CMS: Use Modifier With All Drug Waste for Single-Use Vials; Audits Will be Easier

Starting July 1, hospitals must use modifier JW on all Medicare claims for discarded drugs, possibly as a prelude to audits in this area. Some Medicare administrative contractors (MACs) already require the use of the modifier, but CMS has decided to go national with it, according to a new Medicare transmittal (R3508CP). Hospitals that bill for wasted drugs now but don’t have to play show and tell on their claims will need a workflow for modifier use.

“Providers are required to use the JW modifier for claims with unused drugs or biologicals from single use vials or single use packages that are appropriately discarded...and document the discarded drug or biological in the patient’s medical record,” CMS said in MLN Matters MM9603, which was released May 3 and refers to the Medicare transmittal.

The universal use of the JW modifier will shine a light on drug waste because CMS will always know when it’s being billed without having to audit the documentation.

continued on p. 6

Hospital Uses Fake Phishing Emails in Security Training; Will Move to Gamification

Every month, employees at Lawrence General Hospital in Massachusetts receive phishing emails with enticing subject lines, including “Prince’s last words on video: breaking news from CNN” and “Banking statement: Your transaction failed.” They are designed to test whether employees will open the email and the link to an attachment. Even though employees have ongoing information security training, where they learn about phishing, some of them open the emails. Fortunately, there has been no cyberattack, because the phishing is part of the hospital’s information security training program.

“We try to trick employees,” says Alex Laham, information security manager. It’s a training tool to reduce phishing, which is a primary way that hackers try to sneak sensitive information out of people. Fake phishing also is a method for hospitals to identify employees who need to be re-trained, he says. If they click on the link, employees get this message: “Oops: you clicked on a simulated phishing email” and tips on how to “catch a phish.”

Laham also gives “instant feedback” to all employees on the training exercise, including how many phishing emails he sent out, how many were clicked on and the number of attachments opened. “We are tracking and training,” he says. If employees continue to open attachments in three separate phishing attacks despite education, they will face remediation.

The message he is broadcasting: even a security fortress can’t protect the hospital from an employee letting in a virus or malware by clicking on a phishing email or...
making a similar bad move (e.g., using an infected flash drive), Laham says. “It takes one employee one time to bypass everything we have put in place to protect the hospital. We have strong email filtering, but at the rate new viruses and malware are generated, email filtering companies can’t always keep up to new malware signatures,” he notes.

But piling on the training can suck the life out of employees in regulation-heavy health care, Laham says. Computers and mobile devices may be essential to their work, yet “IT and security are not immediately perceived as part of their job. It seems like an additional burden.” That’s why the hospital is trying to “morph our training into the use of gamification,” he says.

“Gamification is the application of game principles to encourage voluntary user participation, with a defined reward process for having people engage,” Laham says. That’s the idea behind the Starbucks reward card, for example. Customers get points for joining membership and are rewarded for their membership. “The idea is to encourage voluntary user participation, with a defined reward process,” he says. Gamification can be used to motivate employees to engage in cybersecurity training.

Laham thinks this could work at Lawrence General Hospital. “In the near future, we are moving to create that same feeling,” he says. If employees know they are getting credit toward some concrete goal, which is not yet determined, they are more likely to sit for an online training module on cybersecurity, read the poster they ignored 100 times before and take a short quiz (see box, p. 3). A point here and a point there could add up to a gift card at the end of the month, for example.

Employees Learn to Spot Social Engineering

Gamification aside, Laham thinks it’s critical for employees to be trained by someone they know — “someone who doesn’t pop up out of nowhere or is only seen once a year. There has to be a trust factor.”

While phishing emails are the “biggest training platform” because “that’s the primary way cyber criminals get to organizations,” Laham’s training covers other ground. He addresses mobile device, web site and flash drive security, and explains how to avoid traps while on the web. Employees learn about social engineering, “which is the global platform for how cybercriminals trick people,” he says. Cyber criminals use social engineering to take advantage of “the natural tendencies of people to trust” to get them to reveal information. For example, a hacker poses as someone from the IT department and calls an employee, saying he is applying a software patch and needs the employee’s user name and password. The employee complies, unwittingly exposing the hospital’s information system to a malicious stranger.

Phishing falls under social engineering, and it’s taking different forms. There’s vishing, which is short for voice phishing and refers to tricking people over the phone, Laham says. Smishing is the text-message version (e.g., click on this link to collect a gift card). “It shows itself in a wide variety of scenarios, but the one we see most in the news is phishing emails,” Laham says.

Tips to ID Scams

He gives employees tips to identify phishing emails. “The biggest thing is to be cautious with all emails and to take your time when evaluating an email. Take the time to hover that cursor over the link and stop and think about whether this email really makes sense that you received it.”

Other tips to help employees “catch a phish”:

- Do they know the sender of the email? Is it from inside the hospital or outside? Is the address spelled correctly?
- Is the employee the main recipient of the email or were other people copied?
- Is there a greeting? “Most phishing emails use general salutations like ‘dear customer’ or ‘dear account holder,’” Laham says.
He has been “shocked and thrilled” by the positive response of employees after training. They hadn’t realized how vulnerable information is, both at the hospital and their homes, and were deeply affected by this realization. Employees say they are much more conscious about changing their passwords and spread the word to family. “If you have a system at home that’s not as secure and you use it to connect to the hospital, you pose a risk to us,” whether it’s email or mobile devices, he says.

Contact Laham at Alexander.Laham@lawrencegeneral.org.

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**Wound Care Weak on Medical Necessity, Shows Outpatient Flaws**

Documentation of medical necessity at wound care centers tends to be spotty because they’re overly focused on preventing claim denials on the front end, one expert says. It’s typical of the problems in the outpatient side of the hospital world, where chargemasters are messy and bills re-worked to get them paid without a lot of problem-solving.

“Some wound care centers are horrible about documenting medical necessity,” says Toni Turner, owner of InRich Advisors in The Woodlands, Tex. Provider-based clinics often think it’s a win when claims are partially or

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**Quick Quiz: Employees and Information Security**

After introducing employees to information security concepts at orientation, Alex Laham, information security manager at Lawrence General Hospital in Lawrence, Mass., gives them this quiz. He is also using more advanced techniques to train employees on information security (see story, p. 1). Contact Laham at Alexander.Laham@lawrencegeneral.org.

<table>
<thead>
<tr>
<th>Lawrence General Hospital Information Security Orientation Quiz</th>
</tr>
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<tbody>
<tr>
<td>Employee Name: _____________________________________________</td>
</tr>
<tr>
<td>1. To be truly secure, passwords should be at least how many characters long?</td>
</tr>
<tr>
<td>a) 6 Characters</td>
</tr>
<tr>
<td>b) 8 Characters</td>
</tr>
<tr>
<td>c) 10 Characters</td>
</tr>
<tr>
<td>2. It is ok to provide your username and password if someone asks for it?</td>
</tr>
<tr>
<td>a) Yes</td>
</tr>
<tr>
<td>b) No</td>
</tr>
<tr>
<td>3. If you find a USB flash drive (memory stick) on the ground, you should:</td>
</tr>
<tr>
<td>a) Take it home and use it</td>
</tr>
<tr>
<td>b) Plug it into your work computer to see what is on it</td>
</tr>
<tr>
<td>c) Bring it to the IS department.</td>
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<tr>
<td>4. Which of the following help to identify a potential phishing email?</td>
</tr>
<tr>
<td>a) Poor spelling and grammar</td>
</tr>
<tr>
<td>b) Generic salutations</td>
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<tr>
<td>c) Sense of urgency or immediate action required</td>
</tr>
<tr>
<td>d) The email doesn’t pertain to you or your job</td>
</tr>
<tr>
<td>e) All the above.</td>
</tr>
<tr>
<td>5. If you believe that you have encountered an information security breach, you should contact:</td>
</tr>
<tr>
<td>a) The LGH Service Desk</td>
</tr>
<tr>
<td>b) The local newspaper</td>
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<tr>
<td>Employee Signature: ____________________________________________</td>
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fully paid because the procedure is linked to a covered diagnosis code. “But they are scrutinized in a different realm now,” Turner says. “This has been a news flash for hospitals.” Medical reviewers want to know why they are paying provider-based wound care clinics for an advanced level of care. What’s the medical necessity for treating that wound? Why can’t the patient just go to a physician’s office for a new wrapping?

“Providers have to understand the scope of medical necessity,” she says. “It is not just the diagnosis that equates to coverage. It is specific to the severity of the patient’s condition and balanced by the resource setting in which they will receive the care. There’s a difference between clinical medical necessity and billing medical necessity.”

The documentation should describe the patient with the diabetic ulcer, who has multiple comorbidities, is immunocompromised or post-surgical or has limitations on mobility — whatever explains the need for an advanced level of care. The documentation should “talk about Mr. Jones and the whole picture of medical necessity and reasonableness,” she says.

For example, it’s not uncommon for wound care centers to bill evaluation and management (E/M) services for patients who come in week after week, month after month, Turner says. Not much has changed with their chronic condition, such as venous insufficiency, which requires compression wraps. “They were initially referred to the wound center because the condition was very bad, but now it’s plateaued,” Turner says. “We have moved from a goal of aggressive wound healing to palliative care. Do they still need to be in this level of care? Is there a chance of reaching a [curative] goal? The goal may be very reasonable, but if we are not getting there or we reached it, it’s time to transfer or reassess the patient. They lost their medical necessity months ago.” The fact the diagnosis is supported by a test — venous Doppler — will not push through indefinite visits to a provider-based wound clinic, and the use of words like “palliative” is asking for trouble, Turner says.

Electronic-health records in some ways have undermined medical-necessity documentation, she says, a concern expressed with increasing frequency (RMC 5/2/16, p. 1). “They have further detached clinicians from articulating the patient’s deterioration,” Turner says. “You just get fields to fill out. It’s a math problem for the EHRs.”

Wound care problems also show up in the chargemaster, another sign of weaknesses on the outpatient side of the hospital, Turner says. Chargemasters are the master lists of CPT/HCPCS codes and prices for hospital goods and services. Often there is a disconnect between the way skin substitutes are used in wound care and the way they are listed in the chargemaster. Medicare pays for skin substitutes by the unit (RMC 1/27/14, p. 1). But hospitals sometimes list them in their chargemasters according to the manufacturer’s packaging, Turner says.

Medicare pays for Apligraf, for example, by the unit, which represents a square centimeter. But some hospitals “build their own packaging concepts into the chargemaster and duplicate the product to correlate with the packaging size in which it is purchased,” she says. Some skin substitutes come in sheets of 13 or 39 square centimeters, which means there often will be leftover product. But if there is no charge for a single square centimeter to choose from on the chargemaster, the variable wasted amounts cannot be reported.

Many clinicians skip documenting waste because they know it’s not going to be reported on the claim. Think how that looks to an auditor when a wound is 14 square centimeters and the nurse opens a package of 44 square-centimeter sheets and doesn’t note any waste. The auditor wonders what happened to the skin substitute. Did the nurse squish the entire amount on the wound? “It now challenges the integrity of the application according to most manufacturers’ guidelines and thus medical necessity is questioned,” Turner says. “And it all starts with not setting up the chargemaster in a way that reflects what the payers pay. It’s a big problem.”

**Revenue Center Codes May Be Off**

Turner says there are other structural flaws in the outpatient “business model,” and they will have to be addressed as the industry moves toward value-based purchasing, which took another transformational step forward with CMS’s April 27 announcement of proposed regulations on the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) under the 2015 Medicare Access and CHIP Reauthorization Act (MACRA). Even though MIPS and APMs are solely for physician practices, Turner thinks they will become increasingly relevant to hospitals since she doesn’t think provider-based space is long for this world. If wound care centers and other off-campus provider-based clinics become freestanding clinics down the road, they will have to adapt to MACRA and support the physicians’ reporting needs to comply with supervision of services. Congress already put an end to new outpatient provider-based space in the Bipartisan Budget Act of 2015 (RMC 11/23/15, p. 1; 11/2/15, p. 1), with some exceptions.
Hospitals will have to get to the root of the problems that plague outpatient departments, which already are in some turmoil as they adapt to far more packaged payments under the outpatient prospective payment system (RMC 7/13/15, p. 4). Turner says it’s not always appreciated how much everything feeds into everything else. For example, when surgeries are performed in outpatient clinics (e.g., pain management or infusion clinics), they tend to use the surgery revenue code, 360, on the claim form. “I get why that seems logical, but it reflects lack of understanding of the outpatient methodology,” she says.

Medicare wants hospitals to use revenue codes to convey where the services took place, and using the surgery revenue code is misleading, Turner says. If all the surgery codes are classified on the chargemaster under the surgery revenue center code, but they actually were performed in various clinics, that affects future payment rates. “The weights used in cost reports and clinic codes will be so little because no credit is given to the outpatient clinics,” Turner says. “All the outpatient clinic data got lumped into surgeries so the clinics will get shorted.”

Some of Turner’s suggestions:

1. Tell EHR vendors what you need. Hospitals are the customers and should be able to call the shots and have software customized.

2. Work through denied claims. She says billers will do a lot of workarounds to get claims paid, which is fine for revenue in the short run but doesn’t solve problems. It’s another reflection of siloes. “99% of the problems I find could easily be solved if someone looked beyond the activities of their own function,” she says. It shouldn’t be considered a win when payers pay $25 on a $200 claim.

3. Maintain the chargemaster. That includes reviewing for duplicated line items, deleted codes, hard-coded modifiers, pricing instability, variable procedure rates used in different cost centers and misleading revenue code assignment.

Contact Turner at toni@inrichadvisors.com.

Lawyers: Self-Disclosure Protects From FCA Cases; May Be a Ruse

Self-disclosures may be used against providers by whistleblowers if they aren’t done in good faith, a whistleblower lawyer says. But self-disclosures will shield providers if they are done right, and providers have a good chance of avoiding a false claims lawsuit even without a release from the False Claims Act, according to government lawyers.

“Self-disclosures are a blessing and a curse,” Atlanta attorney Marlan Wilbanks said at the Health Care Compliance Association Compliance Institute in Las Vegas on April 17. “I have used it effectively to show it’s a continuation of a pattern of fraud.” There have been times that providers were violating Medicare rules and then tossed a [cover your ass] letter over the wall to the Department of Justice,” said Wilbanks, who represented the whistleblower in the Stark-based false claims case against Halifax Health (RMC 3/10/14, p. 1), which settled for $85 million, as well as the whistleblower in the false claims case against DaVita HealthCare Partners, which paid $450 million to resolve allegations it created unnecessary waste in administering two drugs.

Self-disclosure also has protected providers in false claims cases, said Wilbanks, with Wilbanks & Gouinlock. “I have seen defendants use it effectively to show they were in the process of cooperating and [to argue] the relator is opportunistic,” he said. “That was not my vision. Mine was that it was part of the ruse. But I have seen it used effectively.”

Self-Disclosure Is a Good Solution

Robert K. DeConti, assistant inspector general for legal affairs with the HHS Office of Inspector General, said the OIG’s Self-Disclosure Protocol (SDP) “is a good place to get these matters resolved fairly.” It takes about 10 months from submission to resolution, he said. “In the world of False Claims Act cases, that is lightning fast” and damages are typically 1.5 times the amount of the overpayment — “less than anyone would pay if a relator had to bring the case” — assuming the self-disclosure is made in good faith, DeConti said.

While civil monetary penalty cases resolved by OIG after an SDP submission don’t have False Claims Act releases, the Department of Justice takes the self-disclosure into account when considering whether to pursue a false claims lawsuit, said Robert McAuliffe, senior trial counsel in the DOJ civil division. “If you have a good faith self-disclosure, it’s a tough case for us to make,” he said.

When whistleblower allegations come in, McAuliffe says, he often assumes what the relator said is true. Then he assesses the “falsity component.” Were the violations material? “That boils down to whether they affected the government’s decision to pay,” he said. Did the provider have knowledge of the falsity of the claims? “This takes the most time in our investigation,” McAuliffe said. DOJ tries to answer this question by interviewing people and subpoenaing documents. Did the provider act knowingly, or with reckless disregard or deliberate ignorance? If so, was the government damaged?

Did providers learn about errors through an external or internal audit? “If they did, that shows knowledge,” McAuliffe said.

When there’s a self-disclosure, it’s hard to establish knowledge and damages because the provider has

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already come forward and the government has been made whole. “If there’s a good-faith self-disclosure and a reasonable resolution,” McAuliffe said, DOJ probably won’t pursue a false claims lawsuit.

He said DOJ doesn’t “go looking for cases that target hospitals...We look for cases with an eye toward making sure the Medicare trust fund is protected.” Sometimes that means working with whistleblowers who don’t have clean hands, and McAuliffe said he often hears people question why DOJ listens to whistleblowers with an axe to grind. Sometimes “you want to use a rogue to catch a rogue. While some relators may not be boy scouts or girl scouts,” the use of insiders to protect federal programs “is as old as the False Claims Act.”

Contact Wilbanks at mbw@wilbanksgouinlock.com and DeConti at Robert.DeConti@oig.hhs.gov.

CMS Requires JW Modifier

continued from p. 1

“It’s an area you routinely should be monitoring because it’s not intuitive to document,” says Wendy Trout, director of corporate compliance for WellSpan Health in York, Pa.

Medicare Part B pays for wasted drugs, which refer to the medication left over in a single-use vial after the prescribed amount is administered. It’s a reimbursement opportunity because patients often get less than the amount in a single-use drug vial, and the rest should be thrown out according to guidance from the Centers for Disease Control and Prevention. But drug waste is also a compliance risk if there isn’t documentation to explain a discrepancy between the dose administered and the dose billed. Many expensive cancer drugs, for example, come in single-use vials.

Billing for wasted drugs is now an honor system in some MAC jurisdictions. Elsewhere, MACs require hospitals to bill one drug with two line items, appending the JW modifier to one line item of the HCPCS J-code to reflect how much of the drug was wasted. Either way, Medicare pays. But as of July 1, everyone will be on the same page.

Novitas Solutions, which is WellSpan’s MAC, doesn’t require the JW modifier. “We were happy to not have to use it in the past since it will be a challenge to implement, but I understand the rationale for it. It ties drug usage all up into a nice package,” Trout says. The modifier also will help with internal audits, she adds.

It’s not clear yet where in the process to add the JW modifier. At WellSpan, drugs are wasted at two points:

(1) Pharmacy: The pharmacists compound medications and enter them in the pharmacy system, which maps charges to the billing system. When pharmacists use part of a medication and waste the rest, they fill out a form to that effect and it’s scanned into the patient’s medical record. The full dose of the drug is billed out of the pharmacy system (in billable units), and if an auditor pokes around, “we have the documentation to support the part given and the part wasted,” Trout says.

(2) Nurses: When nurses pull medications, usually from a Pyxis machine, the charge crosses over to the billing system. Nurses are expected to document the dose they administered and the dose they wasted.

No Opportunity to Add a Modifier

The challenge: there’s no opportunity to add a modifier in either “source system” — the pharmacy or Pyxis, Trout says. “The billing system will need to be accessed by someone and the modifiers added when needed.” One option is to ask the pharmacist to check off every drug as “no waste” and “waste” depending on the situation. That would map to billing without a modifier when there is no waste or it would map to billing with a modifier if there is waste. The downside: “That would be a lot of work and it would be an easy place for errors to be made,” she says. “We will have to figure out how we will do this.”

CMS said in the transmittal that the JW modifier must be appended to a separate line item for the drug waste. “For example, a single use vial that is labeled to contain 100 units of a drug has 95 units administered to the patient and 5 units discarded. The 95 unit dose is billed on one line, while the discarded 5 units shall be billed on another line by using the JW modifier,” the transmittal states.

Because drug waste has to be a separate line item, hospitals that didn’t have to report drug waste with a JW modifier will have to divorce the charges, says Stephen Gillis, director of compliance coding, billing and audit at Partners HealthCare in Boston. Its MAC, National Government Services (NGS), also did not mandate use of the modifier. “We have been combining the two items into one line item. Now we will be keeping them separate,” he says. The charges will come from pharmacy or from nurses through Pyxis machines. “The JW could be easier or more challenging depending on how your charging process is set up,” Gillis says. “If you have a two-step charging process — one charge for waste and one charge for dispensing — then you are in a better position to add the JW modifier to one of your transactions than if you just charge on dispensing.” For example, if the nurse pulls a 100 mg vial out of Pyxis and that generates a charge, but the dose was only 75 mg and the nurse wasted 25 mg, the hospital has to distinguish between the two through the documentation and the modifier. “It’s more
involved and you have to create two line items on the claim,” he says. “Before the JW modifier, I could send the bill out without differentiating the drug from the waste.”

Hospitals also have to guard against overcharging for drug waste by vial size, Gillis says. Pharmaceutical manufacturers may give a 50% discount on 200 mg vials of a drug available in a 100 mg size. “Medicare says you can only bill for waste up to the smallest vial size.” If the nurse draws 75 mg of a drug out of a 200 mg vial, it seems like the normal charging process would leave the hospital with 125 mgs of drug waste. “But Medicare says the most you can bill for is 25 mg,” he says. “It’s a risk if people haven’t set up processes to prevent billing for waste equivalent to the smallest size.”

The JW modifier will give CMS a leg up in audits, Gillis says. “It will make it a lot easier for Medicare to target where you are billing for waste and to say ‘show me where you are documenting waste,’” he says. In fact, Gillis and Trout bet that’s the reason for universal adoption of the modifier. “They want to identify how much waste they are paying for,” he says, and also perhaps whether hospitals are billing for wasted drugs that are not from single-use vials.

Hospitals should review their own documentation of waste because “it’s an area rife with mistakes,” Trout says. Consider looking at a sample of charts to determine if nurses remember to note drug waste, perhaps annually. “It’s not natural to document this,” she says. “Nurses are taking care of the patient and their documentation is what they are doing for the patient. It’s common sense to them that they wasted the drug because it’s what was left over in the vial after using whatever dosage. I have to remind them we are going to bill for it and I need to have the documentation.” The same conversation happens with the pharmacist.

When staff turns over, Trout says it’s a good time for reminders and documentation reviews. Drug waste can easily fall through the cracks.

Hospitals also have the option to wash their hands of this altogether. “Some facilities may have decided not to bill for waste because they couldn’t come up with a solution on how to bill for waste or how to ensure it’s documented,” Gillis says. It can be overwhelming, with hundreds of thousands of drug orders coming out of the pharmacy every year. “Setting up the process may not be worth the effort,” but it is a loss of revenue.

Contact Trout at wrtrout@wellsplan.org and gillis at sgillis@partners.org. View the transmittal at http://tinyurl.com/gq4zgsh.
**NEWS BRIEFS**

- Cornerstone Hospital of Bossier City, La., was overpaid $321,971 for inpatient claims with the diagnosis code of Kwashiorkor (ICD-9-CM 260), the HHS Office of Inspector General said. OIG audited 73 of the 189 claims with Kwashiorkor submitted by the 62-bed long-term acute-care hospital, which is part of Cornerstone Healthcare Group, from 2010 to 2014. None of them complied with Medicare billing rules for Kwashiorkor, which is a form of severe protein malnutrition. The hospital should have coded for other kinds of malnutrition, OIG said. This is typical of the findings in OIG’s national review of Kwashiorkor because the diagnosis is exceedingly rare in the U.S. But compliance officers should question OIG auditors during these reviews because documentation may be misinterpreted or overlooked (RMC 3/17/14, p. 1). Cornerstone Hospital told OIG in written comments that it was true the patients shouldn’t have been coded for Kwashiorkor. Visit http://go.usa.gov/cunC5.

- In a somewhat unusual review, the HHS Office of Inspector General concluded that Tufts Medical Center in Boston was overpaid a net amount of $118,000 during two years, mostly for failing to report manufacturer credits for replaced medical devices. The mistakes were made on both the inpatient and outpatient sides. But OIG also said Tufts submitted four claims for inpatient admissions that should have been billed as outpatient or outpatient with observation services. “These errors occurred primarily because Tufts (1) staff had inadequate education on inpatient level-of-care criteria and lacked documentation necessary to determine the appropriate level of service and (2) lacked the level of oversight and the coordination between departments to correctly report the device credits it received for warranted or recalled medical devices,” OIG stated. In a written response, Cara Merski, chief compliance and privacy officer at Tufts, agreed with OIG’s findings, and said Tufts has developed a task force to analyze medical device replacements and identify claim errors. View the report at http://go.usa.gov/cunCx.

- Pharmaceutical companies Wyeth and Pfizer Inc. have agreed to pay $784.6 million to settle allegations that Wyeth reported false and fraudulent prices to the government on two of its proton pump inhibitor (PPI) drugs, Protonix Oral and Protonix IV, the Department of Justice said on April 27. New York City-based Pfizer acquired New Jersey-based Wyeth in 2009, about three years after Wyeth quit the alleged conduct that led to the settlement. The government alleged that Wyeth neglected to report “deep discounts on Protonix Oral and Protonix IV that it made available to thousands of hospitals nationwide.” PPI drugs treat acid reflux. Wyeth allegedly sold Protonix Oral and Protonix IV in a bundle, which meant hospitals got discounts on both drugs if placed on the formulary. “Through this bundled arrangement, Wyeth sought to induce hospitals to buy and use Protonix Oral, which hospitals otherwise would have had little incentive to use, because other pre-existing oral PPI drugs were priced competitively and were considered to be as safe and effective,” DOJ alleged. “Wyeth wanted to control the hospital market because patients discharged from the hospital on Protonix Oral were likely to stay on the drug for long periods of time, rather than switch to competing PPIs, during which time payers, including Medicaid, would pay nearly full price for the drug.” Visit http://tinyurl.com/jqlx6d8.

- Medically unnecessary ambulance services were again at the center of a false claims settlement (RMC 3/21/16, p. 1), this time with the New York City Fire Department. The U.S. Attorney’s Office for the Southern District of New York said May 5 that New York City “agreed to pay $4.3 million and admitted and accepted responsibility” for overcharging Medicare for emergency ambulance services. The city voluntarily disclosed problems with ambulance billing to the U.S. attorney’s office. According to the settlement, between October 2008 and October 2012, the Fire Department of New York (FDNY) billed Medicare for emergency ambulance services. The government alleged that FDNY for such claims, but did not take steps to inform Medicare of its consistent receipt of Medicare reimbursement for such claims until December 2012.” Visit http://tinyurl.com/hsd9pyw.
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