G-2 Compliance Report

WASHINGTON G-2 REPORTS

Vol. VIII, No. 10, Nov-Dec 2006

For Hospitals, Laboratories and Physician Practices

OIG Sets Enforcement Priorities For 2007

The Department of Health & Human Services Office of Inspector General (OIG) will examine compliance with the Deficit Reduction Act of 2005 (DRA) and ensure proper implementation of Medicare Part B drug pricing regulations and Part D drug benefit provisions during 2007, the agency says in its work plan for next year.

The work plan, released each fall, serves as a blueprint for what the OIG intends to focus on in the coming year. While many of the planned reviews are carryovers, the OIG also announces some new enforcement areas each year.

For example, in fiscal year 2007, the OIG will investigate whether inpatient rehabilitation facilities are complying with admissions and billing regulations based upon the DRA's alterations to the compliance threshold criteria. The OIG will also evaluate methodologies used by drug manufacturers to calculate their average manufacturer price for the Medicaid drug rebate in light of DRA modifications.

The OIG also plans to continue its review of several issues related to laboratory and pathology services, according to the work plan. Specifically, the agency will examine: ➥ *p. 2*

Inside this issue

House Bill Would Replace CLIA Cytology PT Program

Legislation introduced in the House shortly before Congress recessed at the end of September would replace the existing cytology proficiency testing program under the Clinical Laboratory Improvement Amendments (CLIA) with an alternative that does away with annual PT of pathologists and laboratory professionals who do Pap smear screening and diagnosis.

The bill instead would require annual continuing medical education that provides opportunities for improving screening and interpretation skills. The College of American Pathologists (CAP), which is spearheading the lobbying campaign for the legislation, says this approach is modeled on that used by the Food and Drug Administration to assure mammography quality. CAP is opposed to the existing CLIA cytology PT program, saying it is based on outdated science and clinical practice and needs a fundamental overhaul.

On the regulatory front meantime, the Centers for ➥ *p. 9*

OIG Sets Enforcement Priorities, *from p. 1*

- ***Physician pathology services.*** Medicare pays more than $1 billion annually to physicians for pathology services. The OIG will audit the billings for pathology laboratory services performed in physicians' offices to determine if the claims comply with Medicare Part B requirements.

  The College of American Pathologists notes that it continues to alert the OIG and CMS to abuses by physician groups seeking to capture the revenue stream for the self-referrals of pathology services through a variety of arrangements that "circumvent the spirit and intent of the anti-kickback statute and the ban on physician self-referrals under the Stark law." The OIG began its review of these abusive billing arrangements as part of its 2005 work plan but has yet to release any audit results.

- ***Laboratory services rendered during an inpatient stay***. The OIG is continuing to audit the extent to which lab services rendered during an inpatient stay are unallowable. CMS pays for laboratory services that are allowable under Part B based on the clinical diagnostic laboratory fee schedule. A preliminary review of the payment data indicated that $73 million of laboratory services were rendered in hospital settings during inpatient stays during calendar year 2001. The OIG notes that this is a considerable increase in costs over similar services provided in prior periods. The OIG will determine the percentage of those costs that are unallowable.

- ***Medicare pricing of laboratory services***. The OIG will compare Medicare payment rates for certain laboratory tests with the rates of other federal and state health programs and private payers. The study will build upon prior OIG work in which the agency found that Medicare paid significantly higher prices than other payers for certain lab tests. In 2003, Medicare-allowed charges for tests paid under the laboratory fee schedule totaled $3.2 billion.

The OIG will be investigating a variety of payment practices that may be of general interest to all physicians, including:

- ❑ Reviewing relationships between billing companies and physicians to identify the types of arrangements and the impact of the arrangements on physicians' billings;
- ❑ Examining the extent to which providers bill beneficiaries in excess of the Medicare allowed co-payment amount and the awareness of beneficiaries of their rights and responsibilities for provider billing and coverage violations;
- ❑ Evaluating the appropriateness of Medicare services furnished "incident to" the professional services of physicians to determine the extent the services met standards for medical necessity, documentation, and quality of care; and
- ❑ Determining whether the Medicare program has made payments for duplicate claims and examining the current edit process to identify potential duplicate claims.

Resource

- OIG 2007 Work Plan: *www.oig.hhs.gov/publications/docs/workplan/2007/Work%20Plan%202007.pdf*

Tenet Agrees To Five-Year Integrity Agreement

Hospital company Tenet Healthcare Corp. (Dallas) has entered into a corporate integrity agreement (CIA) in conjunction with the $900 million Medicare billings settlement the company reached with the federal government in June.

The five-year CIA establishes annual training requirements and compliance reviews by independent organizations in certain specific areas, according to Tenet. The CIA had been expected since late June when Tenet reached the settlement agreement with the Department of Justice to resolve allegations of unlawful Medicare billing practices.

Under the settlement agreement, Tenet agreed to pay $725 million plus interest over four years and to waive Medicare payments of $175 million to which the company may be entitled.

"We believe the requirements of this corporate integrity agreement are consistent with standards we already live by and principles we strongly believe in," said Tenet President and Chief Executive Officer Trevor Fetter. "Because of the many changes and enhancements we have made at Tenet in the past three years, we already have in place many of the procedures and systems called for by this corporate integrity agreement."

Under the CIA, Tenet will maintain its existing compliance programs, including the oversight role of its board of directors with respect to compliance.

In addition, the CIA includes the following requirements:

- Tenet must maintain companywide quality initiatives in the areas of evidence-based medicine, standards of clinical excellence, and quality measurements;
- Tenet must maintain a companywide compliance program and code of conduct;
- Tenet must formalize in writing its policies and procedures in the areas of billing and reimbursement, compliance with the federal anti-kickback and Stark laws, and clinical quality, almost all of which, the company says, it has in place, with the remainder to be in place soon;
- Tenet must provide a range of general and specialized compliance training to its employees, contractors, and physicians it employs or who serve in medical directorships and/or serve on a Tenet hospital governing board; and

Fraud Control Units Recover $1.2 Billion

States' Medicaid Fraud Control Units (MFCUs) recovered more than $1.2 billion in program funds lost to fraud, waste, and abuse in fiscal years 2004 and 2005 and were responsible for more than 2,200 convictions during the same period, according to a recent Department of Health and Human Services report.

The HHS Office of Inspector General (OIG) also said in its September 28 report that MFCUs were responsible for handling a number of neglect and abuse cases in Medicaid-funded facilities—most notably nursing homes—that did not generate large monetary recoveries, but nonetheless were key to ensuring high-quality healthcare for beneficiaries.

The report—*State Medicaid Fraud Control Units Annual Report, Fiscal Years 2004-2005*—also addressed other MFCU duties, proposals affecting the Medicaid program presented to state legislatures, recommendations for policy and regulation changes to state Medicaid agencies, and participation in joint state-federal enforcement efforts.

Among successful MFCU cases the OIG highlighted in its report was one in Illinois. That state's fraud control unit in 2004 used the results of an Illinois Department of Public Aid audit to launch an investigation against a laboratory that was submitting false claims to the Medicare and Medicaid programs. The lab owner was indicted on 17 counts of fraud and was ordered to pay $3.2 million in restitution and serve 60 months in jail.

- Tenet must engage independent outside entities to provide reviews of compliance and effectiveness in five areas, including Medicare outlier payments, diagnosis-related group claims, unallowable costs, physician financial arrangements, and clinical quality systems.

Resource

- Tenet CIA, available at *www.tenethealth.com*

Plan For Helping Suppliers Raises Kickback Concern

A proposal by a durable medical equipment manufacturer (DME) to underwrite advertising and provide free consulting services for suppliers of its products poses substantial risk of generating disguised kickbacks for referrals for federally reimbursed products, the Department of Health and Human Services Office of Inspector General (OIG) said in an October 10 advisory opinion (No. 6-16).

The OIG said the proposed arrangement clearly would constitute remuneration to DME suppliers, which are in a position to generate federal healthcare business for the requestor, a wheelchair manufacturer, and that the availability and value of the advertising assistance to suppliers would be determined in a way that considered volume and value of the suppliers' past and expected future purchases.

Combined, those elements raise substantial anti-kickback concerns, the OIG said, adding it could impose administrative penalties in connection with the program.

Specifically, the proposed arrangement would provide free advertising for suppliers or underwriting for advertising expenses incurred by suppliers, the opinion stated. In one scenario, the manufacturer said it might reimburse a supplier for advertising it had developed on its own. In another, the manufacturer said it might develop and pay for broadcast advertising on behalf of suppliers, featuring the requestor's products and directing viewers to contact a call center operated by the manufacturer.

The consulting services aspect of the request would involve the manufacturer offering free services, such as claims reviews, claims appeals, and assistance with assessing and documenting patients' medical needs for certain DME.

Overutilization Feared

The OIG said the proposed arrangement threatened to drive overutilization and increase program costs.

"The proposed arrangement would give DME suppliers an incentive to steer patients to requestor's products, even if products from other manufacturers were less expensive or more appropriate," the OIG said, adding the arrangement could amount to unfair competition because the requestor's provision of remuneration would encourage DME suppliers to purchase DME from requestor to the potential detriment of competitor DME manufacturers that do not provide similar unlawful benefits to their customers.

"In short, there is substantial likelihood that the proposed arrangement would be a vehicle to pay unlawful kickbacks," the OIG continued. "Accordingly, we conclude that the proposed arrangement, if implemented, could be subject to sanctions."

Resource

- Advisory Opinion 06-16: *www.oig.hhs.gov/fraud/docs/advisoryopinions/2006/AdvOpn06-16A.pdf*

COMPLIANCE PERSPECTIVES

Lab Institute 2006: Update On Critical Issues

Proposed sites for Medicare's laboratory competitive bidding demonstration are currently under review by the Office of Management and Budget (OMB) and should be announced soon, Linda Lebovic, project officer for the demo, told attendees of Lab Institute 2006 on September 28. The conference, Making Connections Work, was held in Arlington, Virginia.

Once the sites are announced, CMS will hold an open door forum, put together a bidders' package, and hold a special bidders' conference at the selected sites. Lebovic notes that there is a special provision for smaller labs (those with less than $100,000 in demo test annual Medicare payments in the bidding area). Those labs are not required to bid, and if they don't, they will be paid the competitively bid fee schedule for demo tests.

Michael Snyder, Principal, Clinical Lab Business Solutions; Linda Lebovic, Project Officer, Competitive Lab Bidding Demonstration, CMS; Greg Richard, President, Accumin Diagnostics Inc. and formerly Vice President for Managed Care, Quest Diagnostics

"If you're a small business and you see this as an opportunity to grow, you're more than welcome to bid, but then all of the rules will apply to you. So if you bid and win, then you can participate in the demonstration, but if you bid and don't win, then you won't be eligible for Medicare reimbursement for the demonstration tests. So there is a key business decision to be made for small businesses," she said.

Criteria used to select a winning lab include ownership, quality, financial stability, demonstration test bid price, capacity and geographic coverage, the ability to subcontract and refer tests, and antitrust issues.

"Anti-trust decisions will be made by the FTC (Federal Trade Commission) and the DOJ (Department of Justice). We do not have that jurisdiction," said Lebovic. "All I can tell you is what they've told me in trying to get guidelines to put into the bidders' package, and that is, [antitrust] is like pornography—we'll know it when we see it."

Robert Waters, a partner with the law firm of Gardner Carton & Douglas (Washington, DC), told attendees that labs have legitimate reasons to be concerned about lab competitive bidding demo. "Ultimately, there's a problem," he said. "And that is two laboratories comprise more than 60% of market share. This

has pretty profound implications when you think about trying to rearrange the market structure in this area. One of my concerns is perhaps, unwittingly, the government may be party to increasing, rather than decreasing, the concentration in the marketplace, which will be injurious to the government actually getting the kinds of prices that it wants."

In addition, if the purpose of the demonstration is to determine the fees that should be paid, then it ought to include all tests, all laboratories, and all geographic areas, Waters said. "We all know that ultimately, when this is done, the numbers will be used by somebody to say that this is what the fee schedule should look like, so by definition, at the end of the day, whatever results are produced by this demo will not reflect what the market price is."

Waters suggests that maybe it's time to "rethink the problem." If the government's actual goal in launching the competitive bidding demo is to limit excess profit and prevent Medicare from paying substantially in excess of the market price, then the solution should be more targeted, he said.

"Maybe that's what our focus should be," Waters suggested. "Maybe if Medicare is paying substantially in excess for some tests, that's where we should focus our attention. That wouldn't necessarily disrupt the market and reallocate market shares. The path that we're going down is not going to produce accurate cost data nor a process that will be easily implemented. There are no do-overs here. Once you change this marketplace, it is irrevocable."

Reimbursement Pressures

Competitive bidding for lab services is just one example of the reimbursement pressures facing clinical laboratories, noted Greg Richard, president, Accumin Diagnostics Inc., and formerly vice president for managed care for Quest Diagnostics. Among other challenges faced by labs is fair reimbursement of new technologies.

"There is increased rigor being applied to new diagnostic technologies, and I would say it's becoming more similar to the technology assessment applied to prescription drugs," he said. "I think the diagnostics and laboratory industry is facing much more robust scrutiny relative to coverage and reimbursement."

The fact that insurers often have different criteria for assessing new technology

Competitive Bidding Structure

- Two demonstration sites. The demos will have staggered starts and each demo will last three years
- Not based on laboratory's location, but based on beneficiaries who live within competitive bidding area (CBA)
- Excludes hospital inpatient testing and outpatient, as well as physician office lab (POL) testing
- Includes testing provided by independent labs, as well as hospital nonpatient and POL nonpatient testing
- Covers all tests paid under the Medicare Part B clinical laboratory fee schedule except for Pap smears, colorectal cancer screening tests, and new tests added to the lab fee schedule during the course of the demonstration
- Labs with $100,000 or more in demonstration test annual Medicare payments in CBA are required to bid
- Firms with less than $100,000 in demo test annual payments are not required to bid, but will be paid the competitively bid fee schedule for demo tests provided to beneficiaries residing in the CBA (annual payments are capped)
- Labs that are required to bid but do not will be ineligible for Medicare Part B reimbursement for demo tests provided to beneficiaries residing in the CBA
- Labs that bid and do not win will be ineligible for Medicare reimbursement for demo tests provided to beneficiaries residing in the CBA
- Labs that bid and win will be paid under one competitively set demonstration Medicare Part B clinical laboratory fee schedule for lab tests provided to beneficiaries living in the demo area
- Project Web page: www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMSO23785

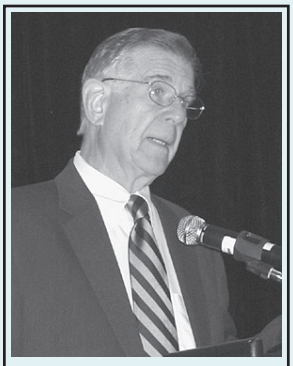
can make this task even more difficult, noted Richard. He advises working closely with manufacturers to develop a reimbursement and coverage strategy and involving the health plan medical director and the new technology assessment committees within the insurance companies early on.

> ***"If you think things have been bad in the past few years in terms of pressures to cut payment for labs, it's only going to get worse. Because of the demographic trends... there's going to be a tremendous fight among providers for their share of the pie."***
> ***—Alan Mertz***

"We would speak with these committees prior to and sometimes well in advance of launching a new technology," he explained. "They appreciated us not throwing things over the transom late in the budget cycle. We tried to give them a heads up on what's coming."

Healthcare Debate On Capitol Hill

It is unlikely that any major healthcare legislation involving Medicare will occur over the next two years, predicted Rep. Pete Stark (D-CA), ranking member of the House Ways and Means subcommittee on health. "We're not going to do a whole hell of a lot in the next two years legislatively," Stark told participants at Lab Institute 2006. "No matter who is in charge, we're still going to have the White House occupied by the same people, and they would like to dismantle Medicare, so we're not going to get very far in reforming it."



Rep. Pete Stark

If Democrats gain control of the Senate or the House, they could prevent major damage from being done, but are unlikely to approve any major new initiatives in healthcare, Stark said.

The issue of competitive bidding for labs is troubling and somewhat confusing, acknowledged Stark. "I think the system is working well as it is," he said. "[Labs] are able to compete effectively. This seems like an overblown effort to basically privatize Medicare. I'd like to make sure Medicare stays the program with the broadest choice and the lowest overhead."

The fact that there is unlikely to be any major Medicare changes in the next couple of years may actually be a good thing for labs if it prevents them from being targeted for further cuts or an extension of the current freeze on the clinical lab fee schedule, noted Alan Mertz, president of the American Clinical Laboratory Association (ACLA).

Alan Mertz

However, Mertz believes there is a good chance that legislation will pass in the lame duck session of Congress that will cancel the scheduled reduction in Medicare payments to physicians, which is currently scheduled to take effect January 1.

There is even some possibility of a small increase for the physician fee schedule sustained growth rate, perhaps 0.5% or 1%, tied to some kind of performance measure, he added, noting there is bipartisan support for such a move.

"If you think things have been bad in the past few years in terms of pressures to cut payment for labs, it's only going to get worse," said Mertz. "Because of the demographic trends, going from 40 million Medicare beneficiaries to almost 80 million in the next 10 years, there's going to be a tremendous fight among providers for their share of the pie."

Mertz echoed comments made by Thomas MacMahon, chairman and CEO of LabCorp, who urged labs to set aside their differences and work together as an industry to ensure labs are paid fairly.

As for competitive bidding, Mertz said he has tried to make the case on Capitol Hill that lab tests are not commodities, but are complex services that play an important role in treatment of patients. He likened it to CMS competitively bidding physician services in the Washington, D.C., area. "We could pick one group practice in Washington to serve all two million Medicare beneficiaries in the area," he said. "The doctors could probably charge a little less because they'd have so much business. But what would happen to the beneficiaries? They would have no access; they couldn't get in for two years, and quality would almost certainly suffer."

Despite all the problems with lab competitive bidding, CMS is moving forward with the demo and says it will announce the winning bids in January, with the first demo to begin in April. However, as of mid-October, the agency had yet to announce the two demo sites.

ICD-10 Transition

Mertz also addressed the transition from ICD-9 coding to ICD-10. A health information technology bill (HR. 4157) passed by the House mandates a transition from ICD-9 to ICD-10 beginning Oct. 1, 2010. A Senate health IT bill is silent on the issue.

Currently, under ICD-9, there are about 8,000 diagnosis codes, while ICD-10 would involve more than 130,000 codes, explained Mertz. Because labs must rely on physicians to provide the correct diagnosis code in order to bill for their services, such an expansion will be very difficult for the lab industry, he said, noting that ACLA is pushing for a longer transition to educate physicians. The group favors implementation of ICD-10 no sooner than 2012.

Award Winners Announced

Washington G-2 Reports/IOMA announced the recipients of two annual awards at this year's Lab Institute during a presentation ceremony September 28.

Michael Laposata, M.D., Ph.D.

Educator and researcher Michael Laposata, M.D., Ph.D., was honored with the 2006 Laboratory Public Service National Leadership Award, sponsored by Kellison & Co. He is director and chief of the division of clinical laboratories at Massachusetts General Hospital in Boston and is a professor of pathology at Harvard Medical School.

Dr. Laposata was cited for scientific and educational leadership in pathology and laboratory medicine nationally and internationally, including innovative work in interpretive consultation rounds and research on fatty acid metabolism and alcoholism. He also frequently sees patients for coagulation problems.

Arikpo Onda

The Dennis Weissman/G-2 Reports' Scholarship Award for Excellence in the Clinical Laboratory Sciences (CLS) was presented to Arikpo Onda at the blood center at Rush University Medical Center in Chicago for her leadership potential and excellence in the clinical lab sciences curriculum. She is vice president of the CLS student club at Rush University and has been active in motivating classmates and organizing events. She recently began her tenure as the student forum chairperson for the American Society for Clinical Laboratory Science-Illinois.

CLIA Cytology PT Program, *from p. 1*

Medicare and Medicaid Services (CMS) recently told the Clinical Laboratory Improvement Advisory Committee (CLIAC) that a proposal for revised CLIA cytology PT rules will not be ready until at least February 2007. As a result, PT testing next year will continue under the current rules. There are two nationally approved PT providers: the College of American Pathologists and the American Society for Clinical Pathology. The Maryland health department runs an approved program for specimens of state residents.

At a CLIAC meeting earlier this year, CMS committed itself to revamping the existing PT rules, including addressing such issues as the frequency of testing, scoring, penalties, and diagnostic categories. CMS and CDC formed a workgroup to consider changes in the regulations, as well as a timeline for public comment.

CMS agreed to revisit the PT rules not long after the House passed a bill to suspend the current program until certain changes were considered. The agency said that while revisions were in the works, it would use PT to emphasize improvement versus punitive sanctions. The current rules were written in 1992, but CMS only began nationwide enforcement in January 2005.

Company May Disburse P4P Payment On Behalf Of State

In an advisory opinion released October 6, the Department of Health and Human Services Office of Inspector General (OIG) told a managed care services company that it would not impose sanctions over its agreement with a state Medicaid agency to disburse pay-for-performance financial incentives to physicians on behalf of the state's Medicaid program (Opinion No. 06-15).

The company's duty under the arrangement is to act as the payment administrator for the state's pay-for-performance (P4P) program, the OIG said in the opinion.

Under the circumstances of the arrangement, the federal anti-kickback statute is not implicated, the OIG said. The payments made to providers are funded by the state, not the company; the company has no control or discretion over the payments; and the parties have taken "meaningful steps to minimize any misimpression by physicians" that the company is paying them for referrals of Medicaid business," the OIG explained.

The OIG generally redacts the identifying information of requestors and other parties from its advisory opinions. However, the document did say that the requestor's parent company operates businesses in the pharmaceutical, medical supply, and healthcare technology areas, among others.

The requesting company agreed to develop and implement a disease management program, including a physician pay-for-performance program, on behalf of the agency. The state agency sought proposals from a number of providers of disease management services and chose the requestor pursuant to a competitive bidding program, the OIG said.

Through the P4P component of the program, the state Medicaid agency provides payments to physicians for ordering or recommending certain specified services. Under terms of the agreement, the company is to disburse the state-approved financial incentives to Medicaid providers participating in the P4P program in the form of checks drawn from its own bank account. The funds come from the state's Medicaid program, and the company has no discretion to set or revise the payment amounts.

The company is paid only for the administrative services it provides, the OIG said, and must return any payments that are not disbursed to physicians. The company must also provide the state agency with detailed reports on all of the disbursements "from time to time," the OIG said.

Substance Over Form

The anti-kickback statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services that are reimbursable by a federal healthcare program, the OIG said.

The question of whether the arrangement violates the anti-kickback statute arises "because of the appearance" that the company is making payments to physicians by using P4P checks drawn from its own bank account.

Although the problem could be resolved by drawing payments directly from a state bank account, the Medicaid agency indicated that state law governing its Medicaid program prohibits such direct payments, the OIG said.

Nevertheless, "[i]t is the substance—not the form—of an arrangement that governs under the anti-kickback statute, the OIG said. Acting as an administrator for the state's P4P program does not implicate the federal statute, the OIG concluded.

The OIG added that the opinion does not address the company's role in designing the P4P program or other elements of the agreement.

Resource

- Advisory Opinion No. 06-15: *www.oig.hhs.gov/fraud/docs/advisoryopinions/2006/Adv-Opn06-15A.pdf*

GAO: CMS Should Develop New Ways To Allocate MIP Funds

The Centers for Medicare & Medicaid Services (CMS) should develop a new approach for allocating funds to the Medicare Integrity Program (MIP) to ensure the money goes toward the most effective activities, the Government Accountability Office (GAO) said in an October 6 report.

Funding for each of the five MIP activities has increased each year since 1997, but GAO said the size of the increases varied by activity. CMS told GAO that MIP funds historically have been allocated based on past funding levels, and GAO found that CMS had no qualitative data by which to compare activities' effectiveness relative to funding.

Furthermore, GAO found that CMS had not assessed whether MIP funds were distributed adequately to MIP contractors for each of the five program areas—audit, medical review, secondary payer, benefit integrity, and provider education. GAO recommended that CMS base future MIP funding allocations on the effectiveness of each of the five MIP activities, on contractors' workload, and on Medicare program vulnerabilities.

Allocating Funding

GAO said it was concerned that funding be allocated appropriately for emerging vulnerabilities that could arise from the Part D program and noted that contracting reform would mean different program integrity duties for contractors.

"The agency's funding approach is not geared to target MIP resources to the activities with the greatest impact on the program and to ensure that the contractors have funding commensurate with their relative workloads and risk of making improper payments," the report stated.

CMS agreed with the GAO's findings and recommendations, although the Medi-

care agency noted it had quantitative measures for two of its MIP activities that could provide some measure of effectiveness. Nevertheless, CMS also said such a measure could not "serve as the sole basis for informing funding decisions."

The report was prepared for Senate Finance Committee Chairman Charles Grassley (R-IA). GAO said in the report that questions about the effectiveness of MIP funding were raised when the FBI reported in 2005 that it could not provide adequate accounting for federal funding it received to conduct healthcare fraud and abuse investigations.

Resource

❖ GAO report: *www.gao.gov/new.items/d06813.pdf*

CMS Announces Potential 2007 Quality Measures

The Centers for Medicare and Medicaid Services on October 16 released a list of 86 quality measures, from which it will choose the final measures that will put into place in 2007 under the Medicare physician voluntary reporting program (PVRP).

As part of its overall quality improvement efforts, CMS launched the physician voluntary reporting program on Jan. 1, 2006, with 16 quality measures. Under the program, physicians who choose to participate help capture data about the quality of care provided to Medicare beneficiaries.

In selecting the original 16 measures, CMS sought to cover as many physician specialties as possible given the measures that were available. The original measures covered 19 of the 39 Medicare physician specialty designations. The new list covers 32 specialties; seven do not yet have measures endorsed by the Ambulatory Care Quality Alliance or the National Quality Forum.

Included in the list of 86 are four quality measures that fall under the specialty of hematology: cytogenetic testing on bone marrow; iron stores prior to erythtopoietin/darbepoeitin therapy; multiple myeloma treated with biophosphonates; and flow cytometry evaluation in chronic lymphocytic leukemia patients.

CMS expects to announce the final measures for 2007 prior to January 1.

Resource

❖ CMS Physician Voluntary Reporting Program: *www.cms.hhs.gov/PVRP/*

Fraud Savings: The Healthcare Fraud and Abuse Control (HCFAC) program has returned more than $8.8 billion to the Medicare Trust Fund since 1997 and returned more than $1.5 billion to the trust fund in 2005 alone, according to the annual report on the enforcement program released by the Department of Health and Human Services Office of Inspector General. In addition, HCFAC returned more than $63 million in federal Medicaid dollars to the Centers for Medicare & Medicaid Services, noted the report, which is available at *www.oig.hhs.gov/publications/docs/hcfac/hcfacreport2005.pdf.*

LabCompete 2007

Washington G2/IOMA's Inaugural LabCompete Conference—Strategies for 2007 and Beyond. December 6-8, 2006 at the Sheraton Wild Horse Pass Resort and Spa in Chandler, AZ.

Keynote Address: Where is your Lab Going Now that it's Faced with a Duopoly? David Nichols, President of the Nichols Management Group

Don't miss these "How To Compete" workshops for executive level lab management.

1. Lab MBA, The first of its kind business decision support curriculum designed by lab executives for lab executives
2. Show me the money: the art of the deal—what investors and partners look for (and avoid) as they finance, merge, acquire, divest, spin-off
3. Sales and marketing toolbox—how to hire, train, compensate and retain top sales people while delivering your market message
4. Integrating web connectivity and maintaining the competitive edge

Thirty speakers. Industry leaders. Dealmakers. The New Rules for Competition. Come to LabCompete. For complete program information and a brochure go to *www.g2reports.com*

Ambulance Company Settles: American Medical Response Inc., an ambulance company based in Austin, Texas, has paid the federal government $9 million to settle allegations that it violated the False Claims Act by providing discounted ambulance transports to Texas hospitals and healthcare facilities in exchange for referrals, the company and the Department of Justice announced in separate releases October 5. The settlement in a Texas federal district court resolves allegations that the company provided or offered inducements to Texas hospitals under "swapping arrangement" contracts from 1994 through 2001. The contracts give medical facilities discounted transport in return for referral of all or some of the ambulance transportation of patients discharged from hospitals. The charges are billed to Medicare.

G-2 Compliance Report Subscription Order or Renewal Form

❑ ***YES***, enter my one-year subscription to the ***G-2 Compliance Report (GCR)*** at the rate of $419/yr. Subscription includes the ***GCR*** newsletter, The G-2 Compliance Resource Guide, the Quarterly Compliance Tips on Disk, and electronic access to the current and all back issues at www.ioma.com/g2reports/issues/GCR. Subscribers outside the U.S. add $50 postal.*

❑ I would like to save $184 with a 2-year subscription to ***GCR*** for $754*

❑ ***YES***, I would also like to order *Diagnostic Imaging Compliance, Coding & Reimbursement Manual* for just $595 (G-2 subscribers price $545) 1777C

Please Choose One:

❑ Check Enclosed (payable to Washington G-2 Reports)

❑ American Express ❑ VISA ❑ MasterCard

Card # _____ Exp. Date _____

Cardholder's Signature _____

Name As Appears On Card _____

Ordered by:

Name _____

Title _____

Company/Institution _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

e-mail address: _____

*By purchasing an individual subscription, you expressly agree not to reproduce or redistribute our content without permission, including by making the content available to non-subscribers within your company or elsewhere.

Mail to: Washington G-2 Reports, 3 Park Avenue, 30th Floor, New York, NY 10016-5902. Or call 212-629-3679 and order via credit card or fax order to 212-564-0465

GCR 11-12/06

 G-2 Compliance Report (ISSN 1524-0304) is published by Washington G-2 Reports, 3 Park Avenue, 30th Floor, New York, NY 10016-5902. Tel: 212-244-0360. Fax: 212-564-0465. Order line: 212-629-3679. Web site: www.g2reports.com.

Kimberly Scott, Managing Editor; Dennis Weissman, Executive Editor; Janice Prescott, Sr. Production Editor; Perry Patterson, Vice President and Group Publisher; Joe Bremner, President.

Receiving duplicate issues? Have a billing question? Need to have your renewal dates coordinated? We'd be glad to help you. Call customer service at 212-244-0360, ext. 2.