Report on
MEDICARE COMPLIANCE

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Weekly News and Compliance Strategies on Federal Regulations, Enforcement Actions and Audits

Contents

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Medical Group Settles HIPAA Case After Physician Talks About Patient to TV Reporter

Allergy Associates of Hartford, a medical group in Connecticut, agreed to pay $125,000 to settle potential violations of the HIPAA Privacy Rule after one of its physicians talked to a television reporter about a patient after the privacy officer told him not to, the HHS Office for Civil Rights (OCR) said Nov. 26. Allergy Associates didn't discipline the physician or take corrective action, OCR said.

The case was set in motion with the patient's Feb. 20, 2015, visit to the doctor's office. The patient told Fox61, a TV station in Connecticut, that the physician "kicked her out" because she showed up for her appointment with a service dog, according to the TV station. The reporter also spoke to the physician, but the story has no details because it says the physician decided his comments weren't on the record. The resolution agreement with OCR simply states that "an Allergy Associates Workforce Member had a conversation with a Reporter regarding the Reporter's investigation of the Complainant's allegation that she was turned away from Allergy Associates because of her use of a service animal. The Workforce Member impermissibly disclosed the PHI [protected health information] of the Complainant. Following the impermissible disclosure, and after HHS notified Allergy Associates that it initiated its investigation, Allergy Associates failed to sanction the Workforce Member for the impermissible disclosure."

When providers are slammed in the media or online, they have to keep mum, says attorney Thora Johnson, with Venable LLP in Baltimore. "Every bone in your body wants to be able to respond with facts that might indicate they are your patient or something about their condition, and that you can't do," she says. "The mere acknowledgement that someone is your patient is protected health information."

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OIG: Too Much Fraud Risk in Plan to Give Drug Free to Hospitals; Price Has Skyrocketed

A pharmaceutical manufacturer's plan to give hospitals an expensive drug to treat infants diagnosed with a form of epilepsy—for free—was nixed by the HHS Office of Inspector General because it could implicate the Anti-Kickback Statute. As appealing as the freebie is to help tiny patients while they are in the hospital, OIG essentially saw the proposal as a Trojan horse: Inside the offer is the potential for future purchases of the drug with no benefit to federal health care programs, according to the advisory opinion (AO-18-14), which was posted Nov. 16.

"The advisory opinion is remarkable," says former federal prosecutor Robert Trusiak, an attorney in Buffalo, New York. "The clinical efficacy of the drug is clear and important. Notwithstanding the efficacy, the present absence of federal savings and the real danger of increased costs resulted in an absolute rejection by OIG. Free plus clinical efficacy is no defense to kickbacks."

But it's a hard thing to swallow, he says. "No situation is more vexing to a hospital compliance officer than saying no to free products. It is counterintuitive to refuse

continued

free products for hospital patients serving to reduce hospital costs. The hospital finance officer is concerned about the bottom line," Trusiak explains.

The drug company, which was not identified, asked OIG whether it would impose sanctions if it gave free doses of the drug to hospitals to use only with patients diagnosed with the form of epilepsy, which is called "the syndrome" in the advisory opinion, with a dose when they go home. The syndrome occurs within the first two years of life, and the drug company says patients are usually diagnosed in the hospital after extensive testing.

According to the opinion, treatment involves a one- to five-day inpatient stay. Sometimes hospitals don't stock the drug because it's pricey and vials may expire before use. "Requestor certified that many hospitals are reluctant to administer the Drug to patients with the Syndrome during an inpatient hospital stay because government programs and other insurers do not provide sufficient reimbursement to cover the cost of the Drug and other services related to the inpatient stay; as noted above, the Drug is not separately reimbursable when administered in the inpatient setting," the opinion states.

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The price of the drug—which has FDA approval for 19 conditions—has soared in recent years even though it's been around a long time, receiving FDA approval in 1952, according to OIG. One vial cost about $40 in 2001, when it was purchased by the drug company. The price of the drug rose from $1,650 to $23,000 per vial in 2007, and the drug company's website states the current list price is $38,892 per vial. "According to Requestor's most recent 10-K filing, net sales for the Drug reached $1.195 billion for 2017," OIG says. "Given that net sales for the Drug were more than ten times higher in 2017 than they were in 2008, whereas the number of patients diagnosed with the Syndrome remains approximately the same from year to year, the market for the Drug's other indications—for which Federal health care programs may pay—appears to have expanded."

OIG Sees Risk of Seeding Arrangement

Under its proposed arrangement, the drug company would stock the drug at participating hospitals on consignment. If a physician diagnoses a patient with the syndrome and wants to prescribe the drug, the prescription would go to the drug's "reimbursement hub," and therapy would begin with a free vial, according to the opinion. If necessary, the drug company will provide another vial to the hospital to treat the patient, and then more for the patient's caregiver to administer at home for two weeks until the drug is tapered off. The post-discharge dose will only be free if the patient's insurance doesn't cover the drug. Hospitals, prescribers and caregivers will be notified that accepting the free vials doesn't obligate them to buy the drug or other products from the manufacturer, and the arrangement wouldn't be advertised where physicians or patients would see it.

OIG concluded the drug company's proposed arrangement would implicate the Anti-Kickback Statute. The free drug would be remuneration to hospitals, which could be referral sources—directly if their employed physicians prescribe the drug and indirectly through formularies that influence the drugs that physicians administer or dispense. "Giving the Drug for free to hospitals for inpatients diagnosed with the Syndrome could induce the hospitals to arrange for or recommend future purchases of the Drug," the opinion states.

Although OIG recognizes the drug is a "first-line treatment for the Syndrome" and it's important to start some kind of treatment close to diagnosis, there's no way around the fact the arrangement "presents more than a minimal risk of fraud and abuse under the anti-kickback statute." OIG cited these reasons:

◆ The steep price increases are probably why hospitals don't stock the drug, and the freebie would clear the

way for the drug to be administered to inpatients who are diagnosed with the syndrome.

◆ The federal health care programs wouldn't save any money from the arrangement because they pay the same for inpatient stays whether or not it's used. It just reduces hospital costs.

◆ This could wind up being a "seeding arrangement," OIG said. After patients are discharged, their insurers would be charged for the drug, including federal health care programs. "Moreover, giving the Drug for free to this specific patient population in the inpatient setting facilitates Requestor's high price for the Drug's other indications; Requestor represented in a certified submission to the OIG that it could not offer a discounted price for the Drug for the Syndrome because 'such a discount could not be taken without a devastating impact on Best Price.' In other words, rather than reducing the price of the Drug for patients with the Syndrome (which also would reduce costs for Federal health care programs because of the best price requirements), Requestor seeks to give the Drug for free to hospitals for a narrowly defined subset of patients and to retain the higher price for all other patients who use the Drug (for any of its indications) and all payors, including Federal health care programs."

◆ The proposal may result in steering or unfair competition. There is another FDA-approved drug to treat the syndrome, and other drugs are used off-label to treat it. In a recent settlement with the FTC over allegations it illegally "acquired the U.S. rights to develop a competing drug," the drug company agreed to pay $100 million and grant a license to develop a competing synthetic drug substance to treat the syndrome and other conditions to an FTC-approved licensee. "Therefore, prescribers have various treatment options, including but not limited to the Drug, to consider, and hospitals have a choice of which drugs to stock. It is possible that hospitals could influence prescribers to consider the Drug as a first option, either directly or through formulary decisions, as a result of the Proposed Arrangement," OIG said.

◆ "Requestor's certification that receipt of the free vial of the Drug is not contingent on future purchases rings hollow," OIG said. The drug company said it's dangerous to discontinue the drug after the patient leaves the hospital. After discharge, patients are expected to use their insurance coverage to get the drug, but if they're unable to, the drug company might give it to them free. "In essence, the receipt of the free vial would be contingent on future purchases of the Drug for patients with insurance coverage for the Drug," the advisory opinion states.

Contact Trusiak at robert@trusiaklaw.com. View the advisory opinion at https://go.usa.gov/xP7xH. ✧

CMS Starts New Home Health Claims Review Demo With Three Options

On Dec. 10, CMS is taking another shot at a home health pre-claim review demonstration, although calling it that would be a misnomer. Home health agencies (HHAs) will have three choices—pre-claim reviews, post-claim reviews or virtually no review in exchange for a 25% pay cut. There's also a reward of sorts for more compliant providers.

CMS on Nov. 27 unveiled the details of its five-year Review Choice Demonstration for Home Health Services, which was developed in response to mounting evidence of fraud and abuse in home health care and the persistence of inadequate documentation to support certification of home health eligibility, according to slides on the CMS website.

Palmetto GBA, a Medicare administrative contractor (MAC), will run the demonstration, which starts in Illinois. Sometime soon, CMS will implement the demonstration in four other states—Florida, Ohio, North Carolina and Texas—but HHAs there will have 60 days' warning. It could eventually hit additional states. The previous version of the demo began in 2016 but was suspended last year because of glitches.

'Another Preauthorization Process'

The demonstration amounts to another preauthorization process in Medicare, says Patrick Kennedy, compliance officer for UNC Hospitals in Chapel Hill, North Carolina. There are already prior authorization demonstrations for non-emergent hyperbaric oxygen therapy, repetitive non-emergent ambulance transport and power mobility devices. While preauthorization is mostly used on the commercial side, not in Medicare, it seems to be going in that direction, he notes. Hospitals also have related experience because MACs are reviewing a sample of claims before paying them under Targeted Probe and Educate (TPE), CMS's national medical review strategy, although the home health demonstration calls for 100% claims review, Kennedy says. "We know we have to do this right on the front end—not provide services and then get the documentation. I don't know that private home health agencies have been as involved in Medicare's pre-claim review processes, so that may be where the greater challenge exists," he says. HHAs that are part of a larger system "are accustomed to" TPE and recovery audit contractor (RAC) audits, so there is more infrastructure in place to manage them.

In the demonstration, Palmetto will review home health claims for compliance with Medicare's home health benefit. Patients must be confined to their home, be under the care of a physician, receive services under a physician's plan of care, require skilled services, and

have a face-to-face encounter with a physician or non-physician practitioner that's related to the main reason the patient needs home health care no more than 90 days before home health care starts or 30 days after.

HHAs can take their pick of three choices in the demonstration:

◆ Pre-payment review of all claims: HHAs submit a request for a pre-claim review, including their documentation, and it can encompass more than one episode of care. After reviewing the HHA's claim information, the MAC will send a decision letter provisionally "affirming" or "non-affirming" the request for a pre-claim review, which appears to be CMS lingo for an approval/denial. If they're affirmed, Palmetto will pay the claim. If they're not affirmed, HHAs have another choice to make: (1) submit the claim, which will be denied but can be appealed, or (2) continue to address the reasons the claim was non-affirmed as many times as they want before they submit the claim, but if they're still rebuffed, "pre-claim review submissions can't be appealed."

CMS said decision letters will explain exactly why claims were not affirmed and include a pre-claim review unique tracking number. There's a penalty for dropping the ball: If HHAs select the prepayment review option but fail to submit a pre-claim review request before submitting the final claim, Medicare will chop 25% from their payment.

◆ Post-payment review of all claims: This is the post-payment review familiar to providers. Life will proceed normally, but MACs will do complex medical reviews on claims submitted at six-month intervals. MACs will send HHAs additional documentation requests after they get claims.

If HHAs don't make a selection in the demonstration, they will automatically land in post-payment review.

◆ Minimal review with payment reduction: Claims will be paid the usual way, but "HHAs will receive an automatic 25% reduction on all payable home health claims," CMS said. With this option, claims are free from TPE, but they could be subject to review by RACs. Denied claims will retain appeal rights. If HHAs select door number three, they are stuck with it for all five years of the demo.

Compliance Has Its Rewards

CMS also modified the demonstration to reward providers who show compliance with Medicare policies, officials said at an open-door forum, according to people who attended (open-door forums are off the record to reporters). That will play out in the "subsequent review choice."

The affirmation (claim approval rate) will be calculated every six months for HHAs that select pre-claim or post-claim reviews. HHAs that score 90% or greater will find their world opening up: They can continue with pre-claim or go for "selective" post-claim reviews, or a totally new thing: spot checks.

With selective post-claim reviews, the MAC will audit a statistically valid random sample of claims. The HHA will remain in this option for the rest of the demo. With spot checks, the MAC will randomly select 5% of claims for prepayment review every six months. If HHAs fall out of compliance, they must go back to one of the three original options.

Kennedy says CMS deserves credit for "having thought a lot of the nuances through. It seems pretty well planned, which is nice," and officials answered almost all the questions on the open-door forum. It's helpful that HHAs can submit the pre-claim reviews through electronic exchanges (i.e., Electronic Submission of Medical Documentation System, known as esMD).

However, he has some concerns. For example, what happens if the MAC doesn't affirm the HHA's claim after receiving the certification and treatment plan, but the patient's care is already underway? "How will that play out with the patient? Do you stop because you might not get paid for it, issue an advance beneficiary notice or continue to provide the care because they need it? I think there is a balancing act," Kennedy said. "Providers will have to make that decision."

The demonstration's Dec. 10 start date could be delayed a bit because CMS is still awaiting approval under the Paperwork Reduction Act, but it anticipates getting started.

Contact Kennedy at patrick.kennedy@unchealth.unc.edu. Visit go.cms.gov/homehealthRCD. ✧

Disappointed by Survey, Compliance Managers Talk to All Employees

One finding from an external effectiveness review of Novant Health's compliance program was that some employees couldn't name the compliance officer and didn't know how to report a compliance concern. It's never welcome news, and Novant Health, which has 13 hospitals and hundreds of outpatient centers and physician offices in North and South Carolina and Virginia, wanted to know more about its employees' knowledge of compliance and privacy. Although the standard operating procedure is to survey employees about the compliance and HIPAA program, that didn't go according to plan.

The next idea had a bigger payoff, says Loree Simmons, assistant director of compliance.

First the survey: Novant Health emailed it to a sample of its 26,000 employees. The number of responses was disappointing, partly explained by the fact that

some of them don't have access to email or don't check it (e.g., float nurses), she says. So the compliance department developed a different approach to outreach, which is interactive and promotes problem solving. Since January 2018, three compliance program managers and two compliance educators have been slowly making their way through the hospitals, outpatient departments and physician offices, asking employees about compliance and HIPAA basics, and spot-checking a few things while they're there. For example, do employees know that Novant Health has a compliance officer and what her name is? Do they know where to access compliance policies and social media and photography policies on the intranet? Can they show the compliance program managers and educators how they would access the hotline if they wanted to report a concern? Do they feel comfortable reporting wrongdoing? Do they know how to access the code of ethics and disclose conflicts of interest? Do they know where to go if they have compliance questions (e.g., call the general compliance phone number, use multiple compliance email addresses, ask supervisors and managers)? Are they aware they should reject offers of cash or cash equivalents from patients, family members, vendors and suppliers? Do they know how to access the disciplinary standards?

The compliance program managers and educators are talking to every employee and giving them flyers with some of the touchstones of compliance

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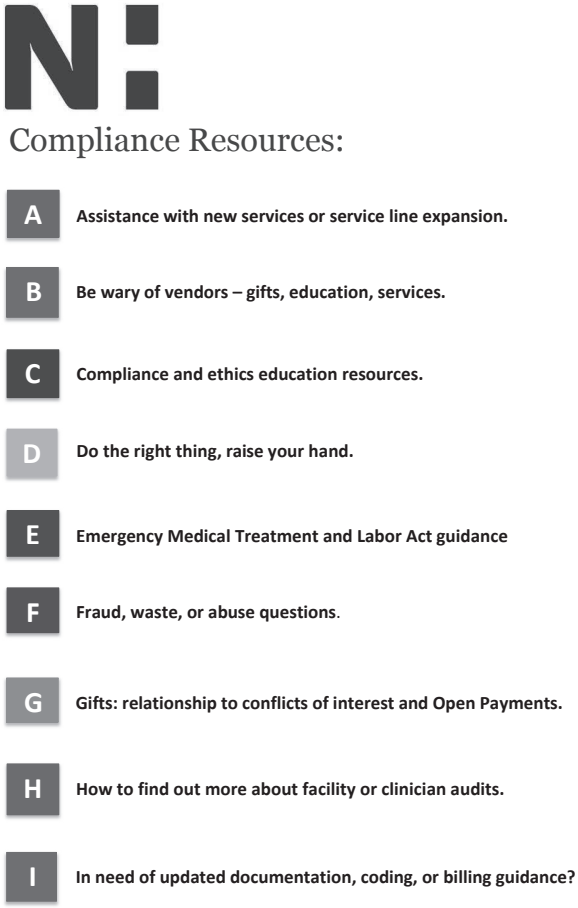
Spreading the Compliance Word

When compliance program managers and compliance educators do "purposeful rounding" at Novant Health (see story, p. 4), they give employees a flyer (below, right) of the ABCs of compliance "ideas to think about," says Loree Simmons, assistant director of compliance. The poster on the left is posted around the hospitals and other entities. Contact Simmons at clsimmons@novanthealth.org.



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(see box, p. 5) and contact cards so they are clear about who to reach out to with concern. "We call this purposeful rounding," Simmons says.

Compliance teamed with the privacy office to add HIPAA to the visits, so there are also privacy questions. For example, they ask employees whether the notice of privacy practices is visible to patients. "We have questions on shred bins and off-site storage," Simmons says. "It's good for team members to see we are working together."

Compliance program managers and educators also look around for signs of noncompliance, such as whether unattended computers are logged.

"You can give that real-time feedback to team members if they don't know where something is," Simmons says. "Show them where it is on the intranet but also catch potential real-time issues if you notice HIPAA concerns."

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The HIPAA Balancing Act: Understanding Disclosures

Trish Manna, corporate compliance officer and director of audit and HIPAA privacy at Greater Hudson Valley Health System in Middletown, New York, distributes this flyer to help employees navigate the HIPAA Privacy Rule (see story, p. 1). Sometimes employees won't disclose protected health information when it's permitted, and they may need reminders that voices carry. Contact Manna at tmanna@ghvhs.org.

HIPAA
DISCLOSURES OF PHI

Healthcare providers are required, under the HIPAA Privacy Rule, to protect and keep confidential any personal health information. Reasonable safeguards should be taken at all times when discussing patient information.

Reasonable safeguards include:

- Avoiding conversations about one patient in front of other patients or their visitors/families.
- Lowering voices when discussing patient information in person and/or over the phone.
- Avoiding conversations about patients in public places, such as elevators, public hallways, or the cafeteria.

The following ***examples*** illustrate how reasonable safeguards should be used to minimize the chance of disclosing patient information to others who may be nearby:

Healthcare staff may orally coordinate services at hospital nursing stations, but should avoid yelling down the hallway or having conversations in areas where patients or visitors/families are standing.

Physicians, nurses or other health care professionals may discuss a patient's condition over the phone with the patient, a provider, or a family member, but should speak quietly.

Physicians, nurses or other health care professionals may discuss a patient's condition face to face with a patient, a provider, or a family member who is permitted to receive this information, but should do so in a private area so as to avoid others from over hearing the conversation.

Healthcare professionals may discuss a patient's condition during training rounds, but should speak quietly and avoid having conversations in public areas where patients and families are present.

Conversations discussing PHI should be conducted in a private area or room, especially when discussions involve highly confidential information. Consider how you would want your patient information discussed in a hospital, and remember to use reasonable precautions.

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The compliance program managers and educators have been well received. "Most folks, once they realized that we weren't there to give audit results or do an investigation, there were smiles," she says. "You're really here just to be helpful. That was really fun. It combats the impression that compliance is always there when something is wrong. It loosens up the conversation. We are just trying to gauge everyone's awareness. People were willing to talk."

On their rounds, they discussed with employees Novant's recently revised non-retaliation policy. Before it updates policies, Novant puts out a draft for comments. The timing was good in this case because the compliance program managers and educators were able to get feedback on their rounds. For example, an employee shared that she felt it was easy to determine the identity of the hotline caller based on certain factors, such as the details reported or the size of the department named. "As a result, the process may not be truly anonymous," Simmons says. "Because our program managers and educators spend time rounding, we can provide just-in-time education to allay team member concerns. In this case, when team members share these kinds of concerns, we can point to our non-retaliation policy."

Contact Simmons at clsimmons@novanthealth.org. ✧

Medical Group Settles HIPAA Case

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Johnson recommends providers make general statements in response to a criticism in the media or online, such as, "We strive to provide the best service to all our patients." She says providers can then reach out to the patient behind the scenes.

"I get why this is hard," Johnson says. While patients are free to put their own information out there, providers must have a written HIPAA authorization to speak about patients. "It's a very human instinct" to want to set the record straight, "but there's no exception for physicians to disclose in response," Johnson says. "This case struck me as a good reminder of how to deal with complaints. You cannot do it in a public forum."

In the Allergy Associates case, the privacy officer told the physician either not to answer the reporter or to say "no comment." But allegedly there was no follow-up with corrective action. That was addressed, however, in the resolution agreement. Allergy Associates, which has four locations, is required to adopt a corrective action plan. The medical group didn't admit liability. Two people from the practice who signed the resolution agreement didn't return *RMC*'s calls for comment.

The parameters of the Privacy Rule have to be continually reinforced, says Trish Manna, corporate compliance officer and director of audit and HIPAA privacy at Greater Hudson Valley Health System in Middletown, New York. But often Manna, like other compliance and privacy officers, are not facing loose lips.

CMS Transmittals and *Federal Register* Regulations
Nov. 16–29

Live links to the following documents are included on *RMC's* subscriber-only webpage at hcca-info.org. Please click on "CMS Transmittals and Regulations."

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update, Trans. 4167 (Nov. 16, 2018)
- Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE, Trans. 4168 (Nov. 16, 2018)
- New Waived Tests, Trans. 4169 (Nov. 15, 2018)
- Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement, Trans. 4170 (Nov. 16, 2018)

Pub. 100-20, One-Time Notification

- Implementation of a Bundled Payment for Multi-Component Durable Medical Equipment (DME), Trans. 2206 (Nov. 21, 2018) -- https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2206OTN.pdf

Pub. 100-19, Demonstrations

- Next Generation Accountable Care Organization (NGACO) Model Post Discharge Home Visit HCPCS, Trans. 215 (Nov. 28, 2018)
- IVIG Demonstration: Payment Update for 2019, Trans. 211 (Oct. 19, 2018, recommunicated Nov. 16)

Federal Register

Final Regulations

- Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program-Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions From the Medicare Shared Savings Program-Accountable Care Organizations-Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder Under the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, 83 Fed. Reg. 59452 (Nov. 23, 2018)
- Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 83 Fed. Reg. 58818 (Nov. 21, 2018)

Instead, employees may not disclose PHI even when HIPAA permits it. "It's a constant education to make sure they don't take HIPAA too far," she says.

Recently, employees at a skilled nursing facility owned by Greater Hudson Valley Health System became alarmed because a patient's husband was threatening her, and her order of protection had expired. "They were saying, 'You can't tell law enforcement because of HIPAA,'" Manna says. "But you would never compromise the safety of the individual," and the Privacy Rule permits disclosures to law enforcement under certain circumstances without the patient's authorization (e.g., to prevent harm to a person or others).

HIPAA Doesn't Require Private Rooms

Manna also recently had a floor nurse ask if it's OK to do discharge planning with a patient in a semi-private room because the other patient may hear. "I think nurses will say it's a HIPAA violation, but I tell them it's an incidental disclosure," she explains. "HIPAA doesn't require us to have private rooms for everybody."

She keeps HIPAA in front of employees with education in employees' emails, on breakroom corkboards, in medical newsletters to physicians, on the intranet and at department presentations. Manna also distributes tip sheets, including one on disclosures (see box, p. 6).

The Allergy Associates settlement is not the first stemming from a disclosure to reporters. In 2013, Shasta Regional Medical Center (SRMC) in California agreed to pay $275,000 and implement a corrective action plan to settle potential violations of the HIPAA Privacy Rule. OCR investigated after an article in the *Los Angeles Times* indicated that two SRMC senior leaders met with media to talk about medical services provided to a patient. "OCR's review indicated that senior management at SRMC impermissibly shared details about the patient's medical condition, diagnosis and treatment in an email to the entire workforce," the press release says.

According to the resolution agreement, for example, "On December 13, 2011, SRMC sent a letter, through its parent company, to California Watch, responding to a story concerning Medicare fraud. The letter described the Affected Party's medical treatment and provided specifics about her lab results. SRMC did not have a written authorization from the Affected Party to disclose this information to this news outlet." Workforce members were not sanctioned for the impermissible disclosures, OCR said.

SRMC didn't admit liability in the resolution agreement.

Contact Johnson at tajohnson@venable.com and Manna at tmanna@ghvhs.org. Visit http://bit.ly/2P9RrAq. ✧

NEWS BRIEFS

◆ **CMS may issue subregulatory guidance in early 2019 that loosens up restrictions on provider-based departments sharing space with freestanding clinics** as long as patient safety and quality of care are not at stake, says attorney Katie Ilten, who said a CMS official revealed CMS's plans in a Nov. 27 webinar sponsored by the American Health Lawyers Association. The CMS official said in the webinar that there may be situations where the agency would not consider shared space, including hallways, waiting rooms and bathrooms, a violation of provider-based requirements (42 CFR 413.53). CMS has long taken a dim view of comingled space *(RMC 5/19/14, p. 1)* and has recouped payments from hospitals because of it. "The possibility of relaxing the prohibition is a positive for flexibility in arrangements. It's also more consistent with the [provider-based] rule, which doesn't expressly prohibit space sharing," says Ilten, with Fredrikson & Bryon in Minneapolis. Allowing co-location "is better for patients and providers." Contact Ilten at kilten@fredlaw.com.

◆ **The Medicare fee-for-service improper payment rate dropped to 8.12% in 2018 from 9.51% in 2017, CMS said.** That's a $4.59 billion decline in estimated improper payments based on claims processed from July 1, 2016, to June 30, 2017. CMS attributes the reduction to "actions to address improper payments in home health and skilled nursing facility claims." Visit https://go.cms.gov/2Qr4a69.

◆ **Vital Energy Occupational Therapy and Wellness Center LLC in South Carolina agreed to pay $200,000 to settle allegations it submitted false Medicare and Medicaid claims for physical and occupational therapy services,** the U.S. Attorney's Office for the District of South Carolina said Nov. 26. The settlement resolves allegations that Vital Energy billed the government payers for individual therapy when group therapy was provided and billed for therapy services under former employees' names and billing numbers when the services were not provided by the former employees, the U.S. attorney's office says. Vital Energy denies the allegations. Visit http://bit.ly/2KQm7Gp.