

MEDICARE COMPLIANCE

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

Contents

- 3** OIG Says DME Closets in Hospitals Are OK; Lack of Vendor Fee is Key
- 4** Bayer Will Pay \$97 Million For Alleged Cash-for-Patient Scheme
- 7** *Sample Contract Review Document*
- 8** *News Briefs*

Hospitals Face Risks Unless Coders Are Ready When New CPT Codes Kick in Jan. 1

Hospitals have less than a month to absorb the changes in the 2009 CPT code book. Applying them correctly is essential to compliance and reimbursement because CPT codes are used to bill Medicare and other payers for both the technical and professional aspects of procedures. Coders should get comfortable with the new CPT codes, which include newer procedures for obstructive sleep apnea, hernias and biopsies, as well as deletions, revisions and notes. They take effect Jan. 1.

The American Medical Assn. (AMA), which publishes CPT code books, uses color-coded information to highlight the changes, says Lori Purcell, associate vice president for coding and reimbursement at Quorum Health Resources, LLC. In the 2009 version, red bullets indicate new codes and blue triangles signal revised codes. Text is printed in green when explanations are necessary about a new or revised code or AMA warns hospitals against repeating a common mistake. For example, AMA didn't change the urology codes, but the CPT book has a new note in green underneath codes 53605 and 53665 to raise awareness of problems with accurate coding in this area.

It's important for coders to study the new book, dump old codes from their memory and replace them with new ones. "The best way to learn new codes is to open up the

continued on p. 5

After Self-Disclosing to Feds, Hospital Pays \$36 Million For Alleged Sweetheart Deals

Condell Medical Center's \$36 million settlement is a powerful argument for contract audits and management systems because the hospital didn't learn it had a multitude of potential Stark and kickback violations until its due diligence for a pending sale, people involved in the case say. When the rocks were overturned, scores of dubious deals came to light. So in late May, Condell voluntarily disclosed its possible Stark and kickback issues to the U.S. Attorney's Office for the Northern District of Illinois, which announced a settlement Dec. 2. Meanwhile, Condell's sale to Advocate Health Care has been consummated.

On the up side, Condell, the largest provider in Lake County, Ill., avoided a false claims lawsuit by coming forward when it found suspicious financial relationships (e.g., below-market leases, improper loans, payments to physicians for patient services without written agreements). Linda Wawzenski, the assistant U.S. attorney in Chicago who handled the case, says the Condell experience was a model for voluntary disclosure. "This was one of the fastest settlements from start to finish. To have a deal by Dec. 1 is like warp speed," Wawzenski tells RMC. "And it had to be approved at a pretty high level of the Department [of Justice]." Time was of the essence because of the pending deal with Advocate, which was essential to Condell's survival. The hospital "was extraordinarily cooperative," she says, and "gave us access to every piece of paper we could want. It's an example of how voluntary disclosure should work."

continued

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On the down side, the 238-bed hospital is paying the feds \$33.12 million to settle claims involving Medicare and Medicaid and the state of Illinois \$2.88 million to settle claims relating to Medicaid. The scope and nature of the alleged Stark and kickback violations — which Condell formally denies in the settlement — are striking. According to the settlement and to sources, over 100 physicians had arrangements with Condell that did not meet a Stark exception and/or may have violated the anti-kickback statute. In certain scenarios, the physicians allegedly agreed to refer patients only to the hospital.

“This case is a poster child for not paying attention to physician relationships,” says Nashville, Tenn., attorney Patsy Powers, with the law firm of Waller Lansden Dortch & Davis (who was not involved in the case).

According to the settlement, some of Condell’s arrangements with referring physicians for various professional services did not always comply with a Stark

exception. Brian Annulis, a Chicago attorney who represented Condell during the voluntary disclosure and settlement process, tells *RMC* that while he can’t comment on the specifics of the settlement, physician recruitment was a big part of the problem. Using various incentives, Condell allegedly recruited physicians who would refer patients to the hospital. But the hospital ran afoul of the Stark recruitment exception and anti-kickback statute, according to the settlement. The settlement also states that Condell never assessed whether there was a community need for the recruited physicians’ services, the settlement states. Some of the recruited physicians were already practicing in the hospital’s service area, it says.

Despite the fact that some of the physicians didn’t need incentives to be lured to a place where they already worked and the lack of clarity about the need for their services, Condell “entered into agreements which benefited individual physicians or physician groups rather than the community, and entered into multiple such agreements with the same physician or physician groups,” the settlement states. Many support agreements barred physicians from getting privileges at other hospitals. The recruited physicians received “certain financial support agreements and loans secured by promissory notes,” the settlement states.

MDs Allowed to Work off Loans

“They were bringing in new doctors and giving them loans to set up new practices, and then they would allow them to work off the loans. Rather than pay them back in cash, they could pay them back in kind,” Wawzenski says. “But then the [hospital] did nothing to figure out the appropriate hourly rate.” The settlement states that the hourly rate was greater than fair-market value. Condell didn’t use a valuation expert to determine whether the deals were fair-market value, Wawzenski says. Annulis concedes that some of the permitted work-off activities were “suspect.”

There were other Stark and anti-kickback violations alleged. Physicians rented space in medical office buildings owned by Condell. The physicians’ rent was below fair-market value, or Condell allowed rent abatement or deferred collection of rental payments, the settlement states.

According to the settlement, Condell paid physicians for performing services at the hospital without written agreements, as required by a Stark exception. *One example:* EKG interpretations. The physicians assigned their billing to the hospital, and the hospital paid the physicians pursuant to a predetermined fee-schedule amount. Annulis says all the professional services were provided as charged. “These were not payments for phantom services,” he tells *RMC*. “We are confident that the services were actually

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rendered and paid for, but we had a technical Stark law problem because the hospital lacked a signed agreement.”

It’s unclear why Condell didn’t know about its alleged sweetheart deals. But lawyers say it’s not uncommon for hospitals to discover Stark violations only when there’s a pending sale because the buyer must perform due diligence (which is a thorough legal and financial review of a target entity).

“These things can come up in due diligence for an acquisition,” Powers says. “If questionable financial arrangements are discovered during due diligence, a new owner may insist on a clean bill of health. If a buyer plans to pay millions for a hospital, it wants some assurance that it won’t be investigated for the compliance failures of its predecessor, and voluntary disclosure is the best assurance. Unfortunately, it can be very expensive. If this hospital had conducted routine contract audits and employed third party valuations, these alleged improper arrangements would not have continued. The hospital decision-makers would know the problem and implement the appropriate compliance measures before facing a disappointed suitor.”

But the unwillingness to tackle Stark and kickback compliance pre-emptively is perilous. In addition to self-disclosures forced by acquisitions, there is always the potential for whistleblowers to file lawsuits — a growing threat given the success of Stark-based False Claims Act lawsuits and the financial appeal of potential whistleblower rewards in these difficult economic times, Powers notes.

Expect Stark Oversight to Intensify

Meanwhile, Stark oversight will intensify in the near future for many hospitals because of the Disclosure of Financial Relationships Report (DFRR), contends Cynthia Wisner, assistant general counsel for Trinity Health in Novi, Mich. Until DFRR, CMS and OIG had no mechanism to routinely audit Stark compliance. But 500 hospitals will soon be required to complete the DFRR, a detailed form eliciting details about all physician agreements. Hospitals have to complete it and return it to CMS with copies of every contract.

“DFRR is a report that requires you to self-assess your status,” Wisner says. The same way that filing tax returns forces organizations to know their taxable transactions, preparing the DFRR will push hospital compliance officers and executives toward intimacy with physician dealmaking. CMS has said that if it can find a way to reduce the burden, may require more hospitals to fill out the DFRR.

Speaking generally and not specifically about the Condell settlement, Annulis says many hospitals lack adequate policies and procedures for implementing and maintaining contracts with potential referral sources. “A hospital would be well-served to invest the time and resources necessary to ensure that its physician contracts and

arrangements are compliant with the law,” he says. Invest in the front end; put in the necessary time and resources to develop a contract implementation and management system, Annulis advises. “When someone comes knocking and asks questions, whether it’s a government investigator or prospective buyer, you need to be able to produce and support the contract. You can’t say, ‘I called a couple brokers, and they thought reasonable and fair-market value for the lease was X dollars.’ I know no one wants to spend the money, but in the long run, it’s worth it. You can’t cheat on this piece, especially with the new Stark rules,” says Annulis, with the law firm of Katten Muchin Rosenman LLP.

CMS created an alternative path to fixing Stark non-compliance, penalty-free, in the final FY 2009 inpatient prospective payment system regulation published in the Aug. 19 *Federal Register* (RMC 8/11/08, p. 1). Annulis notes that even before the settlement and proposed sale, Condell had hired new management, “which had begun to identify and address the problems in question.”

Contact Annulis at brian.annulis@kattenlaw.com, Powers at patsy.powers@wallerlaw.com and Wisner at wisnerc@trinity-health.org. Read the press release at www.usdoj.gov/usao/iln/pr/chicago/2008/index.html. ✦

OIG Says DME Closets in Hospitals Are OK; Lack of Vendor Fee Is Key

Almost eight years after issuing a special fraud alert about durable medical equipment (DME) “consignment closets,” the HHS OIG gave a clean bill of health to a plan to locate them in certain hospitals, according to a new advisory opinion (08-20).

The opinion, posted on the OIG Web site Nov. 26, describes a plan by two Medicare-approved suppliers of DME, prosthetics, orthotics and supplies (DMEPOS) to (1) stock consignment closets at certain hospitals, and (2) provide staff to teach patients to use respiratory equipment. The advisory opinion was requested because of the potential for violations of the Civil Monetary Penalty Law barring kickbacks, which were cited in the fraud alert.

According to the opinion, hospital discharge planners give a list of local suppliers to home-bound patients who need DMEPOS. Patients are free to use any supplier, though the discharge planners will highlight the supplier used by that particular hospital. The suppliers will stock supplies in consignment closets at the hospitals, but pay nothing for that privilege. Supplies include portable oxygen, walkers, wheelchairs, canes and continuous positive airway pressure devices. When patients choose the supplier with the consignment closet, the supplier will bill the patients or their payers directly.

The DMEPOS suppliers with the consignment closet will also provide licensed staff to help patients who buy their respiratory equipment. The staff will, among other things, (1) confirm the order with the prescribing physician, as needed, and recommend changes; (2) make sure the equipment delivered was actually ordered; and (3) teach patients to set up, use, clean and maintain respiratory equipment.

For their part, the hospitals will make available (free) to the DMEPOS' staffers a desk and phone linked to the hospital's internal phone system. This is designed to "facilitate the coordination of these services with the patient's treating physician, other clinicians, and the hospital's discharge planning staff," the OIG opinion says. The deal between the suppliers and the hospitals will be in writing.

Normally, OIG is suspicious about DME marketing, especially when it calls for personal contact with patients. "These activities are highly susceptible to fraud and abuse, as they can lead to overutilization, increased costs to the Federal health care programs and beneficiaries, and inappropriate medical choices," the opinion states. Arrangements like the consignment closet, which offers DMEPOS suppliers access to hospital staff and patients, "are particularly susceptible to problematic marketing schemes," the opinion says.

In the 2001 fraud alert, OIG warned that consignment closets in physician offices may be a vehicle for kickbacks if DME suppliers pay physicians rent for the space. "OIG has always been concerned when a DME supplier is paying for the rental of a closet," says Heidi Sorensen, former chief of the OIG Administrative and Civil Remedies Branch. "The concern is that there is illegal remuneration disguised as a rental payment and that

it's above fair-market value. OIG thinks there should not be any payment."

Overall, the lack of rent payments carried the day for the consignment closets in the new advisory opinion. OIG concluded the arrangement doesn't run afoul of the anti-kickback law because the DMEPOS suppliers are not paying the hospitals — which are referral sources — for use of the consignment closets or desks and telephones. The lack of remuneration got the DME suppliers over a big hurdle, notes Sorensen, with the law firm of Foley & Lardner LLP in Washington, D.C. In this case, the money is going the same direction as the referrals (from the hospitals to the DMEPOS suppliers), which alleviates the OIG's concerns, she says.

Sorensen adds that these deals also may have a better shot at passing OIG inspection if multiple suppliers have consignment closets at a hospital. OIG prefers it when one company doesn't have a lock on patient referrals.

Contact Sorensen at hsorensen@foley.com. Visit AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "OIG Advisory Opinions." Read the 2001 fraud alert at <http://oig.hhs.gov/fraud/fraudalerts.asp>. ♦

Bayer Will Pay \$97 Million for Alleged Cash-for-Patient Scheme

Bayer HealthCare LLC will pay \$97.5 million plus interest in a civil settlement to resolve allegations that its diabetes care division "engaged in a cash-for-patient scheme," the Department of Justice (DOJ) said on Nov. 25.

The feds allege that Bayer's diabetes testing supply manufacturer paid durable medical equipment (DME) mail-order suppliers and diabetic supply distributors to convert Medicare beneficiaries to Bayer's products from its competitors' goods, according to the settlement. The conduct, which occurred from January 1998 through August 2003, violated the anti-kickback statute and caused the suppliers to submit false Medicare claims, the feds say.

For example, the feds say Bayer paid Liberty Medical Supply Inc. about \$2.5 million between 1998 and 2002 to convert its customers to Bayer products. "The alleged kickbacks were based on the number of patients that Liberty successfully converted to Bayer suppliers and were disguised as payments for advertising," a Nov. 25 DOJ prepared statement says. Bayer allegedly also paid 10 other suppliers about \$375,000, the feds say.

Bayer does not admit liability in the settlement. In a prepared statement, the company says it is settling "to

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avoid the time, uncertainty, and expense of litigation." It cooperated fully with DOJ during the investigation, the company adds.

Bayer also entered a five-year corporate integrity agreement (CIA) with the HHS OIG. Among other things, the CIA requires that certain employees of Bayer affiliates (e.g., presidents, chairpersons, CEOs, executive directors, etc.) certify annually that their areas of authority are compliant with federal health care program requirements.

The company must also add to its policies and procedures "appropriate ways to conduct Promotional and Product Services Related Functions in compliance with all applicable Federal health care program requirements, including, but not limited to the Federal Anti-Kickback Statute...and the False Claims Act," according to the CIA.

Bayer's compliance programs "have undergone continuous improvement in all areas of the company in the past years," the company's statement says. "In addition, employees receive regular training in order to promote understanding and compliance. As required by the CIA, Bayer HealthCare will review and enhance the compliance programs and employee training."

Visit www.usdoj.gov and www.bayer.com. Read the CIA at www.oig.hhs.gov/fraud/cia/agreements/fully_executed_bayer_cia_112508.pdf. ♦

New CPT Codes Take Effect Jan. 1

continued from p. 1

book and read," Purcell says. Don't rely on encoders to do your thinking for you, she cautions. An encoder — a software tool designed to help coders find the right code — is designed to be a "helpmate," not substitute for a coder's judgment, Purcell says. But "an encoder is only as good as the person using it," she says.

Two of the new CPT codes are for procedures to treat obstructive sleep apnea, a condition that has attracted the attention of Medicare reviewers because of the growing number of diagnosed cases and the rising costs of medical and surgical treatment. Adding to the spiral, CMS this year released a Medicare National Coverage Determination that makes more patients eligible for continuous positive airway pressure treatment, a procedure to ease sleep apnea.

One of the new codes sleep apnea is 41512 (tongue base suspension). One method includes a Tongue Stabilization System for preventing the tongue from blocking the airway. Using this procedure, a surgeon creates support using a miniature screw with two attached sutures. The screw is inserted into the inner table of the mandible, and the attached permanent sutures are passed

through the tongue. The suture is tensioned just enough to pull the tongue anteriorly.

The other new code for obstructive sleep apnea is 41530 (submucosal ablation). This procedure uses radiofrequency to reduce the size of the tongue base and open up more airway space. If the physician doesn't use the proper name of the procedure, coders may be able to code properly by looking for words like "radiofrequency" or words like "destruction" instead of "ablation." Or maybe the physician will write "tongue ablation" instead of "submucosal ablation." Coders familiar with the new codes probably can put two and two together, Purcell says. Then they will confirm with the physician and say, "Would you mind calling it submucosal ablation?"

Here are other key changes in the forthcoming CPT code book, according to Purcell, who got a preview at AMA's 2009 CPT and RBRVS (Resource-Based Relative Value System) annual symposium in Chicago Nov. 12-14:

♦ **CPT code 64455:** This is a new code for injecting an anesthetic agent and/or steroid into a plantar common digital nerve for Morton's neuroma. Another new code, 64632, addresses the same nerve, but this code is for destruction of the nerve. So one code is for injecting an anesthetic, the other for nerve destruction. A common problem occurs when physicians don't use the correct language, she says. To figure out what they actually did, it may be necessary to read into the body of the operative report to answer the question of whether the nerve was destroyed or injected with an anesthetic. And if the physician uses the phrase "Morton neuroma injection" without specifying whether it was an injection or destruction, there is still too much ambiguity to select the proper code. A query may be necessary. AMA also added a note underneath code 20550 (injection into a tendon sheath) stating that it should not be used for Morton neuroma injections.

♦ **CPT code 62267:** This is a new code for percutaneous aspiration within the nucleus pulposus, intervertebral disc or paravertebral tissue. Though fluids are often aspirated as a treatment, this code is for diagnostic purposes. Usually it's performed when infection is suspected. Purcell notes that this code can't be used more than once when the needle is re-inserted at a different angle. Imaging guidance is coded separately with 77003 or 77012. The significance of the diagnosis aspect is that imaging is involved, which means coders have to watch the radiology department charges. "A lot of facilities forget to charge for imaging, or they charge it to the wrong CPT code," she says. To ensure a hospital gets all the reimbursement it deserves and doesn't submit inappropriate claims, coders and compliance

analysts should monitor radiology charges. "It's hard for the radiology department to know what they can charge separately. That's why they make a lot of mistakes," Purcell says. "It's a great idea for coders to walk down to radiology and say, 'let's make sure we have our act together.'" Determine which procedures allow separate charges for imaging and which don't.

◆ **CPT code 46930:** This is a new code for various hemorrhoid destruction procedures by thermal energy. Several of the hemorrhoid procedures codes have been deleted, Purcell says. The new code applies only to internal (not external) hemorrhoids. The new code has instructions that coders should read.

◆ **CPT codes 49652 to 49657:** These are new codes for laparoscopic hernia procedures. All of these codes include the insertion of mesh, she says. However, only mesh insertion (covered by code 49568) can be coded separately with open procedures. Mesh insertion is often performed during laparoscopic hernia repair and is not coded separately. Coders may have a hard time breaking this habit, Purcell says, so they have to burn into their brains the fact that mesh is coded separately only for open (non-laparoscopic) surgery. Even if physicians document mesh insertion as a separate procedure, coders can't code it that way with the new codes. Also, incisional hernias are coded differently than other hernias (e.g., ventral, umbilical). If a ventral or umbilical hernia is an incisional hernia, use the incisional hernia codes.

◆ **CPT codes 20696 and 20697:** These are new codes for the application of multiplane, unilateral, external fixation with stereotactic computer-assisted adjustment. They "provide for simultaneous correction of multiple axes of a fracture or deformity," the 2009 CPT code book says. Code 20697 is used for the exchange of each strut, and 20696 describes the application of the device. Again, pay attention to whether imaging is included in the codes.

Many Revisions Made to Prostate Codes

Because of coding errors around urethral dilation procedures, the 2009 CPT book has new notes under these existing codes, Purcell says. "Take this opportunity to carefully review your coding of urethral dilation procedures, which are CPT codes 53605 and 53665," she advises. "What's new is AMA's recognition that coders are making errors with these codes."

There are a lot of revisions to codes for prostate procedures, she says. A quick summary:

◆ **CPT code 52606 (post-op bleeding after transurethral resection of prostate) has been deleted.** It will now be included in code 52214. There is a potential for error here, Purcell says. Because the definition of 52214 was

not revised to include language referring to post-op bleeding for prostate resection, coders may not adapt to this change. "It's not self-explanatory," she says. They will have to remember that 52214 now includes language referring to post-op bleeding, even though it's not explicit.

◆ **CPT code 52630 has been revised** to include resection of residual or regrowth of prostate tissue. It used to be coded with 52620, which has been deleted.

◆ **CPT code 55706 is new.** It was created for transperineal, stereotactic template guided saturation sampling prostate biopsies. This procedure is typically performed using ultrasound guidance under general anesthesia. This procedure differs from code 55700, which is also a prostate biopsy. But unlike a regular biopsy, where six to 12 samples are extracted, this new procedure allows the surgeon to take 35 to 60 samples, Purcell says.

Some New Codes Addressed by Chargemaster

All the above codes will be coded by the health information management department. In contrast, other coding changes in the CPT book will be hardwired into the hospital chargemaster, Purcell explains.

For example, there are new CPT codes for wearable mobile cardiovascular telemetry (93228 and 93229). These are based on an up-to-30-day time frame, so don't report the codes if patients wore the devices for fewer than 10 days. All components of 93229 must be reported to use the code.

Another example: The CPT book revises the way coders should report combination echocardiographic imaging. A new code, 93306, has replaced three separate codes for 2D echocardiogram with doppler and color flow, Purcell says. When patients receive all three, coders must report only 93306. However, if contrast is used, report the combined service with a new C code, C8929. Although AMA created a new CPT code, 93352, for the use of echocardiography contrast, it has a status indicator of M and can't be used for hospital reporting. Instead, stick with the C codes set up by Medicare.

"I anticipate problems," Purcell cautions. "People won't read the book closely enough and pay enough attention to realize that the new code replaces three codes," she says. "You will never again use the three new codes [together], but you might use the codes individually" if, for example, an echocardiogram is performed without the other two procedures.

As for drug administration, the CPT code book didn't change the definition of the codes. The codes have been moved to a new section, which means charge forms and the chargemaster will have to be revised.

Contact Purcell at lori_purcell@qhr.com. ♦

Sample Contract Review Document

Trinity Health, a large, integrated delivery system based in Novi, Mich., uses this form as documentary evidence that an internal lawyer has reviewed and approved new physician relationships. Contact Cynthia Wisner, assistant general counsel, at wisnerc@trinity-health.org.

Date of review:

Date of contract:

Physician name/group:

Description of contract:

I have reviewed:

(1) the above described contract;

(2) the form of a completed Officer's Certificate and I have been advised that this certificate will be completed and signed and shared with the committee;

(3) the separate fair market value review (i.e., the completed toolkit template and supporting documentation or comparable review documentation in lieu of completed template); and

(4) evidence that a Health Care Needs Assessment was conducted.

The purpose of the review was to confirm that the actions were taken and documents completed supporting the relationship as required to satisfy the requirements of the Trinity Health Policy on Hospital/Physician Financial Relationships (*for a copy of that policy, see RMC 9/22/08, p. 3*).

Both Trinity Health policy and applicable healthcare regulations, including, but not limited to the Internal Revenue Code, the Stark and fraud and abuse laws and regulations, require the Board of Directors, or a designated Committee of the Board, to approval all Hospital/Physician financial relationships prior to the effective date of such agreements. Please be advised that due to the proposed retroactivity of the effective date of this arrangement, this arrangement may not be afforded the regulatory protections for the period of retroactivity up to the date of Board approval.

Notwithstanding the retroactivity of this arrangement, the materials I reviewed document that the proposed financial relationship satisfies, in all material respects, Trinity Health policies on Hospital/Physician Financial Relationships. I have not, however, independently verified that the payments to be made actually do represent fair market value for the transaction or that there is an actual need for the transaction to take place. Nevertheless, I am aware of no facts that have lead me to believe that the payment is at other than fair market value or that there is not a need for the arrangement.

Signature line

NEWS BRIEFS

◆ **St. Vincent Health System Inc. in Erie, Pa., has agreed to pay a whistleblower \$1.9 million to settle a false claims case stemming from outlier payments,** said Phillips and Cohen LLP, the firm representing the whistleblower, on Nov. 24. The suit was filed in 2005 by Anthony Kite, an independent hospital consultant, and is related to several other cases involving outliers filed by multiple whistleblowers (*RMC 2/18/08, p. 5*). It is the second suit that Kite and his attorneys pursued without government intervention, although the feds intervened in several of the other cases, the firm points out. Medicare makes outlier payments for cases in which the cost of care is unusually high. St. Vincent said in a prepared statement that it did not admit fault or wrongdoing in the settlement and was prepared to defend its actions in court, but decided to avoid the "time, distraction and expense of litigation." For more information, visit www.phillipsandcohen.com.

◆ **Manchester Memorial Hospital in Connecticut will pay more than \$700,000 to settle allegations that it overbilled Medicare for infusion therapy and chemotherapy administration services,** the U.S. Attorney's Office for the District of Connecticut said Nov. 25. Manchester submitted claims for about \$356,000 for the services between Aug. 1, 2000 and Dec. 31, 2004. During that period, Medicare allowed payment for one unit of infusion therapy and chemotherapy administration per-patient visit, but Manchester often billed for between two and nine units, the feds say. The hospital is paying double damages in the settlement. Manchester does not admit liability in the agreement, but settled to avoid the delay, uncertainty, inconvenience and expense of litigation, the settlement says. The hospital adds in a prepared statement that at least six other Connecticut hospitals have reached similar settlements. "The issue resulted from changes made in 2000 to the specific billing unit recognized by Medicare for billing purposes," it says. "A number of hospitals in Connecticut and across the country either missed the announcement or did not implement the change correctly. Furthermore, software billing systems were not upgraded to reflect these changes in Medicare billing methodology. Adding to the confusion was the fact that some managed care companies still required hospitals to bill on a per-unit basis," Manchester says. Visit www.usdoj.gov/usao/ct and www.echn.org.

◆ **The Department of Justice and HHS OIG won or negotiated about \$1.8 billion in judgments and settlements in FY 2007,** according to the Health Care Fraud

and Abuse Control (HCFA) Program annual report for FY 2007, released Dec. 2. U.S. attorneys' offices opened 878 new criminal health care fraud cases involving 1,548 defendants, according to the report. Prosecutors had 1,612 health care fraud criminal investigations pending that involve 2,603 defendants. They also filed criminal charges in 434 cases with 786 defendants. According to the report, 560 defendants were convicted of health care fraud-related crimes during the year. Also, DOJ opened 776 new civil health care fraud investigations and had 743 civil inquiries pending at the end of the fiscal year. It opened 218 new civil cases during the year. Visit www.oig.hhs.gov/publications/docs/hcfac/hcfacreport2007.pdf.

◆ **CMS did not resolve all of the audit recommendations made by HHS OIG in a timely manner during FYs 2006 and 2007,** OIG says in an audit report (A-07-07-04112) posted Nov. 25. Out of 4,650 audit recommendations completed during the audit period, CMS resolved 3,462. But it did not resolve 2,813 of them within the Office of Management and Budget's required six-month period, OIG says. Also, as of Sept. 30, 2007, CMS had not taken care of 1,188 recommendations that were past due. OIG says CMS should (1) resolve all recommendations within the required six-month period, and (2) resolve the past-due recommendations. OIG notes that CMS revised its resolution procedures during the audit period and has made progress in resolving some of the outstanding recommendations. CMS agreed with OIG's recommendations. Visit AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "OIG Audit Reports."

◆ **HHS OIG saved or recovered more than \$20.4 billion for FY 2008,** according to its Semiannual Report to Congress, released Dec. 3. One of OIG's achievements for the year was an agreement with Staten Island University Hospital, which paid almost \$89 million to resolve allegations that it defrauded Medicare, Medicaid and TRICARE (*RMC 9/22/08, p. 5*). Another significant case involved the pharmaceutical company Cephalon Inc., which agreed to enter a criminal plea deal and pay a total of \$425 million in criminal fines and civil settlements to resolve allegations that it engaged in off-label marketing of three drugs resulting in false claims submissions to federal health care programs (*RMC 10/6/08, p. 8*). Visit AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "OIG Semi annual Audit Reports."

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