Issue 13, Fall 2017

This newsletter is prepared by the Office of Compliance and is intended to provide you with current information about healthcare compliance and HIPAA privacy issues. For

Compliance Week's A-Coming!

Corporate Compliance & Ethics Week is November 5 - 11. The Healthcare Compliance Team will be setting up a table and photo booth at various locations to celebrate the week. Stop by the photo booth to meet your Compliance partners, sign up for a focus group, and complete a survey to be entered for a chance to win a $50 USC gift card.

Keep an eye out for flyers and e-mails with a list of locations, dates, and times.

Former Executive of a Tenet Hospital Charged Along With Clinic Owner and Operator in $400 Million Fraud and Bribery Scheme

A former executive of a Tenet Healthcare Corporation-owned hospital and the owner and operator of an Atlanta-area chain of pre-natal clinics were charged in a superseding indictment that also added additional charges against another former Tenet executive for their alleged roles in an over $400 million fraud and bribery scheme. The indictment alleges that the scheme victimized the United States government, the Georgia and South Carolina Medicaid Programs and patients of Tenet hospitals.

The indictment includes charges against the former chief executive officer of Atlanta Medical Center, Inc. with conspiracy to defraud the United States and pay and receive health care bribes, wire fraud, falsifying corporate books and records, and major fraud against the United States. The indictment charges Cota, who served as the president and chief executive officer of Hispanic Medical Management, Inc., which did business as Clinica de la Mama, and later Cota Medical Management Group, Inc., with one count of conspiracy to defraud the United States and pay and receive health care bribes, three counts of receiving health care bribes, and three counts of wire fraud.

The indictment alleges, among other things, that the defendants caused the payment of bribes in return for the referral of patients to certain Tenet hospitals and took affirmative steps to conceal the scheme by, among other methods, circumventing internal accounting controls, falsifying Tenet's books, records and reports, and making, and causing to be made, false representations to the federal government. According to the indictment, these bribes helped Tenet bill the Georgia and South Carolina Medicaid Programs for over $400 million, and Tenet obtained more than $149 million in Medicaid and Medicare funds based on the resulting patient referrals.

Read the full release here.

Attorney General Sessions Announces Opioid Fraud and Abuse Detection Unit

Attorney General Jeff Sessions announced the formation of the Opioid Fraud and Abuse Detection Unit, a new Department of Justice pilot

additional information, to view past newsletters, or to provide comments about this or any future issues of this newsletter, please contact the Office of Compliance at (213) 740-8258 or at compliance@usc.edu.

The USC Help & Hotline can be used by all faculty, staff, and students to report suspected violations of an applicable law, regulation, or university policy confidentially and without fear of retribution. The Help & Hotline can also be used to ask questions about applicable laws, regulations, and university policies that may impact your job duties.

*The USC Help & Hotline is staffed 24 hours a day, 365 days a year: (213) 740-2500 or file on the web and enter **UOSC** as the access code.*

program to utilize data to help combat the devastating opioid crisis that is ravaging families and communities across America. The new Opioid Fraud and Abuse Detection Unit will focus specifically on opioid-related health care fraud using data to identify and prosecute individuals that are contributing to this prescription opioid epidemic.

Additionally, as part of the program, the Department will fund twelve experienced Assistant United States Attorneys for a three-year term to focus solely on investigating and prosecuting health care fraud related to prescription opioids, including pill mill schemes and pharmacies that unlawfully divert or dispense prescription opioids for illegitimate purposes.

As additional evidence of the Department of Justice's ongoing efforts to battle the opioid epidemic, the DOJ announced a $7.55 million settlement with Galena Biopharma Inc. to resolve allegations under the False Claims Acts that it paid kickbacks to doctors to induce them to prescribe its fentanyl-based drug, Abstral.

Read the full Opioid Fraud and Abuse Detection Unit release here.

Read the full Galena settlement release here.

Nationwide Medicare Electronic Health Record Incentive Payments to Hospitals to be Reviewed

The OIG plans to review hospitals' incentive payment calculations to identify potential overpayments that the hospitals would have received as a result of inaccuracies in the hospitals' calculations of total incentive payments.

Medicare incentive payments were authorized over a 5-year period to hospitals that adopted EHR technology (Recovery Act, § 4102). From January 1, 2011, through December 31, 2016, CMS made Medicare EHR incentive payments to hospitals totaling $14.6 billion. Previous OIG reviews of Medicaid EHR incentive payments found that State agencies overpaid hospitals by $66.7 million and would, in the future, overpay these hospitals an additional $13.2 million. These overpayments resulted from inaccuracies in the hospitals' calculations of total incentive payments.

The OIG's Work Plan can be viewed here.

Review of Medicare Payments for Telehealth Services

The OIG will review Medicare claims paid for telehealth services provided at distant sites that do not have corresponding claims from originating sites to determine whether those services met Medicare requirements.

Medicare Part B covers expenses for telehealth services on the telehealth list when those services are delivered via an interactive telecommunications system, provided certain conditions are met (42 CFR § 410.78(b)). To support rural access to care, Medicare pays for telehealth services provided through live, interactive videoconferencing between a beneficiary located at a rural originating site and a practitioner located at a distant site. An eligible originating site must be the practitioner's office or a specified medical facility, not a beneficiary's home or office.

Detroit Area Medical Biller Sentenced to 50 Months in Prison for Her Role in a $7.3 Million Dollar Healthcare Fraud Scheme

According to the evidence presented at trial, from June 2014 through June 2015, Dawn Bentley knowingly submitted fraudulent bills on behalf of a co-conspirator physician for services she knew could not have been rendered, and for services she knew had not been rendered as billed. In

exchange, Bentley was paid 6% of the total billings paid to the physician from Medicare, the evidence showed. Bentley's largest client was Waseem Alam, who pleaded guilty to a $33 million Medicare fraud scheme in March 2016. Bentley billed $1.9 million of this fraud from June 2014 to June 2015, and was paid 6% of Alam's receipts for the fraudulent billings, the evidence showed. Bentley's company received over $100,000 from Alam's practices between June 2014 and June 2015, the evidence showed.

The FBI and HHS-OIG investigated the case, which was brought as part of the Medicare Fraud Strike Force under the supervision of the Criminal Division's Fraud Section and the U.S. Attorney's Office for the Eastern District of Michigan. The Fraud Section leads the Medicare Fraud Strike Force. Since its inception in March 2007, the Medicare Fraud Strike Force, now operating in nine cities across the country, has charged nearly 3,000 defendants who have collectively billed the Medicare program for more than $11 billion. In addition, the HHS Centers for Medicare & Medicaid Services, working in conjunction with the HHS-OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers.

Read the full press release here.

Jacksonville Cardiovascular Practice Agrees To Pay More Than $440,000 To Resolve False Claims Act Allegations For Failing To Reimburse Government Health Care Programs

Acting United States Attorney, W. Stephen Muldrow, announced on October 13, 2017 that First Coast Cardiovascular Institute, P.A. ("FCCI") has agreed to pay $448,821.58 to resolve allegations that it violated the False Claims Act by knowingly delaying repayment of more than $175,000 in overpayments owed to Medicare, Medicaid, TRICARE, and the Department of Veterans Affairs.

Specifically, the government alleges that FCCI accrued credit balances or overpayments owed to federal health care programs. These credit balances often occur in a medical practice, for example, when two insurers share responsibility for a payment and one pays too much. In 2009, amendments to the False Claims Act made it a violation to knowingly fail to pay back an obligation owed to the United States and its federal health care programs. Despite repeated warnings, FCCI failed to pay back the money it owed to Medicare, Medicaid, TRICARE, and the VA until being notified that the Department of Justice had opened an investigation into their failure to repay the government.

Read the full press release here.
