CCH Healthcare Compliance LETTER

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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.

HIPAA survey: Imperfect TCS compliance; Security efforts lagging

by Jennifer Carsen, JD, Contributing Editor

The Healthcare Information and Management Systems Society (HIMSS) and Phoenix Health Systems (Phoenix) have released their quarterly HIPAA survey for Fall 2003. The survey was conducted two weeks prior to the Transactions and Code Sets (TCS) compliance deadline of October 16 and emphasized the healthcare industry's TCS compliance progress. The survey focused on readiness efforts, prioritization of specific electronic transactions, the impact of the Contingency Plan offered by CMS, and the impediments to compliance faced by each industry segment.

TCS compliance. The survey reports that, since the Summer 2003 Survey, fewer payers, vendors, and clearinghouses predicted readiness to transmit all required HIPAA transactions. Only 53 percent of payers (down from 62 percent in the Summer 2003 Survey), 41 percent of vendors (down from 46 percent), and 41 percent of clearinghouses (down from 63 percent) expected to be able to accept and transmit all transactions by the October compliance deadline. Eighteen percent of providers reported they would be able to transmit all transactions by the deadline (providers were not asked about this issue in the previous survey).

The Fall 2003 Survey also revealed decreased internal transactions testing—45 percent of all industry segments, down from 77 percent in Summer 2003.

Many participants felt CMS should maintain its Contingency Plan beyond the official October deadline. Forty percent of providers and 23 percent of payers indicated CMS should maintain it for up to 90 days after the deadline; 52 percent of providers and 59 percent of payers wanted the plan extended up to six months or longer. However, the existence of the Contingency Plan did not generally affect organizations' actions with regard to TCS; 58 percent of providers said they were unaffected, with 23 percent saying they were affected "somewhat."

"Resolving issues with third parties" was ranked by a third of participants as the number one obstacle to HIPAA compliance. "Interpretation of HIPAA regulations" was second, followed by "not enough time." Clearinghouses (91 percent) and payers (70 percent) said they had communicated "all" or "much" information to their clients regarding HIPAA compliance. However, only 51 percent of providers felt clearinghouses were "forthcoming," and 44 percent of providers said payers were "somewhat forthcoming."

Privacy. The HIPAA Privacy Rule deadline passed in April 2003, but all surveyed industry segments reported imperfect compliance, ranging from 73 percent for vendors to 88 percent for payers. Vendors were actually down from

81 percent last quarter, making them the least privacy-compliant segment of the healthcare industry.

The survey reports that many "publicly visible" HIPAA privacy requirements have been implemented, such as providing the Notice of Privacy Practices, obtaining Patient Authorizations, and enabling patients' rights to review, amend, and restrict access to medical records. However, less visible requirements—such as establishing required Business Associate Agreements and pitting privacy compliance monitoring programs into place—have not been implemented as fully.

The survey concludes that those with access to protected health information (PHI) may not yet be protecting patient privacy to the extent necessary. More than half of providers and about half of payers reported the occurrence of privacy breaches.

Security. The security efforts of many respondents are lagging. Almost half of providers and payers reported they would not be fully compliant by the April 2005 Security Rule deadline. Moreover, 12 percent of providers and 22 percent of payers have not yet met the security requirements mandated by the Privacy Rule, which should have been completed by April 2003. Most survey respondents predicted completion of security remediation at the end of 2004 or beginning of 2005.

Most respondents had few security breaches—the vast majority reported fewer than five, and between 59 percent and 75 percent reported no breaches at all. However, 70 percent of providers were affected by the Internet worm attacks of August 2003, with 28 percent of those affected "significantly" or "severely."

Methodology. The HIMSS/Phoenix survey was conducted anonymously over HIPAAdisory.com, a website run by Phoenix, during the first two weeks of October 2003. A total of 428 healthcare industry representatives responded. Eighty-three percent of respondents held an "official" role within their organization for HIPAA compliance, with 29 percent working specifically in the compliance/security arena.

A report of the HIMSS/Phoenix Health Systems survey is available at http://www.hipaadvisory.com/action/surveynew/fall2003.htm. ■

CCH Chicago Bureau, December 1, 2003

AHA urges HHS to reduce Privacy Rule paperwork burden

by Sharon Sofinski

Lawrence Hughes, regulatory counsel and director of member relations for the American Hospital Association (AHA), recently testified before the Department of Health and Human Services (HHS) National Committee on Vital and Health Statistics Subcommittee on Privacy and Confidentiality, urging HHS to quickly issue rule changes to reduce the paperwork burden on hospitals and to provide additional guidance on Privacy Rule compliance.

Paperwork burden. Hughes testified that hospitals' experiences with Privacy Rule compliance so far indicate that some aspects of the Rule may be harmful to patient care and hospital operations. The current HIPAA requirements for accounting of disclosures of information "will require hospitals to create a burdensome paperwork system to account for these numerous and frequent disclosures of information reported to public authorities," only adding to the regulatory paperwork burdens hospitals already shoulder.

Hughes asked the Subcommittee to recommend that HHS modify "without delay" the regulatory language of the Privacy Rule to eliminate this paperwork burden. Since HHS is limited to modifying the Rule annually, in the interim he proposes that HHS "carve out distinct categories of disclosures that arguably should be excluded entirely from the accounting requirements or for which an alternative simplified form of accounting should be allowed."

Business associate requirements. Hughes also recommends that HHS issue guidance clarifying who qualifies as a business associate and when business associate agreements are necessary. Further, the AHA believes that HHS should streamline the business associate process "by eliminating the burden on hospitals of negotiating hundreds or thousands of business associate agreements by designating private entities to certify business associates as HIPAA compliant."

Lastly, Hughes urges HHS to issue guidance to hospitals detailing how to balance Privacy Rule obligations with their responsibility to ensure patient safety: "The AHA believes a hospital's patient safety obligations supersede the individual employee's privacy rights in cases where patient care and safety are threatened."

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Hospital and radiology groups to pay $1.6 million for false claims

by Sharon Sofinski

The United States Attorney for the District of Maryland announced that Western Maryland Health System, Sacred Heart Hospital, Memorial Hospital and Medical Center, and three radiology groups—Summit Radiology, Centre Radiology, and Tri-State Radiology—have agreed to pay a $1.6 million settlement to resolve false claims allegations.

In 1999 a former radiologist and chairman of diagnostic radiology at Memorial Hospital, Dr. Keith S. Pumroy, filed a lawsuit under the qui tam provisions of the False Claims Act after he discovered billing irregularities at Sacred Heart Hospital and Summit Radiology. (Sacred Heart Hospital and Memorial Hospital merged in 1997). The United States intervened in the civil action in 2003.

From 1996 to 2002, Western Maryland Health System, which operates Sacred Heart and Memorial, and certain radiologists billed Medicare for thousands of radiological exams and procedures they performed that had not been ordered by treating physicians and were medically unnecessary. The unnecessary procedures included more extensive diagnostic radiology exams than were ordered by physicians. Two of the defendants also billed Medicare for diagnostic mammograms when screening mammograms were actually performed.

Furthermore, some of the unnecessary procedures were risky investigational surgeries such as angioplasties and stenting of carotid arteries.

Pumroy, aware that the merged entities would adopt these fraudulent practices, refused to be affiliated with them. "Dr. Pumroy chose to start a new practice in a new town rather than participate in fraud," said Bonny Harbinger, an attorney with Phillips & Cohen LLP, which represents Pumroy. "For a well established physician to take such a step shows how wrong he thought they were."

The hospital and radiology groups also defrauded Medicare by:

- unbundling (separately billing services that were already included in more comprehensive charges), and
- upcoding (charging for more expensive services when less expensive ones were performed).

Sacred Heart Hospital will pay $1.1 million of the settlement; Summit Radiology will pay $363,345; and Centre Radiology and Tri-State Radiology will pay $57,385. In addition to the monetary settlement, the defendants have agreed to enter into corporate integrity agreements with the Office of Inspector General. The U.S. Attorney's press release is at http://www.usdoj.gov/usao/md/press_releases/press03/WMHSsettlepr1.pdf. ■

CCH Chicago Bureau, December 3, 2003

On your toes: Staying on top of compliance trends

by Nancy Shalowitz, MHA, JD

In the beginning, there was hospital risk management. Risk managers handled everything from hospital safety to litigation management. Some risk managers were nurses, some attorneys, and others trained on the job. Then federal laws were enacted that regulated self-referral activity and proscribed transactions and activities that could be perceived as kickbacks in exchange for referrals. What we now know as Stark and anti-kickback laws created a new meaning for risk management. The government called it "compliance" and created Compliance Guidelines that changed the business of health care.

Even now, recent developments in the law have made the Compliance Officer's job more complex. Although still the most ominous, anti-kickback, or fraud and abuse, scrutiny is not the only game in town. The challenge for Compliance Officers is how to stay informed about laws that affect their institutions. The following are a few of the most talked-about laws of which Compliance Officers need to be aware.

Anti-Kickback Laws

The federal statute prohibits kickbacks in exchange for referrals. The statute defines kickbacks, or illegal remunerations, in part, as knowingly and willfully soliciting or receiving any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a federal health care program.[1] The regulations provide "safe harbors" into which a transaction may fit, thus providing protection for the parties.[2] Violation of anti-kickback laws can subject both or all parties to the transaction to civil monetary and/or criminal penalties. The Office of Inspector General (OIG) of the Department of Health and Human Services enforces these laws. Of significant note is the recent focus on the pharmaceutical industry and the federal government's adaptation of PhARMA compliance guidelines. The pharmaceutical industry has now delineated its own set of risk factors to be addressed in addition to the risk factors outlined in the general fraud and abuse compliance guidelines.

"Stark" Anti-Self Referral Laws

The Medicare program found that it was paying out significant reimbursement to laboratories and other ancillary entities in which referring physicians had investment interests. Medicare's working assumption was that the investment interest would be enough of an incentive for physicians to refer only to those entities in which they had a financial interest or to over-utilize unnecessary services for financial gain. The Stark law, therefore, was enacted to prohibit physicians from making referrals to entities in which they or an immediate family member had a financial interest and for which payment would be made by Medicare.[3] The law also outlines exceptions similar to the safe harbor provisions referenced above. The enforcement and penalties are also similar to the Anti-kickback law. In addition to federal law, many states have enacted anti-self referral legislation.[4]

Privacy Laws

Although a myriad of state privacy laws (and confidentiality acts) have existed for years, HIPAA has created the latest stir. The privacy provisions of HIPAA require that health care providers, health plans and clearinghouses protect identifiable patient information by instituting a series of measures including de-identifying data, entering into business associate arrangements, and requiring waivers and consents for use of information from patients.[5] Penalties for violation of state law vary by law and by state. HIPAA is enforced by the Office for Civil Rights. Violation of HIPAA could subject offenders to civil money penalties.

Sarbanes-Oxley Act

The purpose of this new law is "[t]o protect investors by improving the accuracy and reliability of corporate disclosures made pursuant to the securities laws, and for other purposes."[6] This federal corporate responsibility law was drafted for public and for-profit entities; the application to non-profit (health care) institutions is becoming clearer with time. Although enforced by the Securities and Exchange Commission (SEC) and referring to "investors," this law has a direct impact on all health care organizations because of board accountability,

attorney involvement, fiscal responsibilities to bondholders, and duties owed to the general public with respect to the operational integrity of the institution. We have already seen criminal actions brought against corporate officers of proprietary healthcare companies; non-profits are soon to follow. With health care specific laws expanding their scope of violations and general accountability laws stretching applications to health care, how does the Compliance Officer keep up with current developments? There are a number of ways in which the Compliance Officer may learn about new developments in these areas.

1. *Periodicals.* Most trade organizations include a newsletter as a benefit of membership. In addition, there are a number of independent resources that publish regular updates and articles of interest on current topics (such as CCH's Healthcare Compliance Letter). When evaluating periodicals, it is important to consider whether the content is timely, the frequency of distribution, and the qualifications of the author/contributors. It is also important to realize the cost-benefit of a subscription to a reliable periodical that provides value in your job. Some organizations provide an electronic newsletter as an alternative to a print version. Some law, consulting and accounting firms with health care practices send electronic updates to clients and others on their mailing list. This service is free of charge. Contact local firms to put your name on mailing lists for free newsletters; if you find that the newsletter is not worthwhile for you, you can always remove your name from the list.
2. *Professional organizations.* Aside from the organizations whose membership shares your job description, it is also important to consider other organizations or associations that may provide you with a different level of information. Some of these associations are nationally based (such as the American College of Healthcare Executives) and some are local (such as the Chicago Health Executives Forum). Many organizations that seem to have limited membership may allow associate members who are not, for example, hospital CEOs or attorneys. Consider the content of their meetings, the ability to network, periodicals as benefits, and whether the organization is meeting your professional needs. If all of these criteria are acceptable to you, then membership is worth the cost and costs do vary.
3. *The Web.* There is so much data speeding along the information superhighway that it is almost difficult to parse through the volumes of sites to find the answer to your query. The flip side is that there is so much information that you are likely to find an answer to your questions online. Be sure to include all aspects of your query, however, in your search as it is very common for more than one law to apply to a situation, and, in most instances, several laws must be read together to provide you with a complete answer. Government (state and federal) websites are especially helpful, as many include phone or e-mail contact information for specific inquiries. For example, HIPAA information may be found at http://www.hhs.gov/ocr/hipaa/. The Web is an inexpensive, but potentially time-consuming route for gathering information.
4. *Meetings.* When you receive fliers for seminars, make sure that the program is worth your time and your institution's money. Before committing to the event, check the sponsor of the event, the qualifications of the speakers, the time frame (a two-hour program or an all-day program), whether you will receive printed materials, and whether the intent is to push a product (e.g., a computer program, books, staffing). Law firms with significant health care practices often host briefings for clients that provide an update of current laws and case law. Meetings may be productive networking opportunities at which participants can share ideas and raise questions in the educational sessions as well as at coffee breaks.
5. *Formal education.* Many graduate schools offer some form of continuing education for non-degree seeking individuals. If you are interested in a particular topic, ask a local business school, law school, or health administration program whether they offer instruction in that area. Some schools provide mini-courses, some offer full-semester sessions, and some sponsor individual events at which speakers focus on one topic. The cost for continuing education in this venue is higher than in most of the previous options, but may provide a greater return in the long run. Ask your employer about tuition reimbursement benefits or partial payment for continuing education. An academic institution can provide a stimulating means to meet your needs and a prime networking location.
6. *Networking.* There is no substitute for talking with people. Call a former classmate. Ask friends if they know of "anyone who". Contact a former teacher. Seek the perspective of a colleague in a related discipline. There are many venues in which networking can take place, but most of the follow-up is done by phone or e-mail at your instigation. To learn non-proprietary information about how another institution addresses specific issues is invaluable; and, although its solution may not meet your institution's needs, it broadens your scope of knowledge and your perspective.

Part of networking is also sharing your information with others. Critical to the success of any compliance program and to your role is communication/education of everyone affiliated with your institution, including your Board. Provide managers and Board members with copies of updates that you have received or with synopses of articles. If you are not regularly on the agenda of Board or management meetings, ask to present periodic updates. This will keep you fresh and will provide valuable in-

University of Illinois pays $2 million to settle whistleblower suit

by Jennifer Carsen, J.D., Contributing Editor

The University of Illinois has paid $2 million to settle a lawsuit alleging the university's Medical Center at Chicago improperly diagnosed and hospitalized certain patients in the late 1990s to allow them to become eligible sooner for liver transplants.

The State of Illinois and the United States intervened in a whistleblower lawsuit brought in 1999 by Dr. Raymond Pollak, a liver transplant surgeon and professor at the University of Illinois College of Medicine, alleging fraudulent practices in liver transplant programs.

Patients needing a liver or other organ are assigned a medical status level to determine their priority for transplant. In the late 1990s, due to a shortage of available livers, patients not meeting the two highest status levels were less likely to receive a transplant under ordinary circumstances. Pollak's suit claimed the University of Illinois at Chicago (UIC) improperly diagnosed and hospitalized patients and exaggerated the seriousness of their medical conditions to liver Status 1 (confined to intensive care and likely to die within seven days) and liver Status 2A (chronic liver disease with sudden deterioration, in intensive care and likely to die within seven days).

The settlement agreement contends the U.S. has certain civil claims against UIC for submitting medically unnecessary and falsely diagnosed claims to Medicare and Medicaid between 1995 and 1998. The agreement provides that UIC denies and claims valid defenses to all of the allegations in the lawsuit, and maintains that its conduct "was at all times appropriate and lawful." UIC says it settled solely to avoid the expense, delay, and uncertainty of protracted litigation. At the same time, the settlement does not concede that the claims of United States, the State of Illinois, and Pollak were ill-founded.

"In addition to the payouts, the settlement agreement contains several integrity requirements effective for three years, including a provision that the UIC Medical Center must continue to implement its existing Corporate Compliance Program."

The University paid the United States $1,001,645.39, of which the government paid $250,411.35 to Pollak. UIC also paid $751,234.04 to Illinois, and separately paid Pollak $250,411.35. Pollak's share of the total settlement proceeds was 25 percent—the maximum allowed by law.

In addition to the payouts, the settlement agreement contains several integrity requirements effective for three years, including a provision that the UIC Medical Center must continue to implement its existing Corporate Compliance Program. The Medical Center must also

- promptly report and repay overpayments by federal health care programs,
- report discovery of any program violations,
- submit annual reports certifying compliance with integrity provisions,
- cooperate with any government audits or inspections, and
- retain reimbursement records from federal health care programs for four years.

If UIC fails to comply, it will be subject to agreed-upon monetary penalties.

As part of the agreement, the U.S. Department of Health and Human Services Office of Inspector General will not take any administrative action to exclude UIC from Medicare, Medicaid, or other federal health care programs.

The U.S. Attorney's press release is at http://www.usdoj.gov/usao/iln/pr/2003/pr111703_01.pdf. ■

CCH Chicago Bureau, November 25, 2003

formation for your colleagues. Most important, ask questions. One thing always leads to the next you may find important essentials from a source not otherwise contemplated. ■

Nancy Shalowitz, MHA, JD, a member of the Editorial Advisory Board of the CCH Healthcare Compliance Letter, is the Director of Graduate Programs at the De-Paul University College of Law where she also teaches courses in health care law. She is an attorney and mediator, focusing her practice on health care issues. Prior to becoming an attorney, Ms. Shalowitz was a hospital administrator and management consultant.

1 42 U.S.C. 1320a-7b.

2 42 CFR 1001.952 (a) through (v).

3 42 USCS § 1395nn. The "Stark" laws are named for Rep. F. "Pete" Stark who sponsored the law.

4 See, e.g., 225 ILCS 47/1 et seq., the Illinois Health Care Worker Self-Referral Act.

5 Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191; Privacy Rules at 45 CFR Parts 160 and 164.

6 Public Law 108-44.

Quality management and compliance should be integrated, experts say

by Catherine Hubbard, MA, Contributing Editor

In light of recent ethics scandals in the health care industry, developing a fully integrated compliance program is a best practice. The program should include quality management, ethics-based measures and technical compliance measures and should be applied throughout the organization. In addition, managers should involve both lawyers and compliance officers when dealing with an investigation, according to experts who spoke at the Fall meeting of the Health Care Compliance Association/ National Healthcare Lawyers Association.

Compliance officers should incorporate quality management into all of their compliance efforts, according to experts who spoke at a recent conference in Washington, D.C. "You should have a common denominator of quality indicators that can be pulled into a compliance reporting program. They shouldn't be separate functions," said Linda Hellier of Deloitte and Touche, Los Angeles.

Furthermore, Hellier said, officers should also coordinate compliance programs throughout their entire health care organization. She recommended health care organizations conduct periodic self-assessments of their compliance programs at all levels--from the governing board to employees. "Take a look, interview staff in focus groups or other anonymous methods so you can find out what individuals know about your compliance program, how they can access it and whether it's really meaningful to them at their job and their level."

The governing board and the senior management should show a very consolidated lead and fully embrace a compliance program, said Hellier. "It's not going to work if you don't have a strong and effective management support of your compliance program," she said.

Sheryl Vacca, also with Deloitte and Touche, added that entities should measure the benefit their compliance programs provide. "Measure the rate of return on investment on your organization. That needs to be at the forefront of your activities." She recommended companies educate everyone in the organization from the lowest to the highest level. "The return on investment is a message that absolutely has to get out. It needs to be part of the business strategy." If there isn't a demonstrable return to the organization, directors will question the value of your compliance program, she warned.

The organization also needs to "create a culture of compliance," said George C. Demos, chair of the health care law practice at O'Melveney and Myers, Los Angeles. In addition, he said the governing board needs to communicate the message, and teach ethics-based principles and decisions during training programs. "These ethical standards must flow from the top."

"If there isn't a demonstrable return to the organization, directors will question the value of your compliance program."

Investigations and disclosures. Also at the conference, David Deaton, O'Melveney and Myers, Los Angeles, recommended companies accurately and thoroughly document all of the training and auditing activities, as well as the complaints and resolution of complaints. "The resolution is very important. If you do not document the timely and effective resolution of those complaints, your losing credit that's very well deserved." Companies need to develop a strategy for documenting board decisions, while protecting the business judgements of directors, he said. "You want to show they had some deliberative process on compliance issues, but not set forth privileged information."

In addition, stakeholders need to see the emphasis the organization has put into developing its compliance program, Demos emphasized. "You want to be able to clearly demonstrate that you have put in substantial resources and effort into the development of your compliance program," he said. "If you are ever investigated," he noted, "the Office of Inspector General is willing to work with providers demonstrate they took compliance seriously from day one."

Demos said organizations should develop proactive strategies with both inside and outside counsel before facing an investigation. "Work with counsel and develop procedures and strategies that take into account factors such as the laws that cover a providers' disclosure obligations," he said. "Build that sense of awareness into your procedure."

Company leaders should consider the mechanics of what to disclose, when to disclose and whom to disclose to, including the OIG, and the regional offices or the national office of the Department of Justice, said Deaton. "You have to know ahead of time which complaints warrant an investigation, which complaints you are going to move to legal counsel, which compliance issues should be disclosed," he said. "This is a very a detailed discussion that you together with your organization and legal counsel need to have," he told the group of mostly compliance officers. "These are very difficult issues, but if you haven't thought through these, you're going to be fumbling around."

Demos concluded that companies need to rely on both the lawyer and the compliance officer. "Compliance officers and lawyers need to work together."

Follow through. A common weakness in health care organizations is lack of follow through on compliance programs, said Vacca. It's not enough to identify the problems and determine a plan for resolving them, she said, noting the compliance plan needs to be enforced. "You need follow through." ■

CCH Washington Bureau, December 3, 2003

18-year exclusion found reasonable

by Richard C. Sarhaddi, Esq., Contributing Editor

In April 1999, Anwar Yamini, Sr., owner of Medco Physicians Unlimited, Inc. (Medco), was indicted in the Illinois Circuit Court of Cook County for, among other things, one count of theft/deception over $100,000. The indictment charged that from February of 1996 through June of 1998, Yamini caused Medco to submit fraudulent bills totaling $600,000 to the Illinois Medicaid Program (IMP) for multiple-family group therapy sessions that Medco never provided. Yamini pleaded guilty, and was convicted of vendor fraud and false statements. He was sentenced to 30 months of supervised probation, and was ordered to pay $600,000 in restitution to the IMP. Several months later, the HHS Office of Inspector General notified Yamini that he was being excluded from participating in Medicare, Medicaid, and all other federal health care programs for a period of 18 years.

Yamini appealed the Inspector General's decision, arguing that (1) the Inspector General did not have the authority to exclude him because his criminal offense was not related to the delivery of a health care item or service under §1128(a)(1) of the Social Security Act (the Act); and (2) the 18-year exclusion is unconstitutional because 18 years is punitive and excessive. The Departmental Appeals Board (DAB) found that Yamini's criminal offense and subsequent conviction were related to the delivery of a health care item or service under the Medicare/Medicaid programs within the meaning of §1128(a)(1) of the Act because, according to the charges in his indictment, Medco, under Yamini's direction, submitted fraudulent claims seeking reimbursement for services never rendered to Medicaid patients. In addition, the Board found that the Inspector General was authorized to extend Yamini's exclusionary period beyond the five-year minimum, to 18 years, due to two aggravating circumstances, (1) that Yamini's criminal acts were committed over a period of one year or more (two years in Yamini's case), and (2) that his actions resulted in financial loss to a government program or to one or more entities of $5,000 or more. In determining that Yamini's actions resulted in a loss of more than $5,000 to the IMP, the Board relied on the court's restitution order, ordering Yamini to pay IMP restitution in the amount of $600,000.

The Board explained that the nature of §1128 of the Act is remedial and its purpose is not to punish the excluded individual, but to protect federally funded health care programs and beneficiaries and recipients of program funds. Further, the Board stated that the length of an exclusion is reasonable if it is necessary to protect programs and their beneficiaries and recipients from untrustworthy individuals. The trustworthiness of the excluded individual is the key factor in assessing whether an exclusion is reasonable. In light of the evidence that Yamini caused a $600,000 loss to the IMP as well as the absence of mitigating factors, the Board found that Yamini's 18-year exclusion is reasonable and sufficient to guard federally funded programs, their beneficiaries, and similar individuals from his untrustworthiness. ■

Anwar Yamini, Sr. v. The Inspector General, ¶180,074

Formal disciplinary proceeding requirement fulfilled in P.A.'s exclusion

by Richard C. Sarhaddi, Esq., Contributing Editor

In June of 2003, the Idaho Sate Board of Medicine (Board) and April Ann May, P.A., signed a stipulation and order (stipulation) stating that the Board had received information that May had engaged in excessive use of alcohol, which could constitute violations of the Idaho Medical Practice Act because her alcohol use could compromise her ability to practice medicine with reasonable skill and safety to patients. In lieu of instituting a formal investigation and hearing regarding the matter, May and the Board entered into the stipulation to craft an acceptable procedure for dealing with May's alcohol problem. Under the stipulation and order, May promised to: (1) execute a contract with a physician health program and fully comply with its terms and conditions; (2) submit to random urine or blood screenings for drugs and alcohol; and (3) provide all employers, partners, administrators, and chiefs of staff at each hospital with a copy of the stipulation. Subsequently, May violated the stipulation and order, and later signed an additional stipulation stating that she would (1) surrender and not renew her physician assistant license and (2) not practice as a physician assistant in Idaho for a period of three years. Shortly thereafter, May was excluded by the Inspector General (IG) from Medicare and other federally funded programs, including state Medicaid programs, until she regained her physician's assistant license.

May then appealed her exclusion to the Departmental Appeals Board (DAB). The issue was whether May surrendered her license to provide health care in Idaho while a formal disciplinary proceeding was pending against her relating to her professional performance. May argued that the process that culminated in her surrendering her license was not a formal disciplinary proceeding, but rather a compliance proceeding intended to enforce the earlier stipulation. The DAB, however, found that the entire process that resulted in May's license surrender satisfied the statutory requirement of a "formal disciplinary proceeding" and concerned her professional performance as a physician assistant because, had she not executed the stipulations, she would have been subject to formal disciplinary proceedings. Therefore, the DAB found that May surrendered her physician assistant license in Idaho during the pendency of a formal disciplinary proceeding against her which concerned her performance as a physician assistant in Idaho. Accordingly, the IG was authorized to exclude her for the period in which May's license to provide health care was surrendered pursuant to Sec. 1128(c)(3)(E).

April Ann May, P.A. v. The Inspector General, ¶180,073