Report on
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Weekly News and Compliance Strategies on CMS/OIG Regulations, Enforcement Actions and Audits

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Prosecutor Will Reduce Reliance on Whistleblowers; OIG Does Low-Dollar Cases

Whistleblowers probably won't be calling the false claims shots in the state of Maryland anymore, a top federal prosecutor said.

"We have decided we want to develop the cases ourselves," Thomas Corcoran, deputy chief of the civil division in the U.S. Attorney's Office for the District of Maryland, said April 13 at the Institute on Medicare and Medicaid Payment Issues sponsored by the American Health Lawyers Association. The office has had enough of whistleblowers driving the False Claims Act agenda, he contended.

It's possible to adjust the prosecution strategy because of leads generated by data mining, Corcoran said. The U.S. attorney's office has hired people to work on data analysis to identify outliers and aberrant patterns that may indicate the presence of fraud and abuse. There's an advantage to initiating cases and not depending so heavily on whistleblowers, Corcoran said. Because homegrown cases zero in on Maryland providers, they often are more manageable. "A lot of whistleblower cases we were doing" — including device and pharmaceutical manufacturer cases — "were national, with national implications and were more cumbersome," he explained.

The Department of Justice must promptly investigate all federal false claims lawsuits filed by whistleblowers and decide whether to intervene. If there is a settlement or the provider is found liable in a trial after government intervention, whistleblowers receive 15% to 25% of the money. If the government doesn't intervene and there's a settlement, whistleblowers get as much as 30% of the settlement or judicial award.

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MD's Victory in Meaningful-Use Appeal May Be Good Sign in World of Punishing Audits

Wyoming surgeon Razi Saydjari passed his meaningful-use audit with flying colors except when it came to the security risk assessment. He flunked that, according to the auditors hired by CMS to audit physicians and hospitals that had accepted payments to adopt certified electronic health records (EHRs). If they are out of compliance with any of the dozen or so core measures, CMS takes back the entire EHR incentive payment for the audit period. That could have happened to Saydjari, but he won his appeal of the audit, against all odds, according to his attorney, which means the surgeon will keep his $18,000 EHR incentive payment for 2012.

Saydjari's experience captures many of the aspirations and shortcomings of the EHR incentive-payment program. They include the dismay of health care organizations hit by the all-or-nothing nature of meaningful-use audits, the surprising room to maneuver with auditors, the possibility of prevailing during the unconventional CMS appeals process and the persistent gaps in security risk assessments.

The twist in this case is the boost the surgeon got from the successful class-action lawsuit against his EHR vendor, Allscripts Healthcare Solutions, for its alleged

meaningful-use failures — and the related message it carries for health care organizations. "Don't rely on your vendors to keep meaningful use information on their systems," says attorney Richelle Marting, who represented Saydjari and has won a number of meaningful-use appeals. "Have it available and onsite so you can provide it for auditors."

The EHR incentive program, which was created by the HITECH Act in the 2009 stimulus law, uses carrots and sticks to get providers on board with the technology. Hospitals and physicians started receiving money for becoming meaningful users of certified EHRs in 2009 and so far the federal government has given them $40 billion. Penalties kicked in last year. Compliance is audited after the fact, and four types of audits are underway *(RMC 2/15/16, p. 1)*. The pass/fail audits by Figliozzi & Co., the C.P.A. firm hired by CMS, are most feared by hospitals and physicians because CMS recoups the entire incentive payment for that reporting period if there is a failure of any meaningful-use core measure, including security risk assessments.

"The whole process seems corrupt — the way you get an email out of the blue that you have been selected for a meaningful-use audit," Saydjari tells *RMC*. If he had known in 2012, when he signed up for the incentive payment program, that CMS could retrieve the money because of one mistake, the surgeon says he would have paid for the EHR system himself. "Why not take back 10%? I would write a check in a heartbeat. But to take back all the money is unjust and unfair."

And Saydjari says he had all the documentation Figliozzi wanted except the security risk assessment because he thought Allscripts was on top of it. That's not uncommon; security risk assessments are the most common deficiency found in meaningful-use audits, Marting notes. "Auditors seem to be pretty lenient on how you document other measures, but if you can't produce the security risk assessment, it's very difficult to pass that audit and [win] that appeal," she says.

The reason why Saydjari didn't have documentation of the security risk assessment suggested the larger fiasco with the EHR vendor and that played into his successful appeal, she says. When Figliozzi audited Saydjari's meaningful-use compliance, he turned around and asked Allscripts for documentation to prove he had performed a security risk assessment. Saydjari had spent a pretty penny on Allscripts' EHR product, MyWay, and assumed the proof was on its server. As it turned out, everything on the server had been deleted. "That's why he failed the audit," Marting says.

Surgeon Relied on EHR Vendor

That allegedly wasn't MyWay's only problem. "It had a lot of known issues, so it came out with a new platform and upgraded everyone for free," Marting says. "But some people were unhappy because they couldn't go back and access data from the new platform." People like Saydjari were out of luck. "He was under the impression Allscripts was responsible for completing the risk assessment and keeping that on file to be able to produce it in the event of an audit," she says.

Some disgruntled physicians filed a class-action lawsuit against Allscripts, and Saydjari, like many physician practices, signed on. The class-action lawsuit, which began with Pain Clinic of Northwest Florida, described problems with MyWay, an EHR application sold to about 5,000 solo and small physician practices for about $40,000, according to the complaint. MyWay was most often described as "buggy," and allegedly didn't satisfy HITECH meaningful-use criteria, the complaint stated. It was withdrawn from the market in 2012, and some physicians, including Saydjari, are using Allscripts' replacement platform. The lawsuit was settled in late March, with Allscripts shelling out almost $10 million. Saydjari's share was $1,200.

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That left the meaningful-use appeal to CMS, and Marting had doubts about its prospects. "We put together an affidavit [from Saydjari] explaining that Allscripts did a security risk assessment and that Allscripts was to store it on its server, but it was deleted," she says. There was no other proof the security risk assessment was performed, which fortunately means CMS took Saydjari's word for it, she says. The only thing that Allscripts could confirm was that information previously stored on its server was deleted. "I anticipated Medicare would say that if you didn't download it and keep it, you are just as much at fault as Allscripts," Marting says.

But happily for them, Saydjari won his appeal. She attributes this to three things: (1) the class-action lawsuit over the MyWay server; (2) the deletion of everything on MyWay's server; and (3) an email Saydjari received from Allscripts saying it would look into the security risk assessment on the server. "I am seeing more leniency and understanding with the challenges providers face in the program than in the beginning of the audit and appeal process," she says.

One-Shot Appeals Are by Email

The victory came in an April 1 email from CMS's HITECH/EHR Incentive Program Appeals Team. It's the strangest appeals process she has seen in Medicare. Providers submit appeals by email and there's no one to talk to if they have questions or want to submit additional materials. If providers lose, it's one and done. The HITECH Act was vague on the subject; "there's mention of a right to an appeal process, but there is nothing stating a provider only gets one shot. It's the fact that there is nothing saying they get more than one shot that Medicare has relied on in only granting a single appeal opportunity," Marting says.

But the interaction with Figliozzi auditors was heartening compared to earlier experiences with them. They have gotten more receptive to discussions during the process, Marting and others say. "It's not like one shot and you are done," Marting says. "Now Figliozzi usually sends follow-up requests and answers the phone. I have had lots of conversations with their auditors."

That's good news because hospitals and physicians have a better chance of hanging onto their meaningful-use money if they win over auditors than rely on appeals. "The appeals aren't as easy as you would expect," says attorney Brian Flood, with Husch Blackwell in Austin, Texas. "The auditors are being a little more cooperative. They are taking more time to listen and getting used to reading the paperwork and asking better questions. But it's still documentation intensive."

While hospitals and physicians are getting better about performing and documenting their security risk assessments, they're still blowing audits, says Mike Orr, a director at BKD LLP in Waco, Texas. The relevant meaningful-use core measure requires hospitals and physicians to do a risk analysis to "protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities." That includes generating audit logs, ending electronic sessions after a predetermined period of inactivity, encryption and authenticating EHR users.

Orr says some hospitals fail the Figliozzi audit because they don't update their security risk assessment. "You have to have a new security risk assessment for every reporting period you attest to or update a prior period's remediation plan," Orr says. "As long as you can show you are working to update that full security risk assessment, it's OK. But you can't do nothing. This is where people get into trouble." Don't rely on your vendor to do it for you, he cautions. Another way that health systems go wrong is conducting a security risk assessment of the hospital but overlooking their physician practices, Orr says. When Figliozzi asks for evidence that the practice had its security risks evaluated, the health system may come up empty. "Clinics are sometimes an afterthought of bigger hospitals and health systems," he contends.

Orr's advice to hospitals and physicians is to document ad nauseam. It's a lot harder for them to lose a Figliozzi audit if they can put their meaningful-use money where their mouth is.

But don't rely too heavily on vendors to complete your security risk assessments and retain the documentation of this and other core measures. Still, it irks Saydjari how much CMS seems to expect physicians, who are busy with patient care, to delve into the security details. "To suggest physicians would understand encryption and other nuances is absurd," Saydjari says.

Contact Marting at rmarting@forbeslawgroup.com, Orr at morr@bkd.com and Flood at Brian.Flood@huschblackwell.com. ✧

CMS Transmittals and *Federal Register* Regulations

April 8 – April 14

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

Transmittals

- None posted.

Regulations

- None published.

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Critical Care Coding Trips Up Providers, Catches Eye of Auditors

Physicians may assume they can charge Medicare for critical care services because patients are in the intensive care unit or that the opposite is true when patients are on a regular med-surg floor. But there isn't a hard-and-fast rule, a fact that may interfere with critical care billing compliance. Although odds are good that critical care patients will be in the ICU or coronary care unit, critical care services may be provided anywhere. What matters is whether patients meet the definition of critically ill and require high-complexity interventions. If that's the case, compliance will turn on documentation of the minutes physicians spend with patients because critical care is exclusively a time-based code. And it's a high-yield code for physicians, reimbursing more than the top-paying evaluation and management hospital service.

"Requirements for critical care are pretty specific," says Debbie Barnes, senior compliance manager for physicians at Optum360 in Mesa, Ariz. "It can be rendered anywhere," as long as physicians are performing medically necessary interventions (e.g., intubation). But time is of the essence. Medicare pays physicians based on the number of minutes they spend with critical care patients, and they must interact the entire time. Medicare, Medicare Advantage, private payers and recovery audit contractors (RACs) have their eye on critical care, denying claims when the minutes don't add up, says Julie Ward, vice president of revenue cycle quality and compliance at Optum360.

RACs also will deny one claim when two physicians in the same specialty from the same medical group bill a critical care code on the same calendar day for the same patient, says attorney Richelle Marting, with the Forbes Law Group in Overland Park, Kan. "One thing that may cause a lot of denials is that only one provider can report one critical care per day, when multiple providers in a group have seen the patient that day," she says. "That has created a lot of administrative challenges." There are RAC-approved audits on this, which is frustrating because it means one of the physicians from the same group won't get paid even though the patient may require two critical care services in the same calendar day, Marting says.

Medicare pays for critical care with CPT codes 99291 and 99292 (see box, below). They represent services provided by physicians to critically ill or critically injured patients. "A critical injury or illness acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition," according to Medicare Transmittal 1548 (Change Request 5993). By definition, critical care requires high complexity medical decision making to treat or prevent organ failure and/or "life-threatening deterioration of the patient's condition."

MDs, NPPs Do Critical Care But No Split Bills

Physicians (and nonphysician practitioners) must spend 30 minutes or more with the patient to charge Medicare for 99291, and the coding gets more complicated from there. That means direct, one-on-one management of the patient. Physicians can't count the minutes they are looking at the computer or talking to nurses. The minutes, however, can be "intermittent and out of order," as long as the physician reports only the minutes actually spent treating and managing the care of the patient, she notes (see Chapter 12 of the *Medicare Claims Processing Manual*).

How would this play out? During an eight-hour period, the physician may be in and out of the room treating other patients while providing two hours of face-to-face time to the critical care patient. In that scenario, only two hours counts toward the critical care — which, again, is the only E/M service that's exclusively time-based, Barnes says.

In a recent audit, Barnes says the physician documented 65 minutes of critical care and coded 99291 and 99292. The physician had spent 25 minutes personally performing CPR on the patient and did a good job documenting the services. "But it was inappropriate because you can't include the time spent performing CPR,"

Understanding the Use of Critical-Care Codes

Coding for critical care, a time-based code, is confusing and may be the source of errors in your organization. The box below appeared in Medicare Transmittal 1548. Visit http://tinyurl.com/z7sajgr.

Total Duration of Critical Care Codes	
Less than 30 minutes	99232 or 99233 or other appropriate E/M code
30 – 74 minutes	99291 x 1
75 – 104 minutes	99291 x 1 and 99292 x 1
105 – 134 minutes	99291 x1 and 99292 x 2
135 – 164 minutes	99291 x 1 and 99292 x 3
165 – 194 minutes	99291 x 1 and 99292 x 4
194 minutes or longer	99291 – 99292 as appropriate (per the above illustrations)

SOURCE: CMS

Barnes says. "Physicians can bill for one unit of critical care — 99291 — and they can bill CPR as a separate procedure. Any time spent doing CPR procedures has to be excluded from the critical care time." Conversely, Ward says, critical care includes many procedures that are not separately billable (e.g., nasogastric intubation, ventilator management).

It's also important to convey to physicians they must perform interventions that are medically necessary, such as defibrillating patients in atrial fibrillation or monitoring a deteriorating dialysis patient in acidosis. If compliance officers or coders have any doubt about why physicians charged critical care or related procedures, they can clarify by submitting a query form, Barnes says. She uses a documentation tool to help them think through the requirements for critical care documentation (see box, below).

Barnes adds that time spent with patients by residents in teaching hospitals doesn't count in terms of adding up critical care minutes. Also, only the physician or NPP counts critical-care minutes per patient in terms of crossing the 30-minute threshold. In other words, "a split/shared E/M service performed by a physician and a qualified NPP of the same group practice (or employed by the same employer) cannot be reported as a critical care service," CMS says in Chapter 12 of the *Medicare Claims Processing Manual.*

Some Procedures Can't Be Billed Separately

Another risk with critical care is billing Medicare separately for services, such as vascular access procedures and ventilator management, that should be bundled, Marting says. "If coders don't realize that, you may get a lot of denials," she notes.

She also worries about the definition of critical care, which seems fairly subjective. What exactly would be considered a "high probability of imminent or life threatening deterioration in the patient's condition," as set forth in the transmittal? Marting adds there's a disconnect between the way clinicians speak and the language required to report a critical care code. If you're worried noncompliance is lying in wait, consider using similar standards for high complexity decision making that you use for other evaluation and management services, Marting says. Further, document thought processes that would explain the anticipated risk to the patient's condition.

Then there is the problem with Medicare administrative contractors denying the subsequent claim when two of the same specialists from the same practice provide critical care services on the same calendar day. "It's driving doctors crazy," she says.

Marting suggests physician groups and, if relevant, their hospital owners consider the following:

◆ Do medical groups know whether another provider billed critical care for a patient on a particular day?

◆ If so, is the physician who is providing the subsequent critical care service in the exact same specialty?

◆ If not, do concurrent care rules apply that would allow both providers to report their services separately?

◆ When the critical care isn't billable, can the medical group use regular hospital visit codes?

◆ Have practices and/or hospitals considered how this affects internal provider productivity reports? "This has been a big issue for our clients," Marting says. "If productivity appears low based on work relative value units, there may be issues with fair market value compensation of physicians."

Visit Ward at julie.ward@optum360.com, Barnes at deborah.barnes3@DignityHealth.org and Marting at rmarting@forbeslawgroup.com. View the transmittal at http://tinyurl.com/z7sajgr. ✧

Check-Off List for Providing Critical Care Services

Here is a tool to help improve documentation of critical care, according to Debbie Barnes, senior compliance manager with Dignity Health in Mesa, Ariz. She distributes this to physicians and coders. "The goal is for them to think through the requirements," Barnes says. Contact her at deborah.barnes3@dignityhealth.org.

- Are one or more vital organ systems acutely impaired?
- Is there a high probability of imminent or life threatening deterioration?
- Is the medical decision making (MDM) of high complexity?
- Does the MDM assess, manipulate and support the vital organ system?
- Would the failure to initiate these interventions on urgent basis result in sudden, clinically significant or life threatening deterioration in patient's condition? (CMS)
- It is the criticality of the patient plus the actions documented by the physician (mantra).
- Three requirements:
  _____ Time
  _____ Medical criticality
  _____ Interventions

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Prosecutor Wants to Drive Agenda

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Their share of the recoveries was increased in 1986 False Claims Act amendments, and so were the penalties, which are now $5,500 to $11,000 per claim on top of treble damages. The rewards have attracted more whistleblowers, who have exposed more complicated frauds. Whistleblowers are pretty much driving DOJ's agenda, but the whistleblower explosion has had unanticipated consequences, as Deputy Assistant Attorney General Joyce Branda recently pointed out (RMC 11/2/15, p. 1).

Former federal prosecutor Robert Trusiak, however, doesn't see it this way. "Whistleblowers don't drive the False Claims Act agenda," says Trusiak, who is a principal at Health Care Compliance Solutions in Buffalo, N.Y. "Whistleblowers file cases investigated by the U.S. attorney. The U.S. attorney, through intervention or declination of the whistleblower action, drives the agenda." Anyway, he says, "so what?" What's the downside to whistleblowers leading the way to medically unnecessary short inpatient stays, for example, which, Trusiak says, saves taxpayers millions of dollars? "Is it in any way a bad thing that whistleblowers drove an agenda resulting in the discovery and False Claims Act liability for pernicious and unlawful hospital/physician relationships, as in the Tuomey Healthcare System, Halifax Health, Children's Hospital and dozens of other Stark/False Claims Act settlements?" As far as he's concerned, whistleblowers supplement federal investigators with insider knowledge that can't come from data alone. "Whistleblowers are designed to be partners with the federal government and provide valuable and meaningful insight into fraud that would otherwise go undiscovered due to its invisibility to data mining and complexity," Trusiak contends.

In fact, data mining can only go so far. He agrees that data mining is a very useful investigative tool, but it has limitations in terms of proof and the type of fraud. "Data provides only a basis to investigate and secure explanations," Trusiak contends. For example, there's no proof of fraud in the fact that a provider bills the highest level of evaluation and management codes exclusively. The proof exists in the medical records and witness testimony. "It seems to matter little whether the witness is a whistleblower or fact witness who is not a whistleblower," he says. More significantly, there's not much that data can accomplish in certain circumstances, Trusiak says. "Data mining is a fine tool to identify outliers or upcoding by plotting billing conduct against peers. Data mining, however, has no value in identifying such important fraud settlements as Stark violations," he contends. "Stark is

How CMS's Medicare Part B Payment Model Could Transform the Pharma Landscape

- How are Medicare Part B drugs paid? Where are they provided? What does Medicare spend on them? And how would all this change under the proposed model?
- Why has CMS proposed these changes? What is the agency expecting to achieve? What would be the impact of the Part B Drug Payment Model on overall Medicare expenditures?
- To what extent would the value-based purchasing strategies in Phase II conflict with ongoing efforts from private payers?
- What would be the potential impact of the ASP add-on change proposed for Phase I on drug reimbursement for the physician office and the non-340B hospital outpatient and 340B hospital outpatient settings? What would be the impact on pharmaceutical manufacturers? On patients?
- What has the reaction from the physician and patient community been to the proposed experiment?
- How should different stakeholders change their business practices in response?

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based on the existence of a financial relationship between the physician and hospital — a fact invisible to data mining."

Corcoran described the two types of "predicates" for false claims liability:

◆ ***Claims that are false on their face.*** That includes providers billing for services they didn't perform or items they didn't deliver.

◆ ***Claims that aren't flat-out false,*** but the provider has violated a separate statute, regulation or contractual term that is a condition of payment. The "underlying violation" makes the claim false or fraudulent, Corcoran explained. These claims are "not factually false," he said, "but these are just as righteous." They include false claims from violations of the anti-kickback statute, Stark self-referral law and Food, Drug & Cosmetic Act.

Watershed Moment: Implied Certification

Extending this further is the theory of implied certification under the False Claims Act now under review by the U.S. Supreme Court. It will hear arguments the week of April 19, said Washington, D.C., attorney Laura Laemmle-Weidenfeld, with Jones Day, at the AHLA conference. Under the implied certification theory, the mere submission of a claim for payment carries with it the assurance that the claimant has complied with all conditions for payment, even if it has not expressly certified compliance *(RMC 12/14/15, p. 5)*. The case before the Supreme Court involved services provided in a mental health clinic. If the Supreme Court says "no" to implied certification, "it could dramatically change enforcement practices," she said. "It could be a watershed moment."

The U.S. courts of appeal for various circuits are divided on the application of the implied certification theory and often analyze FCA cases on the basis of whether the underlying statute or regulation is a "condition of payment" or a "condition of participation." Most federal circuit courts have ruled that, if the underlying statute or regulation is a "condition of participation," no FCA liability attaches. The FCA can go forward only if the court finds that statute or regulation is a "condition of payment." Even where the circuit courts recognize implied certification, the application of the theory varies. In the appeal to the Supreme Court, the appellant, Universal Health Services, challenges the U.S. Court of Appeals for the First Circuit's holding that the underlying Massachusetts regulation governing mental health services reimbursed by Medicaid was a condition of payment, and therefore plaintiff Julio Escobar's allegations satisfied the state FCA requirements (*Universal Health Services, Inc. v. Escobar*, No. 15-7). Escobar alleged that the care provided to his daughter, who subsequently died, was provided by unlicensed, uncertified and unsupervised providers at a satellite facility owned by Universal Health, which violated the state regulatory requirement that "[s]ervices provided…are reimbursable only if the program meets the standards" of proper supervision.

Although Corcoran's office is trying to originate more of its own cases, the whistleblower phenomenon will not go away anytime soon, in Maryland and everywhere else. Corcoran described the "emergence of the new whistleblower," including consultants and auditors hired by health care organizations. Whistleblowers also count in their ranks competitors, physicians and compliance officers. If attorneys come forward, he turns them away. "It's too hot for me to handle because of attorney-client privilege," Corcoran said.

In terms of enforcement actions, providers shouldn't think they are home free because their violation cost Medicare or Medicaid only a couple of bucks. If the HHS Office of Inspector General thinks a case has merit, it will pursue it, even if the dollar value is relatively small, said Geoffrey Hymans, senior counsel in the OIG, at the conference. "There is a perception you have to bill $200,000 to get the attention of the OIG. That's not true anymore," he said. "We are pursuing cases of lower value. There's no lower bound for fraud and abuse."

Hymans is part of OIG's new 10-attorney litigation team, which focuses exclusively on civil monetary penalty and exclusion cases *(RMC 7/27/15, p. 1)*. They fill in some of the enforcement gaps that result from the Department of Justice's (DOJ) pursuit of larger-dollar or major patient-harm cases *(RMC 7/20/15, p. 4)*. "It's a niche practice," Hymans said. "We pick and choose cases carefully," with an emphasis on supporting certain "overarching goals" (the work of other OIG components, including the Office of Audit Services and Office of Evaluations and Inspections). The litigation team is working to resolve cases faster — within a year. "We also try to support DOJ," he said.

'Culpable' Individuals Are Accountable

That includes the implementation of DOJ's Yates memo *(RMC 2/29/16, p. 1)*. In a policy change announced in September 2015, DOJ said it won't settle civil and criminal corporate fraud cases unless corporations cough up names of "culpable" individuals, who will be held accountable *(RMC 12/14/15, p. 1; 9/14/15, p. 1)*.

The number of exclusions and dollars recovered in CMP cases has been steadily rising since 2012, Hymans noted. In 2012, OIG imposed 3,131 exclusions and collected $15.1 million. Last year, there were 4,112 exclusions and $66.9 million in CMP settlements.

Contact Hymans through OIG spokesman Donald White at Donald.white@oig.hhs.gov, Laemmle-Weidenfeld at lweidenfeld@jonesday.com and Trusiak at robert@trusiaklaw.com. ✧

NEWS BRIEFS

◆ **PremierTox 2.0, Inc., which provides drug urine screening services, paid $2.5 million to settle false claims allegations that were first lodged by the former CEO turned whistleblower,** the U.S. Attorney's Office for the Middle District of Tennessee said April 11. The company was accused of submitting false claims to Medicare and to the Kentucky and Tennessee Medicaid programs. The U.S. attorney's office alleged that PremierTox and Nexus, which was the name it did business under in Tennessee, submitted three types of false claims between September 2011 and June 2014. First, PremierTox allegedly had a swapping arrangement, which involved Nexus giving discounts on urine drug screening to Tennessee patients who lacked insurance in return for physician referrals of Medicare and TennCare patients to Nexus. Second, in Tennessee, Nexus allegedly billed Medicare and TennCare for lab tests that weren't always medically necessary. Third, in Kentucky, "PremierTox provided point of care testing cups to medical offices free of charge to induce those providers to use PremierTox's services," the U.S. attorney's office alleged. Visit http://tinyurl.com/hd69h8n.

◆ **Saint Louis University Hospital in Saint Louis, Mo., was overpaid $119,000, according to a Medicare compliance review.** The HHS Office of Inspector General audited 261 claims submitted to Medicare in 2011 and 2012 by the 356-bed teaching hospital and found errors on 18 of them. The errors included failure to report manufacturer credits for replaced medical devices; admissions that should have been billed as outpatient or observation services; separate claims for discharges and related admissions on the same day; and incorrectly coded claims that affected MS-DRG payments. In its written response, Kate Dunn, a hospital compliance officer for Tenet Healthcare, which owned the hospital during the audit period, said the hospital agreed with OIG's findings, and described its coding and compliance measures. Visit http://go.usa.gov/ctW8Y.

◆ **OIG published its annual Compendium of Unimplemented Recommendations,** which is its list of the top 25 reforms that would serve HHS best in terms of saving money and/or improving quality "and should, therefore, be prioritized for implementation." *Among them*: OIG suggests reducing hospital outpatient payment rates for ambulatory surgical center-approved procedures to ASC payment rates, which would save Medicare and beneficiaries billions of dollars. CMS says this requires legislation. *Another recommendation*: implementing a hospital transfer payment policy for early discharges to hospice. *One more:* changing the way coinsurance is calculated at critical access hospitals. Visit http://go.usa.gov/cteZJ.

◆ **MedStar Health on March 28 alerted the public via Facebook and Twitter that it had temporarily suspended its networks to prevent the spread of a virus.** The hospital did not confirm that the virus was a ransomware attack, but claims its initial analysis showed that no protected health information (PHI) had been accessed. MedStar said in late March it had reached 90% functionality. Ransomware is a growing threat to hospitals, but the more they do "defense in depth," the more likely hackers will move on to more vulnerable organizations *(RMC 3/14/16, p. 1)*. For more information, visit http://tinyurl.com/jloxnj3.

◆ **Maryland physician Paramjit Singh Ajrawat was sentenced to more than nine years in prison for health care fraud, making a false statement related to a health care program, obstruction of justice, wire fraud, and aggravated identity theft related to the pain clinic he owned with his wife,** the U.S. Attorney's Office for the District of Maryland said on April 11. In June 2014, a federal grand jury indicted Ajrawat, who specialized in interventional pain management, and his wife, psychiatrist Sukhveen Kaur Ajrawat, both of Potomac, on charges related to Washington Pain Management Center in Greenbelt *(RMC 6/30/14, p. 8)*. They were convicted in September 2015, but the government dismissed the charges against her after her death on Feb. 1, 2016, the U.S. attorney's office said. According to the indictment, from August 2008 through May 2014, the Ajrawats allegedly defrauded Medicare, Medicaid, TRICARE, the Federal Employees Health Benefits Program and the Office of Workers' Compensation Programs, the U.S. attorney's office said. They allegedly submitted claims for more expensive procedures than were actually performed or were not performed in compliance with reimbursement requirements. For example, the indictment alleges that Paramjit Singh Ajrawat injected patients with lidocaine but billed for epidurals. Visit www.justice.gov/usao/md.

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