Report on
Medicare Compliance

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

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Simplified E/M Coding Guidelines Spread to Hospitals Jan. 1, Raising the Compliance Stakes

Even though a patient spends a long time with their physician, that doesn't necessarily translate into high medical decision-making. The patient may require lots of attention—maybe they diagnosed themselves on the internet and the physician is reorienting their thinking and there are several treatment options to discuss—but the medical decision-making could be low. The dance of time versus medical decision-making has big implications now that physicians base their evaluation and management (E/M) levels of service on the documentation of either one without factoring in the history and exam. That applies to office and other outpatient visits now, and will reach hospital visits starting Jan. 1.

Choices about coding based on time versus medical decision-making can get complicated, said Raemarie Jimenez, chief product officer for the AAPC, on Aug. 20 at the Collaborative Compliance Conference sponsored by AAPC and the American Health Law Association. "A physician can code the service based on time or medical decision-making and make that decision patient by patient," she said. Some physicians may always choose medical decision-making. Other physicians will code based on time because "medical decision-making is too hard to wrap their heads around and they can track their time and feel good about it," Jimenez said. "There's nothing wrong with that." The question is whether facilities take the higher

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New Lawsuit Aims to Require Medicare Auditors to Include Underpayments in Audit Samples

In a lawsuit filed against HHS Aug. 4, a lab alleges that a Medicare program integrity contractor failed to include zero-paid claims with the overpayments in its audit sample, or share required audit papers, in violation of federal law.[1] The lawsuit is a reckoning over statistical sampling and extrapolation, with the larger goal of fairness for providers by compelling Medicare auditors to add underpayments and zero-paid (unpaid) claims to their audits and show their work, as required by the 2006 Tax Relief and Healthcare Act and the Medicare Program Integrity Manual (MPIM),[2] according to the allegations in the lawsuit and an attorney who represents the lab.

"Imagine that every time a provider is audited, they have to balance out how much they underpaid the provider versus how much they overpaid," said attorney Stephen Bittinger, with K&L Gates in South Carolina, who represents the plaintiff, Compass Laboratory Services LLC, of Tennessee. "It would dramatically change how audits are performed."

The government's general argument is it doesn't need to include underpayments and zero-paid claims because it's only looking for overpayments, "but the statute said you should," Bittinger contended.

If the U.S. District Court for the District of Columbia, where the lawsuit was filed, sides with Compass, the impact could be "immense," said statistician and auditor

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Bruce Truitt, a former faculty member of the Medicaid Integrity Institute in Columbia, South Carolina, who is not involved in the case. It could create a "consistent compliance environment" by forcing alignment of the same rules for Medicare program integrity audits and self-audits under the Medicare-Medicaid 60-day rule. The MPIM only applies to Medicare contractors, not providers doing self-audits under the 60-day rule, which requires providers to report and return Medicare and Medicaid overpayments within 60 days of identifying them.

"If you're auditing under the program integrity manual, you have to take underpayments into account," Truitt said. But self-audits under the 60-day rule only consider claims with positive dollar values. "The 60-day rule clearly said underpayment issues are outside the scope of the rulemaking," he noted.

In this and other lawsuits Bittinger plans to file, he alleges HHS and its contractors failed to comply with the law and with MPIM provisions on statistical sampling. The 2003 Medicare Modernization Act (MMA) requires a determination of a "sustained or high level of payment error, or documented educational intervention has failed to correct the payment error" before Medicare contractors could use extrapolation, and the Tax Relief and Healthcare Act elaborated that contractors identify underpayments in addition to overpayments, according to the lawsuit. Truitt noted that "payment error" in the MMA does not specify an underpayment, zero-payment or overpayment—"it just says 'payment.'"

The MPIM sets forth the statistical sampling methodology that Medicare contractors must use. It includes "the overpayment estimation, the overpayment estimation methodology, and the calculated sampling error" and "The amount of the actual overpayment/underpayment from each of the claims reviewed." Contractors are required to document the random selection process to make sure the information is available for anyone trying to "replicate" the sample selection.

"Once the sample is constructed, each sampling unit is audited by the contractor's medical review staff to determine whether the claim was properly paid, overpaid, or underpaid," the lawsuit states. According to the 2022 update to the MPIM, "the universe of claims from which the sample is selected will consist of all fully and partially paid claims submitted by the provider/supplier for the period under review."[3] The MPIM also states, "Sampling units that are found to be underpayments, in whole or in part, are recorded as negative overpayments and shall be used in calculating the estimated overpayment."[4] In other words, there should be an offset against the actual overpayment, Bittinger said. If the auditor finds an overpayment of $1 million and an underpayment of $100,000, the net overpayment is $900,000.

Underpayment Argument Was Mostly Ignored

The lawsuit argues the Compass audit wasn't consistent with the law or MPIM. Compass was audited in late 2014 by a zone program integrity contractor (ZPIC), AdvanceMed, when the 2011 version of the MPIM was in effect. It used stratified random sampling to select a sample of 66 claims for diagnostic tests with dates of service between Feb. 1, 2014, and Sept. 30, 2014. After auditing them, the ZPIC denied all claims for lack of medical necessity, finding an overpayment of $9,115 that was extrapolated to $3,354,936. In its appeal to Cahaba—the Medicare administrative contractor (MAC)—Compass challenged the validity of the ZPIC's sampling and extrapolation and its medical necessity findings because a physician had ordered the lab tests. The lawsuit alleged AdvanceMed excluded zero-paid claims and never produced "replicable information" for Compass to evaluate.

Cahaba ruled against Compass without mentioning the zero-paid claims or producing the documentation on the audit, the lawsuit alleged. "However, Cahaba claimed to have successfully replicated the sampling frame created by AdvanceMed, and concluded AdvanceMed used statistical sampling appropriately to extract the random sample and project the overpayment

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in Compass's audit," the lawsuit alleges. Compass appealed to the qualified independent contractor and pretty much the same thing happened. Next Compass appeared before an administrative law judge (ALJ), again challenging the validity of the statistical sampling because the ZPIC allegedly didn't produce the universe of claims or include zero-dollar claims.

Then, Compass headed to the Medicare Appeals Council, which didn't acknowledge the appeal—"To date, Compass has not received a decision, dismissal, or remand by Council"—and now is making its case in federal court.

In the lawsuit, Compass alleges, "AdvanceMed improperly excluded unpaid claims from the sampling frame in conducting its statistical sampling and extrapolation, in violation of statutory and regulatory mandates and MPIM guidance." The failure to include unpaid claims results in "statistical sampling that is biased against the provider and causes the extrapolated demand to be exaggerated." Also, "the Secretary and his agents" didn't provide information required to recreate the sampling frame. "Without this statistical information, Plaintiff was deprived of its right to independently verify the Secretary and his agents' alleged overpayment amount throughout the entire administrative appeals process," according to the lawsuit.

MPIM Has Conflicting Provision on Unpaid Claims

Bittinger said he has won similar arguments before ALJs several times, and lost others, and will appeal the losses in federal court. In the cases he has lost, the ALJs cite MPIM language that conflicts with language requiring the inclusion of underpayments and zero-paid claims.

The 2022 MPIM, for example, states that, "Sample units with no final payment made at the time of sample selection should not be included in the sample frame. Claims with no payment may be included in the universe from which the sample frame is constructed and should be excluded when establishing the sample frame."[5] That indicates zero-paid claims don't have to be included in audit samples. But Bittinger contends the language conflicts with the statute, and statutes trump manuals.

"The legal authority is very clear," Bittinger contended. The statute controls when there are conflicting provisions in the manual. The hierarchy is well-established: statutes take precedence over regulations, which outrank guidance (e.g., manuals), policies and procedures, for example.

Truitt thinks he has a good case because the argument is from "the top down rather the bottom up. What usually happens is that defendants argue their case up from the bottom. They try to fight upwards against the guidance, rule, or regulation when they should be trumping the guidance, rule, or regulation from above, that is from the level of legislation or law." That's the only way "to rationalize the compliance environment," Truitt contended.

Bittinger has also argued that the "in whole" language from the MPIM[6] shows that zero-paid claims should be included in the sampling unit and universe. But he said, "ALJs have taken the position that the MPIM language makes clear that only fully and partially paid claims need to be included in the initial universe and sampling frame, and allow for the possibility that, once medical review has been completed, if some of the reviewed claims actually turn out to be underpayments, that those underpayments can then be reconciled into the calculation of a final 'net overpayment.' ALJs have reasoned that just because a submitted spreadsheet of claims does not contain zero-paid claims does not mean that spreadsheet of claims cannot be the universe."

Truitt noted that "a zero-paid claim is a paid claim because it has been reviewed for payment and adjudicated, which is the very definition of a paid claim."

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Endnotes

1. Complaint for judicial review, Compass Laboratory Services, LLC v. Becerra, No. 1:22-cv-02304-CJN (D.D.C. 2022).
2. Centers for Medicare & Medicaid Services, "Chapter 8 – Administrative Actions and Sanctions and Statistical Sampling for Overpayment Estimation," *Medicare Program Integrity Manual*, Pub. 100-08, 2011 version, https://bit.ly/3TA4ehE; 2022 update, https://go.cms.gov/32woneV.
3. CMS, "Chapter 8," § 8.4.3.2.1(A), *Medicare Program Integrity Manual* 2022 update.
4. CMS, "Chapter 8," § 8.4.5.2, *Medicare Program Integrity Manual* 2022 update.
5. CMS, "Chapter 8," § 8.4.3.2.1(A), *Medicare Program Integrity Manual* 2022 update.
6. CMS, "Chapter 8," § 8.4.5.2, *Medicare Program Integrity Manual* 2022 update.

Three-Step Process Helps Manage Patients Who Decline Discharge

This may sound familiar: A patient with dementia is ready for discharge and a bed is available in a dementia unit, but the patient declines to leave because the unit is two hours away from family. With no medically necessary reason for the patient to stay in the hospital and its beds desperately needed by other patients—emergency department boarders, urgent day-of-surgery patients and pending outside transfers—the hospital must usher the patient out the door. Sometimes that's easier said than done.

"It's not a comfortable conversation for physicians or nurses to have with patients," said Steven Grant,

M.D., associate chief medical officer of care coordination and patient transitions at University of Vermont Medical Center (UVMC) in Burlington. Facilitating discharges and transfers of patients who have declined them requires a thoughtful, multidisciplinary approach.

There are different reasons why patients refuse discharge. The No. 1 reason is their destination—an available bed in a skilled nursing facility (SNF), for example—is too far from home and they're holding out for a bed in a closer SNF. There are other explanations, such as unflattering remarks they've heard about a SNF or other post-acute care facility. Whatever the reason, the patient isn't budging, even though they've been informed about shouldering the costs of the continued stay.

To address this challenge in a way that respects its commitment to patient and family-centric care, UVMC developed a policy to help clinicians move discharges along when there's resistance. It was guided by certain principles, including the patient's right to a reasonable discharge plan. The policy was developed by a multidisciplinary team that included physicians, compliance, nurses, finance, ethics, medical psychologists and others.

Taking it One Step at a Time

Grant described the three steps of the policy (which was first printed on the American College of Physician Advisors' website):

"Step 1: Explore and respond.

- "Reflect on your own response: hearing 'no' can trigger negative reactions. Before engaging with the patient, take a moment to reflect on your response and put yourself in a calm frame of mind.
- Explore the reasons for refusal, identify and address barriers**:** approach the discussion with curiosity and compassion, consider the principles of trauma-informed care, and work with others in your system to resolve barriers where possible.
- Defer payment issues to Case Management: while Physician Advisors have the expertise to have these discussions, many front-line clinicians do not.
- Respond based on discharge location: details vary depending on the discharge location. If the discharge is to a non-hospital setting, this is the time to discuss the risks of remaining hospitalized, such as hospital-acquired conditions. It's also when we emphasize the safety risk their refusal poses to other patients.
- Explain that remaining hospitalized will not be the default option and that further discussion will follow.
- Re-evaluate if the discharge plan is still reasonable: after inquiry we sometimes agree that the proposal is no longer appropriate.
- If still appropriate then re-attempt discharge."

"Step 2: Escalation

- "If the patient continues to decline discharge, we escalate the review to Case Management Leadership. If they agree that the discharge plan is reasonable, then the patient is given the option of accepting the discharge plan or discharging to self-care.
- Throughout Steps 1 and 2, we move forward with discharge planning. We set a date, arrange transportation, and complete all discharge tasks.
- The timeline for Steps 1 and 2 combined is 24 hours."

"Step 3: Adjudication

- "If the patient declines both options, the primary team disagrees with the escalation decision, or an administrative discharge to self-care appears unrealistic then the case is sent to the Adjudication team (see Figure 1), who make the final decision.
- The timeline for Step 3 is one business day."

Grant also developed a flowchart to help clinicians visualize the process (see box, p . 5).[1]

Patients 'Appreciate Having a Conversation'

Most conversations with patients "go pretty well," Grant said. "They understand hospital beds are limited" and people boarding in the emergency department or coming from other hospitals need the beds. "It's their preference to stay but they appreciate having a conversation." With this approach, patients have for the most part agreed to be discharged. There was one patient, however, who stayed in the hospital because a dialysis slot near the SNF was taken by the time the adjudication team reviewed the case, and another patient who the hospital agreed to keep because the patient had a legitimate conflict with an employee at the community hospital that he was transferred from. "It was compelling enough where we said, 'I don't think we should send them back,'" Grant said.

Grant has found that money is not a driving force at the time patients are reluctant to be discharged, even though it may sink in later. For example, hospitals are required to deliver the Important Message from Medicare to Medicare patients when they're admitted and before discharge, informing them of their discharge appeal rights and, if they refuse to leave then they're stable for discharge, the Hospital-Issued Notice of Noncoverage, which informs them the services are not covered. But Grant said the risk of having to pay a large bill doesn't typically motivate the patient to leave.

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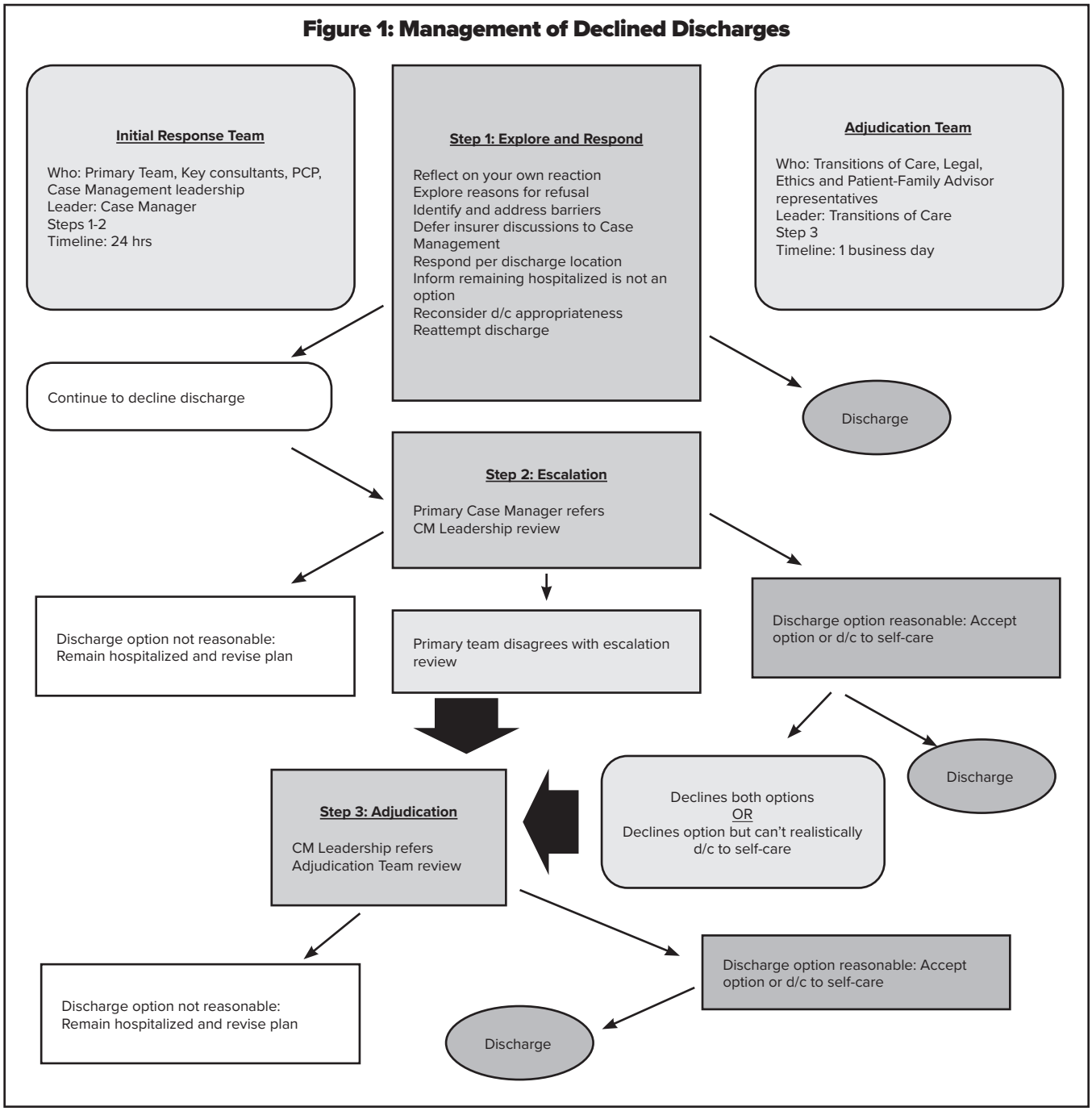
Flow Chart for Managing Patients Who Decline Discharge

University of Vermont Medical Center in Burlington developed this process to help facilitate discharges and transfers of patients who have no medically necessary reason to be in the hospital, said Steven Grant, M.D., associate chief medical officer of care coordination and patient transitions (see story, p. 3).[1] Their beds are desperately needed by other patients—emergency department boarders, urgent day-of-surgery patients and pending outside transfers—but sometimes patients resist leaving for various reasons. Contact Grant at steven.grant@uvmhealth.org.

Figure 1: Management of Declined Discharges



Endnotes

1. Nina Youngstrom, "Three-Step Process Helps Manage Patients Who Decline Discharge," *Report on Medicare Compliance* 31, no. 32 (Sept. 5, 2022).

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"I don't find the nonpayment thing to be much of a lever," Grant said. The hospital gives patients who decline to leave some interim paperwork showing them the bill they have accumulated, but "it's just a piece of paper. It's not real yet." And most Medicare Advantage plans won't transfer liability to the patient, he said.

Contact Grant at steven.grant@uvmhealth.org. ✧

Endnotes

1. Nina Youngstrom, "Flow Chart for Managing Patients Who Decline Discharge," *Report on Medicare Compliance* 31, no. 32 (Sept. 5, 2022).

Medical Group Settles CMP Case for $807,255 Over Professional Fees

Florida Hospital Medical Group Inc., d/b/a AdventHealth Medical Group, has agreed to pay $807,255 in a civil monetary penalty settlement about billing professional fees for procedures that allegedly weren't performed.

According to the settlement, which was obtained through the Freedom of Information Act, the HHS Office of Inspector General (OIG) alleged that AdventHealth Medical Group submitted claims to Medicare, Medicaid, TRICARE and Railroad Medicare for items or services that were fraudulent from May 1, 2015, through April 31, 2021.

OIG contends AdventHealth Medical Group billed professional fees for a physician's "pulmonary, laparoscopic, hiatal hernia repair, rib resection, and thoracoscopy surgeries that included codes for procedures that were not performed." The settlement stemmed from a self-disclosure. AdventHealth Medical Group was accepted into OIG's Self-Disclosure Protocol on Aug. 3, 2021. It didn't admit liability in the settlement.

No additional details were available and AdventHealth declined to comment. But the case highlights the challenges of "auditing for a negative," said attorney Bob Wade, with Barnes & Thornburg in South Bend, Indiana. Wade said he's involved in another case about a physician who allegedly was documenting and billing for services never performed. "When there are allegations of billing for services not rendered, you can't take medical records at face value. There are other ways you need to audit."

With these situations, Wade has found schedules to be indispensable in supporting or refuting the documentation. Is there a discrepancy between the number of procedures on the schedule and the number of professional fees billed for the procedures on that date of service? "You would think medical records would be missing, but there are so many forms and templates. They can create some beautiful patient records," Wade said. Whether it's a true story is another question.

Schedules also give auditors a sense of the veracity of the billing in terms of time, Wade said. Evaluation and management services have approximate times attributed to them. For example, CPT 99214 is 30 to 39 minutes. "Is the physician performing an unbelievable amount of patient encounters? This is where the qui tam bar goes," Wade said. "They take the assigned time for each level of service and try to determine whether the physician has billed for an unbelievable day. Has the physician billed for more than 24 hours in a day consistently? That would raise a red flag."

Metadata Helps Look Behind Medical Records

Some experts also recommend pulling back the curtain on medical records by looking at the metadata, which is information about the information. Metadata helps overcome the risks that have been introduced by electronic health records and the limitations of conventional audit strategies.

The question is if current auditing methods allow compliance auditors to determine whether the patient was seen by a qualified provider, whether the patient is truly seen by the provider who signed the record, whether the information in the record matches what happened in the encounter, when the documentation was created, who created it, how it was created and whether the documentation is unique, according to Amy Bailey, principal of HBE Advisors LLC, and Sharon Parsley, president of Quest Advisory Group. Metadata and other less traditional approaches to auditing may help compliance departments uncover noncompliance that doesn't show up in the usual medical-record review, they said at the Health Care Compliance Association's Compliance Institute in March.[1]

Wade said practices also should look at whether they set up billing based on the order instead of the performance of a diagnostic test. How do they know the tests were performed? The patient may not have followed through. If the order is the triggering mechanism to submit a bill, "you have to have a back-end process to check," he said.

Contact Wade at bob.wade@btlaw.com. ✧

Endnotes

1. Amy Bailey and Sharon Parsley, "Evolving Auditing Methodologies Are a Game Changer for Effective Compliance," Compliance Institute, Health Care Compliance Association, March 29, 2022.

Simpler E/M Guidelines Hit Hospitals Jan. 1

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code when coders recognize the service would generate more reimbursement if it's coded based on time versus medical decision-making or vice versa. Either way, they have to "honor" that it's the physician's provider number and "what their comfort level is," Jimenez said. She suggested facilities have a policy to guide these decisions.

Time versus medical decision-making is one of the challenges that has come up since the switch was flipped on coding and documentation by the American Medical Association (AMA) CPT Editorial Panel for office/outpatient visits (99202-99215) in 2021. CMS in the 2020 Medicare Physician Fee Schedule regulation aligned with the AMA's E/M guidelines but deferred them to 2021.[1] And now the 2023 E/M guidelines will apply to E/M services provided in the hospital, including observation, initial and subsequent visits, consultations and admissions and discharges on the same date of service, according to Jaci Kipreos, president of Practice Integrity LLC in San Diego.[2] "This is huge," Kipreos said at the conference. "It will take a while to get used to." (One exception: Medical decision-making will be the only driver of E/M levels in the emergency department).

Although it's sometimes misunderstood, physicians don't have to meet both medical decision-making and time to assign an E/M level of service, Jimenez said. It's one or the other.

No Requirement to Document Both

"There's no requirement for you to document both. We apply this the same way we did with 1995 and 1997 guidelines. From an audit perspective it was whatever guideline is the most advantageous."

Jimenez explained that the calculation of time is no longer limited to the face-to-face encounter with the patient. The CPT definition is more expansive now. "When the concept of medical decision-making or time was introduced, the AMA created a comprehensive list of all activities done by the provider that would count toward the calculation of time," Jimenez said. They must be performed on the same date of service as the patient encounter to count toward the calculation:

- "Preparing to see the patient (e.g., review of tests);
- "Obtaining and/or reviewing separately obtained history;
- "Performing a medically appropriate examination and/or evaluation;
- "Ordering medications, tests or procedures;
- "Referring and communicating with other health care professionals (when not separately reported);
- "Counseling and educating the patient/family/caregiver;
- "Ordering medications, tests or procedures;
- "Documenting clinical information in the electronic or other health record;
- "Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver;
- "Care coordination (not separately reported)."[3]

Potential Audit Risks with Time-Based Coding

Jimenez pointed out some potential audit risks. Providers don't have to worry about documenting start and stop times along the way—no payers are requiring that—although providers should document total time and the medical services provided to the patient. But they only count the time for services performed on the date of service, not before, she noted. And they can't include clinical staff time in the calculation. "Providers may oversee them, but clinical staff time can't be included," she noted.

Also, "if the provider bills for an E/M based on total time and an EKG interpretation, they can't use the time they spent interpreting the EKG in total time used for the E/M because they are already being paid for it with the EKG CPT code," Jimenez said.

The E/M guidelines state that the time spent on the date of service may be counted in the total time. Jimenez said it's not uncommon for providers to finish their documentation after appointments elsewhere (e.g., rounding in the hospital or accessing electronic health records (EHR) from home).

CMS Transmittals and *Federal Register* Regulations, August 26-September 1

Transmittals

Pub. 100-04, Medicare Claims Processing

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2023, Trans. 11583 (September 1, 2022)

Pub. 100-20, One-Time Notification

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)–January 2023 Update, Trans. 11584 (August 31, 2022)

Federal Register

Final rule

- Radiation Oncology (RO) Model, 87 Fed. Reg. 52698 (August 29, 2022)

Proposed rule; extension of comment period

- Clinical Laboratory Improvement Amendments of 1988 (CLIA) Fees; Histocompatibility, Personnel, and Alternative Sanctions for Certificate of Waiver Laboratories; Extension of Comment Period, 87 Fed. Reg. 52712 (August 29, 2022)

"Every EHR has an audit log of who accessed the medical record and when," she said. "If it becomes a question, the practice/facility can provide that audit log."

Rounding up the minutes is also a vulnerability. "If you round up every encounter by a few minutes, you will inflate the encounter time you are billing in a given day," she said.

Coders should also be alert to physicians who bill every encounter as 40 minutes long, Kipreos said. Unless it's a therapy session, it's unusual for providers to spend the same amount of time with every patient, she said.

Getting Your Arms Around Medically Appropriate

Almost two years after the E/M guidelines were revised to base coding selection on time or medical decision-making only for office visits (without counting elements of the exam or history), physicians are still getting accustomed to it. "They are still struggling and a lot of EHRs have not adapted to the new guidelines," Kipreos said. And now they are four months away from the same revision applying to hospital services. "It will be a whole new way of documenting," she said.

Although physicians don't have to factor in the exam or history anymore, the guidelines state the history and exam documented must be "medically appropriate." What does that mean? Although the extent of history and exams needed aren't going to be dictated by check boxes or bullet points, "providers still need something that says why they're seeing the patient and what they did," Kipreos explained. "Auditors are no longer looking at the history and pulling out quantitative data or looking at the exam and pulling out quantitative data, but it still needs to support the assessment." For example, Kipreos has been auditing ear, nose and throat practices and found documentation of sinus problems lacking specificity.

"You can have allergy symptoms and it can be very acute, or seasonal allergies that are chronic. These definitions depend on acute versus chronic," she said. "When the provider does not document the history to include details of the condition, I would not know if it's acute or chronic. They are leaving out a key piece of information." Without that information and other details, she can't determine the number and complexity of problems addressed during the patient encounter, amount or complexity of data to be reviewed and the risk of complications and/or morbidity or mortality of patient management—the three elements of medical decision-making in the revised AMA table.[4]

Contact Kipreos at jaci@practiceintegrity.com and Jimenez at raemarie.jimenez@aapc.com. ✧

Endnotes

1. American Medical Association, *CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes*, last accessed September 1, 2022, http://bit.ly/36FLiVU.
2. American Medical Association, *CPT® Evaluation and Management (E/M) Code and Guideline Changes*, last accessed September 1, 2022, https://bit.ly/3ylFT5v.
3. AMA, *CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes*, 3.
4. American Medical Association, "Table 2 – CPT E/M Office Revisions Level of Medical Decision Making (MDM)," last accessed May September 1, 2022, https://bit.ly/2T3azEH.

NEWS BRIEFS

◆ **San Diego neurosurgeon Lokesh Tantuwaya pleaded guilty Thursday, Sept. 1, to federal charges related to accepting $3.3 million for performing spinal surgeries at a now-defunct Long Beach, California, hospital**, the U.S. Attorney's Office for the Central District of California said Sept. 1.[1] Tantuwaya pleaded guilty to one count of conspiracy to commit honest services fraud and to violating the Anti-Kickback Statute. According to his plea agreement and statements in court, Tantuwaya took money from Michael Drobot, who owned Pacific Hospital in Long Beach, in return for performing the surgeries at the hospital. "The bribe amount varied depending on the type of spinal surgery," according to the U.S. attorney's office. "Tantuwaya admitted that he knew the receipt of money in exchange for the referral of medical service was illegal and that he owed a fiduciary duty to his patients to not accept money in exchange for taking their surgeries to Pacific Hospital." Drobot went to prison after being convicted for committing a massive workers' compensation system scheme, the U.S attorney's office said.

◆ **In a Medicare Advantage compliance audit of specific diagnosis codes submitted to CMS by WellCare of Florida Inc., the HHS Office of Inspector General found that "most of the selected diagnosis codes that WellCare submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements."**[2] OIG sampled 250 enrollee-years with high-risk diagnosis codes for which WellCare got higher payments in 2015 and 2016. For 153 enrollee-years, OIG said the diagnosis codes weren't supported in the medical records. That resulted in net overpayments of $410,100, which was extrapolated to $3.5 million in 2015 and 2016. In response to the report, WellCare said, among other things, that OIG's "audit methodology is flawed" and that WellCare's medical records support the diagnoses.

Endnotes

1. U.S. Department of Justice, U.S. Attorney's Office for the Central District of California, "Surgeon Pleads Guilty to Federal Charge for Accepting $3.3 Million in Illicit Payments to Perform Spinal Surgeries at Corrupt Hospital," news release, September 1, 2022, https://bit.ly/3wQiRng.
2. Amy J. Frontz, *Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Wellcare of Florida, Inc.*, (Contract H1032) Submitted to CMS, A-04-19-07084, U.S. Department of Health and Human Services, Office of Inspector General, August 2022, https://bit.ly/3wO9pRG.