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For Hospitals, Laboratories and Physician Practices

OIG Considering Safe Harbor For EHR Technology

The Health and Human Services Office of Inspector General (OIG) is considering several approaches to implementing a safe harbor for the provision of electronic health record (EHR) technology, the chief counsel to the agency told lawmakers in early April.

Lewis Morris said his office is reviewing 70 comments received in response to a 2005 proposed rule on safe harbors under the anti-kickback statute for arrangements involving EHRs. Morris testified April 6 during a hearing before the House Ways and Means Subcommittee on Health.

Morris's testimony came as the chairman and ranking member of the subcommittee expressed frustration with the pace of efforts to develop a coordinated health information technology infrastructure.

Subcommittee Chairwoman Nancy Johnson (R-CT) said that, despite the opportunity to reduce costs, clinical errors, and redundant medical procedures, the speed of adopting EHRs and other interoperable systems has been "disappointing and slow." Rep. Fortney (Pete) Stark (D-CA), the ranking minority member, said that talk on the topic has been going on for over a decade but little progress has been made.

Instead of taking the lead, the administration is "giving far too much deference to the private IT corporations to resolve their age-old disputes about what standards we should be using. It's time to get federal bureaucrats off their butts," Stark said. ➥ *p. 2*

Inside this issue

Making The Most Out Of Your Outreach Structure: Legal Opportunities & Challenges

So your hospital is ready to start a lab outreach program, but you're not sure just which legal structure would be most appropriate. Should you create a corporation, a partnership, or a limited liability company?

The answer, says attorney Hope Foster, depends on several factors, including control, liability, continuity, and taxes. Foster, of Mintz, Levin, & Cohn in Washington, D.C., discussed the pros and cons of each type of structure during Washington G-2 Report's Lab Outreach Conference, held April 6 to 7 in Atlanta.

"When a hospital is considering whether to establish a new outreach program, or expand one it currently has, an important question is how should the program be operated. Should it be part of the normal hospital's legal entity, or is there a ➥ *p. 9*

EHR Technology, *from p. 1*

The OIG and the Centers for Medicare & Medicaid Services (CMS) last October proposed several exceptions to the Stark self-referral law and the anti-kickback statute for certain arrangements involving the provision of electronic prescribing technology (*GCR*, Nov.-Dec. 2005, pg. 1).

One safe harbor proposed by the OIG would protect donations of electronic health records software and related training services, provided that the protected software includes an electronic prescribing component. The software would have to be essential to and used solely for the transmission, receipt, and maintenance of patients' electronic health records and electronic prescription information. Donations of technology used by a recipient solely to conduct personal business or business unrelated to the recipient's medical practice would not be protected.

'This approach to selective criteria, if adopted, would be a deliberate departure from other safe harbors that prohibit any determinations that take into account, directly or indirectly, potential referrals or other business generated between the parties.' — Lewis Morris.

The proposed safe harbor would protect the same donors and recipients that Congress included in the Medicare Modernization Act (MMA) safe harbor for electronic prescribing arrangements. Accordingly, the protected arrangements would be limited to: 1) hospitals donating to members of their medical staffs, 2) group practices donating to members of their practice, and 3) prescription drug plan sponsors and Medicare Advantage organizations donating to network pharmacists and pharmacies and to prescribing healthcare professionals.

To promote the objectives of an interoperable health records system, the proposed safe harbor would require that protected software be certified in accordance with product certification criteria for interoperability adopted by the Secretary of the Department of Health and Human Services, said Morris.

"We believe that donations of technology that meet uniform interoperability standards for electronic health records adopted by the Secretary, as well as product certification criteria to ensure that products meet those standards, will help preclude unscrupulous donors from using closed or isolated systems to tie recipients to particular providers or suppliers," Morris testified. "In light of the enhanced protections against some types of fraud and abuse that would be offered by certified, interoperable systems, we indicated that we are considering giving donors some additional flexibility in selecting recipients of the technology."

Specifically, the OIG is considering permitting donors to use selective criteria for choosing recipients, provided that neither the eligibility of the recipient, nor the amount or nature of the items or services provided, is determined in a manner that directly takes into account the volume or value of referrals or other business generated between the parties.

Examples of criteria that might be appropriate under this proposed condition might include a determination based on the total number of hours that the recipient practices medicine or the size of the recipient's medical practice. Donors could not select recipients based on the number or value of Medicare-payable items or services referred to the donor.

"This approach to selective criteria, if adopted, would be a deliberate departure from other safe harbors that prohibit any determinations that take into account, directly or indirectly, potential referrals or other business generated between the parties," said Morris.

The OIG is also considering capping or otherwise limiting the aggregate value of the donated technology, he added.

Resources

- April 6 testimony of Lewis Morris: *www.oig.hhs.gov/testimony/docs/2006/Health%20IT-House-4-6-06.pdf*
- OIG proposed rule on safe harbors, Oct. 11, 2005: *http://oig.hhs.gov/authorities/docs/05/101105e-prescribingPR.pdf*

CMS Proposes Payment & Policy Changes For Inpatient Hospital Services

The Center for Medicare and Medicaid Services (CMS) on April 12 issued a notice of proposed rule making that it says would begin the transition to the first significant revision of the Inpatient Prospective Payment System (IPPS) since its implementation in 1983.

The proposed rule will be published in the April 25, 2006, Federal Register. *Comments will be accepted until June 12, and a final rule will be published later this year.*

When fully implemented, which is planned to occur by fiscal 2008, the revised IPPS would improve the accuracy of payment rates for inpatient stays by basing the weights assigned to Diagnosis Related Groups (DRGs) on hospital costs rather than charges and adjusting the DRGs for patient severity, says CMS in a statement.

CMS has received three applications for new technology add-on payments in fiscal 2007, and the agency is soliciting comments on whether these technologies meet the criteria for the temporary add-on payments.

The estimated market basket increase of 3.4% in fiscal 2007 would increase payments to acute care hospitals by $3.3 billion. More than 1,000 hospitals in rural areas would see an average increase of 6.7%, according to the agency.

The proposed changes reflect recommendations from the Medicare Payment Advisory Commission (MedPAC) and respond to some congressional concerns that the existing system may create incentives for certain hospitals to "cherry pick" more profitable cases. The reforms will significantly affect payments to specialty hospitals – those that typically are owned, in whole or in large part, by physicians who serve as referral sources. The growth in specialty hospitals has been slowed temporarily by statute or regulation.

Two-Step Process

CMS is considering a two-step process of transformation. The first step, set out in the proposed rule, would assign weights to DRGs based on hospital costs, rather than hospital charges. This would eliminate biases in the current DRG system arising from the differential markup hospitals assign for ancillary services among the DRGs, says the agency. The new DRG weights would go into effect Oct. 1, 2006.

A second step, currently scheduled for fiscal 2008, would replace the current 526 DRGs with either the proposed 861 consolidated severity-adjusted DRGs or an alternative severity-adjusted DRG system developed in response to public comments CMS is soliciting on this issue. CMS is also considering ways of improving recognition of severity in the current DRG system by fiscal 2007. When the two steps are implemented, hospitals can expect more accurate payment for their services, according to the agency.

CMS is proposing to increase the outlier threshold for fiscal 2007 to $25,530, up from $23,600 in 2006. This proposed increase is based on data suggesting a consistent pattern of inflation in hospital charges that affect hospital cost-to-charge ratios used in determining eligibility for outlier payment. The proposed FY2007 threshold is expected to keep aggregate hospital outlier payments within the target of 5.1% of total payments under the IPPS, says CMS.

Under the proposed rule, new technologies would be eligible for temporary add-on payments if they are: 1) new—that is, less than two to three years old; 2) expensive—as determined by a defined cost threshold in relation to the underlying DRG; and 3) proven to provide a substan-

tial clinical improvement for the Medicare patient population. CMS has received three applications for new technology add-on payments in fiscal 2007, and the agency is soliciting comments on whether these technologies meet the criteria for the temporary add-on payments. CMS is also proposing to continue new technology payments for two of the three technologies that were approved for payment in fiscal 2006.

Resource

❖ Proposed changes to IPPS for fiscal 2007: *www.cms.hhs.gov/AcuteInpatientPPS/downloads/cms1488p.pdf*

Group Opposes Extended Prison Sentence For Lab Exec

The Washington Legal Foundation on March 20 filed a brief in the U.S. Court of Appeals for the First Circuit asking the court to reject a Department of Justice request to increase to five years the prison sentence of a former clinical lab executive who was convicted on conspiring to defraud the Medicare program.

William Thurston, a former vice president of Damon Clinical Laboratories Inc. in Massachusetts, was charged with participating in a scheme to submit false and fraudulent claims for medically unnecessary blood tests.

The company's former president, Joseph Isola, pleaded no contest to one conspiracy count and was sentenced to three years of probation. Thurston rejected a similar plea agreement and was eventually convicted of the conspiracy charge in late 2001. The federal district court judge sentenced him to three months in prison and three months home confinement, which he has since served.

Sentencing Disparity

The DOJ appealed the district court's ruling, and, in August 2003, the First Circuit extended Thurston's sentence to five years, citing federal sentencing guidelines requirements. The extended sentence was overturned in January 2005 after the U.S. Supreme Court ruled the mandatory federal sentencing scheme implemented under the U.S. Sentencing Guidelines was inconsistent with the Sixth Amendment of the U.S. Constitution.

On remand, a second district court judge declared the original six-month sentence reasonable. The disparity between the five-year term sought by the government for Thurston and the three-month probation it agreed to for Isola would "injure respect for the law and confidence in the administration of justice," the judge said.

The DOJ again appealed, asking the First Circuit court to reinstate the five-year prison term. Washington Legal Foundation's (WLF) amicus brief opposes the DOJ's latest request.

"It's just an outrageous abuse of prosecutorial discretion," WLF senior executive counsel Paul Kamenar said of the Justice Department's latest appeal. "Just because Thurston decided to exercise his right to a trial does not mean we should throw the book at him." Kamenar predicted a favorable ruling for Thurston.

Deadline For Part D Fraud Control Set

Part D drug plan sponsors will have until Jan. 1, 2007, to implement a compliance program to control fraud, waste, and abuse (FWA), an official with the Centers for Medicare and Medicaid Services (CMS) said March 21.

Lauren Haley, a health insurance specialist with the CMS Program Integrity Group and co-author of the draft guidance, said CMS expects to issue final guidance on fraud controls by April 23.

The final provision will be encompassed in Chapter 9 of the Prescription Drug Benefit Manual. Haley made her comments at a breakfast briefing co-sponsored by law firm Mintz, Levin, Cohn and consulting firm EduNeering Inc.

CMS issued draft Part D compliance program provision on February 8 to assist sponsors in implementing a comprehensive program to detect, correct, and prevent FWA.

COMPLIANCE PERSPECTIVES

An Organization's Duty To Self-Report Misconduct: Mandatory Or Voluntary?

Gabriel L. Imperato, Esq., is the managing partner of the Fort Lauderdale office of Broad and Cassel. He is certified as a specialist in health law by the Florida Bar and is also certified in Healthcare Compliance by the Healthcare Compliance Association. He was recently elected as a member of the Healthcare Compliance Association's board of directors.

Many healthcare providers have instituted corporate compliance programs in response to historical enforcement of the healthcare fraud and abuse laws by the state and federal government authorities. Other providers have had so-called "corporate integrity agreements" imposed through settlement agreements resulting from investigations conducted by the Department of Justice (DOJ) and the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS). Even if a healthcare provider has not adopted a corporate compliance program (voluntarily or otherwise), problems or misconduct may occur that are reported up the chain of command in healthcare business organizations.

These reported compliance matters should not be ignored in any case. Often a decision has to be made whether to disclose the problem or misconduct to agencies of the state or federal government (i.e., government agencies such as DOJ, the OIG, or fiscal agents for the Medicaid and Medicare programs). There are circumstances where disclosure is mandatory and also those circumstances where disclosure is advisable, though not necessarily mandatory.

Matters That Trigger Disclosure Considerations

Medicare/Medicaid reimbursement laws and regulations are extremely complex and, consequently, have produced complex claims and reimbursement systems. A typical healthcare organization will submit Medicare and/or Medicaid claims that total in the tens or even hundreds of millions of dollars for a wide and complex array of healthcare services and many problems may arise in Medicare and Medicaid billing systems. The legal characterization of these problems (ranging from simple errors or mistakes to fraud) will dictate how an organization will address these compliance problems and whether to commence an investigation and whether and to whom to disclose the matter.

The characterization of these billing problems by the federal government has also been controversial and indicative of the ambiguity inherent in applying legal standards to these matters. The complex reimbursement system under federal health programs can result in several types of errors or problems including, but not limited to: incorrect or improper coding; incorrect or improper inclusion of items on cost report claims; inadequate documentation of services rendered; billing for services that are not allowable (e.g., not covered or medically unnecessary); and mistaken or purposeful billing of services that were not rendered.

Numerous statutes are designed to combat healthcare fraud. There are a number of criminal statutes, including the recent Health Insurance Portability and Accountability Act of 1996 (HIPAA), which added a new crime of healthcare fraud (18 U.S.C. § 1347) and a new crime related to theft or embezzlement in connection with healthcare (18 U.S.C. § 669). These laws merely supplemented an already wide array of federal criminal statutes that have historically been used to prosecute healthcare fraud (i.e., mail fraud, wire fraud, etc.).

The fact is that federal law governing the Medicaid and Medicare programs penalizes acts or omissions that arise in these very complex billing systems. For example, the U.S. Civil False Claims Act (the primary tool used by the government in false claims investigations) prohibits the knowing submission, or anyone causing the submission, of a false or fraudulent claim (*see* 31 U.S.C. § 3729(a)).

The statute defines "knowing" as including acts in deliberate disregard of the truth or falsity of the information and, in fact, states that ". . . no proof of intent to defraud is required." (*see* 31 U.S.C. § 3729(b)). Because of the breadth of the False Claims Act, a simple billing error that produces a "false claim" (i.e., one that is materially inaccurate) may result in liability under this statute.

Duty To Disclose

As a general rule, businesses and individuals are under no legal obligation to report misconduct or noncompliance to the government. The Fifth Amendment protects *individuals* from compelled disclosure of incriminating evidence, and therefore a rule requiring individuals to report regulatory noncompliance may be unconstitutional if the regulatory noncompliance is evidence of a crime. However, the Fifth Amendment does not protect a corporation and other fictitious persons, and, therefore, business organizations may disclose anything that is in their best interest to disclose (regardless of individual employee interests).

Under the HIPAA law, it is a felony if a provider knowingly and willfully falsifies, conceals, or *covers up* a material fact (18 U.S.C. § 1035). It is unclear whether a failure to disclose, in contrast with an intentional act to conceal, could be construed as "covering up" a material fact for purposes of this law, but, generally speaking, the crime of concealment requires an affirmative act by the alleged offending party.

However, the Medicare fraud and abuse statute specifically references the failure of a provider to disclose a "known overpayment." This statute provides, in pertinent part, as follows:

"Whoever having knowledge of the occurrence of any event affecting his initial or continued right to . . . [a] benefit or payment [from a federal healthcare program] . . . conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount than is due or when no such benefit or payment is authorized" is punishable by a sentence of up to five years imprisonment and a fine of $250,000 for individuals and $500,000 for corporations (42 U.S.C. § 132a-7B(3)).

This statute does not provide any procedure for disclosure, and it does not state to whom a disclosure should be made. There are very few reported cases construing this statute. The statute also appears to require a provider to disclose receipt of an overpayment even where the cause of the overpayment was a mistake by the government.

A healthcare provider is not necessarily obligated to report any act or omission that constitutes a violation of law or regulation governing Medicare. The government rec-

Court Actions

The courts have had to limit the government's enthusiastic use of both criminal healthcare fraud and abuse provisions and the civil False Claims Act. For example, a court in the Northern District of Ohio dismissed a lawsuit filed by the Ohio Hospital Association and the American Hospital Association challenging the government's use of the False Claims Act in a controversial investigation of hospital lab billing practices. Although the court dismissed the suit on jurisdictional grounds, the judge lectured the government on its "extremely onerous" use of the False Claims Act and noted the "very real possibility" that its use of the statute is "wrong" (see *Ohio Hospital Assn. et al. v. Shalala*, Case No. 1:96-cv-2165, dec. Sept. 18, 1997. Also see e.g. *United States ex. rel Hochman v. Nackman, et al.*, 145 F.3d 1069 (9th Cir. 1998) and *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir. 1995)).

Generally, the courts have required a showing of intentional violations of a known legal duty, but the government has had success in the courts, even though it has also had some notable losses. A fair review of healthcare fraud issues by courts and administrative tribunals, however, does not occur often because the overwhelming majority of cases settle. This is unfortunate in many respects because government settlement terms are not necessarily commensurate with the actual merits of a case when reviewed by an independent trier of fact and law.

ognizes this principle, and, to encourage reporting, the OIG has developed a voluntary protocol for self-disclosure. Moreover, the civil False Claims Act itself affords more lenient treatment of those who are facing civil penalties for False Claims Act violations if they choose to disclose the problem in a timely manner.

The basic rule of thumb for determining the retroactive scope of a 'known overpayment' is 'reasonableness.'

There are, however, instances where reporting may be mandatory. Arguably, there is a legal obligation to disclose a problem that has resulted in a "known overpayment" by the government to the provider. The reason is that once the provider becomes aware of the overpayment and does not report it, the provider potentially is "retaining" federal property with an "intent to convert it to [its] own use" in violation of the statute defining criminal conversion and theft.

In addition, the fraud and abuse language that mandates disclosure of "an event" that affects the continued right to retain a payment is also implicated in the case of an overpayment if the government were to prevail with the proposition that the discovery of an overpayment is "an event" within the meaning of that statute. Finally, although the HIPAA criminal statute seems intended to punish traditional embezzlement or theft, its language may arguably apply to retention of funds that were originally honestly claimed.

There is also the issue of the scope of a "known overpayment" under the Medicare fraud and abuse statute. A useful guide for determining how far back in time a provider should go to determine the scope of "known overpayments" is provided in the regulations governing recoupment by the government. Four years is the time frame established in 42 C.F.R. § 405.300 et. seq. The basic rule of thumb, however, for determining the retroactive scope of a "known overpayment" is "reasonableness." The advice of competent counsel can be important in these situations because what may be "reasonable," under the circumstances will be materially affected by the careful application of the law to the facts.

Voluntary Disclosure Considerations

The *Compliance Program Guidance for Hospitals* (CPG), published by the OIG in 1998, suggests a *voluntary* reporting standard of misconduct for providers. The use of the term "misconduct" in the CPG suggests that this standard applies to something more than mere negligence, although the CPG is intended to create a structure that uncovers every misstep ranging from mistakes to a conscious concerted effort to defraud the government. The other compliance models (e.g., for home health, and third-party billing agencies) suggest reporting the "credible evidence of misconduct" within 60 days of determining credible evidence of a violation. [See *www.oig.hhs.gov* for all compliance documents.]

As indicated earlier, not all problems that arise in a complex billing system are required to be reported even though, by definition, they violate law or regulation (although some may only violate the government's interpretation of a rule). The threshold issues for determining whether an entity is required to report such a violation is whether there is a "known overpayment" or whether failure to disclose would necessitate the making or filing of a materially false document or statement of some sort.

If, on the other hand, a matter involves misconduct and/or fraud, counsel should be consulted at the outset and be retained and considered to lead an investigation under privilege. In that instance the provider should reach the disclosure decision, as well as the proper mode of disclosure, with the advice of counsel after completion of an internal investigation.

Options For Disclosure

A. Disclosure to Carrier or Intermediary

Once a decision has been made regarding disclosure, the question becomes to what agency does one disclose a matter. For errors resulting in overpayment, pro-

viders have generally notified the Medicare and/or Medicaid carrier or fiscal intermediary, and documented the problem and followed the applicable repayment method (e.g., adjustment on cost report or overpayment refund procedures).

A disclosure to the carrier or intermediary may be appropriate if the provider determines, after an internal audit, that an overpayment was received and there was no indication of intentional wrongdoing. The provider returns a check to the intermediary or carrier with the full amount of the overpayment and an appropriate explanation giving rise to the overpayment with no penalties or interest included with this type of refund. At one point, the OIG indicated that it wanted to be advised of all such overpayments and disclosures to carriers or fiscal intermediaries, but does recognize in its CPGs that this method of disclosing and rectifying a problem is appropriate.

B. Provider Self-Disclosure Protocol

Another method of disclosure to consider is the avenue provided by the Provider Self-Disclosure Protocol, offered by the OIG. (*Provider Self-Disclosure Protocol*, Office of the Inspector General, 63 Fed. Reg. 58399, October 30, 1998, hereinafter "Protocol"). Generally, the Protocol requires the reporting entity or person disclosing the matter to furnish a statement that describes the nature of the problem, who is involved, what investigations have been undertaken, and what methodology will be utilized to determine the extent of the problem (including specific auditing and sampling procedures).

The Protocol clearly states that its use will not necessarily result in a specific amelioration of penalties. Moreover, it does also clearly state that other enforcement authorities will be contacted if the OIG determines that criminal behavior is implicated. The OIG Provider Self-Disclosure Protocol has been used sparingly by the healthcare industry, but should be seriously considered in certain circumstances (i.e., considerations of continued participation in federal health programs) in conjunction with the careful and competent advice of counsel.

C. Disclosure to the Department of Justice

A disclosure may also be made to the DOJ or local United States Attorney depending on the facts and circumstances and the application of law. The False Claims Act includes a section that permits the court to reduce the civil penalty levied against an individual or entity if it disclosed the problem in a timely fashion.

A disclosure to the Department of Justice of either criminal or civil misconduct is often times a much better and more local option for business organizations who decide it is prudent to disclose misconduct, but it depends greatly on the facts and circumstances in each case and the potential outcome to be achieved by disclosure.

Conclusion

There are definitely circumstances when disclosure is mandatory and requires the return of a "known overpayment." It must first be determined, however, that there is a "known overpayment," and this is always a determination that is made in connection with a careful review of the facts and applicable law. This is not the same as disclosing individual misconduct or culpable behavior by individuals, which is specifically protected from compelled disclosure by the Fifth Amendment to the Constitution.

There are occasions where disclosure of individual misconduct may be prudent and appropriate, especially for a business organization (which has no Fifth Amendment rights) interested in continued participation in the Medicare and Medicaid Programs. This may be the case even though such disclosure is not legally mandated. A mandatory or voluntary disclosure should nevertheless be driven by the facts and circumstances in each case and made in conjunction with the advice of competent counsel.

Gabriel L. Imperato, Esq, can be reached at Broad & Cassel, P.O. Box 14010, Fort Lauderdale, FL 33302. Phone: 954-745-5223. E-mail: gimperato@broadandcassel.com.

Hope Foster, Esq.

Outreach Structure, *from p. 1*
reason for a separate entity?" asks Foster. "The organization form that is most advantageous will depend on the facts unique to each case, including the laws of the state in which it is formed."

Reimbursement is also affected by the legal structure, she adds. If your outreach program is considered an independent laboratory because it is a separate legal entity and is not controlled by the hospital, this will have an impact on application of the three-day window for lab testing, whether the testing is considered outpatient or nonpatient, whether you deal with intermediaries or carriers, and whether you submit claims on UB-92s or 1500s.

In addition, legal structure also can determine application of the federal laws on kickbacks and anti-trust. "The kickback rules typically require that there be two separate entities for a violation to occur," she adds. "So while the reimbursement consequences might be quite favorable if there are two separate entities, the kickback and anti-trust issues are less favorable."

So just what types of legal forms might an outreach program take? Foster discussed several, ranging from corporations to partnerships to limited liability companies.

Corporations

The benefits of a corporation include limited liability for owners, easy transfer of ownership, and potential perpetual existence. However, a corporation is more costly to establish and maintain, requires a separate tax return, and can result in double taxation.

A charitable corporation, on the other hand, is exempt from taxation based on the theory that it makes up for revenues that would otherwise be lost by the government if the government were responsible for providing the services the organization provides, such as healthcare.

A nonprofit hospital launching a for-profit outreach program may opt for a joint-venture arrangement, notes Foster. The main concern here is what impact the joint-venture will have on the tax-exempt status of the charitable partner for federal income tax purposes.

According to the Internal Revenue Service (IRS), the key to a nonprofit joint venturer retaining its exempt status is to maintain control over the venture. If the exempt organization has control over the venture, the exempt organization can ensure that its charitable mission is taking precedence over the interest of the for-profit organization. The question is not whether the charitable mission is being fulfilled; rather, it is whether the nonprofit has the power to control the venture.

The composition of the governing board determines control of the joint venture, explains Foster, who recommends that the majority of board members be appointed by the charitable organization. The governing documents may specify that the charitable mission takes precedence over any profit interest. Failure to meet the IRS requirements for a tax-exempt organization could result in loss of tax-exempt status and exposure to taxable unrelated business income tax.

If an exempt entity is contemplating participation in a joint venture that it will not "control" in accordance with IRS standards, a better approach might be to participate in the joint venture through a taxable, for-profit subsidiary, Foster advises. Income from the activity will be subject to tax, but the exempt organization will not risk its entire exempt status in the venture.

Partnerships

Another option for establishing a legal structure for your outreach program is a partnership (general or limited). Partnerships are flexible, permit ownership by more than one individual, avoid double taxation, and involve few legal formalities. On the down-side, however, there is unlimited personal liability for business losses, each partner is legally responsible for the acts of the others, and the partnerships may dissolve upon the death of a general partner.

A partnership agreement should address the amount of time or money that each partner will contribute to the business;

What Is Outreach Testing?

By definition, outreach testing is testing performed by a hospital lab for individuals who are neither inpatients nor outpatients of the hospital on specimens that are collected by individuals who are not employed by the hospital.

how business decisions will be made; how profits and losses will be shared; how to handle the death, disability, or retirement of a partner; how long the partnership will last; and when the partnership will make distributions to its partners. The agreement should also state the percentage of the business that each partner will own.

A word of warning, notes Foster: Any partner can bind the partnership and the individual partners by signing a contract or undertaking a legal obligation on behalf of the partnership, even if the other partners have not consented. Partners also share "joint and several liability," which means that a creditor could require any individual partner to pay the debts of the business. That partner could then seek reimbursement from the other partners.

A partnership continues as long as the partners agree that it will. If a general partner dies or leaves the business, the partnership dissolves and the assets must be sold to pay off creditors with the remainder divided among the remaining partners. The partnership agreement, and sometime state law, determines whether or not a partner may sell his or her partnership share.

The partnership does not pay taxes on income generated by the business. Instead, each partner pays taxes on his or her share of the business income. Partners may also pay self-employment tax on partnership income.

A limited partnership involves two classes of partners: limited and general. General partners are similar to partners in a general partnership, while limited partners are similar to shareholders in a corporation. Limited partners do not elect board members or participate in day-to-day management of the business. What's more, limited partners are not generally liable for the acts of the partnership or the general partner. Under state law, a limited partnership cannot be dissolved without consent of all the partners.

A limited liability partnership (LLP) is a relatively new business form that operates like a limited partnership, but members may play an active role in the business of the partnership without being exposed to personal liability for others' acts, except to the extent of their investment in the LLP. Many law and accounting firms now operate as LLPs.

Limited Liability Company

A limited liability company (LLC) combines features of both the partnership and corporate structures, says Foster, who explains that all states have statutes allowing for the establishment of this type of business entity.

To form an LLC, articles of organization must be filed with the Secretary of State and appropriate fees paid. An operating agreement is not always required, but is advisable. A single person can establish an LLC. The owners, or members, must determine how the LLC will be controlled and ensure that their decisions are reflected in the operating agreement. An LLC, like a corporation, exists as a separate entity, and members are shielded from the company's debts unless they have signed a personal guarantee.

The LLC's operating agreement sets forth the events that cause dissolution of the entity, such as the death or bankruptcy of a member. In addition, the agreement provides rules for the transfer of LLC interests (for example, a right of first refusal for remaining members).

All business profits, losses, and expenses flow through the company to the individual members. An LLC is not a separate entity like a corporation, notes Foster – it is a "pass-through" entity that may be classified as a partnership or a corporation for federal tax purposes.

The pros of an LLC are limited liability, administrative simplicity (no minutes, meetings, or recorded resolutions), and flow-through taxation. On the downside, the LLC has a limited life, may dissolve at an inopportune time, and involves some tax complexity.

Resource

Hope Foster: 202-434-7300

OIG Frowns On Free Home Safety Assessments

An arrangement by an operator of home health agencies to provide prospective customers with a free preoperative home safety assessment could generate civil money penalties (CMPs) and could violate the anti-kickback statute, the Department of Health and Human Services Office of Inspector General (OIG) said in an advisory opinion issued March 27 (No. 06-01).

Based on the facts certified in the request, the OIG concluded that the free home safety assessment may constitute grounds for imposition of CMPs. The OIG also concluded that the arrangement potentially generates prohibited payments under the anti-kickback statute, which could result in administrative sanctions.

Preoperative home safety assessments are not a covered service under Medicare or Medicaid, the OIG said. Some managed care payers cover in-home preoperative safety assessments, paying the requester between $85 and $100 for each visit.

The unnamed requester operates a nationwide network of home health agencies (HHAs) that provide a variety of home healthcare services, including skilled nursing care, home health aide services, personal care assistance, home medical equipment, and rehabilitation services. The requester provides free preoperative home safety assessments for patients scheduled to undergo orthopedic surgery either over the phone or in person at the patient's home.

The OIG said the assessments appear to be valuable services, worth $85 to $100. Evaluating a safety assessment by telephone, however, is more problematic, although the absence of a paying market for such services is not a deciding factor, the OIG determined.

The absence could indicate that the service has little or no value, that the service is simply novel or emerging in the marketplace, or that the market has been distorted by the availability of free services. The OIG said it was persuaded by the requestor's claim that the telephone assessments cost less than $10 to provide since the value to the beneficiary, which is the appropriate focus under the CMP, may exceed that amount.

Accordingly, the OIG concluded that both the in-home and free safety assessments are potential payments to beneficiaries.

Resource

OIG Advisory opinion 06-01: *www.oig.hhs.gov/fraud/docs/advisoryopinions/2006/AdvOpn06-01A.pdf*

For the Record

CMS To Allow Use Of Surrogate UPIN

In a recent policy reversal, the Centers for Medicare and Medicaid Services (CMS) has decided not to eliminate, effective April 1, 2006, the use of the surrogate UPIN OTH000 on Medicare claims from physicians, clinical laboratories, and other healthcare providers.

CMS announced the change on March 31 (Change Request 5019). Under the now-defunct policy eliminating use of the "dummy" Unique Physician Identification Number (UPIN; Change Request 4177), Medicare would have required labs and other providers to submit the referring/ordering physician's actual UPIN or the claims would be returned as "unprocessable."

The surrogate UPIN was intended for interim use when a UPIN had been requested but not yet received. A Medicare audit in 2004 found that an excessive number of claims used the surrogate when UPINs had been assigned in many cases. In addition, the audit found that more than 10 million claims were submitted with the surrogate UPIN during the period studied.

In lobbying for the policy reversal, the billing committee of the American Clinical Laboratory Association (ACLA) argued that because clinical lab testing is time-sensitive, member labs typically perform the service and provide test results whether or not they have a UPIN for the ordering physician or practitioner. Not all providers have UPINs or must have one, ACLA noted, adding that without the surrogate, labs will be providing services for which they won't be paid.

Use of UPINs on claims will be phased out completely by May 23, 2007, in Medicare's transition to the National Provider Identifier (NPI) as required under the Health Insurance Portability & Accountability Act. Since Jan. 3, 2006, Medicare systems will accept claims with an NPI, but an existing legacy Medicare number must also be on the claim.

Jury Deadlock: The jury in the second trial of the federal government's long-running case against a Tenet Healthcare Corp. San Diego hospital for what prosecutors alleged was the use of physician relocation agreements to pay kickbacks for patient referrals has deadlocked, as did the jury in the first trial, Tenet announced in a statement April 4. The second trial, which began in May 2005, lasted even longer than the first, but both ended in similar fashion – with jurors telling U.S. District Judge M. James Lorenz they were unable to reach a verdict against Alvarado Hospital Medical Center Inc., its former chief executive officer Barry Weinbaum, and Tenet HealthSystem Hospitals Inc. Lorenz declared a mistrial. It's not clear whether the government will seek a third trial.

Improper Consultations: Three-fourths of physician consultation services billed to Medicare in 2001 did not meet program requirements, costing the federal government almost $1.1 billion in improper payments, according to a March 29 report from the Department of Health and Human Services Office of Inspector General (OIG). In its report, "Consultation in Medicare: Coding and Reimbursement," the OIG's Office of Evaluation and Inspections found that 45% of consultations billed to Medicare used an incorrect type or level of consultation code. In 19% of the cases, Medicare allowed reimbursement for services that did not meet the definition of a consultation. A further 9% did not have supporting documentation. The report (OEI-09-02-00030) is available at *www.hhs.oig.gov*.

Overbilling Settlement: UHS of Delaware Inc. will pay the United States $1.5 million to resolve allegations that it overbilled Medicare in cost reports it filed on behalf of a behavioral health center in Georgia, under terms of a settlement announced April 10 by the U.S. attorney's office for the Eastern District of Pennsylvania. A subsidiary of Universal Health Services Inc. (King of Prussia, PA), UHS of Delaware manages hospitals, behavioral health facilities, and ambulatory surgical and radiation centers nationwide. The government alleged that the Medicare cost reports the company filed for fiscal year 1997, 1998, and 1999 on behalf of Turning Point Care Center in Moultrie, Georgia, included $1,497,036 in nonreimbursable costs.