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Lawyers denounce DOJ's McNulty Memo

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

The Department of Justice (DOJ) McNulty Memorandum has not diminished what many believe to be the government's improper requests for waiver of privileges in corporate investigations, according to the testimony of witnesses from major law firms, corporate America, and the American Bar Association (ABA) given at a hearing on "The McNulty Memorandum's Effect on the Right to Counsel in Corporate Investigations" before a House judiciary subcommittee.

The McNulty Memo, released on December 12, 2006, was an attempt by the DOJ to address growing concerns that, in the wake of the Enron scandal, federal prosecutors were routinely requesting that corporations waive attorney-client privilege and release otherwise confidential information to avoid indictment. William M. Sullivan, Jr., a partner at Winston & Strawn, LLP., in Washington D.C., testified that "waiver requests are made even before I have completed my client's internal investigation and, thus, even before I have determined waiver is in my client's best interest."

According to Karen J. Mathis, J.D., president of the ABA, not only has the McNulty Memo failed to eradicate such prosecutorial overreaching, it has made the situation worse by making what was once a formal request an implicit requirement. Mathis argued, and other witnesses agreed, that the practice of routinely requesting waivers continues under the McNulty guidance.

The consensus of the testimony was that the McNulty Memo is not a genuine departure from its predecessor, the Thompson Memo, which sanctioned the use of waiver requests to gauge a corporation's willingness to cooperate in an investigation and avoid possible criminal indictment. According to Sullivan, the DOJ's current policy hinders the seeking out of corporate malfeasance by inhibiting candid discussions with corporate counsel for fear of that information being disclosed to the DOJ. Sullivan and others called for a legislative response, such as the Attorney Client Privilege Protection Act introduced by Senator Arlen Spector in December 2006. The Act would allow prosecutors to pursue information they believe is not confidential but would recognize and protect valid claims of attorney-client privilege.

DOJ's defense of the Memo. Barry M. Sabin, Deputy Assistant Attorney General, who represented the DOJ at the hearing, stressed that Congress should give the new guidance time to work before passing legislation. He argued that the DOJ's approach to corporate investigations under the McNulty guidance respects the importance of attorney-client and work product protections and protects investors by promoting integrity and honesty in corporate governance. He added, however, that in some situations, a waiver may advance important objectives.

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Corporate Governance (cont.)

According to Sabin, since the release of the McNulty Memo, there have been no formal requests for waivers in the Deputy Attorney General's Office, and only five in the criminal division of the DOJ. In response, Mathis argued that the lack of formal requests supports the contention that under McNulty, the routineness of the requests continues on an informal basis and is consequently more difficult to track. ■

Hearing on: The McNulty Memorandum's Effect on the Right to Counsel in Corporate Investigations, ,U.S. House of Representatives, Committee on the Judiciary, Subcommittee on Crime, Terrorism, and Homeland Security, March 8, 2007.

Administration

GAO examines DMEPOS payments, physician profiling

by Jenny Burke, J.D., Contributing Editor

Recent studies by the Government Accountability Office (GAO) found that (1) shortfalls in program safeguard contractors' (PSCs') automated payment controls resulted in overpayments for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); and (2) physician profiling may identify inefficiencies in the physician payment system. GAO explained its findings and recommendations in a report issued on March 1, 2007, and testimony before the U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health, on March 6, 2007.

Improper DMEPOS payments. Almost $700 million in improper payments for DMEPOS were made between April 1, 2005, and March 31, 2006, according to the GAO report. The report examined CMS and its contractors' activities to prevent and minimize improper payments for DMEPOS, and analyzed PSCs' automated prepayment controls and related claims analysis functions.

GAO found that, despite CMS contractors' program integrity activities, three shortfalls exist in the automated prepayment controls used to identify claims that should be denied or reviewed. First, the durable medical equipment regional contractors and PSCs lacked predesignated thresholds to identify claims for medical review that were part of an atypical increase in billing. Second, in at least three instances, contractors did not have edits in place to identify items that are not likely to be prescribed in the course of routine quality medical care. Finally, contractors do not and are not required by CMS to share information on their effective edits with contractors in other regions.

CMS oversight of PSCs includes written manuals and contracts to guide the PSCs' work. Additionally, CMS is implementing an annual contractor performance evaluation process, based on three evaluation tools, to assess each PSC's performance. CMS will use the results of these evaluation tools to determine (1) whether to renew a PSC's contract, and (2) whether a PSC may earn award fees for good performance, in addition to the regular payments received under its contract.

GAO recommended that CMS require its contractors to develop thresholds and automated payment controls to identify unexplained increases in claim volume. GAO also recommended that CMS require DMEPOS contractors to exchange information about automated prepayment controls with each other. CMS agreed with these recommendations.

GAO Report, GAO-07-59, March 1, 2007.

Physician profiling. Another GAO study showed that, while a majority of physicians provided care that was not excessive, physicians in every part of the country provided more services than were required, according to testimony by Bruce A Steinwald, Director of Health Care to the Subcommittee on Health of the U.S. House of Representatives Committee on Energy and Commerce.

The study was conducted in an effort to examine aspects of physician compensation in Medicare, identify potential improvements to the physician payment system, and identify an alternative to the sustainable growth rate system to control spending on physician services. GAO examined the use of physician profiling practices used by other health care purchasers and recommended that CMS use physician profiling to identify physicians that are providing excessive care.

According to GAO, Medicare's data-rich environment is conducive to identifying physicians who are likely to practice medicine

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Requests for information about article submission and comments from readers are welcome and should be directed to Susan Smith at susan.smith@wolterskluwer.com, Tel. 847-267-2780, Fax 847-267-2514. Customer service inquiries should be directed to 800-449-9525.

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inefficiently. CMS has tools to identify physicians who are practicing inefficiently, such as comprehensive medical claims information, sufficient numbers of physicians in most areas to construct adequate sample sizes, and methods to adjust for differences in beneficiary health status. CMS could make methodological decisions similar to those made by other health care purchasers.

As part of its study, GAO created its own profiling analysis of physician practices in the Medicare program. By identifying patients whose total expenditures far exceeded those of other patients in the same health status group, then linking them with their treating physicians, GAO was able to determine which physicians treated a disproportionate share of these patients. Although a vast majority of physicians did not provide excessive care, GAO's analysis revealed outlier generalist physicians in each area studied. Physicians providing excessive services accounted for more than 10 percent of the generalist physician population in only two areas. In the remaining areas, the proportions ranged from two to six percent.

GAO believes physician profiling has the potential to address a principal criticism of the sustainable growth rate system, which only operates at the aggregate physician level. A primary virtue of profiling, GAO stated, is that coupled with incentives to encourage efficiency, it can create a system that operates at the individual physician level.

Although efforts to improve efficiency alone would not generate enough savings to correct Medicare's long-term fiscal imbalance, GAO believes such efforts could be an important part of a package of reforms aimed at future program stability. ■

GAO Testimony, GAO-07-567T, March 6, 2007.

CMS terminates specialty hospital's provider agreement

by Jenny Burke, J.D., and Valerie L. Witmer, J.D., Contributing Editors

CMS took action to terminate the Medicare provider agreement it holds with the West Texas Hospital because the hospital's noncompliance with Medicare conditions of participation (CoPs) represented an immediate threat to patient health and safety, according to a memorandum issued by Sen. Chuck Grassley (R-Iowa) on March 19, 2007. The agency will terminate the physician-owned specialty hospital's agreement on March 31, 2007.

Noncompliance. Investigation of the hospital began following the death of a patient who suffered respiratory arrest after spinal surgery and was transferred by ambulance to a local community hospital when emergency services were not available at the specialty hospital. The hospital was placed on a termination track due to deficiencies that represented a serious and immediate threat to patient health and safety. The hospital originally was out of compliance with the Medicare hospital CoPs for governing body, patient rights, nursing services, and emergency services.

Following the hospital's submission of a plan of correction, a revisit and full survey of all hospital CoPs was conducted and revealed that eight CoPs were out of compliance: (1) governing body; (2) patient rights; (3) quality assessment and performance improvement program; (4) medical staff; (5) nursing services; (6) utilization review; (7) physical environment; and (8) infection control. The hospital's continuing noncompliance with the CoPs for patient rights and nursing services and its recent noncompliance with the CoP for physical environment represented an immediate threat to patient health and safety and warranted the termination of its provider agreement.

Questions from lawmakers. Grassley, along with Sen. Max Baucus (D-Mont.) and Rep. Pete Stark (D-Calif.) recently sent inquiries to the Acting Administrator of the Medicare Program and released those inquiries to the press, questioning the actions of the Medicare contractor who found the hospital eligible for participation in Medicare despite an enrollment suspension on specialty hospital participation. As the investigation broadens, additional questions have surfaced as to how a hospital that is out of compliance with so many CoPs received Joint Commission accreditation less than two years ago.

Grassley commented, "I'm alarmed that the subsequent review of this physician-owned specialty hospital revealed so many serious deficiencies especially since it was basically given a 'second chance.' To the extent these deficiencies are products of how these physician-owned specialty hospitals are operated, Congress must act quickly to address the situation." ■

U.S. Congress Press Release, March 6, 2007; Memorandum from Sen. Chuck Grassley, March 19, 2007.

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On The Front Lines

Teleradiology: Compliance concerns and solutions, Part II

by Fay Rozovsky, J.D., M.P.H., and Susan T. Goodwin, R.N., FACHE, Contributing Editors

This two-part article is a condensed version of an in-depth review of teleradiology issues related to compliance, clinical risk, and quality that will be published in three parts in the January/February, March/April, and May/June 2007 issues of the Journal of Health Care Compliance. This version is offered as an overview of what promises to be a burgeoning area in the healthcare field that merits focused attention.

Part one of this two-part article provided an overview of the role of teleradiology technology in contemporary health care and defined the two fundamental teleradiology models. It also identified ten key issues implicated by the use of teleradiology technology and addressed contracting, credentialing, and patient consent, providing a description of each issue and offering strategies to deal with the identified concerns. Part two covers the seven remaining issues: data security and privacy; transmission capabilities and diagnostic accuracy; medical liability and jurisdictional issues; clinical communication; documentation practices; billing and coding; and quality assurance processes and accountabilities.

Data security and privacy

Because diagnostic imaging includes patient level data and identifiers, it triggers concerns about privacy under the Health Insurance Portability and Accountability Act (HIPAA).[10] In addition, electronic data transmission within a state, across the country, or overseas also raises the specter of the HIPAA security requirements.[11] Concerns about this issue are reflected in a September 2006 Government Accountability Office (GAO) report dealing with a related topic, use of overseas transcription services with respect to Medicare, Medicaid, and TRICARE recipients.[12]

The HIPAA privacy regulations oblige a hospital, ambulatory care center, or radiology group to follow well-established practices with respect to protected health information (PHI). A diagnostic image encoded with a patient's name, social security number, patient identification number, address, and other identifying factors is ripe for exploitation. The hospital, ambulatory care center, or local radiology group may follow the rules, but what about the teleradiology group?

Strategies

A well-crafted business associates' agreement is in order to preclude unacceptable practices and should anticipate the use of support service entities by the teleradiology vendor. Another good strategy is to identify such would-be conflicts and make certain that the teleradiology vendor agrees to and abides by the HIPAA requirements. A third good strategy is to enlist the assistance of the Chief Information Officer, Chief Privacy Officer, and Information Technology (IT) department to make certain the teleradiology contract addresses these regulatory requirements.

Transmission capabilities and diagnostic accuracy

The case study in part one of this article highlights a key issue in teleradiology: equipment compatibility. The originating site may have state-of-the-art equipment. The location may have highly skilled radiology personnel to use the equipment. The diagnostic images may be in perfect order. Problems can occur, however, when the teleradiologist uses incompatible or inferior equipment.

Strategies

Putting the American College of Radiology (ACR) Guideline into practice requires thoughtful strategies. Because the "guideline" may be interpreted as a legal standard of care in professional liability claims, the originating site would do well to insist that the teleradiology entity comply with the technical standards. Another useful strategy may be to require computerized authentication to confirm that the offsite equipment is appropriate and compatible with the entity's IT. Local radiology service leaders can help identify the specifications. IT also can assist with confirming transmission lines.

Medical liability and jurisdictional issues

If a misadventure occurs that involves a misdiagnosis or missed diagnosis by a teleradiologist, the patient is apt to file a claim against the hospital, the ambulatory care center, or the local radiology group. The reason is simple: the patient looked to the institution or radiology group for care. The teleradiologist may be named a third-party defendant.

While the teleradiology vendor may agree to be contractually obliged to participate in professional liability claims stemming from its provision of interpretive services, there are some chal-

On the Front Lines (cont.)

lenges to this approach. How will one serve notice of a claim to a teleradiology group based in India or Australia? Does the vendor have a local agent for service of process? Even if the vendor admits to its responsibility for the misadventure, how can it be compelled to satisfy a judgment? What if the vendor's local professional liability insurance coverage does not include errors and omissions emanating from teleradiology services? What if the teleradiology group has shared limits among several radiologists and the group has exhausted the limits of the policy?

Strategies

One strategy is to avoid use of teleradiology vendors who are not subject to the jurisdiction of American courts. Another strategy is to require by contract designation and maintenance of a U.S. based agent for service of process. The contract also can serve as the vehicle for another strategy, namely to require the teleradiology vendor to carry professional liability insurance with appropriate limits for each radiologist offering services to patients in the U.S.

Clinical communications

As with other areas of health care delivery, teleradiology is at risk for a breakdown in communication. Teleradiologists trained abroad and unfamiliar with American idioms or phraseology may use terms that do not convey the urgency of a situation or the importance of an area detected on a diagnostic image. For their part, American health care providers who initiate the request for "after hours" teleradiology services may not appreciate the communication divide. They may draw the wrong inference after reading a radiologist's report from abroad. A diagnostic image that is degraded during transmission can contribute to the problem with a less than refined view leading to an ambiguous report.

A key area in clinical communications is timing. A "critical" diagnostic image must be read within a defined timeframe for the radiologist to provide important information to the attending care provider. The failure to communicate the urgency of the situation can lead to a delay in care and patient injury.

Sometimes a delay in care is occasioned by equipment failures or transmission line problems. Trying to work on this problem can delay communication of critical results, again leading to patient injury. This is the type of problem that can happen with any type of telemedicine, not just teleradiology, whether domestic or international.

Strategies

One strategy is to develop a consistent taxonomy of terms or "universal" language to be used by teleradiologist and originating sites in communicating diagnostic imaging information and results. A second strategy is to develop a standardized method for reporting results. A third strategy is to set a norm for timeliness of communication. Finally, redundancy should be built into the system for those occasions in which there is a failure of the primary method of communicating diagnostic imaging results.

Documentation practices

With many, if not most, overnight teleradiology programs, the initial diagnostic imaging report is considered a "preliminary reading" until there is an overread by a radiologist at the originating site. In the overnight hours, other care providers rely upon the preliminary report to develop a care plan and order additional tests and medications. The preliminary report also may suggest that a suspected health concern should be ruled out. The result may be to follow a more conservative approach in treatment. Local care providers may not know until the overread is completed that there was a misdiagnosis or missed diagnosis based on the preliminary reading. By that stage in the patient's treatment, irreparable harm may have occurred, setting the stage for potential litigation if not regulatory review.

When there is a difference of opinion, which diagnostic imaging reading constitutes "the" report? Is it the preliminary diagnostic interpretation performed by the teleradiologist? Or, will it be the overread report? Will the local radiologist sign the preliminary diagnostic imaging report even though he or she disputes the finding? Will the local radiologist add comments to the preliminary report to explain the disputed finding? Or, will the local radiologist sign just the overread and use that report as the basis for coding and billing?

There are many thorny issues associated with use of preliminary reports. If a preliminary report is overridden based on an interpretation by a local radiologist, what should become of the preliminary report? Will some think it prudent to destroy that report, fearing that it serves as evidence of a breach of a standard of care? If such thinking prevails, could it not set the stage for a claim of spoliation of evidence in subsequent litigation when the plaintiff seeks through discovery to obtain a copy of the preliminary report? Moreover, would destruction of the preliminary report hamper efforts to bill correctly for the diagnostic imaging service? Another concern is retention of diagnostic imaging information and results.

Strategies

One strategy is to assemble a team of key stakeholders to obtain valuable input on a process that can serve as the basis for a cogent policy and procedure. A second strategy is to establish a process for working with preliminary diagnostic imaging reports. A third strategy is to curtail the timeframe between a preliminary diagnostic imaging report prepared via teleradiology and the overread or final interpretation.

Billing and coding

One area ripe for corporate compliance intervention is establishing a framework for billing and coding for teleradiology services. Lacking the requisite knowledge on the subject can expose a health care entity to needless regulatory difficulties.

CMS is quite explicit on the subject.[13] Other than a few narrowly defined exceptions,[14] Medicare will not pay for services performed outside the U.S. This includes radiological interpretations performed by radiologists located outside of the U.S. who hold licensure in an American state. The payment prohibition has been reiterated in the *Medicare Benefits Policy Manual*.[15] The payment prohibition is significant. Billing for a service that is prohibited by Medicare can set the stage for a false claim and possible fraud and abuse.

The impact of the prohibition on the current practice of getting reimbursement for an "overread" by a credentialed and privileged radiologist located in the U.S, and using part of that reimbursement to pay for the teleradiology reading, must be carefully evaluated. In a transmittal issued on February 23, 2007, CMS stated:

> Payment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States. For example, if a radiologist who practices in India analyzes imaging tests that were performed on a beneficiary in the United States, Medicare would not pay the radiologist or the U.S. facility that performed the imaging test for any of the services thatwere performed by the radiologist in India.

This change has raised concern among compliance professionals and health care attorneys as they differ about the application of the recent transmittal language. Some fear that it casts a shadow on billing Medicare for teleradiology services that involve even a portion of a service completed by a radiologist overseas. Others do not share this concern. That there is such a difference of opinion in the meaning of the transmittal suggests that CMS may have to issue further explanatory language. One item is clear, however: serious risk exposure exists for those hospitals that do not comply with acceptable procedures when billing and coding for off shore teleradiology services.

Strategies

A key strategy is to enlist the help of the corporate compliance officer and those responsible for billing and coding. Another strategy is to determine what should be done in those instances in which a delay or poor interpretation does not rise to the level of quality care sufficient to bill the payer. Finally, hospitals, ambulatory care centers, and radiology groups should ask their compliance officer and legal counsel to keep them up-to-date on billing and coding developments in this area.

Teleradiology quality assurance processes and accountabilities

Teleradiology services require alignment with federal rules that address quality assurance and performance improvement.

Governance responsibilities

The hospital conditions of participation state that radiological services may be provided by a hospital directly or through a contractual arrangement. The expectation is that the same standards apply regardless of direct provision or contracted radiological services. Additionally, the standards require a hospital's governing body to be responsible for services provided under a contract.[16] The Interpretive Guidelines for radiology services also specify that the hospital's radiological services, including any contracted services, must be integrated into its hospital-wide quality assessment and performance improvement (QAPI) program.[17]

Joint Commission requirement for oversight of contract services

Under the Joint Commission standards for hospitals, various Leadership Standards and Elements of Performance, when viewed together, establish concepts that a hospital must undertake in performing its oversight of contract services. For example, Standard LD.3.30 requires that "a hospital demonstrate a commitment to its community by providing essential services in a timely manner." The Elements of Performance include diagnostic radiology as an essential service. The Rationale Statement for this standard requires that leaders conduct planning (1) to determine which services are essential; (2) to determine whether the hospital will provide such services directly or through referral, consultation, contractual arrangement, or other agreements, and (3) *to establish time frames within which these patient care services will be provided*.

Standard LD.3.20 requires that "patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital." The Rationale Statement for this standard explains that "leaders must make sure that factors such as *different individuals providing care*, treatment, and services, different payment sources, or *different settings of care* do not intentionally negatively influence the outcome" of care (italics added). Based on this standard, it could be expected that a hospital will ensure that the level of care and services provided by an after hours teleradiology provider will be comparable in timeliness and quality to that of the radiologists providing services at other times of the day. Specific requirements also require individual teleradiologist performance to be measured and compared. With the publication of new Medical Staff Standards for 2007, the Joint Commission introduced requirements for continuous evaluation that is used for ongoing privileging decisions [MS.4.15, MS.4.30, MS.4.40].[18]

Based on both CMS and Joint Commission requirements, QAPI activities must include teleradiology services used by the hospital. When services are provided after hours by a teleradiology group, comparative data should be used to evaluate the performance of the teleradiologists as compared to the radiologists providing services during the day to ensure the same level of quality. Additionally, the performance of individual teleradiologists should be measured for ongoing evaluation as required by the Joint Commission.

Strategies

One of the traditional approaches to a review performance for radiology services has been to measure and evaluate the rates of

disagreement in imaging interpretations. The results should be stratified by type of study, for example, plain radiography, fluoroscopy, angiography, ultrasound, computed tomography, mammography, nuclear medicine, and magnetic resonance imaging. To the extent that teleradiologists provide interpretation for the different types of studies, the data should be further stratified and evaluated to compare the performance of teleradiologists with that of radiologists who practice within the facility. Disagreement rates should be within acceptable limits and the rates of disagreement for interpretations by teleradiologists should not be significantly statistically higher without triggering further investigation to identify causes and take steps to improve performance.

Because teleradiology services are used in many hospitals to improve timeliness of interpretations, hospitals should include in their evaluations some measurement of interpretation timeliness, such as reporting "turn around times" (TATs). Actual performance should be compared to performance expectations. The hospital should anticipate teleradiology TATs to fall within an expected range. Joint Commission Standard LD.3.15 requires planning and assessment by hospital leaders with regard to patient flow, including a requirement to measure support service processes that impact patient flow.[19] Of specific interest to the hospital should be how well the use of teleradiology services enhances timeliness of services and facilitates patient flow.

The Joint Commission also has established a National Patient Safety Goal that requires hospitals to measure and assess and, if appropriate, take action to improve the timeliness of reporting and the timeliness of receipt by the responsible licensed caregiver of critical test results and values.[20] Radiology reporting must be included when defining critical test results and the acceptable length of time between availability of a critical result and receipt by the responsible licensed caregiver.

Finally, a comprehensive QAPI strategy includes use of relevant quality control data, and is required by the Joint Commission [PI.1.10].[21] Quality control activities should include monitoring the performance of teleradiology equipment and data transmission quality. QAPI data regarding the rates of disagreement in imaging interpretations should be evaluated to determine if the variable causing any unacceptable rate might be due to teleradiology equipment or transmission capabilities.

Conclusion

Teleradiology offers a promise of prompt, cost-effective, efficient, accurate, and useful diagnostic imaging information to assure quality, safe patient care. To realize this promise, however, many challenges must be addressed. Key hurdles include contracting, consent, confidentiality, licensure and credentialing, insurance coverage, regulatory compliance, billing, coding and accreditation issues. Through a series of practical strategies, many of these challenges can be addressed. A team effort will be useful, enabling key stakeholders to share their insights in designing a sufficient program for teleradiology services. ■

Fay Rozovsky is the President of The Rozovsky Group, Inc. and a faculty member in the Department of Legal Medicine at Virginia Commonwealth University Medical College and the Barton Certificate Program in Healthcare Risk Management. She has more than two decades of experience in healthcare risk management. She has published more than 500 articles on subjects in health law, risk management, patient safety, and medical ethics. Ms. Rozovsky is a member of the CCH Health Care Compliance Editorial Advisory Board.

Susan T. Goodwin is an Assistant Vice President in the Quality, Safety, and Performance Improvement Department of the Hospital Corporation of America, with expertise in the areas of governance/leadership, medical staff affairs, performance improvement, risk management, and regulatory/accreditation compliance. Ms. Goodwin is a registered nurse (RN), a Licensed Risk Manager in Florida, a Certified Professional in Healthcare Quality (CPHQ), a Fellow of the National Association for Healthcare Quality (FNAHQ) and a Fellow of the American College of Healthcare Executives (FACHE). She is currently a member of the Joint Commission's Committee on Healthcare Safety, and the Hospital Professional Technical Advisory Committee (PTAC) representing the National Association for Healthcare Quality (NAHQ).

10 *Final rule*, 67 FR 53182-273, Aug. 14, 2002.

11 *Final rule*, 68 FR 8334-81, Feb. 20, 2003.

12 *See* Government Accountability Office, GAO-06-676, Sept. 2006.

13 *See* 42 U.S.C. §1395y(a)(4), as amended (2003).

14 *See* 42 U.S.C. §1395(f), as amended (2002).

15 CMS, *Medicare Benefit Policy Manual*, Pub. 100-02, Ch. 15 (Rev. 53, July 7, 2006). *See also* CMS, *Services Not Provided Within the United States*, Pub. 100-02, Transmittal No. 66, Feb. 23, 2007 (effective date: Nov. 13, 2006; implementation date: April 2, 2007).

16 42 C.F.R §§482.12, 482.26; *see also* CMS, *Survey Protocol, Regulations and Interpretive Guidelines for Hospitals*, State Operations Manual, App. A, §§482.11(c), 482.26(c)(1) (Rev. May 21, 2004).

17 *See id.* at §482.26.

18 Joint Commission, Comprehensive Accreditation Manual for Hospitals, Update 2, Sept. 2006.

19 *Id.* at Joint Commission Leadership chapter.

20 *Id.* at chapter on National Patient Safety Goals, Requirement 2C.

21 Joint Commission, *supra* note 18.

Tax Exempt

Illinois hospitals provide billions in community benefit, IHA says

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

Illinois hospitals provided community benefits of almost $3.7 billion in programs and services in their fiscal year 2004–2005, a number that far exceeds the value of their tax exemptions, according to a report issued by the Illinois Hospital Association (IHA). The report, entitled "Illinois Hospitals Helping Their Communities: It's About More Than Just the Numbers," stressed the financial impact of community benefit initiatives on hospitals.

The report comes on the heels of two recent decisions by the Illinois Department of Revenue to revoke state property tax exemption from two hospitals for their failure to provide, in the Department's opinion, a sufficient level of charity care. In recent years, Illinois has been a microcosm of the tax-exempt/char-

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ity care debate, in which hospitals have been arguing for a broader definition of community benefit beyond a simple calculation of the amount of free care provided to low-income or indigent patients.

According to IHA's report, Illinois hospitals reporting under the state's Community Benefit Act provided $1.1 billion worth of services for which bills were not paid; $1.6 billion to make up the underpayment by government-sponsored programs such as Medicare and Medicaid; $261 million to educate and train future physicians, nurses, and other critical health care workers; $250 million in free and discounted care; $215 million in subsidized health services; $36 million in research; and $50 million in other unreimbursed community services such as language assistance.

IHA highlighted twenty-five examples of community benefit initiatives, including a downstate hospital giving free screenings and follow-up care for chronic kidney disease and a major medical center running a health and education program for children whose parents are appearing in court.

According to IHA, providing health care to those in need and improving the quality of life in their communities is becoming increasingly difficult for Illinois hospitals. More than one-third of Illinois hospitals have a negative operating margin and nearly two-thirds have a negative patient margin – that is, they receive payments that are less than the cost of providing care. Twenty-two Illinois hospitals have closed their doors since 1994.

Despite these challenges, the state's hospitals have contributed programs, services, and tangible economic benefits to their communities. "As this report shows, our hospitals go far beyond medical care to keep their communities strong and stable," said IHA President Kenneth C. Robbins. "In today's environment of heightened debate about the costs and revenues associated with health care, this provides a dramatic picture of the often overlooked ways Illinois hospitals help real people and solve human problems." ■

IHA Release, March 15, 2007.

In the News

CMS announces California collaborative

The California Cooperative Health Care Reporting Initiative (CCHRI) is the newest participant in CMS' effort to produce more accurate, comprehensive measures of quality of services at the provider level. Through the Better Quality Information to Improve Care for Medicare Beneficiaries (BQI) project, CCHRI will combine its claims data or clinical information with that of Medicare to provide consistent measures of the quality of provider services. The results will provide quality of care information to Medicare beneficiaries, as well as performance information to physicians who treat Medicare beneficiaries. Currently, the BQI project is being implemented in four regional collaboratives around the country.

CMS Release, March 14, 2007.

HealthSouth, physicians settle FCA allegations

HealthSouth Corporation, the Seacoast Trust, and three physicians who are or were partners in the Seacoast Trust have paid the United States over $1 million to settle allegations that their lease arrangement violated the federal False Claims Act. Between 1996 and 2006, HealthSouth operated a facility that provided physical and occupational therapy services in a building owned by the Seacoast Trust. The Seacoast Trust also rented space to Sports Medicine Atlantic Orthopaedics, P.A. (SMAO), in which the physicians are or were shareholders. The government investigated allegations that the rent that HealthSouth paid to Seacoast Trust exceeded fair market value and reflected the value of referrals that HealthSouth received from the partners in Seacoast Trust who practiced medicine at SMAO. Without admitting liability, HealthSouth agreed to pay $775,000 to the U.S. The physicians and the Seacoast Trust agreed to pay an additional $275,000, for a total recovery of $1,050,000. As a result of the settlement, the whistleblower suit that prompted the government's investigation will be dismissed.

DOJ Press Release, March 7, 2007.

New enrollment appeals process approved

A new proposed rule would establish an appeals process for providers and suppliers whose applications for enrollment or renewal of enrollment in the Medicare program were denied. The rule would affect providers and suppliers that are not covered under the existing Medicare appeals provisions in 42 CFR Part 498. The rule would grant providers and suppliers the right to a hearing by an HHS Administrative Law Judge (ALJ) after an adverse decision at the reconsideration level. In addition, this proposed rule would grant providers and suppliers the right to Departmental Appeals Board (DAB) review of an adverse ALJ decision. It would establish timeframes for deciding enrollment appeals by an ALJ or the DAB, as well as timeframes in which contractors must process all provider and supplier enrollment actions. Finally, the rule would establish the use of electronic funds transfer for all federal payments to providers and suppliers.

Proposed rule, 72 FR 9479, March 2, 2007, Health Care Compliance Reporter, ¶730,014.