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

Contents

Publisher's Note

RMC will not be published for two weeks. The next issue will be dated January 7, 2019.

Happy holidays!

HCCA

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In Negotiating Hospital Self-Disclosure Over Supervision, OIG Adds MA to FFS Overpayments

Milton S. Hershey Medical Center in Pennsylvania agreed to pay $382,074 to settle allegations it billed Original Medicare, Medicare Advantage (MA) and TRICARE for outpatient radiology services that were performed without the personal supervision of a physician, according to a new civil monetary penalty (CMP) settlement that began with a submission to the HHS Office of Inspector General's Self-Disclosure Protocol (SDP). It's unusual for MA claims to be resolved through the SDP, but hospitals should brace for this, according to the attorney who represented the hospital.

OIG alleged that Hershey Medical Center's employed radiologists didn't personally supervise the imaging provided by employed radiology assistants (RAs) from Jan. 26, 2011, through July 16, 2018. Most of it was fluoroscopy, which is a type of imaging that shows a continuous X-ray image on a monitor, says Washington, D.C., attorney Mark Fitzgerald, who represents the hospital. The radiologists were providing direct supervision, which means they were immediately available to help patients if necessary—"on the floor of the hospital"—but were supposed to provide personal supervision, which means "at the bedside," he says.

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DOJ Moves to Dismiss 11 FCA Suits With Same Relators Alleging Nurse Educators Are Kickbacks

Instead of just bowing out, the Department of Justice (DOJ) on Dec. 17 asked federal courts around the country to dismiss 11 whistleblower lawsuits filed against pharmaceutical manufacturers that were "spearheaded by a professional relator" and funded by venture capital. DOJ doesn't buy into the False Claims Act (FCA) allegations against the pharmaceutical manufacturers—that they used free nurse educators to induce physicians to prescribe their drugs in violation of the Anti-Kickback Act—and contends the whistleblowers got information for the lawsuits "under false pretenses," according to motions to dismiss the complaints, which are largely driven by data gathering rather than information from insiders, such as executives and physicians, lawyers say.

"It's a thunderbolt coming from the Department of Justice," says former federal prosecutor David Schumacher, with Hooper, Lundy & Bookman in Boston. "It deals these cases a substantial blow. This is not an attractive fact pattern to DOJ, which traditionally wants to see true insiders" rather than "research firms," he says. "The company was created for the purpose of being a relator, and they want human beings."

But whistleblower attorney Peter Chatfield says FCA lawsuits shouldn't necessarily be dismissed based on how information was obtained and by whom. "The one thing the False Claims Act recognizes is sometimes you need the help of rogues to catch rogues," says Chatfield, although he isn't saying that's the case here. "Whistleblowers need not always be insiders or transparent about their motives. Context matters."

continued

The 11 complaints were filed against 38 defendants, including AstraZeneca Inc., Amgen LLC and Biogen, in seven judicial districts, "each raising substantially the same allegations under the FCA," DOJ said in a memorandum of support to dismiss the complaint against Amgen. DOJ earlier this year declined to intervene in the lawsuits.

The case against AstraZeneca, for example, was filed on Sept. 1, 2017, by SCEF LLC and Lynne Levin-Guzman and Stanley Jean. DOJ said SCEF was created solely to serve as a relator in the case by Venari Partners LLC, which does business as National Healthcare Analysis Group (NHCA Group). NHCA Group is made up of limited liability companies that were formed by investors and former Wall Street investment bankers, according to the motion to dismiss the complaint against AstraZeneca.

The motions asked the various courts to dismiss the complaints against the pharmaceutical manufacturers because they "lack sufficient merit to justify the cost of investigation and prosecution and otherwise [are] contrary to the public interest."

Dismissals of whistleblower cases were expected because DOJ has a new policy of asking judges to throw out cases that lack merit rather than simply not intervening in them. In a Jan. 10 internal memo, Michael Granston, director of DOJ's civil fraud section, said "the department should consider moving to dismiss where a *qui tam* complaint is facially lacking in merit—either because relator's legal theory is inherently defective or relator's factual allegations are frivolous" *(RMC 2/5/18, p. 4)*. The memo, which was sent to lawyers in the commercial litigation branch, also described six other factors that should be used as a basis for dismissal of whistleblower cases (e.g., they're "opportunistic").

When DOJ doesn't intervene, whistleblowers may move ahead on their own. When cases are dismissed, they're dead (at least in terms of false claims submitted to federal health care programs). Seeking dismissal of 11 of them on the same day caused some buzz. "We are seeing the Granston memo in action," Schumacher says.

Complaint Alleged 'White Coat Marketing'

DOJ has several concerns about the pharmaceutical FCA lawsuits. They have to do with the substance and procedure of the complaints, Schumacher says, and their potential to suck up too many DOJ resources.

According to the complaint against Amgen, which also names other companies, including Ashfield Healthcare LLC and Express Scripts Holding Company, Amgen paid millions of dollars to Ashfield and others to employ nurse educators for "white coat marketing." The idea was nurse educators would have better luck than pharmaceutical sales reps getting time with physicians. "Defendants are paying Nurse Educators—medical professionals—to promote Amgen products under the guise of providing providers and patients with 'education,'" the complaint alleged. In return, physicians allegedly were expected to write prescriptions for Amgen medications. "Not surprisingly, Amgen also saw its drugs sales increase each time a Nurse Educator was deployed," the complaint alleged. Because of the "schemes," pharmacies submitted Medicare and Medicaid claims that were "tainted by kickbacks," the complaint alleged.

NHCA Group filed "sweeping allegations of nationwide misconduct" that for Medicare Part D alone involve more than 73 million prescriptions written by hundreds of thousands of physicians for millions of beneficiaries.

In the motion to dismiss the AstraZeneca complaint, which mirrors the other motions to dismiss, DOJ talked about the business model of the whistleblowers. Quoting a 2017 article from *Wired*, a technology magazine, DOJ said NHCA Group investor John Mininno explained that when CMS "made vast amounts of Medicare claims data available to the public, he viewed it as 'a massive business opportunity,' specifically with regard to *qui tam* suits."

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To get information for the whistleblower lawsuits, NHCA Group uses a database of résumés from public sources to identify "potential informants," according to the motion. "It then contacts these individuals under the guise of conducting a 'qualitative research study' of the pharmaceutical industry, offering to pay each witness for their participation in a standardized interview session. NHCA Group uses this information obtained under false pretenses to prepare *qui tam* complaints filed by its shell company relators."

DOJ: Cases Are Not Worth the 'Immense Cost'

NHCA Group holds itself out as a health care research company and tells witnesses they're doing a study on the effectiveness of the pharmaceutical manufacturer's investment in nurse educators, the motion alleges. "Notably, the witnesses are not told that the interviewer is acting at the direction of attorneys to collect information that will be used in lawsuits involving the witnesses' current or former employers, nor are they told that they will be named as corroborating 'witnesses' in those lawsuits."

The False Claims Act empowers the attorney general to dismiss a complaint over the whistleblower's objection. How much DOJ has to justify its request depends on the appeals court's interpretation. In *United States ex rel. Swift*, the U.S. Court of Appeals for the D.C. Circuit ruled that DOJ is free to dismiss just because it can. In *United States ex rel. Sequoia Orange Co.*, the U.S. Court of Appeals for the Ninth Circuit said there has to be a "rational relationship" for dismissal but "recognizes in assessing that relationship that the United States has broad prosecutorial discretion to dismiss even meritorious *qui tam* cases if the reasons for dismissal are rationally related to a legitimate government interest," the motion states.

DOJ argued in its motions that the NHCA Group's complaints pass both the *Swift* and *Sequoia Orange* tests for dismissal. After an extensive investigation and consulting with the HHS Office of Inspector General on safe harbors and industry guidance, "the government has concluded that further expenditure of government resources is not justified."

'It Leaves The Industry Scratching its Head'

DOJ also said the allegations conflict with the government's health care "policy and enforcement prerogatives." For example, the complaints allege that free patient education is a kickback. "But given the vast sums the government spends on the medications at issue, federal healthcare programs have a strong interest in ensuring that, after a physician has appropriately prescribed a medication, patients have access to basic product support relating to their medication, such as access to a toll-free patient-assistance line or instructions on how to properly inject or store their medication. In another context, HHS-OIG has advised that the provision of educational materials or informational programs to patients, without more, does not constitute 'remuneration' See 81 Fed. Reg. 88368-01 at 88396 (Dec. 7, 2016)," the motion contends.

Schumacher thinks it's "extraordinary" for DOJ to say there's no merit in the allegations that nurse educators are sales reps in disguise, at least in this complaint. "It's striking because of OIG's oft-stated concerns with white-coat marketing in the context of health care professionals having contact with beneficiaries," he says. "It leaves the industry scratching its head where the lines are."

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Chatfield understands DOJ's misgivings about the whistleblower's information-gathering methods, although "we don't know all the facts." But the FCA allows much worse, with DOJ sometimes working with whistleblowers who participated in the fraud, which isn't alleged here. "The mere fact someone doesn't have clean hands is not enough to automatically exclude them as long as they are bringing information of real value and don't violate other laws or rules of ethics," says Chatfield, with Phillips & Cohen in Washington, D.C.

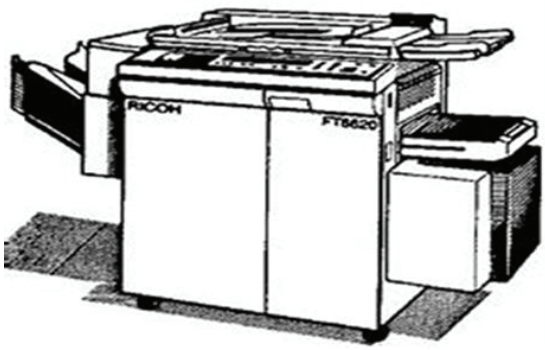
The prognosis of FCA lawsuits driven by data whistleblowers is uncertain. "If you are not bringing special insight beyond analyzing the data in a certain way that reveals only a potential for fraud, that is not insider information the FCA was intended to try to get to," Chatfield says. "It's not really knowledge with particularity about a specific fraud. It's more a suspicion, and DOJ has a legitimate interest in not having its resources hijacked for very large investigations that may or may not be fraud." However, there may be very sophisticated, data-driven FCA cases that uncover clear evidence of fraud by specific entities, he says.

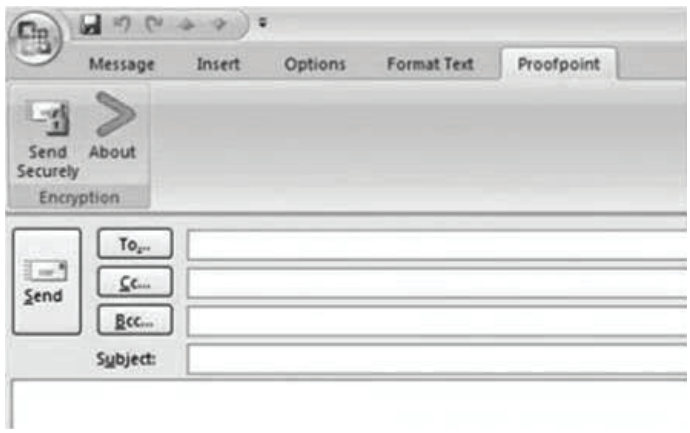
Another data-driven FCA complaint is pending now against Providence Health & Services in Renton, Washington *(RMC 9/10/18, p. 4)*. Integra Med Analytics LLC of Austin, Texas, used statistical analysis of

Raising Compliance and HIPAA Awareness With Monthly Tips

When an employee from the health information management (HIM) department at Stormont Vail Health in Topeka, Kansas, was scanning a document into a medical chart, she realized that the physician office—which was responding to a request for information from a life insurance company—had scanned the requested part of the medical records on the hospital's copier and emailed it directly from there. As a result, the email, with patient information, went out unencrypted. After the employee realized the copier doesn't encrypt emails, the employee reported that to Barbara Duncan, HIPAA privacy officer at Stormont Vail Health. Episodes like this are prime material for monthly tips, and she turned it into a teachable moment. Duncan emailed all employees a reminder that emails generated at the copier aren't encrypted and should be forwarded to their computer to send securely from there (see below). "If there is anything that comes to our attention privacy wise, I come up with a HIPAA tip and email it once or twice a month," Duncan says. Compliance Officer Christine Hogan-Newgren does the same for compliance issues. Contact Duncan at bduncan@stormontvail.org and Hogan-Newgren at choganew@stormontvail.org.

Be careful when emailing from the copy machine!
Emails from copy machines do not encrypt.





To protect the privacy of your patients, email the document to yourself, forward to the appropriate party and make sure you click on the "Send Securely" button on the left side of your tool bar.

Medicare data to allege that Providence added "unsubstantiated" major complications and comorbidities (MCCs) to increase its MS-DRG reimbursement, egged on by a consultant.

So far, in the NHCA Group's pharmaceutical lawsuits, a federal judge in Boston on Dec. 18 threw out the whistleblower's case against Biogen at its request, a day after DOJ filed its motion to dismiss, Schumacher says. Meanwhile, state attorneys general in states where the whistleblower lawsuits were filed did not join DOJ's motions to dismiss, so the complaints could proceed, but they would be limited to Medicaid false claims.

Contact Schumacher at dschumacher@health-law.com and Chatfield at peter@phillipsandcohen.com. ✧

Compliance Ground Will Shift if Court Decision Invalidating ACA Is Upheld

The grounds of compliance and enforcement could shift because of the Dec. 14 court decision invalidating the entire Affordable Care Act (ACA) by Judge Reed O'Connor from the U.S. District Court for the Northern District of Texas. Along with creating the health insurance exchanges and expanding Medicaid, the ACA has a multitude of compliance, enforcement and related provisions that will be DOA if the court decision is affirmed on appeal. They include the 60-day Medicare overpayment return requirement, the Physician Payments Sunshine Act, the hospital pricing transparency requirement, 501(r) regulations for nonprofit hospitals and new authorities for Medicare watchdogs.

Now what? Attorneys say nothing changes while the court decision, *Texas vs. United States*, is appealed, presumably to the U.S. Court of Appeals for the Fifth Circuit and then the U.S. Supreme Court, which may or may not hear the case. O'Connor denied the plaintiffs' request for an injunction that would have stopped the entire ACA in its tracks (for now), and HHS announced it would implement and enforce the ACA pending the outcome of an appeal.

"The obvious takeaway is that until we get a final decision affirming O'Connor's ruling, the 60-day rule and every other provision of the ACA and every implementing regulation that stems from it remain the law of the land," says attorney Christopher Kenny, with King & Spalding in Washington, D.C. "No one should think they [don't] have to meet their obligations under the ACA because even under the terms of O'Connor's ruling, the law still remains operative on appeal."

To recap, briefly: 20 Republican state attorneys general (AGs) on Feb. 20 asked the judge to throw out the entire ACA, arguing it can't stand without the tax penalty on people who don't buy health insurance, which was zeroed out in the 2017 Tax Cut and Jobs Act. The judge agreed, and went so far as to declare that the rest of the law must fall because it can't be severed from the individual mandate, Kenny says. On Dec. 18, in response to a request by 17 Democratic attorneys general (AGs), O'Connor issued an order confirming the ACA remains in effect nationally while his decision is appealed, according to the American Hospital Association. O'Connor ordered an expedited briefing on the appeal, AHA said, giving the Republican AGs until Dec. 21 to respond and the Democratic attorneys general until Dec. 26 to reply.

So hospitals and other providers should keep on keeping on. "There is no change right now in what providers are required to do, and I think anybody who claimed this ruling as a defense to not comply would find it has no persuasive effect on the enforcement authorities," Kenny says.

ACA Is Full of Program Integrity Measures

Attorneys have doubts that O'Connor's ruling will be affirmed on appeal or that the sweeping health reform law will be completely swept away. "This is one district court in Texas and the reasoning—particularly the reasoning of extending the ruling to all of those aspects of the ACA—is not very likely to be upheld," says Ankur Goel, an attorney with McDermott Will & Emery in Washington, D.C. "The notion is that the mandate was the linchpin for the law, and if the mandate is gone, then the other provisions must fall because that's what Congress intended. As we know, many of the provisions have no relationship to the mandate or individual market or insurance reforms, so it's not likely to be upheld." It's hard to predict what the courts will do, and it could take a year or two to find out. "But if I were going to Vegas to play a bit, I don't think the entire law will be invalidated," Kenny says.

If the ACA walls come tumbling down, however, what would it mean? There are countless provisions that have nothing to do with insurance. A lot of them are program integrity measures, and some put new obligations on hospitals and other organizations, while others gave CMS, the HHS Office of Inspector General (OIG) and the Department of Justice more authority to go after Medicare fraud, waste and abuse. For example, the ACA requires providers to report and return overpayments 60 days after they are identified, and empowers OIG to levy civil monetary penalties for knowing retention of an overpayment *(RMC 10/29/18, p. 1)*. The Physician Payments Sunshine Act, which requires pharmaceutical and medical device manufacturers to report to CMS certain payments and other transfers of value to physicians and teaching hospitals, and then requires CMS to make the payment information available in a

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public, searchable online database, came from the ACA *(RMC 6/4/18, p. 4)*. CMS got the authority to suspend Medicare and Medicaid payments to providers during investigations of a "credible allegation of fraud" from the ACA, which also gave CMS more tools to keep high-risk providers out of Medicare and Medicaid. For example, CMS now periodically imposes a six-month enrollment moratorium on new providers of certain types (e.g., home health, ambulance) in certain geographic areas. The ACA also enhanced Medicare and Medicaid enrollment screening requirements, and it made compliance programs a condition of enrollment, although CMS never issued implementing regulations except for skilled nursing facilities.

The ACA added Sect. 501(r) to the Internal Revenue Code, which obliges nonprofits to meet higher standards in return for their tax-exempt, charitable status (e.g., nonprofit hospitals must conduct community health needs assessments at least once every three years and implement a financial assistance policy and emergency medical care policy). The hospital price transparency requirement also comes from the ACA, although CMS has overstepped in interpreting the provision in the eyes of some hospitals and attorneys (*RMC 10/15/18, p. 1; 12/10/18, p. 8*).

Still other ACA provisions fall generally under compliance, such as Sec. 1557, which prohibits discrimination based on race, color, national origin, sex, age or disability, and requires hospitals to provide a qualified interpreter to limited English proficient patients (*RMC 9/19/16, p. 1; 3/19/18, p. 3, 5*).

The list goes on.

What Happens if the ACA Disappears?

All the architecture could disappear if O'Connor's court decision stands. "How do you unwind all these provisions? Some of these principles have become so embedded," Goel says. Maybe Congress would put them back in place. The jury is out, although anti-fraud, waste and abuse measures are usually bipartisan and not that heavy a lift, relatively speaking.

There's a possibility Congress would enact the program-integrity parts of the law all over again. Nicole Tieman, press secretary for Sen. Charles Grassley (R-Iowa), the architect of the Physician Payments Sunshine Act, said "It's unclear what might happen with the courts, and since the legal outcome is unknown, it would be premature to speak specifically to what action Congress would take. But Sen. Grassley has supported legislation to protect pre-existing conditions, and if the courts were to strike down those or any other provisions Sen. Grassley has championed, he would of course work to fix the problem."

If O'Connor's decision is affirmed and the ACA evaporates, Kenny is confident Congress will take up an insurance-market stabilization bill, which could be a vehicle to revive some of the popular provisions of the ACA, including some compliance, enforcement and transparency requirements. He thinks the 60-day rule probably will be revived, and maybe Congress could add some clarity around definitions of identifying an overpayment, for example. The reporting obligations under Sec. 501(r) also "will likely be reinstituted in some way," and the same goes for the Physician Payments Sunshine Act. "The one wild card is that even though there is bipartisan support for a lot of these individual provisions, it is unclear if the parties will be able to get to that kind of agreement because they have such profound disagreements about health insurance coverage. Other popular provisions could simply become casualties of that fundamental dispute," Kenny explains. But he thinks hospitals should forget about recovering the Medicare payment cuts that the ACA used to fund insurance subsidies.

Long term, if the ACA goes down, Goel and Kenny contend that CMS and OIG may be able to jury-rig authorities from existing statutes and regulations. For example, "there have been previous proposed rules requiring providers to return overpayments even before the ACA," Goel notes. And a law unrelated to the ACA—the Fraud Enforcement and Recovery Act—subjects providers to the False Claims Act if they retain overpayments. "While we built this compliance architecture around [the ACA], even if it vanishes, you still can't keep money you are not entitled to," Kenny says.

Contact Kenny at ckenny@kslaw.com and Goel at agoel@mwe.com. ✧

TRICARE Changes Its Mind, Proposes Coverage of OTA, PTA Therapy Services

In the wake of a crackdown on billing by hospitals and other providers for physical therapist assistants (PTAs) and occupational therapy assistants (OTAs), TRICARE has done a 180 and is opening the door to reimbursement for services provided by OTAs and PTAs. A Dec. 20 proposed regulation said TRICARE would cover services provided by OTAs and PTAs to improve access for its beneficiaries.

"This rule proposes to extend coverage of PT and OT services, as required by NDAA-18, to include services provided by licensed or certified physical or occupational therapy assistants operating under the supervision of a TRICARE-authorized physical therapist or occupational therapist," the Department of Defense noted in a proposed rule published in the *Federal Register*.

The proposed rule says TRICARE would pretty much follow Medicare in terms of billing and supervision requirements. OTAs and PTAs must be licensed and certified, and services will be billed under a TRICARE-authorized occupational/physical therapist.

The supervision requirements are the same as Medicare, although they're setting-specific. In private-practice settings, PTAs and OTAs are subject to direct supervision, and in most other settings, they're subject to general supervision.

"They are taking definitions that are already established," says Nancy Beckley, president of Nancy Beckley & Associates in Milwaukee, Wisconsin. "But it's interesting they note that for direct supervision, the physical therapist must be in the room." In Medicare, direct supervision means the PT or OT must be in the office suite; personal supervision requires their presence in the room, Beckley says. "Medicare doesn't require them to be in the room" for direct supervision, she says.

TRICARE Had Warned of Fraud

If finalized, the regulation will come as a relief to hospitals that were billing TRICARE for services provided by PTAs and OTAs, Beckley says. Last year, the American Occupational Therapy Association warned its members that TRICARE was taking a strict interpretation of regulations on the use of OTAs. "Until recently, the American Occupational Therapy Association (AOTA) believed that TRICARE's non-coverage of OTA services applied only in private practice and freestanding clinics, but TRICARE has recently stated that it applies in all settings. TRICARE is interpreting the regulations very strictly, and it is our understanding that under recent new contracts, TRICARE contractors are beginning to enforce these restrictions and demand repayment. For these reasons, we advise that only occupational therapists should treat TRICARE patients, not OTAs. This also applies to patients with TRICARE as secondary insurance, so it is important to determine a patient's coverage as soon as possible. TRICARE policy staff has advised that 'if services were provided by an OTA and billed by an OT, that would be fraud.'"

TRICARE's 2017 position on billing for PTAs and OTAs "has caused substantial problems for affected therapists that practice in communities with a high military family presence" (e.g., Florida, Virginia and Texas), Beckley says. "It's a reality. The process is starting, and for everyone who has OTAs and PTAs in their facility, they're encouraged to comment on the rule."

Contact Beckley at nancy@nancybeckley.com. View the rule at http://bit.ly/2R9Fyzd. ✧

Hospital SDP Resolution Includes MA

continued from p. 1

Supervision of outpatient radiology was on Hershey's radar because of an Oklahoma hospital's 2017 false claims settlement, which "percolated through the professional radiology community," says Fitzgerald, with Powers Pyles Sutter & Verville. "It brought awareness to the issue." Norman Regional Health System and a former senior vice president agreed to pay $1.6 million to settle allegations that it billed Medicare for radiology procedures performed by radiology practitioner assistants (RPAs) without personal supervision, as required by Medicare *(RMC 4/24/17, p. 1)*. Six physicians also were held accountable for the alleged false claims, and they had to pony up part of the $1.6 million false claims settlement.

OIG Worked In MA Overpayments

In the wake of the settlement and the resulting chatter, Hershey's compliance department reviewed outpatient radiology services. Because some problems cropped up, the hospital applied to the SDP and was accepted on June 27, 2018. Fitzgerald recommended the SDP instead of a simple overpayment refund to the Medicare administrative contractor because the mistake continued for a while.

Hershey Medical Center came to the SDP table prepared to dispense with alleged fee-for-service

CMS Transmittals
Dec. 14–20

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. 100-4, Medicare Claims Processing Manual

- New Physician Specialty Code for Undersea and Hyperbaric Medicine, Trans. 4184 (Dec. 20, 2018)
- Calendar Year (CY) 2019 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule, Trans. 4181 (Dec. 14, 2018)
- Calendar Year (CY) 2019 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment, Trans. 4182 (Dec. 14, 2018)

Pub. 100-02, Medicare Benefit Policy Manual

- Updates to the Inpatient Psychiatric Facility Benefit Policy Manual, Trans. 253 (Dec. 14, 2018)

Pub. 100-08, Medicare Program Integrity Manual

- Medical Review of Diagnostic Laboratory Tests, Trans. 850 (Dec. 14, 2018)

Pub. 100-06, Medicare Financial Management Manual

- New Physician Specialty Code for Undersea and Hyperbaric Medicine, Trans. 309 (Dec. 20, 2018)

overpayments for outpatient radiology services. But there was a surprise package. "OIG offered to resolve MA overpayments through the SDP," Fitzgerald says. "We have not seen that before." There's nothing in the SDP itself "about including MA claims in the damages estimate."

Hospitals should prepare themselves for possibly including MA overpayments in their self-disclosures from now on. "It's an offer you can't refuse," he remarks.

The upside to this development is "you get broader relief," and the downside is "you get a multiplier applied to all the results," Fitzgerald says. "We would prepare our clients to include all those amounts. It could depend on the type of services."

Hershey Medical Center didn't admit liability in the CMP settlement "but entered into it to avoid the uncertainty and expense of litigation," he notes.

OIG spokesman Donald White says a 2017 CMP settlement included MA claims. St. Joseph Hospital, Breese of the Hospital Sisters of the Third Order of St. Francis in Illinois agreed to pay $421,692 to resolve allegations that two physicians allowed clinical staff to sign orders for outpatient diagnostic and therapeutic services on their behalf *(RMC 2/20/17, p. 1)*. OIG alleged the hospital billed Medicare Parts C (MA) and B, as well as Medicaid, TRICARE and Veterans Affairs, for items or services that were fraudulent because they weren't provided as claimed. The physicians also allowed clinical staff to use pre-signed orders and signature stamps on orders. The conduct occurred between Feb. 23, 2009, and Feb. 23, 2015. The hospital, which self-disclosed to OIG, didn't admit liability in the settlement.

Moving forward, personal vs. direct supervision of RAs won't be a problem, at least in some states, including Pennsylvania. Effective Jan. 1, the supervision rules change. The 2019 Medicare Physician Fee Schedule shifted the supervision level for outpatient radiology services performed by RAs from personal to direct. The change in supervision level only applies in states that recognize RAs.

There were at least two other supervision-related settlements this month (*RMC 12/17/18, p. 3; 12/10/18, p. 1*).

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NEWS BRIEFS

◆ **McBride Orthopedic Hospital in Oklahoma agreed to pay $414,649 in a Civil Monetary Penalties Law settlement with the HHS Office of Inspector General.** The settlement stemmed from the hospital's self-disclosure. OIG alleged the hospital submitted false or fraudulent claims to Medicare, Medicaid, TRICARE and the Rural Carrier Benefit Plan from July 1, 2011, to June 30, 2017. The hospital allegedly billed (1) for professional services related to surgeries performed by two employed physicians with the modifiers 51, 58 and/or 59 improperly appended; (2) professional and facility fees related to post-surgical visits provided by a licensed practical nurse without physician supervision; and (3) evaluation and management services provided by an employed physician during office visits that had modifier -25 improperly appended and/or billed as split/shared, according to the settlement. OIG also alleged the hospital knew about the overpayments from "educational audits" but didn't report and return them. The hospital didn't admit liability in the settlement and declined to comment. It was accepted into OIG's Self-Disclosure Protocol in June 2018.

◆ **Admission orders are not a "required documentation element" for inpatient rehabilitation facility claims, according to the Dec. 20 *MLN Matters* (SE17036 Revised).** "This article was revised on December 20, 2018, to remove the Admission order requirement from the portion of the article under 'Required documentation elements for an IRF claim include, but are not limited to.' Please note that the regulation, CMS-1688-F, removed the admission order documentation requirement from the IRF payment regulation(s) in an effort to reduce duplicative documentation requirements. CMS will continue enforcement of the hospital conditions of participation," CMS said. Visit https://go.cms.gov/2BxnSUD.

◆ **CMS is asking for "comment on the financial relationships between CMS-approved Accrediting Organizations (AOs) and the healthcare facilities they review and monitor."** View its Request for Information at http://bit.ly/2rORGr6.

◆ **The HHS Office of Inspector General has posted an update to its Work Plan.** Visit https://go.usa.gov/xEcXv.

◆ **A Tennessee psychologist was arrested Dec. 17 and charged with two counts of health care fraud, the U.S. Attorney's Office for the Middle District of Tennessee said.** Donald M. McCoy, a licensed psychologist who provides individual psychotherapy and family psychotherapy to patients—usually minors—in the care of the Department of Children's Services, is accused of billing for more hours than it's possible to provide on any given day between January 2014 and Dec. 7, 2018, the U.S. attorney's office said. The complaint alleges he received more than $2.16 million from TennCare. Visit http://bit.ly/2GAWpqV.

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