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February 11, 2019 | Vol. 33, Issue 6

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All Medicare fees are par, office, national unless otherwise noted.

Compliance

Have policy, procedures, provider checks to protect from vendor kickback scandals

A sensational case involving kickbacks to doctors from a pharmaceutical company serves as a warning: Without effective policy and procedures for providers' financial relationships with vendors, you risk serious damage to your practice.

Several former executives of Insys Therapeutics are accused of various crimes including violation of the anti-kickback statute for what the grand jury indictment portrays as a massive

(see *Anti-kickback*, p. 4)



PBN Perspectives

Medicare Advantage program frees up copays, telehealth for eligible encounters

Prepare for greater levels of experimentation in plan design, copays and eligible service offerings among your Medicare Advantage payers as CMS opens up its hallmark value-based program to the nation.

Currently available only in select geographic areas, the Medicare Advantage Value-based Insurance Design (VBID) model will be

(see *Medicare Advantage*, p. 6)

Get a boost with electronic E/M services



CMS now covers interprofessional consults performed by a specialist who does not see the patient and "communications-based" check-ins via phone, portal, or other telecommunication methods. Get a grip on the new services during the March 12 webinar **Electronic E/M**

Is Here: Earn Revenue for Virtual Consults, Visits and Remote Monitoring. Learn more: <http://codingbooks.com/ympda031219>.

Ask Part B News

What's a 'minimum' assist? For modifier 81, a late entry

Question: *One of our surgeons recently performed a procedure in which she was assisted by a colleague – but only just a little. We're debating whether this requires the use of modifier 81 (Minimum assistant surgery) rather than 80 (Assistant surgery).*

Answer: First, let's make sure everything else is correct: If you're claiming an assistant, and the colleague in question is a non-physician practitioner, you must use **AS** (Assistant at surgery) rather than any of the three other modifiers that are appropriate to assisted procedures, including **82** (Assistant surgeon when qualified resident is not available). As the second provider helped "only a little," we can rule out the possibility that modifier **62** (Two surgeons) is needed; ditto **63** (More than two surgeons).

Also, make sure the procedure is one that can have an assistant surgeon — per CMS, those that appear in the Medicare National Correct Coding Initiative database with the indicators "2" or "0" rather than "1" or "9," warns Terry Fletcher, BS, CPC, CCC, CEMC, CCS, CCS-P, CMC, CMCS, ACS-CA, SCP-CA, QMCRC, QMGC, a health care coding consultant in Laguna Niguel, Calif. Procedures with "1" may be paid upon review, but "providers need to

document in their operative reports why assistants are required for the surgery." This would include "specific documentation of the assistant's activities" and the time the assistant clocked in and out. To get an assistant paid on a procedure with an "0" indicator, says Fletcher, document "potentially complicating patient characteristics" such as "extremes of age, obesity, bleeding tendency, immune status, cardiovascular status, metabolic status and concurrent illness" that justify the assistant's use.

But what makes the contribution minimal? "If the operative note said that a second surgeon arrived during the procedure to assist for a specific portion of the surgery and was not present from the beginning to the end of the case," according to Nancy Enos, FACMPE, CPC-I, CPMA, CEMC, a Medical Group Management Association (MGMA) consultant in Rhode Island. This is appropriate for situations in which, for example, "a surgeon is doing a case and an issue may come up and they ask another surgeon, possibly from a different specialty, to come and take a look," says Margie Scalley Vaught, CPC, a consultant based in Chehalis, Wash. It may seem a moot point for Medicare, which pays about 16% of the full charge regardless, but some private plans do pay less. That doesn't mean that if the second provider was there for the whole procedure, but did very little (which documentation would show), that you could get away with 80 – but coming in at the middle is a sure sign of 81.

– Roy Edroso (redroso@decisionhealth.com)

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Senior Director of Medical Practice and Post-Acute Products:

Maria Tsigas, x6023
mtsigas@decisionhealth.com

Content manager, medical practices:

Karen Long, x6016
klong@decisionhealth.com

Editor:

Roy Edroso, x6031
redroso@decisionhealth.com

Editor:

Richard Scott, 267-758-2404
rscott@decisionhealth.com

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Ask Part B News

Focus on 3 areas to get your annual depression screening claims through

Question: *My practice has started to report more depression-screening services, but we're still seeing a decent share of denials. My doctors want to make sure the claims are getting paid. What might I be doing wrong?*

Answer: When it comes to facing denials on Medicare-covered depression screening services, you're hardly alone. Many practices struggle to get their claims through, as evidenced by a national denial rate of nearly 25% when reporting code **G0444** (Annual depression screening, 15 minutes) in 2017, the latest year of available Medicare claims data.

That hasn't stopped practices from increasingly reporting the code. In the five years from 2013 to 2017, G0444 claims have skyrocketed by 540%, rising from 278,000 claims to nearly 1.8 million in the latter year. While payments have also increased, topping \$23 million in 2017, denial rates haven't budged much from around the 25% mark.

However, the denials are largely due to a common set of obstacles that you should be able to overcome with some practice, advises Brenda Edwards, CPC, a coding and compliance consultant with Soerries Coding and Billing Institute in Topeka, Kan. Edwards points to three trouble areas that may be tripping up your claims: frequency, same-day billing and diagnosis coding.

"If they are experiencing denials, I would look at frequency to ensure there has been a full 11 months since last screening," she says. As the code description makes clear, the service is billable on an annual basis — and not twice or more in the same 11-month span. That may trip up some providers who think that they can report the service just because the calendar has flipped to a new year. For instance, if you perform a depression screening on John Smith on Dec. 15, 2018, you won't be eligible to report another one until at least after Nov. 15, 2019.

Your providers also may be wrapping the depression screening into services that are bundled together, Edwards warns. The G0444 code "can be billed with a problem-focused visit but not separately payable when billed with Welcome to Medicare or initial Medicare annual wellness visit [AWV]," she says. That is, G0444 is bundled with **G0402** and **G0438** and you'll likely get denied if you try

to push the services through on the same day. However, remember that you can report G0444 with subsequent AWW code **G0439** because the services are unbundled.

"The diagnosis could be another place for denial if they are not associating it with the screening code," Edwards warns. CMS doesn't list a full slate of appropriate ICD-10 codes, so Edwards suggests you defer to **Z13.89** (Encounter for screening for other disorder) to stay coding compliant. Also, don't forget that, when it comes to the depression screening, specialty matters. Only primary care providers are eligible to report the service; other specialties will get denied. — *Richard Scott* (rscott@decisionhealth.com)

From the *Part B News* blog

Take note of the news that happens between *Part B News* issues by checking out the free *Part B News* blog at <https://pbn.decisionhealth.com/Blogs/default.aspx>. Here's a sampling from this week.

New CMS-855I provider enrollment form debuts

CMS has announced a new version of its CMS-855I provider enrollment form, up now at the CMS website and available for use. Read more: <https://pbn.decisionhealth.com/Blogs/Detail.aspx?id=200777>.

Can you describe a procedure in 80 characters?

A description that is short but not too simple is the challenge posed by claims with unlisted or not otherwise classified codes. Read more: <https://pbn.decisionhealth.com/Blogs/Detail.aspx?id=200776>.

Caution: Chronic care management claims denied in error

Providers operating within the jurisdiction of National Government Services (NGS) should take stock of their recent chronic care management (CCM) claims. You may be seeing errant denials on good claims. Read more: <https://pbn.decisionhealth.com/Blogs/Detail.aspx?id=200774>.

Medicare to consider coverage of acupuncture for low back pain

In a move that appears to be prompted by the U.S. opioid addiction crisis, Medicare has launched a national coverage analysis for acupuncture to address chronic low back pain (CLBP). Read more: <https://pbn.decisionhealth.com/Blogs/Detail.aspx?id=200775>.

Anti-kickback

(continued from p. 1)

campaign to induce providers to improperly prescribe – in return for improper payments – fentanyl spray, a powerful opioid. The case is now being tried in U.S. District Court in Boston.

Prosecutors charge that Insys’ “Speaker Program events,” which were portrayed for reporting purposes as legitimate educational presentations for which providers were paid, “were often just social gatherings at high-priced restaurants that involved no education and no presentation” and sometimes no legitimate attendees at all.

Providers are mentioned in the indictment as “co-conspirators” and are left anonymous, identified only as numbered “practitioners.” For example, “Practitioner #3” operator of a large pain management clinic in Saginaw, Mich., is praised for his corruption in an Insys internal communication mentioned in the indictment: “It’s the [Practitioner #3s] of the world that keep us in business, lets [sic] get a few more and the rest ... of this job is a ‘joke.’”

There are also what sound like HIPAA violations: “To accomplish this, Practitioner #8 routinely assembled the medical charts of each patient for whom he prescribed the fentanyl spray and gave them to the sales representative or to a company employee assisting the sales representative,” the indictment says.

Might these providers expect a call from the feds, and possibly state authorities, in the near future? “It seems prosecutors have been reluctant to go after the providers in these cases,” says Kevin Campbell, a partner at Bradley Arant Boult Cummings in Nashville. “They’re going after the sales reps and managers who are orchestrating the scams. But you can’t count on that — the anti-kickback statute works in both directions. It’s just as illegal to receive kickbacks as to dispense them.” Also, don’t forget about whistleblowers who may turn over the rock on your misbehaving providers.

What to do?

The potential for mischief — not to mention indictments and blowback for the practice — leads some attorneys to advise a hard no-vendor-payments policy. “The easy answer to this and best practice for a physician, in my opinion, is to avoid any and all [appearances of or potential for] kickback relationships in their practice,” says James Smeriglio,

associate attorney at Jordan Law FL, P.A. in Orlando, Fla. “While this may be overly cautious, it’s simply not worth the headache, publicity or legal fees that could potentially be incurred if someone ever blew the lid off of such an agreement and filed a class action suit.”

On the other hand, “you’ll still have doctors talking with reps,” says Glenn P. Prives, attorney with McElroy, Deutsch, Mulvaney & Carpenter LLP in Morristown, N.J. “The reality is pharmas and their reps will always try to talk with doctors. It’s not realistic to stop those conversations, so you need a policy” for gifts and payments.

Have a policy

Jay Anstine, a health care corporate compliance expert in Fort Collins, Colo., recommends a policy covering “anyone doing business with the practice.” The practice should make clear what gifts and payments are unacceptable, using Stark law, anti-kickback statute and other relevant laws like the Sunshine Act as guidelines. For example, medical staff incidental expenses such as parking covered by a vendor should not exceed the \$34-per-instance limit under Stark.

The policy “should also spell out the process for approval to give or receive such a gift,” says Anstine — that is, how much discretion the practice gives each provider to make these decisions. It would cover, for example, training encounters to which vendors often invite providers — which “could range from a modest lunch-and-learn brought in to the practices to lodging and travel expenses at a distant location.”

This not only lets the providers know what’s expected of them; it also protects the practice in the event of a problem. Part of the purpose is to “shift responsibility onto the rogue employee,” says Eric Fader, partner with the Rivkin Radler firm in New York. “If the provider’s going to go rogue, even if he’s been trained not to, as long as the company’s doing what it’s supposed to do, then at least the entity won’t take the fall.”

4 anti-kickback tips

- **Check on your providers.** Your compliance officer should be at least surveying doctors in your practice, says Prives: “Require them to attest in writing that nothing was received or, if it was, to turn over documentation” on their payments. “Periodic required disclosure of financial arrangements might discourage [illicit] behavior and also identify issues so that you can screen them away from decision-making where they do have a financial tie,” says Campbell.

You could even monitor a provider’s prescribing habits, he suggests, “and look to see if certain drugs are being

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Benchmark of the week

Denial rates favor NPP surgical assistants over physicians for common procedures

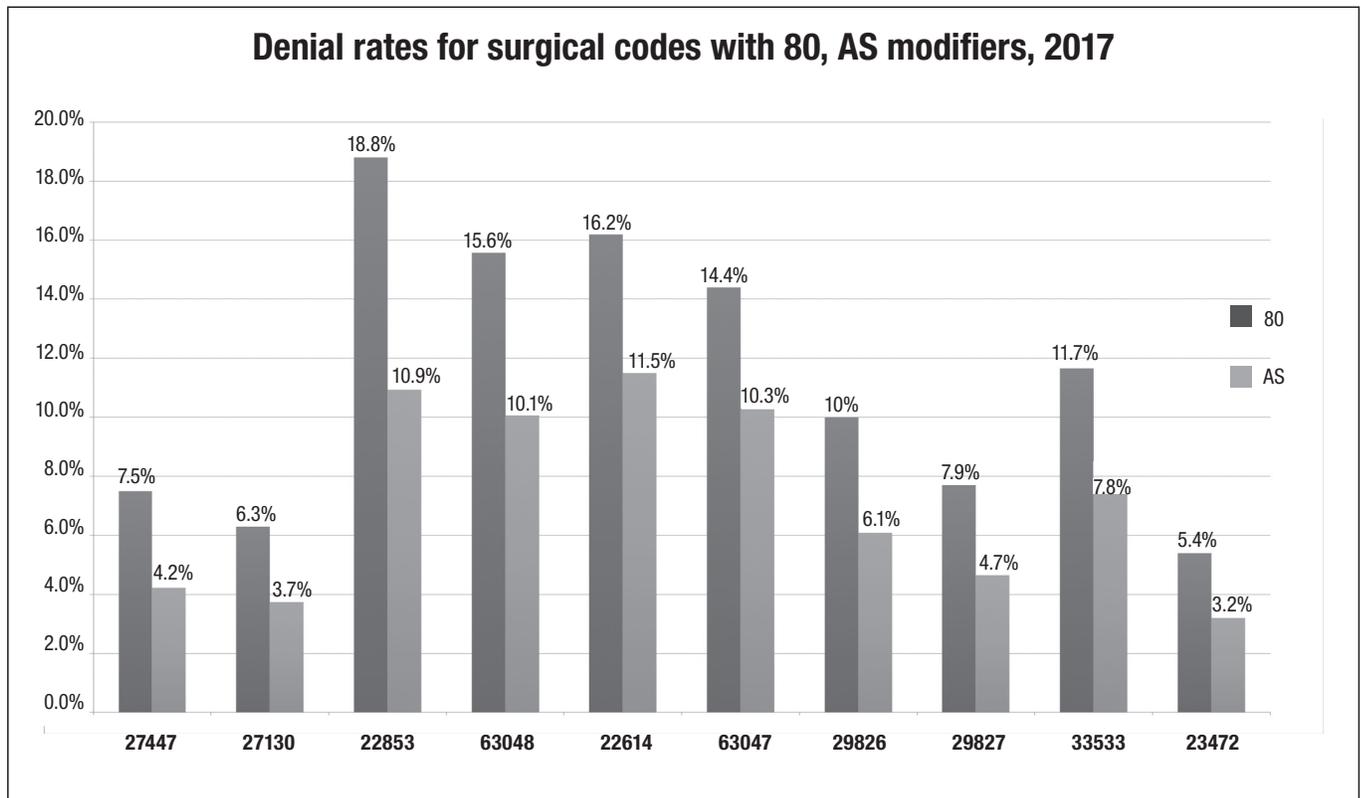
When it comes to documenting a helping hand during common surgical procedures, practices tend to turn to modifier AS (Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery) rather than a range of CPT assistant-surgical modifiers — and find success in doing so.

The denial rates that practices incur during surgical procedures involving an assistant surgeon skew significantly lower when reporting the AS modifier instead of the **80** (Assistant surgeon), **81** (Minimum assistant surgeon) and **82** (Assistant surgeon [when qualified resident surgeon not available]) modifiers that may also be appropriate.

In 2017, providers reported all four of the surgical modifiers most often with a single code: Total knee arthroplasty procedure code **27447**, according to the latest available Medicare claims data. Nationally, in 2017, providers submitted more than 162,000 knee-replacement claims with the AS modifier; 18,000 claims with modifier 80; 479 claims with modifier 81; and 8,800 claims with the 82 modifier. Judging by claims success, the AS-appended claims took top prize, with a 4.2% denial rate. The second most-reported modifier, 80, returned denials at a 7.5% rate.

Netting a lower rate with the AS modifier was a consistent trend among the most-reported surgical claims, as the chart below details. In many cases, providers saw a significant gulf in performance between the two modifiers. For hip replacement procedures (**27130**), providers saw a 6.3% denial rate when reporting an 80 modifier, yet that decreased to below 4% with AS. For code **22853** (Insertion of interbody biomechanical device[s], when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace), the modifier 80 rate was 19%, compared with a denial rate below 11% with the AS modifier.

The disparity in denials may come down to CMS’ stricter medical necessity rules pertaining to the modifiers — 80 signifies an M.D. was the assistant, which may prove harder to justify than the non-physician practitioners (NPPs) who represent the AS modifier. — *Richard Scott (rscott@decisionhealth.com)*



Source: Part B News analysis of Medicare claims data

(continued from p. 4)

prescribed in an outlier manner” that correlate with the provider’s financial ties.

- **Check Open Payments.** CMS will send you emails when the Open Payments data that vendors have reported to CMS on their payments to providers is available to check, says Anstine; it usually becomes public towards the end of June each year (*PBN 1/12/15*). This launches a process that allows providers to dispute the data, but managers might want a peek, too.

“Checking the database will help ensure that the data being reported by vendors about your physicians is accurate,” says Anstine. “Also it will help ensure on the practice side that your physicians are being transparent with what they’ve received or any investments interests they may have in a pharmaceutical company or medical device manufacturer.”

- **Don’t forget your own state laws,** which can in some cases be more restrictive than federal ones, says Prives. Last year, for example, New Jersey passed a new regulation “that strictly limits what kind of benefits doctors can receive — and that includes even ‘independent agents’ of pharmas” who are not directly employed by them, says Prives. “Now there’s very little they can give to a doctor. It covers meals and even the little things like pens and notepads with the company logo. And it hits speaker fees at even legitimate events.”

- **Redirect potential whistleblowers.** “Any large company that doesn’t have a whistleblower hotline or some mechanism like that is making a big mistake,” says Fader.

The idea is to intercept and deal with complaints — including complaints about doctors getting shady compensation — before they turn into a legal nightmare for the company. — *Roy Edroso* (redroso@decisionhealth.com)

Resource:

► **U.S. Department of Justice case information,** United States v. Michael Babich, Alec Burlakoff, Richard Simon, Sunrise Lee, Joseph Rowan, and Michael Gurry, John Kapoor: www.justice.gov/usao-ma/victim-and-witness-assistance-program/united-states-v-michael-babich-alec-burlakoff-richard-simon-sunrise-lee-joseph-rowan-and

Medicare Advantage

(continued from p. 1)

open to payers in all 50 states and Washington, D.C., starting in 2020, according to CMS officials.

On Feb. 1, CMS unveiled a request for applications (RFA) for the 2020 plan period. Payers that choose to participate in the model will find more lenient rules under which they can shape their plan offerings, such as eliminating copays for office visits and expanding the use of telehealth services, as CMS seeks innovative ways to fuel more cost-effective care.

“This is more evidence that CMS is moving toward significant changes in the payment of health care,” says Robert Ramsey, health care attorney with Buchanan, Ingersoll and Rooney in Pittsburgh.

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PAS 2019

Eligible Medicare Advantage organizations must file applications for the 2020 coverage period by March 1, 2019, and CMS will provisionally approve model participants in April, said Laura McWright, deputy group director of the Seamless Care Models Group with the MA-VBID team, during a Jan. 30 webinar on the 2020 application process.

There is no limit on the number of plans that can partake in the VBID model in the coming years; however, plans are required to approach their service offerings from a coordinated, wellness-focused perspective — and practices that treat the more than 20 million current Medicare Advantage beneficiaries may stand to benefit from the patient-centered, creative payment mechanisms.

A look back at some of the plan designs that Medicare Advantage carriers have offered to patients during the VBID model offers a glimpse of how providers may be affected. Consider the following examples:

- One Medicare Advantage carrier offered quarterly rebates of up to \$200 annually for cost-sharing expenses when patients with diabetes completed screening exams with primary care physicians, ophthalmologists and podiatrists.
- Another Medicare Advantage plan eliminated cost-sharing for up to four primary care visits per year and reduced cost-sharing for specialist visits to \$10 for patients with COPD or diabetes. The plan also extended supplemental benefits to include no-cost periodontal surgical procedures and other services, such as a diabetic retinal photograph, with zero out-of-pocket expenses.

“If a medical practice has a fairly high number of people with these diagnoses, they’re going to see some benefits,” Ramsey says. “This could really increase, in the short term, the number of office visits.”

Assessing the 2020 outlook

The VBID model is open in 25 states in 2019 and will expand nationally in 2020 and beyond. The expansion — both geographically and in terms of available benefits — comes as Medicare Advantage on the whole continues to grow. This year, more than 22 million patients are projected to be enrolled in a Medicare Advantage plan, and payers have greater leeway than ever before to provide benefits that are not traditionally covered by the federal government ([PBN 11/5/18](#)).

Payers opting for the VBID model can accelerate the push to value-based care even more given the greater degree of flexibility and cost-sharing options wrapped up in the

program. Even some of the early constraints of the VBID model are being eased. For example, in 2017 and 2018, all supplemental benefits or cost-sharing changes are applicable only to patients with specific diagnoses, such as diabetes, COPD, congestive heart failure or hypertension.

Looking ahead to 2020, plans can identify their own high-cost patients either by diagnosis or socioeconomic status. That means a plan could offer specific benefits to patients with low-income status, not just those with a certain chronic disease. All interventions must gain approval by CMS during the application period.

Key takeaways for providers

In the shifting payer landscape, many providers may find opportunity for adding revenue because plans are essentially incentivizing patients to stay healthy and avoid long-term complications by focusing on preventive care. That focus is baked into every contract a payer makes with CMS.

“Participating plans will be required to submit, receive approval for and comply with a strategy regarding the delivery of timely wellness and health care planning (WHP) services, including advance care planning (ACP) services, to all enrollees,” the 2020 RFA states.

Some practices may be more equipped to take advantage of the prevention-focused coverage that VBID-MA plans are rolling out, says Ramsey. For instance, practices that have launched a chronic care management (CCM) program could be in a position to succeed with the Medicare Advantage plan offerings. “They’re probably better prepared,” Ramsey says.

Some of the plans that are currently on offer require that patients take part in a care-management or disease-management program and meet eligibility parameters, such as taking part in monthly or quarterly wellness checks. Only then can the cost-sharing benefits kick in, so it behooves practices to ramp up their care-coordination efforts to keep their patients up to standards.

The important step for practices is to check in with your payers that are involved in the model, advises Andrew Kadar, managing director with L.E.K. Consulting in Boston. You’ll want to know key things like, “What copays are you adjusting?” Kadar says. The model is especially attractive to specialties such as primary care that focus on preventive health, Kadar says. That’s where involved insurers are pushing their payments.

VBID payers gain additional opportunity to offer telehealth services in 2020, as well. Plans will have free rein to pursue telehealth services for eligible patients and disease states that go beyond the rigid offerings currently covered under Medicare. Tech-savvy providers will be able to capitalize on the offerings, but practices that aren't up to speed likely won't net any contracts, according to CMS plan documents.

“As part of their application, organizations should include the providers and services, along with the appropriate clinical standards, that are being proposed for use in this component of the Model consistent with professionally recognized standards of health care,” the RFA states.

“CMS really seems to be embracing the concept of telehealth,” Ramsey says. “For providers, they should be taking a serious look at [it]. I think virtual visits and the like are really the wave of the future.” – *Richard Scott (rscott@decisionhealth.com)*

Resources:

- ▶ VBID model FAQs: <https://innovation.cms.gov/Files/x/vbid-cy2019faqs.pdf>
- ▶ VBID RFA: <https://innovation.cms.gov/Files/x/vbid-rfa2020.pdf>
- ▶ VBID overview: <https://innovation.cms.gov/initiatives/vbid/>

Part B News briefs

- **Pain management doctor pays \$1.7 million for drug screen, anesthesia fraud.** The second principal owner of Fort Myers, Fla., Advanced Pain Management Specialists has something in common with the practice's co-owner, Michael Frey, M.D.: He has to pay more than \$1 million to resolve allegations of fraud. Jonathan Daitch, M.D., will pay \$1.72 million to resolve allegations that he submitted claims for medically unnecessary definitive urine drug screens that were performed in the practice's in-house lab, the Department of Justice announced Dec. 20. The money will settle allegations that he improperly referred patients to an anesthesia group that he owned with Frey. In addition, Daitch and the ambulatory surgery center he also owned with Frey will be subject to a five-year corporate integrity agreement. However, Daitch got off lightly compared to Frey, who plead guilty to two counts of conspiracy to receive health care kickbacks and could spend up to five years in prison. In addition, he agreed to pay a

\$2.8 million civil settlement in June. To read more about the Daitch settlement go to www.justice.gov/usao-mdfl/pr/fort-myers-doctor-agrees-pay-more-17-million-resolve-allegations-fraud. Details of Frey's settlement are available here www.justice.gov/usao-mdfl/pr/fort-myers-pain-management-physician-pleads-guilty-healthcare-offenses-and-agrees-28.

- **Physician assistant faces jail time for accepting kickbacks.** Share the case of New Hampshire physician assistant Christopher Clough if your doctors and non-physician practitioners are tempted by money for nothing from medical representatives. The physician assistant could spend up to 40 years in jail for accepting kickbacks in exchange for prescribing fentanyl spray to patients. The drug was cleared by the FDA for breakthrough cancer pain and Clough did prescribe the drug to those patients. But he also prescribed it to patients who did not have breakthrough cancer pain and “rebuffed patients and their family members who stated they no longer wanted the drug,” the Department of Justice stated in a Dec. 18 press release. The manufacturer paid Clough to speak at more than 40 programs between June 2013 and the fall of 2014. However, many of the programs were really dinners with employees or representatives of the drug company where Clough didn't give a presentation about the drug. In addition, “Clough and others often forged signatures of attendees on sign-in sheets in an effort to make the dinners appear to be legitimate. Evidence at trial demonstrated that Clough received over \$49,000 in payments from the drug manufacturer.” He is scheduled to be sentenced on March 29. To read the complete press release, go to www.justice.gov/usao-nh/pr/former-physician-assistant-convicted-kickback-scheme.

- **The nerve: Neurosurgeon will pay nearly \$81,000 to settle fraud allegations.** Michael Drerup, M.D., and the Alexandria Neurosurgical Clinic, of Alexandria, La., will pay \$80,941 to the HHS Office of Inspector General (OIG). “The settlement agreement resolves allegations that Drerup submitted claims to Medicare for nerve conduction studies that are considered screening exams and not covered by Medicare,” the OIG announced Nov. 27. Go to <https://oig.hhs.gov/Fraud/enforcement/cmp/index.asp> to read the announcement.

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