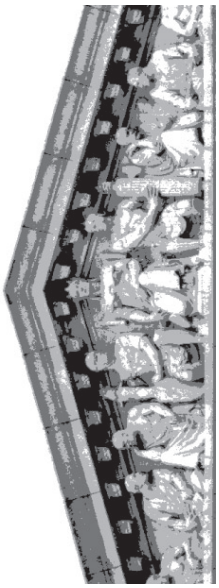

G-2 Compliance Report

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For Hospitals, Laboratories and Physician Practices

Medicare Increases Payments To Hospitals, Lowers Outlier Threshold For 2005

Effective Oct. 1, 2004, the outlier threshold for inpatient hospitals will be set at $25,800, a decrease both from the $31,000 in FY 2004 and from the $35,085 originally proposed for 2005. Reducing the outlier threshold will make it easier for hospitals to qualify for outlier payments for high-cost patients, according to the Centers for Medicare and Medicaid Services (CMS).

The change is included in the 2005 hospital inpatient prospective payment system final rule, published in the August 11 *Federal Register*. The final rule also implements major payment and policy changes for acute care hospitals required by the Medicare Prescription Drug Improvements and Modernization Act of 2003 (MMA).

CMS projects that the combined impact of the inflation update and other proposed changes will yield an average 5.7% increase in payments for urban hospitals in FY 2005, while rural hospitals will see an average increase of 6.2%. Medicare payments to about 3,900 hospitals under the inpatient prospective payment system are projected to be $105 billion, up from about $100 billion in FY 2004.

Under the final rule, hospitals that report specific quality data will receive an inflation update ➥ *p. 2*

Inside this issue

IRS Targets Excessive Compensation In Tax-Exempt Organizations

Hospitals and other healthcare organizations should take steps to document how they set salaries of highly compensated executives lest they run afoul of the Internal Revenue Service (IRS), advises Mark Schieble, an attorney in the San Francisco office of Foley and Lardner.

The IRS announced in August that it is launching a new enforcement program designed to halt abuses by groups that award excessive compensation and benefits to officers and insiders. About 2,000 charities and other tax-exempt organizations will be targeted for review under the program.

"We are concerned that some charities and private foundations are abusing their tax-exempt status by paying exorbitant compensation to their officers and others," IRS Commissioner Mark Everson said in announcing the program. "Particular organizations that we contact may or may not have problems in the compensation area, but specific aspects of their operations have raised questions that must be answered."

➥ *p. 9*

Medicare Increases Payments, *from p. 1*

equal to the hospital market basket percentage increase of 3.3%. Hospitals that do not report this information will receive the market basket percentage increase less 0.4 percentage points, or a 2.9% increase. The market basket increase refers to the projected rate of inflation for goods and services used by hospitals in caring for Medicare beneficiaries. This is the first time that hospital payment rate increases have been tied to performance. CMS estimates that the overwhelming majority of acute care hospitals will be eligible to get the full update for 2005.

The final rule also addresses the impact of the new Metropolitan Statistical Area (MSA) definitions on hospital geographic classification. The MSAs, developed by the Office of Management and Budget on the basis of 2000 Census data, will replace the current MSAs, which reflect 1990 data. As a result of these changes, a number of rural hospitals will benefit from being classified into areas with higher payment rates.

CMS estimates that the overwhelming majority of acute care hospitals will be eligible to get the full market basket update for 2005.

For hospitals that will experience a decrease in their wage indices, CMS will phase in the new MSAs over a two-year period. Hospitals that will get an increase as a result of the new MSAs will receive the full benefit of the new labor markets in FY 2005. In addition, hospitals that had been reclassified by the Medicare Geographic Classification Review Board will continue to be paid according to their reclassification.

Those hospitals that had applied for reclassification in 2005 will be permitted to withdraw their applications if reclassification will no longer be to their advantage. Hospitals previously reclassified to an adjoining MSA that has been split under the new MSA definitions will be reclassified to the new MSA nearest them. In addition, for hospitals in areas that have been redesignated from urban to rural as a result of labor market areas changes, CMS is providing a three-year period during which those hospitals will continue to be paid as urban hospitals.

The final HIPPS rule also:

- Modifies several policies affecting arrangements in which a long-term care hospital is located within another hospital. For example, CMS has jettisoned a provision that would have required long-term care hospitals to admit no more than 25% of their patients from their host facility, which generally is a larger hospital. The agency also has eliminated a provision requiring separate ownership for the long-term care hospital and its host facility, although they will be required to maintain separate administrations.
- Makes several changes to diagnosis-related groups (DRGs), including increasing payment to hospitals for treating burn patients who have respiratory failure and require the long-term use of mechanical ventilation. The rule also reassigns heart assist devices, including left ventricular assist devices, to the DRG for heart transplants.
- Reduces the cost threshold to qualify for new technology add-on payments. It also provides an add-on payment for two new medical technologies in FY 2005: an implantable neurostimu-lator for deep brain stimulation used for treating patients with Parkinson's and a technology that combines resynchron-ization therapy with defibrillation for patients with heart failure.
- Redistributes unused residency slots among teaching hospitals to better reflect changes in the location of residency training. Hospitals located in rural areas are given first priority. It also allows hospitals to receive full payment for up to four years of specialty training when a resident matches simultaneously to a generalized, preliminary year of training and a subsequent specialty-training program.

Resource

Hospital inpatient prospective payment system final rule for FY 2005: *www.cms.hhs.gov/providers/hipps/frnotices.asp*.

Medicare Proposes Changes To Outpatient Payment System

Comments on the proposal will be accepted until October 8, and a final rule is slated to be published by November 1.

Medicare payments to hospital outpatient departments will increase by an average of 4.6% in 2005 under a proposed rule published August 16. The rule incorporates provisions mandated by Congress in the Medicare Prescription Drug, Improvement and Modernization Act (MMA), including a free physical for new Medicare enrollees.

Under the proposed rule, payment to urban hospitals will rise by 4.5%, while payments to rural facilities will increase 5.3%, according to the Centers for Medicare & Medicaid Services (CMS). The increase will take effect Jan. 1, 2005.

For the first time, new Medicare beneficiaries can get a "Welcome to Medicare Physical" that will provide baseline information on health status. To be paid for by Medicare, the physical must be performed within six months of the beneficiary's enrollment in the program.

When the exam is provided in a hospital outpatient department, Medicare is proposing to pay the hospital $75 for the use of the hospital facility. A separate payment will be made for the physician's professional services under the Medicare physician fee schedule, as proposed on July 27.

Screening Exams

In addition to the new physical, the proposed rule would increase payment to hospitals for screening examinations that are already covered by Medicare. Proposed payment increases are as follows:

- Pelvic and breast exams to detect cervical and breast cancer, 3.24%;
- Barium enema to detect colorectal cancer, 4.25%;
- Bone density studies, 4.25%;
- Flexible sigmoidoscopy to detect colorectal cancer, 7.42%;
- Screening colonoscopy, also for colorectal cancer, 9.9%; and
- Glaucoma screening, 10.4%.

The proposed rule will also implement significant increases in payments for mammograms. The MMA required that diagnostic mammograms be removed from payment under the outpatient prospective payment system (OPPS) and be paid, like screening mammograms, under the Medicare physician fee schedule (MPFS). Although CMS has not finalized the payment rates for the MPFS for 2005, the agency expects that payment for traditional diagnostic mammograms will increase by nearly 40% over the current OPPS rates. Payment for digital diagnostic mammograms is expected to increase under MPFS by about 60% over current rates.

In addition, the proposed rule would decrease beneficiary liability for coinsurance for outpatient services. The rule proposes to reduce the maximum coinsurance rate for any service to 45% of the total payment to the hospital in 2005, down from 50% this year. As a result, the average coinsurance rate would drop from 34% in 2004 to 32% in 2005. Under the MMA, the cap on coinsurance rates is to be reduced gradually until all services have a coinsurance rate of 20% of the total payment.

Resource

Proposed revisions to hospital outpatient payment system for 2005: *www.cms.hhs.gov/providers/hopps/2005p/1427p.asp*.

Baltimore Lab Closed For Violations

Maryland health officials have ordered a Baltimore lab to shut down after inspectors discovered multiple violations, including failure to report sexually transmitted cases to the Baltimore County Health Department and failure to conduct required controlled testing on lab equipment and materials.

Reference Pathology Services of Maryland has agreed to shut its doors September 5 and offer free re-tests to 3,000 patients for chlamydia, gonorrhea, and human papillomavirus.

State officials say the problems at the lab, along with similar violations at Maryland General Hospital uncovered earlier this year, raise questions about standards used by the College of American Pathologists (CAP), which accredited both labs. According to the *Baltimore Sun*, Maryland officials met with CAP representatives in June and asked for details of the group's accrediting process. Critics have said that CAP is not tough enough in its accrediting, a charge that the group disputes.

For more on the concerns about CAP accreditation and the group's take on violations at the Maryland labs, see the October issue of *G-2 Compliance Report*.

Hospitals Note Conflicts In OIG Compliance Guidance

The draft guidance is available at www.oig.hhs.gov/authorities/frnotices.html.

The American Hospital Association (AHA) and the American Association of Medical Colleges (AAMC) have raised concerns about draft compliance guidance issued by the Health and Human Services Office of Inspector General (OIG).

The OIG guidance, issued June 8, is a supplement to the original compliance program guidance for hospitals issued in 1998.

According to comments on the draft submitted by AHA, the OIG takes a different view than the Centers for Medicare & Medicaid Services (CMS) on several issues. For example, AHA says it is concerned about language in the draft supplement that referred to the application of evaluation and management codes to hospitals, saying those codes apply only to physicians.

"The OIG recommends that hospitals take steps to ensure that E/M codes used to describe medical services provided to patients follow published CMS guidelines," the AHA letter states. "Currently, CMS does not have a uniform methodology for facility E/M reporting. Instead, CMS has directed that each facility develop a system for matching the provided services or combination of services furnished to the different levels of effort represented by the existing codes."

The AAMC believes that the OIG's guidance on billing in excess of usual charges should be removed from the draft supplement until a final decision is made about a recent proposed rule that outlines the OIG's exclusion authority with regard to cases where providers submitted claims for excessive charges.

"[N]umerous comments were submitted in response to the proposed rule," the association writes. "The AAMC and many others requested that the proposed rule be withdrawn since it would affect payment policy, an area that is the responsibility of [CMS] and cannot be delegated to the OIG."

Seattle Man Pleads Guilty In First HIPAA Conviction

A Seattle man pleaded guilty August 19 in federal court to wrongful disclosure of individually identifiable health information for economic gain – the first criminal conviction in the United States under the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA). The privacy provisions, which became effective in April 2003, made it illegal to wrongfully disclose personally identifiable health information.

Richard Gibson admitted that he obtained a cancer patient's name, date of birth, and social security number while he was employed at the Seattle Cancer Care Alliance, and that he disclosed that information to get four credit cards in the patient's name. Gibson also admitted that he used several of those cards to rack up more than $9,000 in debt in the patient's name. Gibson was fired shortly after the identity theft was discovered.

As part of the plea agreement, entered before U.S. District Court Judge Ricardo Martinez, Gibson faces 10 to 16 months in prison or a combination of prison and home confinement. He will also pay restitution to the credit card companies and to the patient for expenses he incurred.

Martinez will decide whether to accept the plea agreement at a hearing November 5. If Martinez rejects the agreement, Gibson will have an opportunity to withdraw his guilty plea.

FRAMING the BIG PICTURE

What's The OIG Focusing On Now?

Find out at the next Lab Institute, September 29- October 2 in Arlington, VA. Darlene Hampton, senior counsel for the Health and Human Services Office of Inspector General, will give the OIG's perspective on lab compliance during a special lab reimbursement and compliance academy.

Also on the agenda:

- ❑ Karen Straub, vice president, compliance, Quest Diagnostics, will discuss compliance challenges on the front line;
- ❑ Carrie Valiant, Esq., a partner with Epstein, Becker & Green, will give insight into the current compliance and regulatory environment for labs;
- ❑ Joan Logue, principal, Health Systems Concepts; and Mitchell Burken, MD, Mid-Atlantic Medicare medical director for TrailBlazer Health Enterprises, will update attendees on critical coding and reimbursement issues.

To register, go to *www.g2reports.com* or call 1-800-401-5937.

COMPLIANCE PERSPECTIVES

Roaming the Random Range

Defending against governmental extrapolation of high-dollar recoupment claims through statistical sampling in Medicare and Medicaid overpayment and fraud actions

Gregory Piche', Esq., is a partner in the Denver office of Holland & Hart

When federal or state Medicare or Medicaid oversight agencies use "statistical sampling" techniques to extrapolate overpayment amounts from a universe of claims based on a limited sample, human process errors can provide the foundation for an effective defense.

It can be a shock to open a government overpayment determination notice and view the announcement of a recoupment action against your company to reclaim, say, $3 million in alleged overpayments based on an agency's "statistical sampling" methodology.

Welcome to the bewildering world of statistical sampling and extrapolation of data in the public funding of healthcare services. The government has taken a "footprint" review of a few of your files, deemed your documentation wanting, and has extrapolated a "dinosaur" determination that the universe of your submitted claims is similarly wanting and your company owes big bucks and maybe even the "farm" to the government.

The agency formerly known as the Healthcare Finance Administration[1](HCFA) adopted a rule permitting the use of statistical sampling techniques as part of the armamentarium of the government in the exercise of its program review and integrity function. The Social Security Act requires the government to review, identify, and/or deny inappropriate, medically unnecessary, excessive, or routine services.[2] Sampling may be used where claim volume of a provider under review is "voluminous," the claims reflect a "pattern of overbilling," and a case-by-case review is "not administratively feasible."[3]

Given the large number of claims processed by home health agencies and other healthcare providers relying on some level of federal reimbursement, the use of statistical sampling in lieu of a review of all of a provider's claim files is a cost-saving boon to federal and state governments administering Medicare and Medicaid programs. It also has an extraordinary "in terrorem" effect on providers because of the process of extrapolation of small review samples into huge financial obligations cutting across all claims submitted during the audit period.

Home health agencies have been particularly vulnerable to statistical sampling problems because of the complexity and difficulty of maintaining adequate file documentation in a labor intensive enterprise performed in patient homes. The government treats all services not adequately documented as not having been provided and therefore the basis of an overpayment claim and recoupment action.

Typical Audit

A typical audit usually starts with a "random" selection and review of a small number of files to determine the adequacy of the documentation for claims previously presented for payment. The files, once identified by a computer

[1] Now the 'friendlier' sounding "Centers for Medicare and Medicaid Services" (CMS).

[2] Section 1842(a)(2)(6) of the Social Security Act. See Also 42 C.F.R. §421.200.

[3] HCFA Rule 86-1.

"randomizing" program, are reviewed by nurses or other trained personnel representing the government to see if there exists a "pattern" of overbilling. If the government perceives a pattern, it selects and reviews a larger randomized sample of claims (*i.e.*, 100). The documentation error rate in the larger sample is then determined. If the hapless provider has another 10,000 claims during the audit period, a computer program is used to extrapolate the error rate in the 100 files over the entire 10,100 files, and pretty soon we are talking about big money.

The computer program, at the end of the process, usually spits out a high and low range of probable overpayment, and the government usually selects the lower number (call it $2.9 million instead of $3 million) just to show how conservative and careful the government is being. Your company has just been mortally wounded, if not actually killed, by a computer in the hands of government statisticians.

The seeming irrefutability of computer-generated numbers can be at least as terrifying as the size of the numbers generated through sampling techniques. To the uninitiated (which includes most of us) the nature and practice of statistical analysis is arcane and impenetrable. The memory of regression analysis problems from a required econometrics course in college still sends shivers down my spine. How does one defend against the clinical determinism of computer-driven mathematics?

The very agency cost concerns that led to the adoption of statistical sampling techniques also provide the seeds of defenses against them.

The answer is—human process flaws. Ironically, the very agency cost concerns that led to the adoption of statistical sampling techniques also provide the seeds of defenses against them. The reality is that there are significant costs in utilizing statistical sampling correctly, and review agencies, either through lack of funding or ignorance with the technical requirements of the sampling process, rarely get it right—leaving room for significant challenges to the validity and accuracy of the final numbers.

Mounting A Defense

The first line of defense is in any inaccuracy of the initial review. If the claims reviewers made subjective judgments about the adequacy of the documentation in the claims files or if the provider is able to supplement missing data to the manually reviewed documentation, the validity of the deficient samples can be severely compromised under GIGO, the axiom of "garbage in-garbage out."

The second line of defense relates to "due process" or procedural fairness requirements for the validity and accuracy of the methodology used by the agency in determining the sample to be extrapolated. This is not the same as being "processed duly." The agency utilizing statistical sampling techniques has the burden to establish that the sample developed is in fact random and statistically valid. In the seminal case of *Chaves County Home Health Services v. Sullivan,* 931 F.2d 914 (D.C. Cir. 1991), the District of Columbia Circuit Court of Appeals held that the use of statistical sampling techniques was not in and of itself a violation of due process of law "in light of fairly low risk of error so long as the extrapolation is made from a representative sample and is statistically significant" (*Chaves* at 922).

Is the sample truly representative and is the extrapolation statistically significant? There are two general sources of guidance as to the assurance of the representative accuracy of the sample and the statistical significance of the extrapolation, and both really relate to the precision in the tolerances of the sample.

The first source emanates from the rules and procedures adopted by the government. The

[4] *MCM, SGA §2.5.*

second derives from generally accepted standards within those disciplines regularly engaged in the practice of statistical analysis. CMS originally published its own *Sampling Guidelines Appendix* (SGA) in the *Medicare Carrier's Manual* setting out minimum standards to assure the integrity of the sample.

The SGA identified the basic sampling unit, "a service, a bill, or a beneficiary for a particular period of time."[4] The SGA identified a number of factors affecting the accuracy of the sample—the time frame of the sample, the size of the sample, the size of the claim amount sought, the stratification of the sample universe, the randomness of the selection, and the complete documentation of the process so as to enable others to reproduce the results.

The degree to which the sample universe is homogenous is an important accuracy factor. The greater the degree of heterogeneity, the more difficult and complicated the process.

The SGA explicitly recognized that the second source—"persons with competence in statistical sampling can provide effective guidance in using more sophisticated techniques which might ensure a better result for the same degree of effort."[5] It specifically listed Cochron, W.G., *Sampling Techniques*, 2nd edition, New York; John Wiley and sons, 1963, Hansen, Morris H., William W. Hurwits and William G. Madow, *Sample Methods and Theory*, New York; John Wiley and Sons, 1953 and Kesh, Leslie, *Survey Sampling*, New York; John Wiley and Sons, 1965 as "useful sampling references."

The effect of compliance with the SGA minimum standards was to assure that certain precision standards in the results were achieved. Unfortunately, in practice, oversight agencies tended to ignore the standards or to farm out the sampling process to subcontractors who were unfamiliar with them. This was particularly true with respect to the selection of sample size to be used. Instead of using statistically significant sample sizes to achieve acceptable accuracy tolerances in the results there was a tendency to select an arbitrary number of say 100 or 200 when the SGA and other authorities might require a minimum of 400. (The actual minimum number required can be determined mathematically and almost always ends up being an odd number like 353 rather than a round number like 200, which is generally an indication of a too low arbitrary number used because of agency resource limitations.

The Social Security Administration, Office of Hearings and Appeals, for example, overturned a $1,248,747 overpayment determination in 2000 after a representative of the Office of Inspector General testified that the OIG could not have looked at the required minimum of 400-sample size due to "lack of audit resources and availability of staff" and that the OIG failed to preserve the sample "frames" and other data to permit a replication of the sampling.

Some states have adopted their own standards for statistical sampling, while many have not. The applicability of the federal Medicare standards to state Medicaid recovery actions is not anywhere made explicit, but the logic of their use in state actions flows from the fact that both programs involve the recovery of federal funds.

In 2001, HCFA replaced the SGA with PMB-01-01[6] that eliminated the minimum sample size and sampling detail requirements contained in the SGA. It also suggests that the probability sample and statement results are "always" valid, which is unsupported in any professional literature on the subject. This is a prime example of the principle that if you can't win by playing by the rules (or even not

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[5] *MGM, SGA §1.1.*

[6] *See PIM, Exhibits 7-7.7.*

by the rules), then just get rid of the rules. The fundamental problem for the government is that the procedure used by the agency must still stand up to due process requirements to be upheld, and the effect of this loosy-goosey dilution of precision in the sampling requirements has yet to be determined in the courts.

How Accurate Is The Sample?

Sample size and reproducibility are but two factors affecting the accuracy of a representative sample. A representative sample is one from which all bias has been removed. A basic sample is random if every name or thing in the whole group has a mathematically equal chance to be in the sample. The question is how accurate a sample can be taken to represent the whole universe measured in figures (*i.e.*, "probable error" and "standard error").

There is almost always room to mount a formidable defense in statistical sampling recoupment actions.

The degree to which the sample universe is homogenous is an important accuracy factor. The greater the degree of heterogeneity, the more difficult and complicated the process.

In a recent audit in Colorado, the state Department of Healthcare Financing utilized sample units described as TCNs (Transaction Control Numbers). These were individual billings for one patient for varying periods, encompassing different units of service. No effort was made to use more homogenous units or to "stratify" the disparate elements of the units into discrete categories so as to establish greater reliability in the sample accuracy. Further, the state predicated its analysis on "rows of TCNs." It discarded entire rows of units of service when there was any defect in the documentation of any individual TCN in the row.

There were also two huge "outliers" in the selected samples, which alone accounted for 20% of the sample claims. The final result was an asymmetrical distribution of the sample. (A normal distribution looks like a bell curve with the mean being the same value as the median.) The state's mean of $100.69 was asymmetrical from the median of $33.72, reflecting a demonstrable lack of precision in the integrity of the sample as fairly representing the universe of TCNs.

Government agencies will sometimes rely on concepts like the "central limit theorem" to compensate for the lack of stratification or homogeneity in the sample. The theorem provides that when averaging over an increasing number of different elements with varied distribution, averages of those elements become increasingly closer and closer to normal or "Gausian" distribution—a standard distribution. The problem is that it takes a very large sample to reach the standard distribution, and the argument is therefore circular.

It is amazing how infrequently agencies calculate the coefficient of variation (COV) of the sample, which is a mathematical measure of the imprecision of the sample – the higher the value, the more imprecise the sample. The COV is the best overall measure of the validity of the sample. To achieve improvement in the tolerances as measured by the COV, the agency must adjust for outliers, stratify sample categories, and/or increase the sample size.

Once statistically acceptable precision in the sample is determined, there are a number of methods of extrapolation that can be applied to reach a representative amount—the method selection is generally not statistically significant in recovery actions, unless clerical errors exist.

Despite the perception of mathematical unassailability, overpayment and fraud developed through statistical sampling are rarely determined with sufficient care and precision to overcome the basic constraints of due process of law and fundamental fairness. There is almost always room to mount a formidable defense in statistical sampling recoupment actions.

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Mark Schieble

IRS Targets Excessive Compensation, *from p. 1*

While the IRS has not said specifically that it will focus on hospitals or other healthcare providers, it's likely that many of those targeted will be within the healthcare industry since many healthcare organizations are tax exempt, Schieble tells *GCR*.

"CEOs in large health systems tend to be highly compensated, so those organizations may well receive inquiries," he says.

The program appears to be less focused on uncovering specific instances of wrongdoing than on gathering general information on compensation and reporting practices that the IRS can then use as a baseline to support the development of specific enforcement and administrative initiatives, such as a redesign of the annual Form 990, compensation disclosure requirements, or the adoption of new examination guidelines and internal IRS education programs, believes Schieble.

IRS Tax-Exempt/Government Entities Commissioner Steven Miller told reporters August 10 that some organizations will be receiving a letter, similar to an Information Document Request, asking them to detail current compensation practices. Others may receive specific inquiries related to information reported on Form 990.

Focus areas will include those organizations with individuals who are highly compensated in comparison to the organization's assets and gross receipts, loans, and transfers of income assets, essentially all transactions within the purview of the intermediate sanction provisions of Section 4958. If information received from an organization looks to be in order, the inquiry will be closed rather quickly, Miller said.

However, information that appears amiss could lead to anything from a penalty for filing incorrect or inaccurate information to a revocation of exemption. "Everything from 'Thank you very much, sorry to bother you,' to 'You don't appear to be achieving a charitable purpose at this point,'" Miller said of possible responses from the service.

According to Schieble, the new program, and the spotlight it casts on potential excess benefit transactions punishable under Section 4958, reinforces the value to be derived from the adoption of procedures that will clothe an exempt organization with the "presumption of reasonableness." Specifically, the regulations under Section 4958 provide that compensation and other economic arrangements between an organization and its insiders will be deemed presumptively reasonable if the arrangement is:

- Approved by a board (or committee holding board authority) composed entirely of disinterested members;
- The approving board (or committee) obtained and relied on objective comparability data (such as salary surveys, expert valuation opinions, and competing offers) in approving the arrangement; and
- The approving decision of the board (or committee) is documented in minutes or similar writing that reflect not only the decision reached but also the deliberative processes behind the decision, including reliance on the objective comparability data.

"This presumption of reasonableness essentially shifts the burden of proof to the IRS, so the IRS would have to establish, by a preponderance of evidence, that in fact the decision was unreasonable," says Schieble. "But I think as a practical matter, you get more of a benefit than just a shifting of the burden because I believe that if IRS agents see that an exempt organization observed these procedures in approving a transaction, they are much less likely to challenge it."

> ***"The value of the presumption of reasonableness cannot be underestimated."***
> ***—Mark Schieble, Esq.***

Thus, organizations that can point to a policy and practice of strict observance of the procedures that qualify it for the presumption of reasonableness should receive a significantly lesser degree of scrutiny, Schieble believes. "The value of the presumption of reasonableness cannot be underestimated," he says.

Resources

Mark Schieble: 415-434-4484

IRS announcement: *www.irs.ustreas.gov/newsroom/article/0,,id=128328,00.html*.

OIG Calls For Improved Monitoring Of Compliance By Hospitals-Within-Hospitals

Almost 22% (19 of 87) of the hospitals-within-hospitals reviewed by the Department of Health and Human Services Office of Inspector General (OIG) exceeded the annual 5% threshold for readmissions at least once during the fiscal years ending in September 2000 through December 2002, according to a new OIG inspection report.

The report, "Long-Term Care Hospitals-Within-Hospitals," concluded that the Centers for Medicare & Medicaid Services should develop a system to monitor hospital-within-hospitals' compliance with readmissions rules and require hospitals-within-hospitals to demonstrate their organizational and financial independence on a continuing basis.

"As Medicare's prospective payment system for long-term care hospitals is fully implemented, paying hospitals-within-hospitals that are over the 5% readmission level could result in increased costs to the Medicare program," the report warned.

The report also found that fiscal intermediaries lack access to data to verify average lengths of stay at long-term care facilities, which by definition are to have an average length of stay greater than 25 days. Medicare excludes long-term care hospitals from its acute care hospital prospective payment system.

The location of long-term care hospitals-within-hospitals within acute care "host" facilities creates potentially inappropriate financial incentives, the report says. For example, these arrangements make it possible for a hospital-within-hospital to discharge a patient to the host hospital and then readmit the same patient for additional care.

For hospitals-within-hospital that readmit more than 5% of patients discharged to the host hospital over the course of the hospital-within-hospital's fiscal year, CMS reduces its payments. CMS currently has no system to detect readmissions, many of which involve high-cost diagnosis related groups.

CMS says it generally supports the OIG's recommendations, noting that it is formulating an effective program to enable fiscal intermediaries to enforce the onsite discharge and readmission policy under the long-term care hospital prospective payment system.

Resource

Inspection report, "Long-Term Care Hospitals-Within-Hospitals": *www.oig.hhs.gov/oei/reports/oei-01-02-00630.pdf*.

Insurance Cos. To Pay $20 Million To Resolve Fraud Charges

Travelers Insurance Co. and United Healthcare Insurance Co. have agreed to pay the United States $20.6 million to resolve allegations they violated the False Claims Act by defrauding the Medicare program.

Under the settlement, announced August 12, Travelers will pay the government $10.9 million and United Healthcare will pay $9.7 million.

From Oct. 1, 1998, through Jan. 3, 1995, Travelers acted under various contracts with Medicare to serve as the Part A fiscal intermediary for parts of three states (Connecticut, Michigan, and New York) and as the Medicare Part B carrier for four states (Connecticut, Minnesota, Mississippi, and Virginia).

Travelers also had served as the nationwide carrier for the Railroad Retirement Board and as the Durable Medical Equipment carrier for Region A, according to David Kelley, U.S. Attorney for the Southern District of New York. United Healthcare carried out the same contracts from Jan. 3, 1995, through Dec. 31, 2000.

Before each fiscal year, Travelers and United Healthcare were required to submit for government approval a proposed budget for each of the operations the companies were obli-

gated to perform under the contracts with Medicare. According to whistleblower Robert Klenasewiski, beginning in October 1989 or earlier, Travelers devised a scheme whereby it knowingly falsified figures for its expenditures under cost reimbursement contracts to fraudulently obtain greater reimbursement and performance incentive payments from the government.

Specifically, the complaint alleged that, in performing the contracts, Travelers routinely exceeded its government-approved budget for certain required operations. In addition, the company spent far less on other operations mandated to root out fraudulent claims and provide overall cost savings for the government.

Travelers allegedly submitted cost reports and other documents that misrepresented it was carrying out its contractual obligations at or near the government-approved budget, the release said. However, there were substantial cost overruns in certain operations, and other operations were significantly under budget, according to the complaint.

The government alleged that its investigation revealed that Travelers kept two sets of books, one with actual costs and the other with costs as reported to the government.

When United Healthcare took over the same contracts from Travelers in 1995, it allegedly engaged in the same fraudulent billing practices.

No Action Expected Against EMS Service

No administrative or monetary penalties are expected to be imposed against an unidentified county's exclusive arrangement for emergency ambulance services that could produce prohibited remuneration under federal anti-kickback law, the Heath and Human Services Office of Inspector General concluded in an advisory opinion released August 11 (04-10).

The anti-kickback statute could be applicable, the advisory opinion said, because the county is soliciting payment for first responder services in exchange for an exclusive contract to provide nearly all emergency secondary response ambulance transportation services in the county, some of which may be reimbursed under federal healthcare programs.

In forming its opinion, the OIG found the proposed first-response fees to be only part of a comprehensive regulatory scheme to manage the delivery of emergency medical services. In addition, the county expected the fees to be only partial compensation for the actual cost of the delivery services.

Moreover, the per-response fees and exclusivity of the contract do not post an increased risk of overutilization or increased costs to federal healthcare programs, the OIG determined. It found the exclusivity of the contract would not adversely affect competition and that any prohibited remuneration would benefit the public rather than any private or government venture.

Its decision might be different, the OIG acknowledged, if the arrangement involved a fundamental change in how the country delivered services, or resulted from a unilateral solicitation by an individual ambulance company, or core components of the arrangement came from a bidder rather than the county.

Resource

Advisory opinion 04-10: *www.oig.hhs.gov/fraud/docs/advisoryopinions/2004/ao0410.pdf.*

❖ **CMS Faulted On Fraud Fighting:** The level of resources the Centers for Medicare & Medicaid Services (CMS) devotes to fighting Medicaid fraud is not enough to counter the large financial risks fraudulent activities pose to the program, according to an August 19 report from the Government Accountability Office (GAO). In 2004, CMS designated $26,000 and eight staffers nationally to oversee the states' Medicaid programs anti-fraud efforts. "This level of effort suggests that CMS's oversight of the states' Medicaid program integrity efforts may be disproportionately small relative to the risk of serious financial loss," says the GAO report: "Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments." The report is available at *www.gao.gov/new.items/d04707.pdf*.

❖ **Exclusion Procedures Detailed:** The Centers for Medicare & Medicaid Services (CMS) has outlined its procedures for excluding providers from the Medicare program. The proposal, published in the July 23 *Federal Register*, is based on similar procedures established by the Department of Health and Human Services Office of Inspector General for imposing its exclusion authority. Comments on the proposal are due September 21. The proposed rule is available at *www.cms.hhs.gov/providerupdate/regs/cms6146p.pdf*.

❖ **Tenet Still Under Microscope:** Tenet Healthcare Corp.'s relationships with its doctors continue to be the focus of federal scrutiny, with the U.S. attorney's office for the Eastern District of Louisiana recently subpoenaing documents from three New Orleans hospitals, the company said in August 3 financial reports to the Securities & Exchange Commission. Tenet said it is cooperating with the government, adding that it believes all of its relationships with physicians are potentially under review by the government.

❖ **Medicaid Recoveries:** Medicaid Fraud Control Units (MFCU) recovered $268 million in court-ordered restitutions, fines, civil settlements, and penalties and helped secure 1,096 convictions during fiscal year 2003, the Health and Human Services Office of Inspector General said in an August 18 report. As a result of the MFCU, 538 individuals and entities were excluded from participating in Medicaid and Medicare based on the referrals the fraud units made to the OIG. MFCUs also opened 5,570 patient abuse and neglect cases, according to the report, "State Medicaid Fraud Control Units: Annual Report for Fiscal Year 2003." The report is available at *www.oig.hhs.gov/publications/docs/mfcu/MCFU2003.pdf*.

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