Report on
MEDICARE COMPLIANCE

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Weekly News and Analysis on New Enforcement Initiatives and Billing/Documentation Strategies

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CMS: Providers Will Face Only Automated Reviews as Permanent RACs Get Feet Wet

Though the permanent recovery audit contractor program is now getting under way, providers initially don't have to worry about medical-necessity reviews, the top CMS RAC official said March 25. "There will be no medical-necessity reviews right at the starting gate," Connie Leonard, director of the Division of Recovery Audit Services, said at the Institute on Medicare and Medicaid Payment Issues, sponsored by the American Health Lawyers Assn. RACs will focus on automated reviews, and perhaps DRG validation.

That's a big deal because claims that allegedly lacked medical necessity were a significant part of the Medicare recoupments during the three-year RAC demonstration.

Automated reviews, such as coding audits, don't require providers to turn over medical records. RACs use claims data already in their possession to hunt for clear-cut errors, such as two appendectomies performed on the same patient, and determine whether an overpayment occurred. An error prompts a RAC "demand letter" informing the provider of an overpayment. RACs now invite providers to discuss overpayment determinations outside the normal appeals process, Leonard said.

In contrast, complex reviews require RACs to examine medical records. RACs will accept imaged medical records on CDs and DVDs. CMS won't allow providers to transmit medical records to RACs over the Internet, but that's possible down the road, Leonard

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Latest OIG 'Open Letter' Bars Stark-Only Violations From Self-Disclosure Protocol

Providers can't resolve potential Stark law violations through the HHS Office of Inspector General's Provider Self-Disclosure Protocol unless they're paired with anti-kickback violations, according to OIG's March 24 "open letter" to providers. The letter, signed by Inspector General Dan Levinson, also notes that providers can't get past OIG's front door in this context unless they anticipate a minimum kickback settlement amount of $50,000.

"To more effectively fulfill our mission and allocate our resources, we are narrowing the [Self-Disclosure Protocol's] scope regarding the physician self-referral law," the letter states. "OIG will no longer accept disclosure of a matter than involves only liability under the physician self-referral law in the absence of a colorable [plausible] anti-kickback statute violation." Levinson emphasizes that dissuading kickbacks is a top goal for OIG.

The Stark law bans Medicare payments to entities that provide designated health services if they are provided to patients referred by physicians who have a financial relationship with the DHS entity, unless an exception applies. The Self-Disclosure Protocol invites providers to reveal their transgressions in exchange for reduced penalties (if certain criteria are met).

continued

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Tony Maida, deputy chief of OIG's administrative and civil remedies branch, says the new letter was necessary to put to rest a misconception in the industry that arose after Levinson's 2006 and 2008 open letters. In the 2006 open letter, Levinson encouraged providers to use the Self-Disclosure Protocol to resolve potential anti-kickback and Stark violations. The 2008 open letter, which emphasized kinder, gentler corporate integrity agreements, referred to Stark violations without mentioning the anti-kickback statute.

As a result, some providers apparently assumed they could resolve technical Stark violations that didn't implicate the anti-kickback law through the Self-Disclosure Protocol, Maida tells *RMC*. But that was never what OIG intended, he says. The new open letter is designed to send a clear message that the Self-Disclosure Protocol was not designed to resolve technical Stark violations, which don't pose much risk to patient safety or Medicare revenue, Maida notes.

Is CMS Not Ready for Self-Disclosures?

However, it may be unclear where providers should go to voluntarily resolve Stark problems with the government now that OIG has taken itself out of the mix, says a lawyer who asked not to be identified. Another attorney, Gabriel Imperato, says he doesn't believe CMS is currently equipped to handle self-disclosures, though he adds that this may change in the future. In the meantime, the options are limited, and the problem with going to Medicare fiscal intermediaries or carriers is that they resolve problems on a claim-by-claim basis, which is exactly what providers are trying to avoid because it would result in Draconian penalties for even procedural infractions, says Imperato, with the law firm Broad and Cassel in Fort Lauderdale, Fla.

That leaves the U.S. attorney's office. But again, the lawyer says there is fear the provider will have to pay damages based on all claims stemming from the illegal Stark referral. So the OIG Self-Disclosure Protocol will be missed — though the lawyer has his beef with that as well. He says it tends to "make a bigger deal out of this stuff than it deserves, and that OIG tries to [extract] as much money out of providers as they can."

Contact Imperato at gimperato@broadandcassel.com. View the open letter at http://oig.hhs.gov/fraud/docs/openletters/OpenLetter3-24-09.pdf. ✧

Hospital Dashboard Best Practices Help Boards Boost Quality of Care

As hospital boards ramp up their quality-of-care oversight, some are seeking feedback directly from patients. They may offer patients seats on the board or create a quality subcommittee made up of patients and/or their families. At least one hospital has established a rapid-response team that can be activated directly by patients who perceive risk of harm. "Establishing mechanisms for patients to tell their stories will provide a clear picture of opportunities for improvement," according to a March 23 report from OIG and the Health Care Compliance Assn. (HCCA).

The report, *Driving for Quality in Acute Care: A Board of Directors Dashboard*, is the product of 55 people from 27 health systems and the government. It grew out of a Nov. 10, 2008, roundtable focusing on how hospital boards can use information dashboards to promote quality of care. Participants identified best practices for tracking measures of quality, safety, customer satisfaction, and financial and employee perfor-

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mance, and suggested ways to increase accountability for better outcomes, OIG says.

Dashboards are a kind of scorecard with snapshots of performance in various areas so board members can quickly identify areas for improvement and recognize progress. OIG and HCCA previously collaborated on a roundtable about dashboards for long-term care institutions *(RMC 1/21/08, p. 1)*.

According to the report, hospital administrators want their boards to lead the way in quality improvement and not just wait passively for information. However, data presented to the board — notably dashboards — should be a tool for change. "The board must establish specific system-level goals and use dashboards to help ensure that those goals are met," the report notes.

Michael Pugh, a senior faculty member of the Institute for Healthcare Improvement and the keynote speaker at the roundtable, said that all hospital boards need to be able to answer the following questions: "How good is your hospital?" and "How do you know?" Dashboards can be useful in interpreting the mounds of data presented to boards and quality committees. Although organizations work to get data on a timely basis, getting data that are accurate, valid, and reliable involves multiple complex processes.

Best Practices for Dashboard Use

At the roundtable, Pugh described best practices for pursuing quality initiatives. Among the suggestions related to dashboards:

(1) Put a human face on the data. Dashboards should focus on the patient, not the statistics. For example, tell the board that 35 patients suffered adverse medication errors that month instead of reporting a metric that the medication error rate was .004%. "By looking at specific patient impact, the scorecard will begin to tell a story often hidden by traditional reporting about the quality of the care practiced at the facility," says the report.

(2) Establish ambitious targets. "Dashboards are excellent tools for monitoring system-level improvement by showing performance measures, specific targets for reducing harm, and specific processes for increasing quality," the report says. For example, in some cases, such as accidental overdoses, the board should set zero-tolerance policies. But interim measures will allow the hospital to show progress between actual practice and target goals.

(3) Be careful with color coding because it may skew expectations. In many dashboards, the colors green, yellow and red indicate how a hospital is performing in a particular area (i.e., red signals a problem, green means everything's OK). "Although using color coding is simple, it is often deceptive because without numbers, it can mislead the board if tied to targets that have been set too low," the report states.

(4) Keep things simple. "The ideal dashboard format is simple — charts and data graphed over time," the report states. That way, it's easy to see whether the hospital is headed in the right direction.

(5) Involve quality and compliance leaders so they can help the board distinguish areas for quality improvement versus quality reporting. Pugh recommends presenting topic-specific scorecards (safety, mortality, infection control, etc.) so the board can understand lots of data in different areas. Compliance officials also must ensure data integrity in board reporting and adherence to internal and external policies and procedures when medical errors occur. Patients should not be charged "for care provided as a result of the harm event," the report states.

Also during the roundtable, three participants described their experiences with quality measurement and reporting and creating dashboards. Here are some of their insights:

◆ ***Statistics matter:*** "By viewing the cold facts, the board can begin to build a sense of urgency and understand that 'we have to do this.' The board must be behind quality initiatives if they have any chance of succeeding," the report notes.

◆ ***Consolidate and package data:*** With dashboards, all data can be put in one central location. Then the board

can use the data to guide its quality strategy (e.g., data on nosocomial infections helps determine housekeeping disinfection protocols), the report says.

◆ ***Perform a quality self-assessment:*** Hospitals should identify their specific risk areas before deciding what to monitor, the report states. "It is often best for the quality audit to focus on internal controls, quality process, and high-volume services."

View the report at http://oig.hhs.gov/fraud/docs/complianceguidance/RoundtableAcuteCare.pdf. ✧

Hospital, New Owner Will Pay for False Claims From Previous Owner

Two former employees of Cornerstone Hospital of Huntington (CHH) in West Virginia tried to warn hospital executives about allegedly improper Medicare billings. But according to their False Claims Act lawsuit, the two employees instead watched the alleged problems continue and good executives leave as a result. Eventually, the two former employees were fired, according to court documents.

Now CHH and its current owner have to pay $690,000 to reimburse Medicare for false claims that were submitted by the previous owner, the U.S. Attorney's Office for the Southern District of West Virginia said March 10. The new owner was not involved in the alleged conduct that led to the false claims settlement, the feds say.

The whistleblowers, who filed a complaint against CHH in 2006, were Jesse Dick Jr., who was a materials manager from October 2005 to May 2006, and Tamela Bragg, a unit clerk from May 2005 to June 2006. Both say they reported the alleged conduct to executives and supervisors at the hospital and its parent company. But the hospital "continued to engage in and forced employees to engage in blatant and pervasive fraudulent Medicare billing practices," says the complaint.

The government intervened in February 2009. The current owner, Austin, Texas-based Cornerstone Healthcare Group, was not aware of the improper billings by the previous owners and cooperated with the investigation, according to a press release from the U.S. attorney's office. The former owner's name is not mentioned in the court documents.

Cornerstone does not admit liability, but settled to avoid the delay, uncertainty, inconvenience and expense of litigation, according to the settlement document.

Dick reported that CHH overbilled, double billed and charged for unnecessary tests and durable medical equipment. He went to CHH's former CEO and chief financial officer (CFO) with this information in 2005, and the CEO reported it to the previous owner. Executives there responded that they had no concerns about the conduct, court documents say.

According to the whistleblower complaint, the CEO and CFO were fired in early 2006. The alleged fraudulent conduct seemed to worsen under the new administrators, the complaint says. Employees were told to double charge for tube feedings, and to start charging for straws, combs, toothbrushes and toothpaste, among other items. Dick contacted a former Medicare inspector to try to confirm that what he witnessed was fraudulent. She told him "you are correct and you can go to jail for doing that," the complaint says.

After an executive from the parent company came to CHH and told everyone that revenue had to increase, the interim CEO instructed employees to "discard patients after a 25-day length of stay if they did not have another form of insurance," the complaint says. "The employees were instructed that CHH should 'keep the patient until they either died or their 25 days are up.' During this period, CHH saw an increased volume in patient deaths resulting from failure to provide the correct drugs, failure to provide any care at all, and failure to carry out physician orders," according to the complaint.

Dick was fired in May 2006 for refusing to sign falsified purchase orders, the complaint says.

Clerk Was Told She Had Attitude Problem

As a unit clerk, Bragg was given a list of 25 to 30 items to be charged to patients every day, she alleged in the complaint. "Ms. Bragg was instructed to go to each patient room, each day, and to charge any item on the list seen in a patient's room," it says. When she was questioned by supervisors why specialty chairs, specialty beds and IV poles were not being charged daily, Bragg said that not all items had doctors' orders for them. She was told to "ALWAYS" charge for those items, according to the complaint.

Bragg spoke to supervisors about this conduct and about the fact that lab tests were not being done, even when ordered by physicians. She was told she had an "attitude problem" and was later terminated for allegedly hanging up on another employee, court documents say.

Cornerstone agreed to pay $690,000, which the feds say "more than compensates the Medicare program for the losses suffered through the submission of false claims." The facility also entered a five-year

corporate integrity agreement with OIG. The whistleblowers will receive 20% of the total settlement.

Neither Cornerstone nor its new owner responded to requests for comment. An attorney representing the facility refused to comment about the case except to say that the conduct took place years before the new owners took over.

Visit www.usdoj.gov/usao/wvs. ✧

Radiology Group Settles $2M Case; MD Says OIG Threatened Exclusion

In one of the largest civil monetary penalty (CMP) settlements to date, a Nevada radiology group will pay $2 million to resolve allegations that it submitted false or fraudulent Medicare claims. OIG announced March 25 that it entered into the CMP settlement with West Valley Imaging Limited Partnership and its principals, William Boren, M.D., and Luke Cesaretti, M.D., all of Las Vegas. But Boren tells *RMC* that West Valley Imaging was forced to settle with OIG under threat of Medicare exclusion. In fact, he says, the radiology group was on the verge of signing a more modest settlement with the U.S. attorney's office when OIG took over the case.

According to the CMP settlement, OIG alleged that between Jan. 1, 1998, and June 1, 2003, West Valley Imaging and the two radiologists billed Medicare for diagnostic tests, including X-rays, CT scans, mammograms, and DEXA scans (for osteoporosis), without required orders from the treating physicians. OIG also contends that the radiology group billed Medicare for DEXA scans without satisfying Medicare's coverage requirements, billed for CT scans and other tests as if they had been performed "with and without contrast media" when the medical records indicated that the tests hadn't been performed both ways, and used the wrong diagnosis codes on claims to help ensure that Medicare would pay for them.

OIG Replaced U.S. Attorney as Enforcer

The physicians deny the allegations. The settlement states it's "neither an admission of liability" by the radiologists "nor a concession by the OIG that its claims are not well-founded."

OIG officials declined to comment on the case beyond what was in the press release.

Boren says the case began when auditors from the Western Integrity Center, a CMS program safeguard contractor (PSC), launched an audit of their Medicare claims. The audit, conducted in 2004 and 2005, led to negotiations between West Valley Imaging and the U.S. attorney's office in Las Vegas, Boren says.

"We were working with the U.S. attorney's office and had agreed to a settlement" for just under $1 million, Boren says. When OIG joined the party, he expected its role was just to negotiate a corporate integrity agreement (CIA), which is an alternative to exclusion for providers who get in trouble for Medicare violations. Instead, Boren contends, OIG replaced the U.S. attorney's office as the enforcer on the case.

Boren says he was told that OIG had uncovered very incriminating information on the radiology practice, but "not once did we get a satisfying answer to what we did wrong."

As for the allegations, Boren chalks up the lack of physician orders to unintentional lax record keeping. In terms of the CPT codes, when other physicians send patients to West Valley Imaging for a chest CT scan with a physician's order and the radiologists performed it with or without contrast, "Medicare regulations say we can interpret how it should be performed," Boren says.

As part of the CMP settlement, West Valley Imaging agreed to a five-year CIA. Among the CIA terms, the radiology group must audit 60 claims every year plus an additional 15 claims quarterly that relate to physician orders.

Administrative Enforcement Is More Difficult

"This case demonstrates that OIG is getting even more serious about exercising its authorities for administrative enforcement, and that this administrative approach can sometimes be worse than dealing with the U.S. attorney's office," San Francisco attorney Judy Waltz, with the law firm of Foley & Lardner LLP, tells *RMC*. She says the enforcement risks are greater when OIG is actively seeking administrative recoveries — and that the process is much more within OIG's control — than when the case is being directed by the Department of Justice, with its shifting priorities and limited resources.

Also, Waltz notes, "the administrative enforcement process is in many respects more difficult for the provider than defending against civil litigation." For example, providers who file for an administrative hearing have the initial burden of showing the government action is erroneous. By contrast, in a court case, "the government would prove its case first, and if it could not prove its case, the matter would likely be dismissed," she says. And an HHS administrative law judge has no authority to review OIG's imposition of a CMP, so appeal rights are limited, Waltz says. Finally, "OIG's exclusion authority is pretty good leverage" when it comes to scaring a provider into settling at the OIG's expected amount.

Contact Waltz at jwaltz@foley.com and Boren at wboren@cox.net. ✧

CMS Schedule for Provider Outreach Visits to Prepare for RACs

This schedule indicates the imminence of RAC audits in particular locations. CMS officials have said RACs won't start audits until these meetings occur.

Date & Time	Conference Name	Attendee	Location	Presenters
PROVIDER OUTREACH — REGION A				
March 30, 2009, 2-5 p.m.	Greater New York Hospital Association	Provider Outreach	New York	CMS & DCS*
March 31, 2009, 1-4 p.m.	The Healthcare Association of New York State	Provider Outreach	New York	CMS & DCS
April 1, 2009, 11 a.m.	NY Medical Society	Conference Call	CMS	CMS
PROVIDER OUTREACH — REGION B				
April 2, 2009, 1 p.m.	Michigan Hospital Association	Provider Outreach	Lansing, Mich.	CMS & CGI**
April 3, 2009, 2-4 p.m.	Minnesota VHA Webinar	Webinar	CMS	CMS & CGI
April 7, 2009, 9 a.m. - 12:30 p.m.	Minnesota Outreach	Provider Outreach	Sheraton Minneapolis South	CMS & CGI
April 10, 2009, 9 a.m. -12 p.m.	Michigan State Medical Society Webcast	Webcast	CMS	CMS & CGI
PROVIDER OUTREACH — REGION C				
March 20, 2009, A.M.	SC Hospital Association	Hospitals	Columbia, S.C.	CMS & Connolly***
March 20, 2009, P.M.	SC Hospital Association	Physicians	Columbia, S.C.	CMS & Connolly
March 26, 2009, A.M.	Florida Hospital Assoc.	Provider Outreach	Orlando , Fla.	CMS & Connolly
March 27, 2009	South Florida Hospital Association	South Florida hospital membership	Ft. Lauderdale, Fla.	CMS & Connolly
April 28, 2009	SNF-Atlanta RO-Provider Forums Pictel	Provider outreach	CMS	CMS
April 29, 2009	Florida Medical Association	Physicians	Orlando, Fla.	CMS & Connolly
May 1, 2009	Atlanta RO-Provider Forum- Physicians Pictel	Provider outreach	CMS	CMS
May 5, 2009	Atlanta RO-Provider Forum- Physicians Pictel	Provider outreach	CMS	CMS
May 20, 2009	Atlanta RO-Provider Forum- Physicians Pictel	Provider outreach	CMS	CMS
May 21, 2009	Atlanta RO-Provider Forum- Physicians Pictel	Provider outreach	CMS	CMS
June 5, 2009, A.M.	Florida Hospital Assoc.	Provider outreach	St. Augustine, Fla.	CMS & Connolly
PROVIDER OUTREACH — REGION D				
March 16, 2009-March 17, 2009	Utah Hospital Association	Hospitals/Suppliers	Salt Lake City, Utah	CMS & HDI****
March 24, 2009, 2-5 p.m.	Arizona Hospital Association	Hospitals	Phoenix, Ariz.	CMS & HDI
May 1, 2009, 3:45-4:30 p.m.	Nevada Osteopathic Medical Association	Physicians	Las Vegas, Nev.	CMS & HDI
May 4, 2009, 10 a.m. - 1 p.m.	CA Outreach	Hospitals	San Francisco Regional Office	CMS & HDI
May 5, 2009, 10 a.m. - 1 p.m.	CA Outreach	Hospitals	San Francisco Regional Office	CMS & HDI
May 6, 2009, 9 a.m. - 12 p.m.	CA Outreach	Hospitals	San Francisco Regional Office	CMS & HDI
May 18, 2009, 9 a.m. - 12 p.m.	Wyoming Outreach	Hospitals	Cheyenne, Wyo.	CMS & HDI
May 21, 2009, 9 a.m. - 12 p.m.	SD Outreach	Hospital	Sioux Falls, S.D.	CMS & HDI
May 27, 2009, 9 a.m. - 12 p.m.	ND Outreach	Hospitals	Bismarck, N.D.	CMS & HDI
May 28, 2009, 9 a.m. - 12 p.m.	Montana Outreach	Hospitals	Helena, Mont.	CMS & HDI

*DCS = Diversified Collection Services
**CGI = CGI Group Inc.
***Connolly = Connolly Consulting, Inc.
****HDI = HealthDataInsights, Inc.
SOURCE: CMS Web site: www.cms.hhs.gov/rac.

RACs Won't Hit Medical Necessity

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noted. Providers will receive a "detailed review results letter following all complex reviews," she added.

In both kinds of audits, the collection process is turned over to Medicare carriers, fiscal intermediaries and Medicare administrative contractors. They will notify providers of the overpayments on remittance advices, which will include a special CMS-created remark code, N432, to indicate that the error was identified during a RAC audit. The definition of N432 is "adjustment based on recovery audit."

Leonard said the permanent RACs will probably begin with hospitals. But physicians can't escape the inevitable. While evaluation and management coding, a physician's main vehicle for billing, was barred from RAC audits under the pilot, E/M coding is fair game in the national RAC program. "When they do venture out into E/M codes" — notably consultation codes — physicians will know in advance that the audit's coming. And the RAC E/M reviews "probably won't be retroactive," Leonard noted.

Records Requests Unlikely Every 45 Days

CMS does not cap the number of automated reviews that RACs can perform, she said. But with complex reviews, CMS limits the number of records that RACs are permitted to collect every 45 days. However, Leonard said, "I don't believe the majority of hospitals will get [RAC] medical-records requests every 45 days." Large health systems might, but "standard community hospitals won't."

Here's how the CMS limits work: RACs can request medical records for 10% of the average monthly claims at inpatient hospitals, inpatient rehab facilities, skilled nursing facilities and hospices, and 1% of the average monthly services at home health agencies. For outpatient hospitals, labs and durable medical equipment suppliers, CMS caps the medical-records requests at 1% of the average monthly Medicare services per National Provider Identifier (NPI), maxing out at 200. Numbers vary for physicians, depending on the size of their practices. For example, for a medical group of two to five physicians, RACs are limited to 30 medical records per NPI. For a medical group with 16 or more physicians, the RAC can request 50 medical records per NPI. RACs can repeat the requests every 45 days.

Some questions have been raised about how to identify a facility in terms of applying the cap on RAC medical-records requests (e.g., by campus versus by health system). Leonard says if a hospital has multiple outpatient entities with their own NPIs — home health agency, a smaller hospital, physician practice — "we still expect a maximum of 200 per month to apply" to all entities in the aggregate. But if it's a national chain, then the RAC can request 200 medical records from each outpatient entity with an NPI.

Leonard said CMS will work with providers who feel their RAC's medical-records requests have exceeded the allowable number. CMS also plans to take a big-picture look at the medical-record guidelines. Perhaps by the end of 2010, CMS will have enough data to decrease the cap if it's too high, she remarked. "These aren't set in stone."

No RAC Extrapolation Without CMS Approval

RACs will extrapolate error rates from smaller-sample claims reviews *(RMC 3/9/09, p. 1)*. However, "before they do, RACs have to get CMS's permission for a specific approach," Leonard noted. And providers probably won't see extrapolation in the near future. RACs will stick to per-claims overpayment determinations in the beginning.

RACs can't launch any reviews without prior CMS approval. A "New Issues Review Board" must approve RAC plans to target particular DRGs or HCPCS codes, Leonard said. The board includes representatives from CMS's coverage, payment and RAC divisions, as well as RAC officials. RACs must list the potential CMS-approved audit topics on a Web site designed for this purpose. That site must be separate from the RAC's corporate site, she stressed.

Also, Leonard said that by January 2010, RACs have to operate a claims status Web site. Providers will be able to log on and check the status of their medical-record reviews. The site will also give them a point of contact for that review.

In terms of RAC findings, Leonard said that if providers agree with the RAC's overpayment determinations, they can pay by check on or before the 30th day after the overpayment determination and avoid interest or allow automatic recoupment on the 41st day. Or providers can request a repayment plan. When providers disagree with the overpayment determination, they can pay by the 30th day to avoid interest and then file an appeal by the 120th day to get the money back. Or they can allow recoupment on the 41st day and appeal by the 120th day. Recoupment will be halted (at least temporarily) if providers appeal by the 30th day. Leonard said the reason providers may want to repay Medicare even though they are appealing is that if they lose, they are charged interest back to that first date of recoupment notification.

Former compliance officer Jenny O'Brien tells *RMC* that Leonard's remarks indicate that CMS has been listening to industry concerns about the RACs. "The communication that there will be no medical-necessity reviews at the outset and that the focus will be on automated reviews rather than diving right into complex reviews will be positively received by the people tasked with developing an effective RAC response initiative," says O'Brien, who is a partner in the law firm Halleland, Lewis, Nilan & Johnson in Minneapolis. However, she doesn't think the fact that

medical-necessity reviews are not imminent should slow the current momentum that providers and suppliers have in readying themselves for RAC audits. "Providers are well-served to continue the aggressive approach they have in reviewing and enhancing processes around ensuring documentation is in the medical record to support medical necessity. If it's not part of the first go-around of audits, it will be sure to be part of the second go-around," she says.

Submit RAC questions to CMS at RAC@cms.hhs.gov. Contact O'Brien at jobrien@halleland.com. ✧

NEWS BRIEFS

◆ **The Methodist Hospital in Houston has agreed to pay $9.9 million to settle allegations that it improperly inflated charges to Medicare,** the Department of Justice (DOJ) said March 26. The facility allegedly inflated inpatient and outpatient care to make costs for the care appear greater in order to get outlier payments between January 2001 and August 2003, the feds say. Methodist denies the contentions and does not admit liability, according to the settlement document. The facility agreed to settle to avoid the delay, uncertainty, inconvenience and expense of litigation, the settlement says. "Methodist followed all Medicare rules during the time period in question and, in fact, received less money from the Medicare program during this period than it cost to provide the care," the facility says in a statement. "The Methodist Hospital has always had a high number of outlier payments because the hospital is an acute care, urban teaching hospital which treats the sickest and most complicated patients from a broad regional and national service area." Visit www.usdoj.gov.

◆ **New Jersey Governor John Corzine (D) signed a bill into law allowing physicians to refer their patients to ambulatory surgery facilities in which they have a financial interest in certain cases,** his office said March 23. Providers must disclose their financial interests to the patients and must perform the surgery themselves, according to the law. They also cannot be compensated based on the number of referrals they make. The law applies retroactively to past referrals. To read the law, visit www.njleg.state.nj.us and search for S787.

◆ **Medicare payments for negative pressure wound therapy pumps jumped from $24 million to $164 million between 2001 and 2007 and the device's wide profit margins may become a fraud and abuse concern,** OIG says in a Office of Evaluations and Inspections report (OEI-02-07-00660) posted March 19. Durable medical equipment suppliers pay an average of $3,604 for new pump models, but receive more than $17,000 from Medicare for them, OIG reports. Also, suppliers leased, rented or exchanged one quarter of the pumps. OIG also found that suppliers did not always speak with clinicians about patients' wound healing progress and to determine whether use of the pump still qualified for Medicare coverage. OIG says CMS should (1) reduce reimbursement for the pumps through its inherent reasonableness authority or the Competitive Bidding Acquisition Program, (2) monitor the growth of the pump market, (3) educate suppliers on communicating with clinicians, and (4) follow up on claims that could be inappropriate. CMS concurred with the first three recommendations and said it has been working on the fourth. Visit AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "OIG Office of Evaluations and Inspections Reports."

◆ **CIGNA Government Services (CGS), the Medicare Part B contractor for Tennessee, should recover $204,000 in overpayments for high-dollar claims to providers during calendar years 2004 through 2006,** OIG says in an audit report (A-04-08-00045) posted March 19. CGS serves 23,900 providers in Tennessee and processed about 58 million Part B claims during the audit period. More than 1,100 of those claims were for high-dollar payments of $10,000 or more. OIG identified 20 overpayments totaling $204,579. CGS made the overpayments because providers incorrectly billed excessive units of service and because the Medicare claims processing system did not have sufficient edits in place to detect overpayments, according to the audit. OIG says CGS should recover the overpayments. CGS responds that it has adjusted the 20 claims and is pursuing the overpayments. Visit AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "OIG Audit Reports."

◆ **On March 11, the Massachusetts Public Health Council passed rules governing the sales and marketing practices of pharmaceuticals and medical device makers doing business in the state.** The rules mandate reporting and public disclosure of certain fees, payments and other compensation paid to physicians as well as prohibitions on gifts and meals. The rules will take effect July 1 this year. Companies will start public reporting July 1, 2010, and the reports will be posted on the state Department of Health web site. Read more at www.mass.gov and click on "State Agencies."

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