PATIENT COMPLAINTS ANDGRIEVANCES: MANAGEMENT OF	11/2018	●
GHVHS REMOTE ACCESS	9/2018	●
GHVHS SECURITY AND CONFIDENTIALITY OF INFORMATION	3/2018	●
GHVHS WORKSTATION SECURITY POLICY	4/2018	●
ADVANCED BENEFICIARY NOTICE (ABN) OF NON-COVERAGE FOR OBSERVATION PATIENTS	12/2018	●

LEGEND:	● Policy review current (green)	◆ Policy in review (yellow)	■ Policy review past due (red)

of Medicaid Inspector General published compliance review guidance in 2012 (*RMC 5/21/12, p. 1*). Compliance programs are mandatory in New York state for providers that bill Medicaid more than $500,000 a year.

Another suggestion in the OIG resource guide is to make the board audit and compliance committee aware of the status of policy reviews. Sugrue said the health system wasn't doing that, so it immediately shifted gears. At its May 22 board meeting, "we presented a graph of the review status of all our policies to show we review them routinely," he says. The compliance team reviews policies every two years, but had never presented a complete list to the board (see box, p. 4).

More Oversight of Vendors May Be Needed

The resource guide also suggests health care organizations review test scores after training, Sugrue says. "We realized we could do that better," he notes. Employees sit through all kinds of training, including new orientation, compliance, infection control and safety, and take tests after to evaluate their comprehension. Following up on how employees perform on the tests—for example, if they fail or their performance is subpar, should they receive handouts or other forms of additional education?—is a good area to measure, he says. "We are going to think about how to do that as part of our plan," he says.

On a related note, training of vendors is mentioned in the resource guide. In the section on accountability of vendors, the resource guide suggests that health care organizations "review training materials and interview staff to determine the effectiveness of the education" and "audit job descriptions to ensure compliance obligations are clearly articulated." Sugrue tagged this area a yellow, which means it could stand a little improvement. "It's a little more difficult because it involves not just the folks who work at your hospital, but vendors" who make promises in contracts to train their employees, he says.

Although the resource guide is large and may seem overwhelming, Sugrue finds the benchmarking experience very helpful. "Health care is one of the most complicated businesses on the planet," he notes. "At least the government gave us guidance to help us navigate through the complications."

Contact Sugrue at ssugrue@ghvhs.org. View the resource guide at http://go.usa.gov/xX9Dc. ✧

Hospital, Clinic Pay $34M to Settle Stark Case Over Compensation

In a case about compensation for oncologists, Mercy Hospital Springfield and Mercy Clinic Springfield in Missouri agreed to pay $34 million to settle Stark-related false claims allegations, the Department of Justice said May 18. The clinic allegedly took into account the volume and value of the physicians' referrals to Mercy Hospital's Mercy Oncology Infusion Center - Chub O'Reilly Cancer Center in setting their compensation, according to the settlement.

The catalyst for the case was a change in the ownership of the infusion center. Until 2009, Mercy Clinic owned the infusion center, and its profits were distributed among the practicing physicians under a "collection compensation model," according to the complaint. But sometime around 2009, Mercy Hospital converted the infusion center to a hospital outpatient department to generate more profit, partly through eligibility for 340B drug discounts, the complaint alleged.

After the transfer of ownership, patients were seen by their oncologists at Mercy Clinic in the Chub O'Reilly Cancer Center for an evaluation and management service, and then went down the hall to the infusion center for chemotherapy in the hospital outpatient department, paying separate copays.

M.D.s Were Worried About Their Income

Because Mercy Clinic no longer billed for infusions, the physicians were concerned about losing "a substantial portion of the income they had received under the collection compensation model," according to the complaint. It turned out they had nothing to worry about, the complaint alleged. "The physicians practicing in the Cancer Clinic were reassured by Defendants Mercy Clinic and Mercy Hospital that they would be 'made whole for any income they stood to lose as a result of the transfer of ownership of the Infusion Center,'" the complaint alleged.

In March 2009, a new compensation model was introduced that included "margin replacement" based on work relative value units (work RVUs) for drug administration in the hospital department. The work RVUs allegedly would be applied to all patients the physicians sent to the infusion center, according to the complaint. Mercy Hospital paid Mercy Clinic the new work RVUs for drug administration and Mercy Clinic paid the physicians. The complaint alleged that the new work RVU for drug administration wasn't based on physician work, clinical expense or malpractice overhead; instead, it was calculated "by working backwards from a desired level of overall compensation."

According to the complaint, the clinic paid 12 physicians under the new compensation model, for varying lengths of time. The clinic physicians also allegedly were paid fees to manage the infusion center even though they weren't responsible for management of the infusion center. One physician received "substantial medical director

fees" despite the fact he didn't perform services beyond his clinical work, the complaint alleged.

The hospital and clinic did not admit liability in the settlement. Their attorneys didn't respond to *RMC*'s request for comment.

"This settlement demonstrates the government's continuing commitment to False Claims Act cases where only Stark violations are alleged," says former federal prosecutor Richard Westling, with Waller Lansden in Nashville. "These cases have allowed the government to extract high-dollar settlements based on the Stark damages formula that focuses on tainted claims submitted during the period of non-compliance. Hospitals have to be careful when they take a creative approach to physician compensation and ensure they get outside support on fair-market value and commercial reasonableness."

The case was initiated by a whistleblower, hematologist-oncologist Viran Roger Holden. He was employed by Mercy Clinic in Springfield, Mo., between sometime in 2005 and May 2015, the complaint said.

Contact Westling at Richard.westling@wallerlaw.com. Visit http://tinyurl.com/n826yg7. ✧

Physician Settles FCA Case After Disregarding Medicare Exclusion

The five-year Medicare exclusion of an Albany, N.Y., physician became a lot more punitive when he billed the program anyway.

Endocrinologist Michael Esposito, M.D., has agreed to pay $100,000 to settle false claims allegations and to steer clear of Medicare and other federal health care programs for 15 years, the U.S. Attorney's Office for the Northern District of New York said May 23.

In the first go-round, Esposito dealt exclusively with the HHS Office of Inspector General. He agreed in December 2016 to the five-year exclusion in connection with his forging of opioid prescriptions on another physician's pad for himself and someone else.

Because of the exclusion, Esposito wasn't supposed to bill federal health care programs for any goods or services. But he didn't keep his promise, according to the settlement. "The United States contends, and Dr. Esposito admits, that Dr. Esposito presented claims for payment to Medicare for services that he furnished, ordered and prescribed to Medicare beneficiaries from December 9, 2016, to February 15, 2017," the settlement says.

So now the hammer of the False Claims Act falls on Esposito, in addition to an extended exclusion. "It's not just administrative this time around," Assistant United States Attorney Adam Katz says. "When our office learned that Dr. Esposito was continuing to submit claims to Medicare after he was excluded from the program, we pursued that conduct under the False Claims Act."

The federal government learned of Esposito's billing the old-fashioned way. "OIG received a tip that this provider was billing inappropriately, investigated the allegations and determined they were credible," Katz tells *RMC*.

Esposito's attorney didn't respond to *RMC*'s request for comment.

Contact Katz at adam.katz@usdoj.gov. Visit www.justice.gov/usao-ndny. ✧

New RACs Look Back Further

continued from p. 1

At UCHealth, DRG validation is the focus of the RAC documentation requests so far, as it was for hospitals during the first round of the RAC contracts after short hospital stays were taken off the table, Zeller says. "With DRG validations, they looked back six to 12 months," she says. But this first batch of requests was an eye-opener because UCHealth also received requests for older documentation for sacral neurostimulation and cardiac PET scans. That raises the specter of denials based on the inability to locate documentation at all, or in time, rather than the medical necessity of the services performed.

This is worrisome for hospitals that have gone through mergers and acquisitions and/or electronic medical record conversions. That's the case with UCHealth on both counts. "Our electronic medical record and the way we have captured information as recently as three years ago has changed. Documentation lives in a new or different place," Zeller says. "It impacts us in terms of legacy dates of service being pulled for audit."

If the RAC is looking back three years with a medical necessity review of sacral neurostimulation, Zeller

CMS Transmittals
May 19 - 25

Live links to the following documents are included on *RMC*'s subscriber-only webpage at www.hcca-info.org. Please click on "CMS Transmittals."

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- Instructions to Process Services Not Authorized by the Veterans Administration (VA) in a Non-VA Facility Reported With Value Code (VC) 42, Trans. 3779 (May 24, 2017)
- Screening for the Human Immunodeficiency Virus (HIV) Infection, Trans. 3778 (May 24, 2017)

assumes a clean audit will keep the RAC at bay. "But if they deny it, I guarantee there will be four to five claims with the same rationale on the next audit and a broader look-back period," she says. "They are invested and they don't want to waste time."

Because some of the RAC documentation requests may go back further, hospitals may miss medical records unless they validate their accuracy and integrity, Zeller says. That's not always as simple as pushing the ROI button in the EHR system. "The ROI data set may not be the same as what you had three years ago," she notes. To avoid denials for insufficient documentation, UCHealth is doing a preliminary review of medical records before they're released to external auditors, Zeller says. That won't always be possible—for example, there's no way to screen 400 medical records in 30 days—but "when you have a smaller request, now is the time to do smaller reviews." It's a review for administrative error vs. clinical error, she notes.

"And then, on the back end, you analyze denials to determine the root cause," Zeller says. "Was it a deficiency in medical records or services rendered or that you failed to provide documentation to support the services rendered? There were cases where we had the documentation, but we struggled to get it out the door." It becomes more problematic with Medicare administrative contractor (MAC) probe audits and quality improvement organization (QIO) reviews of the two-midnight rule. If the contractor establishes a high base error rate for your hospital, it becomes a target for more auditing, she notes.

That's very much on her mind with the RACs, whose only role with the two-midnight rule is to audit hospitals referred by QIOs for persistent noncompliance. "The RACs are prepped and ready to go," she says.

Beating RACs to the Punch

It may not be long before QIOs refer hospitals that are repeat offenders under the two-midnight rule to RACs, says Ronald Hirsch, M.D., vice president of R1 Physician Advisory Services. Now that CMS has changed the QIOs' marching orders for short-stay reviews—they randomly sample 25 claims at the 175 hospitals with a high volume of short-stay claims or an increasing number of short-stay claims (*RMC 4/3/17, p. 1*)—the noncompliant hospitals presumably will be easy to identify, he says.

"I expect those at the top of the 175 hospital list to get attention not only from the QIO but from other auditors," Hirsch says. He suggests they calculate their own percentage of short stays every week or month based on the Program for Evaluating Payment Patterns Electronic Report (PEPPER). If the number looks high, "it would be wise to audit internally," he says.

Even as clinical and administrative processes have improved at the hospitals within UCHealth, it's a continual struggle to keep everyone on the same page, Zeller says. "It's a collaborative effort, and it's not driven solely by the compliance department. We work on it on an ongoing basis."

Using its internal data, Partners HealthCare is moving fast to get a jump on the RACs. "We are taking advantage of the approved items list and trying to establish our own internal controls to prevent billing incorrectly and identify ways to prevent the RACs from taking money back," Gillis says. He is focusing on 28 risk areas from the approved issues on the web site of Performant Recovery, the RAC for Massachusetts. There are a lot of discharge status codes on its hit list "and I am drilling down in a greater way than they do," he says. "It's a much larger issue than it was five or 10 years ago." Two hospitals just settled civil monetary penalty cases for billing Medicare for patients transferred to home health as if they were discharged (*RMC 5/22/17, p. 1*).

Confirming patients were transferred to an inpatient rehab facility (IRF), skilled nursing facility (SNF) or a psychiatric hospital, for example, is feasible when they're owned by Partners HealthCare, but it's an uphill battle if they go to unrelated facilities. "We just don't have the data," he says, although hospitals can get it from the Medicare common working file. Meanwhile, he is setting up edits in the billing system to minimize the risk of improperly coded transfers. For example, if there are SNF, IRF or long-term hospital claims with an admit date identical to the date of discharge, they will be flagged for review.

Automated reviews are probable errors, Gillis says. He hadn't seen it before, for example, but the RAC plans to review claims with more than four billed units of zoledronic acid. "We want to figure out why that's a problem," he says. "Why wouldn't we set up our system to look?"

In terms of complex reviews, bariatric surgery, cardiac PET scans and cataract surgery (*RMC 3/27/17, p. 1*) are familiar, but panretinal (scatter) laser photocoagulation (excess frequency) is a new one. If they weren't high-risk areas, RACs couldn't have gotten CMS approval to audit them, he says.

RACs Are All Over Physicians

Physicians will be getting a lot of attention from the RACs. "Physicians need to be aware their money is at risk," Hirsch says.

Most physician billing reviews on the RACs' list are automated, says Betsy Nicoletti, a consultant in Northampton, Mass. What's unusual is the errors should have been prevented by the MACs, she says. "They're

the lowest-hanging fruit in terms of whether the MAC is processing things correctly," Nicoletti notes. For example, is cataract removal performed twice on the same eye? Was the add-on procedure code billed without a primary code? Was modifier 57 billed appropriately with the global surgery code?

There are also complex reviews that are very specific. The RACs plan to review, for example, whether "modifier-59 has been inappropriately appended when Endomyocardial Biopsies and Right Heart Catheterizations are billed together." They're a hospital outpatient target as well.

The RAC is taking this on from the HHS Office of Inspector General, which recently released a report that concluded "hospitals nationwide generally did not comply with Medicare requirements for billing outpatient right heart catheterizations and heart biopsies provided during the same patient encounter, resulting in estimated overpayments of $7.6 million over approximately 2 years." Some of the errors stemmed from misuse of modifier 59, OIG said.

RACs "seem to be picking on a lot of things where the OIG has shown success," Gillis says. "Would you rather have an OIG perform a comprehensive compliance audit and extrapolate their findings or have the RAC audit these areas and simply take the money back for occasional errors in a more timely fashion? I'd rather have the RAC audit us. It also potentially takes risk areas off the table for future OIG hospital audits if the RAC is continuously looking at data and taking one-offs back."

Although the RACs are gearing up, this second round probably won't be as aggressive as the first round, says attorney Andrew Wachler, with Wachler & Associates in Royal Oak, Mich. CMS has made it a slightly kinder and gentler program. For example, the number of additional documentation requests is now correlated to a provider's denial rate. "There's recognition if you demonstrate substantial compliance, you will have a lower limit," he says. Also, RACs must maintain an overturn rate of 10% or less at the first level of appeal. "So they won't throw everything against the wall and see what sticks," Wachler predicts.

Contact Gillis at sjgillis@partners.org, Zeller at Katie.Zeller@uchealth.org, Wachler at awachler@wachler.com, Hirsch at rhirsch@r1rcm.com and Nicoletti at betsy.nicoletti@gmail.com. ✧

NEWS BRIEFS

◆ **A Missouri physician and her neurology practice agreed to pay $291,288 to settle false claims allegations over Medicare claims for Botox and Myobloc injections,** the U.S. Attorney's Office for the Eastern District of Missouri said May 22. Sherry X. Ma, M.D., of Ladue, and AIMA Neurology, LLC, received free vials of Botox and Myobloc that were intended for use with specific patients covered by private insurers. When there was leftover medication in the single-dose vials, Ma didn't discard them, the U.S. attorney's office alleged. She kept and stored the leftover Botox and Myobloc at AIMA Neurology, and allegedly used the rest on Medicare patients, submitting claims as if she had bought new vials. "Dr. Ma and AIMA Neurology's medical records for certain Medicare patients were false in that they contained incorrect lot numbers of the Botox® and Myobloc® vials used in treatment with Medicare patients," the U.S. attorney's office alleged. Visit http://tinyurl.com/yb4leael.

◆ **A Houston-area psychiatrist was convicted May 23 for his part in a $158 million Medicare fraud scheme,** the Department of Justice and U.S. Attorney's Office for the Southern District of Texas said. A federal jury found Riaz Mazcuri guilty of one count of conspiracy to commit health care fraud and five counts of health care fraud in connection with the notorious Riverside General Hospital case. So far, 15 other people have been convicted of offenses stemming from the scheme, which involved paying and receiving kickbacks. The case centered on the hospital's partial hospitalization program (PHP), which is an intense outpatient program for severe mental illness. According to DOJ, Mazcuri was part of the scheme to pay kickbacks to employees of nursing homes and owners of group homes to send Medicare patients to Riverside's PHPs. "Mazcuri indiscriminately admitted and readmitted these patients into these intensive psychiatric programs—often for years on end—many of whom suffered from severe Alzheimer's or dementia and were unable to participate in the treatment purportedly provided at the PHPs, and who therefore did not qualify for the services, the evidence showed," DOJ stated. Among the other people convicted are Earnest Gibson III, the former president of Riverside, and Earnest Gibson IV, the operator of a Riverside PHP satellite location. Visit http://tinyurl.com/y9dyq383.