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Law & Business

DOJ revises charging guidelines for prosecuting corporate fraud

by Katherine Geraghty, J.D., Contributing Editor

The highly anticipated release of the Department of Justice's (DOJ's) new guidance regarding corporate charging guidelines for federal prosecutors was announced by U.S. Deputy Attorney General Paul J. McNulty on December 12, 2006. The guidance, which replaces a Memorandum from Deputy Attorney General Larry D. Thompson entitled "Principles of Federal Prosecution of Business Organizations" issued January 20, 2003 (see *Health Care Compliance Reporter* ¶630,002), continues to require consideration of the nine factors outlined in the Thompson memo, but also creates new approval requirements with which federal prosecutors must comply before they can request that corporations waive attorney-client privilege and work product protections in criminal investigations.

McNulty, who announced the new guidance in a speech at a meeting of the Lawyers for Civil Justice in New York, said the new guidance is meant to encourage full and frank communication between corporate counsel and its employees, while at the same time preserving the DOJ's ability to prosecute corporate fraud cases successfully. In addition, the DOJ wants to "encourage corporations to prevent corruption through self-policing and continue to punish wrongdoers through cooperation with law enforcement," he said.

Requests for waiver. The new guidance creates a tiered approach for determining when prosecutors may request that a corporation provide protected materials. Under this scheme, prosecutors must first request purely factual information, or Category I information, which may or may not be privileged, relating to the underlying misconduct. Category I information includes copies of key documents and witness statements. Only when Category I information provides an incomplete basis to conduct a thorough investigation may prosecutors request the corporation provide attorney-client communications or nonfactual attorney work product, or Category II information.

The guidance also requires that prosecutors obtain written authorization from the U.S. Attorney, who then must provide a copy of the request to the Assistant Attorney General for the Criminal Division before granting or denying a request to waive the attorney-client or work product protections. In addition, the request for information must set forth a legitimate need for the information and identify the scope of the waiver sought.

Advancement of attorney's fees. The new guidance prohibits prosecutors from considering a corporation's advancement of attorney's fees to employees when making a decision to charge a corporation, unless this action is taken by a corporation to impede the government's investigation. When seeking approval for fee advancement, federal prosecutors must follow the same authorization process established for seeking approval from the Deputy Attorney General to request waiver of attorney-client communications.

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Fraud and Abuse (cont.)

Legislative action. A week before McNulty's announcement, Senate Judiciary Committee Chairman Arlen Specter (R-Penn.) introduced legislation to protect the attorney-client privilege during corporate criminal investigations. The "Attorney-Client Privilege Protection Act of 2006" would make it illegal for any government agency, including DOJ, to use the waiver of attorney-client privilege and work product protections, as outlined in the Thompson memo, to determine the level of cooperation of companies under investigation. The bill also would prohibit prosecutors from considering a company's decision to pay the attorney's fees of an employee under investigation. ■

Department of Justice News Release, Dec. 12, 2006.

Tax Exempt Organizations

First federal charity care bill prompted by results of CBO reports

by Stacey Fahrner, J.D., M.P.H., Contributing Editor

Legislation entitled the Tax Exempt Hospital Responsibility Act (HR 6420) that, for the first time, would require not-for-profit hospitals to provide a minimum level of charity care has been introduced by Rep. Bill Thomas (R - Calif.), chairman of the Ways and Means Committee. The bill was proposed as a result of two recent reports by the Congressional Budget Office (CBO), which found little difference between the levels of charity care delivered by for-profit and not-for-pofit hospitals, and determined that many hospitals are financing operating assets through tax-exempt debt as opposed to spending their own investment assets.

Proposed legislation. Thomas' bill would require a minimum standard for hospital charity care for individuals with incomes under 100 percent of the federal poverty level and would limit expected payment by individuals with incomes under 200 percent of the federal poverty level to no more than the average insured rate.

CBO report results. In one report, the CBO directly compared the provision of community benefits by not-for-profit hospitals to for-profit hospitals. Community benefits included the provision of uncompensated care, services to Medicaid patients, and the provision of certain specialized services that have been identified as generally unprofitable. According to the report, not-for-profit hospitals were more likely than otherwise similar for-profit hospitals to provide certain specialized services, but were found to provide care to fewer Medicaid patients. Furthermore, not-for-profit hospitals were found to operate in areas with higher average incomes, lower poverty rates, and lower rates of uninsurance than for-profit hospitals.

While the report concluded that not-for-profit hospitals spent approximately $3 billion in uncompensated care in 2003 compared to $1 billion spent by for-profit hospitals, the difference in the total amount was largely attributable to the higher market share of not-for-profit hospitals. Likewise, the cost of uncompensated care as a share of hospitals' operating expenses was 4.7 percent and 4.2 percent at not-for-profit and for-profit hospitals respectively, while the uncompensated care share at government hospitals was 13 percent. According to Thomas, the Tax Exempt Hospital Responsibility Act would "create a more level playing field."

The second report requested by the Ways and Means Committee analyzed the magnitude of the tax advantages provided to not-for-profit hospitals as a result of their exemption from corporate taxes and ability to issue tax-exempt debt. The report concluded that under the current tax-exempt regulations, hospitals may be wasting resources by making less productive use of capital. Specifically, the report highlighted the use of tax-exempt bonds to finance buildings and equipment that could have been financed by selling their own investment assets.

"For those institutions that have been given much by their communities and by the American taxpayer, it is reasonable to expect a minimum benefit to the community in return," Thomas said, adding "It is my hope that this bill might serve as a discussion point in the next Congress.

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CCH Health Care Compliance Letter

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Tax Exempt Organizations (cont.)

The committee has done a lot of work in this area and I think it requires further legislative action." ■

Nonprofit Hospitals and the Provision of Community Benefits,CBO Report No. 2702, Dec. 2006; Nonprofit Hospitals and Tax Arbitage, CBO Report, Dec. 2006; Committee on Ways and Means Press Release, Dec. 11, 2006 .

Hospitals meeting community benefit standard, AHA says

by Stacey Fahrner, J.D., M.P.H., Contributing Editor

Hospitals responding to the 2006 Internal Revenue Service (IRS) questionnaire on community benefit services are meeting the standard established by IRS Revenue Ruling 69-545, according to a November 27, 2006, report prepared for the American Hospital Association (AHA) by Ernst & Young.

Key findings. The current charity care standard requires that tax-exempt hospitals provide substantial charity care and other community benefits, including immunizations and medical screenings. Of the 132 hospitals polled, 100 percent of the general/medical hospitals operated emergency rooms that provided services regardless of the patient's ability to pay. All of the hospitals had written policies stating the circumstances under which the hospital would provide uncompensated care. Finally, the hospitals reported providing uncompensated care to, on average, 12 percent of their total patients during the past year, which amounted to about $14 million per hospital.

Conclusions. The report concluded that the IRS should carefully analyze the lessons learned from the questionnaires before imposing additional reporting requirements on tax-exempt hospitals. In addition, the report urged the IRS to allow hospitals to tell their community benefit story in more than a simple yes or no response, including through filing their community benefit report with the IRS. The report also recommended that the IRS clarify questions and definitions to ensure uniform and reliable answers.

The AHA, which requested the report, said it plans to meet with the IRS to determine ways it can further comply with IRS regulations in "gathering consistent and uniform information about the community benefits that hospitals provide." ■

Community Benefit Information from Non-Profit Hospitals: Lessons Learned from the 2006 IRS Compliance Check Questionnaire, Nov. 27, 2006.

Medicaid Fraud and Abuse

OIG reviews first state false claims laws

by Michelle L. Oxman, J.D., LL.M., Contributing Editor

Following the Office of Inspector General's (OIG) review of ten state false claims acts, only three have met the requirements set out in section 6031 of the Deficit Reduction Act of 2005 (DRA) (PubLNo 109-171). As of January 1, 2007, states with laws meeting the DRA requirements qualify for an additional 10 percent share of any Medicaid funds recovered from providers or suppliers.

DRA requirements. To qualify for the additional funds, the state law must: (1) create liability to the state for presentation of false or fraudulent Medicaid claims; (2) provide incentives for the reporting and pursuit of those claims by allowing individuals to sue the providers in *qui tam* actions that are at least as effective as those in the federal False Claims Act (FCA); (3) require individuals to file their actions under seal for review by the state Attorney General so that the state can decide whether to become a party to the lawsuit; and (4) contain civil penalties that are at least equal to the federal FCA.

Results of the first reviews. Of the ten states that had submitted their FCAs for review, the OIG found that Illinois, Massachusetts and Tennessee met all four requirements. The most common reason for the OIG's disapproval was the requirement that the civil penalties match or exceed the federal law. California, Louisiana, Nevada and Texas failed to provide for a $5,000 minimum penalty for each false claim. Florida, Indiana and Michigan failed to impose liability for all of the improper claims covered by the federal law, and Florida and Nevada required earlier deadlines for bringing the lawsuit than the federal law. The Texas and Louisiana laws granted the relator a lower share of the recovery than the federal law, and the Texas law did not permit the relator

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Keeping your friends close and your business partners closer: Legal dynamics in the relationships among hospitals, physicians and manufacturers (Part IV)

by Steve Miller, J.D., and Jeffrey Miller, J.D., Contributing Editors

Hospitals, physicians, and manufacturers of health care-related products around the world strive to provide the highest quality health care products and services achievable. In a complex (and sometimes counterintuitive) regulatory environment defining the limits to appropriate business transactions can be a challenge. This four part article provides an introduction to the federal anti-kickback statute that addresses hospital and manufacturer rules in discounting prices without discarding compliance, and provides guidelines for physician consulting and professional services arrangements.

Part I of this article provided the background on the anti-kickback statute and the details of how an arrangement may be protected from prosecution under the statute. Part II provided details of the discount exception and potential discount risks; consignment arrangements; implementing controls to prevent unidentified discounts; and the effect of failing to satisfy the requirements of the safe harbor. Part III focused on manufacturer-physician consulting and professional services arrangements including compensation arrangements. Part IV, the final part, discusses charitable donations to hospitals and industry guidance regarding hospital and manufacturer relationships.

Manufacturer and suppliers grants and charitable donations to hospitals

As health care margins decline, not-for-profit health care providers are increasingly dependent on the ability to raise charitable donations to meet their mission of service to the community. At the same time they continue to struggle to identify sources of funding for community or physician education. On a larger scale, with the aging of the baby-boomer population, there is an impending growing need for additional hospital in-patient beds in the next 20 years.[66] This rising tide of need comes at a time when many are questioning the role of the for-profit health care sector. The increased need for support of community initiatives presents the for-profit sector with an opportunity to demonstrate "good corporate citizenship" and achieve a level of public goodwill, beyond meeting profit margins and shareholder expectations.

This new opportunity also brings with it corresponding legal and ethical challenges for compliance officers of both constituencies. To meet both of these goals, compliance officers and legal counsel will need to develop policies, procedures, and controls addressing charitable donations between business partners, especially those that provide and purchase health care items or services. These policies should take into account relevant statutory authorities, legal guidance from enforcement authorities, and the latest in industry guidance and trends.

The main legal concern involved in these relationships is the federal anti-kickback statute. Under the statute, it is a criminal offense to knowingly and willfully offer to pay, solicit, or receive any remuneration with the intent of inducing referrals of items or services reimbursable by federal healthcare programs.[67] In other words, the statute makes it illegal for a person or entity to offer to give something of value to cause another person to provide the offeror a business opportunity that will be paid for through the Medicare or Medicaid programs. A violation of the statute is a criminal offense and, as such, a violation occurs only when remuneration is paid with the intent of inducing the referral of items or services reimbursable by a federal healthcare program. The statute provides penalties for both the person offering the inducement and the person accepting the inducement.[68]

The United States Court of Appeals for the Third Circuit has interpreted the statute to cover any arrangement in which only one purpose of the remuneration is to obtain money for referral of services or items.[69] Violations of the statute constitute a felony and can result in criminal penalties, including a maximum fine of $25,000, five years imprisonment, or both. A provider also can be excluded from participation in federal healthcare programs for a violation of the statute.

Application of the anti-kickback statute to charitable solicitations or donations

In a series of guidance publications, the HHS Office of Inspector General (OIG) has discussed the application of the anti-kickback statute to charitable donations by vendors of health care providers participating in federal health care programs.

In Advisory Opinion No. 01-02, the OIG used the vehicle of a charitable golf outing to express its opinion that contributions by a vendor to a health care provider's charitable fundraising initiative clearly implicates the statute:

> This Office's concern with the provision of monetary donations to actual or potential referral sources is longstanding and clear: such arrangements are suspect and may violate the anti-kickback statute if one purpose is to induce or reward referrals of Federal health care program business. Those concerns are not necessarily ameliorated when the donation is in the form of sponsorships or participation in a charity golf tournament that would benefit the Requester, an actual or potential source of Federal health care program business for some sponsors and participants.[70]

While the OIG recognizes that most donations made by vendors are for true charitable purposes, it believes these arrangements should be carefully crafted to avoid abuse. "We accept that the majority of donors who make contributions to tax-exempt organizations, including donors with ongoing business relationships with the donees, are motivated by bona fide charitable purposes and a desire to help their communities."[71] The charitable and tax deductible nature of the donation, however, does not remove concern over the donation's potential effect on medical decision making, quality of care, and utilization. While the bona fide purposes do not make the donation exempt under the statute, the OIG cited certain safeguards that may reduce the likelihood that the OIG would implement sanctions.

- First, funds must be donated to a bona fide charitable purpose or event that is intended to provide community benefits. To meet this standard, it is important that the recipient of the funds be able to demonstrate the purpose to which the funds will be dedicated.[72]
- Second, fundraising solicitations should not be limited to business partners or suppliers. The not-for-profit organization should be able to demonstrate that it solicited support from its community in general. This can be supported by having the fundraising campaign run by a committee made up of members of the community and having materials that are widely distributed.[73]
- Third, the organization soliciting the funds should have a policy that expressly states that it will not take participation in the fundraiser into account when awarding or renewing contracts. This policy should be communicated to all recipients of fundraising materials.[74]

While the above safeguards are not onerous, they will not fit every fundraising situation, especially those that are geared toward larger, capital campaigns. Additionally, OIG Advisory Opinions are only applicable to the requestor. The concepts can be used, however, when designing controls for fundraising solicitation campaigns.

Educational grants

Educational grants are another area that presents significant risk. An OIG Compliance guidance and two industry created voluntary codes are valuable in analyzing these arrangements.

The 2003 Compliance Guidance for Pharmaceutical Manufacturers contains substantial discussion of educational grants to health care providers and provides a window to federal concerns about these arrangements.[75] The OIG recognizes that pharmaceutical manufacturers sometimes provide grants to physicians and other health care providers for various educational activities. Noting that these donations fall within the broad scope of the statute, the OIG identified particular concern when the funding is conditioned on the purchase of product or when the donor has control over the substance of the program.[76]

One factor that the Guidance states can help reduce the chance that a grant will run afoul of the statute is separating the sales, marketing, and grant-making functions. By separating these duties, the provider can better ensure that grants are not influenced by inappropriate business concerns or marketing campaigns. Additionally, the OIG recommends the use of objective criteria for determining who is eligible to receive a grant and under what conditions a grant will be made. Of course, these factors cannot involve, directly or indirectly, the volume or value of business that a grantee brings or may bring to the grantor. The OIG also believes that the grantor should not control the speaker or the substantive content involved in the educational session. Finally, the provider should have effective procedures to monitor and document compliance with its procedures.[77]

Other industry guidance

AdvaMed Code of Ethics on interactions with health care professionals

The AdvaMed Code of Ethics addresses the use of charitable donations to sponsor product training and education, third party educational conferences, and grants and other charitable donations. The Code's standards for all types of charitable donations are similar and focus on ensuring that the charitable action serve a bona fide purpose and insulating the donation from affecting the donee's purchasing decisions.

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Member sponsored product training and education. When distilled to its core elements, four factors are important in separating bona fide product training and education from less legitimate functions.

- The first factor is that the program serves a bona fide need. In other words, the code emphasizes that the need met by the training session be real, and the content of the session be substantial. To that end, training sessions should be led by qualified individuals with appropriate credentials. Citing Food and Drug Administration requirements, the Code takes the position that members have a responsibility to make this training and education available.
- Second, the location of the training environment must be conducive to education. Hotels or other conference centers can be appropriate, but when the training need is "hands-on," the setting should be more clinical.
- Third, the clear and overriding purpose of the session should be educational; any incidental entertainment or hospitality associated with the program should be limited. This means that meals and hospitality receptions should be modest in nature and value. Time spent on these extracurricular events should be substantially small when compared to time spent on education and training.
- Finally, reimbursement of travel and lodging expenses, while permissible, should be limited to individuals with a real educational reason to attend the session. It is not appropriate to reimburse expenses for spouses of attendees who are not attending the sessions for educational purposes. The limitation on meals, entertainment and other hospitality promote the bona fide educational nature of the program and limit any effects that the program will have on the donee's purchasing decisions.

Third party educational conferences. Like member sponsored product education and training, the Code focuses on the bona fide nature of the program and limiting factors that may detract from independent purchasing decisions on the part of attendees. Programs should be independent sessions promoted by genuine scientific conferences, especially those sponsored by major professional associations. The Code endorses its members providing grants directly to a program sponsor either to reduce costs of attendance or to provide a scholarship for attendance by residents or other health care professionals in training.

Funding also may be provided to defer the costs of course faculty, but like funding for attendees, payments should be made to the conference organizer and not individual members. The content of the sessions, the attendees and the speakers should all be chosen by the training organization. As with member sponsored product education and training, meals and other hospitality and entertainment should be modest, open to all attendees and limited in time and scope.

Other charitable donations. In terms of supporting other charitable functions, the AdvaMed Code approves the donation of funding to support genuine independent medical and scientific research and education, "indigent care, patient education, public education or the sponsorship of events where proceeds are intended for charitable purposes." The broad language of this provision appears to encompass most traditional fundraising campaigns by not-for-profit organizations. Independence is the key factor in supporting the legitimacy of such donations. Donations should be made by the charitable wing of the member, and should go directly to the charitable wing (in most cases foundation) of the not-for–profit. Donations should not be made to organizations whose primary mission is not charitable, and donations to individuals should occur rarely.

PhRMA Code on interactions with health care professionals

The PhRMA Code is voluntary for members of the association and provides guidance on issues of charitable donations between members and other health care providers. The Code addresses charitable donations for the purpose of supporting third party educational meetings and scholarships. Noticeably lacking from the PhRMA guidance is a discussion of charitable donations for other purposes, such as to support indigent care or scientific research.

The PhRMA code approaches the sponsoring of third party educational programs in a fashion similar to the AdvaMed Code. PhRMA endorses the funding of continuing medical education (CME), or other third party scientific conferences when:

- the conference is for a bona fide educational purpose;
- the location of the conference is conducive to its educational purpose;
- the subsidy is made directly to the conference sponsor;
- the third party retains control over the substance of the session; and
- the third party retains control over faculty and attendees.

Financial support can be provided to cover or reduce hospitality and meal costs but should be modest in value and nature and conducive to the educational nature of the function. Members also can fund scholarships, but the third party organizer must determine who receives the scholarship. Finally the code makes the blanket statement that no funding should be provided in a manner to interfere with the independent medical decision making of attendees of the conference.

Conclusion

Read together, the OIG guidance and the industry codes largely approve of charitable support of not-for-profit organizations by health care manufacturers and suppliers, when the support can be done in a manner that does not negatively affect independence of medical decision making. When a supplier desires to support the charitable mission of purchasers and potential purchasers, consider implementing the following controls:

- establish formal standards for the types of organizations or activities that are eligible for support and for determining the level of support each organization can receive;
- establish a formal process for selecting organizations that will receive support;
- ensure that the controls above are independent from the sales function by confining the process to a charitable wing or department of the member; and

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On the Front Lines (cont.)

- prohibit charitable donations that are connected, directly or indirectly, to marketing campaigns or sales goals or history.

Finally, all such arrangements should be reviewed with the sometimes jaundiced view of compliance. It may be impossible to remove all undesired affects of such sponsorship. An unbiased review of the arrangement and the removal of factors that tend to create even the appearance of impropriety, however, will go a long way toward supporting one social good, without sacrificing the necessity of fully independent and honest medical decision-making.

[66] Under-bedded? What a difference a decade makes: Empty wings and shuttered facilities are now giving way to a demand for more hospital beds. Sharon M. Ruff Richter The Journal of Health Care Contracting, http://www.jhconline.com/article-marapr2005-construction.asp.

[67] 42 U.S.C. §1128(b).

[68] Under the Statute, the term "remuneration" is very broadly defined and includes any benefit in any form, with no minimum value required. Remuneration can be presented as a payment, rebate or a benefit of any kind, including the transfer of anything of value, "in cash" or "in-kind," directly or indirectly, covertly or overtly. The basic test of whether remuneration is involved in a transaction is whether the benefit offered has materially influenced the professional clinical judgment of the other party. See Letter dated May 20, 1991, from Richard P. Kusserow, Inspector General to Paul C. Rettig, Executive Vice President of the American Hospital Association (asserting that case law "makes it clear that the Statute's prescriptions apply to those who can materially influence the flow of Medicare or Medicaid business").

[69] *United States v. Greber*, 760 F.2d 68 (3rd Cir.), cert. denied, 476 U.S. 988 (1985).

[70] OIG Advisory Opinion, No. 01-02, Page 4, March 27, 2001.

[71] See *Id.* at Page 5.

[72] *Id.*

[73] *Id.*

[74] *Id.*

[75] Notice, 68 FR 23731, May 5, 2003.

[76] Notice, 68 FR 23731, 23735, May 5, 2003.

[77] *Id.*

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Medicaid Fraud and Abuse (cont.)

to pursue a case when the state chose not to participate.

The OIG has added a page to its web site on the state false claims acts. An explanation and the action on each law are available at http://oig.hhs.gov/fraud/falseclaimsact.html#1. ■

OIG Release, Dec. 29, 2006.

Hidden camera probe at nursing home reveals patient neglect, fraud

by Valerie L. Witmer, J.D., Contributing Editor

Nine employees of New York's Hollis Park Manor Nursing Home were arrested after a hidden camera investigation revealed that they failed to provide required care for a patient. The former medical director of the nursing home, two licensed practical nurses, and six nurse aides face multiple criminal charges as a result of the investigation, which was launched as part of a statewide initiative by the Attorney General's Medicaid Fraud Control Unit (MFCU) to combat nursing home abuse and neglect.

Patient neglect. Prosecutors allege that the camera, which was hidden in a resident's room to monitor her care over a five-week period, captured evidence of the nursing home staff's chronic patient neglect. The patient allegedly did not receive physician-ordered range of motion therapy to prevent contractures, was not turned and repositioned every two hours as required to prevent bedsores, and was not given prescribed medication. Additionally, the patient often failed to receive needed assistance while eating and frequently went without eating or drinking at all.

Fraud. The complaints also allege that the staff attempted to cover up its neglect by falsifying the patient's medical records to reflect that the required care had been provided. Specifically, the former medical director recorded that he examined the patient twice, once for a monthly physical exam and once for treatment of lung and abdomen problems; however, the hidden camera revealed that he entered the patient's room only once and never examined her.

Prosecutors have charged the former medical director with two counts each of endangering the welfare of an incompetent or physically disabled person, willful violation of health laws (patient neglect), both misdemeanors, and first degree falsification of business records, a felony carrying a four-year maximum prison term. The nurses and nurse aides have been charged with one count each of endangering the welfare of an incompetent or physically disabled person and willful violation of health laws (patient neglect) and multiple counts of first degree falsification of business records.

To date, the state's MFCU nursing home initiative has led to nine convictions, 19 arrests, indictment of one nursing home, and a civil suit against another. The investigation at Hollis Park Manor is ongoing. ■

New York Attorney General Press Release, Nov. 22, 2006.

Medicare

New restraint and seclusion rule protects patients' rights

by Stacey Fahrner, J.D., M.P.H., Contributing Editor

A final rule amending the Medicare conditions of participation regarding the use of restraints and seclusion requires that health care workers undergo more rigorous training to assure the appropriateness of the treatment and to protect patient rights. The rule also expands the category of practitioners who may conduct patient evaluations when a restraint or seclusion tactic has been implemented.

New requirements. The rule retains the requirement that a patient be evaluated "face-to-face" within an hour of a patient being restrained or secluded for the management of violent or self-destructive behavior; however, the final rule permits a trained registered nurse or physician assistant to review such actions in addition to a physician or other licensed independent practitioner. The basic rights specified in the final rule include a patient's right to notification of his or her rights in regard to care, privacy and safety, confidentiality of records, and freedom from the inappropriate use of all restraints and seclusion. Hospitals must provide the individual or family member with a formal notice of the patient's rights at the time of admission. These rights include freedom from restraints and seclusion in any form when used as a means of coercion, discipline, convenience for the staff, or retaliation. Stricter standards applicable when a health care facility must report the death of a patient associated with the use of restraints and seclusion also have been adopted with this rule.

According to Leslie V. Norwalk, acting administrator of CMS, the rule will allow CMS to "hold all hospitals accountable for the appropriate use of restraint and seclusion." The requirements apply to all participating hospitals including short-term, psychiatric, rehabilitation, long-term, children's and alcohol/drug treatment facilities. The final rule becomes effective on February 6, 2007. ■

Final rule, 71 FR 71378, Dec. 8, 2006, Health Care Compliance Reporter, ¶700,021.

In the News

CMS to send second annual provider satisfaction survey

CMS announced that it will conduct its second annual provider satisfaction survey of Medicare fee-for-service contractors who process and pay more than $280 billion in Medicare claims each year. The results of the first Medicare Contractor Provider Satisfaction Survey (MCPSS), released in September 2006, showed that the vast majority of Medicare health care providers is satisfied with the customer service, claims processing, and educational activities provided by these contractors. The survey focuses on seven major parts of the provider-contractor relationship – provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. CMS will send the survey to about 35,000 randomly selected providers, including physicians and other health care practitioners, suppliers, and institutional facilities that serve Medicare beneficiaries across the country. Providers should respond by February 2007. Survey results will be available in July 2007.

CMS Press Release, Dec. 28, 2006.

New taxonomy code requirement for institutional providers

Effective January 1, 2007, institutional Medicare providers who submit claims for their primary facility and its subparts (such as psychiatric unit, rehabilitation unit, etc.) must report a taxonomy code on all claims submitted to their fiscal intermediary. Taxonomy codes must be reported by these facilities whether or not the facility has applied for a national provider identifier (NPI) for each of its subparts. Institutional providers that do not currently bill Medicare for subparts are not required to use taxonomy codes on their claims to Medicare. A recent MedLearn Matters article discusses this requirement in more detail and may be viewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5243.pdf on the CMS website.

MLN Matters, MM5243, Dec. 20, 2006.

Hospital patient IDs stolen

A Seattle, Washington hospital announced it is cooperating with legal authorities on an investigation of a large, organized identity theft ring operating in the region. Two former staff members allegedly accessed and used private patient information for illegal purposes, including bank fraud and identity theft. The hospital has contacted all the known patients whose identification may have been illegally accessed and is providing them with credit restoration services.

Virginia Mason Hospital Press Release, Dec. 2006.

SEC announces SOX compliance date extension

The Securities and Exchange Commission adopted an extension proposed in August to further postpone the date by which smaller public companies must comply with the internal control reporting requirements mandated by Section 404 of the Sarbanes-Oxley Act of 2002. Previously, nonaccelerated filers (companies that do not meet the Exchange Act definition of either an accelerated filer or a large accelerated filer) were scheduled to begin including both management's assessment and an auditor's attestation to management's assessment on the effectiveness of the filers' internal control over financial reporting in their annual reports for fiscal years ending on or after July 15, 2007. The Commission is extending the date so a nonaccelerated filer will provide management's assessment regarding internal control over financial reporting in its annual reports for fiscal years ending on or after December 15, 2007.

SEC Press Release, Dec. 15, 2006 .