

Health Care Compliance LETTER

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CMS to provide more guidance on addressable items in Security Rule

by Catherine Hubbard, MA, Contributing Editor

The Centers for Medicare & Medicaid Services plans to provide additional guidance on how covered entities should handle audits and workforce training, according to Brad Peska, from the Office of HIPAA Standards, who participated in a CMS roundtable discussion on the HIPAA Security Rule on November 10.

CMS is working on the details about the length of time that audit information must be retained and on information about the detailed content of the audit material itself, Peska said. "I assure you we do have that as an issue that we are actively working on for future clarification," he said in response to a question, adding that the guidance will likely be posted as a Frequently Asked Question on the CMS website. "We will be providing an FAQ in the future that provides more detail on this specific standard."

Encryption. CMS also wants to provide more guidance on alternatives to encryption, an addressable item under the Rule, Peska told the 2,030 callers.

While the implementation specification for encryption is addressable, the standard for transmission security is not addressable. That standard says covered entities must implement a technical security measure to guard against unauthorized access to electronic personal health information (e-PHI) being transmitted over an electronic communications network.

"If we rule out encryption, what else could we implement to meet that standard?" one caller asked. Peska said CMS is currently not able to provide any additional information. But he noted that since encryption is an addressable standard, there could be alternative measures out there. "This is another issue we're looking at to determine if there is additional information we could provide for the industry," he said. "It is very contextual based on the covered entities that we have out there," he said, adding, "We have to make sure any answers we have apply to all covered entities."

Passwords. Peska answered a host of questions from the teleconference audience. Some callers were concerned that the Security Rule does not have specific standards for passwords. When asked if there should be a minimum of complexity of a password, Peska explained that each covered entity would have to determine the level of complexity they need based on the characteristics of their environments.

HIPAA (cont.)

Stan Nachimson, senior advisor to the Office of HIPAA Standards, acknowledged that concern over password complexity is valid, but he added that, purely from a security rule standpoint, there are no specifics identified under the rule related to passwords. "The approach that we took in the Security Rule is to place

"It's very important that you look at the circumstances for your own organization and determine what's right for you."

the responsibility of what would be right for your organization on you. You've got the flexibility to make some decisions," he said.

CMS was uncomfortable setting minimums in a lot of cases because they might have been too cumbersome for some organizations and not tough enough for others, Nachimson explained. "It's very important that you look at the circumstances for your own organization and determine what's right for you," he said. Nevertheless, covered entities will have to address the issue and document their analyses. "The analysis that you do must be documented," he said.

Training. Callers also wanted to know how they should go about training their workforce. Under the Security Rule, all

workers must be trained at least once before the Rule kicks into effect in April 2005, yet there are no specific requirements after that, said Peska.

Workforce training, like passwords, is another addressable item. The Security Rule includes addressable implementation specifications that provide additional considerations for security awareness standards, but it doesn't identify specific time frames for the training to be performed, Peska noted. He added that the Security Rule preamble discusses security and awareness training that will allow covered entities to determine what works best for their environment.

Also, the first addressable specification for security rule training requires periodic updates for the organization. "That could take on different forms for different covered entities," said Peska.

Documentation. Peska also answered a question about how to document the decision making process for the addressable items. He told the caller that CMS has a requirement for policies and procedures and documentation in the Rule, which require covered entities to document certain activities. "That is a business decision that the organization should make," he said, adding that there are no specifics of how to document the decision-making process.

To a few callers who seemed frustrated that the CMS is still coming out with guidance, Peska explained that CMS is trying to help covered entities by continuing to work on guidance. "The Rule

itself has been out for a year and a half," he noted. "We are providing additional guidance, but we are all working off the same page," he said. "The standards are what they are."

"Security is a very high priority for our office," Peska said. "We are taking it very seriously and are trying to get information out as fast as we can," he said. CMS FAQs are posted at: www.cms.hhs.gov/hipaa/hipaa2. CMS plans to hold the next HIPAA Implementation Roundtable conference call on December 15. ■

CCH Washington Bureau, November 19, 2004



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Proposed arrangement for waiver of cost-sharing amounts okayed

by **Gené Stephens Connolly, JD,**
Contributing Editor

A city's proposed arrangement to treat revenue received from local taxes as payment of applicable cost-sharing amounts owed for emergency medical services (EMS) would not generate a prohibited remuneration under the Anti-Kickback Statute. The city's ordinance allows the municipality to accept residents' health insurance, including coverage from any federal health care program, as "payment in full" for emergency services, and treats the revenue received from local taxes as payment of any additional cost-sharing amounts. The ordinance would apply to tax-paying residents within the city's limits. Additionally, the city would not subcontract these services and would provide EMS 24 hours a day, seven days a week. The city proposal also would not provide routine transportation services for residents.

In the past, OIG previously ruled that programs involving routine waivers of Medicare cost-sharing amounts for reasons unrelated to individualized good-faith assessments of financial hardship would be held liable under the Anti-Kickback Statute. Such cost-sharing waivers would typically constitute a prohibited remuneration to potentially induce patient referrals in violation of the statutory provisions. While the city's proposed arrangement presents an "insurance only" billing plan that would normally implicate the Anti-Kickback provisions, a special rule for providers and suppliers that are owned and operated by a state or political subdivision of a state may reduce or waive its charges for patients unable to pay, or may alternatively charge patients only to the extent of their Medicare and other health insurance coverage. In addition, CMS manual section 50.3, Ch. 16, Pub. 100-02, does not require a city to collect cost-sharing amounts from residents within the city's limits. The advisory opinion does not apply to

waivers of cost-sharing amounts based on criteria other than residency. ■
OIG Advisory Opinion 04-14, ¶500,117

OIG approves proposed nonprofit drug-assistance program

by **Gené Stephens Connolly, JD**
Contributing Editor

A nonprofit, charitable organization's proposed arrangement to establish and operate a patient assistance program to defray the costs of expensive prescription drug therapies incurred by financially needy patients suffering from specific chronic or life threatening diseases would not constitute grounds for the imposition of civil monetary penalties and would not constitute a prohibited remuneration under the provisions of the Anti-Kickback Statute.

The nonprofit organization, which served as a liaison between patients and their insurers, employers and creditors to resolve insurance, job retention and debt crisis matters relative to their diagnosis, received donations from providers and suppliers of health care, as well as from individuals and pharmaceutical companies. The organization certified, however, that it was not subject to the direct or indirect

control of any donor affiliated with a pharmaceutical company. The proposed program would pay all or part of the cost-sharing obligations for prescription drugs for eligible privately insured patients and Medicare beneficiaries. Additionally, the organization established criteria for determining eligibility for assistance in the program based on the patient's illness and financial need (income 250 percent or less of the poverty line set by HHS). Pharmaceutical manufacturers participating in the program would be required to make a participation commitment of at least three years. Patient privacy also would be maintained as part of the program.

Since the organization's program and financial subsidy would effectively insulate beneficiary decision-making from information attributing the funding of the patient's benefit to any donor, the OIG determined that the donor contributions were unlikely to influence any Medicare beneficiary's selection of a particular provider, practitioner or supplier, and as such, would not violate the Anti-Kickback provisions. The OIG also limited the organization's financial assistance of cost-sharing amounts to only privately-insured patients in which the organization would pay all or part of the patient health insurance premium. In most cases, a sliding scale would be used

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Corporate compliance officers should incorporate PEPPER reports into their compliance program auditing and monitoring

by Catherine M. Boerner, JD

In September 2004, Wisconsin's Quality Improvement Organization (QIO), MetaStar, Inc., sent e-mails to Wisconsin hospitals stating that MetaStar would like the hospital's compliance officer to receive and monitor their hospital's quarterly PEPPER reports. MetaStar initiated this because they were becoming increasingly aware that compliance officers were not receiving and monitoring this important compliance data that was being compiled.

Quality Improvement Organizations (formerly PRO—Peer Review Organizations) in every state now receive compiled Medicare Inpatient data on fourteen specific Diagnosis Related Groups (DRG) and discharges that have been identified as high risk for payment errors for every hospital in their state. The QIOs in each state are now starting to provide hospitals with their specific data quarterly in a PEPPER report. Some QIOs may have decided to give hospitals a report only on the high and low statistical outliers target areas for the hospital. Compliance officers can identify their facility's QIO by going to the Medicare Quality Improvement Community's website at <http://www.medqic.org/content/qio/qio.jsp?pageID=4>, where there is a list of each QIO by state with website link and phone number. Compliance officers need to inquire with their state's QIO regarding what data is currently being provided through the Hospital Payment Monitoring Program (HPMP), formerly known as Payment Error Prevention Program (PEPP).

PEPPER stands for **P**rogram for **E**valuating **P**ayment **P**atterns **E**lectronic **R**eport. PEPPER is an electronic report containing hospital-specific data for these fourteen target areas. The source of the data reported in PEPPER is Medicare Inpatient PPS discharge data on claims *paid* by CMS. This electronic report was developed under contract with the Center for Medicare & Medicaid Services (CMS) by the Hospital Payment Monitoring Program (HPMP) Quality Improvement Organization Support Center (QIOSC), which is the Texas Medical Foundation (TMF). Quarterly, TMF provides all QIOs with hospital-specific data for inpatient acute care prospective payment system (PPS) hospitals within their state. Just as CMS, through the QIOs, is monitoring a hospital's Medicare inpatient discharge data, the hospital's compliance officer should be monitoring this same data and auditing to correct any potential problems this data may reveal.

Each state's QIO has developed or is in the process of developing mechanisms to provide this PEPPER data to the hospitals within their state. Some QIOs are sending this

data via CD-ROM or disk, while others at this time are providing hard copy reports. Those QIOs providing electronic access must do so through QualityNet Exchange.

In order for compliance officers to access PEPPER reports through QualityNet Exchange themselves, they must obtain an active QualityNet (QNet) Exchange account. Each hospital should have a QNet Administrator, who will have to assist in signing up the compliance officer for the QNet. Compliance officers should talk to their hospital's Quality Management Department to obtain the name of the hospital's QNet Administrator. Most likely, the hospital's Quality Management Department is also using QNet for quality indicator reporting. QNet Exchange provides secure, interactive applications for the exchange and input of privacy data between healthcare providers and the QIO responsible for their state.

Once a compliance officer is registered with QualityNet Exchange, he or she needs to go to the QNet website at <http://www.qnetexchange.org/public/> and click on "Log In". In order to download the report once logged in, click

on “My Work” and then “File Search and Exchange”. It is important to make sure you are at the inbox and the “New” tab. Also, verify the correct Date Range for the quarter you are looking for is set by clicking on “Set Start Date”. Then, click on “Search New Inbox Files” button and your PEPPER report and User’s Guide documents will appear to be downloaded and saved to your hard drive.

Compliance officers should review their PEPPER reports quarterly. In doing so, keep in mind that reports are based upon CMS’s Fiscal Year, which is October through September. If obtaining your reports through QNet, it is important to save each quarter’s report separately to your hard drive because reports provided by your QIO may be cumulative; therefore, you will not be able to review one specific quarter’s data separately. For example, a hospital’s quarter one data is from October through December, quarter two is from October through March, quarter three is October through June, and quarter four is October through September. If you have saved the reports separately, you will be able to determine the changes from the last quarter alone, if needed.

Currently, PEPPER reports are being released nearly two quarters behind by some QIOs. Therefore, compliance officers should consider checking for and accessing their reports on the following schedule:

Fiscal Year 2004

Quarter 3 (October 2003 – June 2004) = released November 2004
Quarter 4 (October 2003 – September 2004) = released February 2005

Fiscal Year 2005

Quarter 1 (October 2004–December 2004) = released May 2005
Quarter 2 (October 2004–March 2005) = released August 2005
Quarter 3 (October 2004–June 2005) = released November 2005
Quarter 4 (October 2004–September 2005) = released February 2006

It is important to discuss the release status and method with each individual QIO.

PEPPER Target Areas

The target areas were selected by CMS because a national analysis of payment errors identified that they were high in either dollars in error or proportion of payment errors.

One-Day Stays

The PEPPER User’s Guide explains that thirty-eight percent (38%) of all admission denials were for admissions with a length of stay of one day. CMS is focusing on one-day stay data as a whole and with a focus around 4 specific diagnosis related groups (DRGs). These target areas were high in dollars in error or number of payment errors for *both* DRG change *and* admission denials.

The first target area, **One-day stays excluding transfers**, gathers specific hospital Medicare data on the number of discharges with length of stay less than or equal to one day excluding patient status 20 (expired), 07 (left against medical advice), or 02 (transfer to another short-term general hospital for inpatient care) compared to all of that hospital’s Medicare discharges excluding patient status 02.

For example, your hospital’s data may indicate that there were 547 one-day stays excluding transfers out of 2766 total discharges, or 19.78 percent. The PEPPER data also will tell you

how your hospital compares to other hospitals in the state by, for example, providing you the “Statewide Comparative Data for Target Proportion.” If your statewide data indicates that the state Median is 13.99 percent, the state 75th percentile is 16.84 percent and the state 90th percentile is 19.59 percent, you know that you are above the 90th percentile for this area.

Data indicating your hospital is above the 90th percentile in an area does not necessarily indicate that there is a problem. The compliance officer needs to evaluate this data in context with the hospital’s efforts and determine if this higher percentile than other hospitals in the state makes sense to your organization. In this case, this could indicate that there are unnecessary admissions related to inappropriate use of admission screening criteria or outpatient observation.

The compliance officer should initiate a review of a sample of one-day stay cases to determine if inpatient admission was necessary or if care could have been provided more efficiently on an outpatient basis (e.g., outpatient observation). Other suggestions provided include having the hospital generate data profiles to identify one-day stays sorted by DRG, physician, or admission source to assist in identification of any patterns related to one-day stays. Compliance officers may wish to evaluate whether one-day stays are identified for procedures that are designated by CMS as “inpatient only” or whether one-day stays are preceded by an outpatient observation stay. The Texas Medical Foundation (Texas QIO) website has an

“The compliance officer’s review of their PEPPER data quarterly, as well as reporting this data to the Compliance Committee, should become an important part of a hospital’s compliance program.”

On the Front Lines (cont.)

excel spreadsheet you can download listing all Inpatient Only Procedures for 2004, as well as other great tools to assist in your compliance efforts.

Other One-Day Stay Target Areas include the following:

- One-Day Stay Transfers
- DRG 127 (heart failure and shock) One-Day Stays
- DRG 143 (chest pain) One-Day Stays
- DRGs 182 (esophagitis, gastroenteritis and miscellaneous digestive disorders age > 17 with complication or comorbidity) or 183 (... without complication or comorbidity) One-Day Stays
- DRGs 296 (nutritional and misc. metabolic disorders age >17 with complication or comorbidity) or 297 (...without complication or comorbidity) One-Day Stays

Readmissions

CMS indicates that Readmissions have been associated with payment errors due to billing errors, premature discharge, incomplete care and/or inappropriate readmission. The PEPPER data compiles the following three types of data about each hospital's readmissions:

- Seven-day readmit to same facility or elsewhere
- Same-day readmit elsewhere
- Same-day readmit to same facility

It will be important for compliance officers to analyze the rate of readmissions in comparison to other hospitals. A low rate of readmission does not indicate a problem; however, a high rate of readmission will warrant further review. A sample of readmissions cases should be reviewed to identify appropriateness of admission, discharge, quality of care and DRG assignment and billing errors, including wrong patient status codes.

High Dollars in Error for DRG Changes

The PEPPER data also focuses on DRG 079, DRG 014, DRG 416, and DRG 475. For these DRGs, if a hospital's data indicates that the hospital is at or below the 10th percentile in the state, this could indicate that there are coding or billing errors related to undercoding. However, if the hospital's data is at or above 75th percentile in the state, this could indicate that there are coding and billing errors related to overcoding. As stated earlier, just because the hospital is in one of these categories does not indicate there is, in fact, a problem. The compliance officer needs to evaluate this data in context with the hospital's efforts and see if this data makes sense to your organization. For example, if your hospital is already performing a 100-percent review for all pneumonia cases and following

up for appropriate documentation, and you are in the 95th percentile for DRG 079, you may in fact be coding correctly and most other hospitals in the state are undercoding.

Other

The last target area in the PEPPER report involves DRGs 239 (pathological fractures and musculoskeletal and connective tissue malignancy), 243 (medical back problems), and 253 (fracture, sprain, strain and dislocation of upper arm, lower leg except foot age > 17 with complication or comorbidity). Data is compiled looking at the number of discharges with DRG equal to 239, 243, or 253 compared to all discharges. A high percentile of these DRGs could indicate there are unnecessary admissions related

to inappropriate use of admission screening criteria or outpatient observation.

The compliance officer's review of their PEPPER data quarterly, as well as reporting this data to the Compliance Committee, should become an important part of a hospital's compliance program. It can be used as a good benchmarking tool as well as to assist in identifying key auditing and training areas. Keep in mind, the long-term goal of the Hospital Payment Monitoring Program (HPMP) is to help inpatient prospective payment system hospitals monitor payment patterns by analyzing data, conducting focused audits, and implementing system changes to prevent payment errors. Compliance officers should work with their QIOs to help ensure accurate billing and high quality of care. Take advantage of what they have to offer. ■

Catherine M. Boerner, JD, is the Senior Vice President at The Moore Consulting Group, LLC. Throughout her consulting career she has specialized in developing and implementing compliance programs including acting as interim compliance officer and privacy officer roles. She has also conducted business office assessments and policy and procedure development, physician contract reviews, and most recently working with all aspects of HIPAA Privacy, Transactions Standards and HIPAA Security. She has had exposure to a wealth of information pertaining to effective implementation strategies.

Ms. Boerner is the Vice President of Programs for HIPAA Collaborative of Wisconsin and is co-chair of the HIPAA Security Taskforce. She was the Vice President of Region V for the Health Care Compliance Association and currently is an active co-chair for the Chicago regional conference. She has had articles published in publications such as Report on Medicare Compliance and the Preventive Law Reporter. She is a frequent speaker across the U.S. on compliance issues and she contributes bi-monthly articles to the Journal of Health Care Compliance and serves on the editorial board for the publication.

She is a graduate of the University of Wisconsin-Madison and the Creighton University School of Law. She is a member of the Wisconsin Bar Association and the American Bar Association.

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Health care IT initiative would improve care, but at a high price, Institute finds

by Catherine Hubbard, MA,
Contributing Editor

Although the Bush administration is promoting adoption of health information technology (IT), current levels of proposed funding are vastly inadequate to achieve his stated goals, according to a PricewaterhouseCoopers Health Research Institute report, "President Bush's Second Term: Prescribing private solutions for the nation's health-care problems."

Proposed federal funding for health IT is not nearly what's needed to get hospitals and providers in compliance with Bush's plan to have providers use electronic medical records (EMRs) within 10 years, according to Sandy Lutz, research director for the Institute, who spoke at a November 9 briefing in Washington, D.C. "There's a worry that this might be an unfunded mandate for providers," she said.

Hospitals will need to spend significant resources integrating their systems, Lutz said. "Even if the hospital has a lot of IT, there's a lot of cost for integrating that technology and getting those systems talking to each other," she said.

Nevertheless, Bush's initiative may provide new opportunities for hospitals to improve their systems, said the Institute. As more hospitals and physicians implement IT systems, they will be seen as having a competitive advantage. And as more health care IT companies enter the market, the cost of systems may fall, it noted.

During his campaign, Bush pledged to lead the health care sector into the digital era. The administration has advocated expanded use of clinical decision support tools, electronic transmission of lab results, access to information about drugs and their interactions, managed care formularies, standard clinical guidelines and bar-coding. To assist in the financing of these initiatives, Bush has proposed

\$100 million for development of health IT in his 2005 budget. He's also appointed a National Health Information Technology Coordinator, David Brailer, who is currently working to set an agenda that may include federal subsidies for technology, said the Institute.

Nevertheless, Lutz said, \$100 million in proposed funding is a tiny fraction of the amount needed to digitize a \$1.6 trillion industry.

For example, The Lewin Group has suggested it would cost between \$27 billion and \$50 billion to implement electronic medical records nationwide. "If Bush pursues aggressive implementation of EMRs, he will have to find funding to make this possible," said the

"Even if the hospital has a lot of IT, there's a lot of cost for integrating that technology and getting those systems talking to each other."

Institute. Under the HIPAA Security Rule, the standardization of electronic claims processing between providers and insurers is only one to two years away, the Institute noted.

From a quality-of-care perspective, providers are supportive of Bush's initiative. "There is no disagreement on promoting provider technology—better technology makes for better healthcare," said the Institute.

Computerized prescribing systems have been shown to cut the risk of patients receiving the wrong medications by 80 percent or more, the Institute said. On the payer side, it noted, technology speeds up transactions and reduces the labor costs associated with the administrative tasks inherent in health care, tasks that consume nearly a quarter of overall costs. Technology also improves patient safety, privacy, and access to information, it added.

Baby-boomers also support the technology and even expect it from their providers, but they do not want

to pay extra for it, said the Institute. Even so, if research states that medical errors are increasing, the public may demand faster movement on these issues, it surmised.

When the final regulations are published, all data interchanges between providers and payers will be standard and fluid, said the Institute. This may eliminate many of the administrative hassles associated with the claims adjudication process for government and commercial payers and providers, it added. The medical community recognizes the benefit of enhanced IT and has already begun to adopt these systems, with five percent of hospitals having some components of electronic medical records in 2003, and 25 percent expecting to begin implementation by 2006, according to the report.

Investments in technology are on the minds of hospital management, said Lutz. A recent survey by the Healthcare Financial Management Association (HFMA) and PricewaterhouseCoopers shows that the three most frequently cited capital projects intended over the next five years are all IT acquisitions, according to the report.

The PricewaterhouseCoopers Health Research Institute report, "President Bush's Second Term: Prescribing private solutions for the nation's healthcare problems," is available at <http://pwc.com/researchinstitute/healthpolicy>. ■

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Letters to the Editor

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

Fraud & Abuse (cont.)

to determine a patient's eligibility for assistance, which would range from full subsidization of health care costs to significant cost-sharing with the patient. ■

OIG Advisory Opinion 04-15, ¶500,118

Physician sentenced for crimes related to false employment of mob member

by Anuradha Gupta, JD,
Contributing Editor

Jude T. Barbera, a Brooklyn, New York-based urologist, was sentenced to six months imprisonment, followed by three years' supervised release, and assessed fines exceeding \$22,000, by the federal district court in the Southern District of New York. This follows Barbera's June 18, 2003, conviction for multiple counts of fraud, theft, and federal tax offenses resulting from his fraudulent employment of an organized crime family member.

Fraudulent employment. A lengthy federal investigation discovered that from 1995 to 2000, Barbera had been paying a salary to Thomas Gelardo, a member of the Luchese Organized Crime Family, even though Gelardo was not actually working at Barbera's medical clinic. Barbera filed corporate income tax returns which contained a deduction for Gelardo's purported salary, causing Barbera to under-report his own income. Gelardo, who was claimed as a bona fide employee, was provided full benefits, including medical insurance, for himself and his family, through the United Food and Commercial Workers International Union (Union). Barbera, who has no prior criminal history, was convicted on eleven counts of a twelve-

count indictment against him, including the following offenses: conspiracy to defraud the United States, conspiracy to commit theft of union funds, aiding and assisting in the preparation and presentation of a false income tax return, health care fraud, mail fraud, and fraud against a health care benefit program.

Total loss calculation. Barbera and the government argued for different measures used to calculate the total loss incurred by Barbera's criminal offenses. Barbera unsuccessfully argued that the "net loss" should be used as the value of total loss, because he had paid back the premiums for the Gelardo family's medical insurance. Although net loss values can be used under some circumstances, in fraudulent scheme cases, money returned cannot be used to offset the gross loss amount, because that money was paid in furtherance of the fraudulent scheme. In addition, the U.S. Sentencing Commission Guidelines (U.S.S.G.) allow an increase in loss to be added where the total loss exceeds \$5,000. Since the actual loss to the Union fund totaled \$14,935.69, it was appropriate under the U.S.S.G. to increase the offense level by four levels. The Government was unable to prove, however, that Barbera intended to collect the face value of the insurance policies, preventing an additional \$20,000 from inclusion in the computation of loss.

No enhancement. The district court also found that the Government could not prove the necessary elements under the U.S.S.G. to justify applying a four-level enhancement for aggravating role. Only Barbera and Gelardo were found to have knowingly participated in the scheme, although three other individuals had participated in the fraudulent conduct. Despite

testimony by Barbera's office manager, bookkeeper, and brother (who occasionally signed payroll checks) that they never saw Gelardo in the office, the court found that it was not clear that they had the requisite "specific knowledge" under the U.S.S.G. The Government was similarly unsuccessful in proving that the criminal activity was "otherwise extensive," a finding that would have justified the enhancement. ■

U.S. v. Barbera, S.D.N.Y., October 27, 2004, ¶214,589

DOJ announces Adventist Health System and ambulance company settlement

by Gené Stephens Connolly, JD,
Contributing Editor

A health care corporation, three affiliated hospitals and a management company that administered ambulance operations agreed to pay the U.S. \$20.3 million to settle allegations that the entities overcharged Medicare for ambulance transports for patients that were not medically necessary. The government further alleged that a regional emergency services group, in connection with the hospitals, created false physician certifications regarding the medical necessity of the ambulance transports, which caused false claim submissions to Medicare between the years of 1993 through 2000, and between 1993 through 1997 for another medical center. The qui tam relator, who worked as an emergency medical technician, will receive approximately \$1.9 million as part of the government's settlement. A second relator will receive an award of one-half million dollars. ■

CCH Chicago Bureau, November 1, 2004

HIPAA Security Guide

One of the most important facets of healthcare compliance is the challenge of being compliant with the Health Insurance Portability and Accountability Act (HIPAA). CCH's *HIPAA Security Guide* is designed to be an expert yet straightforward resource to help you meet the HIPAA compliance challenge.

Electronic forms and news updates available over the internet

The *HIPAA Security Guide* is not limited to print only, but delivers the power of an online research tool as well. It delivers current HIPAA news and updates while the online research tool provides forms to assist in developing policies and procedures, targeted for HIPAA compliance.

