



COMPLIANCE CONNECTION

Newsletter MAY 2026

This newsletter is prepared monthly by the Midland Health Compliance Department and is intended to provide relevant compliance issues and hot topics.

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Arizona Cardiology Group to Pay \$4.75M to Resolve Allegations of Unnecessary Vein Ablations

Midland Health PolicyTech: Policy #15217 Acceptable Use of Artificial Intelligence (AI)
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FRAUD & ABUSE LAWS

The five most important Federal Fraud and Abuse Laws that apply to physicians are:

- 1. False Claims Act (FCA):** The civil FCA protects the Government from being overcharged or sold shoddy goods or services. It is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent.
- 2. Anti-Kickback Statute (AKS):** The AKS is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients).
- 3. Physician Self-Referral Law (Stark law):** The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies.
- 4. Exclusion Statute:** OIG is legally required to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses: (1) Medicare or Medicaid fraud; (2) patient abuse or neglect; (3) felony convictions for other health-care-related fraud, theft, or other financial misconduct; and (4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.
- 5. Civil Monetary Penalties Law (CMPL):** OIG may seek civil monetary penalties and sometimes exclusion for a wide variety of conduct and is authorized to seek different amounts of penalties and assessments based on the type of violation at issue. Penalties range from \$10,000 to \$50,000 per violation.

Resource:

<https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/>



MIDLAND HEALTH

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Arizona Cardiology Group to Pay \$4.75M to Resolve Allegations of Unnecessary Vein Ablations



Aetna Inc., a national insurer incorporated under the laws of Pennsylvania, has agreed to pay \$117,700,000 to resolve allegations that it violated the False Claims Act by submitting or failing to withdraw inaccurate and untruthful diagnosis codes for its Medicare Advantage Plan enrollees in order to increase its payments from Medicare.

Under the Medicare Advantage (MA) Program, also known as Medicare Part C, Medicare beneficiaries may opt out of traditional Medicare and enroll in private health plans offered by insurance companies known as Medicare Advantage Organizations, or MAOs. The Centers for Medicare & Medicaid Services (CMS) pays MAOs a fixed monthly amount adjusted for various risk factors that affect expected health expenditures for the beneficiary. In general, CMS pays MAOs more for sicker beneficiaries expected to incur higher healthcare costs. To make these "risk adjustments," CMS collects medical diagnosis codes from the MAOs.

The United States alleges that Aetna submitted inaccurate and untruthful patient diagnosis data to CMS in order to inflate the risk adjustment payments it received from CMS, failed to withdraw the inaccurate and untruthful diagnosis data and repay CMS, and falsely certified in writing to CMS that the data was accurate and truthful. The settlement announced today resolves these allegations.

"The government pays private insurers over \$530 billion each year to care for Americans enrolled in Medicare Advantage," said Assistant Attorney General Brett A. Shumate of the Justice Department's Civil Division. "We will continue to hold accountable insurers that knowingly submit inaccurate or unsupported diagnoses to improperly inflate reimbursement."

"The government pays Medicare Advantage Organizations to facilitate vital healthcare to our seniors and other vulnerable citizens. When corporations or individuals threaten the Medicare Advantage program by diverting those limited government resources through fraud, waste, or abuse, we will continue to pursue all available remedies against them," said U.S. Attorney David Metcalf for the Eastern District of Pennsylvania.

"Medicare Advantage relies on accurate reporting and attempts to manipulate the system undermine both the program's integrity and the beneficiaries it serves," said Acting Deputy Inspector General for Investigations Scott J. Lampert of the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG).

Read entire article:

<https://www.justice.gov/opa/pr/aetna-agrees-pay-1177-million-resolve-false-claims-act-allegations>

MIDLAND HEALTH Compliance HOTLINE

855•662•SAFE (7233)

ID#: 6874433130

ID# is required to submit a report.

You can make your report or concern ANONYMOUSLY.



MIDLAND HEALTH



Acceptable Use of Artificial Intelligence (AI)

Purpose: This policy establishes guidelines for the appropriate and secure use of artificial intelligence (AI) tools and services within Midland Health. As AI technologies continue to evolve and offer benefits in healthcare and operational workflows, it is critical to ensure their use aligns with patient safety, regulatory requirements, and our organization's values.

General Guidelines for AI Use:

- Approval Required:** Use of AI tools for any Midland Health operations, clinical workflows, patient interactions, or internal decision-making must be approved in advance by the AI Governance Committee and any additional stakeholders required, depending on the area of use. Unauthorized use is prohibited.
- AI Tool Inventory:** All AI tools or systems in use or under evaluation must be documented in an internal AI inventory managed by IT Security and Compliance. Staff are responsible for submitting requests and ensuring tools are properly recorded.
- All AI usage must adhere to HIPAA, state and legal privacy laws, and other applicable legal and ethical standards.
- Where required, informed consent must be obtained before AI is used in clinical decision-making or patient-facing functions.
- Prohibited Use Cases:**
 - No sharing of PHI (Protected Health Information), PII (Personally Identifiable Information), or PCI (Payment Card Information) with any AI platform under any circumstances.
 - AI tools that are not publicly accessible or vetted by IT (e.g., private, beta, or unreleased models) may not be used for any Midland Health purpose.
 - AI may not be used to make autonomous clinical decisions without oversight from licensed professionals.
 - Midland Health data cannot be used to train AI models without written approval from Legal, Compliance and IT Security.
 - AI cannot be used in ways that could exacerbate inequity, cause harm, or produce discriminatory outcomes.
- Transparency and Oversight:** Any output generated by AI must be reviewed by qualified staff before use in clinical or operational decisions. AI-generated content must not be treated as final or authoritative without human validation.

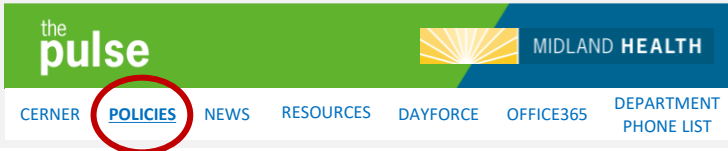
Read entire Policy:

Midland Health PolicyTech #15217 – “Acceptable Use of Artificial Intelligence (AI)”

Midland Health PolicyTech Instructions

Click this link located on the Midland Health intranet “Policies”

<https://midland.policytech.com/dotNet/noAuth/login.aspx?ReturnUrl=%2f>



IN OTHER COMPLIANCE NEWS

LINK 1

What are the HIPAA Laws in Texas?

<https://www.hipaajournal.com/hipaa-laws-in-texas/>

LINK 2

March 1, 2026: Small Healthcare Data Breach HIPAA Reporting Deadline

<https://www.hipaajournal.com/march-1-2026-small-healthcare-data-breach-hipaa-reporting-deadline/>

LINK 3

How Employees Can Help Prevent HIPAA Violations

<https://www.hipaajournal.com/employees-prevent-hipaa-violations/>

LINK 4

Why Do Criminals Target Medical Records?

<https://www.hipaajournal.com/why-do-criminals-target-medical-records/>

Anchorage Doctor Sentenced to Prison for Multi-Million-Dollar Health Care Fraud and Tax Evasion

An Anchorage doctor was sentenced to six and a half years in prison and three years of supervised release for executing a \$12.5 million health care fraud scheme and evading over \$4 million in taxes on the profits of that 15-year scheme. Her husband and co-defendant was sentenced to three years of probation, with two years to be served in home confinement.

According to court documents and statements made in court, Dr. Claribel Tan, 61, and her husband, Daniel Tan, 70, operated a rheumatology medical clinic in Anchorage starting in 2005. Claribel Tan specialized in the treatment of autoimmune and musculoskeletal diseases, such as rheumatoid arthritis, osteoarthritis and psoriatic arthritis, and she prescribed injectable medications to treat those conditions. Although these conditions are often chronic, degenerative and irreversible, certain medicines can slow down or arrest their progression. Daniel Tan assisted as an officer manager at the clinic.

Beginning in 2009 and continuing through 2024, the Tans deceived patients about the medications Claribel Tan administered through injections and then fraudulently billed health insurance plans for reimbursement of medications that the Tans did not purchase. Claribel Tan routinely and surreptitiously injected patients with free samples, expired medications and medications other than those prescribed. The Tans then knowingly billed insurance plans as if she had provided a proper injection to each patient. Specifically, the Tans claimed to have administered 4,829 units of the medications to patients, and billed the insurance plans for that amount, despite only purchasing 369 units of medication.

Read entire article:

<https://www.justice.gov/opa/pr/anchorage-doctor-sentenced-prison-multi-million-dollar-health-care-fraud-and-tax-evasion>

Owner of Durable Medical Equipment Company Sentenced for \$59M Medicare Fraud

A Texas man was sentenced to 90 months in prison for his role in a \$59.9 million conspiracy to pay kickbacks and submit claims for medically unnecessary durable medical equipment (DME) to Medicare.

According to court documents, Patrick Cassells, 65, of Fulshear, Texas, owned and operated three DME companies and concealed his role in one of those companies by falsely identifying another individual as the sole owner and manager in a Medicare enrollment application. Cassells paid illegal kickbacks to co-conspirators who sent him signed doctors' orders and other paperwork necessary to bill Medicare for orthotic braces such as knee, back, shoulder and wrist braces. The kickbacks were disguised by referring to the doctors' orders as "leads" and the services provided as "marketing." Based on these orders, which were issued without doctors examining or treating the patients, Cassells submitted claims to Medicare that falsely represented that the braces were medically necessary. In total, through the three companies, Cassells caused over \$59.9 million in false and fraudulent claims to Medicare, for which Medicare paid over \$27 million. Cassells used proceeds of the fraud to purchase personal vehicles and vehicles that he intended to export to Nigeria.

In June 2024, Cassells pleaded guilty in the Southern District of Texas to one count of conspiracy to commit health care fraud. In addition to the prison sentence, Cassells was ordered to pay \$25,402,614.97 in restitution and forfeiture, and to forfeit four vehicles and three properties in the Houston area.

Read entire article:

<https://www.justice.gov/opa/pr/owner-durable-medical-equipment-company-sentenced-59m-medicare-fraud>



Do you have a hot topic or interesting COMPLIANCE NEWS to report?

If so, please email an article or news link to:

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