CCH Health Care Compliance LETTER

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OIG will not impose sanctions for free transportation program

A nonprofit skilled nursing facility (SNF) will not face sanctions or civil monetary penalties if it implements a proposed arrangement to provide free local transportation for family and friends of its residents. Although the arrangement could potentially generate prohibited remuneration under the anti-kickback statute, nothing in the transportation program shows an intent to induce or reward referrals of federal health care program business.

Transportation arrangement. The SNF is located in an area that is not easily accessible by public transportation, specifically for family and friends living within a nearby historical service area. Moreover, the facility and that historical service area are separated by a bridge that requires a $9 toll to cross. Under the arrangement, the SNF will provide transportation in a van it owns that will be driven by an employee of the SNF. The van will only transport friends and family of SNF residents and will pick up and drop off passengers at designated public locations within the facility's primary historical service area.

The proposed transportation arrangement will be offered uniformly to all SNF residents regardless of income level or source of payment. The SNF will not charge passengers or any third-party payor for the transportation, and it will not claim the costs of the transportation on any federal health care program cost report. The SNF plans to advertise the transportation program only within its primary service area by placing advertisements in a few community newspapers and in handbooks or written materials provided to discharged patients at local hospitals.

Risk of fraud. Although free transportation arrangements can have beneficial effects on patient care and make it easier for patients to receive visits from friends and family, such arrangements are also sometimes part of fraudulent or abusive schemes that lead to inappropriate steering of patients and the provision of medically unnecessary services.

Examples of potentially abusive arrangements include providers offering out-of-state patients free transportation to receive services at their facilities and van drivers offering free transportation to Medicaid patients for health care providers that compensate the drivers on a per patient or per service basis.

Because of the potential for abuse, courts generally evaluate free or discounted transportation service arrangements on a case-by-case basis. Factors to consider include: (1) whether transportation is offered in a manner related to the volume or value of federal health care program business; (2) whether luxury or specialized transportation is provided; (3) the geographic area over which transportation is provided; (4) the availability of other means of transportation; (5) marketing or advertising; and (6) who bears the costs of free transportation.

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Wolters Kluwer Law & Business

Anti-kickback (cont.)

Safeguards. Although this proposed arrangement potentially implicates the anti-kickback statute, the Office of Inspector General (OIG) will not impose civil monetary penalties or administrative sanctions because sufficient safeguards have been built into the program. The arrangement is open to the friends and families of all SNF residents and is not limited to targeted populations of federal health care program beneficiaries. The transportation provided under the arrangement will be reasonable and will not include luxury services. The arrangement will be offered and advertised only locally.

Moreover, the proposed arrangement is narrowly tailored to meet the needs of a community where the availability of public transportation is limited and the SNF is separated from its primary service area by a costly toll bridge. The cost of the transportation will not be claimed by any federal health care program cost report or otherwise shifted to the federal government. Ultimately, the proposed arrangement will align with the SNF's mission to provide residents with quality care in a residential setting through increased companionship resulting from access to friends and family. ■

OIG Advisory Opinion, No, 09-01, March. 6, 2009, Health Care Compliance Reporter ¶500,205

Antitrust

Experts share thoughts about antitrust concerns for health care providers

President Obama has voiced concerns with the current level of antitrust enforcement, especially with regard to the health care sector, so it is important that providers become more aware of any actions that may be perceived as violations. Health care providers may be vulnerable to possible criminal and civil liability related to antitrust violations, according to the presenters at a teleconference entitled "Antitrust Basics for Healthcare Lawyers" sponsored by the American Bar Association's Health Law Section. Such violations may result in the diversion of corporate resources due to the cost and time required to defend such actions as well as significant damage awards and criminal sanctions, according to presenters Bevin M.B. Newman, Esq. of Jones Day and John J. Miles, JD, a principal at Ober/Kaler.

Goals of antitrust laws. Antitrust laws are aimed at safeguarding competition in the marketplace by prohibiting agreements that restrict trade or monopolize any one commercial activity, mergers and acquisitions that lessen competition, and other unfair methods of competition, Newman said. Any aspect of these prohibitions could apply to health care as a marketplace competitor. The prohibitions are provided in laws such as §§1 and 2 of the Sherman Act, §7 of the Clayton Act, §5 of the Federal Trade Commission Act, as well as by individual state antitrust laws. The teleconference focused on §1 of the Sherman Act.

Appliction of Section 1 of the Sherman Act. According to Newman, §1 of the Sherman Act prohibits agreements, both horizontal and vertical, that restrain trade. Horizontal agreements are those among actual or potential competitors, while vertical agreements are those among firms in a buyer/seller relationship. In either case, an agreement must exist, although some need not be formal and may be inferred from the parties' conduct.

1. Horizontal agreements. Horizontal agreements may come in the form of an agreement among competitors, an exchange of information, or the use of competitive intelligence that the competitor has gathered, presenters explained. Especially dangerous are some horizontal agreements which, should they be challenged in court, are always illegal (illegal *per se*) because they are so harmful to competition in the marketplace. Examples of agreements that are illegal *per se* include purchase or selling price fixing, defined as an agreement among competitors directly affecting the price they charge although a specific price need not be set, as well as bid rigging, which is an agreement among prospective bidders as to which will win the bid. According to Newman, health care providers that are in a network are subject to these types of prohibitions.

One example of an agreement between competitors is what is referred to as the messenger model, Newman said. In this model, a health care network is permitted

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to act as a conduit through which payers ("messengers") present offers to network physicians, but the physicians ultimately decide on the offer. A violation of the Sherman Act may result if the network decides to accept or reject the offer without conferring with the physicians as this could amount to organizational price fixing.

Agreements to share information between competitors, while not illegal per se, are a major focus of antitrust laws. Another example of an illegal exchange is a situation in which the information exchanged produces an agreement between competitors, facilitates coordinated behavior, or helps to monitor or maintain an unlawful agreement. Information exchanges, however, are judged by the "Rule of Reason," meaning that the court may take into consideration the benefits that may have resulted from the agreement in comparison to the harm to market competition. According to Newman, it does not matter whether the participants did not intend any harm, buyers provided the information rather than sellers, or it resulted in a decrease in price.

It is important to note that courts will consider how and from whom the information was obtained, how it was used, the type of information (sensitive or confidential), and how current the information was. Newman stressed that health care providers should be aware that this type of violation has wide reaching effects considering the currently pending federal district court class action involving information exchanges based on the compensation of nurses.

II. Vertical agreements. While horizontal agreements are made among competitors, vertical agreements are made between sellers and buyers. Miles noted that courts review vertical agreements under the "Rule of Reason," with no exceptions.

Agreements between buyers and sellers can raise a red flag when one participant has market power, Newman said, noting that the key question for an organization to ask itself with regard to antitrust is whether this participant wants to do business with the organization, or whether it has to do business with the organization. If, for example, an anesthesiologist group requires a provider to use it as its supplier as a condition for a contract for services, this arrangement would amount to tying, or conditioning the sale of one product on the buyer's purchase of another. Other examples of vertical agreements include exclusive dealing, an agreement for which the buyer agrees to purchase all of its needed products from the seller rather than from the seller's competitors; and price agreements, also known as the most favored nation clause when one party makes a promise to another that it will deal with it on terms no less advantageous than those with other parties.

Conclusion. The teleconference illustrated the point that although antitrust laws may at first glance not appear to have applicability to the health care industry, providers are market participants and, therefore, these laws apply to providers just as they apply to the buying and selling of manufactured goods. Because of the added attention the new administration is giving to antitrust enforcement, it is important for providers to be aware how its seemingly innocent actions may be perceived in light of antitrust laws. ■

CCH Chicago Bureau, Mar. 9, 2009

Fraud and Abuse

FCA case proceeds after exception to Stark Law denied

The district court improperly concluded that an arrangement between a hospital and a physicians' group to provide pain management services was within the scope of the "personal service arrangements " exception of the Stark law because it did not meet the exception requirement that such an arrangement be in writing, according to the Third Circuit Court of Appeals. Therefore, the court reversed the opinion and remanded the case to the district court to determine whether a physician, who alleged that the arrangement between the hospital and physicians' group violated the False Claims Act (FCA), could satisfy the remaining elements of his FCA claims.

The case arose from a *qui tam* action in which the physician charged that a hospital's arrangement with a physicians' group to provide pain management services violated the FCA because the hospital falsely certified that claims submitted to Medicare and other health care programs were in compliance with the Stark law and the anti-kickback statute. The district court dismissed

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On The Front Lines

Developing Compliance Issues in OPPS Services — Part I: Facility Evaluation and Management Coding

by Timothy P. Blanchard, Esq.

A number of recent developments in the Medicare outpatient prospective payment system (OPPS) warrant immediate attention in anticipation of additional scrutiny in these areas by Medicare contractors, including Recovery Audit Contractors, and whistleblowers. This article discusses issues involving hospital outpatient facility evaluation and management (E&M) visit coding, supervision requirements for services provided in hospital outpatient settings and issues affecting critical care and emergency department services.[1] Part I of this three part article addresses facility E&M coding for outpatient clinic visits. Part II will address "clarifications" regarding supervision requirements for outpatient services. Part III will address certain issues affecting critical care and emergency department services.

The Original Compliance Challenge: Mandated Use of CPT Codes for Hospital Billing

Confronting the deadline for OPPS implementation in 2000, CMS required hospitals to utilize the Current Procedure Terminology® (CPT®)/Healthcare Common Procedure Code System (HCPCS) developed for physician services to code for hospital clinic and emergency department visits and to establish their own coding criteria to code the level of facility E&M visits.[2] CMS recognized that the CPT® E&M codes were designed to differentiate between levels of physician resource use and are not necessarily a valid indicator of facility resource use and, therefore, specifically instructed hospitals that:

> As long as the services furnished are documented and medically necessary and the facility is following its own system, which reasonably relates the intensity of hospital resources to the different levels of HCPCS codes, we will assume that it is in compliance with these reporting requirements as they relate to the clinic/emergency department visit code reported on the bill.[3]

To comply with these instructions, some hospitals developed score sheets of various complexity capturing inputs and factors affecting facility resource use,[4] including certain patient characteristics and visit time or other time measures. Other hospitals adopted systems that primarily tracked physician coding in certain settings.

Using Patient Characteristics

While the use of certain patient characteristics may be logically appropriate, it poses several compliance risks that need to be understood and addressed in the implementation of a hospital's E&M coding methodology. Although patient characteristics affecting facility resource use can be incorporated into a hospital's E&M coding procedures, certain criteria—including conditions protected under the Civil Rights Act, Americans with Disabilities Act, and Rehabilitation Act—present additional compliance risks if the approach results in higher co-payment charges to members of a protected class.

Hospitals should be very careful when considering criteria that might be considered violations of these statutes and Medicare conditions of participation even if a characteristic is well correlated with higher costs of providing services.[5] While an analysis regarding provider obligations to such patients is beyond the scope of this article, compliance officers should consider these issues when reviewing hospital coding criteria for facility E&M services.

Using Time Factors

Time factors need not be limited to physician face-to-face time because the hospital incurs costs in connection with a visit before and after the physician's personal interaction with the patient. It can be challenging, however, to capture time measures accurately in live clinical settings and differ-

entiate between time associated with the E&M service and time related to separately-reimbursed ancillary services, or noncovered services and activities.

Using Physician Professional Fee Coding

Although CMS indicated that it did not expect to see a high correlation between physician and facility visit coding, it did not categorically prohibit hospital outpatient visit coding based on physician visit coding. Hospitals that base facility visit coding on physician coding should be prepared to explain how they concluded that there is a reasonable correlation between physician coding and hospital resource use in their particular situation.[6]

It is also important for a hospital using this approach to have a system for validating the underlying physician coding; if the physician coding is inaccurate, the assumptions and correlations supporting the use of this approach are likely to be undermined.

Some hospitals have used combinations of these approaches in different outpatient setting within their organizations. While not prohibited, using different approaches within the same hospital presents additional compliance challenges, including potentially more complicated training for affected personnel. Hospitals using multiple coding systems for facility E&M services should carefully monitor the resulting coding and evaluate the resulting charge levels within the system.

Responding to Moving Targets and Changing Approaches

If the development of hospital-by-hospital facility E&M coding criteria were not difficult enough, CMS has continued to delay establishing standard criteria well beyond the temporary period originally envisioned, while continuing to indicate that standard national criteria were right around the corner.[7] During the ever-lengthening period of operation under hospital developed coding criteria, many hospitals refined their coding criteria as they gained experience with OPPS.

Such refinements, while consistent with maintaining an effective compliance program, can themselves complicate compliance monitoring and payment auditing if accurate records regarding the rationale for implementation of revised criteria are not maintained.

More problematic for hospitals have been "clarifications" issued by CMS to effect significant changes in its directives regarding hospital-developed facility visit coding criteria. Two changes in this area warrant consideration by hospital compliance officers because they not only affect coding and payment, they expose providers to potential overpayment demands and false claims investigations.

"Intent" of the CPT Code Concept

In the preamble to the 2007 OPPS final rule, CMS introduced the concept that facility E&M coding should reflect the "intent" of the CPT® code used based on the physician coding descriptors and criteria, in addition to reflecting the relative hospital resource use for the visit.[8] At that time CMS first suggested a requirement in addition to reflecting relative hospital resource use:

> While awaiting the development of a national set of guidelines, we have advised hospitals that **each hospital's internal guidelines should follow the intent of the CPT code descriptors**, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes.[9]

This "intent of the code" element imposes a new requirement upon hospitals that was not required when hospitals developed their coding facility E&M coding criteria. The biggest problem with this change, however, is that it is not well-defined, yet hospitals are likely to be held to differing and evolving interpretations in audits of claims for facility outpatient visits under OPPS.

Coding New vs. Established Patients

The original OPPS rule did not require hospitals to differentiate between "new" and "established" patients when creating their criteria for facility E&M coding.[10] Many hospitals concluded when developing their internal coding criteria that there is no significant difference in the facility resources required to provide services to new (as opposed to established) patients in OPPS settings, other than the cost of initially establishing a patient's medical and financial records. Accordingly, many hospitals used "new" patient status only as a criterion for increasing the **level** of the initial visit service, but used only the established patient series of E&M codes (i.e., 99211-99215) for OPPS billing.[11]

This approach was apparently acceptable to CMS until 2007, when CMS imposed a payment differential between the "new" patient and "established" patient series of codes.[12] For this purpose, CMS revised the decision criterion between "new" and

"established" to the question of whether the patient has a medical record number that was created within the past three years.

Despite many comments urging against the imposition of this distinction—and, indeed, a contrary recommendation from the Ambulatory Payment Classification (APC) Panel -- CMS maintained the imposition of payment differentials but revised the definition of "established" patient to those who had been "registered as an inpatient or outpatient of the hospital within the previous three years."[13]

Because of this change, hospitals must now determine prior to billing whether a patient has been registered as an inpatient or outpatient of the hospital within the prior three years. Because such determinations can be very difficult in practice, some hospitals have decided to continue to code all OPPS visits as established patient visits to avoid the risk of inadvertently misrepresenting an established patient visit as a higher-paid new patient visit. Given CMS' reported use of OPPS claims data for payment policy decisions, however, the potential problem with this approach is that it might be viewed as corrupting that claims data by failing to distinguish between new and established patients.

Conclusion

Although one can argue that these changes in CMS interpretations during the continuing delay in the development of standard national guidelines regarding facility E&M coding are unreasonable and unfair, hospitals appear likely for to face these issues for at lease the immediate future. Part II of this article will address CMS' new position regarding supervision requirements for hospital outpatient services" incident to" physician's services and Part III will discuss recent changes in CMS interpretations affecting critical care and emergency department services. ■

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1 Other compliance issues affecting critical care and emergency department services will be addressed in a forthcoming article.

2 *Final rule*, 65 FR 18434, 18451, April 7, 2000.

3 *Id.* ("[W]e would not expect to see a high degree of correlation between the code reported by the physician and that reported by the facility"). CMS has maintained this to the present.

4 A score sheet approach requires analysis not only of activity of nurses and other nonphysician personnel in furnishing outpatient services, but also identification of activities that are separately reimbursed through ambulatory payment classification (APC) payments for separately billable services, to avoid double-counting of resources.

5 42 C.F.R. §489.10(b).

6 This is most likely in situations in which hospital resource use is believed to be well-correlated with physician face-to-face visit time and the "average" times for visit levels listed in the CPT Manual.

7 Indeed, in 2008 CMS invited comment regarding "whether there is still a pressing need for national guidelines." *Proposed rule*, 72 FR 42628, 42764-42765, Aug. 2, 2007. Meanwhile, CMS has long been warned that "the current lack of uniformity impairs CMS' ability to gather consistent, meaningful data on services provided in the emergency department and hospital clinics." *Final rule*, 69 FR 65682, 65837, Nov. 15, 2004. CMS, however, been accumulating cost and charge data and citing it to support new policy positions when it is difficult, if not impossible, to know what those data mean, given that they result from the individually-developed coding systems of thousands of hospitals rather than a standardized system.

8 *Final rule*, 71 FR 67960, 68125, Nov. 24, 2006.

9 *Id.* (emphasis added).

10 CMS had explained in the 2000 rule, albeit parenthetically, that for OPPS purposes the "meaning[s] of 'new' and 'established' pertain to whether or not the patient already has a hospital medical record number." *Final rule*, supra n. 2 at 18451. This definition made capturing this distinction unreasonably difficult because in most hospitals information to confirm the existence of a medical record is not readily available at the time of charge capture and billing.

11 CMS was aware from the beginning of OPPS that many hospitals concluded "the hospital resources used for new and established patients to provide a specific level of service are very similar." These hospitals advised CMS that it is unnecessary and burdensome to require coding of the two types of visits. Indeed, CMS's own advisory panel recommended elimination of any distinction between "new" and "established" patients in coding hospital clinic visits.

12 In making this controversial change, CMS relied on data from the early years of OPPS:

> [H]ospital claims data regarding the median costs of the specific CPT clinic visit E/M codes consistently indicated that new patients were more resource intensive than established patients across all visit levels. The CY 2006 claims data available for the CY 2008 rulemaking confirmed that the cost difference between new and established patient visits increases as the visit level increases.

*F*inal rule, 72 FR 66580 at 66791-66792, Nov. 27, 2007. CMS failed to explain how such claims data could support any valid conclusions about costs associated with "new" vs. "established" patient visits, given its requirement that hospitals create their own criteria, the resulting hodge-podge of coding approaches underlying the charges, and its failure to require the use of both series of codes prior to the 2007 payment differentials.

13 *Id* at 68678. This revised definition may make it easier for hospitals because accurate prior registration status may be more readily available at the time of charge capture and coding. Unfortunately the inherent irrationality of reliance on charge data based on nonstandard definitions remains:

> Because … we continue to observe significant cost differences between new and established patient visits of the same level, we will continue to recognize new and established patient visit codes under the CY 2009 OPPS, consistent with their CPT **code descriptors**.

Id (emphasis added).

the FCA claims after it found that the arrangement was within the scope of the personal services exception of the Stark law. The physician appealed.

The arrangement. The physicians' group previously had entered into a written arrangement with the hospital to provide anesthesia services. Several years later the hospital opened a free-standing outpatient surgical center and pain management clinic. The physicians provided pain management services at the clinic and referred patients to the hospital for diagnostic tests. The written agreement, however, was never amended to include pain management services at the clinic.

The law. Under the Stark law and the anti-kickback statute, a physician may not make a referral to an entity for health services if he or she has a financial relationship with the entity, which includes a compensation arrangement. An exception to the prohibition may exist for "personal service arrangements," if the arrangement is in writing, signed by the parties, for a period of at least one year, specifies and covers all the services provided, and provides for compensation that does not exceed fair market value.

In this case, there was no signed, written contract regarding the pain clinic, the court said. Even if the previous hospital agreement could be read as reflecting the parties' future arrangement at the pain clinic, that agreement said nothing about the provision of free office space, equipment, and staff, nor could the parties have engaged in arm's length negotiations regarding current fair market value of pain management services at the time of the original agreement, the court concluded.

Because the referral of pain management patients to the hospital for diagnostic tests implicated the self-referral prohibition, the hospital had the burden of demonstrating its right to an exception. The court found that this burden was not met. Because the arrangement did not fit into the personal services exception, the FCA challenge related to false certification of was remanded to the district court to determine specifically whether the hospital knew its certifications were false. ■

U.S. ex rel. Kosenske v. Carlisle HMA, Inc., 3rd Cir., Jan. 21, 2009, Health Care Compliance Letter, ¶800,610

GAO blames fraudulent practices for increase in home health spending

CMS should tighten regulations governing the administration of the Medicare home health benefit to curb the number of improper payments made to providers, according to a report by the Government Accountability Office (GAO). Responding to concerns about rapid growth in Medicare home health spending, the GAO study identified: (1) states where home health spending or utilization growth has been the highest; (2) fraudulent or abusive practices that may have contributed to home health spending and utilization; (3) aspects of the Medicare home health benefit's administration that make it susceptible to improper payments; and (4) lessons learned from recent CMS initiatives to reduce fraud and abuse in the home health benefit.

Upcoding. The study found that upcoding — overstating the severity of a beneficiary's condition — was a common occurrence among some home health providers. A CMS contractor found that only 9 percent of claims were properly coded for 670 Houston area beneficiaries who had been assigned the most severe clinical rating and who were served by potentially fraudulent home health agencies (HHAs)..

The GAO also determined that the inadequate administration has left the home health benefit vulnerable to improper payments. CMS does not require its contractors, known as Regional Home Health Intermediaries, to verify the criminal history of individuals involved with prospective HHAs. Moreover, CMS regulations provide for the removal of HHAs or HHA officials from Medicare for just one type of fraudulent billing — billing for services that could not have been rendered.

Recommendations. The GAO made four key recommendations. According to the report, CMS should: (1) assess the feasibility of verifying the criminal history of all key officials named on an HHA enrollment application; (2) provide a physician whose identification number was used to certify a plan of care with a statement of services the HHA provided to that beneficiary based on the physician's certification; (3) direct contractors to conduct postpayment medical reviews on claims submitted by HHAs with high rates of improper billing identified through prepayment review; and (4) amend current regulations to expand the types of improper billing practices that are grounds for revocation of billing privileges. ■

GAO Report, No. GAO-09-185, Feb. 27, 2009

New e-book guides providers through RAC review process

The *Recovery Audit Contractor Workbook* is a practical guide to assist all providers participating in Medicare prepare for a potential RAC audit, including:

- preparing for a RAC audit, including establishing the internal structure and authority to manage the RAC audit process;
- what to do during a RAC audit, including proper ways to respond to RAC demands and requests, tracking documentation, and preparing for appeals;
- what to do after a RAC audit, including conducting a risk assessment and developing corrective actions.

The workbook includes several helpful charts explaining the RAC review and Medicare appeals process. It also includes several sample letters and forms that providers can use to prepare their organizations for RACs, to communicate with RACs and to establish new internal policies for their organizations. The e-book can be ordered by visiting http://health.cch.com/Products/ProductID-5510.asp.

HIPAA

Physician groups press FTC for exemption from Red Flag Rules

With a May 1 deadline for compliance looming, the American Medical Association (AMA) has asked the Federal Trade Commission (FTC) to suspend the application of the Red Flag Rules to physicians and publish a new rule so that physicians have an opportunity to provide comments. In a March 9 letter to the FTC, AMA Executive Vice President Michael D. Maves wrote that the AMA "strongly believes that the FTC did not provide physicians with an opportunity to review and comment on this Rule."

Controversy. Under the Red Flag Rules, which were finalized in October 2007 under the Fair and Accurate Credit Transactions Act (FACTA), financial institutions and creditors must develop and implement written identity theft prevention programs. FACTA provides a broad definition of "creditor" as "any entity that regularly extends, renews or continues credit." The FTC has interpreted this definition to include health care providers and physicians.

The AMA and several other medical trade associations have taken the position that physicians were not intended to be subject to the Red Flag Rules, but the FTC has held firm in its interpretation, in spite of the objections. In a Feb. 4 letter to the AMA, the FTC reiterated its position that "the plain language and purpose of the Rule dictate that health care professionals are covered by the Rule when they regularly defer payment for goods or services."

The FTC also has taken the position that application of the Red Flag Rules to physicians will reduce the incidence of medical identity theft and will not impose a heavy burden on health care professionals.

Rulemaking process. In addition to its claim that health care providers should not be classified as creditors, the AMA also hasargued that the physician community was not informed that it would be subject to the Red Flag Rules. ■

CCH Chicago Bureau, March 16, 2009

In the News

Obama lifts barriers to stem cell research

President Barack Obama signed an executive order removing federal barriers to human embryonic stem cell research and calling on the National Institutes of Health (NIH) to expand support for such research. Obama's executive order removes funding restrictions put in place by the Bush administration, which limited federal funding to cell lines that had been made by August 2001. Lifting the funding limitations will make hundreds of newer cell lines available for NIH funding. Obama's order gives NIH 120 days to review existing federal guidance and guidelines and modify them to reflect the administration's policy. In addition to making newer cell lines available for federal funding, the order will also eliminate the red tape that forced NIH-funded scientists to set up duplicate labs in which to conduct stem cell research funded by private sources.

CCH Chicago Bureau, March 16, 2009

County pays $6.8 million to settle FCA claims

San Mateo County, California has agreed to pay the United States $6.8 million to settle alleged violations of the False Claims Act. San Mateo Medical Center allegedly inflated its bed count to Medicare to qualify for a disproportionate share hospital adjustment. The county also is alleged to have obtained improper federal payments under the Medicaid program for services provided to patients at the Institutes of Mental Disease who were between the ages of 22 and 64. Such services are ineligible for federal funding and the county was required to report them separately to the state to ensure that no federal funds were used to pay for them. The alleged false claims violations occurred between 1997 and 2007.

Department of Justice News Release, March 12, 2009

City's health care requirement challenged

A San Francisco restaurant group that unsuccessfully challenged the city's requirement that businesses with 20 or more employees either offer health benefits or pay into a citywide fund for the uninsured may take its appeal to the U.S. Supreme Court. The Golden Gate Restaurant Association has argued that under the Employee Retirement Income Security Act (ERISA), local governments don't have the right to order businesses to provide benefits. The Ninth Circuit Court of Appeals has upheld the San Francisco Health Care Security Ordinance, which requires city employers to spend a minimum amount on employee health care plans. If a company spends less on health care than the amount required, it must make up the difference in the form of a tax paid to the city's Health Access Program, which provides free care to low-income residents.

CCH Chicago Bureau, March 16, 2009