Confusion Reigns on MD Supervision and Billing for Hyperbaric Oxygen Therapy

Trouble is brewing with physician supervision and billing for hyperbaric oxygen therapy, a hospital-based treatment for wounds and other conditions. At least two Medicare administrative contractors (MACs) have increased the level of physician supervision required for hyperbaric oxygen therapy, and some hospital claims are apparently under scrutiny in this area.

“My understanding is there are a number of audits and investigations of hospitals for hyperbaric oxygen that span the gamut,” says attorney Gary Ayers, referring to medical necessity, billing and supervision. For example, Promise Regional Medical Center in Hutchinson, Kan., is under investigation by the U.S. attorney’s office in Topeka for its hyperbaric oxygen therapy, says Ayers, who represents the hospital. “We were just told that an audit has led to an investigation. That’s all we know at this point,” he tells RMC. Promise Regional Medical Center has three full-body hyperbaric oxygen chambers. continued on p. 6

First Stark Case Is Resolved Through CMS Self-Disclosure; Is the OIG Option Gone?

CMS has resolved the first Stark self-disclosure case through its new protocol. Although CMS spokeswoman Ellen Griffith confirmed that a settlement was reached, no additional details were available.

However, according to sources, the hospital that is first out of the gate with CMS’s self-referral disclosure protocol is Saints Medical Center in Lowell, Mass. The center’s
alleged Stark violation reportedly concerned night coverage, stipends and medical directorships, sources say.

Through the self-disclosure, the hospital paid $578,000 to resolve its Stark liability, according to the Lowell Sun. The liability could have gone as high as $14 million, the newspaper says. The violation was identified during preparations for a merger with Covenant Health Systems, which never went through, the newspaper notes.

“It’s encouraging to see a protocol participant complete the process and come out on the other side with what appears to be a good result,” says Washington, D.C., attorney Lisa Ohrin, former director of the CMS Division of Technical Payment Policy. “No doubt there were growing pains on the part of the government and the hospital.”

Ohrin notes that Saints Medical Center executives thanked two members of Congress from Massachusetts, Sen. John Kerry (D) and Rep. Niki Tsongas (D), for their help in resolving the hospital’s liability. “It would be interesting to know what impact, if any, congressional intervention had in the outcome of this disclosure and what that could mean for other protocol participants.”

The CMS self-referral disclosure protocol was mandated by Sec. 6409 of the health reform law to resolve “actual or potential” violations of the Stark law. CMS is required to consider reducing penalties when providers come forward and follow the CMS guidelines protocol made public (RMC 1/24/11, p. 1), the way the HHS Office of Inspector General posts settlements on its website.

CMS or OIG: The Plot Thickens

The Stark law bans Medicare payment to an entity for “designated health services” (DHS) when they’re referred by physicians who have a financial relationship with the entity, unless an exception applies. If, for example, an agreement between a hospital and physician violates Stark, the hospital must return all reimbursement.

But there’s a twist to this self-disclosure business that worries Washington, D.C., attorney Kevin McAnaney, former chief of the OIG’s Industry Guidance Branch. It looks like all Stark violations will have to be resolved through CMS, even though the Office of Inspector General has a longstanding self-disclosure protocol. OIG’s version used to be for Stark-only violations, but now it’s just for providers whose conduct ran afoul of both the Stark and anti-kickback statutes, he says.

As of early February, CMS had received about 50 applications to its self-referral disclosure protocol. But there’s a twist to this self-disclosure business that worries Washington, D.C., attorney Kevin McAnaney, former chief of the OIG’s Industry Guidance Branch. It looks like all Stark violations will have to be resolved through CMS, even though the Office of Inspector General has a longstanding self-disclosure protocol. OIG’s version used to be for Stark-only violations, but now it’s just for providers whose conduct ran afoul of both the Stark and anti-kickback statutes, he says.

According to McAnaney, providers will have to separately resolve Stark violations through the CMS self-referral disclosure protocol and kickback violations through the OIG protocol. That’s a sea change from the way things have been done. The catalyst is the health reform law, which requires providers to return Medicare and Medicaid overpayments (within 60 days of identification), and the Fraud Enforcement and Recovery Act (FERA), which makes it a False Claims Act violation to retain overpayments.

“Up until those [legislative] changes, you could go to OIG and you would reach an agreement” under the Stark-related civil monetary penalty law, he says. Even though OIG lacks the authority to settle overpayments, ...
“you knew it was run past CMS and people were willing to take the chance that CMS would not come after you. Since there was no clear overpayment obligation, you were fine and besides, you disclosed it.” But now we have the health reform law and FERA. With these statutory obligations, McAnaney says, providers cannot rely on the OIG self-disclosure protocol alone. “I hear people say if we have [a Stark issue], maybe we will go to OIG. But I think that is potentially a terrible mistake,” he says. “OIG has no authority to settle overpayments.” Even if people in government want OIG to resolve Stark and kickback issues in a single disclosure, their hands are tied, he says. Providers will have to go to CMS “because there is now a legal obligation to repay the overpayment,” McAnaney says.

**What Quid Pro Quo Will Providers Get?**

The implications are worrisome, McAnaney says. For one thing, it’s unclear at the moment what kind of *quid pro quo* providers will get for confessing their sins. OIG’s track record is well-established. It usually settled for some amount that was significantly less than the actual amount of reimbursement stemming from referrals prohibited by Stark under the noncompliant arrangement. For example, if a provider self-disclosed an arrangement that was not fair-market value (FMV), OIG “typically settles on some multiple of the difference between FMV and what was actually paid, and that’s substantially less than the amount of claims between the parties,” he says.

Also, CMS has made it quite expensive to carry out the self-referral disclosure protocol, McAnaney says. For example, even though in most cases CMS can only base its recoupment on four years of historical claims under a noncompliant agreement, the terms of the self-referral disclosure protocol require providers to calculate the value of the claims for the entire “look back period,” which could be 10 years or more. “They want to look at the entire period of noncompliance,” he says. By taking a longer view, CMS can make a more informed decision about how much of a break the provider deserves. But for providers, “that’s a fairly expensive procedure and can be burdensome.”

Ohrin confirms that health care providers and their legal representatives think the documentation demands of the CMS self-referral disclosure protocol are “tedious.” But providers should keep in mind that when CMS gives them a break through this process, “the agency is giving up money owed to it and releasing providers from liability, so CMS has to understand the whole arrangement,” says Ohrin, who is with Katten Muchin Rosenman in Washington, D.C. “CMS is not requesting documentation — even large amounts of documentation — to be difficult. They want to make sure they have everything relevant to the potential violation. People should be okay with giving them all the details.” She says providers want the peace of mind of knowing they are safe from future accusations over a particular set of Stark violations — the so-called “release” — because they told the government the truth, the whole truth and nothing but the truth.

But there’s nothing wrong with providers testing the limits in their attempt to get CMS to reduce the settlement amount. “I think you need flexibility and to push the bounds of your creativity in determining overpayments,” Ohrin says. For example, prepare as many theories of overpayment calculations as possible. And don’t expect this to be a quick fix. You will go back and forth with CMS for a while before anything is resolved, as anyone who has ever sought a CMS or OIG advisory opinion knows, she says.

Ohrin says providers are drawn to the CMS self-referral disclosure protocol because they “are getting more and more nervous” about the risk of so-called reverse false claims, which are lawsuits based on the flouting of the overpayment-return mandate. This anxiety is triggering a new level of internal review of Stark compliance, she says. A common Stark problem is expired agreements between DHS entities and their referral sources (e.g., hospitals and physicians).

CMS may not accept every applicant into the program. For example, South Bend, Ind., attorney Bob Wade represents five of the providers who have applied to resolve Stark problems through the CMS self-referral disclosure protocol. In two cases, CMS accepted the submissions but asked for more documentation; in two other cases, CMS asked for additional information, but the jury is still out on their admission. And there has been no word on the fifth, says Wade, who is with Baker and Daniels. If they get through one hurdle — acceptance — another one looms far larger, Wade says. What will the end result be? Will providers get a reasonable settlement? “We have to trust CMS,” he says.

**Be Specific in Self-Disclosures**

Wade advises providers to be very specific about their compliance programs in self-disclosures. Providers should include in their submissions a separate memo explaining why their compliance programs are effective, with detail about each of the seven elements. A CMS official told Wade that the agency wants to know how providers modified their compliance programs after identifying a problem or violation.

Contact McAnaney at kevin@mcananeylaw.com, Ohrin at lisa.ohrin@kattenlaw.com and Wade at bob.wade@bakerd.com. Pre-disclosure questions should be directed to CMS’s physician self-referral call center at (410) 786-4568.
CMS Will Soon Cancel Signature Requirement for Lab Requisitions

CMS apparently plans to scrap its new physician-signature requirement for lab requisitions. The withdrawal of this plan is a relief for hospitals, which have been troubled by what they saw as a redundant and sometimes impractical mandate.

Alan Mertz, president of the American Clinical Laboratory Assn., tells RMC that Jonathan Blum, CMS’s deputy administrator and director of the Center for Medicare, told him Feb. 11 that the lab requisition signature requirement will be rescinded. The new rule, promulgated in the 2011 Medicare physician fee schedule, took effect Jan. 1, but CMS delayed enforcement until April 1, and Mertz was assured the rescission would occur “sometime before April 1.”

Under the rule, ordering physicians would have been required to sign requisitions accompanying patients or their specimens.

CMS ‘Misunderstood’ How Labs Work

Compliance officers were frustrated by the requisition-signature proposal because physicians already sign orders for lab tests. It was unclear whether they needed signed requisitions and orders or whether requisitions were necessary if orders were signed. Other practical problems emerged as well. For example, if a home health patient needed lab work but was 40 miles from the hospital lab, would it be necessary for the home health nurse to go back to the doctor’s office before getting the specimen processed?

“There is some misunderstanding [by CMS] of the way lab services work and how they are processed. If it was truly understood, I don’t think they would have proposed that,” Mertz says. “I give CMS credit for recognizing this.”

Mertz says the signature requirement was a complete shift of longstanding Medicare policy. As recently as March 2010, CMS reiterated that requisitions don’t need physician signatures. In Medicare Transmittal 327, CMS stated, “There are some circumstances for which an order does not need to be signed. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and Pub. 100-02, chapter 15, section 80.6.1, state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (e.g. a progress note) that he/she intended the clinical diagnostic test to be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.”

The transmittal generally is considered a compliance turning point because it laid down the law for medical reviews related to physician signatures (RMC 3/22/10, p. 1).

CMS’s decision to rescind the requisition-signature mandate came after months of persuasion by various industry groups, including the American Clinical Lab Assn., American Hospital Assn., American Medical Assn. and American Health Care Assn. “We explained the problems with this policy and [Blum] listened and reacted and it appears they will fix it,” Mertz notes.

It also helped that Congress weighed in with letters to CMS Administrator Donald Berwick, M.D. One was signed by 89 members of the House of Representatives and another by 39 senators. The senators’ Feb. 11 letter stated that “under this new policy, laboratories will face a difficult decision when they receive a patient specimen with an unsigned requisition. Laboratories will have to decide not to provide their needed services and therefore be unable to provide the information necessary to make health care decisions, or provide the services without a guarantee of payment and then work to obtain signatures in order to submit claims for payment….In the former scenario, care may be significantly delayed; in the latter scenario, the laboratories who serve a high percentage of Medicare beneficiaries could spend a large amount of time contacting providers to gather the required signatures and could see their payments delayed or face the possibility of being unable to receive payment.”

Contact the American Clinical Lab Assn. through JoAnne Glisson at glisson@clinical-labs.org.

OCR’s Staff Increases Could Lead to Greater HIPAA Enforcement

The HHS Office for Civil Rights (OCR) has moved to steadily increase its staff in Washington, D.C., and its regional offices since the HITECH Act was signed, but the ability to fill “privacy advisor” positions in the field has stayed just out of reach. The jury is still out on how that will affect enforcement of the HIPAA patient privacy and security rules.

According to the Obama administration’s fiscal year 2012 budget request, OCR is asking for 142 HIPAA-dedicated employees for FY 2012. That would be an increase from the 112 full-time employees assigned to privacy rule compliance and enforcement in FY 2010.

The agency has been lobbying for 10 more people for privacy and security enforcement since the FY 2011 budget request, and is asking for them again for FY 2012. A continuing resolution to keep the government running, which expires March 4, is likely what has caused the
The Impact of More Staffing Is Not Clear

“In the big picture, I wouldn’t expect to see an earth-shattering increase in enforcement” in the near future, says Jo-Ellyn Klein, a Washington, D.C., attorney with Akin Gump. “It looks like public education will be the thrust.” But one area that may see some more action is security, with OCR’s new authority in that area, she predicts. OCR’s breach list “reflects what entities face in protecting data. The breaches reflect that physical security remains a challenge and it’s been a recurring problem.”

Klein says there are steps covered entities can take now. They should review (1) their compliance checklists for privacy and security, and (2) the guidance put out by HHS and the FTC, which is accessible via HHS’s website, focusing on the 2006 security guidance on portable devices, the FAQs concerning disposal of protected health information, and the resolution agreements HHS entered into with covered entities (e.g., Providence, CVS).

“Taken as a whole, the additional funding and staffing of OCR should help OCR to be more visible and responsive to covered entities seeking clarification of HIPAA and HITECH compliance issues,” says Reece Hirsch, a partner at Morgan Lewis and Bockius in San Francisco. “It will be interesting to see how forthcoming the 10 new regional office privacy advisors will be in providing meaningful guidance. However, it’s not clear that the increased staffing will result in significantly more aggressive HIPAA enforcement,” he tells RPP. Hirsch says the $1 million for enforcement of the security rule could be a signal that OCR will be more active in that arena, “especially in light of the new security obligations to be imposed on business associates under the HITECH Act.”

But Dallas attorney Jeff Drummond disagrees about the funds for security enforcement, saying the allocation is “awfully thin” for that issue. “Investigating and pursuing security rule problems could be much more cost-intensive than going after privacy rule breaches, and I doubt $1 million will cover OCR’s costs if they really want to work on it.”

But the new hires are a step in the right direction, Drummond says. “I would say that the increase in bodies to OCR’s compliance and enforcement workforce, along with the 10 regional privacy officers, will help. I’m not sure how bad OCR’s backlog is, but in my experience (based on clients who got complaints, and how long those letters from OCR trailed the activity that was the subject of the complaint) they get to complaints without too long a delay for a governmental agency,” he says.

OCR sets goals for itself on how many covered entities take corrective actions based on OCR investigations. In FY 2010, OCR reached its goal of 4,100 corrective actions. For FY 2011, OCR’s target for corrective actions is 4,200, and the goal for 2012 is 4,300.

OCR also aims to reduce its number of open complaints and has set goals to become more efficient at investigating cases. The office says its long-term goal is to start resolving 90% of the privacy cases requiring formal investigation within 365 days (it had a rate of 53% in FY 09). For complaints that do not need formal investigation, OCR says 90% of those also should be completed within 180 days. The goal for FY 2010 was 30%, and OCR achieved 32%, it says.

Visit www.hhs.gov/about/FY2012budget/ocr_cj_fy2012.pdf. Contact Klein at jsklein@akingump.com, Hirsch at rhirsch@morganlewis.com, Drummond at jdrummond@jw.com and Young at young@mammothhospital.com. *

This article is excerpted from the February issue of AIS’s Report on Patient Privacy. For more information or to read a sample issue, visit the Marketplace at www.AISHealth.com.

CMS Proposed Rule Introduces The Medicaid Version of HACs

In a proposed rule published in the Feb. 17 Federal Register, CMS sets forth Medicaid payment cuts for hospital-acquired conditions (HACs), as mandated by the health reform law. CMS proposes to use Medicare HACs as a minimum that states must adopt, but also gives states flexibility to go beyond those conditions if they decide additions are needed.

Big money is at stake, since CMS claims that it saves about $20 million per year when it denies Medicare claims under the HAC policy. According to the proposed rule, states are projected to save $1 million for FY 2011 under their version of HACs, and about $15 million by 2015.

Sec. 2702 of the health reform law required implementation of Medicaid payment adjustments on
amounts expended for treatments of “health care-acquired conditions” (HCACs), effective July 1, 2011.

The Deficit Reduction Act, signed into law in 2006, addressed HACs only in Medicare, leaving out rules on Medicaid payments. It authorized CMS to reduce MS-DRG payments to hospitals if certain conditions were acquired in the hospital. However, CMS released guidance for states encouraging them to adopt their own payment prohibitions to coordinate with Medicare’s, which they could do by amending their state plans. The states had good reason to do so: If Medicare payments were refused for dual-eligible beneficiaries due to HACs, Medicaid would have been left with the bill.

Consistency and Flexibility Are the Goals

Through the proposed rule, CMS wants to provide some consistency across the payers while allowing the states flexibility to design policies suitable for their health marketplaces. CMS is proposing introducing the term “provider preventable condition” (PPC) “as an umbrella term for hospital and nonhospital conditions identified by the state for nonpayment.” PPCs would have two categories:

(1) HCACs, based on the Medicare HCACs, which are narrowly defined conditions and applicable only in the inpatient hospital setting, and

(2) “Other provider-preventable condition” (OPPC), which would be applicable to the other conditions a state identifies, the proposed rule explains. CMS defines the term as “a condition that could have reasonably been prevented through the application of evidence based guidelines.”

To ensure that payment rate adjustments do not result in loss of access to care, CMS proposes that any reduction in payment be limited to the amounts directly identifiable as related to the PPC and treatment for it. “For instance, if a patient develops mediastinitis after a [coronary artery bypass graft], the state would be allowed to deny payment for the treatment of the mediastinitis, but not the CABG,” the proposed rule explains.

According to the proposed rule, criteria for identifying HCACs include:

◆ Cases described by the code (i.e., an ICD-9-CM or ICD-10-CM code or a state’s method of identifying conditions for purposes of payment) that have a high cost or high volume, or both;

◆ The code results in the assignment of a case to an MS-DRG that has a higher payment when the code is present as a secondary diagnosis; and

◆ The code describes such conditions that could reasonably have been prevented through the application of evidence-based guidelines.

CMS says it is taking into account that there is a lot of variation in state payment methodology. For example, some states reimburse hospitals on a per-diem basis. If a HCAC is not present on admission, the state “may need to isolate the increased cost of the services (possibly through a utilization review) and reduce the per diem reimbursement accordingly,” the proposed rule says.

“In addition, we recognize that there is considerable variation among states in the availability of data necessary to identify HCACs and related quality issues. We are proposing to require that states implement requirements for provider self-reporting of HCACs in the Medicaid claims payment process,” it adds.

CMS proposes that existing claims systems be used as a platform for provider self-reporting of the conditions. Quality reporting across the states has also been inconsistent, it says.

CMS has asked for public comments by March 18 on many of the issues in the proposed rule. To read the proposed rule, go to http://ashealth.com, and locate the Feb. 17 Federal Register under “Today from Washington,” at the bottom of the Home page. ♦

HBO Therapy Audits Are Heating Up

continued from p. 1

Ayers warns other hospitals that some codes cited in Medicare’s national coverage decision (NCD) for hyperbaric oxygen don’t match their descriptors. He says they may face claims denials based on discrepancies. “Go through the billing codes and the covered services and compare the descriptions and you will find on more than one occasion, Medicare has billing codes and descriptions that are not consistent,” advises Ayers, who is with Foulston Siefkin in Wichita. “Medicare needs to clean up its description of what’s covered.”

Patients undergoing hyperbaric oxygen therapy, an outpatient service, receive high concentrations of oxygen in a pressurized chamber. The therapy was developed to treat decompression sickness (“the bends”), but is now used mostly to manage non-healing diabetic and other wounds and for other conditions (e.g., acute carbon monoxide poisoning, gas embolism, acute peripheral arterial insufficiency, gas gangrene and cyanide poisoning).

Physician supervision is a hot potato in this area, especially as hyperbaric oxygen technology has evolved and hospitals maintain more tanks. CMS has come down on the side of direct supervision, says Glen Moffett, vice president and general counsel for Wellspan Health in York, Pa. That means supervising physicians must be “immediately available” to intervene if necessary (i.e., interruptible from other services they’re providing), although they can be elsewhere on the hospital campus.
Although CMS has an NCD on hyperbaric oxygen therapy, at least six MACs have published their own versions. Two of these local coverage decisions (LCDs) pose a problem for hospitals because their supervision requirements are more restrictive than CMS’s and those of the other MACs, Moffett says.

Highmark Medicare Services, the MAC for Pennsylvania, New Jersey, Maryland, Delaware and the Washington, D.C., area, recently issued an LCD (L31468) stating that hyperbaric oxygen therapy performed in an outpatient setting requires personal supervision. That means the physician must stay in the room the entire time the therapy is provided.

**LCDs, CMS Statements Seem Incompatible**

Another MAC, Trailblazer Health Enterprises, uses language in its LCD that might be construed to require personal supervision as well, Moffett says. The LCD states that “personal supervision is often necessary for the scope of work required, and therefore, the immediate availability of an [advanced cardiac life support] team is necessary during the hours that the hyperbaric chamber is in operation.”

Moffett says he isn’t clear how these LCDs’ personal supervision requirements can coexist with CMS’s pronouncements on the subject. For example, in a 2002 Medicare Transmittal (AB-02-183) on coverage of hyperbaric oxygen therapy for the treatment of diabetic wounds of the lower extremities, CMS states that “special supervision and credentialing requirements should not be imposed on physicians who perform HBO therapy. You may not impose a higher level of supervision than direct supervision as is required for all ‘incident to’ therapies. CMS encourages physicians who perform HBO therapy to obtain adequate training in the use of HBO therapy and in advanced cardiac life support.”

Although the 2006 NCD doesn’t tackle supervision, CMS does state that hyperbaric oxygen therapy is covered incident to a physician’s service. “Incident to requires direct supervision,” Moffett says. All therapeutic services are in the incident-to benefit category when performed in the hospital.

“Based on this, one would assume the required level of physician supervision for Medicare-covered [hyperbaric oxygen therapy] is direct supervision,” he says.

Another concern with supervision lies in the CPT code definition of the treatment. As of 2010, CPT code 99183 is defined as “physician attendance and supervision of hyperbaric oxygen therapy, per session.” The words “physician attendance” have confused people, Ayers says. They imply the physician must be at the hyperbaric chamber during the entire treatment. “If you didn’t have the word ‘attendance’ and you just had supervision, it would be consistent with the Part A side,” he says, referring to the OPPS regulation’s definition of “direct supervision” for outpatient therapeutic services. “There’s an apparent conflict” between the Part A and Part B supervision requirements, Ayers says. “In CMS’s mind, [supervision] has been resolved, but the CPT code continues to add confusion.”

Washington, D.C., attorney Andy Ruskin also finds it odd that the LCDs would even address supervision. “The purpose of an LCD is to identify what’s reasonable and necessary, not to define supervision levels,” says Ruskin, with Morgan Lewis & Bockius. “This flatly contradicts the regulation requiring incident-to services to have direct supervision and therefore exceeds the scope of their authority.”

Ruskin says hospitals served by Highmark and perhaps Trailblazer have two choices: switch to personal supervision or submit all their claims for hyperbaric oxygen therapy “under protest.” Filing claims under protest is a way for providers to inform MACs they know they are violating a directive, but plan to appeal the inevitable claims denial.

Also, Highmark has an LCD reconsideration process, Moffett notes. Providers can request a revision to part or all of an LCD. This process is described at www.highmarkmedicareservices.com/policy/reconsideration.html.

**‘The Dust Has Not Yet Settled’**

If hospitals are held to the personal supervision standard, physicians will have to staff the hyperbaric oxygen chambers for two to four hours at a stretch. There is debate over whether that’s necessary. “The dust hasn’t really settled on this yet because the industry is rapidly developing,” says one compliance officer who asked not to be identified. “It is a popular, emerging area where delivery of treatment is shifting and modernizing, and technology is expanding delivery of services.” Hospitals used to have one giant tank that serviced two patients at a time, she says. Now it’s possible for a hospital to have eight or nine small pods with smaller pressure requirements, with one pod for each patient. The patients are in the pods for less time, and one physician can supervise all pods, although the compliance officer doubts the physician would leave the area at all in that scenario. “It is possible to say the [MACs] are trying to stay ahead of the curve and are motivated to do that for a lot of good reasons.” But the compliance officer is troubled that the LCDs “conflict with each other.”

Contact Ayers at gayers@foulston.com, Moffett at gmoffett@wellspan.org and Ruskin at aruskin@morganlewis.com. Read the Medicare transmittal on hyperbaric oxygen therapy for diabetic wounds at www.cms.gov/transmittals/downloads/AB02183.pdf.
The Medicare Fraud Strike Force has expanded its operations to Dallas and Chicago, the Department of Justice said Feb. 17. That means the DOJ-HHS fraud fighters are now in nine cities. DOJ also announced the largest-ever fraud takedown with 111 defendants, who were charged for their alleged participation in schemes to defraud Medicare of $225 million. The defendants include doctors, nurses, health care company owners and executives, and others. Read more at www.justice.gov.

Discretionary funding for fighting Medicare fraud and abuse would increase by about $270 million in President Obama’s fiscal year 2012 budget request, even though the overall request for CMS is more than $10 billion below the FY 2011 level. Funding for the Health Care Fraud and Abuse Control (HCFAC) account would rise to about $580.5 million if the entire budget request were approved by Congress. That would be up from the $311 million continuing resolution that funded the program in FY 2011, according to budget figures. The administration had originally asked for $561 million for the HCFAC for FY 2011 (RMC 2/8/10, p. 3). Of the total proposed for the HCFAC, almost $390 million would go to CMS for program integrity efforts, $97.5 million for OIG’s fraud and abuse activities, and $93 million for the Department of Justice’s HCFAC work. HCFAC coordinates federal, state and local health care fraud enforcement activities under the joint direction of the U.S. attorney general and HHS. Visit www.hhs.gov/about/hhsbudget.html.

The New York City Health and Hospitals Corporation (HHC), the largest municipal health care organization in the country, said on Feb. 9 that it is notifying more than a million patients, staff and others that their personal information has been breached. Computer backup tapes for two HHC hospitals — Jacobi Medical Center and North Central Bronx Hospital — were stolen out of a truck belonging to a vendor that HHC uses for the secure transport and storage of sensitive data, the health system says. The data include Social Security numbers, names, addresses and other identifying information, plus health information for patients and workforce members of HHC’s contractors, vendors and other third parties who received screenings or examinations by the hospitals’ occupational health service. The tapes were not encrypted, but HHC says only those with access to the right software and hardware could access the data. Read more at www.nyc.gov/html/hhc/html/pr/notice-to-patients.shtml.

Twenty people, including three physicians, have been indicted on health care fraud, kickback and money laundering charges for their parts in a scheme to defraud $200 million from Medicare for mental health services, the Department of Justice said Feb. 15. The defendants worked with and for American Therapeutic Corporation (ATC) and Medlink Professional Management Group Inc. The feds allege that they submitted false claims for mental health services administered at ATC facilities that were medically unnecessary or never provided. The three physicians charged were medical directors at ATC; two Ph.D.s and a therapist also were charged. To read more, go to www.justice.gov and click on “Briefing Room.”

CMS has revised its limits on recovery audit contractor additional documentation requests for physicians and non-physician practitioners (NPPs). The new limits are based on the provider’s billing Tax Identification Number (TIN) and the first three digits of the ZIP code where they are physically located. So if physician group ABC has TIN 123456789 and two physical locations in ZIP codes 12345 and 12356, it would qualify as a single entity for additional documentation limit purposes, CMS explains. In addition, the limits will be based on the number of individual physicians/NPPs who are located at each TIN/ZIP combination. For example, physician groups of 50 or more doctors will have a maximum record request of 50 records per 45 days, and a group of five doctors or fewer will have to turn over a maximum of 10 records within 45 days. Read about the changes at www.cms.gov/RAC/Downloads/PhyADR.pdf.

The Comprehensive Error Rate Testing (CERT) program identified a large number of errors related to the implantation of cardiac pacemakers, and CMS has issued a fact sheet to help providers, according to a recent MLN Matters. Claims for cardiac procedures are under the spotlight as the feds investigate hospital billing for implantable cardioverter defibrillators, and Medicare issues guidelines on ICDs, pacemakers and cardiac stents (RMC 1/17/11, p. 1). CERT found that, in many cases, a dual-chamber pacemaker was implanted in a patient who needed a single-chamber device. The fact sheet lists common errors and the indications and contraindications for a dual-chamber pacemaker. Read it at www.cms.gov/MLNProducts/downloads/CERT_FactSheet_ICN905144.pdf.
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