Eleven Tips for Hospitals to Consider After The False Claims Verdict Against Tuomey

Hospitals don’t necessarily have to run away from physician arrangements that aren’t ultra-conservative because of the May 8 false claims and Stark verdict against Tuomey Healthcare System (RMC 5/13/13, p. 3). But they may want to reconsider the big picture of their financial arrangements as well as the Stark technicalities in light of the staggering penalties that face the South Carolina health system and other hospitals that run afoul of the law.

“If it smells bad, think again,” says Macon, Ga., attorney Alan Rumph, with Smith Hawkins.

After a four-week trial, a jury in Columbia, S.C., found that Tuomey’s compensation agreements with 18 physicians violated the Stark law, which caused the submission of 21,000 false Medicare claims to the tune of $39.3 million. If the judge imposes even minimum fines and penalties, Tuomey will have to fork over $240 million, although the Department of Justice could accept less.

continued on p. 5
“If you spend a lot of time with Tuomey, you could get spooked very quickly,” says Nashville attorney Thomas Bartrum, with Baker Donelson. Prosecutors may be emboldened by the Tuomey victory to pursue more Stark cases, and Bartrum fears some areas may be more vulnerable — including the uncharted waters of clinical care networks and other configurations developed in response to the pay-for-performance movement.

In the Tuomey case, the U.S. Attorney for South Carolina alleged that Tuomey entered into part-time employment agreements with 18 specialists when it seemed they would shift their outpatient procedures from the hospital to their private practices. Fearing a loss of revenue, Tuomey offered the specialists 10-year compensation deals as long as they performed all outpatient procedures at Tuomey Hospital surgery sites and signed noncompete clauses. The government alleged the compensation was above fair-market value and took into account the volume or value of the physicians’ referrals. The health system always disputed the allegations and fought them through two trials (RMC 4/16/12, p. 1), which is rare considering the stakes of the False Claims Act, with its treble damages and $5,500 to $11,000 per-claim fines.

Post-Tuomey Strategies for Hospitals

Tuomey’s fate is one thing, but what is the verdict’s impact on its hospital brethren? Stark lawyers offer the following insights and suggestions to hospitals as they enter into new arrangements and rethink existing ones post-Tuomey:

(1) Don’t take valuations at face value, says attorney Bob Wade, with Krieg DeVault in Mishawaka, Ind. An independent compensation valuation on an expert’s letterhead isn’t a get-out-of-jail-free-card. “You need to evaluate the defensibility of any fair-market value valuation,” he says. Will the documentation really support the compensation if ever tested? Hospitals have to look both at the standard principles applied to business valuations and the regulatory definition of “fair-market value.” The Stark law doesn’t dictate how to determine fair-market value compensation — “you can use any methodology as long as it’s commercially reasonable” — but it better be convincing to a regulator, judge or jury, Wade says. For example, it wouldn’t pass muster to pay a physician compensation above the 95th percentile if his productivity were below the 25th percentile based on collections or work relative value units (assuming the work is purely clinical), he says (RMC 8/15/11, p. 1).

(2) Re-evaluate the trend of moving ancillary services from physician practices to hospital outpatient departments, where they can be reclassified as provider-based and billed to Medicare at a higher rate, Bartrum says. “We are seeing lots of these arrangements,” he notes. “We set them up to technically fit Stark exceptions, but Tuomey makes you go back and rethink ‘how safe are these arrangements?’” The government’s position in Tuomey can be read as essentially asserting that any uptick in physician’s compensation that can’t be accounted for should be characterized as compensation for future volume or value of referrals.

(3) Don’t get spooked by “loss” arrangements, where hospitals pay employed physicians more than the hospital collects directly from the physician’s personally performed services, Wade says. In light of Tuomey, “people may have a knee-jerk reaction and say loss arrangements are per se not fair-market value. But this is simply not the case as there are situations where loss arrangements are necessary and defensible,” he says. For example, a hospital may open a clinic in a remote area, where it serves mostly uninsured and Medicaid patients. The hospital pays a cardiologist $200 an hour to staff the clinic, but collects only $100 an hour for her services. Wade thinks it’s still permissible because the hospital has a mission to serve the underserved.

(4) Consider taking financial arrangements into the CMS self-referral disclosure protocol if they seem aggressive through Tuomey-colored glasses, Rumph says.

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“Hospitals need to be more proactive in exploring places where the self-referral disclosure protocol is useful. Once the government starts investigating or a whistleblower is involved, the matter is less likely to be favorably resolved,” he notes.

(5) Be on alert for the impact of the Tuomey verdict on the innovations in hospital-physician arrangements emerging from new models of health care delivery, Bartrum says. “Right now, with pay-for-performance, the whole fear is that hospitals are paying physicians for stuff that’s hard to value, such as changing care patterns, monitoring and collecting data and reporting it to the hospital,” he says. Does it mean hospitals are in the crosshairs because of Tuomey? And as hospitals, at the impetus of CMS, move from fee-for-service payments to compensation for outcomes and value, there is a question whether the less-is-more model will be perceived as above-fair-market compensation, Rumph adds. “It’s analytically difficult to fit this into Stark,” he says. Bartrum notes that with clinically integrated networks and accountable care organizations, physician referrals will generally increase to their hospital partners within the network. Medicare ACOs have a Stark and kickback waiver, but more ACOs are being set up in the commercial sector and these arrangements don’t qualify for waivers. Bartrum thinks these can be structured to comply with the Stark law’s risk-sharing exception, but because of the lack of CMS commentary and guidance on that exception, some hospitals are reluctant to rely solely upon that exception.

(6) Steer clear of employment arrangements that are carved out for specific services, Wade says. “I’m not opposed to independent contractor arrangements” for discrete services, Wade notes, but it seems suspicious when the hospital wants to employ physicians only when they are performing specific services, especially if the arrangement is motivated by the desire to expand or retain market share.

(7) Don’t shop for regulatory opinions, Bartrum says. If one lawyer says a financial arrangement violates Stark and/or the anti-kickback statute, there has to be a good justification to run to another lawyer for a different answer.

(8) Carefully consider non-compete clauses in physician contracts. If the government contends a hospital is paying physicians more than fair-market value, then the excess compensation could be tied to the covenant not to compete and construed as an inducement for referrals, Wade says.

(9) Avoid physician contracts of long duration, Wade says. Whether they are with employees or independent contractors, service agreements generally should be no more than three years long — or perhaps five years in the case of acquisitions. They can automatically renew after the initial term, “which causes the parties to come back together to review the terms and ensure that compensation remains fair-market value,” Wade says.

(10) Remember that physicians on the hospital staff may become whistleblowers, which happened in the Tuomey and other false claims cases, Rumph says. “They are in a position to see things that other people don’t see, particularly when negotiations with the hospital fall through,” he says. And when there are big rewards for physician-whistleblowers, “it won’t dissuade other doctors.”

(11) Include all noncash compensation in the fair-market valuation, Wade says. For example, when the hospital adds physicians to its malpractice insurance coverage for their hospital services and private practices, the value of the latter must be separately calculated in the compensation. If the physician’s fair-market value compensation is $200 per hour and the private-practice malpractice premium equates to $50 per hour, the hospital should pay the physician only $150 per hour, he says.

A lawyer representing Tuomey had no comment on whether it will appeal the verdict or what the prospects are for getting the fines and penalties reduced. The assistant U.S. attorney who prosecuted the case did not respond to RMC’s request for comment.

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**RACs Target Admission Errors for Respiratory Neoplasm, Other DRGs**

Medicare auditors are denying claims for respiratory neoplasms with complications or comorbidities (MS-DRG 181) based on a lack of medical necessity, according to CMS’s recent quarterly provider compliance newsletter. MS-DRG 181 claims for short hospital stays associated with scheduled procedures have an increased potential for payment errors, even when patients suffer a pneumothorax, a frequent complication.

“Many of the claims reviewed with MS-DRG 181 were found to have improper overpayments due to medically unnecessary inpatient hospitalizations,” CMS said. Other risk areas cited in the Medicare guidance include admissions for MS-DRG 948 (signs and symptoms without MCCs).

A respiratory neoplasm is a tumor affecting part of the respiratory tract. According to CMS, recovery audit contractors (RACs) found that patients undergoing procedures to treat respiratory neoplasms could have been
treated in the outpatient setting plus observation and sent home within 24 hours.

Depending on the type and cause of the tumor, patients undergo different procedures to treat respiratory neoplasm. In an example in the CMS guidance, a physician used a CT scan to place fiducial markers (gold seeds or stainless steel screws) in or around a 78-year-old patient’s tumor as a radiologic landmark to assist in radiotherapy. The patient was also given a catheter to drain his “iatrogenic pneumothorax,” which means the pneumothorax — abnormal air or gas between the lung and chest wall — was caused by the procedure. The patient fared well overnight and “there was no significant pleural blood or pulmonary contusion,” CMS said. The case could have been billed as an outpatient stay but the hospital charged Medicare for MS-DRG 181.

Even the pneumothorax doesn’t necessarily warrant an inpatient stay, CMS said. “Pneumothorax remains the most common complication of CT-guided lung biopsy. Review of the literature reveals variable rates of pneumothorax that range from 8% to 64%,” CMS said. “Most institutions have moved toward use of 19-gauge needles or smaller to reduce the rate of bleeding complications.”

But sometimes pneumothorax can’t be anticipated or may be more severe and therefore may be grounds for admitting patients, experts say. “The cases in the grey area — a more severe pneumothorax or more seriously ill patient — will represent an area of potential disagreement between hospitals and auditors,” says Mark Miani, M.D., chief medical officer for Medical Audit & Review Solutions (MARS) in West Chester, Pa. If care planning includes placing a catheter in the lung cavity to remove air and that’s expected to happen inside 24 hours, outpatient care may be fine, Miani says. But if the pneumothorax becomes unexpectedly large or the patient gets unstable or critically ill, admission may be necessary.

However, hospitals should keep in mind two things that CMS emphasizes: how common pneumothorax is with neoplasm procedures and how the use of smaller needles reduces the need for an inpatient stay, notes Evan Pollack, M.D., national medical director for MARS.

The key to determining appropriate status is, as always, physician documentation. If a complication compels inpatient admission, the treating physician should describe the complication, the medical care required, and the expected length of stay, Pollack says. Minor complications that don’t increase the expected length of stay beyond 24 hours generally don’t require inpatient admission. Conversely, complications or comorbidities that prompt multiple days of active medical care in the hospi-

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**CMS Transmittals and Federal Register Regulations**

May 10 — May 16

Live links to the following documents are included on RMC’s subscriber-only Web page at www.AISHealth.com. Please click on “CMS Transmittals and Regulations” in the right column.

**Transmittals**

(R) indicates a replacement transmittal.

**Pub. 100-02, Medicare Benefit Policy Manual**


**Pub. 100-04, Medicare Claims Processing Manual**

- Quarterly Update to the Correct Coding Initiative Edits, Version 19.2, Effective July 1, 2013, Trans. 2700, CR 8298 (May 10; eff./impl. July 1, 2013)


- Chapter 41, Skilled Nursing Facility and Skilled Nursing Facility Complex Cost Reports, Form CMS-2540-10, Trans. 5 (May 10; eff. cost reporting periods beginning on or after Oct. 1, 2012)

**Pub. 100-16, Medicare Managed Care Manual**


**Pub. 100-20, One-Time Notification**

- Standardizing the Standard - Operating Rules for Code Usage in Remittance Advice (R), Trans. 1233, CR 8182 (May 9, 2013; various eff./impl. dates)
- New Healthcare Common Procedure Coding System Codes for Customized Durable Medical Equipment (R), Trans. 1232, CR 8158 (May 6; eff./impl. July 1, 2013)

**Federal Register Regulations**

**Proposed Rules**

- FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform, 78 Fed. Reg. 27823 (May 10, 2013)
- Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform, 78 Fed. Reg. 27485 (May 10, 2013)
tal would support the argument that care was necessary and appropriate, Miani and Pollack say.

“We sometimes see hospitals routinely perform these procedures solely in inpatient settings, and that is not a compliant approach since the procedure is not on the Medicare inpatient-only list. The emphasis is on outpatient care to provide these services. Under the new inpatient prospective payment system proposed rule, this expectation of outpatient care for uncomplicated short stays would be even clearer,” says Michael Taylor, M.D., president of MARS.

CMS proposed a span of two midnights as a benchmark for medically necessary admissions in the fiscal year 2014 IPPS regulation (RMC 5/6/13, p. 1). The presumption is that shorter stays would not be payable under Part A unless patients have procedures on Medicare’s inpatient-only list. However, “CMS acknowledges unforeseen circumstances,” a CMS official said May 14 at an open-door forum. In those cases, “CMS would require clear and complete documentation” to support the physician’s determination that the admission was medically necessary and Part A payment. Based on the two-midnight guideline, “CMS would focus on one-day stays” in terms of medical-necessity reviews, the official said.

MS-DRG 948 (signs and symptoms without MCC) was also named in the Medicare quarterly provider compliance newsletter as a cause of unnecessary admissions. “It’s not high volume, but it is high error,” Taylor says.

CMS cited two examples of short-stay patients who were weak and lethargic: one patient had fallen without breaking anything; and the other was recovering from a pelvic fracture. They both were taking painkillers.

“This DRG represents a catch-all basket where, after study and treatment, no specific diagnosis can be assigned,” Miani says. “The great majority would be textbook examples where a period of observation to evaluate the need for further testing and treatment would come.”

Taylor says some cases are inappropriately dropped into DRG 948 when they are social admissions or surgery is cancelled, and the provider doesn’t identify a more specific DRG. “It’s definitely a fruitful area for audits,” he says.

Contact Taylor at Michael.taylor@marsauditor.com, Miani at mark.miani@marsauditor.com and Pollack at evan.pollack@marsauditor.com. View the Medicare provider newsletter at http://tinyurl.com/c5yhr3e

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help meet this responsibility. We necessarily partner with industry and it’s my job to help keep us focused on our core missions of education, research and service.”

Information is at the heart of preventing conflicts of interest. From his perch at the faculty practice plan, Wimsett works closely with the purchasing department as well as the Shands Teaching Hospital & Clinics purchasing department, which have power over the drugs and devices selected for use by physicians and hospitals, and the University of Florida foundation, which accepts gifts, charitable donations and educational grants. “The key is a unified sharing of data,” he says, which provides the puzzle pieces of potential attempts to influence purchasing decisions and clinical trials.

Suppose purchasing is considering a new brand of pacemaker. Before signing off, the University of Florida will do a sweep of the manufacturer’s recent interactions with decision makers. “I want a snapshot of our relationships with that company at that given moment and I want to know as many data points as I can,” Wimsett says. “What are we doing in terms of outside relationships with the company? Are we sending residents and fellows on educational training trips [sponsored by the manufacturer]? The left hand should know what the

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**Whistleblower in Bard Case Alleges Compliance Officers Were Unresponsive**

In a familiar story line, there’s a whistleblower at the center of C.R. Bard’s $48 million false claims settlement with the Department of Justice. Julie Darity, a former Bard manager for brachytherapy contracts administration, filed a lawsuit against C.R. Bard in 2007 after her efforts to fix alleged noncompliance internally went nowhere, she claimed in her complaint.

C.R. Bard, which did not admit liability in the settlement, allegedly induced hospitals and physicians to buy its brachytherapy seeds by giving them grants, conference fees, rebates, marketing assistance and/or free medical equipment between 1998 and 2006 in violation of the anti-kickback law, DOJ says. Hospitals then billed Medicare for the seeds, which are used to treat prostate cancer.

According to the complaint, Darity, who worked out of Bard’s Covington, Ga., office, started questioning Bard’s generosity to hospitals around 2001. She told her staff to send sales representatives’ requests for free goods to her. “Because plaintiff refused to ship equipment in the absence of a contract or purchase order, her reputation among the sales personnel became poor,” states the complaint, filed in U.S. District Court for the Northern District of Georgia. Over time, Darity contends, she was undermined by upper management, which cost her “the confidence of her staff.” In 2003, after she stopped a shipment of a donation to a hospital, Darity alleges she was overruled.

In 2004, Darity filed an ethics complaint and an internal investigation followed, but she never heard the results, according to the lawsuit. The following year, Bard allegedly demoted Darity and told her to work from home because of an office-space shortage. After she returned to the office in 2005, Darity felt mistreated, and suspected it was a response to her ethics complaint. So she turned to the compliance officers for help. “She received no response from her plea,” the lawsuit alleges. In late 2005, she was fired. Darity settled a retaliation claim with Bard for an undisclosed amount in connection with the false claims case, says one of her attorneys, Marlan Wilbanks.

Without Darity, it would have been hard for the government “to connect the dots” in a complex case that involved Bard allegedly inflating the prices of brachytherapy seeds charged to hospitals in exchange for the free goods and services, Wilbanks says. Medicare then paid the hospitals the higher prices because at the time, brachytherapy seeds were pass-through costs.

Bard also entered into a one-year non-prosecution agreement (NPA) with DOJ, a spokesperson for the U.S. attorney’s office says. “If Bard violates the NPA, it is subject to prosecution for any federal violation, including perjury, obstruction of justice, and any offense related to conduct described in the NPA,” the spokesperson says. The NPA also requires Bard to pay $2.2 million and implement compliance reforms, some of which were already underway before the criminal probe began, DOJ says.

In a statement, Bard says “this resolution allows the Company to put this matter behind it and continue to focus on delivering life-enhancing medical devices and technologies to patients around the world. We remain committed to continuously enhancing and improving our compliance programs in accordance with industry standards.” Two outside Bard attorneys did not return calls from RMC requesting comment on the case.

Contact Wilbanks at mbw@wilbanks-bridgeslaw.com.
right hand is doing and we can make good decisions based on evidence-based purchasing.

Wimsett tries to avoid evaluating conflicts in a vacuum. “Everything is looked at in the context of the whole package of a relationship,” he says. Suppose a surgeon advocates the purchase of a robot for robotic-assisted surgery from a particular vendor. The question is: why is this surgeon so high on this particular robot brand? If the surgeon is one of the best robotic surgeons in the world and has consulted for all the vendors, that reduces the risk of a conflict. Regardless, “we will take [him or her] out of the equation and consult other experts in the field,” he says. “Financial relationships intensify the scrutiny and we want to avoid being in a Bard-type situation.”

Wimsett has a database of outside activities to monitor and prevent potential conflicts in coordination with the hospital. It compiles information on physician relationships, which allows him to assess fair-market value. About half of the outside activities involve physicians serving as expert witnesses in medical malpractice cases. They are still vetted for possible “conflicts of commitment” (i.e., doctors shouldn’t testify against their University of Florida colleagues or take on so many cases it distracts from their work in the clinics or hospital).

Probably 75% of the remaining requests are for physicians to serve on scientific advisory boards, which are usually sponsored by medical device and pharma manufacturers. Scientific advisory boards are comprised of the top minds on a topic (e.g., hip and knee replacements) and meet two to four times a year to advise the manufacturer on its products, Wimsett says.

He expects consulting agreements for scientific advisory boards and data safety monitoring boards to set forth goals and deadlines. There’s more skepticism around certain consulting agreements (e.g., marketing), which “are ripe for abuse because it’s hard to pin down the scope of work,” he says. A consulting gig that says “we are retaining you to help out with stuff” is higher risk than “we want you to help on Mondays, Wednesdays and Fridays with this molecule and turn in a report in two weeks.”

Wimsett also scrutinizes educational grants, which are handled by the foundation. University of Florida accepts restricted education grants from medical and pharma manufacturers. There’s no quid pro quo (i.e., a promise to buy a drug or device) and the faculty practice plan controls how many residents, fellows and physicians will attend a training session. For example, a manufacturer may offer fellows and residents a free seminar on their drills or scalpels, which means providing cadavers to practice on. “When they get back, we want to make sure they are not turned into brand champions for a particular device or tool,” Wimsett says. “We have a very sensitive P&T committee that looks into particular requests from brand champions. If the faculty member says, ‘I like this drug or this drill,’ the form requires them to disclose any potential conflicts.”

Even though it is manufacturer sponsored, the training is welcome. “We would not be able to provide it because it’s cost prohibitive,” Wimsett says. Ideally, though, education grants would be unrestricted — no strings attached.

Some institutions are banning pharma sales reps from their grounds altogether, but Wimsett doesn’t like the idea because they have information to share. Instead, the access of sales reps is very controlled at University of Florida, he says. Sales reps must make an appointment to see a physician and wear a badge that states the name of the physician and the time of their appointment. If reps are found wandering the halls beyond the time and location of their appointment, hopefully someone will notice and intervene. “We have disciplined reps for what we consider to be abusive marketing practices,” he says.

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NEWS BRIEFS

♦ CMS’s Medicare Learning Network has released a special edition article (SE1303) explaining the provisions of a final rule, published on Feb. 8, which implements the Physician Payments Sunshine Act. The rule, which is part of the agency’s National Physician Payment Transparency Program: OPEN PAYMENTS, requires device and pharmaceutical manufacturers and group purchasing organizations to report payments and other transfers of value to physicians and teaching hospitals. They also must report a physician’s ownership interest in the organization. The article provides the regulatory definitions of “manufacturers,” “GPO,” “teaching hospital” and “other transfers of value” and summarizes, among other things, what products are covered, the implementation timeline, data collection requirements and penalties. Covered organizations will begin collecting data on Aug. 1, and report five months of data
NEWS BRIEFS

to CMS by March 31, 2014. Subsequent reports will reflect 12 months of data. CMS will aggregate the data and make them publicly available on a website. The first report, based on 2013 data, will be available on Sept. 14. CMS is developing an electronic system to facilitate the reporting and aggregation process. Visit http://tinyurl.com/baoe6ff.

◆ The Medicare Fraud Strike Force unveiled a takedown involving eight cities, 89 individuals and allegations of $223 million of fraudulent Medicare billings, the Departments of Justice and HHS announced at a May 14 press conference. In Miami, 25 defendants were charged for their alleged participation in various fraud schemes amounting to $44 million in false billings for home health care, mental health services, and physical and occupational therapy, durable medical equipment and HIV infusion. The Baton Rouge Strike Force charged 11 individuals in Baton Rouge and New Orleans with schemes involving home health services and community mental health services that allegedly defrauded Medicare of approximately $81 million. Home health care fraud, valued at $81 million, also was the allegation against two nurses in Houston. In Los Angeles, 13 individuals were charged with allegedly defrauding Medicare of $23 million of claims for medically unnecessary DME. Detroit accounted for 18 defendants who were charged in connection with fraud schemes involving approximately $49 million in false claims for medically unnecessary services, including home health, psychotherapy and infusion therapy. Three of the individuals allegedly faked being doctors and signed prescriptions and billed for psychotherapy services that were never provided. Chicago and Brooklyn rounded out the list of cities hit in the takedown — Chicago with seven individuals and Brooklyn four. Visit http://tinyurl.com/af3ga36 and http://tinyurl.com/amb7dkc.

◆ May 20 is the date orthopedic surgeons should watch for a national provider comparative billing report (CBR) on their evaluation and management services, according to the May 16 edition of CMS Medicare FFS Provider e-News. A CBR is a providerspecific analysis of billing patterns for various procedures or services compared to the provider’s peers. Up to 5,000 CBRs are mailed or faxed to providers selected under the topic criteria. CMS assures providers that the reports are not punitive or indicative of fraud. Instead, providers should use them to identify potential errors in their coding and billing practices. Visit http://tinyurl.com/bha2bu.

◆ In a new report (A-01-12-00522), the HHS Office of Inspector General has estimated that Medicare and beneficiaries could have saved a bundle in 2011 on anemia management drugs provided to end-stage renal disease patients if the agency had updated its ESRD base rate — $510 million for Epogen and Aranesp and $19 million for the iron supplements Venofer and Ferrlecit. ESRD facilities shifted to a new payment system in January 2011, and these commonly prescribed drugs, which had been separately payable, were rolled into the facility’s PPS payment. CMS used 2007 utilization data to set the base rate, but if it had adjusted the rate to reflect 2011 utilization, it would have realized these savings. In 2011, Medicare and beneficiaries paid approximately $10 billion for dialysis services under the new PPS; approximately 25% of these payments were attributed to anemia management drugs. CMS, in its response to the OIG findings, said it would propose a reduction in the ESRD base payment rate in the 2014 PPS rulemaking. Visit http://go.usa.gov/THs9.

◆ The HHS OIG has found that state agencies and accredited organizations are conducting recertification surveys within 36 months as required by the regulations. This contrasts with OIG findings in 2008 where the office found the same deficiencies cited during multiple recertification surveys of the HHAs without any follow-up enforcement action by CMS. In the most recent review (OEI-06-11-00400), 93% of the HHAs with the most serious type of deficiency rating (12%) corrected the deficiency within the required 90 days. The other 7% did correct the deficiencies, albeit late, or left the program. Surveyors also investigated nearly all the complaints lodged against HHAs, and again HHAs corrected the condition-level deficiencies. OIG also reviewed whether state agencies conducted “look-behind” surveys of the accreditation organizations to evaluate the organization’s performance. A “look-behind” survey compares the results of two surveys, in this case the state survey and the accrediting organization’s survey. For this study, OIG used data from FYs 2010 and 2011 and found that state agencies exceeded the required number of look-behind surveys. Visit http://go.usa.gov/Ttwm.
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