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◆ **CMS on Oct. 5 posted a new edition of its Medicare Provider Compliance Newsletter.**[1] This issue addresses comprehensive error rate testing of hospital outpatient services and recovery audit contractor reviews of hypoglossal nerve stimulation for obstructive sleep apnea.

◆ **The Cigna Group and its Medicare Advantage organizations (MAOs) have agreed to pay $37 million to settle false claims allegations they submitted false and invalid patient diagnosis codes to inflate payments they got for Medicare Advantage members, the U.S. Attorney's Office for the Southern District of New York said Sept. 30.**[2] "The Government's Complaint alleged that the invalid diagnosis codes were based solely on forms completed by vendors retained and paid by CIGNA to conduct in-home assessments of plan members," the U.S. attorney's office said. Providers—usually nurse practitioners—who did the home visits allegedly didn't provide or order diagnostic tests or imaging that would have been necessary to diagnose the conditions reported and in many cases Cigna didn't allow them to treat patients during the home visits. "The diagnoses at issue were not supported by the information documented on the forms completed by the vendors and were not reported to CIGNA by any other healthcare provider who saw the patient during the year in which the home visits occurred," the U.S. attorney's office alleged. As part of the settlement, Cigna entered into a five-year corporate integrity agreement with the HHS Office of Inspector General. The false claims lawsuit was set in motion by a whistleblower lawsuit in the Southern District of New York but was transferred to the Middle District of Tennessee.

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