Report on
MEDICARE COMPLIANCE

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

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Feds Widen Investigation of Inpatient Spine Surgery; Site of Service Is Under Dispute

The Department of Justice is investigating hospitals around the country to determine whether their Medicare claims for kyphoplasty were improper when billed as an impatient procedure instead of an outpatient service.

Robert Trusiak, chief of the affirmative civil enforcement unit at the U.S. Attorney's Office for the Western District of New York, tells *RMC* that hospitals are vulnerable to false claims allegations if their inpatient kyphoplasty cases weren't medically necessary for that site of service. He cautions that standing orders for physicians to admit all candidates for the spinal procedure may violate Medicare rules.

But attorneys who represent the hospitals say numerous government, quasi-government and industry statements and findings — from CMS, InterQual and Medicare auditors, among others — support inpatient admissions for kyphoplasty and undercut the government's premise for an enforcement action. "This shouldn't be a fraud case," says one lawyer, who declined to be identified for fear of jeopardizing his clients' discussions with the government. "It's a crock."

Trusiak is heading a multi-jurisdictional investigation of inpatient claims for kyphoplasty, which is widely recognized as an effective treatment for vertebral fractures caused by osteoporosis or bone cancer. Under the procedure, surgeons insert a balloon in the fracture and fill it with cement. "[DOJ] does not question the medical necessity of the procedure," Trusiak notes, calling it "outstanding medicine." The government's focus is the alleged abuse of Medicare when admission decisions are driven by the profit

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New Evidence Is Needed to Change RAC Decisions During the 'Discussion Period'

Don't bother to try to reverse a recovery audit contractor (RAC) overpayment determination before the appeals stage unless you have new information, according to the top RAC official at CMS.

Connie Leonard, director of CMS's division of recovery audit operations, said that providers may misunderstand the limits of the "discussion period," which is an opportunity to change the RAC's mind about a claims denial before going the appeals route. The discussion period is not a vehicle for persuasion; it gives providers the chance to submit overlooked medical records, for example, or correct a RAC mistake. Perhaps a page was missing from the patient's chart or the RAC misapplied a local coverage decision (LCD) or retroactively applied an LCD (and therefore unfairly denied payment for a test or procedure based on lack of medical necessity).

"If you disagree with the RAC without new information, it's hard for the RAC to make a revised decision," Leonard said June 23 in an audioconference sponsored by the Health Care Compliance Assn. (HCCA). The permanent RAC program got off the

*PUBLISHER'S NOTE: **RMC** will not be published next week. The next issue will be dated July 13.*

ground in February after CMS resolved a protest filed by vendors who lost their bids to become RACs *(RMC 2/16/09, p. 1)*.

The March 2005 to March 2008 RAC pilot had a similar discussion period. Sometimes it had a positive outcome for providers in terms of reversing overpayment decisions — "if they had new information," Leonard said. "Providers should contact the RAC and discuss [the new information] with the medical director. There is some subjectivity and it's good to discuss it physician to physician. See where the RAC is coming from." But act fast, she advises. The discussion period should be initiated immediately after providers receive a demand letter or review-results letter, which is the method used by RACs to inform providers of alleged errors. Then, if the experience is not fruitful, providers can decide whether to appeal.

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Stacey Levitt, director of patient care management at Lenox Hill Hospital in New York City, found the discussion period effective during the pilot, when she worked at a different hospital. The key, she said, is getting to know the people who work at your RAC. "By establishing a communication line with them through the discussion period, you may be able to glean some information that can be used to educate your staff," she said. Levitt said the pilot RAC for New York state, Connolly Consulting, overturned some claims denials during the discussion period.

One example: With regard to cataract surgery claims denials at her previous hospital, the RAC alleged overpayments because the hospital purportedly billed repeatedly for two surgeries on one eye (per patient). When she investigated the matter, Levitt found that the hospital had performed the cataract surgery appropriately, but a modifier override had sabotaged the claim. For some reason, the person who was in charge of medical records at the time ordered coders to drop a critical modifier (-73 or -74) from the HCPCS codes for cataract surgery. The modifiers convey to Medicare when a procedure is stopped and later resumed for various reasons (e.g., anesthesia problems). Without the modifier, it looks like hospitals are charging for two procedures on the same patient on the same body part. "The RAC denied the claims on the grounds that it appeared to be two cataract removals on the same eye," Levitt told *RMC*. She then called the RAC, explained what amounted to a clerical error, and mailed supporting information. The RAC agreed to void the claims denials — and this all happened without a formal appeal, said Levitt, who also was a speaker at the HCCA audioconference.

But James Bryant, chief compliance officer at Brigham and Women's Hospital in Boston, wonders whether RACs are staffed to deal with potentially hundreds of provider requests to informally reconsider overpayment determinations through discussion periods. "Some guidance on what the RACs will discuss or not would be useful," said Bryant, who spoke at the audioconference.

Records Cap Is 'Huge Deal' for Providers

Leonard updated providers on these other RAC developments:

◆ ***The 200 medical-record maximum that RACs can compel from facilities applies even when they consist of affiliated entities*** (e.g., physician practices, home health agencies). That's "a huge deal" and great news for providers, Bryant says. "It is expected to lessen the burden on complex organizations that have multiple (sometimes dozens) of NPIs [i.e., National Provider Identifiers] for different components and providers within a single facility," said Boston attorney Larry Vernaglia, who is

with the law firm Foley & Lardner LLP. "But until the agency issues a formal policy change, providers should continue to plan and prepare for large numbers of record requests on an NPI-by-NPI basis."

◆ ***RACs won't do medical-necessity reviews until calendar year 2010.*** They will start with automated reviews, which are audits of black-and-white errors, such as claims for performing two appendectomies on the same person. "Then there will be a gradual ramp-up" to coding that may trigger complex medical-reviews, which requires providers to submit medical records, followed by DRG validation. But hospitals have some time before RACs hit at the heart of their reimbursement — the medical necessity of a procedure, for example, or the site of service where the patient was treated.

◆ ***CMS lacks the authority to allow rebilling under the permanent RAC program even though it was permitted during the pilot.*** That's why CMS can't permit hospitals to rebill inpatient claims that were denied when the RACs determine patients could have been treated in an outpatient setting, which CMS calls "site-of-service" errors. Rebilling would allow hospitals to resubmit the claims under the outpatient prospective payment system. This is a controversial area because, even if the treatment or procedure were medically necessary, RACs will order recoupment of the DRG if they believe the site-of-service was overkill *(RMC 1/19/09, p. 1).* Ancillaries can still be charged to Medicare, but they are a reimbursement drop in the bucket. Leonard explained that a change to the Social Security Act would be necessary to permit inpatient-to-outpatient rebilling. However, she says, "nothing stops providers from rebilling [ancillaries] during an appeal" of the inpatient claims denial. CMS addresses rebilling in its "frequently asked questions" on the RAC section of the CMS Web site at www.cms.hhs.gov/rac.

◆ ***CMS is considering a switch from NPIs to tax identification numbers for the process of calculating the number of RAC medical-records requests allowed every 45 days***, Leonard says. Confusion around the application of NPIs in this context has prompted CMS to reconsider their use. Leonard cautioned not to expect changes in 2009 because CMS wants to gather data using the current setup. It plans an October analysis of the RACs' volume of medical records requests. "The intent is not to burden a large facility because they decided to use four to five NPIs," Leonard says. "That's why we have a maximum of 200 records [per facility]." She notes that some RACs have updated their contact forms so facilities (e.g., hospital and affiliated physician clinics) can make it clearer that their NPIs are associated for purposes of qualifying for the 200 medical-record cap.

◆ ***Self-disclosure of overpayments is a smart way to go even with RACs closing in***. But return the money to your claims-processing contractor — fiscal intermediary (FI), Medicare administrative contractor (MAC) or carrier. "I am 99% sure RACs will accept a voluntary refund" to claims-processing contractors when providers find their own mistakes, Leonard says. "The claims in that universe will be excluded from RAC review" and the RAC data warehouse. However, "only the claims processing contractor can determine whether to accept the self-audit or not," Leonard noted. For example, if providers extrapolate an overpayment from a small sample of audited claims, the methodology must be approved by the claims-processing contractor. Vernaglia, who moderated the audioconference, notes that the ability to offer an extrapolated repayment to the FI or MAC and have all affected claims suppressed in the RAC data warehouse presents an important opportunity for the providers and their FIs/MACs to work together to recover overpayments through the voluntary refund process, and avoid some of the harsh results of the RAC program.

Coordinating the Work of RACs and MICs

◆ ***CMS is trying to coordinate the work of RACs and Medicaid integrity contractors (MICs) so a provider isn't hit by both simultaneously.*** Leonard suggested providers "call CMS and get an extension" if they are in this bind. Though both MICs and RACs are contractors hired by CMS to hunt down overpayments, there are differences between them. For example, only RACs are paid on a contingency-fee basis and subject to a cap on the number of medical records they can request per provider every 45 days, depending on type and size. Also, provider deadlines for responding to medical-records requests vary — 45 days for RACs, 15 days for MICs or the deadline set by Medicaid law.

◆ ***Three of the four RAC vendors have operational Web sites,*** with the Web site of the fourth (HealthDataInsights, Inc.) "under CMS review and should be up in the next week or so," she says. RAC Web site addresses and customer service phone numbers can be accessed on the RAC section of the CMS Web site.

◆ ***Providers should make sure RACs have the desired address for receiving RAC medical-records requests and other correspondence.*** "CMS gives RACs the address the claims processing contractor has on file, which is what they will use unless the provider sends in something different," she says. The consequences for letting RAC medical-records requests fall through the cracks are huge; they automatically deny claims when providers fail to submit any or adequate documentation.

Contact Vernaglia at lvernaglia@foley.com and Bryant at jbryant3@partners.org. E-mail RAC questions to CMS at rac@cms.hhs.gov. ✧

Sample Order Form for Diagnostic Tests

Establishing the medical necessity of tests performed in hospital outpatient departments is essential to compliance, but has become a sore subject of late (RMC 5/15/09, p. 1)*. Olympic Medical Center in Port Angeles, Wash., uses this form. Compliance Officer Mic Sager says it was developed for two reasons: (1) to help physicians order services without ambiguity and (2) to prompt physician offices for the legally required data for an order. Contact Sager at msager@olympicmedical.org.*

Medicare and other insurers require coding of specific/definitive diagnosis(es), sign(s) or symptom(s) to reflect the "medical necessity" for each test. **Rule out, Possible or Probable Conditions cannot be coded.** For Medicare Policy information see the Part B bulletin or www.noridian.com/medweb.

REQUIRED	Priority	Height	Diagnosis: _____	Diagnosis: _____
	☐ **STAT**	____	**Signs/Symptoms:** _____	**Signs/Symptoms:** _____
	☐ Urgent	**Weight**	**ICD-9-CM** 1 _____	**ICD-9-CM** 1 _____
	☐ Routine	____	2 _____	2 _____
			Date of Onset: _____	**Date of Onset:** _____

CARDIOPULMONARY

☐ EKG ☐ Drug Stress Echo ☐ Pulmonary Rehab ☐ Treadmill Stress Nuclear
☐ Echocardiogram ☐ Treadmill Stress Echo ☐ Cardiac Rehab ☐ Drug Stress Nuclear
☐ Transesophageal Echo ☐ Simple Treadmill ☐ Pulmonary Stress Test (6-minute walk) ☐ Event Monitor
☐ 24° Continuous Monitor

Comments: _____

RHYTHM MANAGEMENT CLINIC

For consults and new device fax progress notes, test, labs, med lists, etc.

☐ Pacemaker Eval ☐ Implanted Loop Recorder Eval ☐ Arrhythmia Consult
☐ Defibrillator Eval ☐ Transtelephonic Pacer (TTP) Check ☐ Other Consult: _____
Check all that apply: ☐ New Pt ☐ New Device, brand: _____ ☐ New Event ☐ Follow Up Med changes

DIAGNOSTIC IMAGING

Please use form DI21183 — Diagnostic Imaging Orders

NUTRITION SERVICES & DIABETES EDUCATION

Please send recent progress note and lab.

Medical Nutrition Therapy ☐ Diabetes (Nutrition) **Diabetes Education**
☐ Cancer ☐ Weight Management ☐ New Onset ☐ Diabetes Self Management Education
☐ Cardiac Nutrition ☐ Chronic Kidney Disease ☐ Insulin Pump Start ☐ Insulin Start/Adjustment

REHABILITATION SERVICES

☐ Port Angeles
☐ Sequim
☐ PT Evaluation and Treatment ☐ OT Evaluation and Treatment ☐ ST Evaluation and Treatment

Comments: _____
Precautions: _____

RESPIRATORY THERAPY

Please arrive 15 minutes prior to test

Location: ☐ Port Angeles ☐ Sequim

☐ Complete Pulmonary Function Test ☐ ABG (Arterial Blood Gas) ☐ Spirometry/Flow Volume Loop
☐ Methacholine Challenge ☐ O2 Stats (rest and walking)

Comments: _____

OMC Noted By Signature
(First Initial/Last Name/Title): _____ Date: _____ Time: _____

Referring Provider Signature
(First Initial/Last Name/Title): _____ Date: _____ Time: _____
Provider Name (Please Print): _____

Required

Patient Name: _____ **Date of Birth:** _____
Phone: _____ **Service Date:** _____
Cc: _____ Fax _____
Allergies: _____

Eight Indicted in Medicare Fraud Scheme Spanning Five States

Eight Miami residents have been indicted in a "remarkable" and "sophisticated" scheme that attempted to defraud Medicare of about $100 million and spanned five states, the U.S. Attorney's Office for the Southern District of Florida said June 22.

According to the indictment, two different conspiracies were taking place. First, the feds allege that Michel De Jesus Huarte and unnamed conspirators controlled and operated six infusion therapy clinics in Miami-Dade County. De Jesus Huarte allegedly recruited "nominee owners" for each clinic and paid them to sign corporate records, bank records and other business-related documents, the feds say.

The clinics submitted about $50.2 million in false Medicare claims for expensive medical treatments for cancer, HIV, AIDS, chronic pain and varicose veins, the feds say. Medicare paid about $19.2 million out of those claims.

It's 'Easy to Become Numb' to Such Fraud

The feds say the second conspiracy involved De Jesus Huarte and the remaining seven defendants submitting about $19.8 million in false claims to private insurance companies that offer Medicare Advantage plans. This alleged scheme involved eight infusion therapy clinics in Florida, Georgia, Louisiana, North Carolina and South Carolina.

It also involved two check-cashing stores that allegedly would accept the insurance companies' checks, deposit them into corporate bank accounts and wait for them to clear.

The seven co-defendants helped recruit "nominee owners" for the clinics or operated the check-cashing stores, the feds explain. The government says the bogus owners were paid handsomely for their services and there was "the understanding that the 'straw' owners would flee to Cuba to avoid law enforcement detection or capture."

Additionally, the defendants allegedly purchased the names and other personal identifying information of Medicare beneficiaries without their knowledge or permission in order to submit the false claims. They also "misappropriated" the names and identification numbers of physicians to submit the claims, according to the indictment.

"With the new Medicare fraud cases being indicted in the Southern District of Florida every week, it is easy to become numb to otherwise egregious fraudulent conduct and staggering loss amounts," Acting U.S. Attorney Jeffrey Sloman said in a prepared statement. "This case is remarkable, not only in terms of the amounts stolen from Medicare, but also in terms of its sophistication and geographic breadth."

Six of the defendants are charged with conspiracy to commit Medicare fraud and/or conspiracy to commit money laundering. De Jesus Huarte and one other person are charged with Medicare fraud, conspiracy to commit Medicare fraud, money laundering, conspiracy to commit money laundering and aggravated identity theft. The defendants face a maximum statutory sentence of 10 years in prison on each of the fraud counts and conspiracy counts, plus two years for identity theft.

An attorney for De Jesus Huarte could not be reached for comment.

To read the indictment, visit www.usdoj.gov/usao/fls and click on "Press Releases." ✧

Hospital Kyphoplasty Under Review

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motive rather than an individual patient assessment, he says.

The enforcement initiative evokes memories of the national projects that jump-started compliance programs in the 1990s and early 2000s (e.g., hospital lab unbundling and DRG upcoding). Trusiak is investigating hospitals in conjunction with the main DOJ and the HHS Office of Inspector General, and hospitals in multiple states — including Indiana, Florida, Alabama, New York and Minnesota — have received subpoenas and/or letters requesting documents pertaining to their kyphoplasty cases. "The investigation is broad in scope," Trusiak says. "This implicates hospitals on a national scale."

The investigation is a showdown over the reigning program-integrity issue for hospitals: the medical necessity of the site of service where patients are treated. Trusiak says there are ample Medicare regulations explaining when inpatient admission is appropriate versus outpatient care (including observation). The scales tip toward the outpatient side unless the patient's signs and symptoms indicate the need for the more intensive inpatient setting. Kyphoplasty, Trusiak contends, fits squarely within those outpatient parameters because it's minimally invasive.

DOJ Anticipates Hospital 'Excuses'

Trusiak doesn't contend that inpatient kyphoplasty is never appropriate. But hospitals will have to demonstrate that patients were individually assessed and that there were comorbidities or other factors meriting an inpatient stay. "When a hospital has a standing order to always admit kyphoplasty patients without regard to individualized medical-necessity determinations, that may be contrary to the [CMS] medical-necessity requirements," Trusiak says.

In a recent letter to Florida hospitals, Trusiak asks them to submit medical records and financial documents pertaining to their kyphoplasties. The documentation requests cover Jan. 1, 2000, to Dec. 31, 2008, and focuses on zero and one-day hospital stays. He explains that DOJ will assess a hospital's "recklessness" and greater DRG cost by determining whether "medical treatment annotated in the medical record justified the inpatient level of service despite the availability of observation status such that the absence of inpatient care would have significantly and directly threatened the patient's medical condition, safety and health."

Trusiak makes it clear in the letter that DOJ isn't buying certain excuses that some hospitals have offered for their inpatient kyphoplasty billing. For example, "it has been suggested to the government that a monotonous post-procedure kyphoplasty protocol involving the monotonous use of physical therapy, CT scans and/or IV antibiotics transforms kyphoplasties from an outpatient procedure to an inpatient stay," the letter notes. No way, he says, because "a clinical protocol that monotonously requires the delivery of certain services regardless of medical necessity is irrelevant to site-of-service determination." Also, Trusiak says the patient's pain does not justify pre-procedure inpatient assignment. "If pain was managed in a non-hospital setting prior to the surgery, then pain management does not require inpatient-level services simply because the patient entered the hospital for a kyphoplasty procedure," the letter asserted.

Probe Started With Whistleblower Suit

The investigation originated with a False Claims Act lawsuit against Kyphon, Inc., the company that developed kyphoplasty and marketed a kit used in the procedure. The lawsuit was filed by two whistleblowers — Charles Bates, a former Kyphon sales manager, and Craig Patrick, a former reimbursement manager. They alleged that Kyphon embarked on a seven-year marketing campaign to persuade hospitals to perform kyphoplasty as an inpatient procedure when it should have been done on an outpatient basis.

The difference in Medicare inpatient versus outpatient reimbursement is significant. Hospitals are paid $12,000 to $15,000 for inpatient kyphoplasty through MS-DRG 517 (other musculoskeletal system and connective tissue operating room procedures without complications or comorbidities), 516 (same, but with CCs) or 515 (same, but with major CCs). In contrast, under the outpatient prospective payment system's APCs, payments for kyphoplasty range from $2,500 to $4,500.

Ultimately, Kyphon's corporate successor, Medtronic Spine LLC, paid $75 million in May 2008 to settle the case with DOJ. The whistleblowers then lodged the same allegations against hospitals in a separate filing. One settlement has emerged from that case so far. In May, three St. Paul, Minn., hospitals in the HealthEast Care System paid $2.28 million to settle false claims allegations that they charged Medicare for inpatient kyphoplasties between 2002 and 2007 when they could have been performed and billed under the outpatient prospective payment system.

But Trusiak emphasizes that DOJ "is not making conclusions solely on the allegations in the complaint. The U.S. is gathering data, engaging in document review and engaging in conversations with particular facilities and physicians to inform its judgment."

Lawyers representing hospitals under investigation for kyphoplasty claims contend that hospitals have plenty of support for performing the procedure on an inpatient basis. The lawyers, who asked not to be identified to protect their clients, are frustrated that DOJ would turn medical-necessity ambiguity into a false claims case. "It's important for the government to understand that the physician has to make an informed medical judgment at the time of admission based on the expected medical treatment and follow-up care. Just because the patient who received the procedure improved and is ready to be discharged — and it turned out to be a short stay — doesn't mean it was an inappropriate admission," one lawyer says.

CMS, InterQual Endorse Inpatient Kyphoplasty

The attorneys point to these facts to support their position that hospitals were justified in performing kyphoplasty on an inpatient basis:

◆ ***InterQual, a popular admission screening tool, recommended inpatient admission for kyphoplasty between 2005 and May 2008.*** This can't be written off as just some voluntary guidance, one lawyer says; InterQual has received implicit government endorsement. For example, Meadows Regional Medical Center in Vidalia, Ga., was required to use InterQual for admission decisions as part of the corporate integrity agreement in its 2000 settlement with DOJ and OIG. It's hard for the government to argue that InterQual lacks authority or dismiss it as mere guidance when the government required its use in a settlement, one lawyer says. Also, he added several Medicare quality improvement organizations (QIOs) "explicitly told hospitals to use InterQual for analyzing the necessity of inpatient cases."

◆ ***On July 30, 2008, CMS posted a list of topics it was considering for national coverage decision (NCD) development,*** including kyphoplasty and a related procedure, vertebroplasty. (NCDs describe the circumstances in which Medicare will pay for a test or procedure.) CMS stated that "typically, vertebroplasties are performed in an outpatient setting, while kyphoplasty typically requires hospital admission."

◆ ***The American Hospital Assn.'s* Coding Clinic, *the guidelines for ICD-9-CM diagnosis coding,*** said in its fourth quarter 2004 edition that "kyphoplasty is typically performed in an inpatient setting."

◆ ***Medicare auditors of all stripes — the fiscal intermediary, the recovery audit contractor (during the pilot) and the QIO*** — approved the medical necessity of numerous inpatient kyphoplasty claims, a third lawyer says. Even when the claims were initially denied, after an audit, hospitals often got the denials overturned on appeal, the lawyer says. "How can a hospital submit a false claim if the government knows about the claim and found it was appropriate or, if not, could not make [the denial] stick on appeal?" the lawyer posits. "How does a hospital rise to the level of reckless disregard when you have competing views," he adds, referring to DOJ versus InterQual and the RACs versus administrative law judges.

Given all this support for inpatient kyphoplasty, it doesn't seem a good bet for a fraud case, lawyers say. "To accuse hospitals of fraud, you have to be asserting that the hospital's position is clearly unreasonable. If there is a dispute of experts, I don't see how you can say with a straight face that the conduct is fraudulent."

But Trusiak sees things differently. He says the NCD notice "was neither a ruling nor any determination of the appropriate site of service for kyphoplasty," he says. Kyphoplasty does not appear on Medicare's inpatient-only list, which mandates inpatient status for certain procedures. It was added to the procedures that can be performed in an ambulatory surgery center, effective Jan. 1, 2008, Trusiak says.

Trusial: InterQual Has Little Evidentiary Value

He says that InterQual's position is not significant because "it's private guidance." It may be considered for its evidentiary value, but will take a back seat to documentation indicating that a hospital's site-of-service decisions "were made for financial reasons." Without contemporaneous proof that the hospital used InterQual at the time of claim submission, Trusiak says, "InterQual guidance possesses little or no evidentiary value concerning the hospital's judgment." In other words, "a lawyer's claim in 2009 that private guidance affected a hospital's judgment in 2005 possesses evidentiary value only based on proof of reliance in 2005 since no guidance, InterQual or otherwise, permits all kyphoplasties to always be performed on an inpatient basis," he says.

Trusiak also notes that InterQual is irrelevant for site-of-service decisions prior to 2005 because of its absence from the guidance. But the lawyers interviewed say that's not how InterQual works. "I am not aware of a single procedure that started outpatient and became inpatient, so if kyphoplasty was inpatient in 2005, it is reasonable to conclude it was properly inpatient before 2005," one lawyer says.

Also, Trusiak asserts that the government will consider the fact that Medicare auditors approved kyphoplasty claims or lost denials on appeal "before deciding False Claims Act liability," but again, the driving force in the investigation is whether admissions were reasonable and necessary and patients required the intensity of service "beyond the temporal limits of observation as reflected in the medical record."

Contact Trusiak at Robert.g.trusiak@usdoj.gov. ✧

NEWS BRIEFS

◆ **Under the Medicare Fraud Strike Force's expanded operation in Detroit, 53 people have been indicted for schemes to submit more than $50 million in false Medicare claims,** the Department of Justice (DOJ) said June 24. The defendants are charged with offenses including conspiracy to defraud Medicare, criminal false claims and violations of the anti-kickback statute. The schemes primarily involve infusion therapy and physical/occupational therapy providers, DOJ says. The defendants — including physicians, medical assistants, patients, company owners and executives — allegedly submitted claims to Medicare for treatments that were not medically necessary or were never provided. Visit www.usdoj.gov.

◆ **The U.S. Supreme Court said on June 22 that it will hear a case that could dictate how whistleblowers file lawsuits,** according to the court's docket. The question before the court is "whether an audit and investigation performed by a state or its political subdivision constitutes an 'administrative…report…audit, or investigation' within the meaning of the public disclosure jurisdictional bar of the False Claims Act." The U.S. Court of Appeals for the 4th Circuit decided in June 2008 that the public disclosure bar applies only to federal administrative audits, reports, hearings or investigations. It does not apply to those conducted by a state or local government, the appeals court said. The case is *Graham County Soil and Water Conservation District, et al. v. U.S., ex rel. Karen T. Wilson*. Visit www.supremecourtus.gov.

◆ **Robert Bourseau, the former co-owner and board chairman of City of Angels Medical Center in Los Angeles, pleaded guilty June 16 to paying illegal kickbacks for patient referrals,** according to the U.S. Attorney's Office for the Central District of California. Boursea admitted to paying the kickbacks in a scheme to defraud Medicare and Medi-Cal by paying recruiters to find homeless people who would be admitted to City of Angels as inpatients to receive unnecessary health services, the feds say. Bourseau faces a maximum of 10 years in prison when he is sentenced and has agreed to pay more than $4.1 million in restitution to Medicare and Medi-Cal. Visit www.usdoj.gov/usao/cac.

◆ **Louisiana State University Health Sciences Center (LSU) received overpayments totaling nearly $58,000 in 2004 and 2005 for the chemotherapy drug oxaliplatin**, OIG says in an audit report (A-06-08-00086) posted June 19. LSU submitted 18 claims for oxaliplatin treatments during 2004 and 2005. On two claims, the hospital billed for 10 times the number of units of oxaliplatin that were actually administered due to a computer error. OIG recommends that LSU (1) ensure that the overpayments were accurately refunded to the fiscal intermediary and (2) establish procedures to ensure that the units of drugs billed correspond to the units of drugs administered. LSU agreed with the findings and said it has taken corrective action to ensure that future claims are correct.

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