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Report on Medicare Compliance Volume 32, Number 43. December 04, 2023

Excerpt of Sample Agenda for Compliance Risk Assessment Team

By Nina Youngstrom

Here's an excerpt of an agenda for the monthly meeting of the compliance risk assessment team at WellSpan Health in York, Pennsylvania. Contact Frank Mesaros, manager of compliance risk and facility audits, at fmesaros@wellspan.org, and Wendy Trout, senior director of corporate compliance, at wtrout@wellspan.org.

Compliance – Risk Assessment Team

Nov. 20, 2023

1000 – 1100

Introduction: F. Mesaros

Old Business

- Defense Audit updates.

New Business

- Financial Integrity & Compliance Reporting Line updates (WT)
- OIG Updates (FM)
    - Workplan Additions
- OIG Corporate Integrity Agreements (Addenda)
- DOJ Updates (FM)
- CMS Updates
    - LCD updates
- FY24 CRAT Grid (34 - 42) (FM)
- Work Plan Updates (FM)
    - Facility audit updates
    - Professional audit updates (KN)

Open Discussion

• Recommendations for FY24

OIG Updates

Recently Added Items

OIG Updates:

Recently Added Items

Announced	Agency	Title	Component	Report Number(s)
October 2023	Office of the Assistant Secretary for Health, Office of Minority Health	Audit of Morehouse School of Medicine's National Infrastructure for Mitigating the Impact of COVID-19 Initiative	Office of Audit Services	WA-24-0038 (W-00-24-59482)
October 2023	Administration for Children and Families	Audit of Accuracy of CCDF Attendance Records at Minnesota Child Care Centers	Office of Audit Services	WA-23-0039- (W-00-23-20039)
October 2023	Administration for Children and Families	National Snapshot of Recent Trends in the Refugee Resettlement Program	Office of Audit Services	WA-23-0040 (W-00-23-59483)
October 2023	Administration for Children and Families	Audit of Efforts of State Agencies to Ensure the Safety of Children in Foster Care	Office of Audit Services	WA-23-0043 (W-00-24-20040)
October 2023	OS	Review of HHS Government Purchase, Travel, and Integrated Charge Card Programs	Office of Audit Services	W-00-24-59041
October 2023	SAMHSA, IHS	Mandatory Review of HHS Agencies' Annual Accounting of National Drug Control Program Funds	Office of Audit Services	W-00-24-52312;
October 2023	Centers for Medicare and Medicaid Services	Timeliness of Mental Health Care Following a Suicide Attempt or Intentional Self-Harm Incident for Children Enrolled in Medicaid	Office of Evaluation and Inspections	OEI-07-23-00510

Announced	Agency	Title	Component	Grant Number(s)

Timeliness of Mental Health Care Following a Suicide Attempt or Intentional Self-Harm Incident for Children Enrolled in Medicaid - Rates of suicide attempts and intentional self-harm among youth are on the rise. A previous suicide attempt is the most important predictor of death by suicide, and the risk of death by suicide is highest in the period immediately after a hospitalization or emergency department visit for a suicide attempt or intentional self-harm incident. As such, providing timely mental health follow-up care is critical to decreasing the likelihood of rehospitalization and preventing suicide. We will conduct an evaluation to assess whether children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) who had an emergency department visit or hospitalization for a suicide attempt or intentional self-harm incident received mental health follow-up care within established timeframes. We will also examine whether certain groups of children in our population were less likely to receive timely mental health follow-up care after a hospitalization or emergency department visit. Finally, we will interview subject-matter experts to identify the challenges and best practices that states encountered when working to ensure that youth enrolled in Medicaid and CHIP receive timely mental health follow-up care. (WellSpan had specific visit types for outpatient services to prioritize scheduling of patients being discharged from the hospital, but currently the standard work does not address priority for the population outlined above.)

Medicare Advantage Compliance Audit of Specific Diagnosis Codes that Aetna, Inc. (Contract H5521) Submitted to CMS (A-01-18-00504) We sampled 210 unique enrollee-years with the high-risk diagnosis codes for which Aetna received higher payments for 2015 through 2016. With respect to the seven high-risk groups covered by our audit, most of the selected diagnosis codes that Aetna submitted to CMS for use in CMS's risk adjustment program did not comply with federal requirements. For 155 of the 210 sampled enrollee-years, the medical records that Aetna provided did not support the diagnosis codes and resulted in $632,070 in overpayments. On the basis of our sample results, we estimated that Aetna received at least $25.5 million in overpayments for 2015 and 2016. As demonstrated by the errors found in our sample, Aetna's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by federal regulations, could be improved. OIG took a different approach in its audit of Aetna. It ran analytics to populate a sample with specific diagnosis codes and facts that supposedly show the codes were overreported. OIG, for example, populated its sample with claims where the physician diagnosed the enrollee with embolism, and the enrollee never received a prescription for an anti-coagulant. OIG similarly populated its sample with vascular claudication claims where medication for neurogenic claudication (unrelated to vascular claudication) was dispensed. Again, OIG did not build a random sample and review all the diagnoses codes in the sample; OIG began with fact patterns that supposedly showed overreporting of specific diagnoses, and then used analytics to populate the sample to fit those fact patterns. Coding is highly individualized and variable, yet OIG has found the entire industry is coding the same diagnoses in the same incorrect way for seven high risk groups:

- Acute Stroke
- Acute Heart Attack
- Acute Stroke and Acute Heart Attack Combination
- Embolism
- Vascular Claudication
- Major Depressive Disorder
- Potentially Mis-keyed Diagnosis Codes

Medicare Advantage Compliance Audit of Diagnosis Codes that CarePlus Health Plans, Inc. (Contract H1019) Submitted to CMS (A-04-19-07082) CarePlus Health Plans, Inc., (CarePlus) did not submit some diagnosis codes to the CMS for use in the risk adjustment program in accordance with Federal requirements. Although most of the diagnosis codes that CarePlus submitted were supported in the medical records and therefore validated 1,210 of the 1,656 sampled enrollees' Hierarchical Condition Categories (HCCs), the remaining 446 HCCs were not validated and resulted in overpayments. There were an additional 52 HCCs for which the medical records supported diagnosis codes that CarePlus should have submitted to CMS but did not. The population was generated based on monthly-weighted-health risk scores. The sampling frame included enrollees who were not classified as having hospice or ESRD status at any time during the sampling period and continuously enrolled in Medicare Part B coverage during the sampling period and had at least 1 HCC in their 2015 payment year risk scores. Enrollees were stratified into 3 strata based on the score:

- Stratum I: 0.081 to 7.944
- Stratum II: 7.954 to 16.824
- Stratum III: 16.836 to 132.096

Self-Disclosures

After it self-disclosed conduct to OIG, Chesapeake Hospital Authority (CHA), Virginia, agreed to pay $179,610.21 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that CHA paid remuneration to a medical group under a series of arrangements between CHA and the medical group in the form of: (1) excessive payments for physician services; (2) unsupported payments for medical director services; and (3) an excessive settlement payment and release for quality and night physician coverage provided by the medical group.

After it self-disclosed conduct to OIG, PromptCare Home Infusion, LLC (PromptCare), New Jersey, agreed to pay $966,924 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that PromptCare paid remuneration to an account manager in the form of commission under a marketing agreement, and in the form of salary and commission under a part-time employment agreement, for their referral of Federal health care program beneficiaries to PromptCare for services paid by Medicare and Medicaid. After it self-disclosed conduct to OIG, VIZIA Diagnostics, LLC f/k/a Robert S. Smith, Inc. (VIZIA), Georgia, agreed to pay $701,209.50 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that VIZIA submitted false claims to Federal health care programs for pathology laboratory services using the name and NPI number of a physician who did not furnish the services.

After it self-disclosed conduct to OIG, Arete Anesthesia, PLLC (Arete), Illinois, agreed to pay $57,546.45 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that Arete submitted claims for nurse anesthetist services provided by an individual when she did not have a valid license to perform services as a nurse anesthetist.

After they self-disclosed conduct to OIG, Riverside Physician Services, Inc. d/b/a Riverside Medical Group (RMP) and Shore Health Services, Inc. d/b/a Riverside Shore Memorial Hospital (Shore), Virginia, agreed to pay $527,932.50 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that an RMG-employed podiatrist submitted claims to Federal health care programs for services that were upcoded and not covered or medically necessary. OIG further contends that Shore submitted provider-based facility claims to Federal health care programs connected to certain services the podiatrist provided at Shore's provider-based clinics.

After it self-disclosed conduct to OIG, The Meadows of Fall River, LLD (TMFR), Wisconsin, agreed to Pay $80,466.07 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that TMFR employed an

individual that it knew or should have known was excluded from participation in Federal health care programs.

After it self-disclosed conduct to OIG, Fairview Urgent Care, LLC (Fairview), Georgia, agreed to pay $73,641.66 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that Fairview submitted claims to Medicare for services provided by a physician assistant (PA) using a physician's NPI thereby receiving reimbursement at the physician rate. OIG contends this was inappropriate because the PA had been denied Medicare enrollment and the physician did not provide the services. OIG further contends that Fairview submitted claims to TRICARE for the PA's services when they were not credentialed as a TRICARE provider.

After it self-disclosed conduct to OIG, Hoag Clinic, California, agreed to pay $204,916.50 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that Hoag Clinic submitted false claims to Medicare, Medicaid, TRICARE, and the Health Resources Services Administration (HRSA) COVID-19 Uninsured Program for services that were billed at a higher level of service than was provided, billed when not medically necessary, billed using the incorrect CPT code, billed when the service was not documented, separately billed when the claim should have been included in the E&M code, billed without the correct modifier, billed for a duplicate tests, or billed for a service without a valid order.

After it self-disclosed conduct to OIG, Moravian Homes, Inc. d/b/a Salemtowne (Salemtowne), North Carolina, agreed to pay $10,000 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that Salemtowne submitted claims for serviced provided by an unlicensed nurse.

OIG Corporate Integrity Agreements

- The Cigna Group (9/29/2023)

DOJ Updates

Cardiac Imaging Inc. (CII), headquartered in Illinois, and its founder, owner and CEO Sam Kancherlapalli, a resident of Florida, have agreed to pay a total of $85,480,000, to resolve False Claims Act allegations that they paid referring cardiologists excessive fees to supervise PET scans in violation of the Anti-Kickback Statute (AKS) and the Physician Self-Referral Law (Stark Law). CII agreed to pay $75 million plus additional amounts based on future revenues, while Kancherlapalli agreed to pay $10,480,000. In connection with the settlement, CII and Kancherlapalli entered into a five-year Corporate Integrity Agreement (CIA) with DHHS-OIG. The CIA requires, among other compliance provisions, that CII implement measures designed to ensure that arrangements with referring physicians are compliant with the AKS and the Stark Law. The CIA also requires that CII implement a centralized annual risk assessment and internal review process to identify and address the AKS and the Stark Law risks associated with arrangements and retain an Independent Review Organization to perform a systems and transactions review of arrangements.

A Virginia-based nurse practitioner has been charged in connection with a $7.8 million telemedicine fraud scheme involving medically unnecessary durable medical equipment (DME), including orthotics such as back and knee braces. Daphne Jenkins, 64, was charged with one count of conspiracy to commit health care fraud. Jenkins worked with a telemedicine company to sign orders for medically unnecessary durable medical equipment. It is alleged that these orders signed by Jenkins were pre-populated based on telemarketing calls made to Medicare beneficiaries, that Jenkins never had any contact with the beneficiaries herself and had no medical relationship with the patients, and that she generally signed these orders without even reading them. It is alleged that once Jenkins signed these orders, the telemarketing company sold the orders to DME suppliers and laboratories, which then submitted claims to Medicare. As a result of Jenkins' alleged participation in this conspiracy, over $7.8 million in claims were submitted to Medicare for DME that was medically unnecessary, based on false documentation, and tainted by kickbacks.

A California woman pleaded guilty to fraudulently submitting claims to governmental and private insurance programs during the COVID-19 pandemic for expensive and medically unnecessary respiratory pathogen panel (RPP) tests. Lourdes Navarro, 64, of Glendale, conspired with Imran Shams to obtain nasal swab specimens from residents and staff at nursing homes, assisted living facilities, rehabilitation facilities, and students and staff at primary and secondary schools, for the purported purpose of conducting screening tests to identify and isolate individuals infected with COVID-19.

Obtaining those samples enabled Matias Clinical Laboratory, dba Health Care Providers Laboratory (HCPL), to perform RPP tests on some of the specimens, even though only COVID-19 testing had been ordered and even though there was no medical justification for conducting RPP tests. Navarro and Shams submitted, through HCPL, approximately $359 million in claims for the unnecessary RPP tests to Medicare, the Health Resources and Services Administration COVID-19 Uninsured Program, and a private health insurance company, and were reimbursed approximately $54 million.

Dr. Michael Hochman, a 54-year-old Austin resident has been indicted for health care fraud and money laundering. Hochman is an ophthalmologist who owned and operated Michael A. Hochman P.A. and Laredo Laser & Surgery Ltd. in Laredo. Hochman allegedly submitted to Medicare, Medicaid and Tricare fraudulent claims totaling $402,536,174. The charges allege Hochman falsely diagnosed vulnerable patients with ophthalmological diseases and various degenerative eye conditions. Hochman allegedly directed optometry staff to conduct fraudulent, repetitive and excessive medical procedures on patients to maximize profits. Hochman used the proceeds of the fraud scheme to purchase a private airplane, luxury vehicles, high-end antiques, collectible coins and other luxury items.

Oxygen Plus, Inc., a provider of durable medical equipment based in Floyd County, Kentucky, has agreed to pay $200,000 to resolve allegations that it violated the False Claims Act by fraudulently billing Medicare and Medicaid for respiratory devices that patients did not need or use, in contravention of those programs' requirements. Oxygen Plus provided non-invasive ventilators ("NIVs") for home use to patients in Kentucky. NIVs are a type of complex respiratory equipment designed to deliver pressurized air into the lungs of patients with serious respiratory diseases. Medicare and Kentucky Medicaid pay a monthly reimbursement for a patient's rental of an NIV, so long as the NIV is necessary and reasonable for the patient's treatment. Between January 2017 and June 2021, Oxygen Plus submitted over 300 false claims to Medicare and Kentucky Medicaid by continuing to seek reimbursement for NIV rentals even after patients no longer needed the devices or were no longer using them.

Alisha Richardson, 44, of Chicago, devised a scheme to defraud her employer, a Chicago-area nursing home, of funds by falsifying records to generate payments to individuals who never worked at the facility (so-called "ghost" employees). The indictment alleges that, as part of the scheme, Richardson created false records to make it appear as though the individuals were employed as Certified Nursing Assistants, when in fact they were not working at the nursing home. The indictment further alleges that Richardson logged false hours for these "ghost" employees, which caused the nursing home to issue paychecks. According to the indictment, some "ghost" employees cashed the checks and shared the proceeds with Richardson. The indictment further alleges that on other occasions Richardson forged endorsement signatures for the individuals and deposited the paychecks into her own bank accounts. As a result of the scheme, the nursing home paid out over $100,000 for work that was never performed.

A federal district judge has ordered Charles Adams M.D. and his medical practice to pay more than $27 million for violating the False Claims Act (FCA). In June 2023, a federal jury in Rome found that the defendants violated the FCA by submitting false claims to Medicare for chelation therapy reimbursements. Chelation therapy involves the use of drugs to remove heavy metals from the body. The jury found that Medicare reimbursed the defendants

more than $1.1 million for these unnecessary treatments. In a post-trial ruling, the federal district judge added penalties to the jury's verdict, bringing the total amount owed to more than $27 million. Adams operated a medical practice in Ringgold, Georgia, known as Full Circle Medical Center. As a part of his internal medicine specialty, Adams administered the drug edetate calcium disodium ("EDTA") to address a wide range of conditions, including atherosclerosis, high blood pressure, headaches, GI ailments, fatigue, and other generalized symptoms. But these symptoms are not recognized as being treatable using EDTA. According to the U.S. Food and Drug Administration, EDTA is recognized as a treatment only for lead poisoning and lead encephalopathy. Because Dr. Adams' patients did not have lead poisoning or lead encephalopathy, Medicare would not reimburse his use of EDTA. To receive reimbursement for the EDTA, Dr. Adams falsely claimed to Medicare that his patients suffered from heavy metal poisoning. In August 2018, the Government filed a civil complaint alleging that between November 2008 and September 2015, Adams and Full Circle knowingly submitted false claims to Medicare for medically unnecessary and "alternative" chelation therapy that Adams administered using EDTA. The complaint also alleged that in connection with this scheme, Adams and Full Circle unlawfully received approximately $1.1 million in Medicare reimbursements. The jury found Adams and Full Circle liable for submitting more than 4,400 false claims to Medicare. The jury awarded more than $1.1 million in damages. Under the FCA, Judge Ray was required to treble the jury's award and to add penalties based on the number of false claims submitted. Judge Ray issued his final decision on August 25, 2023, ordering the defendants to pay a total of $27,567,729 in damages and penalties. (No Medicare volume for EDTA agents.)

A former executive at HealthSun Health Plans Inc. (HealthSun), a Medicare Advantage organization that operates Medicare Advantage plans in South Florida, was charged for her role in a multimillion-dollar Medicare fraud scheme. Kenia Valle Boza, 39, of Miami, formerly the Director of Medicare Risk Adjustment Analytics at HealthSun, allegedly orchestrated a scheme to submit false and fraudulent information to CMS to increase the amount that HealthSun received for certain Medicare Advantage enrollees. CMS pays Medicare Advantage plans like those HealthSun operates based, in part, on the health condition of their enrollees. To increase the company's profits and their own compensation, Valle and her co-conspirators are alleged to have knowingly submitted and caused the submission to CMS of false and fraudulent information about chronic ailments that Medicare beneficiaries in HealthSun's plans did not actually have, and that non-health care providers, such as coders, added to patient health records. Valle and her co-conspirators allegedly entered and caused others to enter diagnoses into the medical records of beneficiaries enrolled in HealthSun's plans based on diagnostic tests that were not a proper basis for diagnosing those conditions. In addition, Valle and her co-conspirators allegedly obtained the login credentials assigned to certain physicians to wrongfully access electronic medical records (EMR) as the physicians, and falsely and fraudulently entered chronic conditions directly into the medical records of beneficiaries. These diagnoses appeared to have been made and documented by the physicians when, in truth and fact, coders entered the conditions into beneficiaries' medical records, often days or weeks after the physician saw the beneficiary.

Putnam Community Medical Center of North Florida, who owns and operated Putnam Community Medical Center, LLC, a 99-bed hospital located in Palatka, Florida, has agreed to pay the United States $1million to resolve allegations that they violated the False Claims Act by submitting claims to Medicare and TRICARE in connection with a now-closed sleep center that were alleged to have operated with inadequate physician supervision. Putnam Community Medical Center provided diagnostic sleep testing services at its now-closed sleep center, which the United States and the State of Florida allege were not provided with adequate physician supervision as required under certain Medicare coverage determinations and regulations during the period from December 2013 through February 2019.

CMS Updates

Coverage Updates

Revised:

- Billing and Coding: Epidural Steroid Injections for Pain Management (L36920) Article revised on 10/19/2023 in response to an inquiry to revise #12 in the Limitations to remove the sentence "It is recommended not to exceed 80 mg of triamcinolone, 12 mg of betamethasone, or 15 mg of dexamethasone per session".
- The following Billing and Coding articles have been revised to reflect the Annual ICD-10 code updates:
    - Ambulatory electrocardiograph (AECG) Monitoring (A59268)
    - Assays for Vitamins and Metabolic Function (A56416)
    - Bariatric Surgical Management of Morbid Obesity (A56422)
    - Biomarkers for Oncology (A52986)
    - Cardiac Rhythm Device Evaluation (A56602)
    - Cardiology Non-emergent Outpatient Stress Testing (A56423)
    - Controlled Substance Monitoring and Drugs of Abuse Testing (A56645)
    - Diagnostic Abdominal aortography and Renal Angiography (A56682)
    - Electroretinography (ERG) (A56672)
    - Intensity Modulated Radiation Therapy (IMRT) (A56725)
    - Intraoperative Neurophysiological Testing (A56722)
    - Magnetic Resonance Angiography (MRA) (A56085)
    - Monitored Anesthesia Care (A57361)
    - Nerve Conduction Studies and Electromyography (A54095)
    - Neurophysiology Evoked Potentials (NEPs) (A56773)
    - Oximetry Services (A57205)
    - Pharmacogenomics Testing (A58801)
    - Psychiatric Codes (A57130)
    - Single Chamber and Dual Chamber Permanent Cardiac Pacemakers (A54982)
    - Speech Language Pathology (SLP) Services: Communication Disorders (A56631)
    - Thoracic Aortography and Carotid, Vertebral, and Subclavian Angiography (A56631)
    - Transesophageal Echocardiography (TEE) (A56505)
    - Vestibular and Audiologic Function Studies (A57434)