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Congress urged to adopt patient privacy standards for EHRs

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

Congressmen Patrick J. Kennedy (D-RI) is urging Congress to ensure that patient privacy rights are an integral part of any national health care information technology (IT) legislation. Kennedy is working on legislation, called the Electronic Health Information Privacy Act, that will outline and create national standards to ensure the privacy of electronic protected health information.

"To ensure that I.T. enhances rather than detracts from patient policy, we must modernize the Health Insurance Privacy and Accountability Act (PubLNo. 104-191) for this new era," Kennedy said. "If a concept of health care privacy means anything, it is that individuals should be in control of their own health information. If we are to transform health care with I.T., as I believe we must, it is imperative that we address these privacy concerns."

Kennedy's legislation, which is scheduled to be introduced in late May, will update federal privacy rules for the digital era by: (1) covering anybody who has access to individuals' electronic personal health information, (2) requiring patient consent before personal health information is accessed electronically, (3) giving people the right to opt out of including their information in these networks, (4) not pre-empting state privacy laws that provide stronger protections, (5) requiring notification to individuals in the event of security breaches that disclose or may have disclosed their personal information, (6) guaranteeing an audit trail, and (7) protecting doctors and other providers from liability for others' unauthorized access.

Kennedy stated that "[T]he good news is that a digital health care system can enhance patient privacy while allowing us to dramatically improve care." Health information networks can allow the seamless transfer of health data while guaranteeing patient privacy and security. The systems will help doctors streamline their practices by electronically linking medical records, catching conflicting prescriptions, and improving public health monitoring.

"There is bipartisan agreement that health I.T. needs to be a priority, but to realize its potential we also are going to have to ensure that health privacy is rock-solid," Kennedy said adding that "given the diversity of groups signing this letter, that proposition is bipartisan, too." Representatives from the Family Research Council, American Civil Liberties Union, Free Congress Foundation, Electronic Privacy Information Center and Patient Privacy Rights signed the letter to the House of Representatives. ■

CCH Chicago Bureau, April 5, 2006.

HIPAA (cont.)

Lead-risk assessment reports not covered under HIPAA

by Gené Stephens, J.D., Contributing Editor

A state's lead-risk assessment reports and lead contamination notices were not covered under the Health Insurance Portability and Accountability Act (HIPAA) (PubLNo. 104-191) because the reports did not contain protected health information. The reports were issued to property owners of units resided in by children whose blood tests indicated elevated lead levels. Even if the reports did contain protected health information, federal law would not supersede the state law, which required disclosure of the reports.

Background. The state's health commissioner requested copies of 343 lead citations that had been issued from 1994 to the present day. The state's health department refused to provide the reports and cited HIPAA's standards for privacy of individually identifiable heath information.

HIPAA. Under HIPAA, the purpose of the information request must be to obtain or release the protected health information. The lead-citation notices, however, were intended to advise real estate owners about the results of its investigations and identify any existing and potential lead hazards on the exterior and interior of the property and were not intended to release protected health information. In addition, nothing in the records contained individually identifiable information about the children such as a name, age, birth date, social security number, photograph, family information, or telephone number.

A writ of mandamus was granted in favor of the state and an order was granted for the release of the reports. ■

State ex rel. Cincinnati Enquirer v. Daniels, Supreme Court of Ohio, No. C-040064, 2004-Ohio-7130, March 17, 2006, Health Care Compliance Reporter, ¶800,114.

Fraud and Abuse

CMS guidance clarifies "incident to" services

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

Although the regulatory language describing "incident to the services of a physician" prior to a 2002 amendment was ambiguous, a false claims action can be maintained using evidence outside the language of the regulation, such as guidance issued by CMS, according to the U.S. Court of Appeals for the Eleventh Circuit.

Improper billing. A nurse practitioner brought an action under the False Claims Act against her former employer, a health services provider, for improper billing of physician assistant and nurse practitioner services. The nurse practitioner alleged that the provider billed Medicare as though those services were provided incident to the services of a physician even though patients were often treated when no physician was physically present in the clinic. She further alleged that, as a result, the provider recovered approximately 15 percent more than it should have for those services.

The provider argued that the claims could not have been false because until the 2002 amendment the language regarding "incident to" services was vague and subject to interpretation. The nurse presented provisions from the "Medicare Carrier's Manual," Medicare bulletins, seminar programs, and expert testimony to show the meaning of the pre-2002 ambiguous language. Those sources could support a finding that, claims were knowingly falsely submitted by the provider, the court said.

The provider also argued that the nurse's claims should be limited to the two years of her employment. Because the complaint sufficiently alleged that the provider's submission of false claims was ongoing, the nurse could properly claim that the acts occurred after her term of employment ended. The trial court's decision in favor of the provider was reversed and the case was remanded to the trial court for a decision on the merits of the case. ■

United States ex rel.,Walker v. R & F Properties of Lake County, Inc., Dec. 30, 2005, Health Care Compliance Reporter, ¶800,118.

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Supreme Court considers legal standards in retaliation case

by John Scorza, Contributing Editor

The U.S. Supreme Court recently heard arguments in *Burlington Northern and Santa Fe Railway Co. v. White*, (No. 05259), an employment discrimination case with potentially significant implications for healthcare employers. The Court's decision may clarify when employees can bring retaliation claims against their employers and could result in increased employee protection against retaliations. Alternately, it could give companies more flexibility in personnel decisions.

Claims of sexual discrimination and retaliation. The case involves an employee who was the only female on the job. After she complained to management that she was treated differently than male employees, she was transferred to a more strenuous job. When she objected to the transfer, the company suspended her for 37 days without pay. The employee appealed the suspension, which was overturned with back pay. The employee filed a claim against the employer alleging sex discrimination and retaliation in violation of Title VII of the Civil Rights Act of 1964.

The employee's attorney claimed that there is no dispute on whether the employee suffered an adverse employment action. Her loss of compensation and benefits represented a substantial injury, he said.

Curing adverse employment actions. Defending the company's actions, the company's attorney contended that the employee did not suffer an adverse employment action because she received back pay after Burlington rescinded the suspension. The company "cured" the action, the attorney told the court.

Some justices appeared skeptical. Justice Antonin Scalia pointed out that the employee did not receive pay for weeks. "For some people, that's a real hardship," Scalia commented. Justice Ruth Bader Ginsburg speculated that the employee must have undergone considerable stress, wondering how to feed her children or buy Christmas presents.

The company's attorney responded, "[A]nxiety happens all the time in the workplace." He urged the court to adopt a legal standard in retaliation cases that would allow employers a reasonable chance to cure employment actions.

Circuit court standard. The circuit courts are widely divided on the correct standard to apply in retaliation cases under Title VII. Some appellate courts prohibit any adverse treatment "reasonably likely to deter" a plaintiff from engaging in a protected activity. Others only prohibit an "ultimate employment decision," such as a hiring, firing or promotion.

The Sixth Circuit Court of Appeals, which found for the employee on her retaliation claim, prohibits any "materially adverse change in the terms of employment." In applying its definition of adverse employment action to the case, the court determined that the job transfer and the 37 day suspension without pay constituted an adverse employment action regardless of whether the suspension was followed by a reinstatement with back pay.

Parties standard arguments. The employee's lawyer urged the court to adopt a standard based on the retaliation section of the statute – one that would bar any retaliation against an employee engaged in a protected activity. The next best test would be the "reasonably likely to deter" standard, he told the court. The company opposed a broad standard. Employees would become "super-protected" and bring a host of trivial workplace claims to the courts, the company's lawyer contended.

The employee's attorney defended a broader standard in retaliation cases, stating that a broader standard is needed to encourage employees to report workplace discrimination and prevent retaliatory acts by employers.

Government's position. The United States entered the case in support of the employee. But unlike the employee, the government advocates the "materially adverse change in the terms of employment" standard, Deputy Solicitor General Gregory G. Garre told the court. The "reasonably likely to deter" test would be the next best standard to apply in retaliation cases, Garre said. ■

CCH Washington Bureau, April 18, 2006.

On The Front Lines

Law v. Ethics: Which standard should be applied to healthcare contracts?

by Robert A. Wade, Esq., Contributing Editor

On a daily basis, healthcare entities struggle with the tension between following legal requirements or ethical standards. Legal and ethical standards, depending upon the organization's ethical position, can be very different.

The following scenario is very common in healthcare board rooms across the country: A hospital desires to enter into a contract with a large physician group who refer a lot of patients. Hospital leaders, including the compliance officer and legal counsel, meet to discuss the proposed financial arrangement. Understanding the legal risks involved with the arrangement, the Chief Executive Officer (CEO) states that the arrangement must be above reproach. After discussing the legal requirements, the conversation turns to some of the negative consequences related to, and inferences drawn from, entering into the arrangement with the physician group.

As the group discusses various options to either eliminate or decrease the negative inferences, it becomes clear that many of the benefits that could be derived from entering into the financial arrangement would be reduced if the safeguards were implemented. Finally, out of frustration, the CEO turns to the lawyer and/or compliance officer and declares, "Why are you afraid of operating in the grey zone." To which the person replies, "I thought you wanted the financial arrangement to be above reproach?"

Legal v. ethical requirements

Simply stated, legal requirements are established through a governmental process and set a minimum standard for conduct. Ethical standards, alternatively, are established by individuals or organizations, who determine how the individual or organization chooses to interact with others. With the assumption that everyone will choose to abide by legal requirements, ethical standards are thresholds for conduct that are based on criteria that, in most cases, exceed legal requirements.

Ethical standards are based upon personal, professional, and corporate views. The ethical standard can be influenced by many perspectives, including religious, societal, educational, cultural, or environmental. The challenge with establishing ethical standards above legal requirements is determining when such ethical standards should be established and who should monitor and enforce the ethical standards within a healthcare organization.

Corporate v. individual ethics

I served as the General Counsel and Organization Integrity Officer for a hospital system for six and a half years. During my tenure in such position, I frequently encountered the dynamics between individual and corporate ethical standards. Many times, employees confused their personal ethical beliefs with the corporation's ethical standard. If the corporation did not act consistent with the person's ethical standard, some employees believed the corporation lacked integrity.

Every employee is entitled to establish ethical standards by which their personal and professional life will be governed. The ethical standards established by an organization, however, are much more difficult to define, monitor and enforce. Corporate ethical standards are not simply a sum total of the individual ethical standards of the organization's employees. Corporate ethical standards need to be carefully developed, promoted and enforced.

Usually, organizations embed their ethical standards in a Code of Conduct. The real test of the adherence to the organization's ethical standards, however, is determined through the interactions between employees and primarily, the executive leadership of the organization. Every statement and action of an organization's executive leadership will be monitored by employees. Any statement or action taken by an executive will establish, or modify, the ethical bar for the organization.

By way of example, assume the organization's compliance program mandates a minimum of two (2) hours of compliance/ethics education per year. If any senior executive complains or publicly criticizes the mandated compliance/ethics education, the importance of such education will be undermined. Actions similar to this example will lower the organization's ethical standards regardless of what is written in the organization's Code of Conduct.

Is the Stark Act ethical?

Interesting question. The answer depends upon your perspective. Imagine that you own an ice cream stand. You have recently invested in a company that manufactures ice

cream. The government, through a new law, makes it illegal for your ice cream stand to purchase ice cream from the manufacturer in which you are an investor. This sounds like an absurd restriction. This is probably how most physicians feel, however, when they hear about the referral restrictions imposed by the Stark Act.

Most physicians would say that they would never order a test or procedure (if it is a designated health service) unless such test or procedure was medically necessary. With the assumption that all tests ordered by the physician are medically necessary, it is an absurd prohibition that a physician cannot be an investor in and receive financial benefit from an entity where medically necessary tests or procedures are performed on the referring physician's patients.

By lying the Stark Act out in this manner, some (if not most) physicians will come to the conclusion that the Stark Act's restrictions on their referrals have exceeded the physician's ethical standard. This is the reason why many physicians react so vehemently when the Stark Act's restrictions are laid out by an attorney or compliance officer regarding a transaction the physician desires to consummate.

"The challenge with establishing ethical standards above legal requirements is determining when such ethical standards should be established and who should monitor and enforce the ethical standards within a healthcare organization."

Ethical dilemmas even with full compliance with anti-kickback statute safe harbors and Stark Act exceptions

To fully understand the ethical dilemmas with commonplace financial arrangements involving physicians and hospitals, consider the following examples:

- **Ambulatory surgery center ("ASC").** A physician group can invest in an ASC if it meets the ASC safe harbor under the anti-kickback statute and because an ASC is not a designated health service. Although an investment in an ASC may be legal, this investment poses the following ethical dilemmas:
  - Procedures will be pulled out of the hospital, thereby reducing the hospital's revenues; thus, the hospital's ability to provide charity care may be reduced.
  - The ASC may focus on higher reimbursed procedures and payers; thus, access may be limited to Medicare, Medicaid, and charity patients.
  - Most ASCs do not have obstetrics or emergency departments; thus, ASCs are at a competitive advantage over a hospital.
- **Referral requirement for employed physician.** A hospital employs a physician and requires the physician to refer patients to the hospital. Assuming that the employment agreement meets all elements of the employment safe harbor under the anti-kickback statute and employment exception under the Stark Act (including patient choice, insurance and physician judgment), the referral requirement is legal. The possible ethical dilemmas are as follows:
  - The employment arrangement may change the medical judgment of the physician.
  - Patients may be unaware of the physician's contractual requirement. Thus, obtaining informed consent may be difficult without the disclosure of this requirement to the patient.
  - Hospitals may employ physicians in part to establish this referral requirement (does implicate the anti-kickback statute).
- **Productivity-based compensation for employed physician.** Incentive compensation, assuming it is based only on the physician's direct services, meets the employment safe harbor and exception. The possible ethical dilemmas include:
  - Because the physician's compensation is based upon volume of services, the physician has an incentive to see more patients, thus providing less personal contact between the physician and patient.
  - If less time is spent with each patient, the physician may not be able to detect additional medical problems.
  - Patients are unaware that the physician is being incentivized, through his or her compensation to see more patients (or to spend less time with each patient).
  - Guaranteed salary for employed physician. Even guaranteed salary employment arrangements have the following ethical dilemmas:
  - Because physician's compensation is fixed, the physician may not be motivated to work hard.
  - If the physician is too slow, the hospital's financial resources may be wasted (reducing profit or ability to provide charity care).
  - The physician is paid regardless of the profitability of the practice.
- **Block scheduling.** A physician, who is an investor in an ASC, blocks schedules at the ASC with few or no schedule openings to provide services at the hospital. A physician's patient requires an outpatient procedure and requests that the procedure be performed at the hospital. Due to the physician's block scheduling, the patient must either (1) wait a long time to have an open time slot for the

physician to be available at the hospital, or (2) agree to have the procedure at the ASC. This arrangement may meet the ASC safe harbor under the anti-kickback statute. Further, Stark is not implicated because an ASC procedure is not a designated health service. Although legal, the following are possible ethical dilemmas:

- Patients' choice is limited.
- Because of the physician's block scheduling, patients may be directed to the ASC as opposed to offering choice of locations.
- A physician's financial interest and his reserved a block schedule at the ASC may not be disclosed to the patient. If the ASC is relying on the ASC safe harbor, this practice may fall outside of the safe harbor protection.

Conclusion

As you can see, holding a healthcare organization to a higher ethical standard is challenging. First, the organization must determine what ethical standard it wishes to establish. Second, the organization needs to develop a process to promote and educate employees regarding the organization's ethical standards. Third, the organization will need to monitor adherence to the ethical standards, especially amongst senior leadership. Further, violation of the organization's ethical standards must be quickly and equitably resolved.

Even though these steps may be followed, individuals, because of their personal ethical standards, may disagree with decisions made by the organization and believe the organization lacks integrity. It is important to note that regardless of how well intentioned the organization is, others may draw negative inference from the actions taken, although such actions may be legal. These negative inferences also can call into question the organization's integrity.

The bottom-line question is whether the organization believes that its transactions conform to all legal requirements and its established ethical standards, regardless of any negative inferences that may be drawn by persons not involved in the transaction. If the organization's transactions pass this test, then the organization is meeting its legal and ethical standards. If the organization does not pass this test, the organization, and those involved in approving of the transaction, will have their ethical standards challenged. ■

Robert A. Wade, Esq., a partner at Baker & Daniels LLP in South Bend, Indiana, concentrates his practice in representing health care clients including large health systems, hospitals, ambulatory surgical centers, physician groups, physicians and other medical providers. Bob's specialization includes representing clients with respect to the Stark Act, Anti-Kickback Statute, False Claims Act, and the Emergency Medical Treatment and Active Labor Act. He is a nationally recognized expert in all aspects of health care compliance, including developing, monitoring and documentation of an effective compliance program. In addition, Bob has experience in representing healthcare clients with respect to issues being investigated by the Department of Justice and the Office of Inspector General and in negotiating and implementing Corporate Integrity Agreements. Bob also has operationally practical experience having served as a General Counsel and Organizational Integrity Officer for a multi-hospital system for 6-1/2 years. Bob can be contacted at Bob.Wade@bakerd.com.

Anti-kickback

Proposed EHR safe harbor would allow donors to use selective criteria

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

The uniqueness of the Inspector General's (IG's) proposed anti-kickback safe harbors for electronic health record (EHR) was the focus the testimony given by Lewis Morris, Chief Counsel to the Inspector General before the Subcommittee on Health of the House Committee on Ways and Means. Morris noted the process of crating these particular safe harbors requires the Office of Inspector General (OIG) to balance the policy goal of advancing the use of health information technology with the objective the federal anti-kickback statute, which is the elimination of potential financial conflicts of interest in the federal health care programs.

Selective criteria. The OIG is considering permitting donors of technology to use selective criteria for choosing recipients on the condition that neither the eligibility of a recipient nor the amount or nature of the items or services provided is determined in a manner that directly takes into account the volume or value of referrals or other business generated between the parties, Morris explained.

Selective criteria, if adopted, would be a departure from other safe harbors that prohibit taking into account, directly or indirectly, potential referrals or other business generated between the parties. Morris stressed that this approach is a response to the unique policy considerations surrounding EHR systems and the Department's goal of encouraging their adoption. Other provisions of the proposed safe harbor follow the same general structure as the safe harbor for electronic prescribing arrangements set out by Congress in the Medicare Modernization Act of 2003 (PubLNo. 108-173).

Perceived vulnerabilities of donations of EHR technology. In his testimony, Morris reiterated that the OIG's concern with the provision of free or below-market priced hardware, software, or technical support for the establishment of EHRs would induce or reward referrals of federal healthcare program business in violation of the anti-kickback statute. He stated that there also is a risk that a donor of EHR technology will use offers of free technology to induce recipients to change loyalties from other providers or plans to the donor.

According to hospital and other industry stakeholders, as well as government policy makers, however, a safe harbor is necessary. Without protection for donations, hospitals and others would not provide free or very low cost EHR systems to physicians in their service areas, which could slow the implementation of EHRs in the industry. Stakeholders and policy makers have asserted that EHRs are vital to advancing the goals of increased

patient safety and quality and better efficiency in health care delivery.

Safe harbor provisions. Under the proposed rule, protected arrangements would be limited to: (1) hospitals

donating to members of their medical staffs, (2) group practices donating to members of the practice, and (3) prescription drug plan sponsors and Medicare Advantage organizations donating to network pharmacists and pharmacies and to prescribing health care professionals.

The proposed safe harbor also would require that protected software be certified in accordance with product certification criteria for interoperability as adopted by the Secretary. The OIG believes that uniform interoperability standards will help preclude donors from using closed or isolated systems to tie recipients to particular providers or suppliers. Finally, the OIG is considering capping or other otherwise limiting the aggregate value of the donated technology and has solicited public comment on a range of possible options for structuring such a limit.

Testimony Before the Subcommittee on Health of the House Committee on Ways and Means, April 6, 2006, Health Care Compliance Reporter, ¶530,381.

OIG approves drug assistance program but Senators seek further clarification

by Catherine Hubbard, M.A. and Sheila-Lynch Afryl, J.D., Contributing Editors

A pharmaceutical company's inclusion of Medicare-eligible patients in its patient assistance programs (PAPs) is consistent with the Office of Inspector General (OIG) guidelines, according to an OIG advisory opinion issued on April 18, 2006. The OIG issued a favorable advisory opinion stating that the pharmaceutical company's PAP that provides free outpatient drugs to financially needy Medicare Part D enrollees outside of the Part D benefit posed minimal risk of fraud and abuse.

This advisory opinion applies to this manufacturer only, and several pharmaceutical manufacturers have indicated that they will discontinue their prescription assistance due to their concern that PAPs could violate federal anti-kickback laws. Last November, the OIG issued a Special Advisory Bulletin on Patient Assistance Programs for Medicare Part D Enrollees (see *Health Care Compliance Reporter* ¶760,011) stating that manufacturer PAPs that subsidize costs of drugs payable by Part D present all of the usual risks of fraud and abuse associated with kickbacks, including steering enrollees to particular drugs, increasing costs to Medicare, providing a financial advantage over competing drugs and reducing enrollees' incentives to use less expensive, equally effective drugs.

Senators concerns. Just prior to the issuance of this advisory opinion, Senate Finance Committee Chairman Charles Grassley (R-Iowa), Ranking member Max Baucus (D-Mont.), Orrin Hatch (R-Utah), and Jay Rockefeller (D-W.Va.) asked the HHS Inspector General (IG) for clear guidance to ensure the availability of pharmaceutical manufacturer PAPs after May 15, the deadline for Medicare beneficiaries to sign up for the new Medicare drug benefit.

The Senators said that OIG's Special Advisory Bulletin, issued to clarify that the federal anti-kickback statute applies to all PAPs, may have encouraged several manufacturers to discontinue their prescription assistance.

"The Inspector General's office made a good start today by clarifying for one company the legal parameters for operating a PAP, but more needs to be done," Rockefeller said. "The Inspector General must give clear guidance to other drug manufacturers," he added.

In their April 17th letter to the IG, the Senators asked for a quick response to advisory opinion requests to clarify the legal guidance on manufacturer PAPs. "We believe a resolution can be achieved that allows pharmaceutical manufacturers to continue providing much needed assistance to certain groups of Medicare beneficiaries in a manner that does not violate the integrity of the Medicare program," they said.

Manufacture PAPs defined. Manufacturer PAPs provide free or subsidized medications to thousands of individuals, including Medicare beneficiaries, who might not otherwise be able to afford their prescription drugs. Many seniors and individuals with disabilities who participate in manufacturer PAPs have chronic conditions, the Senators said. "Many seniors simply wouldn't get the drugs they need without patient assistance programs," said Baucus.

OIG evaluation. In this case, the manufacturer expanded eligibility for its two existing PAPs, one for the treatment of cancer and hepatitis and one for a broad spectrum of other illnesses, to include Medicare beneficiaries enrolled in a Part D plan. Because the PAPs in question are operated entirely outside the Part D benefit, however, the OIG would not initiate administrative proceedings to impose civil money penalties or exclude the manufacturer from federal health care programs.

Program safeguards. Safeguards sufficient to mitigate the risk associated with manufacturer PAPs include the following:

1. the PAPs notify enrollees' Part D plans that the free drugs are being provided outside of the Part D benefit;
2. eligibility for PAP assistance for Part D enrollees is determined based solely on patients' financial need, using a methodology that is entirely unrelated to the enrollee's choice of Part D plan; and
3. the PAPs provide assistance for the whole Part D coverage year and continue to provide assistance even if the patient's use of the free drug is periodic during the coverage year.

Although the use of physicians to distribute free drugs from pharmaceutical manufacturer PAPs could create an additional risk of anti-kickback violations if the drugs were to inure to the economic benefit of the physicians, this risk is mitigated by several safeguards, including the designation of the drugs for use by particular individuals, limitations on the quantity shipped, and the notification process for the Part D plans and enrollees. ■

CCH Washington Bureau, April 18, 2006; OIG Advisory Opinion, No. 06-03, April 18, 2006, Health Care Compliance Reporter, ¶500,138.

Medical Reimbursement

Carriers pay twice for ambulance services

by Sheila Lynch-Afryl, J.D., Contributing Editor

Medicare paid twice for ambulance services provided to Medicare beneficiaries during inpatient stays at hospitals, according to the Office of Inspector General (OIG). From 2001 to 2003, carriers potentially overpaid $21.7 million for ambulance services by paying the hospital as part of the diagnosis-related group (DRG) payment and the ambulance supplier under Part B. In addition, more than $6.2 million in Medicaid coinsurance and deductibles may have been overpaid.

Inadequate controls. Neither CMS nor its carriers had established computerized edits to detect and prevent the Part B payments, and CMS officials had no post-payment review procedures for identifying payments for Part B ambulance services that duplicated the DRG payments.

Eleven Medicare carriers contacted by CMS did not have adequate controls to deny improper payments for ambulance services. Although all of the carriers said that they had an edit in place for hospital-to-hospital transportation claims, they still erroneously paid claims. Most of the carriers indicated that they had provided education, training, and workshops to ambulance suppliers on the proper billing procedures for services provided to Medicare beneficiaries during inpatient stays.

According to the OIG, if CMS had implemented appropriate edits, the carriers would not have paid most of the 150 sampled items. Ambulance suppliers billed carriers instead of hospitals for 52 of the 150 sampled items because supplier officials did not know that the beneficiary was an inpatient at the time of transport, billed incorrectly with no specific reason given, or were not aware of the Medicare program requirements. For 50 of the 150 sampled items, the ambulance suppliers billed the wrong date of service or the hospitals' inpatient stay dates were incorrect. ■

OIG Report, No. A-01-04-00513, March 17, 2006, ¶530,379.

In the News

State passes mandatory health insurance bill

Massachusetts lawmakers have approved legislation to extend health coverage to more than 500,000 uninsured residents by requiring people to buy basic health insurance by July 2007 or pay a penalty. Private insurers would receive subsidies to provide affordable coverage and premiums would be based on a sliding scale. Businesses with 11 or more employees that do not provide health care coverage would be required to contribute to a fund. Gov. Mitt Romney is expected to sign the bill. White House spokesperson Scott McClellan said CMS has been in close contact with the Governor and the state of Massachusetts as they moved forward on the legislation. "CMS will look forward to seeing the details of the legislation, because part of this includes a component that involves expanding Medicaid coverage to cover some of the children that are currently not getting that insurance coverage," he said at a briefing.

CCH Washington Bureau, April 7, 2006 .

Notification requirements for hotline complaints clarified

The notification requirements for receipt of an Office of Inspector General (OIG) Hotline complaint regarding certain allegations, the definition of a closed case, and the procedures the OIG must use to request data from CMS have been clarified. When certain allegations are made, a telephone call to the special agent in charge or the agent's assistant must be made immediately upon receipt of the allegation and the telephone call must be documented. This will allow the OIG special agent to give specific directions to the Medicare contractor. In addition the Office of Inspector General, Office of Investigation Data Use Agreement has been updated. This agreement describes how data released by CMS to the OIG will be handled.

Medicare Program Integrity Manual , Pub. 100-08, Transmittal No. 144, March 31, 2006..

CMS proposes two-step notice for hospital discharge

A two-step notification process proposed for each Medicare beneficiary discharged from a hospital, includes a generic notice of discontinuation of coverage and a second notice if a beneficiary elects to have an expedited review of the discharge decision conducted by a Quality Improvement Organization (QIO). The generic notice, to be delivered within one day of discharge, would include (1) the date Medicare coverage would end, (2) the beneficiary's right to an expedite appeal and description of the appeal process, (3) the date that financial liability for continued services would begin, (4) the beneficiary's name, and (5) the beneficiary's right to additional information. The second notice must be delivered by the close of business on the day the beneficiary request a QIO review. This notice must include: (1) a detailed explanation of why services no longer are covered; (2) a description of any applicable Medicare coverage rule, instruction or other Medicare policy; (3) facts specific to the beneficiary and relevant to the coverage determination that are sufficient to advise the beneficiary of the applicability of the coverage rule or policy to the beneficiary's case; and (4) any other information required by CMS.

Proposed rule, 71 FR 17052, April 5, 2006.