New 340B Guidance Clarifies Definition of Drugs, Raises Stakes for Documentation

New “omnibus guidance” for the 340B drug discount program just proposed by HHS possibly won’t take effect until the spring of 2016, but the pending changes and current audits make it a good time for covered entities to take stock of their compliance, experts say.

“Covered entities should do a little of both: an analysis of the impact of the omnibus guidance and some auditing based on current standards,” says Tony Lesser, an advisory manager with Deloitte & Touche in Chicago. HHS is pursing its program-integrity lips by requiring covered entities to keep auditable records for five years to prove they and their contract pharmacies are 340B compliant. “The language makes it abundantly clear about their expectations for compliant monitoring,” he says.

In the proposed guidance (RMC 8/31/15, p. 1), which was published in the Aug. 28 Federal Register (80 Fed. Reg. 52300), the HHS Health Resources and Services Administration (HRSA) addressed key aspects of the 340B program. HRSA narrowed the definition of “eligible patient,” clarified the definition of “covered outpatient drugs,”

EHR Vulnerabilities Are Ripe for Review; CCOs Should ‘Commandeer’ Workgroups

When a dialysis patient died in the hospital from complications due to malnutrition, the nurse practitioner scrambled to cover her tracks in the electronic health record (EHR). During the hospitalization, the patient lost considerable weight, and the nurse practitioner intended to refer the patient to a dietitian and record the weight loss in the EHR, but didn’t get to it in time. After the patient died, regulators asked for the patient’s records. Before producing them, the nurse practitioner edited the notes, adding the weight loss and her supposed alert to the dietitian.

Playing this kind of game with EHRs is a big compliance risk, said Cassandra Andrews Jackson, compliance officer and HIPAA privacy officer for SBH Health System in New York City, at an Aug. 27 webinar sponsored by the Health Care Compliance Association. Altering notes improperly is only one way that hospitals may undermine the integrity of their electronic records and jeopardize their reimbursement and patient safety. There’s also the “make me an author” tool, copy and paste, and templates, Jackson said. Misuse of EHRs has drawn warnings from the HHS Office of Inspector General (OIG) and the Department of Justice, a compelling reason EHRs should be part of risk assessments by compliance officers, she said. “Our role is to prevent fraud, waste and abuse in our organizations, and therefore compliance professionals should spend some time looking at this area,” Jackson said. One strategy: “Co-opt” existing committees so they take on EHR vulnerabilities. “This is where your compliance officer personality makes a difference,” she said.

continued on p. 6
addressed program eligibility and termination, and provided guidance relative to duplicate discounts for Medicaid managed care patients.

The bottom line for covered entities is their bottom line may be hurt because drug discounts would be harder to come by, lawyers say.

The 340B program requires pharmaceutical manufacturers to provide discounts on outpatient drugs purchased by certain covered entities that serve the nation’s most vulnerable patients, including critical access hospitals, sole community hospitals, disproportionate share hospitals, freestanding cancer hospitals, children’s hospitals, rural referral centers, federally qualified health centers and hemophilia clinics (RMC 3/17/14, p. 1). They are audited by HRSA and the drug manufacturers that discount drugs.

HRSA was careful to say the 340B guidance intends to clarify key aspects of the program, says Anne Phelps, U.S. health care regulatory leader with Deloitte & Touche in Washington, D.C. It’s not necessarily a new set of rules because the authorizing statute has not changed, Phelps says. In fact, HRSA originally planned to issue a “mega reg” on many parts of the 340B program, but scrapped it in the midst of litigation over its authority to mandate the extension of 340B discounts on orphan drugs to more covered entities when the drugs are used for other purposes (RMC 11/24/14, p. 1; 3/17/14, p. 1).

Instead, covered entities now have this clarification, which reflects HRSA’s thinking and approach to audits. Phelps sees signs the omnibus guidance could be finalized this spring, which means covered entities should take steps toward compliance, she says. Presumably the Obama administration wants the 340B guidance to take effect before turning over the reins to the new reign.

“Then the new administration will be doing any further audits or interpretations,” Phelps says.

**Medicaid Provision Is ‘Crazy’**

The guidance revised the definition of “patient eligibility.” It’s narrower, with six criteria instead of three in the existing regulation. For example, if the guidance is finalized, patients will have to be treated by a provider who is an employee or independent contractor of the 340B covered entity, which can bill for the services rendered by that provider. It doesn’t count when the covered entity refers the patient to an outside provider who writes a prescription, and privileges are not enough to establish a treatment relationship.

“One of the changes is that [HRSA] defines a patient’s status based on what is billed,” Lesser says. This could get messy if patients move between inpatient and outpatient departments, where they receive drugs in both places, he says. Patients present to the emergency room, for example, but may wind up crossing two midnights. However, Lesser notes, only one bill is issued, and if the patient was admitted, it’s an inpatient bill.

“There was a lot of confusion about inpatient and outpatient status and what drugs were covered, so HRSA clarified this,” he says. Clarity is always welcome, but it won’t do much good unless hospitals update their data infrastructure to support the program, Lesser says. Covered entities should analyze the guidance immediately to determine how their software systems can support it, he says. “Once you analyze this, what changes would you make?” Should covered entities make them now? The answers may depend on the potential risk and operational impact.

Another feature of the guidance is its elaboration of drugs eligible for purchase under 340B. The guidance says when drugs are furnished to Medicaid patients incident to the services provided at the covered entity and paid for as part of a bundle, they are not 340B drugs, says Washington, D.C., attorney Andrew Ruskin, with Morgan Lewis. But they can be purchased under a group purchasing arrangement instead. “It is crazy,” he says. “Depending on how the drug is being used, you can...
purchase it under 340B or not.” Because the same criteria wouldn’t apply to commercial-payer patients, “no one is going to be able to figure that out,” he says.

The section on covered outpatient drugs also coordinates the purchase of 340B drugs with Medicaid managed care organization drug buys, says Los Angeles attorney Elizabeth Elson, with Foley & Lardner LLP. As it stands, covered entities must report whether they use 340B for drugs billed to Medicaid fee-for-service, she says. “The omnibus guidance provides that covered entities may similarly choose whether to use 340B drugs for drugs billed to Medicaid MCOs, if they have mechanisms in place to identify Medicaid MCO patients, and information detailing any distinction in the treatment of Medicaid managed care and fee-for-service patients is made available to HHS,” Elson says. HHS is worried, however, there is more danger of duplicate discounts when covered entities use contract pharmacies registered on the 340B public database because it’s assumed they won’t dispense 340B drugs to Medicaid fee-for-service or managed care patients. If covered entities want to buy and dispense 340B drugs to Medicaid patients of all stripes through contract pharmacies, they have to give HHS a written agreement with the contract pharmacy and Medicaid or managed care organization “that describes a system to prevent duplicate discounts,” Elson says.

No Documentation, No Discount

On the program integrity front, the omnibus guidance has some new proposals to take seriously. “There are good things about the auditing and monitoring standards and some pretty ominous things about them,” Lesser says. “You need to have procedures in place to do this or risk program termination.”

For one thing, covered entities must maintain auditable records for five years that prove compliance with the 340B program. If they drop the ball, covered entities could be kicked out, the guidance states. And that in includes records of contract pharmacies used by covered entities. The requirement also extends to “child sites,” which are not located on the main campus of hospitals but are still integral to them. If covered entities are terminated from the 340B program, they still must keep records “pertaining to compliance” for five years, and HHS is entitled to review them.

If covered entities can’t find the records for a patient who got a 340B drug, they may be in violation of Sec. 340B(a)(5)(B) of the Public Health Service Act. They would have to repay the manufacturer, but that’s not grounds for expulsion.

In light of ongoing audits and the forthcoming 340B changes, Lesser recommends covered entities do a sort of risk assessment. Start with the obvious things. For example, they should get their hands on 340B eligibility documentation. Failure to produce it during an audit could result in termination, he says. It’s a good idea to anticipate what could go wrong if the guidance is finalized in its current form. “They may not have to flag all discharge prescriptions as ineligible and notify HRSA, but they should be analyzing the effect of the provision,” Lesser says, referring to the proposal to exclude 340B covered drugs when the prescriptions are written by outside providers even though they are written for patients who have a treatment relationship with the covered entity.

Comments on the omnibus guidance are due Oct. 27.

Contact Phelps at annephelps@deloitte.com, Lesser at alesser@deloitte.com, Ruskin at aruskin@morganlewis.com and Elson at eelson@foley.com. View the guidance at www.gpo.gov/fdsys/pkg/FR-2015-08-28/pdf/2015-21246.pdf.

Incident-to Rules May Have More Leeway; CMS Change May Be Myth

Nonphysician practitioners (NPPs) may have more latitude than they think when providing services incident to a physician. Although the conventional wisdom is that only physicians can treat patients for “new problems,” Minneapolis attorney David Glaser contends there’s nothing wise about it. Medicare never mentions new problems and refers only to participating in a “course of treatment,” which could reduce some of the compliance pressure from incident-to billing rules, he says.

Meanwhile, there has been confusion about a revision to the incident-to rules in the proposed 2016 Medicare physician fee schedule, which was published in the July 15 Federal Register. It has some people thinking that CMS is connecting the ordering and supervision requirement for incident-to services in an unpleasant way. But Glaser says that’s not the case, and he says CMS confirmed his take on it.

Incident-to billing is a significant compliance risk area and sometimes leads to false claims allegations (RMC 1/26/15, p. 4). But providers may be giving themselves too hard a time, says Glaser, with Fredrikson & Byron.

Medicare pays 100% of the physician’s fee schedule for services performed by NPPs, such as physician assistants, if the services are “incident to” a physician’s professional services, assuming certain requirements are satisfied. According to 42 CFR 410.26, “services and supplies must be an integral, though incidental, part of the service of a physician (or other practitioner) in the course of diagnosis or treatment of an injury or illness.” 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 physician must establish a treatment plan and provide the initial service, although NPPs may perform subsequent services, as long as the physician sees the patient as often as reasonable and necessary.

Here’s where Glaser thinks providers are going overboard with the regulatory requirements: They operate on the assumption that physicians must step in when patients present with a new problem. But that language is nowhere in any Medicare regulations or manuals, he says. The Medicare Benefit Policy Manual (Ch. 15, Sec. 60.1) says this on the subject: “…to be considered incident to, each occasion of service by auxiliary personnel (or the furnishing of a supply) need also always be the occasion of the actual rendition of a personal professional service by the physician. Such a service or supply could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment.”

The point is, a “new problem” and “a course of treatment” are different things, Glaser says. You can have a “new problem” that is still part of a “course of treatment.

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**Clarifying Clinical Documentation Through Queries**

Coders use queries to ask physicians for more information so they can select the most specific diagnosis code, which will be critical for ICD-10. This was developed by Debi Primeau, president of Primeau Consulting Group in Torrance, Calif. Contact her at dprimeau@primeauconsultinggroup.com.

<table>
<thead>
<tr>
<th><strong>Eliciting Information on Renal Conditions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The medical record reflects documentation of an acute or chronic renal condition and the following clinical indicators/treatment:</strong></td>
</tr>
<tr>
<td>Documentation options for specificity may include:</td>
</tr>
<tr>
<td>• Acute kidney failure with cortical necrosis</td>
</tr>
<tr>
<td>• Acute kidney failure with medullary (papillary) necrosis</td>
</tr>
<tr>
<td>• Acute kidney failure with tubular necrosis</td>
</tr>
<tr>
<td>• Acute kidney failure, other type</td>
</tr>
<tr>
<td>• Other specified cause</td>
</tr>
<tr>
<td>• Unable to determine/Unknown</td>
</tr>
<tr>
<td><strong>1. CKD STAGE</strong></td>
</tr>
<tr>
<td>• Stage 1</td>
</tr>
<tr>
<td>• Stage 2 (mild)</td>
</tr>
<tr>
<td>• Stage 3 (moderate)</td>
</tr>
<tr>
<td>• Stage 4 (severe)</td>
</tr>
<tr>
<td>• Stage 5/ESRD</td>
</tr>
<tr>
<td>• Other (please specify)</td>
</tr>
<tr>
<td>• Unable to determine/unknown</td>
</tr>
<tr>
<td>Please indicate whether the kidney disease stage has progressed during stay</td>
</tr>
<tr>
<td>Please indicate whether the patient is now dependent on dialysis</td>
</tr>
<tr>
<td><strong>2. UNDERLYING CAUSE</strong></td>
</tr>
<tr>
<td>• Diabetes</td>
</tr>
<tr>
<td>• Hypertension</td>
</tr>
<tr>
<td>• Other (please specify)</td>
</tr>
<tr>
<td>• Unable to determine/unknown</td>
</tr>
<tr>
<td>• None/Not applicable</td>
</tr>
</tbody>
</table>

Stage 1. GFR 90+ - Normal kidney function but urine findings or structural abnormalities or genetic trait point to kidney disease
Stage 2. GFR 60-89 - Mildly reduced kidney function, and other findings (as for stage 1) point to kidney disease
Stage 3. GFR 30-59 - Moderately reduced kidney function
Stage 4. GFR 15-29 - Severely reduced kidney function
Stage 5/ESRD. GFR < 15 - Very severe, or endstage kidney failure (sometimes called established renal failure)

Source: National Kidney Foundation

Below is for physician use only

**DOCTOR, SPECIFY DIAGNOSIS OR DIAGNOSES, IF ANY, ASSOCIATED WITH THE ABOVE INDICATORS:**

Dx: ________________________________

1. **STAGE:**
2. **UNDERLYING CAUSE:**

Physician Signature Date/Time
A classic example would be an infection that arises during chemotherapy. The infection is new, but it certainly would seem to be part of the course of chemotherapy. Although this should be liberating to providers, they will have to figure out what a “course of treatment” means in the real world. “I don’t know where the line is, and, the manual offers no guidance, but if [a test or treatment] is part of the course of treatment, you can do it incident to,” he says. If Medicare patients visit the practice every week for hypertension management, that’s fine for incident to, as long as the physician is involved periodically.

“A more difficult question is whether a new ankle sprain can be considered a course of orthopedics treatment. Should it be considered a new course of treatment if the patient already has an established relationship with the physician?...The answer isn’t obvious,” Glaser observes.

As for the other incident-to issue, CMS may have thrown a wrench in the works when it tinkered with the definition in the proposed Medicare physician fee schedule in July. As it stands now, the Medicare regulation (42 CFR 410.26) states that “in general, services and supplies must be furnished under the direct supervision of the physician (or other practitioner). Chronic care management services and transitional care management services (other than the required face-to-face visit) can be furnished under general supervision of the physician (or other practitioner) when they are provided by clinical staff incident to the services of a physician (or other practitioner).” CMS proposed removing language stating that “the physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) upon whose professional service the incident to service is based.”

CMS explained it is trying to make it clear that the incident-to service has to be billed in the name of the physician who supervises the service. Glaser doubts that’s a necessary clarification because “I thought that was their intent since 2002 — you bill in the name of the supervising physician.” But rumors are spreading that the sentence means the physician who orders the service also must supervise it, Glaser says. That’s false, he says, and CMS confirmed for him that it’s false.

Contact Glaser at dglaser@fredlaw.com. View the proposed Medicare physician fee schedule regulation at http://tinyurl.com/nnq8w5c.

Asking Physicians About Pneumonia (continued)

**Aspiration pneumonia**
- Please document specific aspirate (food, liquids, etc.)
- Newborn (please indicate specific cause)
- Please indicate if this is postprocedural

**Bacterial** (specify organism)

**Bronchopneumonia** (specify organism)

**Interstitial pneumonia**

**Organizing pneumonia/BOOP**

**Pneumonia with influenza, avian flu, or H1N1 flu**

**RSV pneumonia**

**Tuberculosis, pulmonary**

**Viral pneumonia**

**Other pneumonia** (specify)

**Unable to determine/Unknown**

**Also:** Please specify the organism causing the pneumonia, if known

Below is for physician use only

**Doctor, specify diagnosis or diagnoses, if any, associated with the above indicators:**

**Dx:**

Indicate causative organism if known:

**Physician signature**

**Date/Time**

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Review EHR Vulnerabilities
continued from p. 1

EHR systems may make it easy to drift away from compliance. For example, Medicare allows documentation changes within limits, including amendments, corrections, addenda and delayed entries if they are clearly identified, and there is no tampering with original content, like the nurse practitioner did with the malnourished patient. “But some electronic health records may not provide an easy distinction between original and edited text,” said Jackson. “Also, edited text may occur with little or no versioning or track changes functionality.” In fact, one vendor has a tool that permits retroactive alteration of a note, which means there is no flag that a note has been amended, Jackson said.

“Compliance should be concerned about electronic health records,” she maintained.

Jackson described other ways that EHRs can lead to claim denials or fraud through poor design or improper use. Here are some of them:

* The “make me an author” tool: It allows physicians to substitute their signature for that of another person who entered notes in the EHR. For example, physicians can become the author of notes written by medical students. “That’s a design flaw that facilitates inappropriate use,” she said. Some vendors allow the user to opt out of tracking changes, which makes it impossible to figure out who edited the records. That spells all kinds of trouble, especially with respect to medical students because Medicare limits their documentation (Transmittal 1780 — Carriers Manual, Part 3). Medical students are allowed to document past family and social history and review of systems, but if they include other documentation, such as the history of present illness, the physician must verify and document it again. “If the physician intentionally copies the evaluation and management or signs as if she authored notes, the physician will violate billing rules by billing for services provided by medical students because Medicare does not pay for services provided by medical students.”

* EHRs with no place for providers to include narratives: If EHRs lack space for providers to write their observations about patients on a given visit, “they are at greater risk of appearing identical to each other,” Jackson said. “When medical records appear identical from one visit to the next, auditors deny claims for the reason that medical necessity cannot be established.” In fact, some EHRs have no hard stops forcing users to enter required information. The result: “incomplete notes on the status of a patient. Auditors will respond that documentation needed to make payment was incomplete.”

* Copy and paste or cloning: Documentation is considered cloned if every entry in the record is worded the exact same way or it’s very similar to previous entries, Jackson said. When entries are copied and pasted without being edited, this doesn’t meet medical-necessity requirements for Medicare coverage because documentation isn’t specific enough to the patient and his or her experience (RMC 3/25/13, p. 1). “It will lead to denial of services and recoupment,” she said. Suppose the behavioral health staff at a hospital was instructed to use copy and paste to save time on treatment plans in the EHR. Treatment plans must be reviewed and revised every three months based on treatment goals and the patient’s progress, and patients sign off on them. “Generally treatment plans don’t vary significantly, so staff could use the copy-paste function and edit them to reflect patient progress over the prior three months,” said Jackson. But things went awry at this hypothetical hospital. “Staff copied and pasted and did not edit, and they didn’t always discuss treatment plans with the patient,” she said. “Copying plans without editing will result in identical
treatment plans every three months.” That potentially puts patients at risk for inadequate care in addition to violating Medicare billing rules.

Also alarming is the fact that the copy and paste function allows staff to forward the patient’s signature from one treatment plan to another, Jackson said. “That’s forgery,” she said. “A forged signature would void the treatment plan.” In most behavioral health settings, clinical social workers supervise master social workers, who prepare the treatment plans. Clinical social workers who don’t realize signatures can be cloned in EHRs won’t think to question the validity of signed treatment plans, she said. “If, on audit, the regulator should discover forged signatures, the entire program, including its operating license, could be in jeopardy.”

† **Failing to enter information in relevant fields:**
Medicare won’t pay for inpatient admissions without a physician order, but patients may be discharged without a flag in the EHR that it’s missing, Jackson said. Sometimes “the EHR allows the user to skip mandatory information and doesn’t have a hard stop to force entry.” If audited, the admission probably will be denied, she said.

† **Templates:** “Most EHRs have built-in time savers, such as self-populating fields,” explained Jackson. They insert the patient’s medical history into the record when the physician checks a box, which is also referred to as exploding documentation “because the information is populated forward with the click of a mouse,” she said. That multiplies the effect of even one incorrect piece of data. “Inadequately trained staff will use the EHR improperly and sometimes depend too heavily on auto populate features and drop-down menus that may propagate inaccurate information through the medical record,” she said.

Because EHRs put compliance at risk, Jackson suggested that compliance officers do a risk assessment using the 14 “recommended requirements for enhancing data quality in electronic health record systems” set forth in a report by RTI International, a nonprofit institute, and a 2013 HHS OIG report on EHR fraud safeguards. Also ask leaders — the chief medical officer, chief financial officer and IT director — what elements of EHRs trouble them.

Then develop a strategy to address EHR vulnerabilities identified by the risk assessment. “It is our role to make the case for everyone so they cooperate, they participate, and they assume ownership of compliance on an organizational level,” Jackson said. “The ease with which staff cooperates, participates and assumes ownership of compliance is a significant measure of the effectiveness and integration of the compliance program and your effectiveness as a compliance officer.” Compliance officers have to “raise the red flag” about EHR risks by explaining the consequences of abuses — financial, reputational and legal — she said. “Connect the dots with ‘if we don’t fix this’ scenarios,” Jackson advised. “What happens to our reputation as an organization with integrity? What is the potential cost in terms of repayments? Are we at risk for litigation, fines, sanctions? What about the potential for exclusion from Medicare and Medicaid?”

She advised working closely with the people who are most invested in EHRs: IT because it implements and manages EHRs, clinicians because they are end users, coders because they use it to code and revenue cycle because it submits bills.

And “co-opt resources” to get stuff done, Jackson said. If there’s already a committee addressing EHRs, “you want to commandeer their process to accomplish your purpose,” she said. “How easily will your priority become one of their priorities? This is one of those times you find out how well compliance is integrated in your organization.” For example, a committee evaluating medical records for compliance with Medicare documentation guidelines “can tell you about documentation practices, shortcomings and ways the EHRs may contribute to issues; plus, they have a mechanism already in place to correct [problems].” It may be a good vehicle to
create or revise policies on EHR time-saving functions, such as copy and paste.

Here’s one example of a policy for fixing EHR vulnerabilities: When a hospital confirms that an employee, such as the nurse practitioner with the malnourished patient, has retroactively altered a note, a workgroup drafts a plan of correction. It requires the hospital to modify the EHR to ensure there’s an audit trail for the original entry anytime documentation is changed. After the provider signs notes electronically or the encounter is closed, the amendment will be marked as a change, and the amendment will be auto dated with the user’s name. “It will be included with modifications as a user change,” Jackson said. The compliance officer documents the plan, and IT works with the vendor to make the change, which is conveyed to all EHR users. Two months later, the workgroup audits a random sample of records and finds some people are able to turn off the new function (e.g., senior attending physicians). As a result, the workgroup repeats the entire process to ensure no staff can switch it off, Jackson said. And then, she said, “the compliance officer investigates staff who turned off the function.”


**NEWS BRIEFS**

◆ In a new Medicare transmittal that updates signature requirements, CMS tells its contractors to use “alternate medical documentation” to identify/authenticate an illegible handwritten signature in addition to logs and attestations. Transmittal 604 (Change Request 9225), which took effect Aug. 25, is directed to Medicare administrative contractors, zone program integrity contractors, the comprehensive error rate contractor and, for the first time, the supplemental medical review contractor. Visit http://tinyurl.com/osvpg6f.

◆ Moses H. Cone Memorial Hospital and three other hospitals in the Cone Health system in North Carolina were overpaid $1.826 million, according to a Medicare compliance review (A-04-14-04023). The HHS Office of Inspector General (OIG) reviewed 225 claims submitted in 2012 and found errors on 73, which caused a net overpayment of $457,590. OIG extrapolated that to the larger dollar figure. OIG contends the errors were for admissions that should have been billed as outpatient or observation services and incorrectly billed DRG codes, among other things. In a written response to OIG, Robert Carter, vice president and general counsel of Cone Health, said it takes compliance seriously and has hired external parties to audit risk areas and train employees. It also hired more case managers to review admissions. But Carter has problems with some aspects of the Medicare compliance review, which, he says, “erroneously states that the findings are based on a universe of claims for services performed only at Moses H. Cone Memorial Hospital. Although that may have been the intent in designing the sample, the universe actually contains claims from four different Hospitals, each with significant operational differences that cannot be mathematically ‘extrapolated’ to another. An error rate at one hospital does not transfer to another hospital simply because they share a provider number.” Cone Health will appeal some of the cases. Read the review at http://go.usa.gov/3FNUG.

◆ A dermatologist who was convicted in connection with false Medicare and private-payer claims for skin cancer treatments was sentenced to seven years in prison, the U.S. Attorney’s Office for the Northern District of Illinois said Aug. 28. Robert Kolbusz, M.D., was convicted by a jury last year of three counts of wire fraud and three counts of mail fraud. Kolbusz billed payers for treatments to destroy pre-cancerous lesions, but “in reality, his patients did not have pre-cancerous lesions, and many of the treatments billed by Kolbusz were cosmetic procedures, such as Erbium ‘lunchtime laser peels’ performed by non-medical professionals from his office,” the U.S. attorney’s office said. Visit http://tinyurl.com/py24pae.

◆ St. Joseph Hospice Entities, which includes 13 hospices in Alabama, Louisiana, Mississippi and Texas, and its majority owner, Patrick T. Mitchell, have agreed to pay $5.86 million to settle a false claims case, the U.S. Attorney’s Office for the Southern District of Mississippi said Sept. 3. The settlement resolves allegations that the hospice delivered continuous home care hospice services to patients who weren’t entitled to continuous care hospice level treatment. “During the government’s investigation, it was discovered that St. Joseph Hospice was an outlier in its use and billing of continuous care hospice services,” the U.S. attorney’s office said. Visit http://tinyurl.com/nwy76rh.
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