MD Is Acquitted in ‘Regulatory Fraud’ Case Over Billing Incident to, Cancer Surgery

The acquittal of a Virginia physician on health fraud charges interrupts what seemed like a steady stream of false claim settlements and criminal convictions in the health care industry. The case against dermatologist Amir Bajoghli, which centered on incident-to billing and medically unnecessary surgery (No. 14cr00278-001), failed to impress the jury, which found him not guilty on Nov. 30 after a five-week trial.

“People learned it isn’t a slam dunk every time the Department of Justice moves,” says former HHS Inspector General Richard Kusserow, CEO of Strategic Management in Alexandria, Va.

The U.S. Attorney’s Office for the Eastern District of Virginia accused Bajoghli of billing Medicare for services provided incident to his professional services when they were furnished by medical assistants, who are not licensed in the state of Virginia to perform medical procedures, and alleged he falsely diagnosed skin cancer and performed unnecessary Mohs surgery to treat it.

Peter White, one of the defense attorneys for Bajoghli, tells RMC that this sort of dispute should be handled by prosecutors filing a civil False Claims Act lawsuit against the doctor, not by filing more than 40 felony charges against him. “This was a classic example of criminalization of what would normally be business practices — perhaps aggressive business practices,” says White, with Schulte Roth & Zabel in Washington, D.C.

continued on p. 6

Diagnosis Validation Audits Gain Steam With Payers; ARF, Malnutrition Are Targets

Even though a registered dietitian and physician documented a patient’s severe protein-calorie malnutrition (ICD-9-CM 262), the diagnosis was nixed by a recovery audit contractor (RAC) during a “diagnosis validation audit.” The RAC asserted there was a “lack of sufficient clinical evidence to support this diagnosis code” for the 76-year-old patient and removed it as a secondary diagnosis, which changed the MS-DRG. This wasn’t a matter of incorrect coding; the RAC challenged the clinical conclusion after conducting a type of audit that appears to be gaining momentum, experts say. There are ways, however, to prevent denials from the audits and mount effective appeals, they contend.

Diagnosis validation, also known as clinical validation, involves auditors questioning whether evidence in the medical record supports the diagnoses and procedures that wind up on Medicare and other types of claims (RMC 5/27/13, p. 1). CMS in its 2011 statement of work for RACs started to require diagnosis validation audits.

“We are seeing an increase in the number of diagnosis validation audit denials,” said Denise Wilson, vice president of Intersect Healthcare and AppealMasters in Lutherville, Md. “Since the RAC auditors have been prohibited from doing level-of-care...
audits, the number of diagnosis validation audits being done by the RACs seems to be on the rise and has been on the rise over the past nine months or so. We are also seeing a lot of commercial payers auditing diagnosis validation as well, which is not something we were seeing a couple of years ago.”

She sees a lot of diagnosis validation denials for encephalopathy, malnutrition and acute kidney injury (AKI). “It’s a different animal than coding denials,” Wilson said Dec. 16 at a webinar sponsored by Intersect Healthcare and Resonant Physician Advisory Services.

The malnutrition patient may not have seemed like a classic case. She weighed 200 pounds at 5 feet 6 inches and hadn’t lost weight, and no prealbumin levels were drawn, as the RAC denied noted. The RAC added that “according to the World Health Organization, criteria for severe malnutrition is defined by a [body mass index] less than 16, a 25% recent weight loss, characteristic physical signs, and Prealbumin less than 5mg/dL.”

But Wilson said the hospital stands a good chance on appeal because there’s no “single definitive parameter to diagnose adult malnutrition in the context of an adult illness/injury.” In this patient’s case, the dietitian assessed


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December 21, 2015

Report on Medicare Compliance

ZUMKHAWALA-COOK, Chief Compliance Officer for Holy Spirit Health System
Haering presented a hospital claim with a principal diagnosis of acute respiratory failure. The 77-year-old patient was admitted as an inpatient with a chief complaint of shortness of breath but a complex history: hypertension, diabetes, chronic obstructive pulmonary disease and coronary artery disease. The reviews of systems were all negative, and the vital signs weren’t bad, but “we get the opportunity to have acute respiratory failure in the chart because all factors are present for acute respiratory failure, and the query says the doctor put it in the discharge summary,” he said. But there would be problems if it were subject to diagnosis validation. The reason: Haering said “the entire chart showed a slightly different picture.” For example, the respiration rate was cited as 32 beats per minute, which is abnormal, “but when you look at the exam, this patient also is alert and in no acute distress. Breath sounds are clear.” Also, he said, “the doctor is nice enough to say the patient is wheezing, but we don’t have clarity on the wheezing.”

Documentation should have “congruency” and “consistency,” Haering said. That means:

◆ **The history of the patient should match the exam.** The statement “acute respiratory distress” doesn’t mesh with “normal respirations, lungs clear, no apparent distress (NAD).”

◆ **The documentation should fit with other documentation.** That wouldn’t be the case if the physician writes “NAD, unlabored respirations,” while the nurse puts “in distress, tachypnic.”

◆ **The documentation should reflect reality.** If the patient is admitted for ependymopathy with chronic L hemiparesis and a stage 4 decubitus ulcer, it would be silly if the chart states “no neurologic deficit, no rash or lesions.”

◆ **The plan should match the diagnosis.** It wouldn’t be credible if (1) the patient’s diagnosis is sepsis, but there’s no documentation of oral antibiotics, intravenous fluids or follow-up labs, or (2) the patient’s diagnosis is community-acquired pneumonia, but the patient has dysphasia/aspiration and is on vancomycin and Zosyn because “being incongruent goes both ways.” A mismatch between the plan of care and diagnosis/assessment can take two forms, Haering said. The documented diagnosis (1) reflects a severity of illness that’s much higher than the plan of care/intensity of treatment, which means “either the doctor overreported the severity of illness (a diagnosis issue), or the doctor undertreated the patient (a quality issue),” or (2) reflects a severity of illness that is much less than the plan of care/intensity of treatment, which means “either the doctor underreported the true severity of illness (a coding documentation improvement issue) or overtreated the patient (a quality and resource issue),” he said.

Haering suggested that physician advisers audit charts for patterns of “risky documentation.” Their findings can be fed back to physicians, clinical documentation improvement specialists and coders to help reduce diagnosis validation denials. Capturing CCs and MCCs and other improvements will help reduce denials from validation audits.

Hospitals shouldn’t take diagnosis validation denials lying down, Wilson said. There are often grounds to appeal them. It’s a question of “not taking what the payer says as hard and fast rules,” she said. Instead, what do professionals say are the standards for diagnosing a particular condition? What was documented in the medical record, and what are the relevant CCs and MCCs?

Wilson walked through a few denials she has successfully appealed for hospitals. In one case, a payer denied a claim for acute renal failure (ARF) on the grounds it shouldn’t have been coded. The patient was a 72-year-old man with a history of hypertension, atrial fibrillation, stroke, gastroesophageal reflux disease and dementia. The man was admitted to the hospital with complaints of abdominal pain, nausea and vomiting, and he was dehydrated and had a creatinine level of 1.8. After getting IV fluids, the patient’s creatinine dropped to 1.0. In denying the claim, the payer stated that “Acute Renal Failure implies a three fold increase in creatinine, a 75% decrease in Glomerular Filtration Rate [GFR], anuria for 12 hours or a urine output of less than 0.3 ml/kg/hr for 24 hours. The extent of the transient worsening of this patient’s renal function did not justify coding Acute Renal Failure.”

Wilson disagreed with the payer’s denial. “We feel the payer is taking the highest level of acute renal failure and trying to apply those criteria to the patients and saying you can’t code it if they don’t meet the highest level, and that’s not true,” she said. “That’s part of what we argue to payers.” There are different clinical algorithms in use to diagnose ARF, AKI and acute tubular necrosis (ATN).

When appealing diagnosis validation denials, Wilson said that it’s helpful to point out the evidence for the diagnosis that’s in the medical record. For ARF/ATN,
that would include markedly decreased GFR; markedly elevated BUN/creatinine levels; urine osmolality <350; urine sodium >40; red blood cells present in the urine; elevated potassium and phosphate levels; urine sediment; sodium >2%; and urea >50%. For AKI, that would be a GFR decrease of >25% using the RIFLE (i.e., risk, injury, failure, loss of kidney function and end-stage kidney disease) criteria, but there are other AKI diagnostic criteria, she noted.

Encephalopathy is another target of validation denials. Wilson described the case of an 88-year-old woman who was admitted to the hospital in 2013. A secondary diagnosis code of 349.82 (metabolic encephalopathy) was coded, but an auditor removed the code because of “a lack of supporting clinical evidence,” she said. Without that secondary diagnosis, the MS-DRG changed from 064 (Intracranial Hemorrhage or Cerebral Infarction with MCC) to 066 (Intracranial Hemorrhage or Cerebral Infarction without CC/MCC).

Wilson said there were grounds to appeal. The physician had documented “acute alteration of her physical and mental state,” attributing it to a urinary tract infection (UTI). A neurological consultation was requested, and the neurologist’s final impression was “encephalopathy toxic/metabolic.” But the hospital still has to make its case on appeal as a valid diagnosis, Wilson said. Although the UTI culture was negative, imaging showed an acute cerebrovascular accident. She suggested the following reasons for reversing the MS-DRG change: “Per the National Institute of Neurological Disorders and Stroke, ‘Encephalopathy is a term for any diffuse disease of the brain that alters brain function or structure. A change in mental status is the hallmark of encephalopathy.…Depending on the type and severity of encephalopathy, common neurological symptoms are progressive loss of memory and cognitive ability, subtle personality changes, inability to concentrate, lethargy, and progressive loss of consciousness.’”

Contact Wilson at dwilson@intersecthealthcare.com and Haering at DrHaering@resonantadvisor.com.

Electronic Records, Pyxis Data Mining Help Detect Drug Diversion

Signs that a night nurse at a Kaiser Permanente hospital might be stealing drugs surfaced quickly in June, when reports came into the National Compliance, Ethics & Integrity Office. During the previous three years, Kaiser has evolved its data mining capacity — some of it homegrown — to identify anomalies that might indicate drug diversion, and it was paying off, according to Marita Janiga, executive director of investigations, and Mark Horowitz, a pharmacist in the compliance office.

Evidence against the nurse was mounting; for example, she removed narcotics and other medications 58 times from the Pyxis medication-dispensing machine without corresponding documentation; appeared at the hospital on a day she wasn’t working; and accessed Pyxis with a colleague’s log-in, under which four vials went AWOL. The nurse, who admitted stealing an unknown number of partial vials of hydromorphone for personal use at home, quit her job during the investigation. Kaiser plans to refer her to law enforcement.

Data analytics has been a boon to the detection and investigation of drug diversion at Kaiser Permanente, Janiga said Dec. 14 at a webinar sponsored by the Health Care Compliance Association. Kaiser uses the technology at its organization nationally, which includes 659 hospitals, medical offices and other facilities, 17,791 physicians and 49,778 nurses.

Drug diversion is a pressing issue, and there are compliance, enforcement and patient-safety considerations (see box, p. 5). Dilaudid is the most popular drug diverted by employees for their own use, and they also steal fentanyl, morphine, lorazepam, hydromorphone and others. The Drug Enforcement Agency (DEA) is looking for drug diversion in more hospitals (RMC 9/22/14, p. 4). For example, in July 2014, Dignity Health, a San Francisco-based health system, agreed to pay $1.55 million and implement a plan to improve its compliance with the Controlled Substances Act after the DEA investigated outpatient and inpatient pharmacies at one of its hospitals, according to the U.S. Attorney’s Office for the Eastern District of California (RMC 7/21/14, p. 6).

At the heart of the Kaiser data analytics strategy for combating drug diversion are Pyxis machines, which dispense medications, Horowitz said. Pyxis machines use bar code scanning to ensure accurate dispensing and record the identity of the people who pull medication. Kaiser has 2,388 Pyxis machines, which contain a wealth of information. Access is controlled by two identifiers — a biometric (e.g., fingerprint) and a personal identification number — which means Kaiser knows who got medication (presumably for the patient), what medication it was, when it was dispensed and where.

Kaiser Builds Tool ‘From the Ground Up’

Three years ago, Kaiser created a report that linked the removal of medication from Pyxis machines to its electronic medication administration records (eMARs). Horowitz said, “There was no product available. We had to build it from the ground up,” he explained. Then, in early 2015, a team led by Jay Loden, assistant director of information analytics compliance technology, took the next step: generating other kinds of Pyxis reports that could potentially identify drug diversion.
For example, medication that’s wasted — thrown out because the dose in the vial is more than the patient needs — must be documented and witnessed by another nurse. Medication that’s returned to Pyxis because it was removed but not administered or was removed in error is also checked against the eMAR.

“We take the information from the eMAR and bump it up against the reports that come from Pyxis that tell us who was in the machine and what meds were dispensed,” Janiga said. “Reports are done systematically and reviewed, and anomalies show up.”

Another useful piece of data is the relationship between the type of medication/dose and the level of pain expressed by the patient, Janiga said. “If large amounts of a drug are withdrawn from Pyxis, but in the eMAR there’s no record of the patient complaining of pain, and it reaches a certain level of frequency,” the analytics team will be notified, she said. Pyxis machines also dispense drugs according to job classification, said Janiga. Pharmacists and registered nurses, for example, have access to a wider range of drugs than a respiratory care therapist or licensed vocational nurse.

**Steps for Detecting and Preventing Drug Diversion**

Deloitte & Touche suggested that organizations take several steps to “proactively detect and prevent drug diversion,” which it notes is, by definition, a “clandestine” activity (see story, p. 4). Contact David Yarin, a principal at Deloitte & Touche, at dyarin@deloitte.com.

**Proactive drug diversion detection and prevention**

As the diversion of prescription drugs is — by necessity — a clandestine activity, it is incumbent that organizations take several steps to proactively detect and prevent drug diversion. These detection and prevention steps mirror the seven elements of an effective compliance program, including but not limited to:

- Training and education.
- Hotline reporting for suspected violations, including anonymous and confidential communication when needed.
- Job rotation and mandatory vacations for pharmacy purchasing managers.
- Electronic prescriptions for controlled substances.
- Developing written policies and procedures required by state and federal regulations for:
  - Policies and procedures on the wasting of controlled substances.
  - Policies and procedures on the destruction of expired drugs.
  - Discrepancy identification, reporting, investigation and resolution.
  - Ordering drugs from wholesalers and vendors.
  - Segregation of duties in the ordering, receipt, inventory, and storage process.
  - Receiving drugs from vendors.
  - Stocking drugs in the pharmacy vault and on floors/units.
- Reporting questionable transactions or events to an immediate supervisor and/or pharmacy director. For example:
  - An individual request by a physician for controlled substances.
- Properly securing and reconciling DEA-222 forms used for ordering Class II controlled substances.
- Reconciling drug orders to drug receipts to drug stocking.
- Securing the delivery process:
  - The wholesale vendor should deliver controlled substances directly to the pharmacy, where a pharmacist should sign a receipt and take delivery.
  - In addition, drugs should be delivered from the pharmacy to individual floors/units in a secured manner.
  - Limiting, securing and monitoring access to the pharmacy vault in which controlled substances are stored.
- Investigating and reviewing discrepancies on a timely basis. For example, staff working on a unit in which an unexplained discrepancy occurs may be asked to remain at the end of their shift until the discrepancy is appropriately resolved.
- Training and educating employees on the proper use of ASDUs.
  - Physical access to the units.
  - Use of system screens and software.
- Tracking key data produced by the ASDU system, including:
  - High frequency of discrepancies by certain individuals or service areas (including the pharmacy).
  - Higher than expected wasting.
- Questionable transactions — Examples include higher than expected utilization of a controlled substance on a particular floor or unit. In certain instances, a review of related medical records may be needed to confirm both the physician order of the drug and the administration to the patient.
  - Limiting the number of individuals with access to controlled substance ASDU bins.
  - Limiting the number of personnel with “Super User” status in the ASDU system — these users have the ability to modify inventory counts, and add or delete users.
  - Establishing more frequent and unscheduled inventory counts.
  - Although DEA regulations require physical inventory of controlled substances once every two years, consider increasing the cycle count frequency for selected drugs. For example, pharmacy personnel may wish to select a small number of controlled substances and/or high-cost drugs for weekly pharmacy inventory counts, while individual units should be prompted to count back and record beginning inventory when removing a controlled substance from the ASDU.
  - Educating relevant employees on identifying, detecting and reporting potential drug diversion.

*continued*
The data generated by Pyxis and the eMAR don’t necessarily mean employees have diverted drugs, she noted; there can be false positives (e.g., a nurse administering a pain medication without administering a pain scale). But when there are enough red flags, the analytics team will conduct a due-diligence review, she said.

During the process of developing the data analytics, Janiga said the team looked at the range of time it took for nurses to give medications after removing them from Pyxis. “We observed that, on average, that task takes place within a two-hour time frame. If a nurse does not give a patient the medication within that time frame, it definitely does not mean drug diversion — there could be all kinds of reasons for the delay — but since the majority of medications are administered within that two-hour time frame, we set that as one of our parameters when looking for red flags,” she said. It’s not an absolute; “we defer patient-treatment decisions to our medical professionals.”

Compared with data mining, cameras at the Pyxis machines would seem like the path of least resistance to catch drug diverters in the act. But Janiga said it’s not an option “because of HIPAA concerns.”

Kaiser has other data analysis plans in the works to identify drug diversion. One future red flag is the removal of drugs from Pyxis after patients are discharged. “We found out from subject matter experts that if medications are administered, the patients should be in the facility for 30 minutes. So if they’re administered five minutes before, it raises a red flag,” he said. Another is when clinicians remove drugs after a patient’s death.

There have been other quality improvements. “At the end of the day, we have helped hospital compliance programs more than we ever thought we would because once we looked into processes, we couldn’t design the [diversion prevention and detection] program without understanding their work flow,” Janiga said. For example, the Kaiser inpatient director in Anaheim, Calif., said the work on drug diversion has led to a 50% reduction in medication discrepancies, which will help with Joint Commission surveys.

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**Physician Is Acquitted**

continued from p. 1

It has always struck him “as unfair to create a complex system and hold [providers] criminally responsible” for imperfect compliance. He asked the prosecutors why they didn’t pursue the Bajoghli case under the False Claims Act instead of criminally, but “they believed they could prove criminal intent.”

Bajoghli operates the Skin and Laser Surgery Center, with offices in Stafford, Woodbridge and Vienna, Va., and Washington, D.C. He specializes in Mohs micrographic surgery, a technique to remove cancer from the skin in a way that preserves healthy skin and protects the patient’s appearance. Before Mohs surgery is performed, cancer is confirmed by a biopsy.

Mohs surgery may require complex suturing, including the use of a flap closure, where skin next to the wound is moved to cover it, and skin grafts, the indictment stated. Repairs of the wound are typically done right after the Mohs surgery, but sometimes they occur several days later at an office visit.

According to the indictment, Mohs surgery was a vehicle for the fraud that Bajoghli was accused of. The dermatologist “routinely diagnosed benign tissue as skin cancer, informed patients they had skin cancer when they in fact did not, and performed unnecessary and invasive surgery on the patients’ benign tissue — including, at times, multiple stages of Mohs surgery.” He also was accused of billing insurers for Mohs surgery when it wasn’t performed.

Incident-to billing was a big part of the case. Medicare pays 100% of the physician’s fee schedule for services performed by physician assistants, nurse practitioners and other auxiliary personnel, if the services are “incident to” a physician’s professional services, assum-
ing certain requirements are satisfied (RMC 12/14/15, p. 4). Physicians have to provide direct supervision, which means being somewhere in the suite while services are performed and immediately available to step in if the patient needs physician intervention.

The indictment of Bajoghli alleged that he told “unlicensed and unqualified medical assistants to perform wound closures, including complex suturing, flaps, and skin grafts, on Mohs surgery patients at follow-up office visits, including when the defendant was seeing patients at a different office location from where the wound closure was being performed.” Then the dermatologist submitted claims that indicated either he closed the wounds or the wound closures were performed incident to his services — in other words, by his employees, under his personal supervision, the indictment alleged.

“When a medical assistant expressed concern about her competency to perform wound closures, the defendant provided sutures to the medical assistant to take home and practice on raw chicken,” the indictment alleged.

At the same time, Bajoghli allegedly directed his employed nonphysician practitioners to bill for incident-to services although they didn’t comply with Medicare criteria because the dermatologist wasn’t always available to provide personal supervision.

The jury didn’t buy the charges in the indictment. That may stem from the fact that it was a case of “regulatory fraud,” not “fact fraud,” says former federal prosecutor Robert Trusiak, a principal of Health Care Compliance Support in Buffalo, N.Y. When physicians bill for services that weren’t rendered or “act as a drug pusher with an ‘MD’ after their name, those are fact frauds,” he says. Fact frauds favor the government, Trusiak notes. Regulatory frauds are harder for the government to prove — “and you can’t find more confusing criteria because the dermatologist wasn’t always available to provide personal supervision.

The prosecution presented patients and other witnesses who said that medical assistants did wound closures at times when Bajoghli was not in the office suite.

Kusserow sees this case as having “real significance.” When most organizations and physicians are confronted by the Department of Justice (DOJ) with false claims or other allegations, they do a cost-benefit analysis. Even if they win, legal fees may dampen their enthusiasm for a battle with DOJ, and, therefore, the majority of organizations and physicians settle the cases, Kusserow says. “Only occasionally people feel their case is so meritorious they go to trial,” he said. The loss in the Bajoghli case may rein in DOJ a bit, he says. “They probably won’t be so fast and loose in forcing settlements when someone is resisting,” Kusserow speculates.

A spokesperson from the U.S. attorney’s office tells RMC that it “respectfully decline[s] to comment.”

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**NEWS BRIEFS**

◆ Another 32 hospitals have agreed to settle false claims allegations over their inpatient admissions for kyphoplasty that allegedly should have been performed in an outpatient setting, the Department of Justice (DOJ) said Dec. 18. Collectively, the hospitals — in 15 states — will pay $28 million, which means a total of 130 hospitals have now settled allegations that they misharged for kyphoplasty, a procedure to treat spine fractures, DOJ said. All told, the settlements have yielded $105 million. The hospitals did not admit liability in the settlement. The hospitals that settled are all over the country, and include Cleveland Clinic in Ohio; Sacred Heart Medical Center in Spokane, Wash.; and Cullman Regional Medi-
NEWS BRIEFS (continued)

cal Center in Cullman, Ala. Except for three of the hospitals that settled, all of the cases stemmed from a whistleblower lawsuit. The national kyphoplasty initiative has been controversial. While DOJ alleged that “In many cases, the procedure can be performed safely and effectively as an outpatient procedure without any need for a more costly inpatient hospital admission,” attorneys have rebutted that guidance on the matter has been ambiguous (RMC 6/29/09, p. 1). DOJ said it also settled a case in 2008 for $75 million with Medtronic Spine LLC, the corporate successor to Kyphon Inc., over allegations that it caused false claims to be submitted to Medicare “by counseling hospital providers to perform kyphoplasty procedures as inpatient rather than outpatient procedures.” Visit www.justice.gov.

• Malware was at the heart of University of Washington Medicine’s HIPAA settlement, which was announced Dec. 14 by the HHS Office for Civil Rights (OCR). University of Washington Medicine, which includes University of Washington Medical Center, agreed to pay $750,000 to settle allegations it potentially violated the security rule “by failing to implement policies and procedures to prevent, detect, contain, and correct security violations.” OCR investigated University of Washington after it reported a breach of its electronic protected health information (e-PHI). After an employee downloaded an email attachment with “malicious malware,” the covered entity’s IT system was compromised, and the e-PHI of about 90,000 people was accessed, OCR said. Data from two groups of patients were affected, OCR said: “(1) approximately 76,000 patients involving a combination of patient names, medical record numbers, dates of service, and/or charges or bill balances; and (2) approximately 15,000 patients involving names, medical record numbers, other demographics such as address and phone number, dates of birth, charges or bill balances, social security numbers, insurance identification or Medicare numbers.” The settlement requires the covered entity to implement a corrective action plan and report on its compliance efforts. OCR noted that its investigation found that University of Washington’s security policies “required its affiliated entities to have up-to-date, documented system-level risk assessments and to implement safeguards in compliance with the Security Rule. However, UWM did not ensure that all of its affiliated entities were properly conducting risk assessments and appropriately responding to the potential risks and vulnerabilities in their respective environments.” An attorney representing University of Washington did not return RMC’s call. Visit http://tinyurl.com/z8vkwm2.

• Elant, Inc., a skilled nursing facility (SNF) chain headquartered in Goshen, N.Y., agreed to pay $600,000 to resolve allegations that it delayed the discharges of short-term residents, New York State Attorney General (AG) Eric T. Schneiderman said Dec. 16. According to the settlement, between 2008 and 2011, Elant postponed discharges of short-term patients “who were clinically ready to leave... against the wishes or without the informed consent of the residents or their families,” a press release states. Elant senior managers allegedly told SNF administrators to limit these discharges to two or three a week. Most short-term residents of SNFs get rehab after strokes or hip fractures, so delaying their departures — a strategy aimed mostly at Medicare and Medicaid patients — was to make more money, the AG alleged. In connection with the case, two former Elant CEOs and a former SNF CEO surrendered their state Department of Health licenses, the AG said. Elant also entered into a corporate integrity agreement with the New York State Office of the Medicaid Inspector General. Visit http://tinyurl.com/je8p48n.

• Two physicians and a nurse are headed to prison in connection with a $50 million New Orleans fraud scheme, DOJ and the U.S. Attorney’s Office for the Eastern District of Louisiana said Dec. 16. Physician Barbara Smith of Metaire, La., was sentenced to 80 months; physician Roy Berkowitz of Slidell, La., was sentenced to 64 months; and the nurse, Beverley Breaux, of New Orleans, was handed a term of 50 months. They were also ordered to pay restitution of $9,484,939; $4,952,816; and $2,057,179; respectively. According to the U.S. attorney’s office, over a decade, the defendants and others ran a home health fraud scheme involving multiple companies. “Smith and Berkowitz falsely certified that thousands of Medicare recipients were homebound and required nursing or therapy services to be provided in their homes,” the U.S. attorney’s office said. “Breaux falsely certified that these patients were homebound and falsely claimed to have treated patients that she had not seen.” They were convicted by a jury in May. Visit http://tinyurl.com/zk55soy.
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