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New quality measures aim to improve hospital care

by Catherine Hubbard, M.A., Contributing Editor

In an effort to encourage consumers to compare the quality of care hospitals provide and impel hospitals to improve care, CMS has added new quality measures to its Hospital Compare consumer web site, including 30-day hospital mortality outcome measures. These measures assess deaths for any cause within 30 days of hospital admission for a heart attack or heart failure. They are risk-adjusted and take into account previous health problems to (1) "level the playing field" among the 4,500 hospitals that have agreed to submit quality information for Hospital Compare to make public, and (2) help ensure accuracy in performance reporting, according to CMS.

To receive full payment for inpatient services in fiscal year 2008, hospitals must report on 27 quality measures. Twenty-one measures are available on the web site, including: eight measures related to heart attack care, four measures related to heart failure care, seven measures related to pneumonia care, and two measures related to surgical infection prevention. The process of care measures, which show how often hospitals provided recommended treatment for heart attack, heart failure, pneumonia, and surgery, are updated on a quarterly basis. The mortality outcome measures will be updated annually, CMS said.

The first reported information on the mortality outcome measures is based on hospital admissions that occurred between July 1, 2005, and June 30, 2006. The mortality outcome measures result in a rating of "no different from," "better than," or "worse than" the U.S. national rate. According to Herb Kuhn, CMS Acting Deputy Administrator, 38 hospitals were rated above the national rate, and 35 were rated below the national rate.

Kuhn said that CMS took a conservative approach when assessing the hospitals. He also said the agency is not trying to embarrass hospitals that have a low rating; rather, CMS wants hospitals to improve the quality of the care they provide. CMS Acting Administrator Leslie Norwalk noted that hospitals will get detailed reports from CMS that they can use to lower mortality risk for their patients.

HHS Secretary Michael Leavitt said the new quality measures will allow consumers to compare hospitals and find those that provide the best care for all sorts of outcomes. He emphasized that the new enhancements are a "first step." The goal is to drive costs down and quality up. "That's the key," Leavitt said. ■

CCH Washington Bureau, June 21, 2007.

Wolters Kluwer
Law & Business

Disclosure of adverse medical events might reduce errors, experts say

by Valerie Witmer, J.D., Contributing Editor

Recent developments in legislation addressing adverse medical event reporting have led experts to wonder what effect the new requirements will have on reporting and, in turn, what effect reporting might have on the national incidence of adverse events. Speaking at the American Health Lawyers Association Annual Meeting in held in Chicago, Illinois, on June 25-27, 2007, Mark A. Kadzielski, partner and head of Fulbright & Jaworski LLP's Los Angeles office health industry practice, discussed the status of federal and state adverse medical event reporting requirements and questioned the results they will produce.

Responses to IOM report. In 2005, the federal Patient Safety and Quality Improvement Act (PSQIA) was enacted, ostensibly in response to the Institute of Medicine's (IOM's) report, "To Err Is Human: Building a Safer Health System," released six years earlier. The IOM report indicated that between 44,000 and 98,000 hospital deaths occur each year from preventable medical errors, resulting in costs between $17 and $29 billion. The IOM found that health care providers had few incentives to analyze or report errors, and recommended mandatory reporting of adverse events.

According to Kadzielski, the Joint Commission responded to the IOM report by developing National Patient Safety Goals and standards governing sentinel events. In response to a sentinel event, accredited organizations are encouraged, not required, to report events. Likewise, and contrary to the IOM's recommendation, the PSQIA calls for voluntary, not mandatory, reporting of patient safety information, Kadzielski said. He explained that the goal of the PSQIA is to reduce the occurrence of preventable medical errors via:

- formation of patient safety databases by HHS, to collect patient safety information on a national scale and serve as patient safety resources for health care providers;
- formation by private and public entities of Patient Safety Organizations (PSOs) at the local, state, or regional level; and
- protection of privileged and confidential patient safety work product.

Interaction with state laws. Kadzielski noted that the PSQIA does not preempt state laws that mandate the reporting of medical errors, nor does it limit the application of other laws that provide greater protection of patient safety information.

To date, the Agency for Healthcare Research and Quality, which was charged by Congress with implementing the PSQIA, has not released any proposed regulations for public comment, despite the Agency Director's statement that proposed regulations would be forthcoming by the end of 2006, Kadzielski said. States, however, have drawn guidance from a 2002 report issued by the National Quality Forum (NQF). In its report, the NQF identified 27 serious reportable events, or "never events", in six categories: surgical events; care management events; environmental events; patient protection events; product or device events; and criminal events.

According to Kadzielski, at least nine states, including Minnesota, Connecticut, New Jersey, Wyoming, Indiana, Washington, California, Vermont, and Illinois, recently have passed mandatory adverse event reporting requirements based on the NQF's never events. These state laws vary with respect to reporting deadlines, patient notification requirements, information required to be reported, data protection measures, and sanctions for failure to report.

Kadzielski noted that the state mandatory adverse event reporting laws based on the NQF's never events have decreased ambiguity about what needs to be reported and, as a result, may result in more events being reported. He cautioned, however, that different requirements in different states may increase confusion and standardization of adverse event reporting requirements is likely not forthcoming in the near future.

Other implications. The impact adverse event reports will have on medical malpractice litigation has yet to be seen, Kadzielski added. The "ultimate question," according to Kadzielski, is: "Are mandatory adverse event reporting requirements decreasing adverse events?" ■

CCH Chicago Bureau, July 3, 2007

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Health Information Technology

HHS must develop a health IT plan

by Catherine Hubbard, M.A., Contributing Editor

Lawmakers and the Government Accountability Office (GAO) are concerned that HHS has not developed a definite plan and timeline for moving toward a health information technology (IT) system that improves health care while protecting patients' personal health information. While HHS has been working to make a health IT system feasible, the GAO found that HHS was not doing enough to integrate effective privacy safeguards into its long-term strategy, Lacy Clay (D-Missouri.), Chairman of the House Oversight and Government Reform Subcommittee on Information Policy, said at a June 19, 2007, hearing.

Lawmakers called for a comprehensive plan and coordinated approach to health IT. They also asked whether a national information system will lead to cost savings and improved health care quality and when HHS will have a plan ready.

GAO's concerns. Valerie Melvin, director of information management issues at the GAO testified that HHS is in the early stages of its efforts and, while it has initiated activities intended to protect health information, it has not yet defined an overall approach for integrating its various privacy-related initiatives and addressing key privacy principles. Milestones for integrating the results of these activities do not yet exist, she added. "Until HHS defines an integration approach and milestones for completing these steps, its overall approach for ensuring the privacy and protection of personal health information exchanged throughout a nationwide network will remain unclear," Melvin said.

The GAO recommended that HHS define and implement an overall approach that identifies milestones for integrating the outcomes of its privacy-related initiatives; ensures that key privacy principles are fully addressed; and address key challenges associated with the nationwide exchange of health information. ■

CCH Washington Bureau, June 20, 2007.

Pharmaceuticals

Drug company gift registry proposed

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

Senate Special Committee on Aging Chairman Herb Kohl (D-Wisc.) plans to propose a national registry to require disclosure of payments and gifts from pharmaceutical companies to physicians. According to Kohl, "[T]hese interactions involving things of value between the pharmaceutical industry and doctors must be made public."

The Committee met on Wednesday June 27, 2007, to examine the pharmaceutical industry's practice of providing payments and gifts to doctors, and consider the effects of the industry's influence over physicians. Committee members expressed concern that although the pharmaceutical industry is one of the most profitable, Americans pay the highest drug prices in the world, forcing some employers to drop health coverage for employees, squeezing the budgets of state and federal governments, and ultimately raising costs for senior citizens.

According to the Committee, drug companies spend nearly $19 billion annually on doctors in the form of lecture honoraria and conference registration fees, research grants, trips, meals, drug samples, and other freebies. A study published in the New England Journal of Medicine earlier this year reported that 94 percent of physicians have received such gifts and payments from drug companies.

Industry response. Pharmaceutical Research and Manufacturers of America (PhRMA) Senior Assistant General Counsel Marjorie Powell testified before the Committee that pharmaceutical marketing plays a key role in disseminating important information regarding treatment options, which ultimately help reduce overall costs. According to Powell, "[A]rming physicians with essential information about the medicines they prescribe undoubtedly benefits patients and advances health care in the United States."

Powell stated that pharmaceutical companies are complying with strict requirements by the Food and Drug Administration regarding the accuracy of marketing information. In addition, PhRMA's Code on Interactions with Healthcare Professionals provides guidance on how sales personnel should maintain ethical relationships in their discussions with healthcare professionals. ■

Special Committee on Aging Press Release, June 27, 2007; PhRMA Press Release, June 27, 2007.

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On The Front Lines

Looking at executive compensation in nonprofit health care organizations from a compliance perspective, Part II

by Albert Y. Lin, Esq., Contributing Editor

To assist the compliance officer in understanding all of the issues impacting executive compensation in nonprofit health care organizations, this article provides a succinct, yet comprehensive, overview of the legal and practical considerations in evaluating the nonprofit health care organization's executive compensation package.

Part I of this three-part article discussed the legal meaning of executive compensation as it relates to health care organizations, which includes the compensation of medical staff physicians who may not be "executives" in the common-sense meaning, but nevertheless constitute a significant portion of payroll. Part I also began a discussion on the legal framework for analysis of executive compensation in the context of nonprofit organizations, which is continued in Part II. Part III concludes the article by offering compliance suggestions for the nonprofit board.

Legal Framework for Analysis of Nonprofit Compensation

In Part 1 of this article, the legal frame work for analysis of nonprofit compensation discussion focused on applicable state nonprofit corporations statutes and administrative guidelines including the key principles in the Revised Nonprofit Corporation Act and common law fiduciary duties. The discussion continues with an explanation of federal tax law concepts relevant to tax-exempt organizations.

Understand federal tax law concepts relevant to tax-exempt organizations

Particularly important in the current climate, federal tax laws receive more attention than usual with the Internal Revenue Service (IRS) and Department of Treasury in recent years actively soliciting detailed information from tax-exempt organizations following reports of abuse. In 2007, the IRS expects to release new rules that tighten reporting requirements in the Form 990, particularly in the sections of the Form 990 requiring disclosure of compensation and transactions between the organization and its officers and directors. The health care compliance officer should be aware of these upcoming developments and not classify them simply as additional tax reporting requirements, but rather as a call to review how decision-making is accomplished within the organization. The following discussion summarizes the basic federal tax rules as well as newer developments.

Private benefit and private inurement

Section 501(c)(3) of the Internal Revenue Code of 1986, as amended ("Code") provides that a tax-exempt charitable organization includes a corporation or foundation (1) that is "organized and operated exclusively" for charitable purposes, and (2) for which "no part of the net earnings" may "inure" to the benefit of any private shareholder or individual.[6]

The text quoted above gives rise to the "*private benefit*" and "*private inurement*" rules governing charitable, tax-exempt §501(c)(3) organizations.

The second requirement, "*private inurement*," is the more commonly litigated factor and tends to be more quantifiable. It occurs when net earnings of a charitable organization (the excess of funds over reasonable expenses) is redirected to persons (or persons related to such persons) who are essentially in control of the charitable organization. Such persons are referred to as "*insiders*," and the tax rules prohibit any private inurement - the prohibition is absolute.

The first requirement, "*private benefit*," is more subjective and refers to situations in which the overall resources of a charitable organization may benefit a general private interest rather than the public. In proposed Treasury Regulations, the IRS attempted to clarify the concept of private benefit by examples. One example is an art museum that exhibits art by unknown local artists. The art museum, governed by an independent board of trustees, sells the art and retains a 10 percent commission for operating expenses and the artists receive the remaining 90 percent.[7] This IRS example represents "private benefit."

Section 4958 intermediate sanctions

In the past, the only recourse against charitable organizations was the revocation of their tax-exempt status. As an "intermediate" regime of penalties that would be short of outright revocation, the IRS passed somewhat less severe, but still very material, penalties designed to force misbehaving §501(c)(3) organizations into compliance - the "intermediate sanctions." The intermediate sanction penalties

can come into play if executive compensation amounts are found unreasonable.

The intermediate sanctions (also referred to as penalty taxes on "excess benefit" transactions) penalize two key players in a charitable organization: any *disqualified person* and any *organization manager*.

A "disqualified person" includes:

(i) any person who was, at any time during the five-year period ending on the date of such transaction, in a position to exercise substantial influence over the affairs of the corporation;

(ii) a member of the family of a person described above;

(iii) any entity (corporation, partnership, trust, estate, etc.) in which any of the persons described above owns a 35 percent voting interest (or beneficial interest in the case of a trust or estate);

(iv) donors and donor advisors (or family members or 35 percent-controlled entities of such persons), if the charitable organization is a "donor advised fund"; and

(v) investment advisors to the assets of the donor advised funds (or family members or 35 percent-controlled entities of such persons).[8]

An "organization manager" means any officer, director, trustee, or any person with similar powers in the organization.

The penalties themselves work as follows.

(1) *A penalty tax of 25 percent of an "excess benefit" is imposed on the disqualified person - the statute requires the person to pay, and not the organization.*[9] An "excess benefit" arises if an economic benefit (*i.e.*, cash or property) is provided by a tax-exempt organization directly or indirectly for the use of any disqualified person (*i.e.*, the company CEO), and the value of the economic benefit exceeds the value the tax-exempt organization receives in exchange. In other words, when a charitable organization gives a disqualified person compensation or goods, but receives something worth less in exchange, an excess benefit arises and it may be subject to intermediate sanctions.

(2) *If a 25 percent excess benefit tax is imposed as described above, another penalty tax of 10 percent on the excess benefit is imposed on (and paid by) any organization manager who participated in the transaction, unless the participation is not willful and due to reasonable cause*. This tax is limited to $20,000 in the aggregate for each excess benefit transaction, and if multiple organization managers are involved, each is jointly and severally liable.

(3) *An additional penalty tax of 200 percent of the excess benefit is imposed on (and paid by) the disqualified person if the first 25 percent penalty tax was imposed and the excess benefit transaction is not corrected (i.e., the excess monies returned) within a certain period*. Generally, it needs to be corrected before the IRS issues a notice of deficiency, which is a letter that does not arrive until well after the organization and disqualified person are aware of the exposure or investigation.

The defense to private benefit, private inurement, and the intermediate sanction regime is the *reasonable compensation* doctrine. This concept will be described later in this article; the immediate discussion identifies the potential issues surrounding health care executive compensation.

The nonprofit healthcare compliance officer should consider whether "nonqualified" benefit plans for executives have been reviewed or amended in the last two years.

Section 409A rules on deferred compensation

In addition to the general rules outlined above, the nonprofit health care compliance officer should consider whether "nonqualified" benefit plans for executives have been reviewed or amended in the last two years.[10] In particular, he or she should consider whether various deferred compensation arrangements offered to its executives have been amended to take into account new rules for such arrangements as outlined in §409A of the Code.[11] These rules have quite broad applicability and were designed to apply to many arrangements when compensation is deferred and paid at a later date, such as individual employment contracts with deferral and vesting provisions applicable to future payments, as well as more formal nonqualified deferred compensation plans. The §409A rules exclude "qualified" retirement plans such as the traditional 401(k) and 403(b) plans.

The new rules were intended to prevent abusive arrangements whereby executives would avoid current income taxation on compensation amounts that were essentially within their control, although not actually received. Section 409A thus imposed a variety of requirements on any arrangement meeting its definition of a "nonqualified deferred compensation." The new rules require very specific provisions for the deferral elections, restrictions on when distributions may be made (*e.g.*, although emergency distributions for disability may be permitted, §409A has a very specific definition of disability), and a prohibition on acceleration of distributions. In addition, the new rules contain interest and penalty provisions for noncompliance. If a deferred compensation arrangement has not been reviewed thoroughly since 2004, chances are good that it may not comply with §409A.

While outside the scope of this article, the Pension Protection Act of 2006 introduced a wealth of technical changes that will impact all types of retirement plans for the nonprofit health care executive as well.

Recent administrative developments

In March 2007, the IRS issued its *Report on Exempt Organizations Executive Compensation Compliance Project (Parts I and II)*, outlining findings from a study initiated in 2004 of executive compensation in exempt organizations. Health care compliance officers and board members should expect much closer scrutiny of the Form 990 disclosures relating to executive compensation. Moreover, the methods and process for arriving at executive compensation will be held to a higher standard.

The Project contacted 1,826 exempt organizations with respect to executive compensation. From this survey, the IRS concluded:

- Accurate reporting of executive compensation on the Form 990 appears to be the main and most widespread problem. The IRS admits the Form 990 should be revised to facilitate accurate and complete reporting.
- Problems with excessive compensation were not widespread, but where problems were found, the excise taxes assessed were significant and, as such, the IRS feels continued examination is warranted.
- High compensation amounts were not unusual and generally were supported by comparability data.

The IRS recommends a "clearly articulated mission statement" that serves as a guide to the organization's purpose. In the context of executive compensation, the organization's performance needs to be evaluated against the stated purpose.

The findings were consistent with an earlier survey by the Government Accountability Office (GAO) of nonprofit hospital executive compensation. In he GAO survey, 65 hospitals responded and most maintained a separate compensation committee and a conflicts of interest policy, and utilized market comparables in arriving at executive compensation decisions.[12]

The IRS is expected to release additional rules this year. As a preliminary hint of its direction, in March 2007, it issued a four-page document entitled "*Good Governance Practices for 501(c)(3) Organizations,*" which restates the traditional compliance goals of nonprofit health care organizations. The document is relatively simple and easy to understand; the health care compliance officer should incorporate it into its due diligence materials. Its intent is not to set forth explicit IRS requirements, but rather to serve as a roadmap to minimize charitable organizations' problems with the actual IRS exempt organization rules.

The charitable organization should review its documentation and practices in the following listed areas. Each item impacts executive compensation in some manner.

(1) *Mission statement*. The IRS recommends a "clearly articulated mission statement" that serves as a guide to the organization's purpose. In the context of executive compensation, the organization's performance needs to be evaluated against the stated purpose. If the organization is not meeting its stated mission – either by subjective or objective standards – justifying increased compensation will be difficult.

(2) *Code of ethics and whistleblower policy*. The existence of and compliance with a code of ethics and whistleblower policies assist the executive in showing that decisions are made ethically. Demonstrated compliance with these policies from the higher levels of hierarchy helps justify increased compensation.

(3) *Due diligence policies and procedures*. These policies outline the executive's duty of care. The health care compliance officer should assist the board by showing that policies are in place that, for example, inform the executives of the organization's activities and whether goals are met. The executives should be fully informed of financial and other details, and should have regular access to this information. This information also should be easily accessible to members of the compensation committee.

(4) *Duty of loyalty*. The IRS states that this duty is in part fulfilled by the adoption of , adherence to, and regular evaluation of a conflicts of interest policy. Failure to abide by a written conflicts of policy means that the compensation decisions of the organization will be questioned.

(5) *Transparency*. The Form 990 is a critical element of a nonprofit health care organization and should be reviewed carefully and posted on the public web site. The compensation of each director, officer, and key employee (as well as the five highest paid independent contractors) should be disclosed annually. Those charged with reviewing the Form 990 should carefully examine the compensation disclosed and make sure all aspects of compensation – not just salary and bonuses, but also fringe benefits – are listed.

(6) *Fundraising policy*. The IRS recommends that organizations have a written fundraising policy and keep costs reasonable. Care should be taken to document any relationship between outside fundraisers and organization executives, ensure that compensation is arms-length, and ensure that the parties are not receiving excessive benefits from such relationships.

(7) *Financial statements*. The IRS recommends independent auditors if the organization has substantial assets or annual revenue, and recommends rotating firms every five years. This rotation, based on provisions of the Sarbanes-Oxley Act of 2002, ensures a fresh look at financials and compensation practices regularly.

(8) *Compensation practices*. The IRS restates the requirement of reasonable compensation determined by a compensation committee. This requirement relates to the need to have and enforce a conflicts of interest policy. The IRS recommends that the compensation committee be comprised of people who are not compensated by the organization and

have no financial interest in the determination of reasonable compensation.

(9) *Document retention policy*. The IRS recommends that organizations have a written document retention policy. The IRS refers to its Publication 4221, entitled "*Compliance Guide for 501(c)(3) Tax-Exempt Organizations*," which outlines suggested periods for retaining various tax and corporate records. A document retention policy will help compensation committees by providing them easier access to records helpful in making their decisions.

Physician compensation arrangements

Physician employees of a charitable health care system may or may not be considered "disqualified persons" for purposes of the intermediate sanction rules. Traditionally, however, the IRS has closely scrutinized physician compensation arrangements because physicians can be influential regardless of whether or not they serve on the board. Until relatively recently, the IRS has presumed that all physicians are insiders.

The IRS has examined various forms of physician compensation to determine if potential for private inurement exists. The specific methods of compensation that IRS agents will scrutinize especially closely include contingent or percentage of income arrangements, income guarantees, below market loans, rent abatement, bonuses, support services, payments relating to purchases of physician practices, personal expenses, and gainsharing arrangements (in which physicians share in cost savings or productivity improvements).[13] These arrangements are not necessarily prohibited, but it can be very hard to justify their existence, and the compliance officers and board should be prepared to document their reasonableness and a compelling community need (as further discussed below).

One recent area of interest that impacts physician compensation rules is the provision of electronic health records (EHR) systems to medical staff physicians. Providers of such systems work with exempt health care organizations to implement their products, often at substantially reduced fees. The provision of EHR systems needs to be reviewed to ensure that the circumstances do not give rise to private inurement. For example, discounted rates cannot simply be provided to particular physicians chosen by the board. Moreover, the reasons for permitting EHR implementation and the methodology for selecting recipients EHR technology should be documented to overcome any presumption of private inurement.

On May 11, 2007, the IRS issued an internal "directive" (a guideline provided to reviewers and agents within the Exempt Organizations Division) that outlines its policy regarding hospitals' provision of discounted EHR systems to physicians.[14] There are two steps towards ensuring that the provision of discounted EHR systems does not violate private benefit or private inurement rules. First, the hospital should provide EHR systems within the parameters delineated under the HHS final regulations. The provision of EHR software and technical support ("Health IT Items and Services") in compliance with these regulations will not violate the federal anti-kickback statute (42 U.S.C. § 1320a-7b) or the physician self-referral law (42 U.S.C. § 1395nn).

In addition to the HHS rules, the IRS directive requires that:

(1) the provision of EHR systems (called a "Health IT Subsidy Arrangement") require both the hospital and the participating physicians to comply with the HHS rules on a continuing basis;
(2) the Health IT Subsidy Arrangement provide that, to the extent permitted by law, the hospital may access all of the electronic medical records created by the physician under the Health IT Subsidy Arrangement;
(3) the hospital ensure that the Health IT Items and Services are available to all of its medical staff physicians; and
(4) the hospital provide the same level of subsidy to all of its medical staff physicians or vary the level of subsidy by applying criteria related to meeting the health care needs of the community.

Written arrangements for the provision of EHR systems should be reviewed in light of this IRS directive.

Parts I and II of this article discussed the meaning of executive compensation and the legal framework for analysis in the context of nonprofit organizations. Part III will conclude the article with compliance suggestions for the nonprofit board. ■

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[6] 26 U.S.C. §501(c)(3). In addition to the two requirements listed, "no substantial part of the activities" of a charitable organization can be carrying on propaganda or otherwise attempting to influence legislation.

[7] Prop. Treas. Reg. §1.501(c)(3)-1(d)(1)(iii), Ex. 1, 70 FR 53599, Sept. 9, 2005.

[8] 26 U.S.C. §4958 (as amended by the Pension Protection Act of 2006 (PubLNo 109-280, Aug. 17, 2006). This 2006 legislation expanded the intermediate sanctions to include donors, donor advisors, and investment managers for "donor-advised funds."

[9] If the excess benefit relates to a donor-advised fund, the penalty is assessed on the *entire* amount paid and not just the excess. 26 U.S.C. §4958(c)(2).

[10] "Nonqualified" plans may be considered as retirement plans that do not meet IRS requirements permitting various tax advantages such as an immediate employer deduction for contributions, coupled with delayed federal income tax recognition on the part of the employee. "Qualified" plans are the more tax-advantageous plans that follow more rigid requirements (a key plan is the establishment of an actual trust for contributions and deferrals).

[11] Final Treasury regulations on §409A were issued on April 17, 2007.

[12] Government Accountability Office, Pub. No. GAO/06-907R, July 31, 2006, at 5, *available at* http://www.gao.gov/new.items/d06907r.pdf.

[13] IRS Announcement 92-83, Internal Revenue Bulletin No. 1992-22, June 1, 1992.

[14] IRS Memorandum from Lois G. Lerner, Director, Exempt Organizations, to Director of Examinations and Director of Rulings & Agreements, May 11, 2007, *available at* http://www.irs.gov/pub/irs-tege/ehrdirective.pdf.

Fraud & Abuse

Fraud case based on CPT® codes proceeds

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

Billing guidance provided under the current procedural terminology (CPT®) codes was not unconstitutionally vague and, therefore, could properly serve as the basis of health care fraud allegations, the Illinois district court concluded. The complaint alleged that a psychiatrist submitted claims that did not meet CPT® requirements because he spent little or no time with the patient; billed for individual psychotherapy services when he was out of the country; and billed for services when the patient was not present.

The CPT® codes billed include 90807 (outpatient) and 90817 and 90819 (inpatient hospital, partial hospital or residential care setting), which require individual psychotherapy, insight oriented, behavior modifying and/or supportive, with medical evaluation and management services. While codes 90807 and 90819 require approximately 45 to 50 minutes face-to-face with the patient, 90817 requires approximately 20 to 30 minutes. Also in question are codes 90853, group psychotherapy (other than a multiple-family group) by a physician, with continuing medical diagnostic evaluation and drug management when indicated; and 90862, pharmacologic management.

The provider contended that the CPT® code requirements upon which the government based the fraud allegations were vague and, therefore, failed to provide adequate guidance. According to the court, however, the billing requirements were sufficiently clear that no rational physician would believe billing under these circumstances would not likely amount to fraud. The allegations charged the provider with conduct that, if proven, clearly did not fall within the definitions for the CPT® codes. Thus, the code descriptions would provide adequate notice of criminal behavior. ■

United States v. Trikha, S.D. Ill., 06-CR-30098-DRH, June 15, 2007, Health Care Compliance Reporter ¶800,340.

In the News

Organ transplant centers must request new approval under the recently adopted CoPs

As of June 28, 2007, all hospital transplant centers currently approved for Medicare participation under either the End Stage Renal Disease Conditions of Coverage or the National Coverage Decisions must submit a request for new approval under the Conditions of Participation (CoPs) established by the regulations implemented by HHS on March 30, 2007. The new regulations authorized survey and certification and established CoPs for all covered organ transplant programs. Approval requests must be submitted to CMS by December 26, 2007. If an organ transplant center does not submit a request for approval under the new CoPs by December 28, 2007, CMS will conclude that the center no longer desires Medicare certification and will withdraw Medicare approval.

CMS Release, June 28, 2007.

Health information technology safe harbor does not preclude all subsidy arrangements

Health information technology (IT) subsidy arrangements between hospitals and medical staff physicians will not be covered by the safe harbor described in the Internal Revenue Service's (IRS') May 11, 2007, field memorandum if the arrangements are not entirely consistent with the conditions set forth in the memorandum. According to the IRS, however, such arrangements will not necessarily generate impermissible private benefit or inurement, because the memorandum was not meant to set forth the only permissible health IT subsidy arrangement between hospitals and physicians. Rather, the facts and circumstances of any arrangement that does not meet the IRS' conditions will need to be reviewed to determine if it results in any impermissible private benefit or inurement, the IRS said.

IRS Release, June 22, 2007.

Sale of ASC shares poses fraud risk

A proposal for physician investors in an ambulatory surgery center (ASC) to sell a portion of their ownership interests to a local hospital could generate prohibited remuneration, according to the Office of Inspector General (OIG). The hospital would purchase shares from the physician investors rather than invest capital in the ASC. Not all of the physician investors would sell a portion of their shares to the hospital, raising the possibility that one purpose of the hospital's investment was to reward certain physicians whose referrals of patients to the hospital or ASC may be particularly valuable, the OIG said. In addition, the return on investment would be proportional to the investors' ownership interest in the ASC, but would not be directly proportional to the amount of capital invested because the hospital would pay more per share than the physician investors paid. The OIG warned that the proposed arrangement might not meet all of the conditions set forth in the safe harbor for returns on investment in hospital/physician-owned ASCs.

OIG Advisory Opinion, No. 07-05, June 12, 2007, Health Care Compliance Reporter, ¶500,161.