CCH Healthcare Compliance LETTER

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Medicare will delay non-compliant electronic claims

by Sharon Sofinski, Coordinating Editor

Beginning July 6, electronic Medicare claims that are non-compliant with the Health Insurance Portability and Accountability Act (HIPAA) standards will be treated as paper claims and processed more slowly than electronic claims that are HIPAA-compliant, according to a June 30 press release from the Centers for Medicare & Medicaid Services (CMS).

Although Medicare will still accept non-compliant electronic claims, payment will be delayed 13 days. Compliant electronic claims are paid by Medicare no earlier than 14 days after they are received, while paper claims are paid no earlier than 27 days after they are received. Starting July 6, non-compliant electronic claims will be processed in the same time frame as paper claims.

CMS hopes this delay will urge filers to comply more quickly with HIPAA standards. According to CMS administrator Mark B. McClellan, Ph.D., "The great majority of electronic claims we are receiving meet the required HIPAA standards, but for those still not in compliance there is going to be a delay in getting their money." He added that "a two-week payment delay is an important further incentive to get to 100 percent [compliance]."

This change to the CMS HIPAA contingency plan only affects covered entities who are submitting Medicare claims to a Medicare contractor. The deadline for complying with the HIPAA standards was October 16, 2003. Under CMS's contingency plan, the healthcare community was given more time to comply with the HIPAA electronic claims standards.

CMS's press release is at http://www.cms.hhs.gov/media/press/release.asp?Counter=1101. For additional help, claims filers should contact their fiscal itermediaries (FIs) or carriers.

In other HIPAA-related news, the American Hospital Association (AHA), in letter dated June 21, 2004, has urged CMS to "actively seek provider input throughout the development and implementation of the enumeration process" for adoption of National Provider Identifiers (NPIs). The AHA stressed that input from providers will "facilitate, and not hinder, providers' efforts to obtain an NPI." CMS has requested input on the NPI process from potential contractors. A copy of the AHA letter is at http://www.aha.org/aha/key_issues/hipaa/content/NPI_RFI_CMSfinal.pdf. ■

CCH Chicago Bureau, July 1, 2004

Letters to the Editor

The CCH Healthcare Compliance team welcomes comments or questions regarding articles published in the CCH Healthcare Compliance Letter. Send comments to Sharon Sofinski, Coordinating Editor, at sofinsks@cch.com. For more information about the CCH Healthcare Compliance Portfolio visit our online store at http://health.cch.com.

High Court decision renews debate over patients' rights

by Catherine Hubbard, MA, Contributing Editor

The recent Supreme Court decision that limits the ability of patients to sue HMOs in state courts has sparked debate over patients' rights legislation. In *Aetna Health Inc. v. Davila*, decided along with *Cigna Healthcare, Inc. v. Calad*, justices ruled that patients in Texas cannot pursue malpractice claims against their insurers under Texas law. The justices concluded that the Employee Retirement Income Security Act forces HMO patients to sue only in federal courts.

Immediately following the decision on June 21, lawmakers called for patients' rights legislation. "Now, more than ever, we need to pass real patient protections to make certain that all people get the health care they need," said Sen. John Edwards, D-North Carolina. Edwards said the ruling casts a legal cloud over patient protection laws in North Carolina and other states. "Millions of working people still have nowhere to go when HMO bureaucrats overrule their doctors' decisions," he said.

"Today's decision by the Supreme Court is a setback for those who believe that doctors and patients—not the big HMOs and insurance companies—should make the decisions affecting Americans' health care," said Senate Democratic Leader Thomas Daschle of South Dakota. He said the decision "reinforces the need for a real, enforceable patients' bill of rights at the national level," adding that lawmakers should revisit the Senate's patients' bill of rights. The House and Senate each passed patients' rights bills in 2001, but could not resolve their differences. Rep. John Dingell, D-Michigan, has re-introduced the Senate version, which would allow patients to file suit against HMOs in state court for unlimited damages.

In *Davila*, a physician prescribed a medicine thought to cause fewer gastrointestinal problems than other pain medicines on the formulary Aetna administered for Davila's employer. But the formulary required that Davila enter a "step program," meaning that the drug prescribed is a covered plan benefit only if the member has already tried other less expensive drugs on the formulary. Davila failed to avail himself of other options, like representing to Aetna that he could not take the less expensive drug, or invoke his right to an independent appeal, or even pay for the medicine himself, and the medicine led to an adverse reaction. In *Calad*, a woman underwent a hysterectomy and was discharged from the hospital after one day. She suffered complications and had to return a few days later. Like Davila, she did not invoke her right to an independent appeal as to whether an additional stay was "medically necessary."

"the decision 'reinforces the need for a real, enforceable patients' bill of rights at the national level'"

ERISA provides its own remedy scheme for ERISA plan beneficiaries who believe they have been denied benefits to which they are entitled under their employee benefit plans, said Terri Keville, of Manatt, Phelps & Phillips, Los Angeles, California, in a June 30 interview. She noted that in *Davila* and *Calad*, which were consolidated before the Court, the patients argued that HMOs should treat claims involving healthcare benefits differently from other ERISA benefits claims, since they involve medical decisions. Both patients had sued under the Texas Health Care Liability Act, a Texas law intended to create an independent duty for HMOs to use ordinary care in making healthcare coverage determinations, Keville noted.

Private sector reaction. The American Psychological Association Practice Organization said the *Davila* decision "shines a bright spotlight on the 'loophole' that exists in ERISA, which, unfortunately, allows managed care companies to escape liability for denial of care decisions that injure or kill patients."

In contrast, the American Benefits Council lauded the decision. "Employers welcome the Supreme Court's unanimous ruling today on ERISA preemption of state laws in cases involving benefits determinations," said James Klein, president of the Council. He said the two physicians in these

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Managing Editor
Pamela K. Carron, J.D.

Coordinating Editors
Angela Fanelli, J.D.
Sharon Sofinski

CCH Washington Bureau
Paula Cruickshank
DOJ, FTC–John Scorza
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Designer
Don Torres

Comments from readers are welcome and should be directed to Sharon Sofinski at SOFINSKS@CCH.COM, Tel. 847-267-7860, Fax 847-267-2514. Customer service inquiries should be directed to 800-449-9525.

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cases should have acted swiftly to help make sure their patients got the care they were seeking. "In neither case did the patient or their physician seek a further review of the health plan's initial coverage decision, despite being specifically informed of their right to such a review under federal law," Klein said.

"The refusal of the plaintiffs or their doctors to follow the procedures to either have the plan decision promptly reviewed, or to go forward with their preferred medical course of action—taking a different drug (*Davila*) and staying an extra night in the hospital (*Calad*)—even if their eligibility for financial reimbursement was in doubt—makes the plaintiffs' lawsuits far less justifiable," Klein contended.

The review procedures available under ERISA help patients get the care they deserve, quickly and without having to resort to costly and lengthy legal procedures, Klein said. "A speedy and factual review aided by the expertise of the physicians involved with these two cases could have avoided the need for the courts to be involved at all," he said.

Decision clarifies earlier rulings, leaves some questions unanswered. In *Davila*, the Supreme Court clarifies how several of its prior decisions apply to state court lawsuits by patients who get their healthcare coverage through employee benefit plans and who allege HMOs improperly denied them healthcare benefits, said Keville.

For instance, in earlier rulings, Keville said, the Supreme Court held that ERISA's federal remedies are exclusive, so that any state law providing an alternative or supplemental remedy for claims about ERISA plan benefits is preempted by the federal law. But in *Davila*, the Court clarified that an HMO decision to deny care to an ERISA beneficiary is an ERISA fiduciary act, even though the act may have a medical component, Keville said. Therefore, any state law claim for relief in connection with such a denial of benefits is completely preempted by ERISA and removable to federal court, she said.

"The Supreme Court's decision leaves open a number of questions."

Also, the Supreme Court determined in *Pegram v. Herdrich* that when a treating doctor who was an owner of the patient's HMO and also was the person who made the decision to deny care, the doctor was making a "mixed" treatment and eligibility decision, and was not acting as an ERISA fiduciary, Keville said. Davila clarifies that *Pegram* only applies when the patient's treating physician is an owner or employee of the HMO, she said. She noted that some courts and plaintiffs' lawyers had been interpreting the *Pegram* decision to mean that any benefits determination involving a medical component was a "mixed decision" not subject to ERISA.

However, Keville said, "The Supreme Court's decision leaves open a number of questions." For example, she noted, it does not address whether there are circumstances under which HMOs may be liable under state law for the conduct of their contracting physicians who do treat patients. It also doesn't clarify whether ERISA itself may provide monetary remedies to patients who suffer harm as the result of benefits denials, she said, noting this issue had appeared to be foreclosed by other Supreme Court precedents. ■

CCH Washington Bureau, July 1, 2004

Resolving governance conflicts on executive compensation

by Paul R. DeMuro and Daniel J. Fairley

In this article, Paul DeMuro and Daniel Fairley discuss compliance programs' increasing focus on executive compensation and the Compensation Committee.

Recent governance reform efforts either require or urge boards to increase their diligence in matters concerning finance, audit and executive compensation. These reforms are important for the long-term viability of organizations governed by boards. Additionally, the "scandals" behind the reforms have made directors acutely aware about the organization's overall business risks as well as the direct tie to the directors' personal risk and liability.

All of this leads directors to request more information, at a greater level of detail, calculated to gain deeper understanding and to allow them to play a larger role in the decision making process.

This "larger role" is essential, yet the expansion of the director's role creates conflict between a board and management. How this conflict is addressed describes where most of the action has been occurring as boards address reform and position themselves for the future of board governance. The arenas of intense conflict are audit, finance and executive compensation.

Healthcare companies have had compliance programs and compliance committees for a number of years now. Increasingly, even nonpublic companies are establishing audit committees with similarities to those established by public companies subject to Sarbanes-Oxley and the securities exchange rules. In light of the increasing scrutiny over executive compensation plans and packages and allegations of conflicts of interest concerning same, an increasing focus from a compliance perspective is executive compensation and the Compensation Committee which are the subjects of this article.

In the public company context, executive compensation has come under greater scrutiny as shareholders have increasingly raised concerns over it. More focus has been placed on the role of the board's Compensation Committee. In the nonprofit context, the focus is heightened when a nonprofit entity enters into a transaction where its assets might be sold or transferred to an investor owned entity. Questions are often raised with respect to the fairness of the compensation package for the nonprofit executives, and also whether the transaction as a whole is fair to the nonprofit entity, given the potential conflicts of interest inherent in a transaction where nonprofit executives are involved in negotiations.

The Focus of the Executive Compensation Discussion

As a result of greater expectations of company's stakeholders, increased legislative and regulatory scrutiny and greater public attention, Compensation Committees have become much more important. There are at least four areas where the executive compensation discussion focuses, including:

(1) Are the senior executives of the company, including the Chief Executive Officer (CEO) appropriately compensated, or is there excessive compensation?

(2) Is executive compensation reasonably related to corporate and personal performance?

(3) Are corporate interests appropriately considered in determining whether severance and post-employment benefits are reasonable in amount?

(4) Do the compensation programs and policies serve to attract and retain the best management for the company; do they incentivize management and the CEO to increase long-term value for the stakeholders and meet the company's mission and values?

The Compensation Committee Charter

The Compensation Committee should have a Charter that sets forth its purposes. The areas noted above where the executive compensation discussion should focus should be included in developing those purposes. In addition, consistent with these functions and purposes, the Charter should provide that the Committee should continuously strive to improve and promote the Company's policies, procedures and practices on all levels. The Committee should have the ability to obtain advice and assistance from outside consultants, legal or other advisors, as deemed necessary or appropriate to perform its duties and responsibilities.

The Committee (through its Chair) should report regularly to, and review with the Board, any issues that arise with respect to executive compensation. The Compensation Committee should be composed solely of independent directors. They should meet in executive session without management present. Insider relationships and/or interlocking compensation committee membership should be strongly discouraged.

The Compensation Committee's main responsibility is to review compensation packages with executive officers of the Company. Greater credibility is afforded to the Compensation Committee and its actions when it is independent from management. It also should be noted that even if a director meets certain independence standards, if he or she has close personal or business relationships with the CEO, he or she may not be an appropriate candidate for the Compensation Committee.

Although it will be important for the CEO to periodically meet with the Compensation Committee, he or she should not be a member of the Committee and should not be present during all of its deliberations. Many of these executive sessions also should not include the Company's human resources or senior compensation executives. Both the reality and appearance of independence is important.

Principal Functions of the Compensation Committee

The principal functions of the Compensation Committee should include:

- The review and approval of the corporate goals and objectives in the context of the CEO and senior executive compensation, and the evaluation of such executives thereunder;
- The determination or recommendation to the Board of the senior executive and CEO compensation;
- The review and analysis of all compensation arrangements with senior executives and functions, including employment and consulting agreements;
- A focus on mechanisms for the administration of the executive compensation which periodically review such policies to ensure that compensation is reasonably and appropriately recalibrated as necessary;
- The recommendation of incentive compensation plans to the board and executive perquisites; and
- Conducting a Committee self-evaluation.

Tying Executive Compensation to Performance

A basic principle to guide the Compensation Committee is that a significant portion of an executive's compensation should be tied to the economic objectives, fulfillment of mission, and performance of the company. The Compensation Committee should review not only compensation, but also benefits and perquisites, of senior executives, particularly in the context of employment contracts. Executive compensation packages will vary among industries and companies, company size, financial condition, industry characteristics, competitive factors, locations and corporate culture. Consultants can assist in the development of appropriate compensation packages.

There should be an annual performance evaluation of the senior executives against pre-established performance targets, and an ongoing review of the compensation program's effectiveness. In addition, if there is director compensation, either the Compensation Committee or the Governance Committee should be responsible for considering the form and amount of same. The Compensation Committee should seek legal advice with respect to compensation and benefit issues for officers and directors, and be familiar with the legal restrictions in this area.

For public companies, the SEC proxy rules require that there be a report in the annual meeting proxy statement from the Compensation Committee addressing the performance factors that the Compensation Committee relied on in determining the compensation of the CEO, and discussing the Committee's general policies with respect to executive compensation.

Taking Responsibility

As noted above, the board and its Compensation Committee should take responsibility for overseeing all aspects of executive compensation and not just the CEO's compensation. The board should hire and supervise any compensation consultant directly, rather than through management. Conflict arises immediately because CEOs have generally directed the "traditional" manner of addressing compensation in tax-exempt healthcare organizations. This "tradition" is not bad; in fact, it is rooted in many traditions of tax-exempt governance. Nevertheless, the conflict starts here.

Getting Beyond the Tradition

Boards and CEOs want to know how to clarify and solve this conflict of tradition and many more, on the road to better governance. The best approach is to systematically clarify the boundaries between governance and management.

Establishing Boundaries

Using the principles and parameters noted above, the Board should identify those areas that it is or should be concerned with. It should set policies that define the Board's position in these areas and then set priorities. It should not, however, decide how to deal with these concerns. It should delegate the decisions about what to do and how to do it to management and then hold management strictly accountable. If the accountability does not occur, then and only then should the board actively and unilaterally proceed.

The board should insist on getting enough information to fulfill its duty of care; and, it should exercise greater diligence with the information it is already getting. It also should shape the format for information in partnership with the CEO.

Boundaries on Executive Compensation

Particularly, as discussed above, with respect to executive compensation this means:

- Establishing a charter and developing explicit definitions for the activity of a Compensation Committee.
- Making sure that competent independent people are on the Committee.
- Explicitly defining the process for approvals, including the relationship between the board, the Committee and the CEO.

Aspects of a Traditional Approach

The aspects for a traditional approach have been:

- Boards and committees rely on executive staff to gather compensation data, usually requested of the CEO.
- Directors do not determine the appropriateness of the data presented or how the data was collected.
- Staff rely on general surveys or magazine articles as source data. Data collected as such is at best generic, and generic data is often not appropriate for accurate comparability.
- General surveys and magazine articles often do not contain information on all elements of compensation. A failure to look at all components is common.
- Using data from collected IRS Form 990s is dangerous. Executive position descriptions in 990s have no detail about what a job really is, in terms of comparability to accurate data. Dollar figures reported can be misleading because of different accounting and valuation techniques.

Utilizing a Compensation Consultant

Compensation consultants can help an organization move to a better governance model for executive compensation decisions by:

- Providing appropriate comparability data;
- Accurately comparing compensation arrangements;
- Providing carefully reasoned opinions that support findings of reasonableness, particularly under the rebuttable presumption of IRC §4958.

Providing Comparability Data

Studying the position in question, the incumbent's credentials and capabilities, and the nature and scope of the company's services will achieve "appropriateness." Compensation firms have large data sets that allow data to be tailored to this "appropriateness" and the connection between the data and the position can be stated clearly and accurately.

Consultants also can provide information that is not readily available in published sources or in available databases by providing anecdotal information. Examples are:

- Transitional arrangements for terminated executives;
- Bridge arrangements for executives retiring early;
- Recruitment bonuses or retention incentives; and
- Housing subsidies.

Accurate Comparisons

Demonstrating the appropriateness of comparability data requires a good understanding of the job in question, the nature and scope of the organization, any special qualifications of the incumbent, and any other special circumstances. Comparison on title alone is inadequate because titles often do not reflect current responsibilities. This is particularly true for organizations that have grown significantly or have been through mergers or affiliations.

An organization should:

- Conduct a thorough analysis of the actual job.
- Compare the analysis with standard and benchmark positions that are most like the job in question.
- Make sure that benchmarks used are fully understood, in terms of any variation to the job in question. A typical example would be whether or not it matters that a CFO does or does not have responsibility for information systems or managed care contracting.
- Determine how variation from the benchmark is driven by the difficulty of the position, the qualifications of the position and the accountabilities of the position.
- Adjust for differences between actual and benchmark and then apply that to established market value adjustments to account for variation.

Choosing the Right Peer Group

There are multitudes of differences among tax-exempt healthcare delivery organizations. An appropriate peer group at least should match the healthcare organization in question with scope and acuity of services, patient and payer mix, location, sponsorship, degree of independence, parent or subsidiary and size.

Some examples of factors adding a significant degree of complexity to an organization include:

- Having a large number of employed physicians;
- Having a large number of medical residencies and fellowships; and
- Having a risk-bearing managed care organization.

Some examples of important differentiating characteristics include:

- System affiliates are less independent and different to manage than an independent healthcare organization, largely because of the support services provided by the system.
- A subsidiary hospital in a Catholic system typically has more independence than one in a secular system, largely because of different philosophies concerning centralization.
- Hospitals with a heavy load of teaching, research and indigent care are very different from community hospitals.

Clear Circumstances Calling for Reasonableness Opinions

The following is a listing of typical circumstances:

- *Unusually high compensation.* If you think it seems high, it probably is.
- *High profile positions that are paid well.* "Interested" parties are most interested in these positions.
- *Unusual combination of special compensation programs.* An example would be the use of a retention incentive coupled with an already existing incentive compensation program.
- *Need for a rationale to pay above the range of comparability.* Boards are often faced with good reasons to do so and need specific articulation of the reasons and the impact those reasons have on compensation.
- *Unusual contractual or hiring commitments.* Boards consistently face the need to make special arrangements for those special executives that are hard to recruit.
- *Need to rely on data from the Investor Owned sector.* Boards are increasingly faced with the recruitment of individuals that are currently employed in the Investor Owned sector and need packages to attract these individuals.

What Should Be in a Reasonableness Opinion

At the very least, a reasonableness opinion should provide the information needed for establishing a rebuttable presumption. An opinion should provide enough detail to allow any reviewer, including the government, to independently follow and repeat the analysis and see how the opinion was formed. The opinion should be clear, well organized and persuasive.

Here is a list of what should be in the opinion:

- *Description of all terms of the proposed compensation agreement.* There should be no ambiguity or vagueness.
- *Description of the organization.* The description should be to a level that demonstrates that the writer understands the organization well enough to write the opinion.
- *Description of the position.* It is very important to describe how the position matches and varies from the data relied upon.
- *Assertion of appropriateness.* Assert that the position was compared to data from like organizations and represents total compensation for the position.
- *Description of data sources.* Regulations require the description. Cite the sources, describe them and assert they are reliable and reputable.
- *Comparability of total compensation.* Make sure the opinions address all components. Mixing data sets for various components can mitigate the soundness of an overall opinion.
- *Comparability of each element.* Although the test for reasonableness is total compensation, it is generally useful to compare each element. This makes the opinion clear and more persuasive. Additionally, this approach tends to reduce the risk that the reviewer may challenge an unusual element or aspect of the arrangement.
- *Assertion of consultant credentials and all parties to the opinion.* This is required by the regulations as a certification.
- *Charts and graphs.* These will assist in helping the reviewer understand the information.
- *Opinion of reasonableness.* Clearly state this with boldness.

Conclusion

Inasmuch as executive compensation is becoming an increasing focus of companies, it is very important to minimize both the actual conflicts of interest and the appearance of conflicts of interest. As noted above, many nonprofit healthcare companies typically have included the CEO in their compensation deliberations, have retained consultants selected or recommended by the CEO, or the company's human resource professionals who report to the CEO. Such a process is not a best practice. This process at least presents the appearance of a conflict of interest.

Picture the situation where a board of directors' Human Resources Committee attempts to address issues of executive compensation, particularly CEO compensation and benefits, with compensation consultants who have been retained by the CEO or have been providing a substantial amount of consulting work from the healthcare organization under the ultimate direction of the CEO. Add the dynamic that the employees on the Human Resources Committee or those who staff it, either report to the CEO or to an individual who reports to the CEO. The CEO sits in on the compensation discussions. A proposal comes to the full board for approval and the in-house General Counsel of the company who is employed by the healthcare company and who reports to the CEO is asked by the board with the CEO present to comment on his or her compensation package.

Compare and contrast this situation to one where the Compensation Committee of the board is established or exists with only independent directors. It retains a compensation consultant whose only work for the healthcare company is through the Compensation Committee. It retains independent counsel whose firm does not provide any other legal counsel to the hospital. The Compensation Committee meets in executive session without the CEO present, except for occasional discussions about senior executive compensation that may include the CEO in attendance from time to time. The Compensation Committee recommends action to the board of directors with the special outside counsel in attendance. The in-house General Counsel is not asked to comment on the action.

If a question about excessive executive compensation arises, certainly the latter procedure will minimizes allegations of conflicts of interest and impropriety. However, the norm likely will gravitate to a process or procedure somewhere between these two extremes. For nonprofit healthcare entities, it is important to consider what consultants can do to help inoculate such companies from such allegations and to take advantage of the rebuttable presumption under the IRS Intermediate Sanctions Regulations that the executive compensation packages are reasonable.

Portions of this article were adapted from materials prepared by the attorneys in the Latham & Watkins corporate group.

Paul R. DeMuro, CPA, MBA, JD, is a partner in the International law firm of Latham & Watkins LLP, resident in the San Francisco and Los Angeles Offices. Paul practices in the areas of corporate, health care, compliance, tax-exemption and board governance, to name a few. He has practiced law for approximately 25 years. A leading figure in health law, he is included in the listing of The Best Lawyers in the United States, Super Lawyers, various editions of Who's Who, and named in 1993 by Nightengale's Healthcare News one of 15 top transactional healthcare attorneys in the country. Paul practices extensively in the area of corporate governance, having been retained for a number of healthcare advisory and investigation matters, including those which address compensation and benefits and conflict of interest issues for board members and executives. He has authored over 50 publications including a number on corporate governance, Sarbanes-Oxley, and compliance. He is a graduate of the University of Maryland, College Park, with a BA in Economics summa cum laude; a graduate of the University of California, Berkeley, now Haas School of Business, with an MBA in Finance, and a graduate of the Washington University Law School, where he was a member of the Board of Editors of the Law Review.

Dan Fairley is Vice President/Senior Consultant for the Healthcare Group of Clark Consulting, Inc. Mr. Fairley's work concentrates entirely on not-for-profit health systems and hospitals in the areas of executive compensation consulting and CEO leadership transition planning and management. Mr. Fairley is a business school and law school graduate of Indiana University. His entry into healthcare started as the general counsel of VHA Supply Company and Assistant General Counsel of VHA. He served the Service-Master Company as Vice President of Acquisitions. Before working for Clark Consulting, he was a Senior Vice President of the Memorial Health System in Springfield, Illinois.

Fraud and Abuse

OIG advisory on telemedicine screening for low-income rural children

by Suzanne Szymonik, JD, Contributing Editor

Even though it decided that a telemedicine screening service for low income children in rural areas involves remuneration, the Office of Inspector General (OIG) decided that it would not take enforcement action against the arrangement because anti-kickback safeguards were built into the system.

The "telemedicine network" links school-based health center "spoke" facilities manned by nurses with a "hub" where physicians and specialists provide consultations. The network is owned by a health system that operates in numerous locations in rural counties. Anti-kickback safeguards are such that students requiring referrals to physicians are referred to their primary care providers, or if they have none, they are provided with a list of primary care physicians in their communities. The telemedicine consultations are not federally-reimbursed, and the only possible federal reimbursement would be for potential follow-up care.

The OIG decided previously, as it did herein, that non-reimbursable telemedicine screening services do not generally implicate the anti-kickback statute. Furthermore, this arrangement contains sufficient safeguards to reduce the risk of improper referrals, and it promotes a public benefit, healthcare for low income children in rural areas. ■

OIG Advisory Opinion No. 04-07, June 17, 2004,¶150,219

OIG advisory would prohibit physician group's therapy center

by Suzanne Szymonik, JD, Contributing Editor

A physician group practice may not develop and own a physical therapy center and lease the center's space, equipment, and personnel to physicians under fixed, year-long leases that do not consider usage, according to the Office of Inspector General (OIG). The plan would not be protected under safe harbor thresholds, and it would raise fair market value and improper referral questions for the OIG.

Under the plan, each lessee would have paid the same amount for a one-year lease of the center regardless of actual usage. The physician's group characterized the plan as involving full-time leases, but the OIG found that the arrangement is more appropriately characterized as involving multiple, overlapping, part-time leases because the center would be used only on an as-needed, first-come first-served basis. The OIG's advisory opinion stated that such periodic leases do not meet safe-harbor thresholds because they do not specify exact rents for precise intervals of use. Secondly, monitoring the fair market value (FMV) of the leases would be difficult because physicians would pay more or less than FMV depending on usage, and these above-or-below-FMV payments could be remuneration for referrals. Furthermore, according to the OIG, there is a risk that the guaranteed income stream from the fixed leases could be compensation in exchange for referrals. Thus, the OIG could not conclude that the plan posed only a minimal risk of fraud and abuse. ■

OIG Advisory Opinion No. 04-08, June 23, 2004,¶150,220