Report on
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Weekly News and Analysis on New Enforcement Initiatives and Billing/Documentation Strategies

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OIG Frees Providers From CIAs, CCAs For Good-Faith Participation in SDP

The HHS Office of Inspector General (OIG) on April 15 unveiled changes to the self-disclosure protocol (SDP) that may attract more providers that want to escape a corporate integrity agreement (CIA). OIG says providers that follow some new conditions and complete the SDP in good faith generally will walk away without a CIA or a certificate of compliance agreement (CCA), also known as a "CIA Lite." CIAs and CCAs are mandatory compliance measures imposed in fraud settlements, and CIAs in particular are dreaded by the industry as burdensome and expensive.

An Open Letter to Health Care Providers from Inspector General (IG) Daniel Levinson, which he announced April 15 at the Health Care Compliance Assn.'s (HCCA) annual Compliance Institute in New Orleans, lays out the terms of the new *quid pro quo*.

According to the Open Letter, in addition to all the basic information providers must always include in their SDP application, the initial submission also must contain:

(1) "a complete description of the conduct being disclosed;

(2) a description of the provider's internal investigation or a commitment regarding when it will be completed;

(3) an estimate of the damages to the Federal health care programs and the methodology used to calculate that figure or a commitment regarding when the provider will complete such estimate; and

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DFRR Appears in IPPS Rule; CMS Seeks Hospital Feedback on Gathering MD Data

The Disclosure of Financial Relationships Report (DFRR) is alive and well, though CMS is now pursuing it through the regulatory process. After CMS realized it would take a hospital an average of 31 hours to complete the DFRR — far longer than the six hours the agency originally predicted — CMS is asking hospitals to comment on various aspects of the DFRR, according to the proposed inpatient prospective payment system (IPPS) regulation for fiscal year (FY) 2009, unveiled April 14.

The DFRR is a data-gathering instrument designed to capture detailed information about hospital-physician relationships as part of CMS's enforcement of the Stark physician self-referral law *(RMC 11/5/07, p. 1)*. CMS plans to send the DFRR to 500 specialty and acute-care hospitals (and eventually perhaps all hospitals). The DFRR was originally handled as an "information collection request in advance of rulemaking," the IPPS rule states. It still needed Office of Management and Budget approval under the Paperwork Reduction Act, but on April 10 the DFRR was withdrawn, according to the OMB Web site *(RMC 4/13/08, p. 1)*. CMS declined to comment on the reason why. Four days later, the DFRR appeared in the regulation and, though there was only minor tinkering with the form, the regulation had a couple of surprises, lawyers say.

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For one thing, CMS has been busy surveying providers to figure out how much of a burden it would be for hospitals to complete the DFRR. The instrument includes a cover sheet, eight schedules and a CEO attestation as to the accuracy of the contents, and it requires hospitals to send in copies of every physician contract. In the original notice announcing the DFRR, CMS estimated hospitals could get the job done pretty quickly. But CMS decided to take a closer look at this, perhaps at OMB's prompting. CMS asked 60 hospitals — 20 small, 20 medium and 20 large — to complete the DFRR and to "estimate the aggregate number of hours it would take them to complete and submit the entire DFRR collection," the regulation says.

Thirty-three hospitals agreed to the request. Based on their experiences, CMS "determined that the average number of hours to complete the DFRR was 31 hours."

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Given that result, CMS believes "it would be beneficial to seek further comments on the time and burden estimates associated with this information collection instrument."

South Bend, Ind., attorney Bob Wade says he hopes CMS is truly receptive to the comments it receives about the DFRR and "will restructure the process to avoid undue burden on hospitals." To underscore the burden of the DFRR, he says one of his clients on the list of 500 hospitals is thinking of hiring a U-Haul truck and a driver to schlep the physician contracts required under the DFRR because shipping them by UPS would be even more expensive.

According to the IPPS rule, CMS is soliciting comments on:

◆ ***"Whether the collection effort should be recurring,*** and, if so, whether it should be implemented on an annual or some other periodic basis.

◆ ***Whether we are collecting too much or not enough information,*** and whether we are collecting the correct (or incorrect) type of information.

◆ ***The amount of time it will take hospitals to complete the DFRR*** and the costs associated with completing the DFRR; the amount of time we should give hospitals to complete and return their responses to us.

◆ ***Whether we should direct the collection instrument to all hospitals,*** and, if so, whether we should stagger the collection so that only a certain number of hospitals are subject to it in any given year.

◆ ***Whether hospitals, once having completed the DFRR, should have to send in yearly updates*** and report only changed information."

Wade also questions whether CMS really has the manpower to make use of the huge amount of information it will collect from 500 hospitals through the DFRR. The answer is yes, CMS says in the regulation. The agency has "reviewed our available funding and determined that our resources would permit us to review data from 500 hospitals."

CMS Is Softening CMP Stance

CMS also decided to build in some breathing room for DFRR compliance. Hospitals would still have 60 days to complete the forms, but instead of a $10,000-a-day civil monetary penalty (CMP) kicking in on the day after the deadline expires, CMS says it is receptive to extensions and will help coax providers into compliance.

"Although we have the authority to impose civil monetary penalties, we seek not to invoke this authority and will work with entities to comply with the reporting requirements. Prior to imposing a civil monetary penalty in any amount, we would issue a letter to any hospital that does not return the completed DFRR, inquiring as to why the hospital did not return timely the completed DFRR. In

addition, a hospital may, upon a demonstration of good cause, receive an extension of time to submit the requested information," the rule states. CMS also is soliciting feedback on the 60-day deadline for completing the DFRR.

And CMS made a change to the form itself that will lighten hospitals' load a bit: Instead of requiring two copies of all contracts with physicians, the DFRR now requires only one copy, Wade says.

Wade, who is with the law firm Baker & Daniels, urges hospitals to take advantage of the opportunity to make their voices heard at CMS. "This is our opportunity to submit comments to the government and see if we can insist on making the process more reasonable and less burdensome," he says. For example, instead of a hospital having to send in a copy of all its contracts, maybe CMS would be satisfied with a spreadsheet describing the basic terms of all its contracts, he explains. That would be enough information for CMS to evaluate whether a contract fell outside whatever outlier CMS established for a certain kind of contract with a particular specialty and to ask for more details at that point, if that's the approach it planned to take, Wade says.

Comments on the proposed IPPS rule are due by June 13.

Contact Wade at bob.wade@bakerd.com. To view the IPPS regulation, visit AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "Inpatient Prospective Payment System." ✧

CMS Program Integrity Director Challenges Myths About RACs

The permanent, national recovery audit contractors (RACs) will be more provider-friendly because of certain CMS requirements imposed on the contingency-fee contractors, according to the director of Medicare program integrity for CMS. For example, RACs are required to host Web sites that list, in real time, all claims under scrutiny; limit the number of medical records requested from providers every month (the number has not yet been set); employ a medical director; and engage in provider outreach.

"We are requiring RACs to be much more aggressive about educating providers," Kim Brandt, director of program integrity, said April 14 at the Health Care Compliance Assn.'s Compliance Institute in New Orleans.

The various safeguards were largely a response to complaints raised by the provider community. "Hopefully, this will minimize a lot of the angst about" the RACs as they begin setting up shop in May in states around the country, she said.

RACs, which are the first Medicare auditors paid only when they find overpayments and, to a lesser extent, underpayments, began in 2005 as a three-year pilot in New York, California and Florida (South Carolina and Massachusetts were added last year). There have been glitches along the way *(RMC 3/3/08, p. 1)*, but CMS considers the RACs a big success because they identified $440 million in improper Medicare payments *(RMC 3/10/08, p. 5)*. Starting in May, CMS is rolling out the RACs nationally, and hospitals should be preparing for their medical-record demands *(RMC 3/17/08, p. 1.)*.

Brandt listed four major myths about RACs and then countered them:

(1) Myth: RACs make up their own rules. ***Fact:*** RACs apply the same policies as other Medicare contractors.

(2) Myth: RACs use unqualified staffers. ***Fact:*** RACs use nurses, therapists, coders and medical directors.

(3) Myth: All RAC reviews are conducted by black-box computer edits. ***Fact:*** Many RAC reviews involve a medical-record review by a clinician.

(4) Myth: RACs will replace Medicare quality improvement organizations (QIOs). ***Fact:*** "The job of educating hospitals about how to avoid submitting" erroneous claims will still be performed by QIOs and Medicare fiscal intermediaries/Medicare administrative contractors, she said. (However, CMS has ended the Hospital Payment Monitoring Program, which was run by QIOs, so it's not clear at the moment what role QIOs will play in provider education.)

"RACs are not quite the rogues they are portrayed to be," Brandt maintained.

Fort Lauderdale, Fla., attorney Gabe Imperato says he agrees that RACs don't do the extreme things described in the myths, but says their reviews are affected by their incentive payments. For example, "I do not believe they do black-box reviews, but I know their reviews are influenced by the very different incentives they have in the game of recovery. And I do not believe they use unqualified staff, but I bet many of the staff recruits are not nearly as experienced as former CMS contractors were," says Imperato, who is with the law firm of Broad and Cassel.

"These are not public servants attempting to run a fair public health program. And they are not likely rogues either," he says.

Contact Brandt at kimberly.brandt@cms.hhs.gov and Imperato at gimperato@broadandcassel.com. ✧

Communicating With Agents, Vendors and Contractors

Catholic Healthcare Partners, a 36-hospital nonprofit system based in Ohio, requires managers to incorporate the following language into all their contracts with vendors and suppliers. Contact Don Koenig at dkoenig@health-partners.org.

Catholic Healthcare Partners (CHP) has created a corporate responsibility program to ensure we comply with all laws and regulations that apply to a tax-exempt, church-based health care provider. This includes laws concerning health and safety, Medicare and Medicaid, fraud and abuse, tax, anti-trust, environmental and labor laws, among others.

We cultivate a culture of compliance from the boardrooms to front-line caregivers, and we include our credentialed providers, vendors and contractors in that commitment. We commit to an effective corporate responsibility program to sustain that culture. Our program includes education, communications methods to encourage reports of concerns, investigations into concerns, monitoring and auditing for compliance and accuracy, and accountability and corrective action when we detect an error.

Vendors and contractors must be aware of, and agree to abide by, the following three provisions of our corporate responsibility program as a continuing condition to do business with us:

Eligibility to Do Business With a CHP Entity

(1) As a Medicare-participating organization, CHP is prohibited from hiring or doing business with any entity or person who is currently:

A. Excluded from participating in federal or state health programs by the Office of Inspector General of the U.S. Department of Health and Human Services;

B. Barred from contracting with the U.S. Government by the General Services Administration; or

C. Listed as a terrorist organization or supporting individual by the Office of Foreign Asset Control of the U.S. Department of the Treasury.

(2) Vendors must certify their eligibility to do business with CHP by certifying that neither the organization, nor its owners or principals or any vendor employee (collectively, "staff,") who will provide services to CHP, is prohibited from doing business with CHP under paragraph 1. Vendor agrees to provide to CHP the names, addresses and Social Security numbers of key vendor staff, if requested, for CHP to complete required name checks.

(3) Eligibility is a continuing condition of any contract with CHP, and vendors must agree to notify CHP immediately if the government takes adverse action in paragraph 1 against the vendor or any of its staff. Vendors must also notify CHP if they learn of an investigation that could reasonably result in adverse action in paragraph 1 against the vendor or its staff. CHP may terminate a contract where the government takes adverse action listed in paragraph 1 against the vendor or its staff.

Business Ethics, Gifts and Gratuities

(1) CHP does business in an open, fair, impartial and transparent manner and engages in arms-length negotiations with potential vendors, contractors or business partners. CHP requires our employed associates, credentialed providers, board members and volunteers to act in the best interests of CHP at all times. This includes avoiding conflicts of interest that might jeopardize the impartiality of their judgment and decision making, as well as avoiding situations that create a reasonable appearance of a conflict of interest or an appearance of favoritism, partiality, personal gain or insider dealing.

(2) CHP associates may not seek, request or accept any gift, gratuity or other item, regardless of value, that is intended to influence a business decision, or that is offered to them because of their position in a pending business decision. CHP associates may not accept gifts, gratuities, discounts or other things of value from anyone doing business with, or desiring to do business with, CHP or any CHP entity, except in nominal amounts, which they must disclose to their reporting superior.

(3) The corporate responsibility program includes corporate responsibility officers (CROs) who can assist or respond to any vendor concern about possible violations of CHP's policies or applicable laws or regulations. Associates are required, and vendors are encouraged, to report any concerns to either the CRO at (513) 639-2833 or to CHP's ReportLine, which is available 24/7/365 and where anonymous reports can be made, at 1-888-302-9224. CHP policy prohibits retaliation for a report made in good faith.

Required Education on the False Claims Act and Whistle-blower Protections for Providers of Medicaid-Covered Services

Because CHP and its entities receive in excess of $5 million in annual Medicaid reimbursements, we are required to provide additional education to our employed associates, vendors and contractors related to the False Claims Act and whistle-blower protections

Communicating With Agents, Vendors and Contractors (continued)

available under those laws. Our vendors and contractors are required to ensure that their employees who will provide services to CHP receive the following educational information also:

CHP associates work hard to ensure that we create accurate and truthful patient bills and submit accurate claims for payment from any payer, including Medicare and Medicaid, commercial insurance or our patients. It's the right thing to do, reflects our faith-based mission and complies with federal and state laws that require accuracy in health care billing.

The federal False Claims Act (31 USC 3729-33) makes it a crime for any person or organization to knowingly make a false record or file a false claim with the government for payment. "Knowing" can include deliberate or reckless ignorance of facts that make the claim false.

Examples of possible false claims include someone knowingly billing Medicare for services that were not provided or for services that were not ordered by a physician or for services that were provided at substandard quality where the government would not pay.

A person who knows a false claim was filed for payment can file a lawsuit in federal court on behalf of the government and, in some cases, receive a reward for bringing original information about a violation to the government's attention. Penalties for violating the federal False Claims Act can be up to three times the value of the false claim, plus from $5,500 to $11,000 in fines, per claim. While Ohio law does not permit private suits like the federal False Claims Act for Medicaid fraud, Ohio law does include both civil or criminal penalties against those who attempt to obtain Medicaid payments to which they are not entitled or who commit Medicaid fraud (see Ohio Revised Code Sections 5111.03 and 2913.40).

The False Claims Act protects anyone who files a false claim lawsuit from being fired, demoted, threatened or harassed by his or her employer for filing the suit. If a court finds that the employer retaliated, the court can order the employer to re-hire the employee, and to pay the employee twice the amount of back pay that is owed, plus interest and attorney's fees. Ohio law provides equivalent protections from retaliation by an employer for employees who report Medicaid fraud to the authorities (see Ohio Revised Code Section 4113.52(B)).

CHP's corporate responsibility program supports compliance with the False Claims Act by:

◆ Monitoring and auditing business activities to prevent or detect errors in coding or billing.

◆ Educating our associates, vendors and contractors that they are responsible to report any concern about a possible false claim at a CHP facility via our three-step reporting process.

◆ Investigating all reported concerns and correcting any billing errors discovered.

◆ Protecting our associates, vendors or contractors from adverse action when they do the right thing and report any genuine concern via the three-step reporting process. CHP will investigate any allegation of retaliation against an associate for speaking up.

Contractor Scheme With Hospital Official Bilked Millions From NYPH

A recent case in New York highlights the importance of policing vendor relations, especially at nonprofit hospitals. A general contractor for residential and commercial buildings pleaded guilty April 11 to conspiring to defraud New York Presbyterian Hospital (NYPH) by paying kickbacks to the hospital's purchasing official to steer contracts its way.

Aaron Weiner, who owns Aaron Weiner Construction Inc. (AWC), pleaded guilty to participating in the scheme, which allegedly took place from June 2004 to March 2005. He faces five years in prison and a $250,000 fine.

The feds say that Weiner acted as a "conduit" in the plan to bilk NYPH out of millions of dollars. The owner of two New York City-based construction companies allegedly paid Weiner to pose as a consultant in order to pay kickbacks to NYPH's senior purchasing official. The purchasing official awarded construction contracts totaling nearly $20 million to the companies. To conceal the kickbacks, the payments were wired to AWC, and Weiner wrote checks to a shell company formed by the purchasing official in his mother's name, the feds say. About $1 million in kickbacks went to the purchasing official, they say.

The company owner and purchasing official were not named in the information filed against Weiner. The feds say the investigation is ongoing and declined to provide additional information at this time.

The hospital did not respond to requests for comment.

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Lawyers contend that hospitals invite trouble unless there is oversight of the contracting process and the people who potentially stand to benefit from it.

"Particularly when an organization is engaged in negotiations that involve multimillion dollar contracts — whether it is for supplies, construction, a piece of state-of-the-art equipment, [electronic medical records], etc. — the organization must have effective checks and balances or internal controls in place to assure itself and governance that the processes will serve the best interests of the organization at all times," says Don Koenig, vice president and assistant general counsel for Catholic Healthcare Partners (CHP) in Ohio. CHP distributes information about its corporate responsibility program to its agents, vendors and contractors (see box, p. 4).

The risks are particularly acute for nonprofits. "Monitoring individuals who have expenditure responsibility is important from a number of respects," says Todd Greenwalt, a lawyer with Vinson & Elkins LLP in Houston. "First, the hospital's executive management and the board of directors owe a fiduciary duty to the hospital to oversee and protect the use of hospital assets to ensure they are used to accomplish charitable purposes. Second, if the hospital is viewed to endorse an activity that improperly enriches a private party, through either direct action or lax oversight, the IRS could assert that the hospital has violated either the private inurement proscription if the enriched party is an insider, or the private benefit limitation, placing the hospital's exempt status at risk." It seems unlikely that the IRS would take that action here, he adds.

Oversight May Increase as Contract Value Rises

Koenig says large health systems may have tiered systems for contracting that increase the oversight as the value of the contracts increases. "Generally, large systems might have a threshold level of contracting that requires larger dollar contracts to include multiple bids, or even a formal [request for proposal] process with a review-and-evaluation committee that includes financial, legal, logistics and subject-matter experts to ensure that important, large-dollar acquisitions receive the scrutiny, analysis and broad consensus that will protect the organization," he says.

If a failure of control happens anyway, organizations should "undertake a candid, thorough assessment to determine whether the control was not designed properly, not implemented properly or was intentionally overridden. Once the causes are identified, corrective action can be undertaken to strengthen and periodically test those controls to prevent recurrence," says Koenig.

Contact Koenig at dkoenig@health-partners.org and Greenwalt at tgreenwalt@velaw.com. Visit www.usdoj.gov. ✧

Short-Stay Outliers Have Decreased; OIG Questions Some Discharges

Short-stay outliers at long-term care hospitals (LTCHs) have decreased steadily since 2003, but some discharges "raise questions," OIG says in a memorandum report (OEI-01-07-00290) posted April 4.

LTCHs have attracted scrutiny from CMS and the Medicare Payment Advisory Commission because they have multiplied in recent years. This is possibly due to a high-paying prospective payment system and because DRGs are more lucrative for LTCH patients. LTCH services include rehab, respiratory therapy, head-trauma treatment and pain management. Short-stay outliers arise when LTCH patients become eligible for a lower level of care because their acuity and length of stay drop below a certain threshold. The patients are discharged early, so the hospital's costs are substantially below average *(RMC 2/6/06, p. 1)*.

Were Some LTCH Placements Unnecessary?

Short-stay outliers decreased from 40% of LTCH stays discharged in fiscal year 2003 to 27% in FY 2006, OIG says. "When CMS reduced payments for short-stay outliers in FY 2003, it predicted that these stays would decline. At that time, CMS estimated that 48 percent of LTCH stays were short-stay outliers," the report says.

But OIG questions whether the patients should have been placed in LTCHs in the first place "given their short lengths of stay." Between FYs 2003 and 2006, LTCHs discharged more than a third of short-stay outlier patients at least 10 days before they reached the threshold, or "five-sixths of the average length of stay for each LTC-DRG," OIG says. These "very short stays" accounted for 36% to 41% of short-stay outliers during the review period.

"Very short stay patients usually had lengths of stay that were closer to the average length of stay for patients with similar DRGs at general acute care hospitals than the average length of stay for the diagnosis at LTCHs," OIG says. "For example, in FY 2006, the most common LTC-DRG for very short stay patients was 'Respiratory system diagnosis with ventilator support' (LTC-DRG 475). In FY 2006, very short stays for this LTC-DRG lasted 19 days, at most. The average length of stay for this diagnosis in general acute care hospitals was eight days, compared to an average length of stay of 35 days in LTCHs."

OIG also wonders whether financial incentives, not patients' conditions, trigger the discharge date. During the review period, LTCHs gradually discharged patients more and more within two days after they qualified for full LTC-DRG payments. "Each year, LTCHs discharged fewer patients on the day before they qualified for a full LTC-DRG payment than on any of the other four days before or after the short-stay outlier threshold….From FY

2003 to July 2006, LTCH payments increased sharply on the day patients qualified for full LTC-DRG payments," the report says.

Based on quality improvement organizations' reviews of LTCH claims, OIG estimates that about $85 million of Medicare payments for short-stay outlier claims during FYs 2005 and 2006 were erroneous, but that "this…was not statistically different from the error rate for other LTCH stays."

The report contained no recommendations for CMS, but asked that CMS send comments or questions within 60 days.

Read the report at AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "OIG Evaluations and Inspections." ✧

OIG Is Dropping Most CIAs From SDP

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(4) a statement of the laws potentially violated by the conduct."

And providers must finish their investigation and damages assessment within three months after their acceptance into the SDP, the Open Letter states.

In return, OIG says, it generally won't require a CIA or CCA. The reason: Providers will have proved their "commitment to integrity," says the Open Letter.

"By providing that kind of detail, there is now a way to take CIAs and CCAs off the table," Levinson said at the HCCA conference. "Providers can reap the benefits of working collaboratively [with OIG], but we expect providers to be forthcoming." Plus OIG wants to speed up the SDP process.

While OIG offers this CIA carrot to wayward providers who are trying to do the right thing, the Medicare watchdogs are sharpening their sticks for persistent violators. CIA recidivists — companies that complete a CIA and then land in hot water again, winding up with another CIA as the result of a new fraud settlement — will now be subject to additional CIA terms, according to Levinson and Lewis Morris, chief counsel to the IG. "OIG recognizes that exclusion of a health care provider may harm innocent employees and put Medicare and Medicaid patients at risk if the entity is the sole provider of critical services," Morris says. However, "when an entity has been given this opportunity to reform its corporate culture and subsequently engages in additional fraudulent behavior, OIG must consider whether exclusion is a more appropriate response than imposition of a CIA with enhanced terms and conditions."

OIG says 379 health care organizations have gone through the SDP, which was created in 1998. As of March, $120 million has been recovered.

"This is a really significant step — probably the biggest step OIG has made with respect to the protocol," says Heidi Sorensen, former chief of OIG's Civil and Administrative Recoveries Branch and now a lawyer with Foley & Lardner LLP.

Levinson notes in the Open Letter that providers will be dropped from the SDP "unless they disclose in good faith and timely respond to OIG's request for additional information." That's happened before, says Morris. For example, one SDP was terminated because the provider dragged its feet for two years, and then its legal counsel demanded that OIG produce subpoenas for more documents, Morris said at the conference.

The three-month deadline is a way of OIG saying that it shouldn't have to spend its time pestering providers for documentation necessary to move the SDP process along, he noted. The SDP is also not for simple Medicare overpayment returns or innocent errors, Morris said.

Move Has Been in the Works Awhile

The dropping of most CIAs from the SDP is the "final step" in a move that began with the first of four IG Open Letters issued since the SDP's inception, Sorensen says. Former IG June Gibbs Brown, who got OIG's SDP rolling, first mentioned in a 2000 Open Letter that SDP graduates may not be saddled with a CIA if their compliance program was effective and other conditions were met. Then-IG Janet Rehnquist's 2001 Open Letter essentially created CCAs, which generally require the provider to maintain its existing compliance program and don't mandate external auditors; self-disclosure, however, is a prerequisite for the CCA. Then in April 2006, Levinson, hoping to attract more Stark violators to the SDP, moved even closer to exchanging CIAs and CCAs for SDP participation. (He also announced that providers could resolve their Stark problems through the SDP for a fraction of the fines and penalties they actually owed for their period of noncompliance — and that they would face if the government nailed them on its own.)

Now there is Levinson's 2008 Open Letter.

With the prospect of avoiding a CIA or CCA, "it's foreseeable the number of voluntary disclosures will multiply," says Dallas attorney Frank Sheeder, who is with Jones Day. "Historically, a large number of providers have not participated in the SDP because there is no guarantee of any kind. In fact, providers who have recently [participated] found themselves burdened by CIAs."

Contact Sorensen at hsorensen@foley.com and Sheeder at fesheeder@jonesday.com. View the Open Letters at www.oig.hhs.gov/fraud/openletters.html and the SDP at www.oig.hhs.gov/fraud/selfdisclosure.html. ✧

NEWS BRIEFS

◆ **OIG is proposing new compliance program guidance for nursing facilities that would supplement a CPG issued in 2000,** according to an April 16 notice in the *Federal Register*. "The proposed notice takes into account Medicare and Medicaid nursing facility payment systems and regulations, evolving industry practices, current enforcement priorities (including the government's heightened focus on quality of care), and lessons learned in the area of nursing facility compliance. When published, the final supplemental CPG will provide voluntary guidelines to assist nursing facilities in identifying significant risk areas and in evaluating and, as necessary, refining ongoing compliance efforts," it says. The fraud-and-abuse risk areas OIG lists include quality of care, submission of accurate claims, the anti-kickback statute, physician self-referrals and the HIPAA privacy and security rules. Some other compliance considerations are an ethical culture, regular reviews of compliance program effectiveness and communication to decision makers, OIG says. To read the proposed CPG, visit AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "2008 *Federal Register*."

◆ **Fred Steinberg, M.D., a Florida radiologist, and the system of imaging centers that he owns will pay $7 million to settle allegations of health care fraud as well as Stark law and anti-kickback statute violations,** the U.S. Attorney's Office for the Southern District of Florida said April 14. The suit was filed in 2002 by whistle-blower David Clayman, M.D., a former employee of one of University MRI's (UMRI's) facilities. Clayman will receive $1.75 million in the settlement. The feds alleged that some CT scans were not performed, though the services were billed and reported to the patients' doctors as if they were. The feds also allege that other services performed were not medically necessary and not ordered by physicians. The settlement also resolves allegations that, in exchange for patient referrals, physicians received "financial inducements…[in] the form of medical directorship, clinical research, employment, facility use, and equipment lease agreements that exceeded fair market value or otherwise failed to comply with federal law," the feds say. A firm representing UMRI noted that the settlement agreement states that the company denies the allegations, but settled to end the uncertainty of protracted litigation. The firm also says in a statement that the consulting agreements were terminated prior to the feds' investigation, and that the facility and lease agreements were commonly used by imaging centers across the country. Visit www.usdoj.gov/usao/fls.

◆ **On April 14, CMS said it would take more steps to tie the quality of care provided to Medicare patients to payment for hospital services by expanding the list of conditions that are "reasonably preventable."** In the proposed rule updating payment policies for the inpatient prospective payment system (IPPS), CMS also says it is adding 43 new quality measures for which hospitals will have to report data to receive the full annual payment update. The proposed rule would apply to services provided during fiscal year 2009 (which begins Oct. 1, 2008) and would apply to more than 3,500 acute-care hospitals paid under the IPPS. Visit www.cms.hhs.gov/apps/media/fact_sheets.asp.

◆ **Michael Labrada was sentenced to 97 months in prison, and Miguel Castillo received 57 months for their participation in a health care fraud and money laundering scheme that defrauded Medicare of about $1.6 million,** the U.S. Attorney's Office for the Southern District of Florida said this month. The two men allegedly served as straw owners of medical equipment companies, the feds say. They both have plea agreements with the feds, court records indicate. Four other co-conspirators have pleaded guilty. Visit www.usdoj.gov/usao/fls.

◆ **Seven HIV infusion clinic workers have been charged with conspiracy to submit false Medicare claims, to pay kickbacks and to commit health care fraud,** the U.S. Attorney's Office for the Southern District of Florida said this month. Three of the defendants were charged with submitting false claims. One of the defendants is a physician who ordered medically unnecessary tests and treatments, the feds allege. The indictment also says that some of the employees allegedly paid HIV patients $100 to $150 per visit to sign logs and to state that they received treatments that were billed to Medicare, when they had not received the treatments. The clinic received about $8 million for services not provided or not medically necessary, the feds say. If convicted, the defendants face a range of sentences, from 15 to 35 years. An attorney for one defendant said he had no comment at this time. Another attorney said his client denies the charges and looks forward to defending the case in court. Others could not be reached for comment. Visit www.usdoj.gov/usao/fls.

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