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by Timothy P. Blanchard, Esq.

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White House begins Recovery Act implementation

The Obama Administration has begun implementing the health care provisions of the American Recovery and Reinvestment Act (ARRA) (PubLNo 111-5) by immediately making additional funds available to hospitals serving low-income and uninsured persons and making key appointments in the areas of comparative effectiveness research (CER) and health information technology (HIT).

Additional hospital allotments. Hospitals eligible to access a share of additional funding under ARRA are those that serve a disproportionate share of low-income or uninsured individuals. States receive an annual allotment to make payments to these disproportionate share hospitals (DSH) to account for higher costs associated with treating uninsured and low-income patients. The ARRA increases the amount of allotments available to states from approximately $11.06 billion to $11.33 billion for 2009. HHS has announced that the $268 million for additional allotments is now available.

CMS will notify states regarding the availability of the increased portion of allotments for their DSHs. Before this new funding can be accessed, states must demonstrate they have used all of their existing fiscal year 2009 DSH allotments. States must request the additional funds as part of their quarterly Medicaid budget requests. The funds will be distributed as separate Recovery Act DSH grants.

A complete list of the revised DSH allotments is available at http://www.hhs.gov/recovery/cms/dshstates.html.

Comparative Effectiveness Research. HHS has appointed the 15-member Federal Coordinating Council for Comparative Effectiveness Research (FCC-CER) panel. The panel is charged with the task of providing information on the relative strengths and weaknesses of various medical interventions and giving clinicians and patients valid information. It is the expectation that this information will be used to make decisions that will improve the performance of the health care system.

The FCC-CER will: (1) assist the agencies of the federal government, including HHS and the Departments of Veterans Affairs and Defense, as well as others, to coordinate comparative effectiveness and related health services research; (2) consider the needs of populations served by federal programs and opportunities to build and expand on current investments and priorities; and (3) provide input on priorities for the $400 million fund in the Recovery Act that the Secretary will allocate to advance CER. The FCC-CER will not recommend clinical guidelines for payment, coverage, or treatment.

FCC-CER members represent a diverse set of individuals and agencies; most of its members are clinicians. The council plans to hold a public listening session on April 14, 2009. A list of council members is available at http://www.hhs.gov/recovery/programs/os/cerbios.html.

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Wolters Kluwer Law & Business

Health information technology. David Blumenthal, M.D., M.P.P., has been selected by the Obama Administration as National Coordinator for HIT. Dr. Blumenthal will lead the implementation of a nationwide interoperable, privacy-protected HIT infrastructure as called for in the ARRA.

The ARRA includes a $19.5 billion investment in HIT, which is designed to save money, improve quality of care, and make health care more efficient. ARRA mandates the adoption of interoperable HIT by 2014, which is projected to reduce federal health costs by an estimated $12 billion over 10 years.

Dr. Blumenthal most recently served as a physician and director of the Institute for Health Policy at the Massachusetts General Hospital/Partners HealthCare System and as senior health adviser to the Obama for America campaign. He was also a professor of medicine and health care policy at Harvard Medical School and served as director of the Harvard University Interfaculty Program for Health Systems Improvement. Prior to that, he was senior vice president at Boston's Brigham and Women's Hospital and served as executive director of the Center for Health Policy and Management and as a lecturer on public policy at the John F. Kennedy School of Government. During the late 1970's, Dr. Blumenthal worked on Sen. Edward Kennedy's Senate Subcommittee on Health and Scientific Research. ■

HHS Press Releases, March 19 and 20, 2009

Hospitals increasingly using dashboards to convey information to board of directors

When communicating with corporate directors who often have little experience in the health care industry, information dashboards or scorecards can be an effective tool for compliance professionals to use in providing a high-level view of a hospital's financial strength, operational effectiveness, clinical quality and patient satisfaction.

The board of directors sets the tone for an organization and must communicate a commitment to quality, ensuring that a culture of accountability permeates the hospital, according to presenters at a roundtable session on November 10, 2008, sponsored by the Office of Inspector General (OIG) and the Health Care Compliance Association (HCCA). Presenters also agreed that compliance professionals can help engage directors by tying quality and patient safety directly to the financial health of the hospital.

Representatives from 27 hospital systems met with trade association members and government officials to discuss their experiences with various types of quality indicators and share ideas on ways to increase directors' engagement in quality of care issues at the roundtable, entitled "Driving for Quality in Acute Care: A Board of Directors Dashboard." The group's full report was released March 23.

Addressing the board. Michael D. Pugh, president and chief executive officer of Verisma Systems, Inc., gave the keynote address at the roundtable, emphasizing strategies for increasing accountability for quality at the board level and best practices for pursuing quality initiatives.

Pugh encouraged the use of information dashboards to help directors interpret the volumes of data and statistics with which they are often presented at board meetings. Although a high-level dashboard may be most helpful to convey information to the full board, Pugh explained that topic-specific scorecards can be useful in addressing board committees such as finance, strategy, planning, quality and safety.

Pugh also encouraged compliance professionals to put a human face on quality-of-care issues by including stories from real-life patients and "using actual accounts of harm, not rates of harm." Raw data, Pugh advised, often fails to provide directors with a full and accurate account of the story behind a patient safety event. "By looking at specific patient impact, the scorecard will begin to tell a story often hidden by traditional reporting about the quality of the care practiced at the facility," the roundtable report explained. "High profile events, such as wrong-site surgery and other sentinel events, should be reported to the board: not just what happened, but what impact it had on that patient, effectively putting a human face on the data."

Dashboard formatting. Pugh advised that compliance professionals keep the design of information dashboards simple by focusing mainly on charts and data graphed over time. This format al-

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lows directors to see quality trends and visualize whether the hospital is heading in the right direction.

Although many compliance professionals have found color-coded metrics useful, Pugh advised them to take a cautious approach. Depicting a measure of quality with a single color — usually red, green or yellow — can distort the data and give directors the false impression that expectations are always being met. "For example, a dashboard could be predominately green, indicating that targets are being met, but a closer examination might reveal that targets have been set inappropriately low," the report stated. "An incorrect assumption can be made that only the 'red' blocks need attention."

Other quality of care issues. In addition to Pugh's keynote address, the roundtable included several panel discussions and breakout sessions to allow participants to exchange ideas and best practices.

During a session on promoting transparency of quality information and results, the group discussed the types of data a hospital should disclose and to whom the data should be provided. "When there is an adverse event resulting in patient harm, most participants indicated they would tell the patient and family as much information as is known at the time of the event," the report said. The group discussed the most effective ways to tell the patient's family and the appropriate timing of such a discussion.

Another breakout session addressed how to achieve accountability for quality at all levels of an organization — from the board of directors and executive management to physicians and staff. Holding the board accountable, the group agreed, can be difficult because directors rarely have an awareness of day-to-day operations at the facility and often do not understand clinical data.

"The goal is to educate the board about quality issues and, ideally, have independent board expertise in the area so that board members are able to ask tough questions about the organization's quality," the report explained. ■

Roundtable Report, "Driving for Quality in Acute Care: A Board of Directors Dashboard" Government-Industry Roundtable, March 24, 2009

Proposed ASC conditions of coverage changed in final rule

In November 2008, CMS issued the first changes in conditions for coverage for ambulatory surgical centers (ASCs) since 1982 (see *Final rule*, 73 FR 68922, November 18, 2008). The new requirements go into effect May 19, 2009. At the American Health Lawyers Association Institute on Medicare and Medicaid Payment Issues on March 24th, Claire Miley, of Bass Berry & Sims, in Nashville, highlighted some of the significant changes between the proposed rule issued in 2007 (72 FR 50470, August 31, 2007) and the final rule.

Inpatient status. Under the proposed regulations, an ASC would not have remained certified as a Medicare ASC if it provided care that required patient monitoring that extended beyond midnight. CMS explained that a patient's location at midnight is a generally accepted standard for determining his or her status as a hospital inpatient or a skilled nursing facility patient and as such, it is reasonable to apply the same standard in the ASC setting. In the final rule, CMS allows patients to remain in an ASC for 23 hours and 59 minutes, starting at the time of admission.

Pre-discharge anesthesia recovery. The final rule allows qualified nonphysician anesthetists, in addition to physicians, to conduct the pre-discharge evaluation for ASC patients for anesthesia recovery. The proposed rule made no provision for this flexibility.

Radiology department standards. CMS originally proposed to replace the current standards governing the ability of an ASC to provide radiological services, i.e., the same standards as are applicable in a hospital radiology department, with the standards applicable to suppliers of portable X-ray services. After several objections from commentators, CMS maintained the existing hospital radiology department standards in the final rule.

Reporting Medicare violations. A literal interpretation of the proposed rule would have required ASCs to report unsubstantiated allegations of violations of Medicare laws and regulations. The final rule clarifies that ASCs are required to report only "substantiated" allegations.

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On The Front Lines

Developing Compliance Issues in OPPS Services — Part II: Supervision Requirements

by Timothy P. Blanchard, Esq.

Hospital outpatient services will likely be under additional scrutiny by Medicare contractors, including Recovery Audit Contractors, and whistleblowers particularly in connection with the supervision requirements for services provided in hospital outpatient settings. Part I of this two part article addressed facility E&M coding for outpatient clinic visits. Part II addresses "clarifications" regarding supervision requirements for outpatient services. Part III will address issues certain affecting critical care and emergency department services.

Clarifications

In the past two years, CMS has issued two separate "clarifications" regarding the supervision requirements for hospital outpatient services. In February 2008, CMS revised the Medicare Benefit Policy Manual to require that the supervising physician be "a physician who is treating the patient."[14] CMS ultimately reversed and withdrew this clarification on June 19, 2008. It appears that CMS recognized that the clarification had been inconsistent with the long-standing program instructions stating that the supervising physician need not even be in the same department as the ordering physician.[15]

In the second "clarification," which was issued by CMS in the preamble to the 2009 OPPS final rule,[16] CMS addressed the supervision requirements for services covered under the "incident to" provision for hospital services[17] and its long-standing assumption that there was direct supervision in outpatient areas on the campus of a hospital by restating its policy to eliminate the distinction between on-campus and off-campus settings.[18] CMS explained that:

> some stakeholders may have misunderstood our use of the term "assume" . . . believing that . . . we do not require any supervision in the hospital or in an on-campus provider-based department for therapeutic OPPS services, or that we only require general supervision for those services. This is not the case.[19]

CMS then explained that:

> It has been our expectation that hospital outpatient therapeutic services are provided under the direct supervision of physicians in the hospital and in all provider-based departments of the hospital, specifically both on-campus and off-campus departments of the hospital.[20]

CMS' clarified that its longstanding "assumption" that there was direct supervision in on campus hospital settings did not mean that no supervision was required or that general (i.e., not on site) supervision would suffice for services furnished in the hospital or on campus. The clarification should serve as a heads up for hospitals and prompt providers to take reasonable steps to assure the requisite supervision for on campus outpatient services (see discussion below). CMS did not stop by reminding hospitals of its "expectation that a physician would always be nearby,"[21] however. Rather it further "clarified" that: "This means that the physician must be present in the provider-based department."[22]

Compliance Challenges

While beyond the scope of this article, it can be argued that the new "in the department" requirement for on-campus departments operated by the hospital itself, as opposed to another entity,[23] is both substantively and procedurally invalid.[24] Nevertheless, and notwithstanding that CMS has indicated that its focus remains on off-campus departments,[25] this interpretation presents a new compliance risk that must be addressed by hospitals because it creates a new technicality that can be used to deny reimbursement or allege false claims even with respect to services that were supervised by a physician who was immediately available to intervene if necessary.

The resulting compliance challenge for hospitals is compounded by CMS' failure to adequately define "department" and "immediately available." With regard to what constitutes an outpatient department, individual hospitals should have considerable flexibility to consider geographic and functional concepts in developing appropriate policies and positions regarding compliance in this area.[26] In light of the remaining ambiguities, hospitals would be well

advised to review their outpatient department designations and make arrangements for supervising physicians to be in the departments whenever reasonably possible. In some cases, hospitals will find it highly impractical, if not impossible, to satisfy an "in the department" requirement at all times. In such cases, hospitals may need to rely on reasonable arguments regarding the proper application of the clarification and evidence that they satisfy the "immediate availability" requirement.

Immediate Availability

Although "immediate availability" on the part of a supervising physician appears to be the critical requirement, CMS explicitly declined to define it further.[27] While this may allows hospitals to consider local conditions and circumstances, it also leaves hospital positions open to second-guessing upon review. Accordingly, providers should carefully consider their arrangements for supervision in hospital outpatient areas and be able to demonstrate the reasonableness of their arrangements and positions.

"The informal manner in which CMS has chosen to implement this new interpretation regarding physician supervision requirements and the resulting ambiguities complicate the already difficult task of assuring compliance by hospitals."

Several observations maybe helpful in establishing policies and procedures for compliance with these requirements:

- It is important to recognize that the supervising physician must be available to furnish assistance and direction, not merely to respond to emergencies that might arise. Nevertheless, because the supervising physician need not be in the treatment room, hospitals need not require supervising physicians to remain within visual or auditory range or some linear proximity standard. It appears unlikely, however, that CMS would accept availability in another "building" to satisfy this standard.
- Unlike diagnostic services,[28] there are no particular requirements regarding the supervising physician's qualifications, although CMS recently suggested during an Open Door Forum that the supervising physician must be "appropriate to provide the supervision" for the OPPS services.[29] Supervising physicians should be authorized under hospital medical staff rules to provide assistance in connection with the outpatient services.
- Although there are no established response time guidelines for immediate availability, even a physician who is physically in a department would not be considered "immediately available" if he or she is involved in another activity that would preclude providing immediate assistance when needed in connection with the OPPS services. This issue should be evaluated when considering various possible cross-coverage arrangements for supervision.
- Hospitals should review all aspects of coverage and documentation requirements including documentation of the attending physician's ongoing involvement in the care of outpatients on an appropriate periodic basis.[30]
- Finally, in anticipation of scrutiny regarding these requirements, hospitals should be sure that outpatient department personnel are able to identify and readily contact a supervising physician at all times.

Conclusion

The informal manner in which CMS has chosen to implement this new interpretation regarding physician supervision requirements and the resulting ambiguities complicate the already difficult task of assuring compliance by hospitals. The uncertainties and potential traps created by policy-making through "clarifications" and informal communications deprive hospitals of reasonable assurance that their best efforts at compliance will be sufficient. Forewarned is forearmed, however, and attention to these developments may enable hospitals to avoid allegations of inadequate supervision of outpatient services or better position themselves to withstand the heightened scrutiny that may follow these clarifications. Part III of this article will address issues certain affecting critical care and emergency department services. ■

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[14] Medicare Benefit Policy Manual, Pub 100-02, Transmittal 82, Feb. 8, 2008.

[15] Medicare Benefit Policy Manual, Pub 100-02, Transmittal 90, June 19, 2008.

[16] *Final rule*, 73 FR 68502, 68702-04, Nov. 18, 2008; Medicare Benefit Policy Manual, Pub. 100-02, Chapter 6, §20.5.1.

[17] This clarification is applicable only to services covered under the hospital incident to provision of 42 U.S.C. §1395x(s)(2)(B), it does not apply to other hospital outpatient services including radiation therapy, physical and occupational therapy and, effective July 1, 2009, speech and language pathology. See 42 U.S.C. §§1395x(s)

(4), (s)(2)(D); 1395x(p). While currently subject to the clarification, cardiac and pulmonary rehabilitation programs will become subject to separate coverage provisions effective January 1, 2010. See 42 U.S.C. §§1395x(eee) and (fff).

[18] The clarification does not change the rules for off-site departments.

[19] *Final rule*, supra n. 16 at 68702.

[20] *Id.* at 68703-04.

[21] *Id.* CMS explained that this expectation is based on the statutory grant of coverage for services furnished "incident to" physician services in a hospital. See 42 U.S.C. §1395x(s)(2)(B).

[22] *Final rule*, supra n. at 68705.

[23] The regulation, which has not changed, states: "'Direct supervision' means the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure." 42 C.F.R. §410.27(f) (emphasis added). According to CMS, the "premises of the location" means the "premises of the entity accorded status as a department of the hospital." *Final rule*, supra n. 16 at 68703 (emphasis added). In the case of outpatient services furnished in a department that is operated by the hospital itself, based on these definitions, the premises of the location would include the entire hospital because the hospital is the entity afforded hospital-based status. Accordingly, under these circumstances, an "in the department" requirement is inconsistent with the regulatory "premises of the location"/"premises of the entity" requirement upon which CMS says it is based. This does not mean that presence of a supervising physician anywhere in the hospital would be sufficient because it is also necessary for the supervising physician to be immediately available to provide assistance in the outpatient department when needed.

[24] Procedurally, this interpretation imposes a new substantive requirement without complying with proper notice and comment rulemaking or coverage policy procedures. Substantively, it can be argued that the "immediately available" requirement that renders an "in the department" requirement superfluous is arbitrary and capricious.

[25] *Final rule*, supra n. 16 at 68703 ("We will continue to emphasize the physician supervision requirement for off-campus provider-based departments."). CMS indicated that it would address failure to satisfy its expectation of physician supervision for on-campus outpatient services as a quality of care matter, presumably as a survey and certification matter regarding whether the hospital violated conditions of participation. As CMS explained:

> [W]e note that if there were problems with outpatient care in a hospital or in an on-campus provider based department where direct supervision was not in place (that is, the expectation of direct physician supervision was not met), we would consider that to be a quality concern.

Id.

[26] It may be necessary for a hospital to consider its representations in voluntary attestations under the provider-based regulations for consistency with positions in response to this clarification.

[27] *Final rule*, supra n. 16 at 68703.

[28] See 42 C.F.R. §§410.28(e), 410.32(b); *Final rule*, supra n. 16 at 68702.

[29] Statements of CMS representatives during a CMS Hospital and Hospital Quality Open Door Forum on February 25, 2009. CMS did not cite any authority for this additional requirement for therapeutic services. See 42 C.F.R. §410.27(f).

[30] See 42 C.F.R. §410.27; Medicare Benefit Policy Manual, Pub. 100-02, Chapter 6, §20.5.1.

Trends (cont.)

Pre- and post-surgical assessment. The proposed rule required that a pre-surgical assessment must include a determination of the patient's "mental ability" to undergo surgery. Recognizing that this determination "may be beyond the scope of a surgical team," CMS dropped the requirement in the final rule. CMS also removed the proposed requirement that ASCs ensure "a safe transition to home" for patients being discharged and "that the post-surgical needs are met." Under the final rule, the ASC must ensure that each patient is discharged in the company of a responsible adult, except those patients exempted by the attending physician. The discharged patient also must receive appropriate discharge information and necessary overnight supplies. ■

CCH Chicago Bureau, March 24, 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.

Anti-kickback/Physician Self-Referral

OIG narrows focus of self-disclosures to anti-kickback violations

In an effort to prioritize its work and focus its resources on the greatest threats to the integrity of the health care system, the Office of Inspector General (OIG) is narrowing the scope of its Self-Disclosure Protocol (SDP) as it relates to the Stark Law. In an open letter to health care providers, OIG explained that it "will no longer accept disclosure of a matter that involves only liability under the physician self-referral law in the absence of a colorable anti-kickback statute violation."

Refined focus. The OIG will continue to accept providers into the SDP if the conduct involves an anti-kickback violation, regardless of whether it also includes an alleged violation of the physician self-referral law.

The OIG is also establishing a minimum settlement amount. With regard to kickback-related submissions into the SDP, the OIG will require a minimum $50,000 settlement amount to resolve the matter. According to the OIG, the minimum settlement amount is consistent with its statutory authority to impose a penalty of up to $50,000 for each kickback and an assessment of up to three times the total remuneration. The OIG indicated, however, that it would continue to analyze the circumstances of each disclosure to determine the appropriate settlement amount and maintain its practice of generally resolving the matter near the lower end of the damages continuum.

Self-disclosures. The SDP, which was introduced by the OIG in 2006, is intended to be a tool for encouraging voluntary compliance by the health care industry. By allowing providers to investigate, resolve and disclose potential fraud matters, the SDP allows providers "to work with OIG collaboratively" and avoid the costs and disruptions associated with a government investigation.

A provider's participation in the SDP is contingent upon full cooperation and complete disclosure of the facts and circumstances surrounding the violation. Providers may be removed from participation if they fail to disclose in good faith and timely perform the required self-assessment.

In spite of its efforts to narrow the scope of the SDP, the OIG urged providers in its letter "not to draw any inferences about the Government's approach to enforcement of the physician self-referral law." ■

OIG Open Letter to Health Care Providers, March 24, 2009, Health Care Compliance Reporter, ¶530,720

Quality of Care

HHS must improve data collection for HAIs in ASCs, GAO says

Recent high-profile cases of health-care-associated infections (HAIs) have brought attention to lapses in recommended infection control practices in ambulatory surgical centers (ASCs), but the Government Accountability Office (GAO) found that current data collection regarding the prevalence of HAIs in ASCs across the country is inadequate. ASCs patients, in particular, may acquire HAIs from bacteria or viruses on the hands of health care workers or in the tubes that deliver medicine, fluids or blood.

In its report to Congress on the availability of data on HAIs in ASCs, the GAO noted that collecting data may help to reduce the risk of HAIs for patients and prevent risky practices such as reusing syringes or drawing medication for multiple patients from single-dose vials.

Problems with current data collection. Currently, data collection regarding HAIs in ASCs are conducted by five data sources, two operated by HHS, two by professional organizations, and one by a state government. None of these sources, however, collects data from a nationally representative random sample of ASCs; rather, the professional organizations and state source, for example, collect only from narrow subsets of ASCs.

While the Centers for Disease Control's National Healthcare Safety Network collects detailed data on HAI outcomes from hospitals and other health care facilities, it does not collect from a nationally representative random sample and only recently began to collect data from ASCs.

GAO recommendations. To remedy the inadequacy of data collection regarding HAIs in ASCs, the GAO conducted a pilot study to conduct recurring periodic surveys of randomly selected ASCs. The study tested the use of an infection control assessment tool as well as the surveyor's observation of a patient's stay from admittance to discharge, which helped to identify serious lapses in infection control practices that otherwise would not have been detected. Based on the success of the assessment tool and surveyor observation in the study, the GAO recommended that HHS develop and implement a written plan requiring that the methods used in the pilot study be used when conducting surveys of randomly selected ASCs. ■

GAO Report, GAO-09-213, Feb. 25, 2009

Fraud & Abuse

Six plead guilty to HIV treatment fraud

Six south Florida health care providers have pleaded guilty in connection with their roles in a $10 million Medicare scheme involving HIV infusion clinics. Three doctors, a chemist and two medical assistants admitted to working at Midway Medical Center Inc., a Miami clinic that purported to specialize in the treatment of HIV patients.

Fraud scheme. According to court documents, the health care providers billed the Medicare program for services that were medically unnecessary or never provided. Two of the clinic's co-owners, Dr. Roberto Rodriguez and Dr. Carmen Del Cueto, admitted that they purchased only a small fraction of the medication that they claimed to administer to patients.

Most of the services provided to patients at Midway were billed to Medicare as treatments for a diagnosis involving a low count of platelets in the blood. Prosecutors alleged that none of the clinic's patients actually had low blood platelet counts, rather, the doctors used chemists to manipulate the blood samples drawn from patients before the samples were sent to a laboratory for analysis.

Admissions. Alexis Dagnesses, a chemist, admitted that he used a blood centrifuge to separate blood samples into their component parts and extract platelets. He would then return the samples to Midway where the doctors would send them to a lab for testing. Dagnesses usually was paid $1,800 for every vial of blood he manipulated.

Dr. Carlos Garrido also admitted to ordering patients to be treated with medications he knew they did not need and that often the clinic did not have available to provide to patients. Medical assistants Gonzalo Nodarse and Alexis Carrazana admitted to conspiring with the others by making false entries in medical records indicating that they had administered such medications to patients on particular dates and in particular dosages. ■

Department of Justice News Releases, March 23, 2009 and March 26, 2009

In the News

Medical office survey toolkit available

The *Medical Office Survey on Patient Safety Culture*, a new evidence-based tool from the Agency for Healthcare Research and Quality (AHRQ), can help medical offices assess how their staff views different areas of patient safety. The survey captures opinions from all levels of staff on patient safety and quality issues, communication about error, communication openness, information exchange with other settings, office processes and standardization, organizational learning, staff training, teamwork, and work pressure and pace. The survey toolkit is free and available on AHRQ's web site. It includes survey forms and a user's guide that explains the survey process, overall project planning, data collection procedures and analysis and report creation.

AHRQ New Release, March 20, 2009

HHS needs to improve use of HAI data

Leadership is needed from HHS in prioritizing prevention practices, and improvement is needed as well in extrapolating data from multiple databases to provide a better understanding of healthcare associated infections (HAIs) in hospitals. HAIs are infections patients acquire while receiving treatment for other conditions, causing about 10 percent of deaths in the United States. The Centers for Disease Control (CDC) has 13 guidelines for hospitals to prevent and control these infections using 1,200 recommended practices, however, these practices need to be prioritized for them to be effectively implemented. Further, HHS has not effectively used the HAI-related data it collected through multiple databases across the department. A steering committee released in January 2009 the *HHS Action Plan to Prevent Healthcare-Associated Infections* that included strategies to address the reasons for the lack of effective control of HAIs. HHS is soliciting public comment regarding this report and is waiting for the new presidential administration's decision on whether this will continue to be a priority.

GAO Report, GAO-09-516T, March 18, 2009

OIG settles with Las Vegas radiology practice

The Office of Inspector General (OIG) for HHS has entered into a civil money penalty (CMP) settlement and 5-year Corporate Integrity Agreement with West Valley Imaging Limited Partnership and its principles, all of Las Vegas, Nevada. The settlement requires payment of $2 million to resolve allegations that the parties intentionally defrauded Medicare by: (1) improperly providing diagnostic tests without the treating physicians' orders, (2) billing for tests under current procedural terminology codes not supported by medical records, and (3) failing to satisfy other billing and coverage requirements. The parties contested the allegations and denied liability. No CMP judgment or finding of liability has been made.

OIG News Release, March 25, 2009