Report on
MEDICARE COMPLIANCE

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

Contents

*PUBLISHER'S NOTE: **RMC** will not be published next week. The next issue will be dated April 20.*

With RACs Hot for Excisional Debridement, Review Bedside Documentation, DRG Impact

The capacity of excisional debridement to thrust Medicare-severity DRG (MS-DRG) reimbursement upward made it an attractive target for recovery audit contractors during the pilot, and it will probably be a prime focus of the permanent RACs as well. While compliance begins with explicit use of the word "excisional" in the medical record (assuming the procedure was performed), hospitals face subtler coding and documentation challenges involving ICD-9-CM procedure codes and MS-DRGs.

"If hospitals haven't conducted their own audits of excisional debridement, it's something they're advised to do," says Gloryanne Bryant, senior director of the corporate coding and health information management department at Catholic Healthcare West in San Francisco.

In fiscal year 2006, the RACs recouped $13.9 million from hospitals for just one debridement-related DRG (217, wound debridement and skin graft). "RACs found a gold mine" in excisional debridement, which refers to the surgical removal of dead tissue (skin, muscle or bone), says Kathy DeVault, a manager of professional practice resources for the American Health Information Management Assn. "RACs will continue to look at this. They know there is still money to be had."

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On-Call MD Who Is ED No-Show Settles CMP Case; Lawyer Says Transfer Helped Patient

An orthopedic surgeon taking call at a Chicago hospital has settled a civil monetary penalty (CMP) case for failing to show up at the emergency department (ED) to treat a patient with an open leg fracture that required surgery, according to the HHS Office of Inspector General (OIG). Wade Malhas, M.D., was accused of violating the Emergency Medical Treatment and Labor Act (EMTALA) when he didn't examine or treat the patient in person. But Malhas's attorney, James Bream, tells *RMC* that Malhas had the patient's best interest in mind. Since the hospital lacked the equipment to treat the fracture and time was of the essence, Malhas by phone ordered the patient's transfer to a nearby, better-equipped hospital. Malhas believes he fulfilled his on-call obligations, Bream says.

According to the CMP settlement, posted on the OIG Web site in March, Malhas will pay $35,000 for allegedly violating EMTALA's on-call requirements. EMTALA requires hospital EDs to screen all incoming patients and to stabilize those with emergency medical conditions — with no regard to insurance or financial status. Patients can be transferred to other facilities only if there is a medical reason for the transfer and not because they lack insurance. EMTALA requires EDs to maintain a panel of on-call specialists 24/7.

On Sept. 4, 2005, a patient with an open leg fracture presented at the ED at Loretto Hospital in Chicago, the settlement states. Malhas, the orthopedic surgeon on call,

"refused to go to Loretto's emergency department to examine or treat [this patient], who had an emergency medical condition that required orthopedic surgery," the settlement contends. OIG alleged that this implicated the CMP law because "any physician who is responsible for the examination or treatment of an individual in a participating hospital, including a physician who is on call for the care of such individual and who negligently violates his EMTALA requirements, is subject to a civil monetary penalty of up to $50,000."

Bream says it's true that the ED physician asked Malhas to come to the ED and treat the patient in his capacity as on-call orthopedic surgeon. However, Bream says, after learning his history and presentation, Malhas determined that a transfer was the right thing for the patient. The patient required a specific kind of external fixator, an orthopedic device used to treat complex, unstable fractures, and Loretto Hospital didn't have one, Bream says.

"There was an assessment by Dr. Malhas as the on-call physician that the most appropriate and expeditious disposition for the patient was to secure transfer to a facility that could … provide [in a timely manner] the ultimate treatment that was needed," Bream says.

There was no financial issue, Bream says; the patient was fully insured. "There wasn't a refusal to treat based on lack of insurance," he says. And the patient had a good outcome after undergoing surgery at the receiving hospital after the transfer, says Bream, with the law firm Querrey & Harrow in Chicago.

Bream acknowledged that the fact that Malhas determined over the phone that the patient should be transferred is discouraged by EMTALA. But there are situations, he says, where it's clear that the first hospital can't fulfill the patient's needs, so the on-call physician is acting in the patient's best interests to transfer him immediately, even without an in-person visit. Bream says he is aware of a medical malpractice case in which the on-call surgeon ordered by phone the transfer of a patient with a severe laceration because the hospital had no trauma surgeon. The surgeon also did not come to the ED because he could not have performed the surgery anyway, and his visit would have just delayed the transfer for the trauma surgery, Bream says.

Settlement Amount Is High for an M.D.

"Sometimes there may be a disconnect between the intent of a particular piece of legislation and its application in certain conditions, and we feel [the Malhas case] is one of these times because we feel the best interest of the patient was served," Bream contends.

The Malhas settlement amount is high for a physician considering that the maximum fine per EMTALA violation for institutions and physicians is $50,000, contends Houston attorney Nancy LeGros, with the law firm King & Spalding LLP. Malhas' case, Bream notes, is "not based on a repetitive pattern" by Malhas.

But LeGros adds that physicians and hospitals may be improving EMTALA compliance overall. The number of CMP settlements for EMTALA violations has dropped in recent years. There were 24 EMTALA settlements with OIG in 2007, 14 in 2007 and eight last year. Then again, in OIG's view, it may be a question of policing effectiveness. The OIG Work Plan for 2009 includes an audit of CMS oversight of EMTALA compliance.

In the Malhas case, LeGros points out that had the orthopedic surgeon gone to the hospital to see the patient before the transfer occurred, likely no violation would have been found. CMS believes that an on-call physician needs to go to the hospital when requested by the ED

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physician, even if the patient ultimately is transferred to another facility, she says.

Meanwhile, the industry should be on guard because EMTALA violations may be a greater threat to physicians and hospitals as the economy sheds jobs and, as a result, ED traffic increases, LeGros notes. Orthopedic surgeons are among the specialties most in demand at EDs, and thus bear more of the risks and burdens under the law, she says.

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Hit Quality Improvement With New Methods as Stakes Are Raised

As regulators and enforcers move on multiple fronts to reduce medical errors and improve patient outcomes, hospitals need new methods to oversee and police their quality of care. The urgency is intensifying as CMS and Congress embrace value-based purchasing (VBP) and health fraud enforcers use civil and criminal statutes to punish substandard care, experts say.

"Addressing the payment changes and legal risks associated with quality of care is one of the main priorities for health care entities in 2009," said Cheryl Wagonhurst, a partner in the law firm Foley & Lardner LLP. She and attorney Judy Ringholz spoke at a two-part audioconference on quality of care sponsored by the Health Care Compliance Assn. (HCCA) on March 9 and 13.

Wagonhurst says it's important for providers to encourage the board, as part of its fiduciary obligation, to get up to speed on the changes affecting quality of care, and for the board to understand the legal and compliance risks associated with quality of care. Some hospital representatives will say "of course the board understands what it needs to do in terms of overseeing quality. Quality is what health care is all about. Physician-board members in particular say that," Wagonhurst said. However, "what many fail to understand is the new environment," in which the government is using a data-driven approach to evaluate, reward and punish patient outcomes.

Quality oversight and improvement can't always be tackled by existing internal controls and oversight mechanisms, Wagonhurst said. "Many times, the old management structures are not really effective at [ensuring] that quality is addressed," she said.

For example, while peer review is one of the few avenues available for disciplining physicians whose clinical skills leave something to be desired, many times it's ineffective. *One reason:* Doctors generally don't rat on each other. "The problem with peer review is that often there's this context of 'If you don't peer review me, I won't peer review you,'" Wagonhurst says. Or a physician may not face consequences for inappropriate care because of the money he or she generates for the hospital. For example, when a physician performs a higher-than-normal number of C-sections on Medicaid patients — many of which are not medically necessary — administration or the physician's peers turn a blind eye because the procedures are lucrative for the hospital. "No one questions the physician because he's a big admitter," Wagonhurst said in an interview with *RMC*. "That would be discovered through a risk assessment, not through a normal review, because not a lot of people such as case managers will come forward to share critically important information."

Instead of this "case-by-case evaluation of bad apples," Wagonhurst recommends using quality metric data to identify aberrations. She also suggests that hospitals consider incentives to reward physicians for improving patient care, notably the pay-for-quality model approved by OIG in advisory opinion 08-16. "The key to dealing with physicians is getting them on board and allowing them to share in the benefits of providing good quality care," she said.

Another obstacle to improving quality of care is siloed departments (e.g., compliance, risk management, quality assurance, medical staff, case management, clinical departments, legal and human resources). "Quality issues are tracked separately, and the data are tracked separately," undermining efforts to identify a pattern of bad care by a particular clinician, Wagonhurst said. "So what's needed is a structure of integrating quality and compliance."

continued

How do you integrate quality and compliance? Here are tips from Ringholz, who has a nursing background and is a consultant with Huron Consulting Group in Washington, D.C.:

◆ ***Address quality of care and patient safety issues*** in your annual compliance risk assessment and corrective action plans.

◆ ***Get compliance officers to collaborate with clinical leadership***.

◆ ***Integrate quality and legal/regulatory compliance goals, and then link them to performance objectives.*** "Managers are forced to comply because it will affect their evaluations," said Ringholz.

◆ ***Draft operational policies*** so they support clinical quality standards.

◆ ***Make sure the board understands and is involved in quality assessment***. For example, board members should be able to read quality scorecards, understand national health-care quality trends and grasp the implications of quality as a governance issue. Guidance in this arena is available from various documents published by OIG in collaboration with HCCA *(RMC 3/30/09, p. 2)* or the American Health Lawyers Assn.

◆ ***Be aware that recovery audit contractors (RACs) may move into "medical integrity" issues*** (e.g., substandard care) in addition to coding and medical necessity audits, Wagonhurst and Ringholz said.

Government Using Three-Pronged Strategy

Wagonhurst and Ringholz described the government's three-pronged approach to improving quality of care. Here is a brief summary:

(1) Changing payment systems so Medicare pays for quality of services provided, not just quantity of services provided. CMS is using a number of vehicles to accomplish this. VBP is a major strategy. In "Roadmap for Value Based Purchasing," a recent report posted on its Web site, CMS outlined the steps under way toward VBP, which is a pay-for-performance strategy that adjusts Medicare payments based on quality and efficiency outcomes. Experts consider VBP inevitable. In fact, Congress required CMS to report on its progress by May 2010, and a lot of groundwork has been laid in that direction (e.g., the Health Quality Initiative). But CMS has a long way to go, including a modification to the self-referral laws "so that hospitals and other institutional providers may reward physicians for improving quality and efficiency in their local healthcare delivery settings," according to the VBP report.

In addition to VBP, there is the array of Medicare payment penalties for quality lapses. Medicare now denies payment for 11 inpatient hospital-acquired conditions, though Ringholz notes that CMS is trying to make HACs more precise (i.e., adjusting risk based on a condition's prevalence and gauging rates of a condition's occurrence over time). CMS also no longer pays for three surgical never events (which are serious, preventable medical errors). In a National Coverage Determination (NCD), CMS described the circumstances in which Medicare won't pay hospitals. "What I expect is that now that the NCD has gone out and everyone is clearly on notice that certain things should never happen and that it is inappropriate for providers to drop the bill, if that happens, it could be the basis for enforcement," Wagonhurst said. "Compliance officers should start thinking about this."

Next up: applying HAC payment denials to conditions acquired in outpatient hospital departments and certain other settings, such as physician offices. CMS has dubbed them "healthcare associated conditions."

(2) Using public reporting to make providers' quality of care transparent to payers and consumers. For example, under CMS's Hospital Quality Initiative, in 2010, hospitals must report their performance on 42 measures (e.g., pneumonia, heart failure and certain readmission rates) or face DRG payment reduction, Ringholz and Wagonhurst said. CMS launched a comparable program for outpatient hospital reporting in the 2009 outpatient prospective payment system regulation, they noted. Hospitals face a 2% DRG payment reduction if they fail to report on 11 measures.

(3) Enforcing quality of care through the False Claims Act (FCA): For one thing, VBP — which trades greater Medicare payments for higher quality care — is predicated on accurate provider data, she says. Without data integrity, there can be no VBP program integrity. "Enforcement authorities will look to ensure that appropriate data is being submitted for payment," Wagonhurst asserts. "Their concern is that providers will be so eager to get paid that" some may submit false data under VBP, which opens the door to FCA lawsuits. This risk will grow commensurately with the spread of electronic health records, which is expected to happen given the financial carrots and sticks under the American Recovery and Reinvestment Act of 2009 *(RMC 3/2/09, p. 1)*.

In addition to the emerging FCA issue of false data under VBP, quality of care is a prime enforcement target from other perspectives. "Physicians, executives and board members face real risks for poor quality," Wagonhurst notes. Six themes are present in FCA cases in this arena, she said:

◆ Unnecessary treatment;

◆ Kickbacks (e.g., for the referral of patients for procedures who may not need them);

◆ Special treatment given to physicians who are big hospital admitters;

◆ Fraudulent documentation;

◆ "Poorly structured, or failure to follow, internal processes;" and

◆ Underlying regulatory violations (e.g., a violation of the Medicare conditions of participation relating to quality assurance).

The OIG Work Plan for 2009 targets quality of care. Under the Medicare hospital section, OIG plans multiple

Compensation Committee Policy

A compliance officer, who asked not to be identified, designed this policy to govern his hospital's compensation committee. Over the past three years, ABC Hospital (not its real name) has hired or entered into personal services arrangements with a few dozen physicians. "All have been hired at different times, and the compensation methodology is not consistent," the compliance officer says. "The compliance committee will be an effort to make it consistent, more broadly discussed and transparent."

Compensation Committee

Purpose
The purpose of the Compensation Committee shall be as follows:
(1) To develop, implement and monitor the compensation for the Physicians at ABC Hospital
(2) To produce an annual report on physician performance and compensation for presentation to the Budget and Audit Committee of the Board of Commissioners.

Composition
The committee shall consist of one member of the board, one primary-care physician, one specialist physician, the Chief Financial Officer, and the Chief Medical Officer.

Appointment and Removal
The physician members of the committee shall be appointed by the ABC Hospital Operations Council. The board will choose their member. Term of service will be one year. The members of the committee may be removed, with or without cause, by the Chief Executive Officer (CEO).

Chairman
The members of the committee shall designate a chairman by majority vote of the full committee membership. The chairman will chair all regular sessions of the committee, set the agendas for committee meetings, ensure compliance with this charter, and be accountable to the CEO.

Delegation to Subcommittees
In fulfilling its responsibilities, the committee shall be entitled to delegate any or all of its responsibilities to a subcommittee of the committee.

Meetings
The committee shall meet as frequently as circumstances dictate. The chairman of the Committee or a majority of the members of the committee may call meetings of the committee.
As part of its review and establishment of the compensation of physicians, the chair of the committee should meet separately at least on an annual basis with the Budget and Audit Committee of the board.

Duties and Responsibilities
The committee shall carry out the duties and responsibilities set forth below. These functions should serve as a guide with the understanding that the committee may determine to carry out additional functions and adopt additional policies and procedures as may be appropriate in light of changing business, legislative, regulatory, legal or other conditions. In discharging its oversight role, the committee is empowered to study or investigate any matter of interest or concern that the committee deems appropriate.

(1) Establish and maintain a single standardized compensation model that applies to all physicians at ABC Hospital.

(2) Review and consider ABC Hospital's goals and objectives relevant to the compensation model of physicians.

(3) In approving or recommending the methodology of compensation for physicians, the committee shall consider ABC Hospital's financial performance and the value of similar physicians at comparable facilities to establish, document, and maintain a fair market value compensation model.

(4) In connection with physician compensation programs, the committee should do the following:

◆ Review and recommend to the full Board of Directors, or approve, new physician compensation models;
◆ Review on a periodic basis the operations of ABC Hospital's physician compensation models to determine whether they are properly coordinated and achieving their intended purposes;
◆ Establish and periodically review policies for the administration of physician compensation models; and
◆ Take steps to modify any physician compensation model that yields payments and benefits that are not reasonably related physician performance and fair-market value.

Reports
(1) Prepare an annual written report on physician compensation for presentation to the Budget and Audit Committee.

(2) Report regularly to the CEO with respect to matters that are relevant to the committee's discharge of its responsibilities and with respect to such recommendations as the committee may deem appropriate. The report to the CEO may take the form of an oral report by the chairman or any other member of the committee designated by the committee to make such report.

(3) Maintain minutes or other records of meetings and activities of the committee.

audits on serious medical errors (never events) and the reliability of hospital-reported Medicare quality data. In the section on health care fraud, OIG describes its plans to "continue to examine quality-of-care issues in nursing facilities and other care settings to detect and prevent fraud and abuse….We will investigate instances in which the programs may have been billed for medically unnecessary services or for services either not rendered or not rendered as prescribed or for substandard care that is so deficient that it constitutes a 'failure of care.' We will expand our focus on these issues to additional institutions and community-based settings."

Contact Wagonhurst at cwagonhurst@foley.com and Ringholz at jringholz@huronconsultinggroup.com. A link to the CMS report on value-based purchasing is at www.cms.hhs.gov/QualityInitiativesGenInfo/. ✧

DPAs With Four Companies Expire; Feds Dismiss Criminal Complaints

Deferred prosecution agreements (DPAs) with four companies that make hip and knee replacements were terminated March 30 without further action by the feds, according to the U.S. Attorney's Office for the District of New Jersey.

In September 2007, DePuy Orthopaedics, Inc., Biomet Inc., Smith & Nephew, Inc. and Zimmer Inc. entered into civil settlement agreements with the government collectively totaling $311 million. The feds also filed criminal complaints against them at that time, alleging that the companies paid financial inducements to physicians in violation of the anti-kickback statute. The companies said in 2007 that they did not admit any wrongdoing.

The complaints were to be dismissed after 18 months if the companies adhered to compliance procedures and federal monitoring as part of the DPAs *(RMC 10/1/07, p. 8)*. The companies have now fulfilled those requirements, the feds say, so the criminal complaints have been dismissed.

A fifth company, Stryker Orthopedics, Inc., was allowed to enter a "non-prosecution agreement," which included all the same reforms as the other agreements, but Stryker did not have a criminal complaint filed against it. The feds say Stryker also has completed the terms of its agreement.

Together, the companies make up 95% of the hip and knee implant market. The feds say that because of the DPAs, consulting payments from the firms to surgeons went from $272 million in 2007 to $105 million in 2008 (a 61% reduction). And the number of physicians receiving payments from the companies fell from 1,693 in 2007 to 628 in 2008.

Visit www.usdoj.gov/usao/nj. ✧

Debridement Is a Prime RAC Target

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Scanty and/or incomplete documentation is at the heart of the problems with excisional debridement (ICD-9-CM procedure code 86.22 and related codes), Bryant says. Physicians and other clinicians (e.g., nurses) who excise wounds may fail to document the depth of tissue excised (e.g., skin, muscle, bone), the instrument used (e.g., scalpel) and whether it was a single or multiple wounds debrided. These gaps are even more likely to occur when excisional debridement is performed at bedside or in a treatment room on a regular nursing floor rather than the operating room (OR), Bryant says. Some physicians apparently don't think they have to document as completely when a procedure isn't performed in the OR, says Nelly Leon-Chisen, editor of *Coding Clinic* and director of coding and classification at the American Hospital Assn. If they're cutting away dead tissue at bedside from a diabetic patient with peripheral neuropathy in his toes — no anesthesia necessary because of the lack of sensation — physicians are less likely to chart the details necessary to code 86.22 than when they debride a patient with anesthesia in the OR, Leon-Chisen notes.

Documentation Must Be Explicit

When adequate documentation for excisional debridement is AWOL, either coders must code non-excisional debridement (ICD-9 procedure code 86.28), or they have to query physicians for more explicit information if the rest of the documentation indicates surgery took place, Bryant says. And if physicians ignore the query, coders can't code excisional debridement, which affects DRG assignment and, therefore, Medicare reimbursement and compliance.

Here's an example of the impact documentation has on reimbursement: A 76-year-old male Medicare patient is admitted to the hospital with a documented diagnosis of severe sepsis as the primary reason for admission. He also has a history of hypertension and an infected pressure ulcer on the left heel. The pressure ulcer, which was present on admission, is stage two (partial thickness skin loss).

On the patient's sixth day in the hospital, his wound is debrided at bedside. The physician documents only that the patient has "debridement at bedside removing necrotic skin/subq tissue." Bryant says that's not enough documentation to code excisional debridement. "You don't know what technique the physician used nor the depth he went," she says. Either the coder queries the physician for more details, or the case will be coded and grouped to MS-DRG 872 (septicemia or severe sepsis), which means 038.X as the principal diagnosis, she says.

However, if the physician documents more explicitly — stating, for example, "excisional debridement, procedure details and removal of devitalized tissue/skin, instruments (scalpel), depth, etc." — then there's a basis for reporting ICD-9 procedure code 86.22, Bryant explains. That groups to MS-DRG 855, which is infectious and parasitic diseases with OR procedure, without complications/comorbidities (CCs) or major CCs (MCCs), and includes a principal diagnosis of sepsis.

Debridement Codes Drive Up Rates

Coding excisional debridement — assuming complete and accurate documentation exists — has a big impact on the DRG grouping (as is the case here). Excisional debridement code 86.22 will drive up relative weight, and higher relative weights translate into higher DRG payments, Bryant notes. This usually happens because excisional debridement pushes a principal diagnosis from a medical DRG to a surgical DRG. "You have to be careful when assigning [86.22] to make sure you have supporting documentation because it does impact the relative weight of the DRG," she says. If the RACs don't find documentation to support excisional debridement, the DRG will be downgraded and the hospital will face overpayment recoupment.

MS-DRG 872 (septicemia or severe sepsis without MCC), which is a medical DRG, has a relative weight of 1.1209 and a geometric mean length of stay of 4.7 days. As a surgical MS-DRG, 855 (infectious and parasitic disease with OR without CC/MCC) has a relative weight of 1.8140 and a geometric mean length of stay of 5.6 days. Multiply the hospital base rate of $6,000 by the relative weight, and MS-DRG 855 pays $10,884, while MS-DRG 872 reimburses $6,725.

Add CCs and MCCs to the same operative MS-DRG, and reimbursement climbs higher. If there is a CC, it will group to MS-DRG 854 and payment is $17,503. If there is an MCC, it will group to MS-DRG 853 and generate reimbursement of $32,596.

So it's obvious why the pilot RACs pursued errors involving excisional debridement: MS-DRG overpayments can be significant if a hospital's medical records don't support the procedure that changed the nature of the principal diagnosis. And it's likely the permanent RACs will hop on the bandwagon. "Why reinvent the wheel?" Leon-Chisen tells *RMC.*

"RACs were pretty successful in the pilot finding [excisional debridement] errors," so they probably will do the same in the permanent program. And it could come soon. A CMS official said in late March that the permanent RACs would initially focus only on automated reviews and DRG validation *(RMC 3/30/09, p. 1).* While excisional debridement is not conducive to automated reviews because RACs need medical records to evaluate relevant claims, excisional debridement falls under DRG validation, Leon-Chisen says.

Code Only to Deepest Level Debrided

RACs also have zeroed in on errors around coding for the level of debridement performed. ICD-9 procedure code 86.22 — excisional debridement of wound, infection or burn — only refers to skin-level or subcutaneous debridement, Bryant notes. There's also a procedure for the removal/excision of dead muscle tissue and bones. ICD-9 code 83.39 is for debridement of fascia, and ICD-9 code 77.6X is for debridement of bone, Bryant says. Of course, physicians often can't get to the muscles and bones without first excising the skin and subcutaneous tissue above. But ICD coding rules tell coders just to code the most invasive debridement.

"If you have a single wound that needs debridement and the physician debrides the skin and subcutaneous tissue and then goes even further to the bone, you only code to the deepest layer, even though they went through all the layers to get there," Bryant says.

Hospitals that billed for debriding all layers found themselves with RAC overpayment determinations during the pilot, Bryant says. *The reason:* ICD-9 procedure code 86.22 carries a higher surgical weight and triggers a more lucrative DRG than the ICD-9 procedure code for fascia or bone excisional debridement.

For example, the pilot RACs reassigned DRG 217 (wound debridement and skin graft procedures, except hand or musculoskeletal and connective tissue disorders) to DRG 226 (soft tissue procedures with CC) or 227 (same, but without CC). In these cases, physicians performed excisional debridement on patients with a primary diagnosis of osteomyelitis (infection of the bone). If physicians debride the bone, coders should code only to the bone (77.66). If they code 86.22 instead or in addition, that would be a mistake, Bryant says. (This was before implementation of MS-DRGs on Oct. 1, 2007, so some DRGs have changed.)

DRG 217, which can be triggered by 86.22, had a relative weight of 3.0479 for 2007, during the RAC pilot. The relative weight of the other two DRGs is lower: DRG 226 was 1.6350 in 2007 and DRG 227 was 0.8618, she says. Using a hospital base rate of $6,000, the Medicare reimbursement would be $18,287 for DRG 217. But there's a good chance the appropriate payment was much lower: $9,810 for DRG 226 and $5,169 for 227. "That's a huge financial difference that has to be refunded to Medicare," Bryant notes.

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NEWS BRIEFS

◆ **Professional medical associations (PMAs) should reduce and eventually eliminate contributions from pharmaceutical and medical device manufacturers,** an article in the April 1 *Journal of the American Medical Association* (JAMA) says. The authors of the article are past and present leaders of medical societies who make several recommendations for PMAs, including (1) keep PMA leaders conflict free during tenure by not deriving income or research support from the industries, (2) form a practice guidelines committee, and (3) don't solicit or accept product endorsements, among other things. "These recommendations carry a lot of weight and represent a desire to build confidence and take away questions raised by financial ties. I'll continue my effort to bring about full disclosure of money from industry to physicians," says Sen. Charles Grassley (R-Iowa), sponsor of the Physician Payments Sunshine Act of 2009 (S.301). The bill would require drug, device and biologic makers to report to HHS payments they make to physicians, and for that information to be posted on HHS's Web site. Visit http://jama.ama-assn.org.

◆ **CMS will hold two "Special Open Door Forums" about recovery audit contractors (RACs) in April.** The forums will provide more information about the permanent RACs, which begin audits in many states soon. The Part A RAC conference call is April 8 (conference ID 92490299) and the Part B RAC call is April 14 (conference ID 92489480) Both start at 2 p.m. EDT and have the same dial-in number: (800) 837-1935.

◆ **Kaiser Permanente fired or disciplined almost two dozen employees at Bellflower Medical Center for snooping into the medical records of Nadya Suleman,** the *Los Angeles Times* reported March 30. Suleman gave birth to octuplets at the facility in January. The hospital discovered the breaches in mid March and reported them to state authorities and to Suleman, the Times says. Fifteen people were fired and eight were disciplined. A Kaiser spokesman told the Times that the hospital stepped up efforts to protect the records from employees who had no medical reason for looking at them. Officials also performed a privacy refresher course, he said. The spokesman could not be reached for comment. Visit www.latimes.com.

◆ **Massachusetts General Hospital (MGH) informed 66 patients that their personal and medical information was lost on March 9,** the facility said in a prepared statement. MGH's Police and Security Department is investigating the matter and trying to recover the information. A March 24 *Boston Globe* article reports that the information was lost when an MGH employee left it in a subway car. She had taken work home with her, the article says. The information included names, birth dates, diagnoses and the name of their provider. The patients had visited MGH's infectious diseases clinic, according to the Globe. "Our information privacy and security policies and procedures are among the strongest in the health care industry, but incidents such as this remind us that we must continue to review and revise them, as well as continue to educate our staff on best practices to avoid incidents such as this," the MGH statement says. Read the Globe article at www.boston.com.

◆ **Two physicians and two medical assistants were found guilty by a jury March 17 in connection with a scheme to defraud Medicare of $5.3 million,** according to the U.S. Attorney's Office for the Southern District of Florida. David Rothman, M.D., Keith Russell, M.D., Eda Milanes and Jorge Pacheco were found guilty of conspiracy and several counts of health care fraud for allegedly submitting Medicare claims for unnecessary medications. The feds say the defendants worked at two Miami clinics that "purported to specialize in treatment of" HIV. One of the owners of the clinics testified at the trial that the facilities were established for the sole purpose of defrauding Medicare. The clinics billed for $5.3 million and received $2.5 million over two years of operations, the feds say. The owner and several others previously pleaded guilty in connection with the scheme. An attorney for Rothman said they are very disappointed in the outcome of the trail and that the government used testimony from "professional fraudsters" who took advantage of Rothman. The attorney says they will be appealing the case. An attorney for Pacheco said she could not comment on the case, and an attorney for Milanes said they also are considering an appeal. Russell's attorney could not be reached for comment. Visit www.usdoj.gov/usao/fls.

◆ **OIG said April 2 it will be doing its part to prevent fraud and abuse of $135 billion in funds allocated to HHS from the American Recovery and Reinvestment Act of 2009**. A new section of the OIG Web site will track its efforts in this area. Visit www.oig.hhs.gov/recovery.

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