Report on
MEDICARE COMPLIANCE

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Anonymous Email Over IRO Is Challenge for Broward Health; Board Tries to ID Sender

An anonymous email complaint should have been business as usual for the compliance program at Broward Health in Fort Lauderdale, Fla., but it has been a bit of a setback for the public hospital district as it tries to get out from under several investigations and move forward with a corporate integrity agreement (CIA). Board members wanted to identify the author of the email rather than address the substance of the email, which targeted the integrity of an outside auditor and the behavior of general counsel, the compliance officer tells *RMC*.

"I have never seen that happen and I have been in compliance for more than 15 years," says Donna Lewis, chief compliance and privacy officer for Broward Health. "The compliance department receives anonymous allegations on a routine basis, and it's standard practice to investigate them. I have never seen a compliance complaint take up so much time from a governing body." The anonymity of employees who report potential compliance problems is considered sacred and organizations are required to enforce non-retaliation policies. Lewis says the outrage over the board's attempt to out the email's author distracted Broward Health "from a governance perspective" and from its "focus on maintaining the integrity of the compliance program, so some of the trust was eroded at the top. It sparked concerns from our workforce."

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CMS Changes the Billing for Outpatient Therapy Tied to C-APCs, Observation

CMS has given outpatient therapy a new name — "non-therapy outpatient department services" — and upended the way it's billed when therapy is provided with comprehensive APCs (C-APCs) and observation services, according to Medicare Transmittal 3523. Starting July 1, hospitals should not report physical, speech or occupational therapy with CPT codes when C-APCs or observation are on the claim, CMS said in the July 2016 update to the outpatient prospective payment system (OPPS). Instead, hospitals should use revenue code 0940 (other therapeutic services).

There are linguistic and logistical problems with this new policy, says Valerie Rinkle, president of Valorize Consulting. "The language is almost comical," she says. "I think CMS is trying to dance on the head of a needle because outpatient therapy is supposed to be paid under the Medicare physician fee schedule." That used to include therapy provided during observation and therapy that was integral to certain outpatient procedures. But in the 2015 OPPS regulation, CMS introduced C-APCs, which are a big step in the march toward a true prospective payment system. C-APCs are packaged payments for all hospital services covered by Medicare Part B, including labs, radiology, an overnight stay, meals and drugs. There are now packaged payments for 34 C-APCs — up from 25 in 2015 — within nine clinical families, as well as packaged payments for certain ancillary services that are integral, supportive, dependent or adjunctive to a

primary service *(RMC 11/16/15, p. 4)*. Observation is its own C-APC (8011), and includes a single payment for labs and radiology, as well as the visit itself, as long as patients spend eight hours there after a physician order for observation services, there is no surgery and the time is medically necessary.

The full-fledged kind of outpatient physical, speech and occupational therapy provided under a plan of care continues to be paid under the Medicare physician fee schedule when billed on a repetitive monthly claim. But when therapy is provided as part of a C-APC or observation, no plan of care is required because it's considered supportive or adjunctive, Rinkle says. For example, if the surgeon resets a patient's broken ankle and then calls for a physical therapy assessment of the patient's ability to walk with a cast with metal balls on the bottom, that would be included in the C-APC payment, she says.

Since they don't receive separate payments for outpatient therapy when C-APCs or observation is on the same claim, hospitals asked CMS to give them "administrative relief" from functional reporting for outpatients, Rinkle says. Status G codes for therapy describe the patient's mobility, body posture, self-care and other indications of the patient's functional status. CMS was trying to accommodate this request, Rinkle says. In the 2016 final OPPS rule, CMS said the requirement for functional reporting doesn't apply to outpatient therapy services provided with C-APCs or observation.

"But that was regulatory preamble language," Rinkle says. The problem is, CMS didn't change the claim edits. "When hospitals reported therapy services with therapy CPT and revenue codes on the claim, they were told they have to have functional status G codes on the claim."

CMS Fix 'Seems Convoluted'

Hospitals pointed out the problem and Rinkle says CMS appears to be trying to correct it. "But what they have done is more confusing to hospitals," she says — and CMS's fix seems "convoluted." The transmittal pretends therapy is something else and does what seems like an end-run around the statute that requires therapy to be billed to the Medicare physician fee schedule. Just because payment for therapy in these circumstances is packaged doesn't mean the services are no longer therapy.

The transmittal says "non-therapy outpatient department services (that are similar to therapy services) that are adjunctive to a comprehensive APC procedure (status indicator (SI) = J1 procedure) (see 80 FR 70326) or the specific combination of services assigned to the Observation Comprehensive APC 8011 (SI = J2), should not be reported with therapy CPT codes. This includes services described at 1833(a)(8), namely outpatient physical therapy, outpatient speech-language pathology and outpatient occupational therapy furnished either by therapists or non-therapists and included on the same claim as a comprehensive APC procedure. Non-therapy outpatient department services that are adjunctive to J1 or J2 procedures should be reported without a CPT code and instead should be reported with Revenue Code 0940 (Other Therapeutic Services). The status indicator for this revenue code will be changed from SI=B to SI=N, indicating that the payment for these services will be packaged into the C-APC payment."

Conforming to the transmittal will require hospitals to set up new charges in their chargemasters because therapy has to be reported to Medicare with revenue code 0940, Rinkle says. This won't apply to patients with other insurers. It's another hassle because hospitals have to instruct their therapists to report differently when delivering services as part of the C-APC or observation.

Rinkle wonders what would happen if hospitals disregarded the transmittal and continued to report outpatient therapy with CPT and revenue codes even when delivered with C-APCs and observation along with the functional status codes. "You don't know if they will put

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in edits to reject the revenue and CPT codes if hospitals report in a way that makes sense," she says. Also, for APC rate setting, charges billed with revenue code 0940 can't be matched up to the cost centers with therapy expense, which compromises the principles of rate setting, she says.

Rinkle's advice: "For the time being, report therapy services as they have been doing so, and question CMS about this." They also should ask the American Hospital Association's *Coding Clinic* and maybe the American Health Information Management Association about the propriety of CMS changing the rules for reporting outpatient therapy.

But one attorney says CMS's instructions trump guidance in any CPT coding book or other coding manual, such as *Coding Clinic*. "If CMS says you must bill this way, then for Medicare claims, you must bill this way," says the attorney, who asks not to be identified. In fact, the National Correct Coding Initiative Policy Manual for Medicare Services states that physicians follow CPT guidelines when submitting claims only when they don't conflict with Medicare guidelines. "The hard part is the hospital has to know whether or not the individual is under a plan of care. It's not immediately apparent," he says. While the language in the transmittal — non-therapy outpatient department services — is a little odd, there is some basis in the Social Security Act for it. If patients are not receiving therapy under a plan of care and hospitals are providing it "of their own accord, I could argue they are non-therapy services," he says. It seems like CMS is trying to "get everyone on the same page and paid appropriately," but there are problems with claims being bounced.

Contact Rinkle at valerie.rinkle@valorizeconsulting.com. For more information, view the transmittal at http://tinyurl.com/zfdl6l5. ✧

N.J. Hospital Settles Case Over Medically Unnecessary Procedures

A hospital in Newark, N.J., has agreed to pay $450,000 to resolve false claims allegations that it billed Medicare and Medicaid for medically unnecessary cardiac procedures, the U.S. Attorney's Office for New Jersey said on May 31.

Saint Michael's Medical Center billed for percutaneous coronary interventions, catheterizations, and stents performed in its cardiac catheterization lab that allegedly were not medically necessary between Jan. 1, 2009, and Jan. 1, 2015, the U.S. attorney's office said.

The procedures were performed by six physicians and billed under codes G0290, 92980, 92982, 92920, 93454, 92928, 93508, 93458, 93510, 93455, 37205, 92933, 92921, 93459, 93526, and 78452. The lawsuit originated with a whistleblower but is still under seal.

Saint Michael's filed a voluntary petition for bankruptcy protection under Chapter 11 in August 2015, according to the settlement. In November 2015, the U.S. Bankruptcy Court for the District of New Jersey authorized the sale of Saint Michael's to Prime Healthcare Services – Saint Michael's, which, according to the settlement, is a subsidiary of Prime Healthcare Services, a nonprofit with 36 hospitals in 11 states.

Saint Michael's did not admit liability in the settlement.

Visit http://tinyurl.com/h5nuxtr. ✧

Accountability Should 'Follow Risk' To Comply With the Stark Law

When the CEO of Memorial Health, Inc. in Savannah, Ga., tried to reduce the compensation of three employed physicians because it allegedly was above fair-market value, the board fired him. The CEO, Philip Schaengold, filed a false claims lawsuit against Memorial Health and its affiliates —Memorial Health University Medical Center, Provident Health Services, Inc., and Memorial Health University Physicians (MHUP) — alleging they violated the Stark law. The Department of Justice intervened, and the health system settled for $9.8 million in December 2015.

The case represents something essential about Stark compliance: Contracts must have an out clause for reasons beside a material breach, says former federal prosecutor Robert Trusiak. "You need the ability to reset on a semi-annual basis" if problems with physician compensation are identified, he says. "You can restructure that pay and reduce it rather than having to live with it until the end of a three-to-five year contract." A reset button may mean the physician practice isn't profitable on day one, and the hospital may still be paying more than what it collects through CPT codes compared to what it pays physicians in work relative value units (RVUs), but at least there is an opportunity to get back in the Stark comfort zone, says Trusiak, a principal in Health Care Compliance Support in Buffalo, N.Y.

There are more Stark compliance lessons in the Memorial Health case and other recent ones. Memorial Health University Medical Center was under a three-year certificate of compliance agreement (CCA), a less burdensome version of a corporate integrity agreement, when it entered into the physician contracts at the center of the $9.8 million settlement. The CCA, which was imposed by the HHS Office of Inspector General, stemmed from a 2008 false claims settlement, also related to alleged Stark violations involving physician payments, for $5 million.

continued

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This time around, the focus was on MHUP's acquisition of a physician practice, Eisenhower Medical Associates, and the employment of its three physicians in June 2008, according to the complaint in intervention filed by the U.S Attorney's Office for the Southern District of Georgia. One of the physicians had a base salary of $415,000 and was eligible for incentive compensation depending on his work RVUs, as well as a quarterly bonus. His annual compensation was capped at $830,000.

As a result of the Eisenhower Medical Associates deal, MHUP experienced losses of $1.1 million in 2009 and $1.4 million in 2010. That's mainly why the employment of the physicians after their practice acquisition at that compensation rate wasn't commercially reasonable, the complaint alleged. But there was another motivation in mind. "The Board, as well as senior leadership of Memorial and MHUP, expressly considered the volume or value of referrals to Memorial Hospital when making physician compensation decisions," the complaint alleged.

CMS Transmittals and *Federal Register* Regulations

May 27 – June 2

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

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- Annual Update of the ICD-10-CM, Trans. 3532CP, CR 9677 (May 27; eff. Oct. 1; impl. Oct. 3, 2016)
- July 2016 Update of the Ambulatory Surgical Center Payment System, Trans. 3531CP, CR 9668 (May 27; eff. July 1; impl. July 5, 2016)
- Payments to Home Health Agencies That Do Not Submit Required Quality Data, Trans. 3533CP, CR 9651 (May 27; eff./impl. Aug. 30, 2016)
- JW Modifier: Drug Amount Discarded/Not Administered to Any Patient (R), Trans. 3530CP, CR 9603 (May 24; eff. July 1; impl. July 5, 2016)

Pub. 100-08, Medicare Program Integrity Manual

- Medical Review of Skilled Nursing Facility Prospective Payment System Bills, Trans. 651PI, CR 9571 (May 27; eff./impl. June 28, 2016)
- Pub. 100-22, Medicare Quality Reporting Incentive Programs Manual
- Payments to Home Health Agencies That Do Not Submit Required Quality Data, Trans. 57QRI, CR 9651 (May 27; eff./impl. Aug. 30, 2016)

Federal Register Regulations

Final Rule, Correction

- Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, 81 Fed. Reg. 34909 (June 1, 2016)

When Schaengold took the reins of Memorial Health in June 2009, he ordered a review of losses at Memorial. That included hiring an independent reviewer to determine whether physician salaries were fair-market value. After learning they were allegedly above fair-market value — beyond the 90th percentile — senior management approached the physicians about accepting new compensation terms, according to the complaint. The answer was "no." In July 2010, Schaengold told MHUP to give the three doctors 180-day termination notices.

But Schaengold allegedly wasn't getting anywhere in trying to adjust the compensation, and the April 2011 deadline to submit a CCA report to OIG loomed. The CCA required Memorial Health to report matters "'that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health program for which penalties or exclusion may be authorized,' including the Stark Statute," the complaint said.

So the CEO allegedly suggested to the chairman of the board that Memorial Health hire new outside legal counsel to prepare the CCA report, which would include a disclosure of the above-fair market value compensation. "Forty-eight hours later, the Board terminated Mr. Schaengold's employment," the complaint alleged.

Memorial Hospital went on billing Medicare allegedly in violation of Stark for services referred by the three physicians. In 2014, Schaengold filed the whistleblower lawsuit and the U.S. attorney's office intervened.

Executive Rewards Affect Compliance

The Memorial case shows that "Stark compliance requires accountability to follow risk," Trusiak says. "If there is a divorce where the business development personnel making the deal doesn't have to live with the deal and manage the risk, it doesn't matter how much Stark education you have and it doesn't matter whether you have the compliance officer coming to the board annually or monthly. You increase the risk of Stark noncompliance to the extent accountability doesn't follow risk." That means the CEO and CFO should have their hands in fair-market value assessments and commercial reasonableness from the inception of the contract, he says. "If they don't make economic sense from the beginning, from the government's perspective, hospitals are paying for referrals," Trusiak says. "If you're paying $66 per work RVU but only collecting $56 per work RVU, that's a loser. You want someone fine-tuned to that sensitivity."

He also doubts Stark compliance will improve unless hospitals change the way they reward executives, Trusiak says. "You need to incentivize Stark compliance rather than incentivizing noncompliance," he says. He points to All Children's Hospital, All Children's Health System

and Pediatric Physician Services in St. Petersburg, Fla., which settled a whistleblower case for $7 million in 2014. The false claims lawsuit was filed by Barbara Schubert, who was director of operations for Pediatric Physician Services from 2008 to 2011. She developed a physician compensation model designed "to keep salaries and benefits in line with industry norms," Trusiak says. Base pay would be above the 25% percentile but no more than the 75% percentile of fair-market value ranges, according to three salary surveys, Trusiak says. The hospital board approved the model.

But 80 physicians were hired through 2011, and one third of them were paid above the 75th percentile, according to the lawsuit. The hospital allegedly needed referrals partly because it was breaking ground on a new $400 million facility, according to the complaint. The two executives of All Children's Health System who oversaw the hiring — the former CEO and a vice president — were generously rewarded for their efforts, the lawsuit alleged.

"All Children's had a great policy and a forward-thinking compliance officer, but it needed revenue to finance construction so the [executives] allegedly made sweetheart deals and were incentivized through bonuses," Trusiak says. "Stark education had nothing to do with these violations. It had everything to do with having the wrong incentives and accountability not following risk." The Department of Justice didn't intervene in this lawsuit.

Contact Trusiak at robert@trusiaklaw.com. ✧

Wild World of Pricing and Charges Is Confusing, Invites Risk for Providers

Pricing in other industries generally doesn't require as much hashing over laws, regulations and contract language as it does in health care. The upside is that providers may have more room to maneuver when it comes to pricing and discounts than they think, one lawyer says. But they have to walk a careful line to avoid running afoul of the anti-kickback statute and other laws.

"Pricing has not been one of the health care industry's shining moments," says Minneapolis attorney David Glaser, with Fredrikson & Byron. "It's just confusing."

One of the most disputed areas is whether providers can charge different prices for different patients. "The knee-jerk reaction is no," he says. That's correct on legal grounds like race and gender, "but you can discriminate on other bases." It's perfectly legal to have different prices for different payers, Glaser says. But be careful, because "an inconsistent process has collateral consequences." In different payer contracts, it's easy for payers to insert language saying providers can't discriminate. "In pricing there are usually two issues, the law and your contract, or, if you don't have a contract, the terms of the implied contract," Glaser explained.

It should be written in neon that it's not true providers have to give Medicare the lowest rate. Hospitals and other providers are allowed to bill Medicare differently than they bill other payers without running afoul of regulators. Medicare pays the lower of actual charges (i.e., the bill you send), the fee schedule if there is one, or your usual and customary charge. "Medicare says the usual and customary charge is your 50th percentile charge. There is a median charge, a mean charge and a mode charge. If you charge one guy $10, one $11, one $50 and one $100, then $50 is the median, and that is what Medicare will pay you if it's lower than the actual charge and the Medicare fee schedule," Glaser says. "You can give a discount without lowering what you receive from Medicare as long as half your patients are charged more than Medicare."

Throw in private payers and life gets more complicated. For example, physicians may charge Humana $75 for an exam and Blue Cross and self-pay patients $70. But when automobile insurance or workers' compensation companies are footing the bill, the physician's price may be the full rate of $100. These insurers may object and argue that even if they lack a contract with physicians, auto insurers and workers' comp have an implied contract, and take their argument to court, Glaser says. "The contention will be that $100 is not reasonable if everyone else pays around $75," he says. "If they challenge the rate, they will probably prevail if they are the only one paying the higher rate."

Although it varies by state, some payer contracts have most-favored-nation clauses that require providers to give the payer the lowest price. Some states, such as Minnesota, prohibit those clauses. Obviously, it's a good idea to know what's in your contracts, Glaser says.

Medicaid Usually Pays the Least

Also, variable prices are fine for services, but not necessarily goods. "When selling things, it's harder to have different prices" for different payers because of the Robinson-Patman Act, which forbids price discrimination for goods. So be extra careful if you are selling goods, he says.

Whether Medicaid charges have to be rock bottom depends on the state. Some states require providers to charge Medicaid their lowest prices. Other states play by different rules. In Minnesota and elsewhere, providers must bill Medicaid for the usual and customary charges, which they define as the amount that providers charge most often. Other states replicate Medicare rules. "You

have to know what your state does, but it's more common to have Medicaid say it will be the lowest payer," Glaser notes.

There's also a question of whether providers can charge patients more than they are reimbursed by commercial insurers. The answer is it depends. If providers have a contract with the insurer, the answer is almost certainly no. If there's no contract, charge away — but remember, there's that concept of an implied contract.

Providers that participate in Medicare can't charge patients anything beyond coinsurance for a covered service, says Glaser. "If you are designing a concierge service, you must be very careful to be sure you aren't charging for covered services. Phone calls to patients are covered, even though Medicare doesn't separately reimburse for them." If providers don't participate in Medicare, they are stuck with the "limiting charge" — 15% over Medicare's approved amount. With Medicaid, the rules, of course, vary state by state, "but very few allow you to charge patients more," Glaser says.

In the private-payer arena, providers often wonder whether they can give a break to out-of-network patients and charge them the same as in-network patients. "It's an extremely controversial issue," says Glaser, adding "I am nervous about waiving out-of-network charges. Insurers want networks to mean something so they expect you to collect the fee." If insurers pay 80% of charges for in-network patients and providers write off copays, then on a $100 bill, the insurer feels it should only pay $64, which is 80% of $80. However, "there is at least one court case from New Jersey that comes out the other way," Glaser says. A court ruled against HealthNet of New Jersey in a dispute over copay waivers at a surgery center (Health Net of New Jersey, No. A-2430-07T3 (N.J. Super. Ct. App. Div. Oct. 5, 2009)). "That decision surprised me."

Medicare is more clear-cut. There is a civil monetary penalty for beneficiary inducements, which means the HHS Office of Inspector General can fine providers for offering remuneration that could influence the patient's selection of services. Also, if providers waive patients' copays with the intent to get their business, they may be violating the federal anti-kickback statute, and many states have comparable laws. "If you waived the copay because the patient waited 45 minutes in the waiting room, I feel OK about that," Glaser says. "I can't point to a legal provision, but it's unlikely anyone will get mad at you." But he doesn't recommend advertising copay waivers.

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Providers often wonder if they can give free services to their employees. "One thing I hate about this is if you give free care to employees, you are saving the employee copays but you are saving the insurer far more so there is part of me that thinks that makes no sense," Glaser says. If providers feel uncomfortable accepting copays from employees, ask the insurance company in writing if it's OK to bill for the services without charging copays, he suggests. Or collect employees' copays, put them in a jar and use it to benefit all the employees — "have a party or use it to provide free care for the poor or some other charitable purpose," Glaser says.

You have to be more circumspect about offering free services to physicians. "An anti-kickback analysis looks at intent," he says. If you open the patient's chart and it says "don't charge him, he's a good referral source," that could theoretically be enough to support a kickback allegation. It may be OK under the Stark law because there is a professional courtesy exception, as long as certain criteria are met.

Also, recognize that there is risk in giving patients prompt-pay discounts. "On a consumer level, it sounds good," Glaser says. Rewarding patients for paying in cash seems fair because you save on billing. "But it's perilous to give prompt-pay discounts." First, a 5% same-day discount can be characterized as a 5% interest charge for one day. Second, if you characterize the discount as "savings because you don't have to bill," you may run afoul of contracts that ban billing charges.

What about informing patients about prices? "This is usually driven by state law," Glaser says. In some states, providers must give patients a "good faith estimate" of what providers expect to be paid. When that's not the case, Glaser says it may be worth doing because it's less likely people will be annoyed if there's no surprises.

Contact Glaser at dglaser@fredlaw.com. ✧

Email Challenges Broward Health

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Then there was the complaint itself, which was tied up with Broward Health's ongoing problems. About nine months after paying $69.5 million to settle a false claims case over alleged Stark violations *(RMC 9/21/15, p. 1)*, Broward Health is 10 months into its CIA, and two officials from the HHS Office of Inspector General were onsite June 1 and 2 to do a review. But the CIA hit a snag because of that email, which complained about the independent review organization (IRO) hired by Broward Health as part of the CIA requirement to look at physician arrangements. The email complained the IRO

was not truly independent and is "being prosecutorial," Lewis says. As a result, Broward Health "is bringing in an independent entity to investigate the allegations" in the email. "IROs must be objective, remain independent and should not be involved in or make operational decisions. They provide a work plan of what they are going to review and a timeline and a list of documents needed to complete the review. They can't cross any boundaries," Lewis explains. OIG is aware of "all matters going on at Broward Health" and if problems are identified with the IRO, either the public hospital district or OIG can terminate the IRO contract.

The board's pursuit of the email sender's identity was troubling. At a board meeting in late May, an employee from the compliance department spoke about its attempts to identify the person rather than request an investigation of the allegation, Lewis says. The employee essentially told the board that the CIA is an opportunity for the organization to wipe the slate clean and that it starts with the governing body. "They set the tone of the culture of the organization," she says. "We don't retaliate and we want to know about issues."

Anonymous Complaints 'Can Be Dangerous'

Tracking down the source of anonymous complaints "can be dangerous," although it's human nature to want to know who's criticizing you or your department and why, says former Department of Justice attorney Peter Anderson, with Beveridge & Diamond in Washington, D.C. "We all work with people who have incredible credibility. What they say you can take to the bank. We also work with people who tend to be chicken little or wrong or they are rumor mongers," he says. "In an ideal world, it would be great to know who said what to evaluate the bias and whether they are technically qualified to render conclusions, but in the compliance world it's far better to focus on what's being said and looking into it."

Approaching people who file reports anonymously even to just have a conversation is playing with fire. "An attempt to establish a dialogue might be viewed as intimidation and in the anti-retaliation environment you have to maintain, it can be dangerous," he says. "It can have a chilling effect."

Sometimes executives take it very personally when employees lodge complaints. "One of the things I have learned about compliance programs is you need to have a thick skin," Anderson says. "You have to respond whenever a pitch is thrown. People view allegations as a negative thing, but I view the free flow of information as a healthy scenario more than people not talking at all. It's better to have communication open."

Executives will say they shut down their hotline because it wasn't useful; 90% of the complaints were about bathrooms without toilet paper or people parking in reserved spots. But turning off the hotline is a big mistake.

"The value of those systems is not a function of the accuracy of the information. What it reflects is the culture of openness and the willingness to listen," Anderson says. "Even if only about one in 30 calls is worth listening to, it is the fact you have an open vehicle for communication." Anyway, organizations have hotlines willingly or not. "It's called the FBI or HHS. The question is whether you want employees to use yours and have the ability to show transparency, or want them to go externally and stir up trouble that may not be accurate," he says.

Broward Health is still facing an FBI investigation unrelated to the false claims case, as well as a contracts review by the state Inspector General and the Florida governor in March suspended two board members *(RMC 3/28/16, p. 1)*. One of the board members later resigned and has now been replaced. The former CEO, Nabil El Sanadi, M.D., committed suicide in January, but Broward Health has an interim CEO, Pauline Grant. "Our acting CEO is fully committed to the health system and patient care and the physicians and getting us back on track," Lewis says. "She has done an amazing job of ensuring the leadership team is cohesive and accountable and we haven't seen that in a year and a half. Politics has a shelf life and hopefully it will expire soon."

OIG spokesman Donald White says that over the years, OIG has removed "a handful of IROs," according to attorneys in the Office of Counsel. "That would be based on a judgment by our Office of Counsel having to do with the IRO's competence or independence," he says. There have also been times when entities under a CIA changed their IROs. OIG has 30 days to veto a change in IRO.

OIG was not addressing Broward Health specifically.

Broward Health had no comment on the email's allegations about the general counsel, but a spokeswoman says it is "committed to addressing all allegations."

Contact Lewis at dlewis@browardhealth.org and Anderson at panderson@bdlaw.com. ✧

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NEWS BRIEFS

◆ **Physician Jonathan Oppenheimer, former owner and CEO of OURLab, a drug-testing lab in Nashville, and OPKO Health, Inc. and OPKO Lab, LLC have agreed to pay $9.35 million to resolve false claims allegations over donations of electronic health record (EHR) systems to physicians, the U.S. Attorney for the Middle District of Tennessee said on June 1.** Oppenheimer also agreed to be excluded from Medicare and other federal health programs for five years. OPKO is a successor to OPKO Lab, which bought OURLab from Oppenheimer in December 2012, after OURLab and Oppenheimer started the alleged conduct, according to the U.S. attorney's office. OPKO Lab stopped operating in early 2016 and doesn't bill federal programs anymore. The lawsuit alleged that Oppenheimer and OURLab submitted false claims to Medicare Part B by violating the Stark and anti-kickback laws, which stemmed from their donations to EHR systems bought by physician-clients, the U.S. attorney's office said. OURLab and Oppenheimer supposedly contributed to the EHR purchases under a Stark exception and safe harbor to the anti-kickback law, which allowed labs to help a physician practice purchase an EHR system between 2006 and 2013, when drug testing labs were dropped from the provisions. "Although these provisions allowed certain entities to contribute up to 85% of the purchase price of an EHR system to a vendor on behalf of a physician's practice, they placed certain restrictions on such activities," the U.S. attorney's office said, and OURLab and Oppenheimer allegedly "fell outside of the restrictions" set forth in the safe harbor and Stark exceptions. "This laboratory traded physicians free computer software for patient referrals," said Derrick L. Jackson, special agent in charge at the HHS Office of Inspector General in Atlanta. Visit http://tinyurl.com/hsugyep.

◆ **Paradigm Spine, a medical device manufacturer, agreed to pay $585,000 to resolve false claims allegations that it caused providers to bill Medicare improperly for spine surgeries "by marketing the company's coflex-F® device for surgical uses" that were not FDA-approved from 2011 to 2013, the U.S. Attorney's Office for the District of Maryland said on May 27.** The manufacturer also settled allegations that it caused false claims by "giving false recommendations on how to code health claims for procedures involving the company's coflex® device" from 2012 to 2015, the U.S. attorney's office said. Consequently, hospitals and physicians allegedly submitted false claims to federal health care programs for certain spine procedures that weren't reimbursable. The lawsuit was originally filed by a former Paradigm Spine sales representative. Paradigm Spine did not admit liability in the settlement. The case is *United States ex rel. Charles Coyle v. Paradigm Spine, LLC, et al.*, Case No. DKC-14-CV-2086 (D. Md). Visit http://tinyurl.com/jlax935.

◆ **The HHS Office of Inspector General posted its latest semi-annual report to Congress, which summarizes the activities of the OIG for the previous six months.** The report, which covers the period ending March 31, 2016, says OIG expects recoveries of $2.77 billion, including almost "$554.7 million in audit receivables and about $2.22 billion in investigative receivables." Also, OIG reported 428 criminal actions against people or entities; 383 civil actions, which include false claims and unjust-enrichment lawsuits and civil monetary penalty settlements; and 1,662 Medicare exclusions of people or entities. Visit http://tinyurl.com/z222mf6.

◆ **The owners of a Washington, D.C., home health agency were sentenced to prison in connection with a fraud scheme that cost Medicaid $80 million, the US. Attorney's Office for the District of Columbia said on June 1.** Florence Bikundi, a former nurse, and her husband, Michael D. Bikundi, Sr., owners of Global Healthcare, Inc., were found guilty by a jury on Nov. 12, 2015, of health care fraud, money laundering and other charges. Florence Bikundi was sentenced to 10 years in prison and Michael D. Bikundi, Sr., was sentenced to seven years in prison by U.S. District Court Chief Judge Beryl A. Howel. She previously ordered them to forfeit $11 million seized from 76 bank accounts, as well as their home, $73,000 in cash and luxury cars. Florence Bikundi was using her maiden name of Florence Igwacho in 1999 when the Virginia Board of Nursing revoked the nursing license of Florence Igwacho, the U.S. attorney's office said. Then the HHS Office of Inspector General excluded her from Medicare and Medicaid in March 2000. But Bikundi, who married Michael Bikundi in September 2009, hid that information when she applied for a Medicaid provider number for Global Healthcare in June 2009, the U.S. attorney's office said. They billed Medicaid for personal home health aide services that weren't fully provided, dummying time sheets, patient files and employment files, according to the U.S. attorney's office. Visit http://tinyurl.com/joe7rtb.

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