With Stark as the Sword, DOJ Takes On Hospital Over Physician Incentive Pay

Physician incentive compensation is at the heart of a false claims lawsuit against Halifax Hospital Medical Center and Halifax Staffing Inc. in Daytona Beach, Fla. The Department of Justice alleges the hospital and affiliated staffing company violated the Stark law partly because their compensation for certain neurosurgeons and oncologists was linked to the volume and value of patient referrals.

The lawsuit was filed in July 2009 by whistleblower Elin Baklid-Kunz, who worked in the hospital’s compliance department as revenue integrity coordinator before becoming director of physician services at Halifax Staffing. After a two-year investigation, DOJ announced that it is taking on parts of the case, including allegations the hospital used bonus pools to reward physicians for referring patients to the hospital. “The United States has now determined that it has good cause to intervene concerning defendants’ financial relationships with various physicians, which the government believes violate the Stark law and led to the submission of false claims,” according to its motion to intervene. If the U.S. District Court in Orlando accepts the motion to intervene, DOJ will file its own complaint by Nov. 8.

The message from the case is clear. “Unless hospitals structure their relationships with physicians very carefully, Stark makes for easy pickings and the government realizes that,” says Macon, Ga., attorney Alan Rumph, with Smith Hawkins.

But Washington, D.C., attorney Reed Stephens, who represents Halifax Hospital and Halifax Staffing, says “a lot of this case has fallen away.” The whistleblower’s complaint is full of allegations of medically unnecessary admissions and anti-kickback violations, but “DOJ recognized there is no merit to any of those allegations,” says Stephens.

CMS Modifies Teaching Physician Guidance, Clarifies Billing for Low-Level Consults

CMS has revamped its summer guidance on teaching physician billing and documentation.

In Medicare Transmittal 2303, the agency changes its tune on the GC modifier and the supervision of residents with fewer than six months of experience in certain primary care settings. In the process, CMS rescinds Transmittal 2247, which was released in June. But the new transmittal adopts most of the content of the earlier version with the exception of the two changes.

Here are the two changes:

1. CMS says that services provided by a teaching physician must have the GC modifier appended. The transmittal clarifies teaching physicians’ use of the GC modifier and what it signifies with respect to their physical presence and participation.

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(2) CMS recognizes that residents with less than six months of experience can be included in the resident-to-teaching physician ratio (four to one) under the primary care exception rule.

The new transmittal has other important clarifications that are welcomed by teaching hospitals, because CMS formalized guidance that up until now had only been provided verbally. For example, CMS states that teaching physicians can incorporate a resident’s documentation of a patient treated late the night before as long as the teaching physician updates the note.

“When a medical resident admits a patient to a hospital late at night and the teaching physician does not see the patient until later, including the next calendar day: The teaching physician must document that he/she personally saw the patient and participated in the management of the patient,” it says. “The teaching physician may reference the resident’s note in lieu of re-documenting the history of present illness, exam, medical decision-making, review of systems and/or past family/social history provided that the patient’s condition has not changed, and the teaching physician agrees with the resident’s note.”

In another development, CMS issued guidance on physician billing for low-level consultations. This was a compliance black hole when CMS was phasing out the use of evaluation and management (E/M) codes for consultation services.

The agency now says that physicians can use subsequent hospital care E/M codes to bill for consultations if necessary, according to MLN Matters 7405.

CMS Clarifies Consultation Billing

“When documentation doesn’t meet the lowest level of admission code, you can bill whatever subsequent hospital care code is supported by the documentation,” says Millie Johnson, institutional compliance officer for Texas Tech University Health Sciences Center.

The challenge with billing lower-level consultations emerged as CMS eliminated inpatient and outpatient consultation codes (except for telehealth). Effective Jan. 1, 2010, physician consults were billed to Medicare under regular E/M codes (RMC 12/21/09, p. 1). For example, consulting physicians will use 99221 to 99223 for initial inpatient evaluations and 99231 to 99233 for subsequent hospital visits. That means five levels of consultation services must now fit into three levels of services.

As it turned out, some physician consults did not fit in the new scheme of things. They don’t rise to the level of a 99221 initial inpatient visit because the patient exam, history and/or medical decision making is not complex enough (according to Medicare E/M documentation guidelines). But with CMS apparently planning to keep writing checks for low-level consults, Medicare contractors had to devise ways to process these claims. Some Medicare administrative contractors told hospitals and physicians to bill lower-level consultations under unalisted CPT code 99499. Other contractors want these consultations reported as subsequent hospital visits because they believe the use of the unalisted code is inappropriate.

CMS had pledged to issue national guidance and apparently that day has come. According to MLN Matters, “In situations where the minimum key component work and/or medical necessity requirements for initial hospital care services are not met, subsequent hospital care CPT codes (99221 and 99232) could potentially be reported for an E/M service that could be described by CPT consultation code 99251 or 99252....Physicians may report a subsequent hospital care CPT code for services that were reported as CPT consultation codes (99241 – 99255) prior to January 1, 2010, where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider’s first E/M service to the inpatient during the hospital stay.”
Deferred prosecution agreements, which the Department of Justice uses to coax corporations back to good citizenship with the carrot of avoiding criminal charges and Medicare and Medicaid exclusions, have factored prominently in two recent cases.

Under deferred prosecution agreements, DOJ delays execution of criminal charges if the company agrees to a series of reforms, such as compliance programs and the appointment of an independent monitor. If the company abides by the terms of the agreement, which typically lasts two years, it will escape the criminal charges altogether.

In the first case, Maxim Healthcare Services, Inc., a major provider of home health care services, has entered into a deferred prosecution agreement and agreed to pay hundreds of millions of dollars in criminal fines and civil settlements stemming from alleged fraud against certain federal health care programs. The case also is an example of the federal government’s recent efforts to make fraud associated with nursing homes, hospice care and home care a major priority.

The Maxim case stems from a whistleblower lawsuit filed in 2004 by patient Richard West, who received services from Maxim employees at his home in Tuckerton, N.J. West alleged that Maxim was engaging in “no-show billing” as an incentive for nurses to work for the company so it wouldn’t have to give them raises. For example, one of West’s nurses told him the company allowed her to work only three hours on Sundays, but get paid for eight.

It’s rare but not unprecedented for patients to initiate whistleblower cases. For example, HealthSouth paid $325 million in December 2004 when a beneficiary filed a false claims suit after his warnings to Medicare fell on deaf ears.

In May 2003, West said Maxim nurses provided him with 286.75 hours of care, but billed Medicaid for 323.5, more than 33 hours in excess for one patient in one month. He also alleges that the practice prevented him from receiving care because the billings made it look like he was exceeding the cap the state places on services provided under the waiver program.

Maxim, a home health provider in Columbia, Md., was charged on Sept. 12 in a criminal complaint with conspiracy to commit health care fraud. The feds allege the company submitted more than $61 million in fraudulent billings to Medicaid and the Department of Veterans Affairs for services that were not rendered or were otherwise not reimbursable.

The feds add that from 2003 through 2009, former Maxim executives and employees allegedly created or modified timesheets to match billings submitted to Medicaid for services not rendered. Some of the billings allegedly were submitted through licensed offices when the care actually was handled by offices that were operating without licenses and were being concealed from government auditors and investigators. The employees also allegedly generated bogus documentation that purported to show caregivers’ training and qualifications had been met, the feds say.

According to the U.S. Attorney’s Office for the District of New Jersey, nine individuals — including eight former Maxim employees — already have pleaded guilty to related charges, plus creating fraudulent documentation and making false statements to government health care program officials regarding the company’s activities.

But Maxim has entered into a 24-month deferred prosecution agreement (DPA) that allows the company to avoid a conviction as long as it complies with reform and compliance requirements. The DPA “requires Maxim’s acceptance and acknowledgement of full responsibility for the conduct that led to the government’s investigation.” If the government engages in criminal proceedings in two years, the DPA says Maxim will not contest or contradict the facts in the case, according to the agreement.

Maxim to Pay $150 Million

The DPA requires that Maxim cooperate in ongoing investigations of former employees who allegedly took part in the conduct. The company also must develop and operate effective corporate compliance and governance programs with internal controls that will prevent the recurrence of improper or illegal activities, the feds say. In addition to the DPA, Maxim will pay a $20 million criminal penalty.

The company also will pay $130 million in civil settlements with state Medicaid programs and the Department of Veterans Affairs to resolve allegations that it billed for services not rendered, not properly documented and performed by 13 unlicensed offices. Forty-two states will share $60 million of the civil settlement total, with the rest going to the federal government.

Maxim also entered into a corporate integrity agreement with the HHS Office of Inspector General that requires the company to hire an independent monitor.
to review its business operations and report back to the government on whether Maxim is complying with federal and state health care laws and regulations. OIG posted the agreement to its website on Sept. 21. West will receive $15.4 million as part of the settlement agreement.

The government explains that it decided to enter into the DPA with Maxim because current executives there have cooperated with the government while the investigations and charges against former employees have unfolded. The reforms began in May 2009, the feds say, with "significant personnel changes," including terminations of senior executives and other employees who allegedly participated in the conduct, in addition to filling positions such as the chief compliance officer and chief quality officer. "The company has also significantly increased the resources allocated to its compliance program," the government says.

"We take full responsibility for these events set forth in the Deferred Prosecution Agreement and we are pleased to reach a settlement that will allow us to move forward with the important work of caring for our patients and clients who depend on us each and every day," Maxim CEO Brad Bennett says in a statement.

Maxim explains that a compliance officer hired since the investigation began has developed a compliance and ethics program that includes internal audits and training. The person appointed to the position has worked with OIG and DOJ on investigating and resolving False Claims Act cases; reviewing compliance programs; drafting, negotiating and monitoring corporate integrity agreements; and reviewing annual reports, the company says.

This case is more evidence of the federal government’s desire to crack down on fraud in the nursing home, hospice care and home care industries, says attorney Brian McEvoy, with Chilivis, Cochran, Larkins & Bever LLP in Atlanta. And Medicaid Fraud Control Units are constantly working on joint investigations with federal prosecutors on both civil and criminal matters, he adds.

“One tactic becoming more common in health care fraud investigations is to have joint civil and criminal investigations” like this one, he says. Despite the criminal charges, Maxim probably is escaping Medicare and Medicaid exclusion as long as it abides by the terms of the DPA.

In an update to another DPA, Wright Medical Technology Inc. will extend its agreement with the U.S. attorney’s office in New Jersey for another year.

Wright was charged with conspiring to violate the anti-kickback statute and entered into the DPA in September 2010 (RMC 10/11/10, p. 8). The feds alleged that Wright entered into consulting agreements with orthopedic surgeons between 2002 and 2007 to induce them to purchase the company’s products. Wright agreed to pay $7.9 million in a civil settlement agreement.

**Wright Breached the DPA**

Under the original DPA, Wright agreed to set up corporate compliance procedures and work with a monitor selected by the feds to review the company’s compliance with the terms of the DPA and all new contracts with surgeons.

The 12-month DPA was due to expire Sept. 29, 2011, but the U.S. attorney’s office said on Sept. 15 that the company had agreed to extend it for another year. That is six months longer than the extension called for in the original agreement, the feds point out. “Provided that Wright meets all of the requirements of the DPA addendum, the agreement will expire on Sept. 29, 2012, and the criminal complaint will thereafter be dismissed,” says a statement by the feds.

In May 2011, the feds notified Wright that they “had received information that Wright had knowingly and willfully breached material provisions of the DPA.” During the extension of the DPA, the feds will determine whether the breaches have been “cured.” The main points of the DPA will remain in effect, except that the federal monitor will submit only three reports during the extension, which is down from four reports in the first year.

But the feds say Wright made significant changes to its leadership in the first year of its DPA: the president and CEO resigned on April 5 just before a board meeting about oversight of the company’s compliance program; the vice president and chief technology officer was terminated on the same day for “failing to exhibit appropriate regard for the ongoing compliance program”; and three executives, including general counsel, resigned “for good reason” on May 4.

“Wright Medical and our Board of Directors have taken significant steps to enhance the company’s compliance,” according to David Stevens, the company’s chairman of the board and interim CEO. “We believe that voluntarily extending the term of the DPA will provide the company with an opportunity to further demon-
strate its commitment to the highest standards of ethical conduct.”

Read more at www.justice.gov/usao/nj and read the corporate integrity agreement at http://go.usa.gov/8r8. Contact McEvoy at bfm@cclblaw.com.

OIG Plans a Sweeping Review of Physician-Owned Distributors

The HHS Office of Inspector General will conduct a national review of physician-owned distributors (PODs), according to a July 13 letter it sent to the Senate Finance Committee. OIG ultimately may issue guidance on PODs — which sell medical devices to hospitals, where they often are implanted by the surgeons who own the PODs — but IG Dan Levinson said he can’t make any promises.

OIG will “seek to determine the extent to which PODs provide spinal implants purchased by hospitals. The study will be nationally representative of hospitals that bill Medicare for spinal surgery,” Levinson wrote. OIG will find out how pervasive PODs are, identify the services they provide to hospitals and figure out whether PODs save hospitals money in implant acquisition.

“We also will analyze Medicare claims data to determine whether the PODs we identify in our review are associated with high use of spinal implants,” Levinson wrote. He emphasized that OIG is committed to monitoring physician-owned entities and taking enforcement actions against them when warranted.

The letter was a response to a June 9 request from the Senate Finance Committee’s minority staff, led by Orrin Hatch (R-Utah), along with Democratic chairman Max Baucus (D-Mont.). In June, they asked OIG to investigate PODs and recommend strategies for regulating them (RMC 6/20/11, p. 1). The letter was accompanied by a report that describes the growth of PODs, how they operate and their potential damage to Medicare’s bank account and patient safety.

PODs have come under fire because of the risk that they invite overutilization and may be used by hospitals to reward surgeons for referrals. One concern is that hospitals buy devices from surgeon-owned PODs instead of manufacturers as a way to please surgeons, who are referral sources. If hospitals promise to buy from the POD in exchange for referrals, they could violate the anti-kickback law. That fear has prompted some hospitals to pull out of PODs. And if PODs — which typically sell devices developed by their physician investors or by small or medium-sized manufacturers — have a financial incentive to sell more devices, that could lead to medically unnecessary procedures, according to the report from top Senate Finance Republicans.

But PODs also have their defenders. Because they cut out the middleman — large medical-device manufacturers — and thereby eliminate hefty sales commissions, PODs offer lower prices and save hospitals money, says Los Angeles attorney Brad Tully, with Hooper, Lundy & Bookman. He and other lawyers doubt PODs cause surgeons to perform unnecessary procedures because the incentive is so indirect. Some lawyers figure that surgeons who are willing to abandon their “First Do No Harm” oath to perform unnecessary surgery already are motivated by the professional fees they will collect.

Although OIG plans to tackle PODs, Levinson said “OIG’s ability to issue guidance” about the application of the anti-kickback law to PODs is “limited.” As a criminal statute, the anti-kickback law doesn’t lend itself to guidance in this context because the government has to prove the intent to induce referrals and because everything is so fact specific. “Different POD models can raise varying levels of legal concern,” which demands a case-by-case analysis. For instance, determining whether a POD runs afoul of the anti-kickback law would turn on the POD’s “particular characteristics, including the details of its legal structure; its operational safeguards; and, importantly, the actual conduct of its investors, management entities, suppliers and customers during the implementation phase and ongoing operations,” Levinson wrote.

Meanwhile, CMS Administrator Donald Berwick, M.D., responded to inquiries from Hatch, Baucus and other Senate Finance Committee members. They had urged CMS to subject PODs to the disclosure mandates of the Physician Payment Sunshine Act (RMC 6/27/11, p. 1), which is part of the health reform law and requires pharmaceutical and device manufacturers to report to HHS any gifts or payments to physicians over $10. The senators also expressed concern that regulations for Medicare accountable care organizations (ACOs) “will provide an inadvertent loophole allowing the less reputable POD models” to enjoy waivers from the Stark and anti-kickback laws (RMC 4/4/11, p. 1).

Lack of Guidance Is Not a Surprise

Berwick says the Physician Payment Sunshine Act reporting requirement is being studied carefully in terms of PODs. As for ACO waivers, he says comments on PODs, like all comments, are being reviewed as CMS prepares the final waiver rule.

It was no big surprise to Tully that OIG is taking its time with respect to POD guidance, and he doesn’t think the industry should hold its breath. “The OIG is seeing that this is a very complicated area, with a wide range of arrangements. The OIG has also essentially acknowledged that, due to the intent-based nature of the [Anti-Kickback Statute], it is not really an appropriate party...
DOJ Takes On Physician Pay Case
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Stephens, with McDermott, Will & Emery. As for Stark, “there is not any provision in any of the physician agreements that is considered per se illegal under Stark or any fraud and abuse law,” he says.

This is at least the third public Stark-based false claims lawsuit now pending in federal districts around the country. The U.S. attorney’s office for the Western District of Pennsylvania has intervened in a whistleblower case against Bradford Regional Medical Center, which has twists and turns of its own. The 764-bed hospital is a governmental entity created by Florida statute as a special tax district, a fact that Stephens says undercuts the false claims lawsuit. “It doesn’t have the same profit motive that other health systems have,” says Stephens, a former attorney in DOJ’s civil fraud section, which runs False Claims Act cases. The hospital’s affiliate, Halifax Staffing, provides personnel for the hospital, although the two are separate legal entities. The whistleblower and the physicians entangled in this case are employed by Halifax Staffing and work exclusively for the hospital.

Sweetheart Deals With Docs Are Alleged

The lawsuit against Halifax describes a series of alleged sweetheart deals with three neurosurgeons and six oncologists, according to the complaint. The case turns less on how much money the specialists made and more on how they made it, says Atlanta attorney Marlan Wilbanks, with Wilbanks & Bridges, who represents the whistleblower. “The Stark law has pockets of liability regardless of intent,” he says. “If you are compensated by bonus pools influenced by the volume or value of referrals, you fall outside the exceptions of the Stark law.”

The Stark law prohibits Medicare payments to entities that provide designated health services to patients when they are referred by physicians who have a financial relationship with these entities — unless an exception applies. Exceptions exist for employment, leases, personal service arrangements, recruitment and other hospital-physician deals. Most Stark exceptions contain universal criteria. For example, payments between the parties must be fair-market value and can’t take into account the volume or value of the physician’s referrals.

Here are some details of the alleged Halifax deals:

Halifax Hospital allegedly had what amounts to a profit-sharing arrangement with six medical oncologists who refer patients to the hospital. Between 2004 and 2008, the oncologists’ contracts included an “incentive compensation pool” that was equal to “15% of the operating margin of the medical oncology program” at the hospital, the complaint alleges. In other words, the more patients the oncologists referred to the hospital for inpatient and outpatient hospital services, the more they got paid, says Atlanta attorney Scott Withrow, who also represents the whistleblower. It might have been permissible under Stark for the hospital to pay physicians based on services they personally perform, but that wasn’t the case here, he says. And the hospital couldn’t take cover

to sift through these arrangements and to approve or disapprove of particular structures in the abstract,” he says. Because specific POD guidance is not a good bet, Tully says providers can turn to existing guidance and structure arrangements within the law.

For example, OIG has published advisory opinions and settlement agreements about physician ventures. “It’s been OIG’s longstanding view that the opportunity for a referring physician to earn a profit, including through an investment in an entity for which he or she generates business, could constitute an illegal inducement under the federal Anti-Kickback Statute,” Levinson said in the letter. When determining whether a particular deal is bad news, OIG would consider various factors, such as the actual or projected return on the physician’s investment and the revenues generated for the entity by its physician investors, he said.

The next stage of the POD debate could get heated, depending on what OIG finds in its review, Tully says. “We continue to believe that PODs, when properly structured, will be able to withstand the OIG’s review.”

View the OIG letters at http://finance.senate.gov/newsroom/ranking/release/?id=126c415e-f1a3-41e9-665a71188f1c. Contact Tully at wtully@health-law.com.

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in Stark exceptions for employment or independent contractor arrangements because the incentive compensation takes into account the volume or value of physician referrals, the complaint alleges.

The whistleblower broached the subject of the contracts’ alleged illegality with her superiors, the complaint states, but nothing good came of it.

**Three neurosurgeons who referred patients to Halifax Hospital and provided services there have very favorable compensation terms**, according to contracts attached to the lawsuit. The hospital pays the neurosurgeons “incentive compensation equal to all net collections” for their services. “These neurosurgeons are being overpaid because of the large amount of money paid as an incentive for their referrals to defendant Halifax Hospital,” the complaint alleges. Total 2008 compensation for one of the neurosurgeons was $1.725 million and for another was $1.897 million; both figures are above fair-market value, according to the complaint. “The recipient neurosurgeons are very important referral sources for defendant Halifax Hospital,” generating $22 million annually in hospital revenues from surgeries, the lawsuit alleges.

Specifically, the Halifax Staffing contract with one neurosurgeon for 2003 to 2004 paid him an annual base salary of $325,000 plus “incentive compensation equal to all net collections for employee’s services” that exceeds the salary. A 2007 amendment obligated Halifax Staffing to pay for seven nonphysician employees, including an office manager and two physician assistants (PAs), who work at the practice that the neurosurgeon shares with another neurosurgeon. The hospital also pays the neurosurgeons the fees generated by their PAs, and then pays the PAs’ salaries, says Wilbanks.

**More Surgeries = More Money**

Because the neurosurgeons’ compensation increases with every procedure performed at the hospital, “it behooves them to admit patients,” says Withrow, who is with Withrow, McQuade & Olsen. “You do more spinal fusions, you get more money.”

The whistleblower again tried to convince management that the hospital was playing with Stark fire by allegedly exceeding fair-market value in its compensation, and suggested obtaining an independent fair-market analysis. But this allegedly backfired. Management called a meeting with the three neurosurgeons, during which fair-market value was not mentioned. Instead, Halifax management allegedly devised a method to pay the neurosurgeons more. “The net effect was to increase their current compensation packages,” the complaint alleges.

But there are cracks in the Stark allegations, says Rumph, who is not involved in the case. The whistleblower’s argument, which the government has adopted, is that hospitals can’t pay doctors any bonus or incentive compensation unless it’s based on personally performed services. “That overstates Stark and is overly broad,” Rumph says. The Stark law allows both hospital employees and independent contractors — whether they contract with the hospital directly or through a staffing company — to receive incentive compensation as long as it doesn’t take into account (1) employed physicians’ referrals of designated health services or (2) independent-contractor physicians’ referrals for designated health services or other business they generated, Rumph says.

In fact, the earlier terms of the hospital’s contract with the oncologists “probably would not have been a Stark problem,” Rumph says. It states the doctors will be paid “an equitable portion of an Incentive Compensation pool which is equal to ninety percent (90%) of cash collections received as of September 30 that exceed...$2,342,286.00 and are attributable to billings for professional services related to patient care, hereinafter the ‘Production Base,’ provided by [the five members of the medical oncology practice].”

**MD Services Aren’t ‘Designated Health Services’**

Although the incentive payments were not exclusively based on each oncologist’s personally performed services, they are based collectively on the services of the medical oncology group, he notes. “Even if billed by a hospital, physician services are not designated health services,” Rumph says. Fair-market value would have been the Stark smell test, but the complaint doesn’t have a bone to pick with the fair-market value of the oncologists’ incentive compensation, Rumph says.

Stephens says there’s no Stark case to be made against Halifax. “The allegations against the oncologists are very thin,” Stephens says. “DOJ appears to be speculating that the incentive provision in the medical oncologists’ agreement wasn’t paid based on each individual’s level of personally performed services.” Au contraire, he says. Halifax’s payments were based on their productivity — how many patients they saw, how many hours they worked, their work relative value units.

As for the neurosurgeons, Stephens says “we haven’t seen any evidence the compensation paid is not fair-market value.” Halifax Hospital is a level two trauma center that has an agreement with the state to provide neurosurgery 24/7. “We have shown the hospital has an exceptionally high level of transfer cases from other hospitals,” requiring the neurosurgeons to work long hours.

Contact Wilbanks at mbw@wilbanks-bridgeslaw.com, Withrow at swithrow@wmolaw.com, Rumph at alan@shhrlaw.com and Stephens at rstephens@mwe.com.
What appears to be the longest prison term ever in a Medicare fraud case — 50 years — has just been handed down by a U.S. District Judge in the Southern District of Florida. Lawrence Duran, the owner of a Miami-area mental health care company, was sentenced in connection with a scheme to defraud Medicare of $205 million, the Department of Justice and HHS said Sept. 16. Duran also was ordered to pay more than $87 million in restitution jointly and severally with his co-conspirators. Duran pleaded guilty in April to 38 counts in a superseding indictment, including conspiracy to commit health care fraud, health care fraud, conspiracy to pay and receive illegal health care kickbacks, conspiracy to commit money laundering, money laundering and structuring to avoid reporting requirements. Duran’s company, American Therapeutic Corporation (ATC), which purported to provide partial hospitalization programs at seven locations in south Florida, has been defunct since October 2010. Visit www.justice.gov/usaofls.

OIG has posted 17 supplemental letters to states about the status of their state false claims laws. States can receive financial incentives if their laws mirror the federal False Claims Act (FCA) and prevent false claims from being submitted to their Medicaid programs. OIG explains in the letters that the Dodd-Frank Wall Street Reform and Consumer Protection Act amended the FCA by creating a three-year statute of limitations for retaliation actions, among other provisions. The states must update their laws to match those amendments. OIG also reviewed Minnesota’s law and found that it did not meet the requirements for the state to receive financial incentives because it does not mirror several provisions in the federal FCA, including amendments from the Dodd-Frank Act as well as the Fraud Enforcement and Recovery Act. Read the letters at http://oig.hhs.gov/fraud/state-false-claims-act-reviews/index.asp#letters.

The HHS Office of Inspector General released two audit reports Sept. 16 on Medicare overpayments for incorrect use of site-of-service codes. In one report (A-01-10-00516), Medicare contractors overpaid physicians an estimated $9.5 million for Part B services provided in 2009. OIG found that 83 out of 100 sampled claims were coded incorrectly because of the use of non-facility place-of-service codes for services provided in hospital outpatient departments or ambulatory surgical centers. OIG says CMS should recover about $3,000 in overpayments for the services audited in the sample and review all the other claims not in OIG’s sample and recover any overpayments, which could total $9.5 million. Read the report at http://go.usa.gov/0z6. In the other audit report (A-01-10-00513), OIG described the same problem, citing an estimated $19.3 million in overpayments for 2008. Out of 100 sampled claims, OIG found that physicians had coded 89 incorrectly. CMS should recover about $5,000 in overpayments for the services audited in the sample and review all the other claims not in OIG’s sample and recover any overpayments, which could total $19.3 million. CMS concurred with the findings in both reports. Read the report at http://go.usa.gov/0zF.

On Sept. 26, CMS will release another comparative billing report (CBR) on chiropractors practicing in office settings, the agency said in a Sept. 14 listserv email. The CBR is similar to one released last year, but will be based on 2010 data and will be sent to 5,000 providers, CMS says. CBRs use tables and graphs to compare the provider’s billing and payment data to those of their peers located in their state and across the country. Visit www.cbrservices.com.

CMS, through its contractor, TMF Health Quality Institute, has released its first round of comparative data for inpatient rehabilitation facilities (IRFs). The Program for Evaluating Payment Patterns Electronic Report (PEPPER) will help hospital-owned and freestanding IRFs customize their compliance monitoring (RMC 9/5/11, p. 1).

Medicare’s efforts to revalidate provider and supplier enrollment does not affect other aspects of the enrollment process, CMS explains in a Sept. 14 listserv email. New risk screening criteria mandated by the health reform law requires that all providers and suppliers who enrolled in Medicare prior to March 25, 2011, be revalidated. Routine changes such as address updates, reassignments, additions to practices and changes in authorized officials should still be reported, CMS explains. But the Medicare administrative contractors will notify entities about revalidations between now and March 2013, so providers should not submit revalidation forms until they receive that notification. Read more at www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf.
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