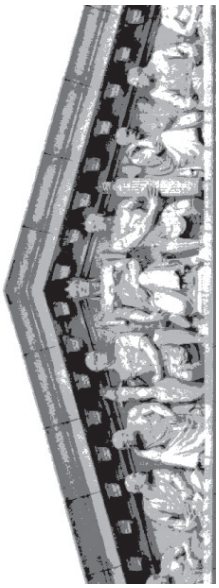

# G-2 Compliance Report

WASHINGTON G-2 REPORTS

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For Hospitals, Laboratories and Physician Practices


## CMS To Revise Controversial MUE Proposal

### *July 1 Implementation Date Delayed Until 2007*

A controversial proposal to limit the units of service for which a provider may bill Medicare per beneficiary per day will not be implemented July 1 as planned. Instead, the "medically unbelievable" edits will be revised and resubmitted for public review and comment, according to the Centers for Medicare & Medicaid Services (CMS). The revised edits will be implemented no earlier than Jan. 1, 2007.

CMS announced the delay at the March 6 meeting of the Practicing Physicians Advisory Council in Washington, D.C. Council members had unanimously recommended the agency "withdraw the plan to create a list of MUEs and resubmit through the normal rule-making process and work closely with the medical community in this effort." CMS followed the announcement with a written statement issued March 15.

The proposed edits, whose use would result in automatic denials of all claimed units of service ceiling, are far-reaching. As proposed, they would affect nearly all CPT/HCPCS non-surgical codes, including more than 1,000 of special concern to pathology and lab groups.

"CMS's intent for these edits is to prevent the payment of obviously erroneous Medicare claims submissions," said CMS in its statement. "For example, CMS wishes to prevent payment for millimeters of a medical product when the unit of billing is liters or billing for 60 services when the provider meant to bill for six services. The medically unbelievable edits are not meant as Medicare payment policy, but only to identify obvious mistakes in billing."

The agency has also extended the deadline for comments on the proposed revisions until June 19. However, CMS notes that it will seek a second round of public comment in the fall.

## Budget Bill Imposes New Compliance Requirements

Under a new law, healthcare providers that receive or make annual Medicaid payments of at least $5 million will be required to expand their compliance training and communication to include detailed information about the federal False Claims Act and corresponding state laws, effective Jan. 1, 2007.

The Deficit Reduction Act of 2005, signed into law in February, provides that such entities must:

➥ *p. 2*

## Inside this issue

**Budget Bill,** *from p. 1*

**A.** Establish written policies for all employees of the entity (including management) and of any contractor or agent of the entity, that provide detailed information about the [Federal] False Claims Act . . . administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any state laws pertaining to civil or criminal penalties for false claims and statement, and whistleblower preventing and detecting fraud, waste, and abuse in federal healthcare programs;

**B.** Include as part of such written policies detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

**C.** Include in any employee handbook for the entity, a specific discussion of the laws described [above], the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

While most entities receiving or making annual Medicaid payments amounting to $5 million have a compliance program already in place, many of them may not include the level of detail required under the new law, notes Edward Hopkins, a partner with the law firm of Broad and Cassel (West Palm Beach).

"If your organization will be required to comply with these new policy and communications requirements, it is not too soon to begin reviewing these materials," he advises.

Making these changes is a condition of receiving Medicaid payments, effective Jan. 1, 2007, adds Hopkins. Entities that do not comply risk violating the FCA by claiming Medicaid payments after that effective date.

**Resource**

- Deficit Reduction Act (S. 1932): *http://thomas.loc.gov/*
- Edward Hopkins: 561-832-3300

# HealthSouth To Pay $445 Million To Settle Lawsuits

HealthSouth Corp. (Birmingham, AL), a leading provider of outpatient surgery, rehabilitation, and diagnostic imaging services, has agreed to pay at least $445 million to settle class-action lawsuits over its accounting and financial reporting.

The company will pay with common stock and warrants valued at $215 million, in addition to $230 million cash from its insurance carriers, for a total of $445 million.

In addition, the federal securities class plaintiffs will receive 25% of any net recoveries from future judgments obtained by or on behalf of HealthSouth with respect to claims against former Chief Executive Officer Richard Scrushy; former auditors Ernst & Young; and UBS, the company's former primary investment bank. The settlement is subject to completion of final documentation and court approval.

The news sent the company's shares up by as much as 7.5% in over-the-counter trading. The shares have plunged in recent years amid an accounting scandal, the ouster of Scrushy, and several government probes. The company said it is not admitting wrongdoing in the settlement, which also covers some former executives and directors.

**Proposed Settlement**

"This proposed settlement represents a major milestone in HealthSouth's recovery and a powerful symbol of the progress we have made as a company," said current president and chief executive officer Jay Grinney. "With the support of our dedicated employees across the country, HealthSouth is on the verge of putting another issue from the past behind us."

Patrick Coughlin, the attorney for the plaintiffs, said that in his view, the settle-

### Calculating Your JCAHO Application Due Date

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is reminding clinical laboratories it accredits that, as of Jan. 1, 2006, it's important to submit your lab resurvey application on time because failing to do so could affect your laboratory's accreditation status.

Here's what you need to know to calculate the due date correctly:

- For labs affiliated with another accredited program, the due date is one year prior to when the lab is due for survey and is the same month as the primary program's due date. For example, if the lab is due for a survey in September 2007 and the hospital is due for a survey in March 2008, the lab application is due no later than March 31, 2006.
- For freestanding labs, the application is due one year before the survey is due. For example, if the lab is due for survey in July 2008, the application is due no later than July 31, 2007.

ment is in the shareholders' best interests and allows the company to move forward in its actions against its auditor and bank, as well as Scrushy.

Gregory Doody, HealthSouth's general counsel and secretary, noted that the proposed settlement—together with the company's agreement with the Securities and Exchange Commission in 2005, its bondholder consent agreement in June 2004, and its previous settlement with the U.S. Department of Justice (DOJ) and the Centers for Medicare and Medicaid Services (CMS) in December 2004—will put the bulk of the legal issues behind HealthSouth.

In the late 2004 agreement with CMS and DOJ, the company agreed to pay the United States $325 million to resolve allegations of Medicare fraud involving outpatient physical therapy services and inpatient rehabilitation admissions. As part of the settlement agreement, HealthSouth entered into a five-year corporate integrity agreement with the Department of Health and Human Services Office of Inspector General.

## OIG Excludes Miami Hospital From Federal Programs

The Health and Human Services Office of Inspector General (HHS OIG) said March 10 that it is excluding Miami's South Beach Community Hospital, formerly known as South Shore Hospital and Medical Center, from participation in Medicare, Medicaid, and all other federal healthcare programs.

The action resulted from South Beach's material breach of the terms of a corporate integrity agreement (CIA) it negotiated with the OIG in 2002 as part of the resolution of a False Claims Act case against the hospital.

"South Beach has committed repeated and flagrant violations of its obligations under the CIA," said Inspector General Daniel Levinson in a statement. "This exclusion sends a clear message to the provider community that the OIG will not hesitate to pursue an action against those providers that fail to abide by their integrity agreement obligations.

On Dec. 2, 2005, the OIG notified the hospital that it intended to exclude it based on the hospital's material breach of its obligations under the CIA. For example, South Beach failed to meet multiple reporting requirements, failed to retain an Independent Review Organization, and failed to provide notification of the sale of the hospital. South Beach had 30 days to demonstrate that it was in compliance with the obligations of the agreement, that it cured the breach, or that it was pursuing cure of the breach with due diligence.

In December, South Beach officials told the OIG that it would cure the material breach of the CIA by February 28. The OIG reviewed written submissions and performed a site visit at the facility to evaluate the extent to which the hospital may have resolved the breach. Based on this review, the OIG determined that the hospital failed to take the timely corrective actions necessary, and, in fact, had failed to meet its own timetable to take such actions.

Based on South Beach's failure, the OIG says it is exercising its contractual right to exclude the hospital from participation in all federal healthcare programs for five

years. The hospital has the right to request a hearing before an HHS Administrative Law Judge, with a right to further appeal to the HHS Departmental Appeals Board.

In anticipation of the action, South Beach in February closed its doors and filed for bankruptcy, according to a report in the *Miami Herald*. A new corporation has applied to the state to take over the hospital, but the Medicare ban will apply to any new owner unless successfully appealed.

## Pathologist Gets $700,000 Settlement

A pathologist who filed a whistleblower lawsuit against his former employer has received a $700,000 settlement, according to a report in the *Press of Atlantic City* (NJ).

The March 9 report said Dr. Ali Daneshvar claimed he was fired by Atlantic Pathologists because he refused to submit insurance claims in cases where physicians failed to include diagnosis codes documenting the need for the tests. Dr. Daneshvar said there were several instances in which a patient's registered diagnosis did not support the ordered test.

Dr. Daneshvar filed the lawsuit after his 2002 termination from the pathology group, the *Press* reported. He had worked there for 11 years. The doctor now runs his own laboratory in Northfield.

"My client tried to resolve this for six months internally between the group and the hospital before he sent (a) letter to the fraud hotline in November 2001," said attorney Mark Pfeffer. "He is an honest guy. The reason it was settled was because it was apparent the jurors would vindicate him based on the questions they asked."

Atlantic Pathologists agreed to the settlement during jury deliberations in the trial before Judge William Nugent in the Atlantic County Civil Courthouse. James Cutro, the attorney for the group, said Atlantic Pathologists agreed to settle for business reasons, "not because they did anything wrong."

While this case may be one of wrongful termination, it also should serve as a reminder to pathology groups that they cannot submit claims for payment that do not contain the appropriate diagnosis codes, notes Barry Portugal, president of Healthcare Development Services, Inc., a lab consulting firm (Northbrook, IL).

"If there's a lesson to be learned, it's that you have to be careful in any business relationship with your partners to have open communication about the policies and protocols of the group, otherwise you run the risk of having these kinds of awards," Portugal tells *GCR*.

**Resources**

- Press of Atlantic City: *www.pressofatlanticcity.com*
- Barry Portugal: 847-498-1122

## ASCP Acquires MIME's Cytology PT Business

The American Society for Clinical Pathology (ASCP) has acquired the complete cytology product line of the Midwest Institute for Medical Education (MIME), based in Indianapolis.

Until recently, MIME was the only approved provider of cytology PT. As of 2006, the College of American Pathologists (CAP) and the state of Maryland (for labs that test specimens from state residents) are also approved providers.

While ASCP now plans to conduct gynecological cytology proficiency testing, officials say they also intend to work with the Centers for Medicare and Medicaid Services to revise the current regulations so that they reflect current practice and scientific and psychometric validity.

To enroll in ASCP's cytology PT program, call 800-267-2727 (option 2) or go to *www.ascp.org/proficiencytesting*.

COMPLIANCE PERSPECTIVES

# The Year Ahead For Laboratories: The View From Washington

*Peter Kazon, Esq., is senior counsel with Alston & Bird (Washington, D.C.)*

When last year ended, Congress was still waiting to pass the Deficit Reduction Act of 2005, which needed a final vote in the House before being sent to the president for his final signature—an act which finally took place on February 8, 2006. Even though the ink is just dry on that significant piece of legislation, it is now time to think about the year ahead and what Congress may have in mind for healthcare providers and laboratories in particular.

Of course, one major difference between last year and this one is that 2006 is an election year, which means that Congress is in session for fewer days. Usually, Congress is less willing to tackle big, difficult issues in election years as well, which will make it harder to pass a large budget bill, such as was passed last year. Nonetheless, it seems clear that the mounting deficits will continue to fuel budget concerns and keep the pressure on the White House and Congress to find additional budget savings. And, Medicare remains the primary target for any budget cuts. So, it's never too early for a little crystal ball gazing to see if we can anticipate what might lie ahead for providers of laboratory services.

One key area of focus for the coming year that will have little direct impact on laboratories is the implementation of the new Part D outpatient prescription drug benefit. The program got off to a "rocky" start when it was implemented this year, and was the subject of numerous articles and reports of start-up difficulties. As a result, it seems inevitable that members of Congress and key committees will spend some time and energy reviewing the Center for Medicare and Medicaid's (CMS) actions in implementing the new Prescription Drug Program.

### Physician Payment

The one issue that will almost certainly require some action is the question of payment for physicians, an issue of importance to pathologists and laboratories performing anatomic pathology and other similar types of testing. Each year, CMS is required to calculate the amount by which physicians will be paid based on a formula that is prescribed by the Medicare statute. Although the analysis is complex, the basic issue is not—each year when CMS applies the formula, it determines that it will be compelled in the coming year to reduce the amount that is paid for physician services under Medicare, a situation that Congress typically acts to reverse.

In 2005, CMS proposed a 4.4% reduction in the physician fee schedule, and Congress acted to fix this situation, and instead froze physician payments for the coming year. However, because these legislative fixes cost money, Congress must offset these increases with additional cuts somewhere else in the budget.

Even if Congress fails to enact a budget this year, members of Congress will face increasing pressure from physician constituencies to prevent another significant reduction in the CY 2007 physician fee schedule. The cost of avoiding such a shortfall is significant, probably as much as $8 billion to $10 billion. If Congress does not complete its work by October 6, when it is scheduled to adjourn, Congress could be forced to return after the elec-

tion. If that happens, the physician budget fix might not occur until later in the year, when it can be added to a major year-end appropriations bill. Though Congress has frequently considered some systemic change to the physician fee schedule, which would fix the recurring issues with the current system, such a solution seems especially unlikely in an election year given the high cost of such a solution. As a result, we are probably looking at another short-term fix, lasting one or two years.

***A key issue for hospitals is likely to be the attention paid to pricing issues, especially with regard to the amounts that hospitals charge to the uninsured and the underinsured.***

**Laboratory Payment**

Clinical laboratory services, which are paid on the basis of the separate laboratory fee schedule, were left untouched in 2005, but that may be due to the bruising battle that took place during consideration of 2003's Medicare Modernization Act (MMA). At that time, Congress rejected the implementation of a copayment for laboratory services, but did impose a freeze on scheduled cost of living increases for laboratories. That freeze is scheduled to run through 2008.

In addition, the MMA also called for a demonstration that would attempt to determine how competitive bidding processes, currently required for some durable medical equipment services, might be applied to laboratories.

The president's budget proposal for 2007, released in February, called for that demonstration to be accelerated and would, if enacted, mandate laboratory competitive bidding across the board on a national basis to begin sometime after 2008. The budget assumes a 5% savings, if the current clinical laboratory fee schedule were replaced by competitive bidding. The proposal has spurred the major organizations representing laboratories to act to oppose the plan, and it is not clear how seriously the proposal will be taken on Capitol Hill, especially given the fact that the laboratory competitive bidding demonstration has yet to get beyond the planning phase.

Meanwhile, CMS continues to work on the demonstration project for competitive bidding for laboratories. CMS has designated a contractor and a consultant to establish the competitive bidding demo. That contractor, RTI, has announced a model that will be used to operate the demonstration; however, a number of key issues remain, including, and most importantly, where the demonstration will occur and when the process is likely to begin. Of course, with the recent announcement of the president's budget, there is also another issue—whether competitive bidding will be instituted for real, before the demonstration even gets started.

**Hospital Payment**

Because of their huge share of the Medicare pie, hospitals are always a tempting target for budget cutters. If there is a need for budget cuts, then hospitals could expect to see some reductions in the market-basket increases that they would otherwise receive. However, the other key issue for hospitals is likely to be the attention paid to pricing issues, especially with regard to the amounts that hospitals charge to the uninsured and the underinsured. Hospital billing practices in these areas has been the subject of a number of high-profile lawsuits, targeted at tax-exempt hospitals. In addition, Senate Finance Committee Chairman Chuck Grassley, of Iowa, has begun his own inquiry into 10 nonprofit hospital systems.

Hospital pricing is also the subject of so-called "price transparency proposals," which have recently been receiving great attention. Roy Ramthun, a special assistant to the president for economic policy, has said that the administration will be asking government healthcare programs, including Medicare, the Federal Health Benefits program, and the Defense Department's TRICARE program to pub-

lish provider pricing information to the public. The argument is that this will allow beneficiaries to make better informed decisions before they decide where or how to be treated.

Earlier this year, at the annual meeting of the Federation of American Hospitals, another representative of the administration, Allan Hubbard, director of the president's National Economic Council, took hospitals to task for failing to take the lead on "pricing transparency." He stated that it was "absolutely indefensible" that the hospital industry did not provide better pricing information to consumers and argued that the administration would go to Congress to get such legislation if hospitals did not act voluntarily. Indeed, several members of Congress have introduced bills that would require hospitals and ambulatory surgical centers to report average and median charges for commonly performed procedures and drugs, information that would then be posted by the Department of Health and Human Services (HHS) on the Internet. Although it is still early, look for "price transparency" to become a new "buzz word" in Washington, like "Pay for Performance" or "eHealth."

**Fraud & Abuse**

The whole discussion of "price transparency" took an unusual detour recently when Congressman Bill Thomas, from California, chairman of the powerful House Ways and Means Committee, wrote to HHS Secretary Michael Leavitt that the administration's emphasis on price transparency was doomed to fail because the Office of Inspector General had not acted on its proposed rule directed at enforcing the "substantially in excess" provision in the Medicare fraud and abuse laws (*see related article on pg. 10*).

The HHS Office of Inspector General (OIG) issued a proposed rule in 2003, which would have enforced a provision in the Medicare fraud and abuse laws that is designed to prevent providers from charging Medicare "substantially in excess of their usual prices." While the provision has never been enforced because of its vagueness, the OIG's 2003 iteration was an attempt to eliminate the prior uncertainty by better defining some of the statute's key terms. The OIG proposal was opposed by most organizations representing providers, and there appeared to be little movement in making it final.

On March 10, however, Thomas urged the OIG to move forward with its rule and argued that it would be impossible to achieve price transparency without such action, because "hospital charges have become so grossly inflated above their private market rates so as to be almost meaningless." The relationship between the OIG's proposed rule and the success of price transparency is not totally clear, but given the powerful position played by Congressman Thomas, the OIG's rule could be the subject of renewed interest.

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The president's budget has also called for an increase in monies for the OIG, which enforces the Medicare fraud and abuse laws, but much of that increase is slated to be used to safeguard the new Medicare prescription drug benefit. Federal prosecutors and officials from the OIG have given numerous speeches emphasizing the fraud and abuse risks created by this new benefit, so we expect a great deal of attention to be given to that area. Nonetheless, the OIG said in its 2006 workplan that it intends to "compare the rates paid by Medicare for certain laboratory tests against the rates paid by other federal and state health programs and by private payers for the same services. This study follows up on previous OIG studies, which concluded that Medicare paid significantly higher prices than other payers for certain tests." Thus, laboratories can still expect to be the focus of some OIG scrutiny.

### Health Information Technology

Another area where there is likely to be great interest is in the growth of health information technology. President Bush's budget called for over $160 million to accelerate progress in promoting the spread of health information technology. Most of that will go to the new office of the National Coordinator for Health Information Technology, currently headed by Dr. David Brailer. HHS Secretary Leavitt has established an advisory panel to help guide the national transition to electronic health records and to move the health system toward a system of interoperable health records.

There are several other key initiatives that are under consideration as part of the movement to the electronic health records. First, CMS and the Office of Inspector General are each looking at new regulations designed to help ease the way to the electronic health record, in the form of new exceptions to the Stark self-referral law and new safe harbors under the anti-kickback law. In addition, Congress is also looking at legislation in this same area.

### Pay For Performance

Although "pay for performance" was the subject of a great deal of discussion in 2005, the Deficit Reduction Act did not actually include any new pay for performance (P4P) provisions. P4P is designed to permit Medicare to vary its payment based on the quality of the services furnished, so that providers of higher quality services are paid more. The Medicare Payment Advisory Commission (MedPAC) has urged Congress to institute measures that would allow it to tie payment to quality for different types of providers. Although P4P was not included in the final legislation that was passed last year, it is clear that Congress continues to be interested in the concept. CMS is also undertaking several initiatives that would allow it to capture data about the quality of care provided to Medicare beneficiaries. For example, in a program that is beginning this year, physicians will have the option of making voluntary reports on key quality of care indicators.

While laboratories have not been the subject of P4P indicators, they will still have an important role to play in the P4P process. MedPAC has proposed that laboratories should be required to furnish certain clinical laboratory values to CMS as part of the billing process, to allow the Medicare program to better assess the quality of care that physicians are furnishing. Many laboratory groups were concerned about the added costs of such proposals, as well as the technological difficulties presented by trying to report laboratory values in a uniform manner. Nonetheless, MedPAC apparently believes that this laboratory information is vital to the P4P process and will look for ways for laboratories to furnish it.

### MedPAC Recommendations

MedPAC has another important role to play with regard to laboratory payment. Although it is primarily an advisory organization that reports to Congress on issues related to the Medicare program, its reports are read very seriously and given close attention by key congressional committees. At its meeting in fall 2005, MedPAC raised a number of issues concerning the volume of growth in laboratory services. This was the first time in memory that MedPAC had taken a close look at laboratory payment. Its primary concern seemed to be with what it believed was a growth in the volume and an increase in Medicare spending for laboratory services. Although MedPAC did not discuss laboratories in its most recent report, issued in March 2006, it seems likely that it may continue to review the issue of laboratory payment and spending.

In sum, although election years are often marked by fewer pieces of "major" legislation, there is still plenty to keep laboratories and their representatives busy in the coming year.

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# Tenet To Pay $7 Million To Settle Florida Charges

Tenet Healthcare (Dallas) will pay the state of Florida $7 million to settle pending allegations, including a civil lawsuit regarding Medicare outlier payments and an investigation into Medicaid payments.

In separate statements issued February 21, Tenet and Florida Attorney General Charlie Crist (R) said the settlement agreement would resolve all issues associated with a March 2005 lawsuit filed by the state in U.S. District Court for the Southern District of Florida on behalf of 13 county hospital districts, healthcare systems, and nonprofit corporations.

In that lawsuit, the state alleged that Tenet violated both the federal and state civil Racketeer Influenced and Corrupt Organization (RICO) statutes by "gaming" the state's outlier fund—a special program that provides reimbursement for expensive procedures exceeding Medicare's standard reimbursement rates—by improperly inflating charges for medical procedures.

The settlement also ends an investigation begun in mid-2003 by the Florida Medicaid Fraud Control Unit of certain Medicaid payments and a separate investigation begun in early 2005 by that unit of Medicaid psychiatric billings at a Tenet hospital in South Florida. Tenet denies all allegations.

The agreement does not resolve a separate $1 billion lawsuit filed by Boca Raton Community Hospital that alleged Tenet inflated reimbursement claims for Medicare outlier patients. Company officials said they have filed a motion for partial summary judgment in the case and are opposing certification of a putative plaintiff class. In that lawsuit, as many as 4,000 public hospitals nationwide could seek treble damages from Tenet.

As part of the settlement, Tenet will pay $4 million to establish an "uninsured patient fund" to pay for care of indigent patients at the 13 plaintiff hospitals in the lawsuit. Another $1.9 million is to go into an escrow account that would be distributed to the plaintiffs, while about $1 million will go to pay for the state's investigation of the case.

**Resources**

- Tenet statement: *www.tenethealth.com*
- Florida attorney general's statement and settlement agreement: *http://myfloridalegal.com/webfiles.nsf/WF/JFAO-6M7RBW/$file/Tenet+Settlement.pdf*

# Kansas AG Investigating Hospital Billing Practices

Kansas Attorney General Phill Kline (R) said March 9 that he has opened an investigation into the billing and collection practices of the state's nonprofit hospitals.

The investigation began during 2005, after Kline's office received complaints from consumers throughout the state claiming that hospitals had engaged in "questionable business practices," according to a statement from Kline's office. "The complaints concerned overly aggressive collection actions, unnecessary collections litigation, and the charging of excessive rates, it said.

Shortly after opening the investigation, Kline discussed the complaints at a meeting of the Midwest Attorneys General Association, where other attorneys general reported receiving similar complaints from consumers in their states, the statement said.

Kline also met with representatives of the state's hospitals "to express those concerns and to begin discussions that, it is

hoped, will result in a system of best practices by which hospitals will operate their billing and collections operations," according to the statement. Kline also appointed a former state attorney general, Robert Stephan, as assistant attorney general to lead the discussions, it said.

### Examination Of Contracts

The investigation will examine contracts between the hospitals and third-party collection agencies, as well as hospital policies covering care to the poor and care for which no payment is received.

In addition, it will look into cases in which hospitals appear to have charged excessive rates, failed to submit timely paperwork to receive insurance reimbursement, and engaged in unnecessary or "frivolous" collections litigation against indigent patients.

"Not-for-profit hospitals provide an invaluable service to the community," Kline said in the statement. "While most of these institutions conduct business in a professional and ethical manner, we must work diligently to ensure that those who can least afford quality healthcare aren't subjected to unconscionable practices by those who do not."

The Kansas Hospital Association (KHA) says it is working with Kline's office to "identify best practices for billing and collection practices." The association first received an inquiry from Kline's office in February.

"Hospitals make every effort to get correct financial and billing information and educate patients on charity programs and payment options," said Tom Bell, president of KHA, in a statement. "It's important to note that hospitals are hard at work, looking for ways to assist patients who are uninsured or of limited means."

Bell estimates that there are about 300,000 uninsured Kansans. There are 127 community hospitals in the state, of which 121 are nonprofit, according to KHA.

### Resources

- AG Phill Kline statement: *www.accesskansas.org*

## HHS Blasted Over Provider Charges Rule

House Ways and Means Committee Chairman William Thomas (R-CA) is criticizing the Department of Health and Human Services (HHS) for delays in setting up a system to determine when Medicare providers are charging too much for healthcare services.

Noting that a 2003 proposed regulation by the Office of Inspector General (OIG) to codify HHS powers on the issue has not been finalized, Thomas said lack of a final rule could jeopardize President Bush's plan to ensure that the prices of medical services are generally known.

In a March 10 letter to HHS Secretary Michael Leavitt, Thomas said the failure to publish a final rule on charges could stymie Bush's plan to create price transparency "because hospital charges have become so grossly inflated above their private market rates so as to be almost meaningless."

Thomas also told Leavitt that the failure of HHS's Office of Inspector General to finalize the rule is "unacceptable" and has led the committee to question whether a proposal in Bush's fiscal 2007 budget blueprint to increase funding for the OIG's Healthcare Fraud and Abuse Control Account is "warranted."

Thomas said the OIG's failure to act is affecting the integrity of the Medicare trust fund "and the success of [Bush's] recent initiative to increase healthcare price transparency." Lack of controls also has led to $9 billion in overpayments from federal healthcare programs since 1988, he added.

The letter comes as issues of price transparency, hospital overcharges, and the nonprofit status of providers are heating up among congressional lawmakers and officials in the Bush administration. For example, in the latest in a series of letters to hospitals, Senate Finance Committee Chairman Charles Grassley (R-IA) on March 8 asked hospitals to put forward within 30 days legislative recommendations to allow hospitals to provide price discounts to their uninsured and low-income patients.

The White House has urged hospitals to make public the prices they charge, and several congressional committees are examining hospital's tax-exempt status and charity obligations, and whether the facilities overcharge the uninsured and low-income individuals for healthcare services. The administration has said it will work with Congress to impose a pricing transparency system on hospitals if they do not voluntarily adopt one.

Most recently, a White House official said the administration will be asking Medicare, the Federal Employee Health Benefits Plan, and the Department of Defense's TRICARE program to give pricing information to the public, so beneficiaries can make informed price decisions before they are treated.

### Congressional Authority

Thomas noted that Congress in 1988 gave OIG the authority to determine what constitutes an excessive level of charges submitted by a provider or supplier to Medicare and Medicaid. The OIG proposed, but then withdrew, regulations on the issue in 1990 and 1997 and has not finalized a 2003 proposed rule. On Sept. 15, 2003, the OIG published a proposed rule designed to clarify the authority to exclude providers that submit Medicare or Medicaid claims containing excessive charges or costs.

That proposal would preclude hospitals, laboratories, and virtually all other Part B providers from charging Medicare or Medicaid "substantially in excess" of their "usual charges" for a covered item or service (*GCR*, Nov.-Dec. 2003, p. 1).

Under the proposal, "substantially in excess" would be any amount more than 120% of a provider's "usual charge," which the OIG would define as amounts billed to cash-paying patients, patients covered by indemnity insurers with which the provider has no contractual arrangement, and any fee-for-service rates that a provider agrees to accept from any third party, including managed care plans.

The proposal was widely criticized in the healthcare community as controversial and poorly written and has languished at the OIG's office since 2003.

## For the Record

### Final HIPAA Enforcement Rule Takes Effect

As of March 16, 2006, the enforcement provisions of the federal healthcare privacy rule will apply to other federal rules implementing administrative simplification provisions for electronic data exchange under HIPAA (the Health Insurance Portability and Accountability Act).

The Department of Health and Human Services announced the change in a final rule in the February 16 *Federal Register*. Affected rules include security, electronic transactions/code sets, and standard unique identifiers for healthcare providers.

Of note, the enforcement rule makes it mandatory for HHS to impose a civil monetary penalty (CMP) if HHS determines that a HIPAA violation has occurred. The amount of the CMP is subject to the following limitations:

- It may not be more than $100 for each violation;
- It may not be in excess of $25,000 for identical violations during a calendar year; and
- If a requirement or prohibition in one administrative simplification provision is repeated in a more general form in another administrative simplification provision in the same subpart, a CMP may be imposed for a violation of only one of those administrative simplification provisions.

The February 16 rule is available at *www.hipaadvisory.com/regs/regs_in_PDF/finalenfor.pdf*

**United Contract Changes:** United Healthcare has added language to its standard agreements in Texas permitting United to deduct from amounts due a pathology provider any amounts billed by the pathology provider to a patient, as well as any costs or expenses (including legal expenses) incurred by the patient or United Healthcare with respect to such billed amounts, according to the law firm of McDonald Hopkins Co., LPA (Cleveland, OH). "Apparently, this means that even if United Healthcare fails to pay for covered services in breach of the agreement, if the pathology provider bills the patient for such services, United can deduct the amount billed as well as costs or expenses incurred by the patient or United in challenging such bill," advises the firm in a recent alert. "It appears as though these changes may have been made by United Healthcare to address repercussions stemming from its termination of payment for the professional component of clinical pathology services."

**Whistleblowers & Health Fraud:** Healthcare fraud cases make up the largest share of False Claims Act whistleblower cases and prove to be the most lucrative in terms of what the whistleblower gets to keep, according to findings issued March 3 by the Government Accountability Office (GAO). The agency said there were 1,145 healthcare fraud cases filed in the 1987 to 2005 period studied, of a total of 2,490 FCA whistleblower cases that were closed and unsealed. Next highest on the list was procurement fraud (818 cases). Healthcare fraud qui tam recoveries were also larger than in other types of fraud, GAO said: $5 billion from 385 recoveries in the 1987 to 2005 period, compared to $1.6 billion in 267 recoveries for procurement fraud.

**Quality Improvement Reform:** The American Health Quality Association (AHQA) is proposing to revamp the beneficiary complaint system operated by the Medicare Quality Improvement Organization (QIO) with a series of proposals that it said would ensure quicker action on complaints and a more transparent process. AHQA, which represents QIOs, called on Congress to pass legislation that would create a Medicare Accountability Program to replace the current beneficiary complaint process. The changes would significantly reduce the amount of time needed for QIOs to investigate beneficiary complaints.



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