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Report on Medicare Compliance Volume 29, Number 4. February 03, 2020
News Briefs: February 3, 2020

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◆ **Central Coast Inpatient Consultants Inc. in California has agreed to pay $750,000 in a civil monetary penalty settlement with the HHS Office of Inspector General (OIG).** The settlement stemmed from a self-disclosure by Central Coast, which was accepted into OIG's Self-Disclosure Protocol in 2017. OIG alleged that Central Coast "submitted claims for services provided to Medicare beneficiaries at a hospital when those physicians were not properly enrolled as Medicare Part B providers and when the names and National Provider Identifier numbers of physicians who did not furnish the services were used on claims submitted to and paid by the Medicare program for the services furnished by those non-enrolled physician[s]." The settlement states that the $750,000 is restitution. The attorney listed on Central Coast's settlement didn't respond to *RMC*'s requests for comment. Central Coast didn't admit liability in the settlement.

◆ **CMS has posted the HCPCS codes for Medicare fee-for-service prior authorization for five outpatient procedures on its web page for the new prior authorization process,[1] which starts July 1.** CMS implemented prior authorization for blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty and vein ablation in the final 2020 Outpatient Prospective Payment System regulation. "We believe that the use of prior authorization in the [outpatient department] context will be an effective tool in controlling unnecessary increases in the volume of covered OPD services by ensuring that the correct payments are made for medically necessary OPD services, while also being consistent with our overall strategy of protecting the Medicare Trust Fund from improper payments, reducing the number of Medicare appeals, and improving provider compliance with Medicare program requirements," CMS said. A prior-authorization denial would extend to all "associated services," including physician services, anesthesiology and/or facility services. However, hospitals can get free from prior authorization if their services are approved 90% of the time over 180 days.

◆ **Arch Health Partners Inc., a San Diego-based medical organization that contracts with physician groups to provide care through the Palomar Health system, agreed to pay $2.9 million to settle false claims allegations**, the U.S. Attorney's Office for the Southern District of California said[2] Jan. 23. The U.S. attorney's office alleged that Arch Health submitted Medicare claims for evaluation and management services without adequate documentation on the nature and complexity of the services. A whistleblower, a former Arch Health employee, got the ball rolling on the False Claims Act lawsuit. Also, the U.S. attorney's office alleged, "based on certain self-disclosures by Arch Health, that it paid compensation to referring physicians and physician groups that was above fair market value in violation of the Anti-Kickback [Statute], the Stark [Law], and, by extension, the False Claims Act."

1 CMS, "Final Rule: CMS-1717-FC: Prior Authorization Process and Requirements for Certain Hospital Outpatient Department (OPD) Services," https://go.cms.gov/3aYqdIU.
2 Department of Justice, U.S. Attorney's Office for the Southern District of California, "San Diego's Arch Health Pays $2.9 Million to Resolve False Claims Act Allegations," January 23, 2020, http://bit.ly/2RMGrxj.

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