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Compliance Report



Vol. VI, No. 3, March 2004

For Hospitals, Laboratories and Physician Practices

S.C. Hospital To Pay \$9.5 Million To Resolve Self-Disclosed Problems

1n one of the largest settlements under the Health and Human Services' Office of Inspector General's (OIG) Provider Self-Disclosure Protocol, St. Francis Hospital Inc. (Greenville, S.C.) has agreed to pay nearly \$9.5 million to resolve Medicare billing improprieties from 1997 through 1999.

Bon Secours Health System Inc., which bought St. Francis in 2000, discovered the billing problems and launched an internal investigation that revealed significant error rates and systematic documentation lapses in its Medicare billings. Bon Secours brought its findings to the OIG under the self-disclosure protocol, which encourages providers to voluntarily report evidence of potential fraud and compliance programs in their organizations.

Due in part to the fact that St. Francis self-disclosed the billing problems, OIG recovered damages in a much lower amount than the treble damages and penalties that it is authorized to seek. Further, because this case involves successor liability and because the hospital voluntarily self-reported its compliance problems and quickly took steps to resolve the problems—including establishing an internal audit program and compliance program—the OIG decided St. Francis would not have to enter into a corporate integrity agreement or other compliance measures.

Acting Inspector General Dara Corrigan says this settlement is a good example of how the self-disclosure protocol benefits both the **→ p. 2**

HHS Clarifies Stance On Discounts For Uninsured Patients

Despite belief to the contrary, hospitals can provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations, Health and Human Services Secretary Tommy Thompson said in a February 19 letter to the American Hospital Association.

Nothing in federal Medicare regulations prohibits hospitals from providing price breaks to uninsured and underinsured patients who can't afford their hospital bills, Thompson wrote to AHA President Richard Davidson in response to an AHA letter to HHS in 2003. AHA had told HHS that it was willing to give price breaks to uninsured, "self-pay" patients, but the group urged HHS to clear away any "underbrush of regulations" standing in the way. AHA said in its December letter that several federal **→ p. 9**

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Gabriel Imperato,
Esq.

Self-Disclosed Problems, from p. 1

integrity of government health care programs and providers who discover and report evidence of potential fraud and overbilling in their organization. Since 1995, 205 providers have voluntarily self-disclosed fraud and compliance problems to the OIG, resulting in more than \$63.2 million in monetary recoveries.

Obligation To Return Overpayment

While the settlement in this case is pretty hefty for a self-disclosure matter and would tend to make providers shy about self-disclosure, Gabriel Imperato, an attorney with Broad & Cassel (Fort Lauderdale, FL) notes that if a provider determines it has received a known overpayment from government payer programs, there is an obligation to return the overpayment.

“It does not necessarily have to be to the OIG, as it can be to the carrier or intermediary or even the Department of Justice in certain circumstances,” Imperato tells *GCR*. “These are decisions that the provider should make with competent counsel and legal advice. I would add that providers should not let the decision on self-disclosure be dictated by how much may have to be returned to the government because, not only is this type of response fraught with other potential liabilities, it must be presumed that the government, in a self-disclosure situation, would take into account the provider’s ability to pay.”

Resources

- ❖ Office of Inspector General: 202-619-1343
- ❖ Gabriel Imperato: 954-764-7060 🏠

11 Indicted On Motorized Wheelchair Fraud Grassley Calls For Review Of Policies

A federal grand jury in Dallas has indicted 11 individuals, including a medical doctor, on charges of defrauding Medicare through inappropriate billing for motorized wheelchairs.

Lloyd McGriff, M.D., a Dallas physician, and 10 wheelchair suppliers allegedly submitted fraudulent claims of more than \$36 million to Medicare for motorized wheelchairs, concealed the submission of the bogus claims, and diverted the funds they received from Medicare for their own personal use and benefit, according to the indictments announced February 5.

Prosecutors said that, under the scheme, if any medical equipment was delivered to the Medicare beneficiaries, it was a less expensive scooter, while the physician and suppliers submitted a claim for the more expensive motorized wheelchair to Medicare. Investigators dubbed their project “Operation Roll Over.”

McGriff and Ignatius Chuka Ogba, owner of Universal Health Services (Dallas), were accused of submitting \$4.5 million in false billings, the largest amount of claims. Uko Edet Essien, owner of Medical Equipment & Supplies of North America (Dallas), is accused of filing \$4 million in bogus claims. Emmanuel Uko Akpan, owner of Stat Medical and General Services (Garland, TX) was charged with

filing \$1.5 million in false billings. Others named in the indictment include Patrick Oke Ekong and Affiong Ekpeme Ekong, owners of Upakeii Corp. (Richardson, TX); Michael Nsekepong, owner of Tachy Medical Equipment and Supplies (Dallas); and Donatus Daniel Usanga, owner of Mendus Medical Equipment and Supplies (Dallas).

In a related development, Senate Finance Committee Chairman Charles Grassley (R-Iowa) said he plans to hold hearings on the issue of power wheelchair fraud. In a February 13 letter to the head of the General Accounting Office, Grassley noted that over the past four years, overall Medicare spending increased by about 11%, while reimbursement for motorized wheelchairs increase almost 450%.

“No one who qualifies for a Medicare-financed wheelchair should be denied one,” Grassley said. “The questions are whether the reimbursement rules are too lax, whether government oversight of those rules are too weak, and if so, whether some providers are exploiting those circumstances to make a fast, dirty buck.”

Resources

- ❖ U.S. Attorney for the Northern District of Texas: 214-659-8600
- ❖ Sen. Charles Grassley: 202-224-3744 🏠

OIG Approves Blood Glucose Supply Waivers

A proposal to waive cost-sharing for blood glucose equipment and supplies used by Medicare beneficiaries in a clinical trial would not constitute grounds for penalties, the Health and Human Services Office of Inspector General (OIG) said in an advisory opinion issued February 9.

The requestor of the opinion, a nationwide supplier of blood glucose testing products, wanted to know whether the waiver would violate the anti-kickback statute. The OIG concluded that, while the proposed arrangement could potentially generate prohibited payments under the statute, it would not impose administrative sanctions.

The Medicare beneficiaries in question are participants in the Bypass Angioplasty Revascularization Investigation 2 Diabetes clinical trial (BARI 2D), sponsored by the National Heart, Lung, and Blood Institute (NHLBI). All BARI 2D patients will be required to self-monitor their blood glucose levels.

Under the proposed arrangement, the clinical units will transmit to the requestor copies of prescriptions for self-monitored blood glucose supplies being used by BARI 2D patients. The requestor will provide the blood glucose supplies and seek reimbursement from Medicare, Medicaid, or other private or public health insurance programs.

In its advisory opinion, the OIG notes that glucose monitoring is vital to diabetes management, and the goal of BARI 2D is to have

the supplies available to all participants. Moreover, NHLBI believes that waiving cost-sharing obligations for the enrollees will promote and enhance patient participation throughout the study, the opinion says.

According to the OIG, waiving cost-sharing obligations for enrollees in clinical trials encourages enrollees to participate in the studies. Alternatively, payments to providers and participating patients potentially present a risk of fraud and abuse.

Nevertheless, the OIG concluded that in the circumstances presented in this request, it would not impose civil monetary penalties, since the proposed arrangement reasonably accommodates the needs of an important government-sponsored scientific study without posing a significant risk of fraud and abuse.

The OIG noted, however, that many clinical trials are managed or sponsored by pharmaceutical companies or other private interests with no government involvement. Since commercial or private studies pose significantly different risks, routine waivers of cost-sharing obligations to enrollees would not necessarily be sheltered from CMPs or sanctions under the anti-kickback statute without an applicable exception, the advisory opinion warned.

Resources

Advisory Opinion 04-01: <http://oig.hhs.gov/fraud/docs/advisoryopinions/2004/ao0401G.pdf>. 

HHS Urged To Boost Funding For Fraud Oversight

Rep. Fortney (Pete) Stark (D-CA) has asked Health and Human Services Secretary Tommy Thompson to increase funding for oversight of the Medicare program, particularly in light of new mandates included in the Medicare reform law.

The additional funding should come out of the \$1 billion dedicated for implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Stark

said in a February 6 letter to the secretary.

According to Stark, the new law will “radically increase” the number of providers, contractors, and transactions under the Medicare program. While the OIG has been successful in enforcing, investigating, and evaluating activities under the program, Stark said the law would impose new obligations.

“Funding for the OIG must be increased suf-

Court Upholds Sentence Of Lab Exec

William Thurston, former executive of Damon Clinical Testing Laboratories Inc. (Needham, MA) must serve his full five-year prison term despite his charitable works, an appeals court ruled February 4 in revisiting an earlier decision.

Thurston was convicted of defrauding the Medicare program of more than \$5 million. In August 2003, the U.S. Court of Appeals for the First Circuit held that a district court judge had been impermissibly lenient in imposing a three-month sentence and extended Thurston's sentence to five years.

The appeals court noted that standards for reviews of sentences had been changed by the Prosecutorial Remedies and Tools Against the Exploitation of Children Today Act of 2003 (PROTECT). In its new action, the court said certain parts of the discussion of the PROTECT law and its effect on Thurston's argument for a lesser sentence needed to be revised. The appeals court withdrew the previous opinion to reflect the changes, but left the remaining parts of the original opinion in place.

ficiently to allow them to effectively continue their oversight responsibilities," notes Stark, who said he was disappointed by the department's fiscal year 2005 budget request, which contained no increase in funding for health care fraud and abuse activities.

Altogether, the budget proposed a \$1 million boost for the OIG, from \$199 million in 2004 to \$200 million in 2005. Stark and Senate Finance Committee Chairman Charles Grassley (R-IA) recommended that the OIG funding be increased \$15 million in 2004 and \$25 million in 2005 with funds drawn from the \$1 billion given to the CMS to implement the Medicare reform law.

Resources

- ❖ HHS fiscal 2005 budget proposal: www.hhs.gov/budget/05budget/fy2005bibfinal.pdf.
- ❖ Fortney (Pete) Stark: 202-225-5065 🏠

Medicare To Pay Some Qualified Rural Labs On Reasonable Cost Basis As Of July 1

 Outpatient laboratory tests performed by certain rural hospitals with fewer than 50 beds will be paid on a reasonable cost basis beginning July 1, 2004.

The Medicare Prescription Drug, Improvement, & Modernization Act of 2003 (DIMA) eliminated the application of the clinical laboratory fee schedule for hospital outpatient laboratory testing by a hospital laboratory with fewer than 50 beds in a qualified rural area for the two-year cost-reporting period that begins July 1, explains Transmittal 100, issued February 13.

The new policy expands on a similar provision for critical access hospitals in the 1999 Balanced Budget Refinement Act and applies to a limited universe of rural facilities—those hospitals that are located in qualified rural areas and have less than 50 beds.

Payment for these hospital outpatient laboratory tests will be based on reasonable costs without coinsurance and deductibles during the applicable time period.

A qualified rural area is one with a population density in the lowest quartile of all rural county populations, the Centers for Medicare & Medicaid Services explains in the transmittal. A file of eligible zip codes will be available to fiscal intermediaries on or about May 15.

According to CMS, reasonable costs will be determined by using the ratio of costs to charges for the lab cost center times the billed charges for outpatient lab services for cost-reporting periods beginning after July 1, 2004, and before July 1, 2006.

In deciding whether lab services are furnished as part of the hospital's outpatient services, the same rules now used for outpatient critical access hospital services will apply.

For more information, contact Linda Easter at CMS, 410-786-6978.

Resource

- ❖ Transmittal 100 (Feb. 13, 2004) available at www.cms.hhs.gov/manuals/pm_trans/R100CP.pdf 🏠

COMPLIANCE PERSPECTIVES

Liability Of Health Care Providers Who Rely Upon Advice Of Consultants *Lessons Learned From United States v. Ernst & Young*



W. Bradley Tully is a principal in the health care law firm Hooper, Lundy & Bookman Inc. (Los Angeles, CA)

The Department of Justice's recently filed suit seeking triple damages and civil penalties against accounting giant Ernst & Young¹ is something more than just another of the constant stream of False Claims Act (FCA) suits in the health care industry. Since Ernst & Young did not itself submit the claims that are the subject of the government's suit, the suit presents the very unusual situation in which a health care consulting firm has been challenged under the FCA for having given advice that, when relied upon by its client, "caused" false claims to be submitted or helped to conceal false claims.

The Ernst & Young suit will prove controversial and cause consternation in the health care consulting community, since it arguably makes consultants liable for the actions of their clients and expands a consultant's obligations beyond the duty of care owed to the client to also create duties to the government. On the other hand, the government may contend that the core meaning of the case is a less controversial principle that consultants are not free to conspire to assist their clients to defraud the Medicare program.

This article will briefly outline the government's theories in the Ernst & Young suit and will examine the circumstances for which a client will be liable under the FCA or for an overpayment, despite their reliance on the advice of consultants. The article will then conclude with a discussion of the steps that health care providers can take to best protect themselves in connection with advice they obtain from their consultants.

The Ernst & Young Suit

The Department of Justice alleges that Ernst & Young engaged in two separate courses of improper conduct. First, according to the government's complaint, the accounting firm, as part of a series of charge master reviews, recommended billing practices to four of its hospital clients that caused Medicare to pay for unnecessary laboratory testing. More specifically, Ernst & Young allegedly recommended to the hospitals that they increase their Medicare revenues by billing or continuing to bill separate charges for certain complete blood count (CBC) indices that were performed automatically and without a requisite physician's order whenever a CBC was ordered.

The government also contends that the accounting firm prepared "misleading" independent billing reviews regarding billing for CBC indices for five other hospitals that were being investigated by federal authorities for alleged Medicare billing fraud. These hospitals had received billing advice from the billing consultant firm Metzinger Associates, which the government believed to be questionable and were asked by the government to have the advice and their billings reviewed by independent professional advisors as an alternative to an OIG review.

Ernst & Young represented the hospitals in this independent review process and submitted reports to the government in connection therewith that the government contends were recklessly created and submitted with the effect of misleading the United States as to the extent of improper billing. Although the re-

¹ *United States v. Ernst & Young LPP*, E.D. Pa., No. 04-cv-00041, filed 1/5/04.

ports were created after the bills had been submitted, the government contends they are actionable under the FCA on the ground that the reports were submitted in support of false claims and to reduce the clients' liability for false claims.

What is obviously unusual about the suit is that Ernst & Young is being sued under the FCA, even though it never billed the government for any of the claims at issue. Such an action is possible because the FCA not only applies to persons who submit false claims, but also encloses within its mantle of liability those who "cause" false claims to be submitted. Traditionally, this "causes to be submitted" branch of the FCA has been used to establish liability on the part of corporate managers who mastermind frauds committed by their companies against the government. They are found liable not because they themselves submitted false claims, but because they caused their organization to do so.

However, Ernst & Young is not a corporate manager, but is instead an outside (and presumably independent) consultant. It gives professional advice to its clients, who it knows will rely on it for its expertise in areas that the client is presumably not in a position to itself competently evaluate. Since Ernst & Young knows that its clients will rely on its advice, the government's view is that it "causes" its clients' actions and therefore, in an appropriate case, can be held responsible under the FCA for claims submitted by its clients.

Liability Of Client For Consultant's Work

Despite the challenge being made to Ernst & Young, the focus of this article is not on the liability of consultants, but rather is upon the potential liability of a provider that has submitted claims in reliance upon the advice of a consultant. Fortunately, a provider will not be liable under the FCA simply for submitting a claim for which it is not entitled to be paid. Instead, the government must also prove "sci-

enter," *i.e.*, that the provider acted with a prohibited state of mind. In the case of the FCA, this means that the provider must have "knowingly" submitted a false claim. For purposes of the FCA, a claim is "known" to be false if the provider has submitted a claim either with actual knowledge that the provider was not entitled to be paid or has acted in deliberate ignorance of, or with reckless disregard for, whether the provider was entitled to be paid.

Obviously, then, a client who has relied in good faith upon the advice of a consultant in submitting claims should not be found to have thereby violated the FCA.

The "defense" that the provider did not act with such a prohibited state of mind is not technically a defense. Instead, the government is obligated to

prove as a substantive element of its case in chief that the defendant acted "knowingly," since that is an express element under the FCA itself. The government has the burden on that. Evidence of advice from a consultant (or, in an appropriate case, from legal counsel), of course, is helpful in negating any evidence that may be produced by the government, but the "defense" that the provider did not act knowingly does not fail simply because the client did not obtain independent advice.

On the other hand, the fact that advice was sought and obtained does not automatically bar FCA liability, and there have been cases in which the government has alleged that a provider has sought to submit false claims and used a consultant, in effect, as an accomplice. When the government attempts to break down a defense of reliance on a consultant's advice, it will typically attempt to show either that facts material to the consultant's conclusions were withheld by the provider from the consultant or that the provider was otherwise aware of facts that should have caused it to know that it was submitting false claims and that it "stuck its head in the sand." Thus, the "ostrich defense" is not an effective strategy under the FCA.

Since Ernst & Young knows that its clients will rely on its advice, the government's view is that it "causes" its clients' actions and therefore, in an appropriate case, can be held responsible under the FCA for claims submitted by its clients.

Since the essence of a false claim is that the government has paid out money that it should not have, a Medicare false claim typically will also be accompanied by an overpayment. However, a provider's exposure to having to repay a program overpayment is governed by slightly different rules than those that govern its FCA exposure, and a provider who has received an overpayment will be obligated to make an appropriate repayment to the government, regardless of whether the provider has acted with the state of mind required in order for its claim to be a false one.

Nevertheless, defenses are sometimes available to the assessment of an overpayment, even where the government's contention that it should not have paid out the monies is correct. These defenses are based upon the essentially similar concepts of "without fault" and "waiver of liability." Pursuant to Section 1879 of the Social Security Act, a provider is entitled to be reimbursed for services rendered when the provider did not know, and could not reasonably have been expected to know, that payment would not be made because of a lack of medical necessity.

Similarly, under the Medicare manuals, a provider is not liable for an overpayment (regardless of whether the issue is one of medical necessity) if the provider is "without fault" with respect to the overpayment. As explained by the manuals, intermediaries and carriers are required to determine whether the provider is liable for any overpayment before instituting any action to collect the overpayment from the provider.

In other words, if it is discovered that a provider was incorrectly paid, the intermediary or carrier must not automatically assume that the provider is not entitled to reimbursement. Rather, the program contractor must deter-

mine whether the provider is without fault. The manuals provide that:

A provider is without fault if it exercised reasonable care in billing for, and accepting, the payment; *i.e.*, . . . on the basis of the information available to it, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct. . . .

However, the provider will have to demonstrate that it acted reasonably. In essence, these are defenses that the provider was not on notice that its claim was faulty — either because the government failed to provide adequate notice of applicable requirements in advance through statutes, regulations, or manual provisions or because, while the provider knew or had notice of the applicable rules, the provider did not have the facts needed for it to be able to apply those standards properly to the particular case at hand. (An example of this latter situation is where a laboratory has billed for a test that is not medically necessary, but the medical necessity determination was made by a physician client of the laboratory without the laboratory having played any role in that decision.)

"Percentage" type arrangements are considered suspect by the government and, although not illegal per se, should typically be avoided since they undermine a consultant's independence by allowing the consultant to participate in the fruits of any wrongful billings.

What Can A Client Do To Protect Itself?

Assuming that a client wishes to rely on a consultant's advice, **Rule No. 1** is that the client will want to ***get the consultant's advice in writing*** so that it will be able to prove that the advice, if incorrect, was not the client's idea. This typically means that the client will have to have gotten the advice in writing at the time it was originally given (when the client believed the advice was good advice). So, Rule No. 1 is really just the general rule that a consultant's advice should always be obtained in writing. Often overlooked, however, is **Rule No. 2, *get the facts that the consultant will rely on to it in writing***. This will prevent the government from establishing later

that the consultant's advice should not have been relied upon since it was not given all of the relevant facts by the client.

Another potentially sensitive issue is how the consultant's compensation relationship has been structured. "Percentage" type arrangements are considered suspect by the government and, although not illegal per se, should typically be avoided since they undermine a consultant's independence by allowing the consultant to participate in the fruits of any wrongful billings. Therefore, ***Rule No. 3 is that percentage compensation arrangements with consultants should be avoided whenever the services being obtained would have***

Providers and billers must follow Medicare and Medicaid "reassignment" rules, which prevent billing/collection agents from being paid on a percentage basis when they are in a position to directly receive payment for the provider's services.

a direct impact on the information contained in the bills that the client would submit.

Most obviously, coding consultants should not be paid on a percentage basis. A "lost charges" consultant would also fit into this category. There is an inherent incentive for abuse in those cases (regardless of the nature of the particular services that would be coded),

and there is no safeguard that would prevent the government from unknowingly paying improper claims. Trying to eliminate percentage arrangements only in those areas that the provider knows have been problematic is unlikely to be a viable strategy. This is because the (many) particular issues with which the government has concerns are constantly shifting, and focusing on what substantive issues have been problematic in the past won't be particularly helpful in identifying the issues that may become problematic in the future.

Generally, however, there should not be a big problem with billing/collection agents being paid on a percentage basis (and, indeed, percentage-based compensation for billers is very common). However, this assumes that the biller/collector would not be involved in the coding, that all coding would be done by provider staff, and that all encountered data is similarly provided by the provider. Moreover, providers and billers must follow Medicare

and Medicaid "reassignment" rules, which prevent billing/collection agents from being paid on a percentage basis when they are in a position to directly receive payment for the provider's services.

The situation is also substantially different when a consultant will review payment denials that a provider has received and will pursue those claims through formal administrative appeals on a contingency-fee basis. In those situations, no payment will be made unless a representative of the Medicare (or other) program (or a tribunal) is convinced that additional payment is due on the basis of the merits.

It would be extraordinarily bold for a consultant to file fraudulent documents in connection with an appeal, but a provider can protect itself from that type of abuse by reviewing the work of the consultant to ensure that everything submitted is accurate. However, even in the above areas where percentage compensation may be permitted, we believe it would be important that the provider follow ***Rule No. 4, that the provider should do what it can to periodically check and verify the consultant's work.***

In addition, it will be important that the provider's contract with its consultant be structured so as to control risks as much as possible. ***Thus, Rule No. 5 is that the agreement between the consultant and the provider should be reviewed and approved by legal counsel and should contain provisions to ensure that the possibility for abuse is reduced to the extent possible.***

Finally, providers must keep in mind that compliance efforts carried out on a piecemeal basis are likely to be less effective than they otherwise could be. Therefore, providers are well advised to follow ***Rule No. 6, that relationships with consultants should be integrated into an overarching compliance program maintained by the provider.***

❖ *W. Bradley Tully can be reached at Hooper, Lundy & Bookman, 1875 Century Park East, Suite 1600, Los Angeles, CA 90067. Phone: 310-551-8111. E-mail: wtully@health-law.com. 🏠*

HHS Clarifies Stance, from p. 1

rules had the unintended consequence of creating possible complications for hospitals if they tried to give special price breaks to uninsured patients or avoided pursuing them if they failed to pay. For one thing, said AHA, hospitals are required by Medicare billing rules to maintain a uniform price structure for all patients. For another, Medicare's bad-debt rules stipulated that hospitals must show that they made reasonable efforts to collect from non-payers.

That is not true, responded Thompson in his letter. "The advice you have been given regarding this issue is not consistent with my

understanding of Medicare's billing rules," he wrote. To clarify the matter, the Centers for Medicare & Medicaid Services and the Office of Inspector General have prepared summaries of HHS policy and posted frequently asked questions online (see excerpts below).

"The guidance shows that hospitals can provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations," Thompson said. "Nothing in the Medicare program rules or regulations prohibits such discounts." 🏠

FAQs On Charges For The Uninsured**Q: Can a hospital waive collection of charges to an indigent, uninsured individual?**

A: Yes. Nothing in the Centers for Medicare & Medicaid Services' (CMS) regulations, Provider Reimbursement Manual, or Program Instructions prohibits a hospital from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured, or medically indigent individuals, if it is done as part of the hospital's indigency policy. By "indigency policy," we mean a policy developed and utilized by a hospital to determine a patient's financial ability to pay for services. By "medically indigent," we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses.

In addition to CMS policy, the Office of Inspector General (OIG) advises that nothing in that agency's rules or regulations under the federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a federal health care program—a highly unlikely circumstance.

Q: What if a hospital wants to discount charges to patients with large medical bills?

A: In the same way that a hospital can waive collection of charges for individuals under its indigency policy, a hospital may also offer discounts to those who have large medical bills. Hospitals have flexibility in establishing their own indigency policies.

The OIG advises that discounts to underinsured patients can raise concerns under the federal anti-kickback statute, but only where the discounts are linked in any way to business payable by Medicare or other federal health care programs. In addition, depending on the circumstances, discounts to underinsured patients may trigger liability under the provision of the civil monetary penalties statute that prohibits inducements offered to Medicare or Medicaid beneficiaries. But again, if no inducement is being offered, neither statute is implicated. The OIG's views on the related issue of reducing or waiving Medicare cost-sharing amounts on the basis of financial hardship is addressed in answers to questions below. Further information on these fraud and abuse issues is available on the OIG Web page.

Q: Does a hospital need to get prior approval from either CMS or its fiscal intermediary before offering discounts? How should discounted charges be reflected on a Medicare cost report?

A: No, a hospital does not need permission before offering discounts. However, the Medicare cost report should reflect full uniform charges rather than the discounted amounts. The hospital should also make the intermediary aware that it has reported its full charges on its cost report.

Source: Centers for Medicare & Medicaid Services 🏠

The complete list of FAQs on uninsured patients is available at www.cms.hhs.gov/FAQ_Uninsured.pdf.

Illinois Hospital Settles Charges Of Pneumonia Upcoding

Shelby Memorial Hospital (Shelbyville, IL) has paid \$1.75 million to the federal government to settle charges that it submitted false claims to Medicare for gram negative pneumonia.

The government filed a lawsuit against Shelby Memorial in February 2002 in which it contended that the hospital had submitted false claims to Medicare since January 1994 using specific diagnosis codes for gram negative pneumonia that were not supported by patients' medical records. The government alleged that the hospital knew or recklessly disregarded the falsity of the diagnosis codes in order to receive a significantly higher reimbursement from Medicare than it would have otherwise received.

While Shelby did not admit to any wrongdoing, it agreed to settle the lawsuit by paying \$1.75 million and to cooperate with the government's ongoing investigation of Medicare fraud.

As part of the civil settlement, Shelby Memorial has entered into a three-year corporate integrity agreement with the Department of Health and Human Services, which commits the hospital to improving its billing procedures.

"Medicare fraud is one of the primary threats to the continuing viability of the Medicare system," said Jan Paul Miller, U.S. Attorney for the Central District of Illinois, in announcing the settlement. "Accordingly, we must carefully scrutinize hospitals who bill the federal government for services to Medicare patients to ensure that the hospital follow the medical coding guidelines. These guidelines are specifically designed to protect every taxpayer's investment in the Medicare system. Failure to comply with these guidelines is a serious violation of federal law that will result in severe penalties."

Resource

❖ U.S. Attorney for the Central District of Illinois: 217-492-4450 🏠

Six Cardiologists Sue Health System Under Anti-kickback Statute

Six cardiologists in Little Rock, Arkansas, have sued the state's largest health care provider in federal court, saying the health system threatened to terminate their privileges at its hospitals because they own an interest in a competing hospital.

The lawsuit alleges that Baptist Health violated federal and state laws through its rules on conflict of interest, which call for termination of privileges for doctors who own an interest in a competing hospital. The lawsuit called the practice "economic credentialing" and said it was "nothing more than a subterfuge for blatant anti-competitive conduct."

Baptist Health is a nonprofit organization that operates four hospitals in Arkansas. The plaintiffs own Little Rock Cardiology Clinic, which owns 14.5% of the stock in Arkansas Heart Hospital, operated by a private for-profit corporation. Two of the six plaintiffs also own

shares individually in the corporation.

The lawsuit contends that the Baptist Health policy violates the federal anti-kickback statute by coercing physicians to refer patients to Baptist Health's hospitals. The law prohibits "soliciting, receiving, offering, and paying any remuneration, directly or indirectly, in return for referring an individual" to services covered in whole or in part by a federal health care program, according to the complaint.

The plaintiffs further allege that Baptist Health's policy violates the Arkansas Medicaid Fraud Act, the state Medicaid Fraud False Claims Act and the state Deceptive Trade Practices Act by interfering with the doctor-patient relationship.

Mark Lowman, a spokesman for Baptist, said the board adopted the policy "to protect patients' access." 🏠

Behavioral Therapy Company Settles Allegations Of Medicaid Overbilling

National Mentor Health care Inc., based in Massachusetts, has agreed to pay \$1.17 million to resolve allegations of overbilling in New Mexico's Medicaid program, according to the U.S. Attorney's Office for the District of New Mexico.

The agreement resolves civil charges in a qui tam lawsuit under the federal False Claims Act, and covers the period from Jan. 1, 1997, to Dec. 31, 2001. The government contends Mentor billed New Mexico Medicaid for behavioral therapy services that were not provided or that were improperly documented. The company has denied any wrongdoing.

Of the \$1.17 million, \$292,500 is to be paid to the state of New Mexico, representing its 25% stake in the Medicaid program. Another \$157,950 is to be paid to Faustino Abila, the former Mentor employee who brought the whistleblower lawsuit.

The company said in a prepared statement that the allegations date back to 1997 when it was under different management. In 2000, a new management team was appointed and began implementing a series of changes, particularly regarding recordkeeping.

The company's improvements, it said, have been validated by a number of internal and external reviews, including a reassessment by the Commission on Accreditation of Rehabilitation Facilities.

"Through our quality improvement initiative, New Mexico Mentor has made enormous strides in the last couple of years," said Dennis James, Mentor's director for New Mexico. "While doing so, we have worked cooperatively with federal and state authorities to resolve this matter." 🏠



90-Day Grace Period For HCPCS Codes Eliminated

Effective Jan. 1, 2005, Medicare providers will no longer have a 90-day grace period to use discontinued HCPCS codes for services rendered in the first 90 days of the year, according to the Centers for Medicare & Medicaid Services (CMS). Use of such codes to bill services provided after the date on which the codes are discontinued will result in nonpayment, the agency said in a February 6 transmittal.

In the past, Medicare has permitted a 90-day grace period after implementation of an updated HCPCS code set to familiarize providers with new codes and to learn about discontinued codes. However, the Health Insurance Portability & Accountability Act (HIPAA) Transaction and Code Set Rule requires providers to use the medical code that is valid at the time the service is provided.

In order for providers to know about the new, revised, and discontinued numeric CPT-4 codes for the upcoming year, they should obtain the American Medical Association's CPT-4 coding book that is published each October. CMS also posts on its Web site the annual alphanumeric HCPCS file for the upcoming year. To view the annual HCPCS update, go to www.cms.hhs.gov/providers/puf/download.anhpcpl.asp.

New Lab Payment Policy Delayed

The Centers for Medicare & Medicaid Services (CMS) has set an implementation deadline of July 1, 2004, for Medicare carriers to switch to new procedures designed to make Part B payments for lab-to-lab referrals more uniform nationwide and speed up payments to labs that do business across carrier jurisdictions (Transmittal 85, Feb. 6, 2004).

According to CMS, each carrier is to have available to it all the local fee schedules nationwide, and beginning July 1, must pay claims based on the fees applicable to the zip code where the testing was performed. Carriers must also discontinue use of reference-only provider IDs for labs outside their jurisdiction. The changes were to have begun April 1, but CMS decided to delay the start date.

Previously, carriers were not required to adjudicate claims for referred services furnished in another jurisdiction unless they happened to have the particular fee schedule for that jurisdiction. As a result, some paid for referred services while others did not. Some labs tried to surmount the problem by enrolling as a reference lab with the carrier having jurisdiction where the test was performed and obtaining a special provider identification number.

Under the new policy, an independent clinical lab may bill only the carrier with which it is enrolled by reason of having a physical presence in that carrier's jurisdiction.

New CMS Administrator Tapped: President Bush will nominate Food and Drug Administrator Mark McClellan as administrator of the Centers for Medicare & Medicaid Services (CMS). McClellan would succeed Thomas Scully, who left the position late in 2003 for a job with the law firm of Alston & Bird. McClellan's nomination is subject to Senate approval. Before becoming FDA commissioner in 2002, McClellan was a member of the White House Council of Economic Advisers and chief administration health policy aide. FDA Deputy Commissioner Lester Crawford will become acting FDA commissioner following McClellan's departure.

Podiatrist Convicted In Billing Scam: An Orange County, California, podiatrist has been convicted on charges of fraudulently billing Medicare for more than \$800,000 in procedures that were never performed. Mark Douglas Little, 43, of Anaheim Hills, was convicted February 17 by a federal jury in Santa Ana of 26 counts of health care fraud. Little operates Astra Foot and Ankle Center and works out of numerous other offices and hospitals throughout Orange County. Little is scheduled to be sentenced on April 9 by U.S. District Judge David Carter. He faces a statutory maximum sentence of 10 years in federal prison for each count.

Hospitals Sue CMS Over Demonstration: Three hospitals in the Robert Wood Johnson Health System have filed a complaint in federal court in Newark, New Jersey, seeking to block a Medicare demonstration project under which physicians at eight New Jersey hospitals can receive incentive payments for reducing hospital costs. The hospitals are seeking to stop the Centers for Medicare & Medicaid Services from proceeding with its "gainsharing" demonstration project, which began January 1. Under the three-year pilot program, physicians who choose to participate will receive financial incentives for lowering hospital costs in a variety of ways. In their lawsuit, the hospitals alleged that limiting the gainsharing program to eight of New Jersey's 84 acute care hospitals is anti-competitive because it will disrupt referral patterns and create an uneven playing field.

Home Health Owners Face 20 Years: Prime Care Services Inc. (Grand Rapids, MI) and owners Elena and David Szilvagyai pled guilty February 10 to charges they passed some of the costs of constructing their home to Medicare and Blue Cross Blue Shield of Michigan by submitting false statements in Prime Care Service's cost reports. The defendants are scheduled to be sentenced May 11 in Grand Rapids. The Szilvagyis face a maximum prison term of 20 years and a fine of \$250,000. 🏠

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