After Employee Tells CCO About Free Services, Clinic Self-Discloses, Settles CMP Case

After a self-disclosure to the HHS Office of Inspector General (OIG), Rehabilitation Hospital of the Pacific-Hilo Clinic in Hawaii paid $231,510 in a civil monetary penalty (CMP) settlement over free services and supplies that an employed hand therapist provided to a private physician practice. Emails she wrote helped convince the hospital to enter OIG’s Self-Disclosure Protocol.

According to the settlement, the certified hand therapist provided the free services and supplies for a decade—from Sept. 14, 2007, to Sept. 15, 2017.

Rehabilitation Hospital of the Pacific, which is on Oahu, is the largest rehab hospital in Hawaii, and has outpatient clinics on some of the outer islands, including Hilo Clinic. In 2017, an employee asked the compliance officer whether it’s appropriate for an employed hand therapist to provide free services to an independent physician, says attorney Bob Wade, who represented the hospital in the settlement. “Someone had their Stark antennae up,” he says. The question triggered an internal compliance investigation of the activities of the hand therapist, who worked at the Hilo clinic.

The findings: the certified hand therapist was visiting the physician’s private practice in Hilo one or two times a week to provide free services and supplies (e.g., splints and bandages), says Wade, who is with Barnes & Thornburg in South Bend, Indiana. “The hand therapist believed it was in the rehab hospital’s best interest and

continued on p. 5

Abuse Icon, Infection Control May Factor Into Compliance With Discharge Planning Rule

About a month before the new patient discharge planning regulation took effect Nov. 29, CMS began posting an icon on the Nursing Home Compare website next to skilled nursing facilities (SNFs) and nursing facilities (NFs) cited for abuse, neglect or exploitation. The red warning sign may come up for SNFs and NFs that otherwise are considered high quality, either on Medicare Compare or a hospital’s own performance metrics, and case managers and social workers should be prepared to address the incongruence with patients.

The abuse icon is one of many considerations for hospitals as they comply with the discharge planning regulation, which expanded Medicare patient-choice requirements. The abuse icon isn’t necessarily a disqualifier for high-performance SNFs and NFs, said Mary Beth Pace, vice president of care management at Trinity Health, at a Jan. 21 webinar sponsored by RACmonitor.com. The reasons for the icon run the gamut from true abuse to falls with a resulting injury. “We’re not saying every nursing facility with an abuse icon is a bad place,” she explained. “We think patients should have a conversation with the SNF and, depending on the response from the SNF, consider them if they’re in our performance network.” Just don’t gloss over the

continued
icon. “It’s a trust factor,” Pace said. Hopefully, in its forthcoming interpretive guidelines on the discharge planning regulation, which modified Medicare’s conditions of participation, CMS will shed more light on what hospitals should do if one of their high-performing SNFs has an icon.

The patient discharge regulation presents challenges in other areas, including infection control and the newly revised Important Message from Medicare and Detailed Notice of Discharge. They’re magnified now that hospitals are required to give patients a list of more types of post-acute care (PAC) providers in the geographic area of their choice even if they don’t have an available bed, including SNFs, home health agencies, long-term acute care hospitals, inpatient rehabilitation hospitals and critical access hospitals. Hospitals must provide information about the PAC providers on quality and resource use in accordance with the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. The quality data is available at Medicare Compare websites, although hospitals are awaiting more information about how to use them in the interpretive guidelines for surveyors, Pace said.

“For years we have had a rule to provide patient choice, but most of the case managers and social workers thought all that meant was giving a list” of PAC providers to patients, Pace said. The regulation requires “an effective discharge planning process that focuses on the patient’s goals and preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care.”

She explained that means really listening to what the patient wants. For example, a 79-year-old woman who lives alone and breaks her hip may want to return home, but her family hopes to transition her to long-term care. “If you don’t listen to the patients, you are doing them a disservice,” Pace said. Unless she’s incapacitated, a frail elderly woman should qualify for therapy in an outpatient setting or home health, consistent with her wishes. “This isn’t the easy button anymore.”

Trinity Starts With Performance-Network Providers

Trinity Health has a two-pronged approach to complying with the requirement to give patients quality information about PAC providers, Pace said. For the most part, it was in place before the regulation took effect, but some changes were made to conform to the new conditions of participation. Patients who are being discharged to post-acute care are given a list of relevant PAC providers (e.g., home health agencies) in Trinity’s “performance network,” which is a list of PAC partners that have its seal of approval (also known as its quality-of-care profile). The criteria Trinity uses at this point for the quality-of-care profile are the CMS star rating, the timely initiation of care rating, hospital readmission rating, specialty clinical programs and additional support services. “We use the quality facilities for all our patients because they have collaborated with us on improving their care and outcomes at the same time that we are improving our care and outcomes,” Pace said. If patients want additional options, Trinity Health refers them to Medicare Compare.

Case managers have expressed concern about steering patients to these performance networks, but it’s not steering, Pace said. “They thought if you told a patient what facilities were better, you were steering them to those facilities. Now you’re allowed to discuss which SNF is a better choice because you’re required to share the quality metrics,” she explained. Just don’t call them “preferred providers.” Although CMS didn’t prohibit that language in the rule, in comments that followed, the agency spoke of that phrase “in a very negative light.”
Tablets Are an Infection Risk

Because patients obviously need access to the internet to search CMS’s website unless the hospital prints out the pages for them, some hospitals may give patients tablets or laptops. But Pace said the infection control department isn’t thrilled with the idea. “Infection control is a big concern for us,” she noted. Think of it this way: every time hospital staffers go in and out of a room, they wash their hands. “How do you wash a laptop? We have the same problem with pens for signatures on the Important Message from Medicare. We give away a lot of pens because of our concern about spreading germs,” although Trinity has reduced the waste by having the person who delivers the second Important Message from Medicare (IMM) sign and date its delivery instead of the patient, she said. Without the use of hospital laptops or tablets, patients who are referred to Medicare Compare will be free to use their own computers or iPhones.

There will be patients who refuse all the SNFs available to them or who insist on a bed in a facility without a bed available. When Medicare beneficiaries are medically stable for discharge but dig in their heels, hospitals may serve them with a Detailed Notice of Discharge (DND), which gives them the steps to appeal their discharge. They’ve already received the IMM, which informs them of their right to appeal the discharge to a quality improvement organization (QIO). CMS has just updated the DND and IMM with more than cosmetic changes and an April 1 implementation date, Pace said. For patients with Medicare Advantage (MA), hospitals have to provide the name of the MA plan and a contact number for a person who will help the patient and/or family with an appeal to the MA plan if they miss the opportunity to appeal to the QIO, Pace said. “What Medicare managed care plan teams have to provide to patients and families is their own appeal process in their MA programs,” she said. Suppose a patient is enrolled in an MA plan that has a contract with three SNFs, but the family doesn’t want the patient admitted to any of them. The family is permitted to file an appeal to the MA plan to perhaps use a contract with a different SNF, she said. “The challenge will be if all of that takes time and the QIO already said they should go, what happens to the” Hospital-Issued Notice of Non-Coverage (HINN)? The HINN informs patients that Medicare probably won’t cover their hospital stay. “Who takes responsibility for that HINN while they find a different facility?”

Case managers may sometimes get “flustered” trying to remember all the information they have to discuss with patients under the discharge planning regulation. “We recommend role playing,” she said. For example, case managers could practice what they will say “in the unfortunate situation” when they go into a room and family members aren’t all on the same page about post-acute care for the patient. “We have to think about what we need our teams to do,” she said. Trinity Health also is asking each hospital to develop a process for a monthly check for the abuse icon on the Medicare Compare website of high-performing facilities.

Another idea is teaching patients about PAC providers on Trinity’s station on the television sets in their rooms, said Pace, who noted that the compliance response to the discharge planning regulation was a team effort and included people from compliance and ethics, care management, legal, population health, continuing care clinical integration, accreditation and regulatory, care management, and audit services.

Contact Pace at pacem@trinity-health.org.

Endnotes


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Hospitals Use NLP, Policies to Reduce Unedited Copy/Paste

When the electronic medical record says the patient “will start antibiotics” or is “febrile” seven days in a row, it’s a telltale sign the physician is using copy and paste without updating the entry. Although the indiscriminate use of copy and paste is driving compliance officers and physician advisors to distraction because it swells the chart and may erode its integrity, some of them have developed ways to identify and circumscribe its use. Without controls on copy and paste and other documentation shortcuts, charts may become increasingly estranged from the patient’s clinical reality, putting quality of care and payment at risk, experts say.

“It looks like a virus because of the amount of replication growing daily,” said David Reed, M.D., medical director of case management and utilization at Stamford Hospital in Connecticut, at a Jan. 7 Finally Friday presentation sponsored by the Appeal Academy. “When you are buried in a morass of duplicative stuff—a four-day stay can have 200 pages—it’s absurd,” and important information may be overlooked.

A study reported in the September edition of JAMA Network Open found that only 38.5% of the reviews of systems and 53.2% of the physical examination systems documented in the electronic health record for 180 patient encounters “were corroborated by direct audiovisual or reviewed audio observation.”

Because the unedited use of copy/paste is threatening the integrity of documentation, hospitals are trying various strategies to cut down on the use of inappropriate copy/paste and to ensure physicians edit their notes. They include natural language processing to identify repetitive phrases and policies that limit its use. The goal is to improve the accuracy of the documentation and reduce its volume.

That doesn’t mean the elimination of copy/paste, which is here to stay because it’s a time saver. “I have no illusion of getting rid of copy/paste, but I’m trying to take steps to improve it,” Reed said. “People are convinced to get the highest level of reimbursement you need a long note, but you can make a good note in half a page.”

The chart has three purposes: to share important information among clinicians for quality of care; to mitigate risk for medical-legal reasons, which means documenting “that people who are caring for the patient did the right thing”; and to support coding for payment purposes, he explained. All are adversely affected when notes are distorted by meaningless entries. But prying physicians from copy/paste may not be easy. “The problem is sort of like an addiction,” Reed said.

Natural Language Processing Is Used in Audits

In his education with physicians, Alvin Gore, M.D., physician advisor and director of utilization management at St. Joseph Health System in Santa Rosa, California, emphasizes the importance of including “unique components” in their note every day. As he tells physicians, “If you want to carry your note forward, I want you to add unique paragraphs to the relevant portions of the exam, diagnosis and treatment. I don’t want to see ‘will consult gastroenterologist’ for the next seven days.” When Gore shows them charts with that kind of repetition, it makes an impact. “It looks ridiculous, and nobody wants to look ridiculous.” He also posts problematic notes on a monitor where physicians eat, because their eyes will inevitably wander to the screen. “Eventually it gets ingrained,” he explained.

Children’s Hospital Los Angeles uses natural language processing (NLP) to identify the use of nonedited copy/paste, said Ara Balkian, M.D., chief medical director of inpatient operations. “Like every hospital, we recognize there’s a problem with notes being too long, not concise and not clear, and with copy and paste, that isn’t always appropriate, so we wanted to find a way of tackling it,” he said.

The Clinical Documentation Quality committee at Children’s Hospital Los Angeles, which Balkian chairs, hoped its electronic medical record system had a product to flag unedited copy/pasted notes, but that wasn’t the case. Instead, a hospital IT employee developed an NLP program that detects repetitive use of certain words in a physician’s assessment and plan. Every month, Balkian sends the names of 10 physicians to an analyst from the health information management department, who pulls five encounters or admissions per physician. The length of stay varies, although only stays with a minimum of three days are included in the review. Then the analyst runs their notes through the NLP program, which highlights key words—consulted, day #, ordered, pending, planned, POD, post-op day, pulled, requested, scheduled, today, tomorrow and yesterday—in orange. If they appear again in the same patient’s notes, the words light up in blue, and the analyst will mark the notes, dates and times. The analyst will then determine if the notes are identical. When that’s the case, she escalates the chart to the physician advisor for review.

“If it’s all blue, it means the [assessment and plan] was not changed at all,” Balkian said. “Sometimes we can’t tell. The patient is stable and awaiting placement, and we say it could be a better note,” but it’s not inaccurate. And there are instances when the note has been edited “and it’s still not a very good note. It’s a quality issue, but this review is not tackling that.”
Balkian emails physicians flagged in the reviews. The email informs the physicians that the Clinical Documentation Quality committee has been auditing notes for the use of nonedited copy/paste and has identified notes for the following patients on these dates, and asks the physicians to review them for “any opportunity for optimization,” Balkian said. “I try not to be judgmental.” Chronic copy/paste abusers are referred to the medical executive or credentialing committee.

“People are usually responsive,” he said. Notes are still too long, and there are other issues affecting quality, including deletions. “There’s some subjectivity about what a good note is, but we can at least get folks to understand we are paying attention.”

‘Physicians Were Aware What Was Coming’

Four years ago, Gore initiated a policy on electronic health record documentation standards, including copy/paste. He started with the medical performance committee and then went to utilization management. After getting support there, “I took the policy to all the major medical staff departments,” he said. “Some were completely supportive and some dissented, but at least physicians were completely aware of what was coming. Their suggestions were incorporated into the policy,” which was adopted in 2016 (see box, pages 6-7).3 “Copy/paste is not going away, so we regulated what are acceptable uses and what are not acceptable uses, and knowing a lot of documentation is done by mid-levels, we made a separate section for them,” Gore said.

For example, the policy states that “while some portions of medical information may be copied and pasted, the Chief complaint, Review of Systems, Physical Examination, Assessment and Plan sections of the patient’s record should not be copied from another author, except in circumstances when information is not obtainable directly from the patient. Interval history, subjective HPI, Physical Examination, Assessment and Plan should not be copied from another author without updating each section of the note with dated current information.”

Every entry in the note also must be dated manually. Before the policy, physicians, especially hospitalists and trauma surgeons, copied previous notes into new notes without mentioning the dates, “so it was a mishmash to review,” Gore said. “Now I can separate the note by the daily entry.”

The policy is enforced. “We have an escalation process,” Gore said. “Anybody, including the patient, has a right to raise questions about copy and paste.” Two years ago, a physician’s hospital privileges were revoked for violating the policy. “It’s not a panacea. I still see some copy/paste, but we have some sort of document and some teeth so we can go back to the chair of the department to work with the physician.”

Reed is creating a medical staff committee to look at policies associated with a medical chart, including copy and paste, which “is the most egregious problem. My dream list is there would be” no copying and pasting into the assessment and in the daily note at a minimum. For physicians who can’t let go of copy/paste, the hospital will offer advanced voice dictation (e.g., M-Modal, Dragon).

Contact Balkian at ara@pediatricrcrg.com, Gore at alvin.gore@stjoe.org and Reed at dreed@stamhealth.org.

Endnotes


Clinic Settles CMP Case

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the physician’s best interest to provide these services and supplies to assist the physician.” There wasn’t a contract between the hospital and physician, who refers patients to the clinic and hospital, and the physician paid no compensation to the hospital or the hand therapist for the services, Wade explains.

Only the hand therapist and her supervisor knew of the arrangement. “No one in the executive leadership was aware it was occurring or condemned it,” Wade says. There was no corresponding spike in referrals to the hospital, he says.

‘We Felt This Was an Innocent Mistake’

It was arguably a Stark Law violation because the services and supplies were provided free to the physician by the hospital through an employee, which could have sent the hospital to CMS and its Self-Referral Disclosure Protocol (SRDP). But the scales were tipped to OIG’s Self-Disclosure Protocol (SDP) because emails the hand therapist sent hinted at a quid pro quo. The emails “said her services and supplies were a mutually beneficial relationship,” Wade says. The SRDP is equipped only for “actual or potential” Stark violations, but the SDP resolves CMPs for a wider range of alleged violations, including kickbacks. “We determined the best approach was to believe at best this could potentially be a CMP because of the inference of intent, and that was expressed in the emails,” Wade says. “We decided to go through the CMP disclosure

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Policy on Copy/Paste, Other EHR Documentation

Alvin Gore, M.D., physician advisor and director of utilization management at St. Joseph Health System in Santa Rosa, California, developed this policy on the use of copy and paste and other electronic health record practices. “We made it clear the physician of record is responsible for everything in the chart,” he says. Contact Gore at alvin.gore@stjoe.org.

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<td>MEDICAL STAFF POLICIES AND PROCEDURES</td>
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I. VALUES CONTEXT

Our values call us to respect the inherent dignity and worth of every individual and develop systems and structures that attend to the needs of those at risk of discrimination because of age, gender, lifestyle, cultural or ethnic background, religious beliefs or socioeconomic status.

II. DEFINITIONS

**Electronic Health Record (EHR) -** patient-related electronic documentation which provides an accurate depiction of treatment surrounding a specific date of service.

Cloning documentation refers to medical record documentation that has been cut and pasted from another source location and, consequently, may or may not accurately reflect information specific to the individual patient encounter once it is completed in its cloned location.

**Automatic Data Recall** shall be understood as electronic functionality that automatically pulls in information from other areas of the electronic record or electronic text or templates that pull in preset information.

**Physician Providers** include any attending physicians (MD, DO, DPM or dentists).

**Non-Physician Providers** include nurse practitioners, certified nurse midwives, and physician’s assistants, who may create clinical notes.

**Providers** will mean both Physician Providers and Non-Physician Providers.

III. SCOPE

All Santa Rosa Memorial (SRM) EHR users, including, but not limited to, Physician Providers and Non-Physician Providers, who document health care items or services and any EHR system as part of providing services on behalf of SRM.

IV. PURPOSE

The purpose of this Policy is to establish the standards and criteria for the appropriate use of the EHR in order to meet Federal and State rules and regulations regarding appropriate Provider documentation and the integrity of the patient record, including the use of Automated Data Recall and Cloning in the Electronic Health Record.

V. POLICY STATEMENT

The EHR should document clinical work performed on each patient each day. Copy and pasting may occur only through a thoughtful evaluative process that assists with the accurate documentation of the specific services provided, supports medical necessity, and produces a record that enhances patient care.

VI. PHYSICIAN’S RESPONSIBILITY AND EXPECTATIONS

1. The Physician Provider is ultimately responsible for the accuracy of the health record for each patient under the physician’s care.

2. Physician Providers are required to document in compliance with all federal, state, and local laws, Hospital policies and procedures, and Medical Staff Bylaws, Rules, and Regulations.

3. Physician Providers are solely responsible for:
   A. The total content of their documentation, whether the content is original, copied, pasted, imported or re-used.
   B. Correcting and dating any errors identified within documentation and clearly noting in the EHR that this is a correction of previously inaccurate information.
   C. Citing outside or a third-party source when external data is documented in a note.
   D. Reviewing, attesting and appropriately updating the Assessment/Problem List of each note.
   E. Attesting and dating that there has been no change, if the Assessment and/or Plan are copied and are unchanged from the previous note.
   F. Checking for contradictory information in the medical record documentation.
   G. Ensuring the accuracy and medical necessity of any information that is imported or re-used from a prior note.
   H. Ensuring that significant abnormalities which are copied into the chart are also documented in the Assessment and Plan section of the note (e.g., an elevated potassium level copied into a note should have a plan to address the abnormality).

4. Providers are discouraged from:
   A. Indiscriminate use of copying or use of the data recall, particularly use which results in redundant information from other parts of the EHR, which makes it difficult to identify current...
information (e.g., other Provider’s progress notes, prior Discharge Summaries, diagnostic test findings).

B. Indiscriminate use of “Normal Limits” shortcut: if the “Normal Limits” shortcut is used, the Provider will de-select items not performed and ensure that abnormal findings are documented correctly.

(5) Providers must notify hospital’s Health Information Management immediately regarding any inaccurate entries that cannot be corrected by the Provider (e.g., wrong patient, wrong record, outside media which cannot be altered).

(6) In addition to a general date reference (e.g., post-op day 1, hospital day 1), the use of a calendar date is encouraged in order to clearly discern when a particular service was delivered.

(7) Once a note has been signed as final, additional information may only be added as a separate addendum that is clearly marked with dates and times.

VII. ACCEPTABLE USE OF COPY AND PASTE

(1) Providers may copy relevant portions of the patient’s previous notes or use the Automatic Data Recall, entered by the same Provider, to the extent it represents the level of work performed by the Provider during the current visit and is revised to reflect any changes in the information. Historic conditions or services will be clearly differentiated from present conditions or services. In such cases, the Provider’s signature shall serve as his/her attestation that the information is accurate, and that all information is current and represents the Provider’s services for that date of service.

(2) While some portions of medical information may be copied and pasted, the Chief complaint, Review of Systems, Physical Examination, Assessment and Plan sections of the patient’s record should not be copied from another author, except in circumstances when information is not obtainable directly from the patient. Interval history, subjective HPI, Physical Examination, Assessment and Plan should not be copied from another author without updating each section of the note with dated current information.

(3) If test results are located elsewhere in the EHR, Providers are encouraged to summarize the diagnostic test findings rather than copying the complete report into a note. When the entire report is used, it should be accompanied by proper notation and clear attribution.

(4) Notes from other Providers may only be used as reference information and cannot be copied into a current note. Providers are responsible for ensuring notes copied from another Provider retain date, time, and original Provider notation. For example: “Per Progress Note of Dr. X dated 1/1/2015.” Notes copied from other Providers will have no impact on the scoring of the current entry.

(5) Automatically pre-populated data, such as Lab results or “Shared queries,” that are not attributable to a specific Provider.

VIII. PHYSICIAN ATTESTATIONS

The Physician Provider will apply the appropriate attestation to accurately reflect their involvement in the care and treatment of the patient and documentation of the visit in compliance with physician guidelines.

IX. NONCOMPLIANCE PROCESS

(1) Noncompliance with documentation standards and guidelines can be identified by any authorized EHR user or patient who reviews the EHR.

(2) When a potential documentation compliance issue is identified, the Medical Record Number (MRN), name of the Health Care Provider, and a description of the error shall be forwarded to the Chief Medical Information Officer (CMIO) for review with the Provider.

(3) If documentation practices remain unchanged following CMIO intervention, the CMIO will escalate to the Chief Medical Officer (CMO) for review and recommendation.

(4) If further escalation is required, the CMO will refer to the Chief of Staff, who will initiate appropriate procedures to address and resolve any incident(s) of noncompliance, including, but not limited to, Education, Monitoring and Corrective Action pursuant to Medical Staff Bylaws.

X. APPROPRIATE DOCUMENTATION BY NON-PHYSICIAN PROVIDERS

(1) Physician Assistants, Nurse Practitioners and Certified Nurse Midwives can document the reason for visit, past medical history (PMH), past surgical history (PSH), social/family history (SH/FH), or review of systems (ROS), as long as the physician reviews and revises as needed, including the information and documentation of services provided.

(2) The Physician Provider or Non-Physician Provider must perform and complete the documentation of the Chief Complaint, History of Present Illness (HPI), Physical Examination (PE) (except for vital signs) and Assessment & Plan (medical decision-making) entries.

(3) If any documentation within these sections was started by someone other than the physician, an attestation statement entered by the physician (separate from the original note template) should reflect the Provider reviewed and edited these sections.

References:


Reviewed/Revised by: SJH Office of General Counsel 5/25/16
Approvals: Medical Record Committee 5/17/16 Distribution: All Departments
Medical Executive Committee 6/14/16
Board of Trustees 6/28/16

Have feedback? Please contact Scott Moe at scott.moe@hcca-info.org with any questions or comments.
Have a story idea? Please contact Nina Youngstrom at nina.youngstrom@hcca-info.org.
and not the SRDP.” But, he maintains, “we felt this was an innocent mistake. The hand therapist didn’t understand the complexities under the Anti-Kickback Statute and Stark Law.”

The CMP settlement is a reminder that hospitals have to make sure their employees, from top to bottom, understand they can’t give physicians freebies. Hospitals can skip the finer points of Stark and kickbacks, but compliance education should touch everyone, or it may take a while for problems to come to light, as in this case, Wade says. “Otherwise, people think all the compliance issues occur at the executive level, and you may enter into noncompliant relationships.” It should be everyone’s “mantra,” he says: “We can’t provide anything of value without the doctor compensating us for the services,” except for the goodies that fall under the Stark nonmonetary compensation exception. “They don’t need to know specifically that it violates the Stark Law or the Anti-Kickback Statute.”

Although Rehabilitation Hospital had 10 years of liability, OIG assessed a 1.5 multiplier on six years of payments stemming from referrals from the physician who received free services and supplies and a single multiplier on the other four years, Wade says. It’s typical to get some leniency after four years, he notes. “We were able to draw the line where the period was” between four and six years. The government trusted our disclosure of the facts because we were very transparent. That’s how we ended up reaching a settlement,” Wade says.

He has seen the kind of noncompliance that happened at Rehabilitation Hospital elsewhere. For example, a hospital’s obesity program may send a clinician to consult with a private practice. It’s permissible under the Stark Law for a nutritionist to provide one-time patient education on nutrition or explain hospital services, “but you start to cross the line if the nutritionist is providing routine nutritional counseling,” Wade says, or if suburban and metropolitan hospitals send employees to help at rural clinics without charging them, hoping for their referrals.

Contact Wade at bob.wade@btlaw.com. ✧

Endnotes


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**NEWS BRIEFS**

♦ Mission, Texas, rheumatologist Jorge Zamora-Quezada, M.D., was found guilty by a jury Jan. 15 for his part in a $325 million health fraud scheme in which he “falsely diagnosed patients with life-long diseases and treated them with toxic medications,” the Department of Justice said. Zamora-Quezada gave many patients a fake diagnosis of rheumatoid arthritis and treated them with chemotherapy drugs and other medically unnecessary medications. As a result, the patients suffered physical and emotional harm. Some patients were as young as 13. Evidence presented at trial showed the physician also falsified medical records, the Department of Justice said. Zamora-Quezada was convicted of health fraud, conspiracy to commit health fraud and conspiracy to obstruct justice.

♦ A primary care physician in Webster City, Iowa, was sentenced to two months in prison in connection with his guilty plea for making false statements related to health care matters, the U.S. Attorney’s Office for the Northern District of Iowa said Jan. 16. Joseph X. Latella, who was the medical director for two nursing homes, also will pay $316,438 to settle False Claims Act allegations that he upcoded Medicare and Medicaid claims for routine visits to nursing home patients from Jan. 1, 2014, to Nov. 30, 2018. In July 2016, a Medicare contractor sent Latella a letter warning him “that his billing patterns were significantly more expensive than other doctors,” the U.S. attorney’s office said. Two years later, Latella submitted sworn letters to the U.S. attorney in which he falsely stated that he spent about 35 minutes each on the care of 12 patients at two nursing homes. “In truth, a federal agent had conducted in-person surveillance of Dr. Latella on that date, and Dr. Latella only was onsite at the first nursing home for a total of 47 minutes and did not visit the second nursing home at all on that date,” the U.S. attorney stated. In addition, the physician gave the U.S. attorney phony “re-created” treatment notes “to cover up his overbilling scheme.”

♦ CMS said Jan. 21 it has finalized a national coverage determination that covers acupuncture for patients with chronic low back pain. “CMS conducted evidence reviews and examined the coverage policies of private payers to inform today’s decision,” the agency said.

Endnotes