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Contents

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As a Gateway to ePHI and Provider Banking Information, Payer Websites Are Ripe for Audit

Knowing that people at health care organizations are able to execute electronic fund transfers on payer websites and access electronic protected health information (ePHI), Ochsner Health in New Orleans grew concerned. It decided the time had come for an audit of access controls on the payer portals, which contain patient and financial information.

Websites for payers like UnitedHealthcare, Anthem and Cigna are used for revenue cycle processes—preauthorization requests, claims submissions and payments, said Kelly Rollins, manager of IT audit at Ochsner. They could be a conduit for a breach because they provide access to ePHI or theft because payers use the portals to make payments to providers through electronic funds transfer/electronic remittance advice (EFT/ERA). It may take a diversion or something close to it for health care organizations to recognize that insurance websites represent another source of HIPAA and financial risk, she said. That's why a different kind of audit and response is necessary.

"Addressing potential financial and patient risks were the drivers for this audit," Rollins said.

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Cases Mount in Investigation of Physician P-Stim Billing; LCD Plays Pivotal Role

A national investigation of physician billing for treating patients with P-Stim and NeuroStim (NSS) devices has led to a series of false claims settlements, but they are also spawning lawsuits against some billing consultants who advised physicians on how to bill Medicare and other government health care programs for the devices and the marketers and makers of the devices. The cases also point to the risks of submitting claims that don't comply with local coverage determinations (LCD).

P-Stim, NSS, ANSiStim and similar devices are used for acupuncture, which is not covered by Medicare, according to the Department of Justice (DOJ). Some physicians allegedly were billing for procedures with the devices, which are not Food and Drug Administration approved, as if they were performing percutaneous implantation of neurostimulator electrode array; peripheral nerve (CPT code 64555), which is a surgical procedure covered by Medicare.

In January, for example, six surgery centers and medical offices in New York and New Jersey affiliated with Interventional Pain Management Center P.C. (IPMC), a company owned by physician Amit Poonia, agreed to pay $7.447 million to settle false claims allegations they billed Medicare and the Federal Employees Health Benefits Program (FEHBP) for neurostimulator implants when they were actually administering P-Stim and NSS devices, from January 2012 through April 2017, the U.S. Attorney's Office for the Eastern District of New York said.[1] P-Stim and NSS devices transmit electrical pulses through needles put under the skin on a patient's ear. The medical and surgical groups also allegedly billed Medicare and FEHBP for anesthesia in connection

continued

with the P-Stim and NSS. Two former employees turned whistleblowers set the case in motion.

But Poonia has a few bones to pick with the way this case played out. Two of his surgery centers were audited by the Medicare administrative contractor (MAC) in 2015 and "they said we were in compliance" with billing, coding and medical necessity requirements, he told *RMC*. Ultimately, there were five audits, and he said he passed them all. In 2016, Medicare explicitly stated that P-Stim, NSS and ANSiStim aren't covered procedures. In a local coverage article (A55240), the MAC, Novitas Solutions, notes that "Acupuncture for stimulation of auricular points is not a covered Medicare benefit" and that CPT code 64555 "does not describe the procedure of auricular acupuncture stimulation and it should be coded using the NOC [not otherwise classified] CPT code 64999 - unlisted procedure, nervous system."[2]

Lawyer: No Multiplier on Pre-LCD Claims

Unfortunately, said his attorney, Adam Tarosky, Poonia "didn't immediately become aware the LCD existed, but a year later he was and immediately stopped billing" the P-Stim and NSS.

In 2017 and 2018, Poonia said the MAC sought recoupment for the P-Stim and NSS procedures and he returned the money. "We were getting the wrong impression from CMS" that the procedures were covered until the LCD said otherwise, he noted. Then came subpoenas from DOJ in the false claims investigation.

Poonia is not alone. "There is a flurry of providers who have settled with DOJ like Poonia for payments they received for the P-Stim," said Tarosky, with Nixon Peabody LLP. "In some cases, they have been tagged with False Claims Act liability." He's troubled by the fact that the audits cleared his clients and the "LCD comes out and says the opposite of what the audits led him to believe," Tarosky said. DOJ applied the False Claims Act (FCA) to the claims submitted after the LCD was published. But no FCA multiplier was applied to the claims submitted pre-LCD, Tarosky said.

"The advice to providers who have performed these services not called to account by the government yet is to self-disclose and return payments to avoid arguments that once the local coverage decision came out you should have known," he said.

'Pursuant to the Manufacturer's Instructions'

In another settlement, Mississippi physician Kevin Cooper M.D. and his practice, Cooper Family Medical Center, agreed to pay $375,000 to settle FCA allegations stemming from P-Stim devices, the U.S. Attorney's Office for the Southern District of Mississippi said in December.[3] Cooper allegedly billed Medicare $900,000 in one year using CPT code L8680 (implantable neurostimulator, pulse generator) and/or CPT code 64555 and was paid $179,106. He was actually administering a P-Stim device, which, "pursuant to [the] manufacturer's instructions, is affixed behind a patient's ear using an adhesive. Needles are inserted into the patient's ear and affixed using another adhesive. Once activated, the device then provides intermittent stimulation by electrical pulses," the U.S. attorney's office said.

These and other settlements are a reminder about the importance of due diligence on the part of providers to ensure they are coding correctly, no matter what a manufacturer or consultant advises, said Richelle Marting, an attorney and certified coder in Olathe, Kansas. "These cases may be a warning to providers that if the payment seems too good to be true, you need to follow your gut—it probably is," she said. At the same time, Marting said, the manufacturers are keeping the money for devices they allegedly knew or should have known would get billed to Medicare. Meanwhile, there are lawsuits pending against some of the billing consultants and distributors associated with the devices.

For example, the U.S. Attorney's Office for the Eastern District of Pennsylvania on Nov. 14 filed an FCA lawsuit against consultant Timothy Warren, a

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chiropractor, and his firm, Titan Medical Compliance LLC.[4] According to the complaint, a company named Access 2 Integration (A2I), which helps chiropractic practices that want to become "integrated," allegedly promoted P-Stim and ANSiStim devices to the practices and encouraged them to have a nurse practitioner apply them to increase revenue. From 2014 to 2018, A2I allegedly paid Warren $1,500 a month to advise its clients on establishing integrated practices and generating Medicare reimbursement for procedures performed there, the complaint says. "A2I relied on Warren to advise clients" on Medicare reimbursement for the P-Stim and/or ANSiStim device. Although Warren knew from about 2007 on that Medicare didn't pay for acupuncture, he advised A2I clients, medical practices and others "that they could seek reimbursement from Medicare for (a) the procedure of applying the P-Stim device or the ANSiStim device, and (b) for the devices themselves," the complaint alleged.

Physician Is Suing Distributor

There's also a proposed class-action lawsuit pending against Innovative Health Solutions Inc. (IHS) and Acclivity Medical LLC, which sold and marketed the NSS.[5] It was filed by Ritu Bhambhani, a physician in Abingdon, Maryland, in the U.S. District Court of Maryland on behalf of other similar plaintiffs. Bhambhani alleged that IHS and Acclivity enticed providers and facilities to buy NSS devices by promoting their billing with certain codes, including CPT code 64555. It's not clear if the proposed class has been certified, and her attorneys didn't respond to requests for comment.

"This is a class of providers who have been audited by the government and asked to return overpayments and appealed overpayment demands but they're on the hook and sued," Tarosky said.

Contact Tarosky at atarosky@nixonpeabody.com and Marting at rmarting@richellemarting.com. ✧

Endnotes

1. Department of Justice, U.S. Attorney's Office for the Eastern District of New York, "Surgery Centers and Medical Offices in New Jersey Settle Allegations of Federal Health Care Fraud," news release, January 12, 2022, https://bit.ly/3rroeaw.
2. CMS, "Billing and Coding: Auricular Peripheral Nerve Stimulation (Electro-Acupuncture Device)," local coverage, A55240, July 17, 2020, https://go.cms.gov/3rqpHxw.
3. Department of Justice, U.S. Attorney's Office for the Southern District of Mississippi, "Physician Agrees to Pay $375,000 to Resolve False Claims Act Allegations of P-Stim Device Fraud," news release, December 13, 2021, https://bit.ly/3rpJc9u.
4. United States v. Timothy D. Warren et al., Case no. 2:21-cv-04511-MSG (E.D. Pa. October 14, 2021).
5. Ritu Bhambhani et al. v. Innovative Health Solutions, Inc. et al., Case no. 1:19-cv-00355-RDB (D. Md. February 6, 2019).

CMS Updates IM; Medicare Notices Shouldn't Be Delivered 'Just in Case'

Case managers at Providence St. Joseph in Burbank, California, have their hands full at the moment with 25 discharged patients who have yet to be placed in a skilled nursing facility because of a lack of available beds in the area and another COVID-19 surge. Delivering the Important Message from Medicare (IM) isn't the first thing they think about.

"The IM is not always in the forefront of their minds," said Jane Winter, director of care management. It was just pushed there, however, because CMS updated the IM Jan. 21 in Medicare Transmittal 1120, and it has some helpful clarifications,[1] she said. "It has always been a challenge making sure the IM is delivered on time and consistently."

Hospitals are required to give all Medicare and Medicare Advantage (MA) patients the IM, which informs inpatients of their hospital discharge appeal rights. IMs must almost always be delivered at least twice before discharge: once at registration and a second time no earlier than two days before discharge. In the transmittal, CMS clarifies that the second IM may be given as late as four hours before discharge, although patients don't have to hang around the hospital after they receive it if they don't plan to appeal their discharge to the quality improvement organization (QIO), said Ronald Hirsch, M.D., vice president of R1 RCM.

CMS's biggest message to hospitals is they shouldn't pile on notices unless patients are supposed to get them, Hirsch said. For example, hospitals may try to cover all the bases by giving patients both the IM and the Medicare Outpatient Observation Notice even though they're mutually exclusive. "There was no change in Medicare policy," he said. "They memorialized it in writing that hospitals can't do that." As the transmittal states, "The IM should only be given when an inpatient admission is pending or has occurred. It should not be given 'just in case', such as a hospital delivering to all Medicare patients being treated in a hospital emergency room."

CMS also clarified that hospitals shouldn't deliver the IM to hospice patients if they're admitted to an inpatient hospice bed. Inpatients who stop curative care likewise wouldn't get the second IM. Winter said she appreciated the clarity in an area that had been ambiguous.

Also, CMS said that "once the discharge date is planned, a hospital does not need discharge orders in advance of delivering the IM." In an email exchange with CMS, Hirsch relayed that "many physicians are reluctant to order 'discharge patient' if they know the patient will be appealing their discharge and not leaving but are willing to document in the chart that 'the patient is stable for discharge.' We have seen QIOs ask for the order." In

response, CMS wrote "No, a discharge order does not need to be in the chart for the QIO to accept the appeal."

Hospitals are required to deliver IMs to a representative (on behalf of the patient) who is not physically present, the transmittal explained. The IM doesn't have to be personally delivered or delivered by courier. "The hospital must complete the IM as required and may instead telephone the representative and then mail the IM. The date and time of the telephone call is considered the receipt date of the IM," CMS stated.

Hospitals Have Automated the Process

Tweaks like this are the reason some hospitals have automated the process. "It has always been a challenge making sure the IM is delivered on time and consistently," Winter said. To improve compliance, her hospital has created a report in EPIC that notifies case management when patients receive the first and second IM. After patients sign, the hospital keeps a copy and scans it into the medical records. "Most hospitals have hard-wired procedures to get the notices delivered," Hirsch remarked. "Every one of the staff could be doing something more productive and more patient-centered than chasing down a representative, but it's a condition of participation, so they have to do it."

The transmittal noted that MA enrollees must get the IM. Winter said this has been a source of confusion. "I have had a lot of caregivers ask me if it's necessary to give the IM to Medicare Advantage patients, and of course we have to give it to them," she said. "Always there's the question of who is responsible and who will follow up." Hirsch said the process changes completely once MA enrollees appeal. MA plans are a voice on the other end of the phone and aren't available to deliver the Detailed Notice of Discharge (DND), which explains why the hospital is discharging the patient. "It's unclear why MA plans are even involved in it," he said, and the *Medicare Managed Care Manual* is vague on the subject. Providence takes on DNDs for MA enrollees who don't have on-site case management for their plans, Winter said. "Most of the time, this is the case." It's also sort of bizarre when it's time for the Hospital-Issued Notice of Non-Coverage (HINN) 12, which informs patients a continued stay isn't medically necessary and they will be on the hook for the costs if the QIO denies their appeal. Hirsch said MA plans can't use HINN 12s, leaving hospitals caught in the middle. "My presumption is the MA plan tells the hospital to deliver it, but my understanding is it's really the MA plan's responsibility," he said.

Hospitals have three months to implement the IM changes.

Contact Hirsch at rhirsch@r1rcm.com. ✧

Endnotes

1. CMS, "Expedited Review Process for Hospital Inpatients in Original Medicare," Trans. 11210, Pub. 100-04, *Medicare Claims Processing Manual* (January 21, 2022), https://go.cms.gov/3umoGsp.

Results Are In: New Round of Mid-Build Audits Go Well for Some PBDs

The results of CMS's do-over audit of the mid-build exception for provider-based departments (PBDs) are coming in, and a fair number of them have been favorable, attorneys said. After failing the audits last year, some of the PBDs passed this time and will be able to continue to bill for their services under the outpatient prospective payment system (OPPS).

It's a good outcome on balance, although not everyone got the audit set aside, and hospitals have no formal appeal rights, said attorney Larry Vernaglia, with Foley & Lardner LLP in Boston. But they have until Feb. 14 for an exit conference with CMS, which represents "their last best chance" to turn things around, he said. Attorneys urge hospitals to give it a shot before they permanently lose the ability to bill OPPS for certain services. If they lose, PBDs are stuck with the lower physician adjusted rate.

"The exit conference has to be accepted or passed on by the 14th,"said attorney Andrew Ruskin, with K&L Gates in Washington, D.C. "Everyone should take advantage of the next process if they weren't satisfied with the response because there is nothing to lose."

A lot of money is at stake because Congress shut PBDs established after Nov. 2, 2015, out of the OPPS, and in the process shaved 60% off their payments. But the 21st Century Cures Act came to the rescue for PBDs that were in the works on Nov. 2, 2015. To qualify for the mid-build exception, hospitals were required to: (1) file an attestation with CMS that the department was, in fact, provider-based, and it had to be signed by a CEO or chief operating officer; (2) add the PBD to its 855A enrollment form; and (3) have proof of a signed contract with an unrelated party for the construction of the PBD before Nov. 2, 2015.

The 21st Century Cures Act also directed CMS to audit compliance with these requirements, and 334 providers that requested the mid-build exception were audited in 2018. In January 2021, CMS told 202 PBDs they failed—three years after conducting the audits.[1] Some hospitals were racking up overpayments in the interim when they thought they qualified for the mid-build exception. "They could have made other plans if they had known earlier that they were going to be denied at that location," Vernaglia said.

Hospitals were stunned by the audit results. For one thing, Cahaba Government Benefit Administrators LLC, the Medicare administrative contractor that reviewed mid-build compliance for CMS, failed many of the PBDs because their construction contract was with the landlord, not a construction company, Vernaglia and Ruskin said. While the 21st Century Cures Act requires hospitals to have a binding written agreement with an outside party for a PBD structure, hospitals don't necessarily have contracts with construction

companies. They often lease space and ask the landlord to build it out. If Congress had meant to be more restrictive, it would have said so in the statute, and if CMS wanted to be more restrictive, it should have issued regulations spelling out what construction contracts would fly under the mid-build exception, according to Ruskin and Vernaglia.

Numerous hospitals expressed their concerns with the process to CMS. In response, CMS withdrew the audit findings Sept. 10 and said it would be back with updated determination letters after a new review.[2] That's where hospitals are now, and they were gratified that CMS apparently accepted their point about the construction contracts.

"The thoughtful and balanced review that CMS gave to the resubmissions evidences the way the system can work when CMS and regulated parties row the oar in the same direction," Ruskin said. He noted there are remaining issues that affect some audits, including whether the proper official signed the mid-build certification.

It's too bad CMS wouldn't budge, because "I don't think Congress meant if the wrong person signed the document that the hospital should lose for such a minor foot fault," Vernaglia said. Otherwise, "I'm very pleased the auditors acknowledged a flaw in the prior audit methodology."

But the higher OPPS payment rate doesn't always apply. Whether they are "excepted" PBDs (established pre-Nov. 2, 2015) and whether they fall under the mid-build exception, all PBDs are paid the same as freestanding physician clinics for G0463 (the catch-all code for evaluation and management services) because of CMS's site-neutral payment policy.

Contact Vernaglia at lvernaglia@foley.com and Ruskin at andrew.ruskin@klgates.com. ✧

Endnotes

1. CMS, "Medicare Mid-Build Off-Campus Outpatient Departments Exception Audit Results," fact sheet, January 19, 2021, https://go.cms.gov/2KvikCx.
2. CMS, "Mid-Build Exception Audit Rescission Announcement," September 10, 2021, https://go.cms.gov/3BYBTbp.

Categorizing the Risks of Payer Websites

Websites for payers like UnitedHealthcare, Anthem and Cigna are used for revenue cycle processes—preauthorization requests, claims submissions and payments—and therefore pose a potential risk to patient and financial information. They may not have adequate controls and are ripe for audit, said Kelly Rollins, manager of IT audit at Ochsner Health in New Orleans (see story, p. 1).[1] Below are the types of payer websites and the level of risk they pose. Contact Rollins at kelly.rollins@ochsner.org.

Auditing Payer Websites: Understanding Your Results

Website Type	Risk Level	Description
Could Not Create an Account	Low	Websites in which an account could not be created.
Created Account (Did not receive authorization)	Low	Websites in which an account could be created but authorization to view data in the website was not received.
Created Account (Needed additional information to view data)	Medium	Websites in which an account could be created and authorization was received but more information (e.g., billing details, patient information) was needed to see data on the website. The information needed to view data on the website would not likely be available to individuals outside of the organization.
No Account Needed (Need additional information to view data)	Medium/ High	Websites in which no user account was needed, but a user would need additional information (e.g., billing details, patient information) to search/view data on the website.
Created Account (Access to data without additional information)	High	Websites in which an account could be created without organization authorization and a user can access electronic personal health information without needing additional information. These websites allow users to search without entering information such as patient ID, claim number, etc.
Created Account (Access to financial information and/or electronic funds transfer [EFT] or electronic remittance advice [ERA] functionality)	High	Websites in which an account could be created and a user can access financial information and/or sign up for EFT/ERA in the portal without authorization from the organization.

Auditing Payer Websites: Lessons Learned

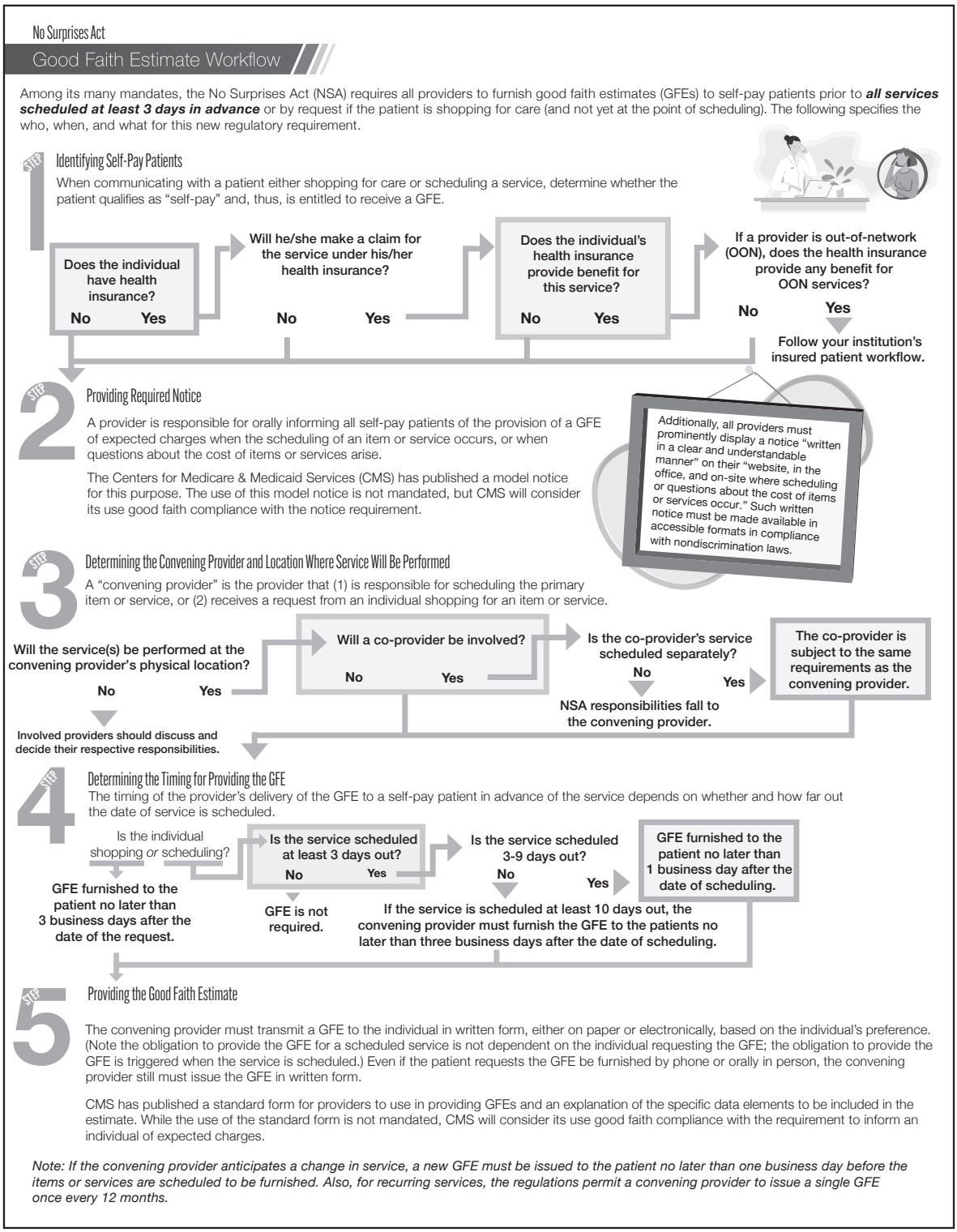
- Evaluate the "controls" on the websites. Don't take them at face value.
- Determine who's managing the EFT/ERA for the payer. If they use a third party, it could enhance the risk.
- Take a multidisciplinary approach. Involve revenue cycle, legal, compliance, etc. to identify the best strategy for your organization.
- Centrally manage website administration (if possible). Identify what team within your organization should manage access to payer websites.
- Implement processes to manage existing and new payer websites. Develop/document policies and procedures.
- You don't know what you don't know. Educate employees on new processes, and ask them to help you identify new payer websites that might have your organization's information.

Endnotes

1. Nina Youngstrom, "As a Gateway to ePHI and Provider Banking Information, Payer Websites Are Ripe for Audit," *Report on Medicare Compliance* 31, no. 5 (February 7, 2022).

Tool: Thinking Through the New Good Faith Cost Estimate Requirement

Here's a workflow tool developed by PYA to help providers comply with the good faith cost estimate requirement in the No Surprises Act.[1] Contact consultants Martie Ross at mross@pyapc.com and Kathy Reep at kreep@pyapc.com.



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1. Nina Youngstrom, "Identifying Out-of-Network Services, Billing Amounts Is 'Hard Part' of No Surprises Act," *Report on Medicare Compliance* 30, no. 45 (December 20, 2021), https://bit.ly/3n278gA.

Payer Portals Are Another Source of Risk

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To get Ochsner's audit of payer websites underway, Rollins asked the revenue cycle department to identify the population (payers with websites) and Ochsner's tax identification numbers (TINs) and national provider identifiers (NPIs). Because there are hundreds of payers, it may be necessary to take a risk-based approach to auditing. "Some of these payer websites are considered self-applying," Rollins said. In other words, anyone with a TIN was able to create an account and access the payer website. "That's where we started. We focused on websites that didn't require authorization or approval from the user perspective from Ochsner. That was the scope," she said.

Then she and her team established criteria for evaluating the payer website. They were broken down by:

- The types of user accounts that can be created on each payer website (e.g., administrator, provider, billing representative).
- The kind of information the user must provide to the payer to create an account (e.g., a hospital's email address, TIN and NPI). Who has access at the hospital to the information required to create the account on the payer's website? Is authorization required to activate it?
- The kind of information that's available on the payer website (ePHI, financial information).
- The website's functionality. Identify what activities users can do on the payer website (e.g., export, modify or remove data; sign up for EFT/ERA).
- The end user agreements. Find out if the websites "have published end user agreements that outline user responsibilities and/or privacy requirements," Rollins said.

When the audit, which was conducted through legal and compliance, got underway, "we used non-Ochsner email addresses" and tested whether "Joe sitting in his basement" could gain access to various payer websites and the data on them, she said. They also tested them with real employees and email addresses. "We wanted to better understand who could create accounts and how easy it was to create accounts," Rollins said. "You'd be surprised at how many times the website allowed us to create an account using unverified information."

Their findings: Some payer websites are low risk for health care organizations because unauthorized users can't create an account, or they're allowed to create an account, but there's no access without authorization to view data. Other websites considered medium risk allow users to create accounts but require some patient or billing information before the door swings opens. In the medium/high risk category are payer websites that let users access information without accounts if they provide some patient or billing data.

'A Lot of Times Their Processes Failed'

Then there are the "high-risk buckets," Rollins said: (1) payer websites that permit users to create an account without the hospital's authorization, and (2) payer websites that allow users to create an account and access financial information and/or sign up for EFT/ERA in the portal without the hospital's authorization (see box, p. 5).[1]

"The account creation process and the user agreement are pivotal points of the audit," Rollins said. That's where the auditor determines whether unauthorized users are able to view and modify data and sign up for electronic funds transfer inappropriately on behalf of the provider. "Not only did we take the privacy lens of seeing ePHI," but also evaluated whether funds can be diverted from the organization.

Rollins was surprised by how many payer websites fell into the high-risk category and how the controls weren't there or weren't working. "I was shocked at how many websites we could get into with just TINs," she said. Some of the payers in the high-risk bucket thought they had verification processes. "A lot of times their processes failed," she explained.

After the audit, Ochsner looked at responding to the findings both internally and externally with the high-risk payer websites. Internally, "we implemented policies and standard operating procedures on how to manage access to the websites," Rollins said. They also devised a strategy around allowing EFT/ERA and communicated it to payers. Essentially, payers are instructed to notify Ochsner if anyone tries to make changes to the EFT/ERA functionality and to adopt

CMS Transmittals, Jan. 28-Feb. 3

Transmittals

Pub. 100-04, Medicare Claims Processing

- January 2021 Quarterly Update to the Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) Fiscal Year (FY) 2021 PPS Pricers, Trans. 10543 (January 28, 2022)

Pub. 100-05, Medicare Secondary Payer

- Electronic Correspondence Referral System (ECRS) Updates to the Medicare Secondary Payer (MSP) Development Letter and Additional Operational Updates, Trans. 11247 (January 28, 2022)

changes only if they're requested by a designated person. One caveat: The strategy might not be effective when payers partner with EFT vendors. "It explodes the risk," she noted. "Vendors are the middlemen. They don't do anything to validate [the users]. Be cautious if you do an audit and find any payers partner with a third party." She said it's essential for payers to communicate your privacy and security strategy to third parties.

For external actions, "we worked with our peers in compliance and legal on how best to start the conversation" with payers, Rollins said. Ochsner wanted to make them aware of the risks posed by a lack of access controls. The payers were asked to review all users who have access to the TINs and NPIs to determine if any are unauthorized and should be removed. They may be people who have left the organization or changed roles, and there's always the possibility of bad actors, Rollins said. During the audit, "we had some people we didn't recognize or people who had left long ago." She also asked the payers if Ochsner could designate an individual who would review and approve new user requests.

In terms of ePHI, this is a shared risk for health care organizations and payers, because both are covered entities under HIPAA. "But these portals aren't managed by providers," Rollins noted. "We can only do so much after this audit." That's why she and her team worked with the Ochsner legal and compliance teams on mitigating the risks, including notifying payer websites about vulnerabilities in their access controls, creating data security standards in-house and asking payers to sign attestations. In the attestations, payers confirm they meet Ochsner's data security standards in terms of the online portal that contains patient and financial information and agree to provide Ochsner with a list of their privacy and security controls for ePHI and banking information. "Once they attested, we talked through their controls," Rollins said. "We got a few back."

Contact Rollins at kelly.rollins@ochsner.org. ✧

Endnotes

1. Nina Youngstrom, "Categorizing Risks of Payer Websites," *Report on Medicare Compliance* 31, no. 5 (February 7, 2022).

NEWS BRIEFS

◆ **The Department of Justice said Feb. 1 it got $5.6 billion in False Claims Act (FCA) settlements in the fiscal year that ended Sept. 30, 2021**.[1] Most of it, $5 billion, came from health care matters, including cases involving drug and medical device manufacturers, managed care providers, hospitals, pharmacies, hospice organizations, laboratories and physicians.

◆ **In another Provider Relief Fund (PRF) case, Ocean Mind and Body, a medical supply company in Encinitas, California, and its CEO, Laura Rausa, agreed to pay $62,528 in a civil monetary penalty settlement with the HHS Office of Inspector General (OIG)**. According to the settlement, which was obtained through the Freedom of Information Act, in April 2020, Ocean Mind and Body received a PRF payment. On April 28, 2020, OIG alleged that Rausa "attested in the HHS Provider Relief Fund Portal that Ocean Mind and Body was eligible to receive this payment because, among other things, it provides or provided after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. However, Ocean Mind and Body did not provide diagnoses, testing, or care for any individuals after January 31, 2020. The OIG contends that Respondents knowingly made, used, or caused to be made a false statement in a document that is required to be submitted in order to directly or indirectly receive or retain funds provided in whole or in part by the Secretary of HHS, in violation of 42 U.S.C. § 1320a-7a(o)(2)." Ocean Mind and Body and Rausa didn't admit liability in the settlement.

◆ **A Michigan woman pleaded guilty to theft of public money in connection with the first criminal charges for stealing PRF money, the Department of Justice said Feb. 1**.[2] Amina Abbas of Taylor admitted she used to own 1 on 1 Home Health, which she shuttered in early 2020 after Medicare hit her with a $1.620 million overpayment demand because the home health agency had billed Medicare for patients who didn't qualify for home health care. "According to the indictment, 1 on 1, which was never operational during the pandemic, received approximately $37,656.95 designated for the medical treatment and care of COVID-19 patients," and Abbas gave the money to her family members for personal use, DOJ alleged a year ago.

◆ **In a letter to facility administrators, CMS Administrator Chiquita Brooks-LaSure said "we are moving full speed ahead on implementing our vaccination rule...We have seen that health care systems that implement vaccine requirements are not experiencing dramatic staff losses."**[3]

Endnotes

1. Department of Justice, "Justice Department's False Claims Act Settlements and Judgments Exceed $5.6 Billion in Fiscal Year 2021," news release, February 1, 2022, https://bit.ly/3L2iSKE.
2. Department of Justice, "Woman Pleads Guilty to Misappropriating Funds for Care of COVID-19 Patients," news release, February 1, 2022, https://bit.ly/3s7NEco.
3. Chiquita Brooks-LaSure, letter to administrators, February 1, 2022, https://go.cms.gov/3uovp54.