Report on
MEDICARE COMPLIANCE

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

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PUBLISHER'S NOTE: ***RMC*** *is taking a holiday break. The next issue will be dated Jan. 12.*

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CMS Guidance Muddies Fate of Provider Arrangements With Mobile Imaging Entities

Providers have been bracing for the compliance and reimbursement challenges of a new Medicare requirement that changes the dynamics of mobile diagnostic testing relationships. The requirements, set forth in the final Medicare physician fee schedule regulation, take effect Jan. 1. But now CMS has thrown a wrench into the works with an answer to a frequently asked question (FAQ) posted Dec. 16 that some lawyers say undermines the new regulatory requirements and leaves hospitals, physicians and mobile diagnostic testing facilities wondering how to proceed.

"This has a lot of people buzzing," says Macon, Ga., attorney Alan Rumph.

At the heart of the controversy is what essentially amounts to CMS's crackdown on the lack of direct oversight of mobile diagnostic testing facilities that provide imaging services. These include the huge vans that cart imaging machines to physician offices, hospitals and nursing homes so patients can receive imaging services, such as MRIs, CT scans and PET scans, that providers can't or don't want to provide on their own.

Providers have typically leased equipment and (usually) technicians from the mobile diagnostic testing facilities and then billed Medicare directly for the technical and professional fees. The mobile diagnostic testing facilities were not enrolled in Medicare, so CMS had no authority to directly monitor their quality and integrity. Instead, oversight of mobile diagnostic testing facilities fell to the physicians and hospitals that contracted for their services because they bill Medicare, says Rumph, with Smith, Hawkins, Hollingsworth & Reeves, LLP. *One major exception:* independent diagnostic testing facilities (IDTFs). A CMS creation, IDTFs can bill Medicare directly, but must abide by strict performance standards.

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CMS Changes Course on MD Supervision of On-Campus Outpatient Therapy Services

Out of the blue, CMS apparently has upped the physician supervision requirement for outpatient therapeutic services provided on a hospital campus, lawyers tell *RMC*. CMS now says that direct physician supervision is not a given just because outpatient services were provided incident to the physician at the hospital site, not off campus, according to the final outpatient prospective payment system (OPPS) regulation, published in the *Federal Register* Nov. 18.

"We require direct supervision for therapeutic services provided in the hospital or in provider-based departments of the hospital," CMS says in the preamble. Although CMS previously assumed that hospitals met the supervision requirements when services were furnished on campus, it now has changed course and is requiring that hospitals assure that a physician is on the premises and immediately

available to furnish services, even on campus, says Washington, D.C., attorney Andy Ruskin. No assumption of compliance applies, CMS says.

Lawyers were thrown for a loop by this development. "It's a departure in interpretation," says Tupelo, Miss., attorney Dinetia Newman, with the law firm Phelps Dunbar LLP. "CMS changed its interpretation from assumed physician supervision for outpatient therapeutic services."

This is the second time a controversy has erupted over direct supervision for therapeutic services provided incident to the physician's services (e.g., infusion, wound care). In early 2008, CMS issued a transmittal that complicated physician supervision requirements for provider-based entities. Transmittal 82 (Change Request 5946) stated that services furnished in provider-based hospital departments must be provided under the direct supervision of a physician who is actually treating the patient. In a July update to the OPPS, CMS reversed its position, presumably because it acknowledged concerns raised by the provider community *(RMC 6/23/08, p. 1)*.

But now CMS has tinkered with physician supervision of therapeutic services performed on campus. It may require hospitals to add physician oversight and/or reorganize existing physician resources, Newman says.

All incident-to services require direct physician supervision. But until now, CMS made a distinction between on-campus and off-campus therapeutic services, Newman says. In the final 2000 regulation establishing OPPS, CMS said that "we require that hospital services and supplies furnished to outpatients that are incident to physician services be furnished on a physician's order by hospital personnel and under a physician's supervision.…We assume the physician supervision requirement is met on hospital premises because staff physicians would always be nearby within the hospital. The effect of the regulations in this final rule is to extend this assumption to a department of a provider that is located on the campus of a hospital." Off-campus hospital departments couldn't make the same assumption, the regulation said.

CMS now appears to have changed its tune. In the preamble to the final OPPS rule published Nov. 18, CMS essentially tells hospitals that all along, they may have read too much into the "generally assumed" concept. "We were concerned that some stakeholders may have misunderstood our use of the term 'assume' in the April 7, 2000 OPPS final rule with comment period, believing that our statement meant that we do not require any supervision in the hospital or in an on-campus provider-based department for therapeutic OPPS services, or that we only require general supervision for those services. This is not the case," the OPPS regulation states. CMS notes that its requirement for a physician to be nearby when therapeutic services are performed is related to its statutory authority for payment of hospital outpatient services.

"My take on this is that in the final 2009 rule, CMS is differentiating between outpatient services provided in a hospital and outpatient services provided in a provider-based department," Newman says.

Questions Loom About Departments Affected

Ruskin questions CMS's use of the word "clarification" to describe this policy. "When CMS says 'clarification,' that is often a CMS euphemism for a new policy direction, while leaving the door open for retrospective application of this new policy. This can mean real dollars to hospitals." He points to the fact that Medicare manuals have historically included the same assumption about the satisfaction of the supervision requirements

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on campus that were identified in the 2000 rulemaking. "Indeed, that same assumption is still in the manual today," Ruskin says, referring to the *Medicare Benefit Policy Manual*.

It's still somewhat unclear exactly which departments in the hospital this new interpretation applies to, Newman says. CMS repeatedly used the word "premises of the location," stating that a physician has to be present on the premises. But what exactly does that mean? If it just means entire departments, like emergency rooms, radiation therapy and radiology, where physicians are always around, then the new language is less burdensome, she says. But if "premises of the location" means any place services are provided, such as infusion clinics and wound care centers, then hospitals face a new compliance hurdle. Ruskin adds that there are some arguments that CMS's new policy can be interpreted as applying only to facilities that are on the hospital's campus but are outside of its main buildings.

Consider Relocating Employed MDs

Newman says that given CMS's apparent new position on physician supervision provided incident to a physician's service on a hospital campus, hospitals will have to analyze their outpatient therapeutic services and decide whether more direct physician involvement is necessary. *Case in point:* The emergency department (ED) is on the first floor, the wound care center is on the second floor, and the infusion lab is on the third floor. "If the doctor is down in the ED, is that close enough to the wound care center" to satisfy CMS standards, Newman asks. Until the 2009 OPPS, the answer would have clearly been yes. But in light of the new clarification, "there is not an assumption of direct supervision when an outpatient therapeutic service is provided in an on-campus department," she says.

Or suppose the infusion center is located in a hospital-owned medical office building across the street from the main hospital building but on campus, and the only physicians in the building are hospital medical staff members practicing in their own offices. Will this satisfy CMS's interpretation?

If it seems that physicians are too far away from a therapeutic service to comply, Newman says hospitals should consider relocating a hospital-employed physician to the outpatient department.

Ruskin questions CMS's true intention here. CMS states that it needs to put this policy in place for quality reasons. But CMS doesn't include in its rulemaking any examples of patient injury resulting from its longstanding policy allowing for the assumption of the satisfaction of the supervision standard on-campus. "CMS is supposed to make policy based on substantial evidence, but here CMS offers nothing to support the new position," says Ruskin, with the law firm of Morgan, Lewis & Bockius. Providers who think that they have a good safety record and proper checks and balances — and perhaps a lot of money at stake — may want to discuss individual circumstances with their CMS regional offices, he says.

Some hospitals may not be greatly affected by this new direction in physician supervision. Wendy Trout, compliance officer for WellSpan Health in York, Pa., says generally there are always enough physicians to meet the higher standards, between hospitalists, ED physicians and clinic physicians, for example. "Any therapeutic services provided in our [on-campus] clinics would have physicians there anyway," she says. Most patients in clinics affected by incident-to rules (e.g., infusion, dialysis) are treated at WellSpan's off-campus clinics. But Trout questions the motive behind CMS's clarification, and wonders how much this may potentially increase the cost of health care unnecessarily. "Shouldn't we be looking for safe ways to provide services at the least cost?"

The final OPPS rule takes effect Jan. 1.

Contact Newman at newmand@phelps.com, Ruskin at aruskin@morganlewis.com and Trout at wtrout@wellspan.org. ✧

NY Medicaid Recovers $551 Million; DRGs, Observation Are Big Problems

Hospitals that improved DRG coding and observation billing under Medicare may still have problems in these risk areas under Medicaid, judging by findings in New York state. Noncompliance with these two risk areas is a significant source of the repayments hospitals are facing as part of the New York Office of Medicaid Inspector General's (OMIG) record-breaking recoupment for fiscal year 2008.

OMIG recovered $551 million in FY 2008 through Medicaid audits, investigations and program reviews, Gov. David A. Paterson and Medicaid Inspector General (MIG) Jim Sheehan announced Dec. 12. That's more than was recovered by all the states combined in 2007, Sheehan says.

"Hospitals and nursing homes were the two biggest sources" of errors identified by OMIG, Sheehan tells *RMC*. For hospitals, "a lot of it" was observation beds and DRG coding. Auditors couldn't find any records for patients at all, or they didn't support the DRG assignment. A patient's diagnosis drives DRG selection, so payments are based on the assigned diagnoses; an inappropriate diagnostic assessment will directly affect the reimbursement claimed and paid. "You'd think hospitals would apply the same analytics and compliance processes to Medicaid as to Medicare, but to some extent you focus on where

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you get the most pushback from government," Sheehan says. And until recently, the lion's share of audits and enforcement has focused on Medicare.

"A lot of health care organizations have not made the investment in processes to ensure they only bill for what they should," Sheehan says. "DRGs and observation are a big issue, and the next thing will be financial relationships with physicians. There has been very little enforcement of the Stark and kickback statutes on a state level."

Because Medicaid is partly funded with federal money, OMIG can wield the Stark and federal anti-kickback laws against illegal financial relationships. In addition, in New York and some other states, hospitals can face additional sanctions — such as fines, penalties or even exclusion — for kickbacks and similar offenses through the use of a state law that bars unacceptable practices under Medicaid, Sheehan says. "The hypothesis is that funds needed for patient care have been diverted to payments to physicians for referrals. We hear that anecdotally and now we need to determine" whether it's true, and if so, how pervasive payments for physicians' referrals are. Other states have anti-kickback or Stark laws.

Assess Medicaid Payment Methodology

Judith Waltz, an attorney with Foley & Lardner LLP in San Francisco, says OMIG's recoveries demonstrate that providers need to focus on Medicaid compliance as part of their overall risk assessments and corrective actions. "Jim Sheehan's Medicaid recoveries suggest that specific requirements for Medicaid compliance may vary from what is required for Medicare compliance, even on the same issue, and Medicare compliance alone will not be enough to avoid enforcement problems," she says.

For example, Medicare observation billing issues typically stem from changes to Medicare reimbursement methodology *(RMC 11/3/08, p. 1)*. CMS generally bundles observation payments into APCs under the outpatient prospective payment system unless it pays a composite APC for observation and emergency department care. Waltz says Medicare's view has been that a big chunk of inpatient errors are a function of unnecessary admissions caused by hospitals admitting "short stay" inpatients to avoid the limits on observation payments. Medicaid programs in a particular state may have different rules about when observation status can be billed, depending upon the state's payment methodology for such services, Waltz notes. Those requirements need to be included as part of the compliance effort.

Sheehan's focus on and recoveries relating to DRGs also illustrates the difference in payment methodologies between states. "In some states, hospital billing isn't based on DRGs," Waltz says. "Each state's rules and requirements must be assessed separately to assure that the provider knows what is expected."

In some states, she says, efforts to comply with Medicaid rules have been difficult because of limited guidance from the states. "Sheehan's office has been proactive in advising providers of its expectations, for example, by issuing a comprehensive work plan identifying areas of focus for various types of providers." But a lack of specific state compliance guidance elsewhere is unlikely to be an excuse for non-compliance, said Waltz.

Like Feds, State Puts Quality High on Agenda

Though OMIG conducted mostly "traditional audits" this year, some audits reflected quality issues, and more will in the future, Sheehan says. So far, the emphasis has been on lack of medical necessity (e.g., Medicaid claims for dead patients or pregnant males). But like investigators and enforcers across the nation, "we will be expanding" the scrutiny of quality, he says. "We will work with hospitals and nursing homes on how quality can be part of compliance and on how to find data streams that will help us focus on organizations" at higher risk for substandard care.

Sheehan's contention is that weaknesses are not compartmentalized; if an organization provides substandard care, there's a good chance it also makes billing mistakes. So OMIG will use adverse-event data that's already collected by the state Department of Health to refine the process of selecting targets for billing audits. That's typical of the partnerships among agencies, which Sheehan says is necessary to improve Medicaid overpayment identification and fraud and abuse.

OMIG's half-billion-dollar recoupment might spur additional states to create a Medicaid fraud-and-abuse czar, especially given the economic meltdown and the big role that Medicaid plays in state budget woes. New Jersey's state Senate on Dec. 15 approved Mark Anderson as the state's first Medicaid Inspector General (MIG). Anderson is a former federal prosecutor in the U.S. Attorney's Office for the Eastern District of Pennsylvania, where Sheehan spent more than two decades fighting health fraud. There are also MIGs in Florida, Kansas, Texas, Illinois and Georgia.

Sheehan is under a lot of pressure to make a big overpayment recovery splash through 2011 because of OMIG's bargain with CMS. In exchange for about $1.5 billion in expansion funds over five years — which, among other things, has paid for a staff of 550 so far — OMIG promised to recover a certain amount of overpayments from providers and suppliers every year through 2011. Under this Federal-State Health Reform Partnership (F-SHRP), OMIG was obliged to generate $215 million recoveries this year, but more than doubled it.

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Providers and suppliers generally repay overpayments through deductions from future Medicaid payments. To avoid the bite of Medicaid repayments, Waltz suggests that providers scrutinize their high-dollar and high-risk Medicaid services with a fresh eye on specific payment requirements. "The risks are definitely higher now on the Medicaid side than they have ever been before, and they will be increasing even further as the CMS Medicaid Integrity Program becomes fully operational," she maintains.

Contact Waltz at jwaltz@foley.com. Read the press release at www.omig.state.ny.us/data. ✧

Carbon-Copy OIG Opinion Approves Hospital's Gainsharing Arrangement

In its latest opinion on gainsharing, the HHS Office of Inspector General (OIG) says a hospital can share half the savings from cost-reduction measures in cardiac catheterization procedures with five physician groups, according to Advisory Opinion 08-21. This opinion is almost a carbon copy of others on these arrangements, and provides more evidence that it is time for a Stark law exception for gainsharing, Washington, D.C., attorney Paul Danello tells *RMC*.

Gainsharing is a way for hospitals to financially reward physicians for their use of cost-reduction measures, but the arrangements have to be carefully structured because of fraud concerns. OIG has issued numerous opinions on gainsharing arrangements in the past few years, and CMS recently proposed a Stark exception for gainsharing *(RMC 7/21/08, p. 3)*.

OIG says this hospital's arrangement could be grounds for the imposition of civil monetary penalties or exclusion, but that it won't sanction the facility because of how the deal is structured.

In this case, four cardiology groups and one radiology group refer patients to the hospital for inpatient and outpatient services. Each group has a separate contract with the hospital that projects potential savings and the share of the savings the physician group could earn through specific changes they make in their cardiac practices over two years. The savings come from standardized use of cardiac cath devices and supplies (e.g., stents, balloons, vascular closure devices, pacemakers, etc.), and from curbing the inappropriate use or waste of items.

The hospital wants to pay each group separately for half of what it saves annually through the recommendations. "At the end of each year of the two-year Arrangement, cost savings were calculated separately for each Group for each of the applicable recommendations; this precluded shifting of cost savings and ensured that savings generated by utilization beyond the set targets, as applicable, were not credited to the Groups," the opinion adds.

All of the program administrator's recommendations in this arrangement implicate the Civil Monetary Penalties Law (CMPL) that bans inducements to reduce services to Medicare beneficiaries, OIG says. But the deal has a combination of features that provide safeguards, including:

◆ ***The cost saving actions and resulting savings are clearly and separately identified;***

◆ ***There is credible medical support that the recommendations do not adversely affect patient care;***

◆ ***The amounts paid are calculated based on all procedures performed,*** regardless of payer and subject to the cap on payment for federal health care program procedures;

◆ ***Physicians still have access to all of the same devices and supplies after implementation of the arrangement;***

◆ ***Financial incentives are reasonable limited in duration and amount;*** and

◆ ***The groups distribute their profits to members on a per capita basis***, so any incentive for one physician to generate disproportionate cost savings is mitigated.

OIG also says the deal could implicate the CMPL barring kickbacks. "Multiple-year gainsharing arrangements raise a particular concern in that they can inappropriately carry over earlier-accomplished savings across years, effectively accounting for them more than once," OIG says.

Other reasons the OIG will not impose sanctions include:

◆ ***Safeguards reduce the likelihood that the deal is used to attract new referring physicians*** or to increase referrals because it was limited to those already on the medical staff at the hospital;

◆ ***There is little risk that the arrangement has been used to reward surgeons*** or other physicians who refer patients to the groups because the groups are the sole participants in The arrangement and are made up of cardiologists or radiologists only; and

◆ ***The particular actions that generate the cost savings are set out in specificity***.

This advisory opinion is virtually the same as the one released earlier this year (08-15), as well as three from 2005, says Washington, D.C., attorney Paul Danello. "This is plainly a very tedious and protracted process that is of limited value for [providers] at this point. I'm hoping that conditions and safeguards will be synthesized in an exception for Stark Law purposes."

In the 2009 physician fee schedule final rule, CMS again proposed a Stark law exception for "incentive payment and shared savings programs." The exception first appeared in the fee schedule's proposed rule, but CMS said it wanted to get more public comments. This indicates that

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regulatory agencies are in favor of a Stark law exception, but that some parts of the industry — perhaps medical device manufacturers — are voicing opposition, Danello says. By re-proposing it, CMS "is not allowing it to die or disappear," he says.

While this latest opinion does not break new ground, it's a good model for providers who want to start gainsharing programs, says Danello. There have been 12 opinions on this topic since OIG released its 1999 bulletin on gainsharing, and this is the fifth that deals favorably with product standardizations, product substitutions and uses of devices "as needed" for cardiac catheterizations, he adds. "This is about as well defined and airtight as anybody could ask for….In terms of utility for providers, the precautions and safeguards are reiterated, so they are as safe as can be."

Contact Danello at pdanello@ssd.com. To read the opinion, go to AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "OIG Advisory Opinions." ✧

Confusion Mounts Over Imaging

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That's where the Medicare physician fee schedule regulation comes in. The final rule, published Nov. 19, requires mobile diagnostic testing facilities that do imaging to enroll in Medicare as IDTFs and bill Medicare directly (performance standards 16 and 17 respectively).

Here's how CMS explains its rationale in the regulation: "In order to maintain program integrity and enable CMS to monitor services furnished by mobile units providing diagnostic testing services, we maintain that a mobile entity providing diagnostic testing services must enroll for diagnostic imaging services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed base location. We are requiring these mobile IDTFs to bill for the services that they furnish unless they are billing under arrangement with hospitals."

There's one exception to the billing part of the new mandate: Hospitals that provide imaging services "under arrangement" with a mobile diagnostic testing facility can still bill Medicare for the services. But the hospital can continue to participate in the under arrangement only if the mobile diagnostic testing facility transforms itself into an IDTF, lawyers say.

The new regulatory requirements require substantial analysis by mobile diagnostic testing facilities and the providers with whom they do business. "This is one of those rules where the law of unintended consequences will hit very hard," says Jean Acevedo, president of Acevedo Consulting Inc. in Delray Beach, Fla.

Mobile diagnostic testing facilities that still want to earn Medicare reimbursement for imaging face multiple challenges.

For one thing, there's enrollment. "It's a big deal to enroll as an IDTF," Rumph says. Enrollment can't begin until the rule takes effect Jan. 1, Acevedo says. Under the rule, responsibility for the quality and testing of the machines shifts from physicians and hospitals to IDTFs, he says. Most Medicare carriers require IDTFs to contract with radiologists (or certain other specialists, such as cardiologists, depending on the type of test) to provide general supervision of the technician and maintain/calibrate the equipment, he notes. The IDTF enrollment application must state the names of supervising physicians.

Also, CMS conducts on-site visits of mobile diagnostic testing facilities applying for IDTF status. "It usually takes a minimum of 60 days from the date the enrollment application was submitted for carriers to schedule site visits," Acevedo notes.

What will happen to reimbursement for services provided to Medicare patients while applications are pending? Rumph says that "an IDTF can, after enrollment is approved, bill Medicare for services provided on or after the date that the Carrier receives the CMS Form 855B Enrollment Application, as long as the application is approved."

Physicians Could Be Hit The Hardest

Physicians may be hardest hit from both a compliance and a reimbursement perspective. "There are thousands of physician offices that have arrangements with mobile diagnostic testing companies," Acevedo says. "They bring ultrasounds, carotid ultrasounds, echocardiograms, etc., plus the technicians, and the physician practices bill for the tests, including the technical and professional components." These arrangements must be unwound because physicians can't bill for the technical part of the imaging anymore. Acevedo is concerned that many physicians around the country are unaware that as of Jan. 1, mobile diagnostic testing facilities can no longer perform imaging services at their offices unless they are Medicare-approved IDTFs.

Hospitals face their own challenges, says Chicago attorney Ken Davis, with the law firm Katten Muchin Rosenman LLP. They're involved in all sorts of arrangements, and the fate of some is unclear under the regulation. For example, some hospitals have a joint venture with radiologists to provide imaging, and the joint venture contracts with a mobile entity for select services, he says. Does the regulation require the hospital joint venture to only do business from now on with an IDTF? Also, some hospitals contract under arrangements with IDTFs, and the IDTFs subcontract with mobile diagnostic testing facilities for

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imaging, Davis notes. Is CMS saying the hospital can't buy any mobile diagnostic imaging services through the IDTF, but instead must contract directly with the mobile entity? These are among the ambiguities in the regulation, he contends.

Also, even though the Medicare physician fee schedule regulation carved out a billing exception for hospital under arrangements with mobile diagnostic facilities, there may soon be a Stark law problem, says Miami attorney Joshua Kaye, with McDermott, Will & Emery. "If the under arrangement was structured to involve referring physician ownership in the company providing services to the hospital, and the fee structure had a per-click or other variable fee component," there is a compliance risk, he says. "In such instances, there are a number of recent changes that were made to the Stark law that make the legal and financial viability of such arrangements much more challenging."

Does FAQ 'Swallow' the Rule?

Now some lawyers think the thrust of the new IDTF enrollment requirement has been called into question by the new FAQ posted on the CMS Web site. *The FAQ states:* "My company leases/contracts diagnostic testing equipment and/or non-physician personnel described in 42 CFR 410.33 to an enrolled Medicare provider/supplier (e.g., medical group practice). Do I need to enroll as an Independent Diagnostic Testing Facility (IDTF)?" *CMS's response:* "Companies that lease or contract with a Medicare enrolled provider or supplier to provide: a) diagnostic testing equipment; b) non-physician personnel described in 42 CFR 410.33(c); or c) diagnostic testing equipment and non-physician personnel described in 42 CFR 410.33(c) are not required to enroll as an IDTF. Medicare continues to evaluate arrangements where both diagnostic testing equipment and non-physician personnel are contracted to a Medicare enrolled provider or supplier and where the Medicare enrolled provider or supplier is billing for the diagnostic service."

The FAQ "swallows the rule," Davis says. "What is left of it?" It seems like CMS pretty much dropped many common types of arrangements from the IDTF enrollment requirement, he contends. Other experts agree. "It's shocking to me that CMS would correct or clarify a formal rulemaking by this informal process, without even mentioning the rule," Rumph says. Acevedo calls the FAQ "a fly in the ointment" of the regulation. Yet another lawyer, who preferred not to be identified, agrees with the assessment that the FAQ "swallows" the rule.

But attorney Daniel Melvin believes the FAQ can also be construed as a helpful clarification of the IDTF enrollment requirements. "The new rule for mobile operators should never have been construed to require portable testing equipment and technologist leasing companies to enroll in Medicare as IDTFs, but CMS made published statements suggesting that this was their intent," says Melvin, with McDermott, Will & Emery in Chicago. "The FAQ can be interpreted as a clarification (or retreat) by CMS, setting the record straight that CMS will distinguish between portable diagnostic equipment and technologist leasing companies on the one hand, and mobile technical component diagnostic service providers on the other. The IDTF enrollment requirement for mobile diagnostic operators may not be the proper or best way to regulate diagnostic testing services furnished to hospital patients 'under arrangements.' But the FAQ provides a much-needed clarification that companies that do no more than send techs with portable ultrasound equipment into physician offices or hospital outpatient clinics on a leased basis will not need to enroll as an IDTF."

CMS did not respond to *RMC*'s questions about the regulation's implications and the FAQ. With uncertainty about the requirements and the impact of the FAQ, experts offered this advice to providers about coping with the IDTF enrollment mandate and its effects on provider relationships:

◆ ***Put the FAQ next to the IDTF performance standards and re-evaluate your relationships*** to determine what aspects are still subject to the regulation, Davis says.

◆ ***Acevedo suggests approaching CMS about the ban on IDTFs performing CLIA tests***, according to an October 2007 provision in the *Medicare Program Integrity Manual*. That is a major obstacle to certain tests, such as radioactive blood sugar tests performed before PET scans for diabetes, she says.

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NEWS BRIEFS

◆ **The former CEO of City of Angeles Medical Center in Los Angeles pleaded guilty Dec. 12 to paying kickbacks for patient referrals,** according to the U.S. Attorney's Office for the Central District of California. Rudra Sabaratnam, M.D., admitted that he paid kickbacks as part of a scheme to defraud Medicare and Medicaid by recruiting homeless people in downtown Los Angeles. Sabaratnam paid Estill Mitts, who operated an "assessment center," nearly $500,000 to refer patients, the feds say. City of Angels then billed Medicare and Medi-Cal (California's Medicaid program) for services that were not needed, the government alleges. Mitts pleaded guilty in September to conspiracy to commit health care fraud, money laundering and tax evasion *(RMC 9/8/08, p. 8)*. Sabaratnam faces a maximum of 10 years in prison for each charge. He is scheduled for sentencing in June 2009. He also agreed to pay $4.1 million in restitution. Visit www.usdoj.gov/usao/cac.

◆ **OIG posted a notice in the *Federal Register* Dec. 17 for the annual "Solicitation of New Safe Harbors and Special Fraud Alerts."** Public comments on the notice are due Feb. 17, 2009. Go to AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "Federal Register."

◆ **A federal initiative that is investigating physical therapy practices in Mississippi added a major case to its roster Dec. 3 with the indictment of a physician who was also the owner of a clinic,** OIG said Dec. 15. The feds say Cassandra Thomas, M.D., owner of Central MS Physical Medicine, Inc., allegedly submitted $16 million in fraudulent Medicare claims for in-home therapy services. She is charged with conspiracy, health care fraud, making false statements and other charges. The feds allege that the services were provided in patients' homes by unqualified, inadequately trained, unlicensed technicians without supervision. Then the services allegedly were billed as if Thomas had performed them, the feds say. An attorney for Thomas said he could not provide comment at this time. OIG started opening cases in 2004 and estimated that the federal government lost about $60 million for fraudulently billed physical therapy services. In 2006, OIG's Office of Evaluation and Inspections issued a report on aberrant physical therapy billing. OIG found that physicians were billing for services performed by unlicensed people in the patients' homes. An OIG attorney deputized by the Department of Justice is prosecuting cases based on this violation in Mississippi *(RMC 10/20/08, p. 1)*. Visit www.oig.hhs.gov.

◆ **A Miami physician was sentenced to 30 years in prison Dec. 17 for her role in a scheme that defrauded Medicare of $11 million,** according to the Department of Justice. Ana Alvarez-Jacinto was found guilty by a jury in October 2008 after a two-week trial. The feds say she and Sandra Mateos, a nurse, ordered hundreds of medically unnecessary HIV infusion treatments while they worked at a Miami clinic. Mateos received a seven-year sentence Dec. 17. Both defendants have been ordered to pay $8.2 million in restitution. Attorneys representing them could not be reached for comment before *RMC*'s deadline. This case is part of an overall scheme that involved 11 clinics in south Florida and defrauded Medicare of more than $100 million *(RMC 9/15/08, p. 8)*. Visit www.usdoj.gov.

◆ **A nonprofit physician group can enter into part-time physician employment arrangements without violating the anti-kickback statute,** OIG says in Advisory Opinion 08-22, posted Dec. 15. OIG would not impose administrative sanctions under the exclusion authority or the civil monetary penalty provision, the opinion says. The group wants to employ two part-time physicians to perform endoscopies on the group's premises. Both physicians have their own medical practices where patients would be seen outside the part-time agreement with the group, OIG explains. The group says the physicians will be bona fide employees under the Internal Revenue Code and would be paid fair-market-value salaries. The anti-kickback statute does not prohibit payments made to bona fide employees, but OIG explains that it is having to rely on the group's certification that the part-time physicians are bona fide workers. Also, the endoscopies they perform are covered by federal health care programs, and their wages will be for services they personally perform, so there would not be prohibited remuneration, OIG says. Go to AIS's Government Resources at the Compliance Channel at www.AISHealth.com; click on "OIG Advisory Opinions."

◆ **CORRECTION:** The story in the Dec. 15 *RMC* on the posting of employee compliance-training attendance by St. Luke's Episcopal Health System in Texas contained some misleading information. In the months leading up to the training completion deadline, 60% to 65% of employees had completed required training. The article incorrectly described the time period as years. Compliance Specialist **Brad Langston** also notes that compliance lessons are electronic, so "attendance" at training has a somewhat different meaning.

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