CCH Health Care Compliance LETTER

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CMS to audit hospital/physician financial relationships for Stark compliance

In the coming months, several hundred hospitals around the country will begin receiving a new mandatory disclosure instrument from CMS – the Disclosure of Financial Relationships Report (DFRR). The DFRR is a Stark law compliance audit intended to analyze all investment interests and compensation arrangements between hospitals and their physicians.

Although originally intended to be a permanent, annual reporting mechanism, CMS has announced that the DFRR will be a one-time event, at least for now. The agency has stated that it will consider scheduling future audits after it has an opportunity to review the administration and the findings of the first DFRR.

Audit goals. Since implementing physician self-referral rules in 1991, CMS has not undertaken a thorough information collection process to examine financial relationships between hospitals and physicians. The DFRR is aimed at identifying arrangements that may not be in compliance with the physician self-referral statute and developing practices that could help in future rulemaking.

CMS plans to send the DFRR to 500 general acute care and specialty hospitals, but in commentary to the fiscal year (FY) 2009 inpatient prospective payment system (IPPS) final rule, the agency advised that it may decide to decrease the number of hospitals.

Comments and changes. After including the DFRR in the FY 2009 IPPS proposed rule, CMS received an array of comments from the public. The feedback ranged from assertions that CMS does not have the authority to impose "such a far-reaching request," to criticism that CMS had drastically underestimated the time and expense associated with completing the DFRR.

Although CMS maintains that hospitals should be keeping most of the data requested in the DFRR in the ordinary course of business, the agency did agree to increase its time and burden estimate from 31 to 100 hours to complete and submit the DFRR. CMS also increased the costs per hospital, associated with completing the DFRR, from $1,550 to $4,080.

In spite of some comments requesting a five month due date period for hospitals to complete and submit the DFRR, CMS stuck to the 60-day timeframe specified in the proposed rule but advised that extensions could be granted in appropriate cases.

A CMS spokesperson was unable to specify when the agency will begin sending out the DFRR or when hospitals will begin receiving instructions. ■

CCH Chicago Bureau, Sept. 23, 2008

Wolters Kluwer Law & Business

Increased regulatory enforcement requires more compliance effectiveness

Compliance professionals received advice regarding increased regulatory enforcement in the Medicare and Medicaid programs and the various ways that compliance professionals can implement effective compliance policies within their organizations from John A. Beattie of Parente Randolph, LLC, a health care consulting group, at a seminar sponsored by the Health Care Compliance Association.

RACs. Beattie identified recovery audit contractors (RACs) and Medicare integrity contractors (MICs) as central to auditing, while noting that Claim RACs will continue in the demonstration states of California, Florida, and New York, and will be expanded to all states by January 1, 2010. The Claims RACs program will expand to Pennsylvania and New Jersey on January 1, 2009. According to Beattie, providers should review their compliance programs for effectiveness by monitoring plans internally and externally, conducting data mining searches, and conduct ing risk assessment analysis to prioritize risks. Providers also should make sure that they have in place procedures to handle requests for medical reviews and an appeals process.

Evaluating effectiveness. Compliance may be evaluated by two dimensions: effort and outcome, Beattie explained. He defined effort as "the time, money, resources, and commitment that an organization puts into building and improving a compliance program," and outcomes as "the impact that our efforts have on our level of compliance."

To build an effective compliance program, organizations must measure their structural elements, processes, and practices, such as the commitment of the board and senior management to compliance issues. Organizations must review whether (1) a compliance officer has been designated, (2) a compliance committee has been formed, and (3) there has been development of compliance policies and procedures and a code of conduct, Beattie said.

Providers will need to define the data elements they will monitor, define any actionable data, and identify legal and reimbursement risk areas. For an effective compliance program, providers must create lines of communication, offer education and training, and provide enforcement and discipline.

Employee feedback. Effective compliance programs require continual enforcement and continual feedback from employees. Employee feedback may be obtained from direct inquiries, reviews, focus groups, town meetings, surveys or questionnaires, and exit interviews. Hotlines are another source of information about compliance issues that providers may utilize. Employees should receive compliance-related, job-specific training at least once a year and any education programs should include high-risk elements for that particular provider organization.

Compliance enforcement must be consistent, documented, and disciplinary standards should be well publicized and readily available, Beattie concluded.

CCH Chicago Bureau, Sept. 5, 2008

Walgreens pays $9.9M to settle false billing charges

Walgreens, a national retail pharmacy chain, has paid the United States and four participating states $9.9 million to resolve allegations of false Medicaid billing. Walgreens submitted claims to four state Medicaid agencies for prescription drugs dispensed to persons covered by Medicaid and private third-party insurance. The pharmacy allegedly charged the state Medicaid programs the difference between what the private insurance companies paid for the drugs and what the state Medicaid programs would have paid in the absence of private insurance. The government alleged that the claims were false because Walgreens was entitled to reimbursement from the Medicaid programs only for the amount the beneficiary would have been obligated to pay the pharmacy had the claims been submitted solely to the private insurers, typically the co-payment amount. Walgreens submitted claims to the Medicaid programs in excess of the co-pay amount. As a result, the pharmacy received reimbursement amounts from the states' Medicaid programs that were higher than it was entitled to receive. ■

DOJ Press Release, Sept. 29, 2008

CCH Health Care Compliance Letter

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Court finds Illinois hospital fails to meet state criteria for property tax exemption

The future of property tax exemptions for hospitals in Illinois is being tested. At stake are the legal definitions of whether a hospital meets the criteria for charitable organization status and what constitutes a critical mass of charitable care for a hospital to avail itself of the property tax exemption.

Application for tax exemption. Provena Hospitals, on behalf of its Provena Covenant Medical Center (Covenant) applied to the Champaign County Board of Review for an exemption from property taxes for tax year 2002 on the ground that Covenant was used primarily for charitable purposes. The outcome of the board's decision led to the Department of Revenue (Department) denying Provena's application for exemption.

After paying $1.1 million in property taxes, Provena sought an administrative hearing, during which it argued that Covenant also had a ground for exemption as a religious organization. Provena claimed Covenant was entitled to the exemption on the basis of its ministry under the auspices of the Roman Catholic Church.

The Department's administrative law judge granted the exemption solely on Provena's charitable uses.

Charitable care. The Director of the Department disagreed with the holding of the administrative law judge and denied Provena's exemption for charitable uses. The Director based the decision primarily on the fact that Covenant had devoted only 0.7 percent of its total revenue in 2002 for charitable care. Covenant had only provided free care to 196 patients and discounted care to 106 patients out of the total of 110,000 hospital admissions during tax year 2002 and hired collection agencies to recover unpaid costs from 64 of the patients who received discounted services.

The Director also denied Provena an exemption based on religious purposes.

Provena then took its complaint to the Circuit Court of Sangamon County where it argued that Covenant had a charity- care policy based on federal guidelines and advertised the availability of financial assistance for patients who met the federal poverty guidelines. (As an aside, Provena argued that providing services to Medicare and Medicaid patients was itself an act of charity considering the meager rates of reimbursement paid by the government.) Provena, again, proffered its argument for exemption based on religious purposes.

The circuit court concluded that Covenant was entitled to an exemption under both the charitable and religious exemption theories, thus reversing the Director's decision. An appeal followed.

Charitable institution defined. On appeal to the Fourth Circuit of Illinois, the court looked to three issues in reaching its decision: charitable purposes, religious purposes, and public policy considerations. Essentially, it found that Provena failed to prove it was a charitable institution as defined in the state statute and it did not meet the test under section 6 of article IX of the Illinois Constitution that the property be used exclusively for charitable purposes.

The court also reined in the scope of the religious purposes exemption, as developed in Illinois case law, to include only property used for public worship or religious instruction. Provena's attempt to declare its religious purpose withered, leaving it without an exemption under the state's Code.

Various amici curiae warned the court that the disappearance of tax exemptions for not-for-profit hospitals would create severe financial restrictions on hospitals' ability to offer services to patients without financial resources to pay for those services. The court avoided discussion of any policy arguments, finding them more the province of the Illinois legislature and not the Illinois courts.

For now, *Provena* sets a higher bar that hospitals will have to meet to secure property tax exemptions in the health care sector. Provena has said it will appeal to the Illinois Supreme Court. ■

Reprinted from CCH Exempt Organizations Reports, Sept. 19, 2008; Covenant Medical Center v. Department of Revenue of the State of Illinois, Ill. App. Ct., 4th Dist., No. 4-07-0763, Aug. 26, 2008, Health Care Compliance Reporter ¶800,560

Getting in touch with your inner regulatory artist: Creative responses to nine privacy problems you never thought about and are probably glad you didn't, Part II

by Stephen Miller, JD, Health Care Compliance Editorial Advisory Board Member

This Article covers scenarios that would come under scrutiny under the Privacy Rule, including mentoring programs, children in the workplace, media access, staff family members as patients, staff as patients, physician access to electronic protected health information (PHI), executive officer access to PHI, and fundraisers.

Part I of this Article introduced the operational demands placed on an entity attempting to meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and provide open communication to promote quality health care. It focused on the regulations related to uses and disclosure PHI and the interplay between the Privacy Rule and shadowing programs for health care facilities.

Mentoring programs

Many hospitals are faced with requests from members of their medical staff to permit young relatives, family friends or members of the community to "round" with physicians or to observe surgical or diagnostic procedures. Often the requests are made under the auspices of providing an educational experience for a "pre-med" or "potential pre-med" student. Careful thought should be given to this request.

An analysis of the applicable regulations yields a similar result as is produced for shadowing programs. The activity is clearly not treatment related. It could potentially be handled under 45 C.F.R. §510(b) *Uses and disclosures for involvement in the individual's care and notification purposes-(1) Permitted uses and disclosures*, if certain safeguards are put in place, but this option presents significant risk. This kind of request is best considered under the definition of health care operations, specifically the language related to education and training programs.

The key to fitting within a fair reading of the definition of "health care operations" is the provider demonstrating that the student is participating in a bona fide educational/training program. In other words there must be a real program, with standards and controls, from which the participant gains an educational benefit. In putting together a "mentoring" program consider the following:

Incorporate the program into your organization's current management of other clinical training programs. Many providers will have a nursing education office or other central function with oversight of training programs. Incorporating a mentoring program into this office helps ensure that it has appropriate oversight.

Include the program in written, officially approved, organizational policy. The policy should include the following:

- **Standards.** Candidates should be appropriate. Consider limiting the program to individuals that are currently enrolled in a pre-med tech-training or other clinical program. Consider requiring candidates to produce a letter of recommendation from an appropriate representative of that program.
- **Open enrollment.** Don't limit the program to family members or friends of the medical staff. Especially for not-for-profit organizations, the program should benefit the community. Allow any member of the public who meets your enrollment standards to apply.
- **Background Screening.** All candidates should be subject to appropriate background and health screening including Office of Inspector General, General Services Administration, and state Medicaid exclusion lists, as well as testing for tuberculosis or other health conditions that the provider's employees receive before starting work.
- **Program duration/limitations.** Limitations on the program should be spelled out in policy. Consider excluding highly sensitive areas such as HIV programs and behavioral health. Limit the number of candidates that can participate in the program at one time and limit the number of encounters that each participant may experience.
- **Training.** Provide privacy training to all participants.

Document the expected benefits of the program to the participant and the community in policy or other official program document. Also consider having the program endorsed by the medical staff and the organization's governing board. These steps help establish the bona fide nature of the program and avoid the appearance that these mentoring encounters

are nothing more than the facility catering to the whims of important members of its medical staff.

Take your child to work day

In some cases, even the highest degree of creative compliance won't make an activity "OK." It's important to be able to recognize these situations and respond appropriately. "Take your child to work day" appears to be one such case. While a widely accepted practice in some fields and industries, take your child to work day does not appear to fare well under regulatory scrutiny. It is unavoidable that participants will have exposure to PHI, and in some cases that exposure will arguably be direct. Unjustifiable under the definitions of "treatment" and "payment" the activity is also not a credible training program for purposes of the regulation. This is an activity that is best left to businesses that do not handle sensitive information.

Full court press — A reporter's life in the ER

Given the number of health care related shows on primetime television it should come as no surprise that journalists are interested in the health care field, especially in emergency health care. Health care providers have good reason to want to encourage that interest. In an era when issues like "community benefit," the cost of health care and medical malpractice reform are hotly debated in the halls of Congress, getting positive press about what health care providers do on a daily basis, especially positive press from an insider's perspective, can be invaluable.

With restrictive privacy rules, however, how do you respond to a reporter's request for access to your emergency department to write a story about what it's like to save lives every day? The answer is by responding with a controlled program that permits limited but real time access to emergency staff that will allow the reporter to generate an interesting story but protect your patients.

The goal of the program is to give the reporter enough access to staff, physicians and patients to write a compelling story, while not violating the Privacy Rule and not giving the public the impression that a reporter had unfettered access to a sensitive hospital area like the emergency department. Selecting the right journalist might be the most important step in designing this program. If you are going to permit a reporter to speak with your staff, you will want to work with one that has a history of treating the organization positively or, at least fairly, in past articles. The reporter should value his or her relationship with the organization and have an incentive not to ruin it by writing a story that will damage the institution's public image. Finally, the reporter should be professional and respect the limitations that the hospital establishes. It would be rare for a journalist to permit the hospital to review a story before it is written, so selection of the journalist will be a critical factor. It doesn't hurt to make it clear that the reporter is being granted special access to staff and the facility, and that any future similar access will depend on the story being fair and appropriate.

When designing the program consider including the following safeguards:

- **Access.** Do not grant the reporter access to actual treatment areas. Access to treatment areas should be limited to individuals who have a "business related" reason to be there. Because the reporter is not treating patients, and is not a true visitor of a patient, there is little justification for permitting him or her to spend time there. Additionally, allowing the reporter access to treatment areas places patients at an unjustified risk of having their health information disclosed. Instead, allow the reporter access to an area where staff can easily visit with her and answer questions about their job.
- **Training.** Train staff members on what they can, and what they cannot say. Make sure they are aware of the organization's privacy policies, and that they cannot disclose PHI to the reporter. In part this means that staff need to stick to generalities and avoid patient specific information. Staff should avoid discussing specific patient injuries; refrain from disclosing condition specific information such as "gun shot wound to liver" or "stabbing injury to left lung." Staff may discuss, in general, the procedures for, and challenges of, treating different kinds of injuries and conditions commonly seen in the department. Keep in mind that the reporter may use publicly available information to "fill in gaps" in what they learn from the experience. If the reporter connects this to a specific patient, it may potentially be the basis for a citation for the provider.
- **Oversight.** A facility representative should accompany the reporter at all times that he or she is on facility property. An employee of your public relations department may be ideal. The facility representative understands the need for the reporter to get a good story, but also has an obligation to protect patient privacy. The facility representative should sit in on interviews and approve photographs before they are taken.
- **Photographs.** Limit photographs to areas that are not being used to treat patients. If it is necessary for a photographer to be present for the entire visit, ask the photographer to take approved pictures and then depart.
- **Patients.** Carefully consider whether to grant the reporter access to patients in the emergency department, even when explicit written authorization can be obtained. Patients may challenge the validity of the authorization later in an action against the hospital. The emergent nature of a patient's condition may provide a sound basis to reject the authorization form.

Figure 2. Example of a Patient Authorization Form

Good Heart Health System

Authorization for Patient Access/Release of Health Information

Patient Name:		Medical Record #:
Date of Birth:	Social Security #:	Phone #:
Home Address:		

1. Type of Request: I hereby authorize Good Heart Health System to verbally disclose my health information as indicated in Section 2:

2. Description of Information To Be Released:

- [X] Medical history
- [X] Diagnosis
- [X] Prognosis
- [X] Treatment Record
- [X] Course of Treatment
- [X] Diagnostic Test Results

Related to inpatient stay beginning: _____

3. Disclose Information To:

[ ] Myself *(the patient or authorized representative)* [X] To the individual identified below:

Organization:	Individual Name:			Phone #:
Street Address: City:		State:	Zip Code:	[ ] Please Mail [ ] Please prepare for pick-up

4. Purpose of Release:
This information may be disclosed for the purpose of my participation in Good Heart Health System's Nurse's Day Program as described in the attached notice.

5. Term/Expiration:
I understand that by law, I do not have to release this information and I choose to do so voluntarily. I may cancel this authorization by executing Section 6, below and providing the authorization form to my nurse. This authorization will automatically expire at [time] p.m. on [date]. *I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that once this information is disclosed, it is no longer protected by Federal Privacy Regulations and that the information could be re-disclosed without my permission.*

Signature of Patient or Patient's Representative _____ Date _____

Relationship to Patient _____ Witness Signature _____

6. REVOCATION OF AUTHORIZATION:
I wish to end my participation in the Good Heart Health System Nurse' Day Program, and revoke this authorization.

Signature of Patient _____ Date _____ Time _____

Staff with family members in the hospital

It can be a significant challenge for a community hospital when the family of a staff member seeks care from the hospital. This situation often raises issues about whether it's appropriate for a staff member to access the information of a family member using work related credentials (i.e. status as an employee or clinical system log on credentials). This issue can be complex and if not handled properly, can results in confusion, potential privacy breaches and staff and patient dissatisfaction.

The best way to avoid potential problems is to set a clear rule: access to patient information, including computer systems, patient care areas and medical record storage areas is limited to "job-related activities." Employees will argue that because it is their family member's information (especially a spouse, child or aging parent) they should be considered "involved in the patient's care" and permitted to access information under 45 C.F.R.§164.508.

A creative compliance officer might attempt to fashion a policy around that concept and allow staff to access the information of these family members. This would be an ill-advised time to "get creative." The policy will likely only lead to confusion and potential privacy breaches. For example, in many states a minor child can present for certain types of care without the consent of an adult. A policy which permits staff to access their child's information using clinical systems or your medical records function without authorization of the patient may result in staff accessing these encounters inappropriately. Moreover, it opens up the organization to the argument that staff were unclear on the rule when they accessed the information, leaving the organization with little room to discipline employees for an inappropriate breach and potentially liable to the patient for permitting an invasion of privacy. Instead, a rule that communicates "job related" limitations to this access will set clear and enforceable standards that will promote both reliability and audibility of your privacy compliance controls.

Staff as patients

Much like the previous scenario, staff as patients always presents certain challenges. If you have set a "job related only" policy as discussed above, staff will have to be trained to understand that they are not involved in their own care as "employees" but as "patients" and as such it is not appropriate to use work related systems to obtain information about their own care. Thus, using the organization's clinical information systems to access even their own information is inappropriate. Again, this is not the time or the place to be creative about your rules. The tenet that patient information should be accessed only for job related reasons is too important to cloud over with exceptions that could create confusion. Any creativity should be applied through systems that provide all patients with access to information, not just those lucky enough to work for the hospital.

Physician access to E-PHI

Physician access to electronic patient information may not, on the surface, seem to be an area that is ripe for creating privacy problems. After all, physicians are involved in treatment and have an extensive need for patient information. Most don't think of physicians as a high risk for gossip-mongering. A deeper look into this issue reveals cracks in which potential privacy problems can lurk. Most institutions have clinical information systems in which physicians can access information about their patients. In many cases these systems do not limit physician access to only those patients for whom they are the official attending or consulting physician. In some cases this is due to the limitations of the clinical system itself. In other cases, it's because the medical staff as a whole has requested broader access. This request is usually based on concerns about patient care. New consulting physicians want to have immediate access to the most up to date information about the patients they are treating. In other cases, a physician may ask for an "informal consult" that never results in the physician being listed on the patient's official record. Allowing broader access may be justifiable for these reasons, but it also increases the potential for abuse. Such abuse may take many forms. In some cases, physicians may review patient data to identify referrals that they did not get. In other cases, physicians may give their access codes to their office staff so they can have reports and data available in their office when the patient is in front of them. In more limited cases, physicians may access patient information out of professional or personal curiosity. If your organization cannot limit physician access to officially designated patients, then there are some steps that can be taken to protect patient privacy:

(1) Institute a reliable audit function. Auditing is perhaps the most effective way of controlling inappropriate access to patient information.
(2) Know who your users are. Don't limit granting user credentials to medical staff. If a physician wants his office manager or nurse to have access to your system, you are better off setting up a process that encompasses these users. You will then have a better idea of who is accessing your system and why. You will need to develop policies and controls to govern this process, and make it reliable.
(3) Refer potential problems to the medical staff governing body. Issues with physician access should be addressed by your medical staff's governing body.

C-level executives and access to PHI

The use of patient information by "C-level" executives is well debated within the hallowed halls of compliance and privacy offices. Whether it involves administrative reports identifying "VIP" inpatients or a "C-level" asking for an update on the treatment of a public figure. As a chief officer of a corporation, whether a chief patient safety officer, chief nursing officer or even a chief executive officer, there is personal responsibility and accountability for the treatment of each patient. It is difficult to argue that these individuals do not have "a need to know" when it comes to information concerning the treatment of a patient. Absent a clearly inappropriate intention (personal curiosity) as opposed to a work related need, it is appropriate to provide these individuals with wide access to patient information.

Fundraising

If you work with an institutionally related foundation or a fund development office, you will no doubt be reminded that since the adoption of the HIPAA Privacy Rule, fundraising has become a significantly greater challenge. The basic rule at 45 C.F.R. §160.514(f)(1), (2) limits the use and disclosure of protected health information for fundraising purposes to "dates of service" and "demographics." This means that while foundations can identify patients and send them fundraising solicitations, it doesn't allow those solicitations to be based on the patient's condition, or the type of treatment they received. In some circles it is argued that because "fundraising" is included as a part of the term "health care operations" in the HIPAA Privacy Rule rulemaking, hospitals should grant foundations wider access to patient information. This is another example of a creative argument that carries a significant amount of risk given the specificity of §160.514. There is another way, however, to identify individuals who have an interest in a particular type of treatment or a health condition. That is to obtain contact information through nontreatment related activities. For example, information obtained from individuals who attend an educational lecture on a particular disease is not PHI. Similarly, information collected from a health information booth at a local mall or grocery store is not PHI. These events provide an opportunity to identify individuals with an interest in a particular heath area or service without accessing your patient databases.

Conclusion

It is true that not every compliance challenge can be solved with creativity. Your "compliance officer radar" should probably go off when you are encouraged to "get creative" to solve a problem. At the same time, careful consideration of complex problems can lead to solutions that will fit within a confining regulatory construct and still meet operational needs. Often, not in the way you or operational management expected. ■

Stephen Miller, JD, Chief Compliance and Privacy Officer, oversees the administration of Capital Health System's (CHS) Corporate Compliance Program. His responsibilities include developing policies and procedures designed to ensure CHS' compliance with all federal, state and local laws. He also oversees compliance audits and annual and risk specific compliance training for CHS employees. He earned his Bachelor of Arts degree from West Virginia Wesleyan College and his Juris Doctor degree from Widener University School of Law, Harrisburg, Pennsylvania. He is a member of CCH's Health Care Compliance Editorial Advisory Board.

Revenue Cycle

Denial reduction requires facility-wide focus, expert says

As claim denials increase, providers should change their practices to reduce denials and receive accurate payments more promptly, according to Michael E. Berger, Director of Revenue Cycle Operations, Management and Performance Improvement Services at Parente Randolph, LLC. Berger, the presenter at a Health Care Compliance Association webinar, noted that payment denials by third-party payers have tripled over the last decade and may amount to 10 percent of a facility's gross revenue. He suggested that all providers institute denial reduction programs.

To reap the benefits of denial management, the organization must commit staff time and resources. The facility must have a permanent working committee including the health information management or records department, access management, internal auditors, patient financial services, senior management, senior medical staff, and contract management.

A single database must contain all relevant information, and all departments must use standardized definitions of codes and services. The database must be flexible to allow searches based on variables, including: the 28 common "high-level denial codes," admission and discharge dates, denied days, service area, admitting physician, date of each remittance, admitting and discharge diagnoses, payer code/financial class, revenue codes, procedure codes, and patient type.

By searching denials across many variables, revenue managers can identify common reasons for denials that can be remedied. For example, one facility experienced an increase in denials for breast cancer services based on a lack of prior authorization. The facility had begun to provide immediate follow-up examinations rather than scheduling a second visit after an abnormal mammogram.The facility was required to contact the payer for authorization before proceeding. ■

CCH Chicago Bureau, Sept. 3, 2008

In the News

CMS publishes Part B billing edits

Beginning October 1, 2008, CMS will publish on its Web site most of the edits utilized in its Medically Unlikely Edit (MUE) program to improve the accuracy of Medicare Part B claims payments. Claims processing contractors utilize these edits to assure that providers and suppliers do not report excessive services. The edits, which are applied during the electronic processing of all claims, check the number of times a service is reported by a provider or supplier for the same patient on the same date of service. Providers and suppliers report services on claims using Health Care Procedure Codes/Current Procedure Terminology® (HCPCS/CPT®) codes along with the number of times (i.e., units of service) that the service is provided. The October 1, 2008, version of MUE contains edits for about 9,700 HCPCS/CPT® codes that have been assigned unit values for MUEs. Each quarter, CMS publishes most MUEs active for that quarter. CMS does not publish all active MUEs because some are designed to detect and deter questionable payments rather than billing errors. Publishing those MUEs would diminish their effectiveness.

CMS News Release, Oct. 1, 2008

OIG issues nursing facility guidance

A new voluntary compliance program guidance (CPG) will help nursing facilities develop compliance programs that address Medicare and Medicaid fraud and abuse problems related to poor quality of care, billing federal health care programs, and kickbacks. The new CPG responds to developments in the nursing facility industry, including significant changes in the way nursing facilities deliver and receive reimbursement, business practices, and changes in federal enforcement. It reflects public input and provides a roadmap for developing, implementing, and evaluating compliance programs. The CPG will help compliance professionals address staffing, resident care plans, medication management, the use of psychotropic medications, and resident safety. It emphasizes the importance of submitting accurate claims and discusses issues related to reporting resident case-mix data, therapy services, screening for excluded individuals, and restorative and personal care services.

OIG Press Release, Sept. 29, 2008; Notice, 73 FR 56832, Sept. 30, 2008, Health Care Compliance Reporter, ¶510,023

Bill requires national EHI standards

Legislation introduced in the House of Representatives in September would require the government to create standards for a national electronic health information system and provide financial incentives for physicians and hospitals to begin using medical record systems that meet those standards. The Health e-Information Technology Act of 2008 was sponsored by Rep. Pete Stark (D-Calif.), chairman of the House Ways and Means Health Subcommittee. Stark said the bill is meant to stimulate the development of a health information system that would allow providers across the country to access patients' medical histories online. Such a system would allow for higher-quality care and avoid duplication of services, Stark added. Physicians who install and utilize an approved system would be eligible for incentives of up to $40,000 over five years, while incentives for hospitals could total several million dollars.

Rep. Stark Press Release, Sept. 15, 2008