CCH Healthcare Compliance LETTER

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CMS offers contingency planning guidelines

by Sharon Sofinski

The Centers for Medicare and Medicaid Services (CMS) has posted contingency planning guidelines for the October 16 compliance deadline for HIPAA transactions and code sets. The guidelines, available on the CMS website, address healthcare industry concerns "that testing rates are low and the process is complex." CMS notes that "many covered entities may not be capable of successfully transmitting HIPAA compliant transactions in time for the October 16, 2003 compliance date," which may affect providers' cash flow. (See also "AHA responds to recent CMS guidance," *CCH Healthcare Compliance Letter*, Vol. 6, Issue 18.)

According to CMS, such a contingency plan should address the possibility of interruptions in claims processing and payment due to transmission problems using the new transaction standards. While each health plan should determine what to include in its contingency plan based on its unique business environment, CMS has outlined seven basic steps for contingency planning:

1. **Assess your situation.** Determine what business processes are at risk, assess your October 2003 financial status, and estimate what financial obligations will be due.
2. **Identify risks.** Assess the likelihood and the impact of potential risks, ranking each as high, medium, or low. Assess your trading partners' readiness for the deadline and how that may impact your operations.
3. **Formulate an action plan.** Choose a strategy that will reduce each risk you have identified.
4. **Decide if and when to activate the plan.** Try to prevent an interruption in current business operations.
5. **Communicate the plan.** Record the plan, the steps that must be taken, and the person(s) responsible for each step. Then communicate the plan to everyone involved.
6. **Test the plan.** Go over each step of the plan with the key players.
7. **Treat the contingency plan as an evolving process.** Continually review your efforts and update your plan as needed.

Noting that "successful contingency plans will greatly enhance communication throughout the industry as it moves towards HIPAA compliance," CMS urges health plans to announce their contingency plans as soon as possible, so their partners have time to make any necessary changes to their business operations.

The contingency planning guidelines are available at http://www.cms.hhs.gov/hipaa/hipaa2/general/default.asp#contingency_guide. ■

CCH Chicago Bureau, October 16, 2003

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.

Senate unanimously approves genetic nondiscrimination bill

by John Scorza, Contributing Editor

The Senate unanimously passed a bill that would prohibit employers and insurance companies from discriminating against people based on their genetic makeup. The Senate passed the bill—the Genetic Information Nondiscrimination Act of 2003 (S.1053)—by a 95-0 vote on October 14. The Bush administration supports the measure.

The bill would bar employers from using genetic information to make employment decisions, including decisions on hiring, firing, job assignments and promotions. Employers could collect genetic information from employees or their family members only in limited cases, such as to monitor the effects of toxins in the workplace. Companies that collect genetic information would be required to keep that information confidential, disclosing it only when necessary to comply with federal, state or local laws, for instance. The Equal Employment Opportunity Commission would enforce the employment provisions of the genetic nondiscrimination law.

"I hope our legislation will mark the beginning of the end of the debate to provide protections from discrimination to every American—regardless of genetic heritage, gender or other impairments," remarked the bill's sponsor, Sen. Olympia Snowe, R-Maine. Snowe, who has introduced versions of genetic discrimination legislation in the past three Congresses, characterized her bill as an extension of current civil rights laws that prohibit discrimination on the basis of race and disabilities.

Under the bill, insurers could not collect a person's genetic information prior to enrolling the person in an insurance plan. Insurance companies could not use genetic information, such as family backgrounds or the results of genetic tests, to deny coverage or set premiums. Insurers with genetic information would be required to comply with existing privacy laws. Violations could result in fines of $100 a day, payable to the individual who was discriminated against. The bill would allow for the retroactive reinstatement of insurance to the date of a violation. The Departments of Labor, and Health and Human Services would enforce the insurance provisions of the law.

"Under the bill, insurers could not collect a person's genetic information prior to enrolling the person in an insurance plan. Insurers with genetic information would be required to comply with existing privacy laws."

The insurance industry opposes the bill, claiming there are adequate safeguards already in place to protect against genetic discrimination. Donald Young, president of the Health Insurance Association of America, said the bill would "only add unnecessary and costly regulatory burdens without, in any way, improving consumer protection."

Medical researchers, on the other hand, support the bill because it could encourage people to participate in genetic research without the fear of discrimination. Dr. Francis S. Collins, director of the National Human Genome Research Institute, National Institutes of Health, remarked, "No one should lose his job because of the genes he inherited. No one should be denied health insurance because of her DNA. But genetic discrimination affects more than jobs and insurance. It slows the pace of science."

Striking a similar note, the administration said the bill "will help guarantee that the nation fully realizes the potential of ongoing advances in genetic sciences." The administration said it is committed to working with Congress to enact the measure. The bill now goes to the House. But action there could be delayed until next year since Congress is working to clear fiscal 2004 spending bills and other priority legislation before breaking for the year. The text of the bill is at http://thomas.loc.gov/cgi-bin/query/F?c108:3:./temp/~c108MrPpBw:e0:. ■

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Managing Editor
Yvonne Kanak

Coordinating Editors
Angela Fanelli, J.D.
Sharon Sofinski

CCH Washington Bureau
Paula Cruickshank
DOJ, FTC–John Scorza
SEC–Peter Feltman
Health Law–Catherine Hubbard
Tax–Jeff Carlson, David Hansen

Designer
Patrick M. Gallagher

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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Learn how to spot the red flags to anti-kickback problems

by Catherine Hubbard, MA, Contributing Editor

Knowing how the government and trial attorneys approach the Stark Law/Anti-Kickback Statute can protect entities from entering into suspicious relationships that lead them into a False Claims Act case, according to two attorneys who spoke at a recent conference.

"Our goal is to focus on the clear cases of violations of the underlying statute to bring the False Claims Act into play," said Jonathan L. Diesenhaus, a trial attorney at the Justice Department's Civil Division. He spoke at the fall meeting of the American Health Lawyers Association and the Health Care Compliance Association. "We're going to take a fact-specific look behind the paper of any relationship to find out what actually happened whether services were actually performed."

For instance, Diesenhaus said his division will look for:

- Excessive payments for professional duties.
- No documentation of performance of the duties.
- No apparent justification for the duties.
- Pile-on relationships. Examples: (1) A doctor has a medical directorship and physicians are being recruited into the physician's practice at the expense of the hospital. (2) The hospital rents storage space from the doctor.
- Hospital leases with below market terms.
- Failure of the hospital to collect payment from the provider.
- Questionable loans to doctors. "A hospital is not a bank," he said.

Excessive gifts and entertainment will also raise eyebrows. Katherine A. Lauer, of Latham & Watkins, San Diego, California, cautioned providers to stay within the $300 limit for gifts and within other de minimis exceptions under Stark. "Be really careful about this. If you get one or two of these on top of [other violations], it's gong to push you over." Lauer and Diesenhaus noted they were speaking on their own behalves.

Questionable relationships and duties are a key red flag, said Diesenhaus. "These are the things that are going to make us drill down and look harder."

Lauer said there were actual cases involving a public relations medical director, a spiritual medical director and a bilingual medical director. Diesenhaus added a medical director for fire extinguishers to Lauer's list. He assured participants that his office will examine such questionable duties. "I'm not here to say you can't have stupid contracts. If the work is being done, that's different." But, he said, when nobody has seen that person show up and do the work, "That's a red flag."

Both attorneys urged providers to keep adequate time records and work product records. "If you don't have them, it makes it very difficult to prove your case," said Lauer. Diesenhaus added that time cards alone won't be sufficient proof. "We're not just talking about time cards." He stressed the agency will also look for evidence of the work product, such as staffing plans and proof that deliverables have arrived. "We're not accepting facial clarity of a contract or a representation that a law is complied with, especially when we have a whistleblower telling us something different." ■

CCH Washington Bureau, October 16, 2003

OIG posts Advisory Opinion FAQs

The Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) has posted answers to "Frequently Asked Questions About The Advisory Opinion Process" to its website. The FAQs provide general guidance on the advisory opinion process, including contact information for further questions, and links to pertinent laws and regulations. The FAQs are at http://oig.hhs.gov/fraud/advisoryopinions/aofaq.html.

When the patient has more than one insurance

by Allan P. DeKaye, MBA, FHFMA

This issue seems somewhat out of place amidst the headlines of healthcare's uninsured problem in America. However, for the provider community, the ability to identify those patients with more than one insurance is not only a matter of getting paid properly, it's avoiding compliance concerns related to establishing and correctly reporting the "coordination of benefits" that must occur. This article will examine the process that needs to be followed, issues impeding compliance, and consequences of incomplete or improper actions.

What Is Coordination of Benefits?

Coordination of benefits (COB) is a process determination that occurs when a patient has, or is covered by, more than one health insurance plan. The process needs to identify all of the insurances covering a patient, and establish the order in which a patient's insurances will be billed in order to obtain payment for services rendered. A "primary insurance" will pay first according to the terms and conditions of its coverage after it has been confirmed that the insured is eligible. If available, a "secondary insurance" will be billed for services not included or covered, such as deductibles, coinsurance, and in some instances non-covered services. Any unpaid balances remaining after all insurances have been billed and settled become the responsibility of the patient.

In order to bill and collect for services rendered, hospitals and physicians must correctly identify a patient's insurance carrier(s). While many patients only have one insurance, it is incumbent on the hospital or physician office to ascertain if a patient has more than one coverage, including coverage from another member of the same household or from another responsible party. As healthcare costs have risen, and patients have had to assume more out-of-pocket costs associated with their care, secondary insurances have become more prevalent. While an individual may have more than one insurance, regulations preclude the sum of all insurance payments from exceeding the cost of the care. The process to ensure that each payer assumes its correct portion of the cost of care is COB.

So Why All of the Fuss?

On the surface, this may look like a problem only for providers of care, who may not be paid in full for failure to properly ascertain the proper COB. To some extent this is true. Many providers simply stop at collecting from a patient's primary insurance, often failing to collect from secondary payers because of their own inability to capture the relevant information, or to properly deliver and have adjudicated a bill to a subsequent (secondary) carrier. But there is another side of the story, when the payer receives too much. The problem becomes more of a concern when this condition exists, especially when improper payments are made from either Medicare or Medicaid, or other government funded program.

There are many challenges associated with implementing an effective COB program. While most of the effort still falls on hospitals and physician practices to secure insurance information from direct patient contact, there has been growing reliance on automated searching of payer databases. However, payers have not been particularly successful in capturing and reporting the existence of multiple insurances. Although government sponsored programs (i.e., Medicare and Medicaid) have been more successful in capturing the co-existence of these two large government programs, much of this success is attributable to audit recovery programs conducted at the federal, state and local levels.

Although insurance carriers usually require the disclosure of other insurance information as part of their enrollment process, little has been done in the area of updating or enforcement. As a result, payers are now more often delaying claims payment until their insured individuals (i.e., patients) update their COB forms. In order for hospitals and physician practices to improve their ability to identify the potential for more than one insurance carrier per patient, enhanced access and searching capabilities are needed. Additionally, the ability to digest and summarize the resulting identification of multiple payers into a "billing hierarchy" that establishes the COB priority would enable providers to improve their billing and collection capability. The availability of such tool/technology would improve data integrity and accounts receivable management.

Who's on First?

Lest this sound like the Abbott and Costello routine, the primary government payers, Medicare and Medicaid, have done a credible job in updating their databases that providers of care can access. Within the COB framework, there is a hierarchy of payers, simplified with these rules:

- Medicaid is the payer of last resort. (This statement is always true.)
- Medicare is the first payer–most of the time.

The exceptions to Medicare are classified within the Medicare Secondary Payer (MSP) program requirements, which are discussed below. These two rules work most of the time, especially for "dual eligibles" (i.e., those covered by both Medicare and Medicaid). But first, the Medicare exceptions need to be presented, and then where the rest of the commercial insurances and managed care plans fit in.

"Penalties can be substantial, especially if as a result of not complying with the MSP questionnaire, the resulting bill is deemed to be a 'false claim.'"

Understanding MSP Requirements

Medicare provides aged Americans with healthcare coverage. Through its Part A coverage, most qualified citizens can obtain inpatient hospital coverage, while under Part B, which is an optional coverage that can be purchased, Medicare covers doctor visits and many outpatient hospital and related services. However, Medicare has established the following conditions where its role as the "primary" payer will be reversed to that of the "secondary" carrier. As such, instead of paying for the services less deductibles and co-insurances, it will allow other payers or programs to pay first. Medicare would then be responsible for resulting deductibles and co-insurances. Six conditions have been designated where this reversal of payer priority must occur.

Medicare is the primary payer, except when any of the following criteria is present:

1. Working aged (over age 65, but still working–or a covered spouse–and covered by a group health insurance plan)
2. Worker's compensation
3. No fault or other liability insurance
4. Veterans Administration
5. Black lung disease
6. End-stage renal disease

For the most part, hospitals utilize a format called the Medicare Secondary Payer Questionnaire. Many hospitals have automated the MSP Questionnaire. Generally, an indication of Medicare coverage entered in a hospital's information system (or its Admission, Discharge and Transfer (ADT) system) "triggers" the appearance of the questionnaire sometime during the admission or registration process. A series of proscribed questions are then "asked and answered" specifically looking to identify the presence of any of the six conditions noted above. The results are captured in the system, and can be retrieved for review, especially in the event of audit.

When an affirmative answer to one of the six conditions is obtained, the hospital's registration staff would identify another insurance plan as "primary" and place Medicare in the "secondary" insurance position. Many systems require the staff to further select a COB billing priority. Where the questionnaire has not been made part of the system functionality, a manual (paper) version of the questions is then administered. In manual systems, the ability to retain and retrieve the questionnaire for audit purposes can be more challenging.

While this is a mandatory process for hospitals, physicians have the option of completing this questionnaire. The benefit should not be viewed solely as a compliance matter, but rather as a necessary step in "perfecting the registration." Although hospitals may treat this as a routine process (almost as though they were "Mirandizing" their Medicare patients), when used properly, and prepared for in a training environment that stresses the importance of data integrity, the benefit can translate to other multiple insurance payer situations.

Applying COB Procedures to Other Payer Combinations

It is common to find family households where working spouses each elect healthcare coverage from their respective employers. With the increasing cost of healthcare coverage, employers tend to provide employee coverage (even with some small premium contribution), but charge a larger premium contribution if an employee selects spousal or family coverage. As a result, many employees elect "single" coverage for themselves. However, in many instances, because of the increasing "deductible and co-payment" provision of these policies, spouses working for different companies often elect to buy the spousal coverage, in order to have coverage for out-of-pocket expenses such as deductibles and co-insurance. Keep in mind that each of these policies may be different. Some many be managed care or HMO policies, and others may be more flexible POS or PPO plans. Each will come with its own rules, regulations and requirements. This area often provides confusion for payers and providers when trying to determine the correct COB order.

As part of the admitting process, hospital staff must determine a patient's marital status (among the many data elements

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needed to register a patient) when the patient is scheduled for inpatient or outpatient services. In instances when working spouses each have insurance, the staff must determine several factors, including (but not limited to):

1. Employer for both husband and wife
2. Insurance company for each spouse
3. Identification numbers and type of coverage of each plan
4. Determine who is the "subscriber," and/or the relationship of the patient to the subscriber
5. Establish which insurance company is primary, and which is secondary (i.e., the "coordination of benefits").

In the above scenario, when either spouse is the patient, it is that spouse's insurance that is generally primary. The other spouse's insurance plan is then made secondary. "Generally" is used because there will be exceptions. This can occur when either or both insurance companies cannot provide the definitive response to a hospital inquiry (which may be made electronically or telephonically). As noted earlier, a subscriber may not have disclosed or been requested to provide other insurance coverage when enrolling. Or if provided, the information may not have been entered, or may not have been updated upon subsequent renewal.

"Hospitals need to continue to improve the training and development of their front-end admitting and registration personnel in order to improve the effectiveness of their interview skills, and data capture and entry."

Also, providers often don't obtain all of the insurance information. In some instances, weak or poor interview skills or registration processes contribute to the problem. Special care and circumstances apply to patients seen in the Emergency Room (ER) setting. The EMTALA requirements indicate that "patients will be entitled to medical screening by qualified personnel regardless of their ability to pay...in emergency situations." Many states have statutes that require patients to be "treated regardless of their ability to pay" when presenting in the ER. In efforts to ensure compliance with these types of regulations, coupled with the occurrence of patients entering the ER comatose or unable to communicate, hospitals are often unable to effect a complete and accurate registration.

Many hospitals rely on post-admission patient interviews, including bedside visits and discharge processing, as a final attempt to secure this information before an inpatient leaves. In cases where patients are "treated and released," it often takes a bill from the hospital to prompt patient responsiveness and identify "other" insurances.

Truth or Consequences and the Impact of HIPAA

Hospitals are subjected to audits and penalties, especially in the review of the MSP requirements. Penalties can be substantial, especially if as a result of not complying with the MSP questionnaire, the resulting bill is deemed to be a "false claim." But like the football team receiving several penalties on the same play, the volume of Medicare patients seen by most hospitals makes the potential impact quite significant and serious. Hospitals need to continue to improve the training and development of their front-end admitting and registration personnel in order to improve the effectiveness of their interview skills, and data capture and entry.

Similarly, the failure to properly identify all patient responsible insurances, as well as establishing the proper COB, will result in claim denials and payment delays. However, the inability of the payer community to provide complete and up-to-date information presents logistical and financial impediments for the hospital. While much has been said about the security and privacy provisions of HIPAA, one area that should receive attention is the transaction sets related to eligibility and claims. In the area of eligibility, electronic transactions that can provide more robust information, especially as it relates to COB, would be helpful to both the hospital and payer communities. With more accurate and complete patient data, the ability to generate a "clear claim" for both primary and secondary payers will be greatly improved, allowing payers to promptly pay for services rendered to their insured patients.

Patients have a role and responsibility in this process, too. All too often, uncooperative patients fail to provide the necessary information to ensure that demographic and financial data is properly captured. Improving patient awareness about insurance is an insurance company responsibility. Community awareness and education of the general population is becoming a more prevalent need given today's economic condition and the growing number of uninsured citizens. In many instances, hospitals find that patients only respond with missing or previously withheld information as a result of the account being sent to collection. In the area of COB, it would seem that the industry and public interest would be better served if each segment of the "community" discharged its respective responsibilities more effectively. Perhaps then we could attain "an ounce of prevention (leading to a) pound of cure."

Mr. DeKaye is President and CEO of DEKAYE Consulting, Inc. His firm assists healthcare clients with financial, operational and compliance issues. He is a frequent speaker at national conferences, author/editor of The Patient Accounts Management Handbook, and creator of the hospital benchmarking system, PFS Power Rankings(sm). For more information: call (516) 678-2754; write dkconsult1@aol.com, or visit www.dekaye.com.

Peer review immunity and the Health Care Quality Improvement Act

by Richard C. Sarhaddi, Esq., Contributing Editor

Peer review board immunity under the Health Care Quality Improvement Act (HCQIA) has been routinely challenged on equal protection, due process and other grounds since its enactment, but peer review members have consistently maintained their immunity in these cases.

Enacted in 1986, the HCQIA provides peer review participants with qualified immunity from monetary damages under any law of the United States or of any state if actions taken by peer review committees comply with the four requirements set forth in the Act. Congress enacted the HCQIA in response to nationwide problems concerning medical care, which it determined that states could not address alone, such as increasing medical malpractice claims and the need to improve the quality of medical care. In addition, Congress further identified the need to restrict the ability of incompetent physicians to move from state to state without disclosure or discovery of the physician's previous damaging or incompetent performance. Congress felt that the proper instrument to remedy these problems was effective professional peer review. Congress was keen enough to understand, however, that attaining effective professional peer review would be difficult if participating physicians and other professionals were not given adequate protection from potential lawsuits brought by those who disagreed with their decisions. Therefore, the HCQIA was enacted to give peer review participants incentive to participate in the review process in the form of full immunity from monetary damages provided that they complied with several requirements.

Immunity requirements—two tiered analysis. Under the HCQIA whether immunity should be granted necessitates a two tiered analysis of each situation. First, those eligible for immunity must be determined. Second, the action taken by eligible individuals must comply with several requirements provided by the HCQIA.

Eligibility. Individuals associated with peer review who are eligible for immunity under the Act include: (1) the professional review body; (2) any person acting as a member or staff of a peer review body; (3) any person under a contract or other formal agreement with the body; and (4) any person who participates with or assists the body with respect to the action taken by the peer review panel. In essence, immunity is available to anyone who is participating in the peer review activity—not only those who sit on the actual peer review board.

"The HCQIA was enacted to give peer review participants incentive to participate in the review process in the form of full immunity from monetary damages provided that they complied with several requirements."

Objective standards for actions taken. After the peer review participants are ascertained, they are granted immunity under the Act only if the professional review is taken: (1) in the reasonable belief that the action was in the furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of (3). 42 U.S.C. 11112(a). Regarding the notice requirement in (3), courts assess the totality of the circumstances in which the notice is given, and there is no black letter rule governing how notice must be given. In most circumstances, if the notice was reasonable, the notice requirement has been fulfilled.

Courts routinely ratify actions taken by peer review participants because they are assessed under a relatively lenient objective standard. In most cases, as long as the action is taken according to what reviewers deem to be in furtherance of quality health care, immunity will be granted.

Recent case. Recently, in *Meyers v. Columbia/HCA Healthcare Corporation*, 341 F3d 461 (6th Cir. 2003), the 6th Circuit revisited the issue of peer review participant immunity. The physician-plaintiffs in *Meyers* claimed that the professional review board's assessment and decision to deny the plaintiffs staff privileges could not be sustained, based on allegations that the board, composed mostly of the plaintiffs' competitors, was biased and therefore had obvious incentive to deny the plaintiffs' staff privileges. Notably, the members of the hospital's peer review board were not the only participants in the peer review process. The court ultimately interpreted the HCQIA as providing immunity for all peer review participants, including non-physicians.

Once the court determined that each individual engaged in peer review activity was eligible for immunity, it analyzed the process utilized and the actions taken by the peer review participants as well as their ultimate decision to deny staff privileges to the plaintiffs according to the reasonableness and notice factors set forth above. In its decision, the peer review committee cited several concerns about one plaintiff's history regarding attitude problems with other hospital staff, which included several instances of throwing a scalpel during surgery, and past undisclosed disciplinary problems. In addition, the committee found that the plaintiff failed to (1) abide by the medical profession's ethics, (2) meet the hospital's standard of care, and (3) timely complete medical records. The committee and other peer review participants decided that

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the plaintiff's problems "could adversely affect patient care as well as disrupt the efficient operation of the hospital" and denied the plantiff staff privileges on that basis. The court examined these facts along with the immunity factors and found that the committee and other peer review participants (1) reasonably obtained the applicable facts, (2) reasonably acted by denying staff privileges and (3) reasonably believed that their actions promoted quality health care. In addition, the court found that the notice plaintiffs received was proper, although it was "short notice" and did not conform to the hospital's by-laws.

Lessons learned. The common thread running through the myriad of cases challenging peer review participant immunity, as well as the illustrated case, is that courts give a high level of deference to the committee and its respective findings. Courts analyze the factors in a light as favorable as possible to the peer review committees, and the vast majority of the time, grant peer review participants immunity for their decisions. As long as those involved in peer review action reasonably comply with the requirements for immunity and promote health care quality, peer review members will continue to enjoy virtually impregnable immunity. ■

CCH Chicago Bureau, October 9, 2003

OIG describes its projects for fiscal year 2004

The OIG Fiscal Year 2004 Work Plan for projects related to CMS puts "Medicare Hospitals" at the top of the list and summarizes 23 projects under that heading. Other headings related to Medicare are: Medicare home health, nursing homes, physicians and other health professionals, medical equipment and supplies, drug reimbursement, managed care and contractor operations. A miscellaneous section focuses on Medicare inpatient rehabilitation payments, ambulatory surgery rates, independent diagnostic facilities, therapy services, rural health clinics, laboratory services and testing, and dialysis in nursing homes.

The issues directly related to hospitals include accreditation, medical education payments for dental and podiatry residents and nursing education, inpatient and long-term care hospital payment, organ acquisition costs, medical necessity related to inpatient psychiatric and rehabilitation, home office costs for critical access hospitals, DRGs, hospital reporting of restraint-related deaths, coronary artery stents, diagnostic testing in emergency rooms, and payments for outpatient services.

Projects related to Medicaid are grouped under these topics: Medicaid hospitals, nursing homes, State Children's Health Insurance Programs (CHIPs), drug reimbursement, and 22 miscellaneous Medicaid issues or services. Projects related to CMS oversight of all health care programs focus on information systems controls, quality assurance issues related to payments and to nursing home care, health care fraud and provider self-disclosure, and compliance issues, including enforcement of antidumping rules.

In the introduction to the work plan, OIG cautions that the focus and timing of all the projects evolve in response to new information, shifting priorities of the Congress, the President, and the Secretary of HHS and, accordingly, may be altered over time. The OIG 2004 Work Plan is at http://www.oig.hhs.gov/publications/docs/workplan/2004/Work%20Plan%202004.pdf.