Report on
Medicare Compliance

Volume 28, Number 27 • July 29, 2019

Weekly News and Compliance Strategies on Federal Regulations, Enforcement Actions and Audits

Contents

HCCA

Managing Editor
Nina Youngstrom
nina.youngstrom@hcca-info.org

Copy Editor
Bill Anholzer
bill.anholzer@hcca-info.org

Under Stark, Factors Besides Productivity May Support FMV Compensation, Attorney Says

A hospital found itself in a jam this summer when its only employed cardiologist threatened to leave unless his compensation was increased considerably. The hike would make the cardiologist's pay out of whack with his productivity, which is a risky proposition because of the Stark Law. Hospitals that pay referral sources must qualify for an exception under the Stark Law, which requires compensation to be fair market value and commercially reasonable.

Although its hands seemed tied, the hospital may be able to consider other factors to "justify the disparity" between compensation and productivity, says attorney Bob Wade, with Barnes & Thornburg in South Bend, Indiana. "Compliance officers are really struggling with this amorphous issue of what is fair market value. The gold standard is if you can align productivity with compensation, but what if you can't?" Factors like the loss of the sole specialist could be used to support fair market value, and he thinks the Department of Justice, HHS Office of Inspector General and lawyers for whistleblowers should keep them in mind before making assumptions about Stark Law violations that form the basis of a False Claims Act lawsuit.

The cardiologist told the hospital he would quit immediately unless he could reduce his work week from five days to four days with the same pay, which is a 20%

continued on p. 6

Data Mining May Show Repeat Debridements; Procedure Notes May Not Support Necessity

Serial debridement on the same patient may turn into a liability now that auditors use data mining to spot patterns of suspicious billing. Some coders are worried that electronic medical records allow physicians to gloss over the medical necessity of the procedures, which are being audited by at least one Medicare administrative contractor (MAC) in Targeted Probe and Educate (TPE). A procedure note won't protect physicians from claim denials unless they have documentation to establish that surgically excising a wound of tissue, muscle or bone is necessary to jump-start healing, and they should investigate the underlying condition because there's a limit to how much excisional debridement a wound can take, one expert says.

"A lot of [physicians] fall into repetitive patterns and forget that payers have ready access to examine practice patterns on a broader scale over time," says Toni Turner, owner of InRich Advisors in The Woodlands, Texas. Auditors will be troubled if a patient receives 12 surgical debridements over 16 weeks of treatment at a wound center, for example. "It's not normal to have a hole in you. If you have a hole for more than six weeks in your body, something is going on to prohibit the normal phases of healing," Turner says. With repetitive excisional debridement, physicians are performing surgery on a patient week after week, and that means they probably haven't addressed the underlying problems that are keeping it from

continued

healing," Turner says. "It's important to look at the whole patient versus the hole."

Excisional debridement is the surgical removal of necrotic or devitalized tissue until "healthy, viable, bleeding tissue is encountered," according to the National Alliance of Medical Auditing Specialists (NAMAS). Selective debridement is the removal of "necrotic or non-viable tissue that is usually superficial and does not enter healthy, viable tissue," NAMAS said in its July 12 newsletter. "Excisional services are not repeatedly performed in a short time for the same patient."

Surgical debridement may have flown under the radar for a long time because wound care is not a physician specialty, which makes it harder to do comparative analyses among the variety of provider types that staff wound centers. "That's slowing auditors who use peer benchmarks to identify outlier procedural billing," Turner says. "But they can compare patients and facilities." Auditors will find a way because this is a high-volume procedure. If anything, there may be more intractable wounds than ever as older and/or heavier patients, some with chronic conditions, undergo surgery, Turner says.

Report on Medicare Compliance (ISSN: 1094-3307) is published 45 times a year by the Health Care Compliance Association, 6500 Barrie Road, Suite 250, Minneapolis, MN 55435. 888.580.8373, hcca-info.org.

Subscriptions to *RMC* include free electronic delivery in addition to the print copy, as well as a searchable database of *RMC* content and archives of past issues at compliancecosmos.org.

To order an annual subscription to **Report on Medicare Compliance** ($665 for HCCA members; $765 for nonmembers), call 888.580.8373 (major credit cards accepted) or order online at hcca-info.org.

Subscribers to this newsletter can receive 20 non-live Continuing Education Units (CEUs) per year toward certification by the Compliance Certification Board (CCB)®. Contact CCB at 888.580.8373.

"Our ability to take higher-risk patients into surgery than ever before means we are potentially contributing to the non-healing patient population faster than we can even heal them," she says.

On the inpatient side, excisional debridement groups to a higher-weighted, surgical MS-DRG, resulting in higher reimbursement, says Wanda Cidor, a manager with Deloitte & Touche. In ICD-10, the procedure is classified to the root operation, Excision. Non-excisional debridement is a non-surgical procedure that can be classified to the root operations of irrigation or extraction depending on whether the procedure involves irrigating, washing, scrubbing or brushing of devitalized or necrotic tissue, slough or foreign material. This groups to a lower-weighted medical MS-DRG, with less reimbursement, Cidor says.

When coding debridement, coders should look for:

- **Technique** used by the provider (cutting, scrubbing, washing, trimming)
- **Instruments** used (scissors, scalpel, pulse lavage, or curette)
- **Nature of the tissue removed** (slough, necrotic tissue, devitalized tissue, or non-viable tissue)
- **Appearance** of the wound (fresh bleeding tissue or viable tissue, necrosis, etc.)
- **Size** of the wound, which is important when coding debridement billed under the outpatient prospective payment system
- **Depth** of the debridement (down to and including, fascia, muscle, etc.)

Physicians should also document the "ancillary circumstances" contributing to non-healing wounds, such as diabetic neuropathy, uncontrolled A1C and tobacco use, Turner says. "If payers don't see the whole condition being cared for and they only see this beautiful procedure note, it is a red flag," Turner says. Have you ordered labs? Talked about the patient's vascular status?

Auditors may question repeated surgical debridement because providers are removing extensive amounts of tissue, bone or muscle. "They can understand a couple because you're trying to turn old wounds into new wounds. But if you're doing that repeatedly, the logical assumption is, how does the patient ever fill that in if you keep removing all that's good?"

The electronic medical records (EMRs) make it easy for physicians to fill out the procedure note with a few clicks and think their bases are covered. "You can consistently capture the right phraseology, but still miss the boat by not addressing patients' unique underlying conditions," Turner says. "Their entire history of billing is going to be a factor in auditing."

Look Internally at Patterns of Care

Wound care centers also may turn debridement into maintenance, which is a different kind of risk. Turner audited a practice recently where the only type of debridement five physicians had performed in the previous 12 months was excisional, which pays significantly more than selective, but similar before-and-after photographs along with only a slight 0.1-centimeter depth change did not support an excisional debridement charge. "They cleaned the wound. They didn't excise it and turn it into a new wound," she says. In that case, there was a question of both medical necessity and upcoding, Turner says. "Measurements are telling the story as well as practice patterns over time."

She suggests provider-based clinics look at their patterns of care quarterly. Some wounds may require frequent excisional debridement, but there has to be documentation to prove it. If they're challenged, physicians may push back, but that won't fly if they did a poor job explaining why it was necessary every week for three months, Turner says. "The patient still has too much foot to validate that scenario."

Wound care physicians who treat patients for intractable wounds also should be talking to other physicians, such as endocrinologists. Collaboration is missing in the medical records, even though Medicare and other payers are shifting to coordinated care and payment for outcomes. "They have to lay down the medical necessity for future procedures in the treatment plans and goals," Turner says. "Just because the claim goes through and they get paid with the right ICD-10 code doesn't mean they will keep the money." She adds that conflicting documentation between nurses and physicians also is a red flag for auditors.

One MAC, Novitas Solutions, is auditing debridement under TPE, although it's focusing on debridement, subcutaneous tissue (HCPCS 11042).

Contact Turner at toni@inrichadvisors.com and Cidor at wacidor@deloitte.com. ✧

Hospital Settles EMTALA Case Over Suicidal Patient With Insurance

Park Royal Hospital in Fort Myers, Florida, agreed to settle allegations of violating the Emergency Medical Treatment and Labor Act (EMTALA) when it refused to accept the transfer of a suicidal patient because the patient's insurance was out of network. The hospital agreed to pay $52,414, according to its civil monetary penalty settlement with the HHS Office of Inspector General.

That's one of two recent EMTALA settlements in which the hospitals allegedly violated basic EMTALA requirements, and both involved transfers, an attorney says.

Under EMTALA, hospitals must give all patients who show up at the emergency room a medical screening exam (MSE) regardless of their ability to pay, and stabilize them if they present with an emergency medical condition (EMC). Patients may be transferred if hospitals lack the capacity or capability to treat them, and receiving hospitals must accept transfers unless they lack the capacity or capability.

Park Royal, which has specialized psychiatric capabilities, refused the transfer of the patient from another emergency room, where the patient had presented after a suicide attempt "and was diagnosed with lacerations to the wrist and an emergency psychiatric condition," the settlement states.

OIG: 'No Reason' Not to Accept Transfer

There was no reason for Park Royal not to accept the transfer, says OIG Senior Counsel Geeta Taylor. "It had the capability and capacity to accept the transfer," she says. The patient wound up receiving care at a different hospital.

"EMTALA expressly requires hospitals with specialized capability to accept appropriate transfers," adds Katie Arnholt, deputy branch chief of the OIG's Administrative and Civil Remedies Branch.

Hospitals shouldn't send away patients based on their insurance or ability to pay, says attorney Catherine Greaves, with King & Spalding in Austin, Texas. "It's the very purpose EMTALA was written." It's curious, though, from a purely financial perspective, to turn patients away when the hospital is out of network. "In some states, typically in emergencies, insurance companies are required to treat the care provided like it's in network, but after that, when there is no longer an emergency, it's out of network. Once the patient is stabilized, you can transfer," she notes. And whether it's in or out of network, the hospital will still get paid something. But there aren't enough details available about the case to know exactly what the circumstances were or draw any conclusions about the hospital's actions, Greaves says.

Park Royal Hospital didn't admit liability in the settlement. It did not comment by press time.

Meanwhile, CMS on July 2 issued guidance on EMTALA and psychiatric hospitals, partly because surveyors have been applying it differently in different regions, attorneys say ("CMS: With EMTALA, ED Doctors Can Do Psych MSE; Transfers May Be OK Despite Open Bed," *RMC* 28, no. 25). The guidance addresses capacity and transfers, among other things.

Patient Came Back to ER in Ambulance

In the other case, Transylvania Regional Hospital in Brevard, North Carolina, agreed to pay $25,000 to settle allegations it violated EMTALA when it didn't provide an adequate MSE and stabilizing treatment to a patient, who was discharged but came back later in worse shape, according the civil monetary penalty settlement with OIG.

The patient first presented at the ER with complaints of abdominal pain and pain radiating bilaterally to his lower extremities. His blood pressure and respiratory rate were elevated. "Despite his presentment, [the hospital] discharged [the patient] without providing an adequate medical screening examination or stabilizing treatment," the settlement alleges. Later the same day, an ambulance brought the patient back to the hospital. This time, however, he complained of paralysis of the lower extremities, leg pain and leg swelling. Transylvania Regional Hospital transferred him to another hospital.

"We see a lot of these cases where the failure to provide an appropriate medical screening exam in the first presentment results in a secondary presentment at the same hospital or a second hospital," Taylor says. "It shows the failure to provide an appropriate medical screening exam on the first presentment resulted in a delay in care." It's unclear what role the delay played in the transfer, but a transfer was necessary to provide a higher level of care, she says.

Transylvania Regional Hospital denied liability in the settlement and had no comment by press time. It is now known as ANC Transylvania Community Hospital.

In terms of EMTALA violations generally, Arnholt says, "the patterns we are seeing" fall into three areas:

1. Patients aren't appropriately transferred or accepted for transfer because of their insurance coverage;
2. On-call physicians fail to come to the emergency room to provide screening and stabilizing services and that results in an unnecessary transfer; and
3. "Cursory" MSEs fail to address patients' presenting complaints or symptoms and lead to transfers, she says.

Lawyer: A Mistake Is Not an EMTALA Violation

Greaves says it's not an EMTALA violation to overlook a medical problem during an MSE. "If someone just eyeballs the patient and the nurse talks to them for two minutes, that is probably not an adequate screening. But if they perform an appropriate exam and make an affirmative screening, I would argue it is an adequate screening, but they made the wrong call," she says.

This has become controversial, now that some surveyors reviewing EMTALA compliance on behalf of CMS are questioning patient care instead of simply checking whether MSEs were performed appropriately. Although patient safety is paramount, EMTALA has a circumscribed goal—to ensure patients receive emergency care until they're stabilized or admitted to the hospital regardless of their ability to pay—as described in the EMTALA regulations. But CMS recently said that "the appropriateness of an examination is determined based on the quality of care provided, not just that an examination was performed" ("Some EMTALA Surveys of MSEs Go Too Far, Experts Say; CMS: MSEs Are Also About Quality," *RMC* 28, no. 3).

Hospitals should concentrate on ensuring they have policies and procedures for EMTALA requirements, Greaves says. They need to address which clinicians are qualified to perform MSEs (i.e., are "qualified medical practitioners") and have policies that reinforce to on-call physicians that coming in to treat emergency room patients is not a choice. The hospital also should decide which clinicians are eligible to screen patients for psychiatric conditions. As the CMS EMTALA guidance said, "It is within the scope of practice for ED physicians and practitioners to evaluate patients presenting with mental health conditions, same with any other medical, surgical, or psychiatric presentation." And it may be worth reminding everyone that the hospital doesn't turn away people without insurance, Greaves says, and take the opportunity to add that it doesn't discriminate based on age, race, national origin, sex, color or disability.

Contact Greaves at cgreaves@kslaw.com and Taylor and Arnholt through OIG spokesperson Sheila Davis at sheila.davis@oig.hhs.gov. ✧

Faxing One-Page Expedited Appeals to MA Plans Is New Strategy for PA

Although CMS has been talking about making fax machines obsolete in Medicare, they're turning out to be useful for filing expedited appeals of pre-service benefit denials by Medicare Advantage (MA) plans. Time is of the essence with expedited appeals, and fax machines are a fast and less torturous way to move them forward, a physician advisor says.

"I no longer ever call the plans," says Brian Moore, M.D., medical director of utilization management and physician advisor services at Atrium Health in North and South Carolina. It's a new posture in his appeals of denials, which initially include fewer medical records.

Moore is an advocate of expedited appeals, which allow physicians and other clinicians to fast-track appeals on behalf of certain patients while shifting the burden to

MA plans to justify denials. He thinks expedited appeals are a game-changer for appealing MA denials, but they are underused by hospitals, possibly because patients and physicians may not know about this pathway ("Expedited Appeals of MA Benefit Denials Could Be 'Game-Changer' for Hospitals," *RMC* 28, no. 11).

Although he used to submit them by phone and send in a full copy of the medical records, that's changed. CMS regulations require MA plans to accept appeals in writing, and "every plan has a fax line dedicated to the process," Moore says. MA plans "must submit an efficient and convenient means for individuals to submit oral and written requests," according to the regulation 42 C.F.R. § 422.570 (2018).

In Writing, Rules 'More Likely To Be Followed'

CMS established expedited appeals as an alternative to regular appeals when physicians and patients believe that waiting for the MA plan to decide on the appeal in the usual way, which takes up to 14 days, "could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function," the regulation states.

Because physicians and patients request expedited determinations from MA plans before claims are paid, Moore says they're particularly useful for pending admissions to post-acute care—skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospital admissions—from acute-care hospitals. Patients

continued on p. 6

Form for Expedited Appeals: Lighting a Fire Under Medicare Advantage Plans

Brian Moore, M.D., medical director of utilization management and physician advisor services at Atrium Health in North and South Carolina, now faxes all requests for expedited appeals of pre-service benefit denials to Medicare Advantage plans rather than requesting them over the phone, and includes a brief description of the reason why the patient requires post-acute care. More documentation will be provided on request, but the clock is ticking because the MA plan has to decide on the appeal in 72 hours. He prefers the paper trail that comes with faxes (see story, p. 4). Contact Moore at brian.moore@atriumhealth.org.

FAX

TO Denying MA Plan

Name: Denying MA Expedited Appeals & Grievances Department
Fax Number: 1-800-555-5555
Date: 6/7/2019
 # Pages:

FROM (Requesting Physician and Patient Information)

Physician: Brian Moore, M.D., NPI 1111111111
Address: 1000 Blythe Blvd. Charlotte, NC 55555
Patient: John Doe
Address: PO Box 5555 Charlotte, NC 55555
Member #: 55555555555 (Plan Number)

Subject

Formal Expedited Appeal Request John Doe's Acute Inpatient Rehab Denial

Message

Type of Appeal Requested: Expedited (Fast) Appeal—Dr. Moore feels John Doe's health and recovery will be adversely affected if required to wait the standard time frame and his recommended Acute Inpatient Rehab is further delayed.

Reason for Appeal: Dr. Moore and the patient strongly disagree with the Medical Director who denied this original request and feel the patient meets Medicare Criteria for Acute Inpatient Rehab and will benefit from Acute Inpatient Rehab that cannot be accomplished at a lower level of care. We formally request an expedited reconsideration of this denial by a second Medical Director. Please review prior clinical information sent with original authorization request and also information received via this fax. Additionally, your company has electronic access to the EMR and should be able to retrieve all clinical information related to this request.

Documents Included: Appointment of Representative (AOR)

Request: On behalf of the patient, please provide me a copy of all medical records, other documents and clinical guidelines used to render your decisions as offered in your denial notice. Thank you.

continued from p. 5

(enrollees) or physicians may file expedited appeals directly. Other hospital clinicians, such as case managers (who are usually nurses), also may file expedited appeals on their behalf when enrollees sign appointment of representative (AOR) forms. "If someone who is not a physician is initiating this, a supporting statement from a physician is needed," says Moore, who is chairman of the American College of Physician Advisors' government affairs committee. Moore also files grievances with CMS when MA plans don't comply with regulations on expedited appeals. For example, Moore says MA plans sometimes refuse expedited appeals because there's no AOR even when they're not required, so he's been filing grievances. "We have case files opened with all the big plans," he notes.

When hospitals file expedited appeals, they're required to submit demographic and clinical information about the patient, including why the appeal is being expedited. Then MA plans must respond in 72 hours, either explaining why they denied authorization or approving and overturning the denial. When MA plans uphold the denial, it's automatically forwarded (by FedEx overnight) to Maximus Federal, the independent review entity for Part C, which also has 72 hours to affirm the denial or reverse it. "Maximus can overturn the denial if the plan can't demonstrate there were significant attempts to get the clinical information," he explains. When Maximus sides with the enrollee/hospital, it's reported to CMS, which tracks denials.

So far, Moore has overturned 50 denials with expedited appeals, but the process is "soul sucking." There are long phone calls, and he has to submit stacks of medical records. That's why he looked for a better method and turned to the fax machine. He notes that expedited appeals cannot be used after a service has been or is being received. "The key is for physicians and patients to know their rights when speaking with an MA plan regarding a denial. If able to handle this in writing, the rules are more likely to be followed."

Clock Starts Ticking With Fax Confirmation

Moore has developed a one-page reconsideration request form for expedited appeals (see box, p. 5). It has a space for the patient's name, address and Medicare number, the medical reason why Moore is requesting the appeal and the reason why it should be expedited—in other words, why adjudicating the appeal in the usual 14 days instead of 72 hours would put the patient's health and recovery at risk. He includes his national provider identifier and contact information, and explains that he has reviewed the medical necessity of the case and asserts that the denial was in error because the patient met criteria for complex rehabilitation needs with frequent visits by a physiatrist to coordinate medical and rehab needs. If the MA plan wants more details, it can reach out to him. The expedited appeal is discussed with the patient (or a surrogate if communication is an issue) and the attending physician before the fax is submitted.

"The beauty of this is, as soon as you fax the request and you have a confirmation number, the ball is in their court," he says. The clock starts ticking on the 72 hours.

Contact Moore at brian.moore@atriumhealth.org. ✧

Other Factors Support FMV of Higher Pay

continued from p. 1

increase, Wade says. The annualized compensation would then exceed the 90th percentile for cardiologists, but his productivity was much lower, based on work relative value units (RVUs), according to data from the Medical Group Management Association. Because meeting the physician's payment demand posed potential risks under the Stark Law, the hospital looked for other options while it recruited a replacement for the cardiologist.

11 Other Factors That Affect Compensation

One option: The hospital could contract with a locum tenens company, although that isn't the no-brainer people sometimes think it is. "You can get a warm body in there, but there are a lot of hoops to jump through—credentialing through the medical staff and payers to get the physician's provider number recognized," Wade says. And the locum tenens company wasn't sure it had any cardiologists available who practice in this particular physician's subspecialty. Maybe the hospital would have to stick with the employed cardiologist for now; could it justify paying the employed physician at the 90th percentile? Wade concluded that "the compensation terms were representative of fair market value" because it's a short-term arrangement and there are no alternatives, he told the hospital. But that doesn't mean hospitals can typically agree to compensation above fair market value. It's only in special circumstances, and hospitals need extensive documentation to support their reasons for the compensation agreement. Here the hospital has substantial communication from the cardiologist saying he won't stay for less than 20% more compensation; proof of active recruitment, including the hospital's contract with a recruitment company and time records showing people were trying to find a new cardiologist; and a letter from the

locum tenens firm saying it isn't sure it can produce the right specialist for the hospital.

There are other factors that can help hospitals make the case for compensation that isn't aligned with productivity, Wade says. Normally, "my rule of thumb is compensation should benchmark by no more than 10 percentage points from productivity benchmarks," he says. For example, if the physician is paid at the 65th percentile for his or her specialty, then productivity generally should be no lower than the 55th percentile, as measured by work RVUs. "But I don't want anyone to believe that's the only test," he says. Hospitals have to tell the whole story behind the compensation.

Here are other factors that Wade says may be considered with respect to determining the fair market value and commercial reasonableness of compensation relationships:

- **A documented deficiency of the specialty in the market** (e.g., the service area needs four physicians in a particular specialty, but three are now practicing). "The deficiency could be an indicator it's harder to recruit and retain [that type of specialist], so compensation has to be higher," he says. Hospitals need persuasive documentation, such as population studies that establish the number of cardiologists needed per capita.
- **The existence of a competing offer** (documented). "If it's genuine, that could be an indicator that higher compensation is warranted," Wade says.
- **Years of experience.** Physicians with many years of experience possibly could be paid more, he contends.
- **The physician is a national or regional expert in the specialty.** If patients flock to the physician from outside the hospital's service area because of his or her reputation, the physician probably can command higher compensation.
- **A higher than normal number of hours worked** (more than 2,100 per year). Full-time is usually 2,080 hours. "If a physician is consistently expected to work 3,000 hours per year providing professional services, you may be able to compensate them more," Wade says. But he warns about misunderstandings. One hospital classified a physician as a 1.5 full-time employee because the physician worked so many hours. "I said, this is one human being. You can't be more than one person—a 1.0," Wade says. However, hospitals can justify compensation that's higher than the 75th percentile—for example, more than $500,000— because of the 3,000 hours the physician is working, but they shouldn't multiply the benchmark data by greater than one.
- **Documented historical compensation.** If physicians always earned $500,000, for example, are they really going to take a pay cut to come work at your hospital?
- **Disproportionate amount of call coverage** (i.e., greater than one out of three days). Assuming they are not paid separately for being on call to the emergency room, hospitals may be able to increase compensation for physicians who are on call every other day.
- **Board certification** (or multiple board certifications). Benchmark data doesn't distinguish between physicians who are board certified and those who aren't. "It's an indicator of higher quality, and I have come across doctors with multiple board certifications," he notes.
- **The need for a certain number of specialists in a service area that doesn't have a big enough population to keep the specialist (e.g., cardiothoracic surgeon) busy full-time.** For example, it's reasonable to pay the specialist compensation in the 75th percentile to set up the practice in a smaller community knowing he or she won't have the same work RVUs, Wade says.
- **Employing a physician because of new technology or a new/expanded service line.** The productivity for the physician could be low while the compensation is high because it's a start-up, and it may take a few years before the service line or technology is up and running optimally.
- **Historic service in a leadership position.** "If the physician is a leader, you can recognize the physician through compensation based on his or her leadership," Wade says. "It's not the same as compensation for referrals."

Contact Wade at bob.wade@btlaw.com. ✧

CMS Transmittals

July 19-25

Live links to the following documents are included on *RMC's* subscriber-only webpage at compliancecosmos.org.

Transmittals

Pub. 100-04, Medicare Claims Processing Manual

- New Waived Tests, Trans. 4336 (July 19, 2019)
- Documentation of Medical Necessity of the Home Visit; and Physician Management Associated with Superficial Radiation Treatment, Trans. 4339 (July 25, 2019)

NEWS BRIEFS

◆ **Van Nuys Healthcare Center, a nursing home in California, has agreed to pay $1.138 million in a civil monetary penalty settlement.** The HHS Office of Inspector General (OIG) alleged Van Nuys Healthcare submitted false or fraudulent claims to Medicare. Specifically, the director of nursing and minimum data set (MDS) coordinator at the nursing home allegedly reported false assessment reference dates on MDS reports from July 1, 2012, to May 1, 2017. The settlement stems from Van Nuys Healthcare Center's self-disclosure to OIG. It was accepted into OIG's Self-Disclosure Protocol. The nursing home didn't admit liability in the settlement.

◆ **Universal Health Services (UHS), a large hospital management company, announced that it has reached an agreement in principle with the Department of Justice (DOJ) to settle a civil investigation of its behavioral health facilities for $127 million.** "We have further been advised that the previously disclosed investigations being conducted by the DOJ's Criminal Frauds Section in connection with these matters have been closed. We are awaiting the initial draft of a potential corporate integrity agreement with the [HHS] Office of Inspector General" that it expects will be part of the settlement, UHS says. The settlement is still subject to approval. Visit http://bit.ly/2ZdjHaX.

◆ **Mid-Maryland Musculoskeletal (MMI) has entered into a voluntary resolution agreement with the HHS Office for Civil Rights (OCR) to resolve a complaint that it allegedly provided an unqualified sign language interpreter to a six-year-old child** in violation of Section 504 of the Rehabilitation Act of 1973 and Section 1557 of the Affordable Care Act, OCR said July 24. That was the fifth complaint alleging that MMI, a medium-sized clinic in Frederick, Maryland, that has 11 physicians and two physician assistants, didn't provide effective communication to people who are deaf or hard of hearing, OCR said. During the investigation into the new complaint, OCR and MMI agreed to resolve it "in a manner that will assist MMI in ensuring that the individuals seeking services from MMI who are deaf or hard of hearing receive effective communication to participate in the activities and services provided by MMI in accordance with Section 504 and Section 1557." For example, MMI will upgrade its assessment of sign-language interpreters. Visit http://bit.ly/30XaJiO.

◆ **The HHS OIG published its annual list of suggestions for reducing fraud, waste and abuse.** At the top of the list of unimplemented recommendations: "CMS should analyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement for skilled nursing facility (SNF) services so that beneficiaries receiving similar hospital care have similar access to these services." Visit https://go.usa.gov/xywPj.

◆ **Hospitals will have to wait longer for relief from CMS's payment cuts to the 340B drug discount program because of a July 10 court decision,** says attorney Chris Kenny, with King & Spalding in Washington, D.C. Medicare's 2018 and 2019 steep payment cuts to 340B drugs previously were voided by Judge Rudolph Contreras of the U.S. District Court for the District of Columbia, but there hasn't been a decision yet on how to provide relief to hospitals without wreaking havoc on the outpatient prospective payment system. In response to a motion from HHS, Judge Contreras refused to reconsider the merits, but has essentially cleared a path for HHS to appeal his rulings to the U.S. Court of Appeals for the D.C. Circuit. Visit http://bit.ly/32z4ByR.

◆ **OIG has published a resource guide that explains its approach for "using claims data to identify incidents of potential abuse or neglect of vulnerable populations."** Visit https://go.usa.gov/xyff6.

◆ **The U.S. Attorney's Office for the Southern District of New York has filed a False Claims Act (FCA) lawsuit against Life Spine, CEO Michael Butler, and Vice President of Business Development Richard Greiber.** The FCA lawsuit alleges that Life Spine, which is based in Huntley, Illinois, paid surgeons millions of dollars in consulting fees, royalties and intellectual property acquisition fees to induce them to use Life Spine's spinal implants, devices and equipment during spine surgeries. "Butler informed Life Spine staff that he expected surgeons who were paid for their consulting services to commit to using Life Spine Products," the U.S. attorney's office alleged. "Life Spine's senior management, including Butler, closely tracked surgeons' usage of Life Spine Products to ensure that the payments to surgeons were generating sufficient sales revenues for the company and that the surgeons were fulfilling their 'commitment' to use Life Spine Products." Visit http://bit.ly/2Ynm65J.