

MEDICARE COMPLIANCE

Weekly News and Analysis on New Enforcement Initiatives and Billing/Documentation Strategies

Contents

- 3** Contract Problems Pose Risk as Feds Push Stark Enforcement
- 4** Table: CMS's Top Risk Areas for Hospitals Under HPMP
- 5** Compliance Chronicle
- 7** IRS Surveys Tax-Exempt Hospitals on Their Charity Care Practices
- 8** News Briefs

PUBLISHER'S NOTE:
RMC will not be published next week. The next issue will be dated July 17.

Managing Editor
Nina Youngstrom

Assistant Editor
Eve Collins

Editor
Neal Learner

Executive Editor
James Gutman

As Errors for One-Day Stays Climb, QIOs Launch Projects Aimed at Observations

Inappropriate one-day stays continue to waste Medicare money and frustrate hospitals. As the numbers worsen, quality improvement organizations (QIOs) are sinking their teeth into this problem with greater intensity under the Hospital Payment Monitoring Program (HPMP), launching new projects to examine causes and help hospitals implement interventions to reduce medically unnecessary one-day stays. In fact, five of the 13 new targets of HPMP — CMS's major vehicle for reducing inpatient acute-care hospital payment errors — relate to one-day stays (see table, p. 4).

For example, "Reimbursement for one-day stays in Michigan has increased 65% since 2000, so it's [very important] to get this under control," says Kristy Wietholter, project manager for HPMP at MPRO, the QIO for Michigan. MPRO is just beginning a study of one-day stays under HPMP. QIOs across the country carry out HPMP under contract with CMS.

CMS has a study under way to examine factors contributing to payment errors, one of which is improper one-day stays. So far, CMS knows that "80% of admission denials were due to the fact that the patient's medical condition did not require an inpatient level of care," says Kim Hrehor, project manager of the TMF Health Quality Institute's (formerly Texas Medical Foundation) HPMP QIOSC, which provides support to CMS and QIOs nationally under HPMP and is conducting the payment-error analysis for CMS. "That is really the big issue. The patient could be treated at a lower level of care [such as observation], but that is just not what's occurring." That means there's a lack of medical necessity or a lack of documentation to support the admission.

continued on p. 5

Tenet Settles Fraud Case for \$900 Million; Consultants Are Still a Target, Expert Says

Tenet Healthcare Corp. has agreed to pay perhaps the largest health fraud settlement ever — \$900 million — with the lion's share stemming from alleged pre-2003 outlier payment abuses. But Tenet's alleged other "unlawful billing practices," according to the settlement announced by the Department of Justice (DOJ) June 29, touch on many compliance risk areas that hospitals face — DRG upcoding, physician financial relationships, modifier billing and mammograms among them.

Tenet did not admit liability or wrongdoing in the settlement. The various Tenet hospitals accused of billing abuses also deny them.

The \$900 million civil settlement — which Tenet will pay over four years — breaks down into a \$725 million payment and the hospital chain's agreement to waive its right to \$175 million worth of Medicare reimbursement for past services, according to a Tenet statement. Because it's global, the settlement resolves all outstanding cases against Tenet and all of its entities in various jurisdictions. The case is partly based on several whistle-blower lawsuits filed over the years against Dallas-based Tenet.

continued

Tenet is the second hospital company to settle allegations in June of outlier payment abuse. Saint Barnabas Corp. in New Jersey agreed to pay \$265 million to resolve false claims allegations stemming from outlier overpayments (*RMC 6/19/06, p. 1*). "It seems like the government is expanding the outlier issue beyond Tenet and looking at other facilities," says Washington, D.C., attorney Lena Robins.

The settlement should make people in the legal/consulting arena nervous, says attorney Gabriel Imperato, who, like Robins, was not involved in this case. The settlement requires Tenet to give DOJ all documents related to the underlying allegations in the case—including documents protected by attorney-client privilege. "[DOJ] may be looking at the kinds of advice Tenet got about these issues, and there's the potential to hold consultants [including attorneys] accountable for issues they advised Tenet about," such as tainted physician

relationships, and reimbursement and cost-report matters, says Imperato, who is with the Fort Lauderdale, Fla., offices of law firm Broad and Cassel.

Tenet Advisers May Still Be Target

"I wouldn't assume this game is over yet for Tenet advisers, though the Tenet settlement is complete," he says, noting that the government insisted on waiver of attorney client privilege and production of documents after the settlement with Tenet was concluded.

But the privilege waiver as an enforcement strategy just got a setback in a federal case involving consulting firm KPMG. A U.S. District Court judge in Manhattan ruled June 27 that certain DOJ polices for prosecuting corporate organizations potentially deprived individuals, such as employees, of their Fifth Amendment right to due process and Sixth Amendment right to counsel, Imperato says.

Here are key categories of allegations settled, according to the settlement:

◆ **Outlier payment abuse (accounting for \$788 million of the settlement amount):** The Tenet settlement resolves allegations that from Oct. 1, 1995, through Aug. 7, 2003, Tenet entities allegedly collected undeserved outlier payments, which are supposed to be reserved for extremely sick, expensive-to-treat patients, by inflating charges "substantially in excess of any increase in the costs associated with that care" and billing for services not provided.

◆ **DRG upcoding (\$46.88 million of the settlement amount):** The settlement contends that certain Tenet hospitals inappropriately billed Medicare for DRGs 79, 106, 124, 415, 416, 475 and 483 between January 1992 and Dec. 1, 1998.

◆ **Physician relationships (\$47.533 million of the settlement amount):** The settlement alleged Stark violations led to false claims submissions.

◆ **Tiered charges (\$822,577 of the settlement amount):** Tenet and the settling hospitals submitted Medicare claims "that used higher charges for inpatient than outpatient services, when those charges were required to be uniform," the settlement states. This allegedly occurred between January 1996 and September 2005.

◆ **Allegations against specific hospitals, such as:** (1) Centinela Hospital Medical Center allegedly billed for medically unnecessary cardiac catheterizations from 1999 to 2005 (no dollar amount stated); (2) Desert Regional Medical Center allegedly billed Medicare for care provided at its cancer center with modifiers 25, 27 and 59 and mammogram codes that were inaccurate and triggered excessive payments, and billed for diagnostic lab and imaging that lacked sufficient documentation, the settlement states. This occurred between January 1997 through May 2004 (\$452,417 of the settlement).

Report on Medicare Compliance (ISSN: 1089-6872) is published 45 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

Copyright © 2006 by Atlantic Information Services, Inc. All rights reserved. No part of this publication may be reproduced or transmitted by any means, electronic or mechanical, including photocopy, FAX or electronic delivery without the prior written permission of the publisher.

Report on Medicare Compliance is published with the understanding that the publisher is not engaged in rendering legal, accounting or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought.

Managing Editor, Nina Youngstrom; Assistant Editor, Eve Collins; Editor, Neal Learner; Executive Editor, James Gutman; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Laura Baida; Production Coordinator, Melissa Muko.

Call Nina Youngstrom at 800-521-4323 with story ideas for future issues.

Subscriptions to *RMC* include free e-mail delivery in addition to the print copy. To sign up, call AIS at 800-521-4323. E-mail recipients should whitelist aisalert@aispub.com to ensure delivery.

To order **Report on Medicare Compliance**:

- (1) Call 1-800-521-4323 (major credit cards accepted), or
- (2) Order online at www.AISHealth.com, or
- (3) Staple your business card to this form and mail it to:
AIS, 1100 17th St., NW, Suite 300, Wash., DC 20036.

Payment Enclosed* \$566

Bill Me \$596

*Make checks payable to Atlantic Information Services, Inc.
D.C. residents add 5.75% sales tax.

Subscribers to *RMC* are eligible to receive 1.0 Continuing Education Credit for each issue of the newsletter, which counts toward certification by the Healthcare Compliance Certification Board. For more information, contact HCCB at 888-580-8373.

Call 800-521-4323 (or visit the Marketplace at www.AISHealth.com) to order **Report on Medicare Compliance on CD**, a searchable CD with all issues of the newsletter published in 2005. (\$89 for subscribers; \$389 for non-subscribers.)

Tenet also said it is working out a multi-year corporate integrity agreement with the HHS Office of Inspector General that the company expects to adopt within 90 days. Plus the hospital firm will continue to operate its own compliance program, which includes 100 staffers. Tenet adds that it will hire an independent review organization to examine the company's ongoing compliance in key areas.

Tenet CEO Trevor Fetter said, "We have made much progress with our reforms in clinical quality, corporate culture, management, transparency, governance, compliance and strategy. The organization was humbled because of what happened, but these challenges galvanized us to make necessary changes. As a result, Tenet is a stronger and better company."

Contact DOJ's public affairs office at (202) 514-2007 and Imperato at imperato@broadandcassel.com. ✧

Contract Problems Pose Risk As Feds Push Stark Enforcement

Pressure is mounting on hospitals to review their physician deals for potential Stark law violations and to consider what steps to take when violations are uncovered. Hospitals face the twin challenges of cleaning up common contractual violations and avoiding the danger inherent in not returning money stemming from illegal financial relationships, experts say.

Officials from the HHS Office of Inspector General again have been encouraging providers to use the OIG Self-Disclosure Protocol to bring Stark violations to the government's attention. This time, Lewis Morris, chief counsel to Inspector General Daniel Levinson, reminded providers of the IG's April 24 "Open Letter to Health Care Providers" during a June 27 speech at an American Health Lawyers Assn. conference in Philadelphia.

The open letter says that providers who resolve Stark or kickback liability through the Self-Disclosure Protocol will receive good settlement terms, paying "near the lower end" of the Civil Monetary Penalty (CMP) fines and penalties they would face in a regular enforcement action (*RMC 5/1/06, p. 1*).

Morris' speech came on the heels of Piedmont Hospital's \$3 million settlement with the U.S. attorney's office in Atlanta partly for alleged Stark violations (*RMC 6/26/06, p. 5*). The government contended the Atlanta hospital did not have written contracts with physicians who provided services in the vascular lab, so the arrangement didn't qualify for a Stark exception. As a result, the hospital violated Stark when the five physicians referred patients to the hospital for services, the feds contended. The hospital denied the allegations in the settlement.

Generally, enforcement of the Stark law has kicked into high gear. "In a lot of settlements now, Stark has been a component," says South Bend, Ind., attorney Bob Wade. "People need to be concerned about Stark compliance. For so long, providers have not been concerned about it."

Wade, who is with the law firm Baker and Daniels LLP, says many hospitals that look internally for Stark violations are probably finding them. Examples of problems that organizations may discover if they review for Stark compliance, he says:

- (1) Expired contracts.
- (2) Financial relationships where no contract ever existed.
- (3) The parties modify the financial terms without putting the modifications in writing.
- (4) The terms were modified during the first year of the financial arrangement (some Stark exceptions require the terms to be in place for one year).
- (5) The agreement incorrectly describes the service (e.g., a lease agreement describes a space of 1,000 square feet but it is really 1,200 square feet, or a medical director agreement calls for a physician to work 100 hours a year but the physician works only 80 hours in a year.)
- (6) The hospital gives a gift or benefit to a doctor that exceeds Stark's \$322 *de minimis* exception. The exception allows hospitals to give small gifts totaling no more than \$322 a year to referral sources without triggering a financial relationship for Stark purposes.

The Risk of Not Making Repayments

When hospitals find these violations, they face a quandary, Wade says. Do they correct the problem (e.g., sign appropriate contracts) and move on, or do they have an obligation to repay the government for any money illegally collected, even if the money was collected pursuant to an illegal contract (e.g., an expired medical directorship) for a very short time? Government officials maintain that under the Social Security Act, it's a felony for providers to knowingly fail to disclose that they have money that belongs to the government once they become aware they were not entitled to receive it (42 USC Sect 1320 a-7b(a)(3)).

Given the inherent risks, Wade emphasizes the importance of health systems ensuring their payments to physicians are consistent with contract terms. "If you don't have a robust contract management program, you better implement one, even though there is a cost, because there's no way to manage your contracts otherwise," he says.

Contact Wade at bob.wade@bakerd.com. ✧

CMS's Top Risk Areas for Hospitals Under HPMP

Here are the updated risk areas targeted for scrutiny by the Hospital Payment Monitoring Program (HPMP), CMS's major vehicle for reducing inpatient payment errors. HPMP is run by Medicare's quality improvement organizations (QIOs). A lot of the risk areas focus on some version of one-day stays (see story, p. 1). These risks were identified for use in HPMP's FATHOM, a data-analysis tool to identify billing outliers, and PEPPER, its hospital companion. Contact Kristy Wietholter, HPMP project manager at MPRO, the QIO for Michigan, at kwiethol@mpro.org.

One-day stays excluding transfers	Numerator: count of discharges with length of stay less than or equal to one day, excluding patient status of 20 (expired), 07 (left against medical advice), or 02 (discharged/transferred to a short-term general hospital for inpatient care). Denominator: count of all discharges excluding patient status 02.
DRG 127 one-day stays	Numerator: count of discharges with DRG equal to 127 (heart failure and shock) with length of stay less than or equal to one day excluding patient status of 20 (expired), 07 (left against medical advice), or 02 (discharged/transferred to a short-term general hospital for inpatient care). Denominator: count of all DRG 127 discharges.
DRG 143 one-day stays	Numerator: count of discharges with DRG equal to 143 (chest pain) with length of stay less than or equal to one day excluding patient status of 20 (expired), 07 (left against medical advice), or 02 (discharged/ transferred to a short-term general hospital for inpatient care). Denominator: count of all DRG 143 discharges.
DRGs 182 and 183 one-day stays	Numerator: count of discharges with DRG equal to 182 (esophagitis, gastroenteritis and miscellaneous digestive disorders age > 17 with complication or comorbidity) or 183 (esophagitis, gastroenteritis and miscellaneous digestive disorders age > 17 without complication or comorbidity) with length of stay less than or equal to one day excluding patient status of 20 (expired), 07 (left against medical advice), or 02 (discharged/transferred to a short-term general hospital for inpatient care). Denominator: count of discharges with DRG equal to 182 or 183.
DRGs 296 and 297 one-day stays	Numerator: count of discharges with DRG equal to 296 (nutritional and miscellaneous metabolic disorders age > 17 with complication or comorbidity) or 297 (nutritional and miscellaneous metabolic disorders age > 17 without complication or comorbidity) with length of stay less than or equal to one day, excluding patient status of 20 (expired), 07 (left against medical advice), or 02 (discharged/transferred to a short-term general hospital for inpatient care). Denominator: count of discharges with DRG equal to 296 or 297.
DRG 014	Numerator: count of discharges with DRG equal to 014 (intracranial hemorrhage and stroke with infarct). Denominator: count of discharges with DRG equal to 014, 015 (nonspecific cerebrovascular accident and precerebral occlusion without infarct), or 524 (transient ischemia). IMPORTANT: DRGs 014 and 015 were redefined and DRG 524 was added effective with discharges starting Oct. 1, 2002. This impacts the comparability of the proportions reported for these DRGs. Trending cannot be conducted for these DRGs using fiscal year 2003 data. Hospitals are recommended to evaluate the fiscal year 2003 data as a stand-alone time period.
DRG 079	Numerator: count of discharges with DRG equal to 079 (respiratory infections and inflammations age > 17 with complication or comorbidity). Denominator: count of discharges with DRG equal to 079, 080 (respiratory infections and inflammations age > 17 without complication or comorbidity), 089 (simple pneumonia and pleurisy age > 17 with complication or comorbidity), or 090 (simple pneumonia and pleurisy age > 17 without complication or comorbidity).
DRG 243	Numerator: count of discharges with DRG equal to 243 (medical back problems). Denominator: count of all discharges.
DRG 416	Numerator: count of discharges with DRG equal to 416 (septicemia age > 17). Denominator: count of discharges with DRG equal to 416, 320 (kidney and urinary tract infections age > 17 with complication or comorbidity), or 321 (kidney and urinary tract infections age > 17 without complication or comorbidity).
Seven-day readmit to same facility or elsewhere	Numerator: count of index (first) admissions for which a readmission occurred within seven days to the same hospital or to another short-term acute care PPS hospital for the same beneficiary (identified using the Health Insurance Claim number); patient status of the index admission is not equal to 02 (discharged/ transferred to a short-term general hospital for inpatient care). Denominator: count of all discharges.
DRG 089	Numerator: count of discharges with DRG equal to 089 (simple pneumonia and pleurisy, age > 17 with complication or comorbidity). Denominator: count of discharges with DRG equal to DRGs 089, 090 (simple pneumonia and pleurisy, age > 17 without complication or comorbidity), or 088 (chronic obstructive pulmonary disease).
Complication/comorbidity (CC) pairs	Numerator: count of discharges for medical DRGs with a CC, excluding DRGs 079/089. Denominator: count of discharges for all medical DRG pairs, excluding DRGs 079/080/089/090.
Three-day skilled nursing facility (SNF)-qualifying admissions	Numerator: count of discharges to an SNF with a three-day length of stay. Denominator: count of all discharges to an SNF (identified by patient status code of 03 [discharged or transferred to an SNF] or 61 [discharged or transferred to a swing bed]).

Errors for One-Day Stays Climb

continued from p. 1

The contribution of one-day stays as a proportion of admission denials has risen. One-day stays comprised 41% of the admissions classified as unnecessary in fiscal year 2004, up from 39% in FY 2003, Hrehor says.

Despite years of OIG and CMS audits and the energy expended to address this problem, it's getting worse. "It seems like QIOs and hospitals are banging their heads against the wall on this," Hrehor says. *One reason:* Physicians drive the admission decision, but signing an order for an inpatient admission that isn't medically necessary in Medicare's eyes doesn't have a financial repercussion for them; the doctors get paid the same for their services even if Medicare rebuffs the hospital claim.

Under the HPMP's eighth scope of work, many QIOs are tackling inappropriate one-day stays. MPRO, for example, is launching a project to try to get to the bottom of this payment error and facilitate hospital networking to help reduce its prevalence.

The most common cause is admitting patients to an inpatient bed when they should be placed in observation.

"That seems to be a huge problem nationally — not understanding the difference between observation and inpatient," says Mary Helderman, HPMP project manager for Health Care Excel, the QIO for Indiana and Kentucky.

For a variety of reasons, the physician order winds up either saying "Admit to inpatient" instead of "Admit to observation" or the order is vague and staff has to interpret it as an inpatient admission order. One of the main reasons that patients land in short-term acute care when Medicare will pay only for observation in that circumstance is that the system, on the one hand, is designed to require physicians to make and document the decision while, on the other hand, is not providing the incentives.

Demonstrating Incentives to Doctors

"There is a disconnect between what the doctors are incentivized to do financially and what the hospitals are incentivized [to do]," says James Mitchiner, M.D., MPRO's Medicare medical director. "CMS says the person who has to make the decision as to where the patient is placed is the physician. What will drive physician decision making, either consciously or subliminally, is

COMPLIANCE CHRONICLE

Compliance Chronicle is a monthly column that contains summaries of recent federal actions of significance. This edition of Compliance Chronicle covers the period between May 23 and June 26.

Proposed Rule

◆ **On May 26, CMS issued a proposed rule that would change the fee schedule for payment of ambulance services through adoption of revised geographic designations for urban and rural areas.**

The areas are described in the Office of Management and Budget's Core-Based Statistical Areas standards. CMS says it also proposes to discontinue the annual review of the conversion factor (CF) and of air ambulance rates. It would continue to monitor payment and billing data on an ongoing basis, CMS says. Comments must be received by July 25. *71 Fed. Reg. 30358-30364*, May 26, 2006.

Transmittals

◆ **Pub 100-04 Medicare Claims Processing Trans. 967 (May 26, 2006)** says that CMS is modifying the claims section criteria logic that the Common Working File (CWF) system applies to processed Medicare claims. CMS explains that it is making this change to more closely estimate in-house systematic logic that

Medicare contractors have historically applied as part of their claims crossover process. CMS also is modifying requirements for transmission of 837 test and production claims to the Coordination of Benefits Contractor (COBC) to ensure that both types of claims may be combined in the same file. The requirement is limited to the Medicare contractors and their data centers, not to the shared system maintainers, CMS says. The effective date is Oct. 1, 2006.

◆ **Pub 100-04 Medicare Claims Processing Trans. 971 (June 2, 2006)** clarifies that carriers are to consider any payable date of service when a provider seeks an adjustment of a replacement defibrillator claim denied for lack of QR modifier, which identifies services being covered under a clinical study. CMS notes that the effective date is not the date of services, but reflects the original "turn-on" date of the QR modifier edits. This clarification is to be implemented no later than 90 days from issuance of this transmittal; if carriers can implement it sooner, they are to do so, CMS says. The implementation date is Sept. 5, 2006.

how they are reimbursed. And there's no incentive to get patients to the right spot."

From this perspective, Mitchiner believes "the solution is to get physicians to understand that what is good for the hospital is good for the physician." Dollars not lost to claims denials for medically unnecessary one-day stays are dollars that can be spent on goods and services that appeal to the doctors — "extra technology for the operating room, an add-on for the radiology suite so patients don't have to wait, enlarging the physician dining room," he says.

"The last thing the hospital wants to do is put patients in a hospital bed and not get paid for it. It's an impairment to the bottom line to do all this work and not get paid. Make sure the doctors understand that a [financially] healthy hospital is [beneficial] for the physician," Mitchiner says.

Early Communication Is Necessary

He also urges more communication between the utilization review (UR) or case manager nurse and the doctor up front rather than retrospectively. Although CMS created condition code 44, which allows a hospital to change a patient's status from inpatient to observation after admission as long as it's before discharge and other criteria are met, Mitchiner says it's preferable to get a medically necessary placement for the patient right from the start. Anyway, it may be too late to fix the improper admission after the fact (e.g., if the stipulations of condition code 44 aren't met).

When doctors order inpatient admissions that don't seem to meet InterQual criteria, the UR nurse/case manager can elicit more information from the doctor, explain the situation and urge more documentation in the chart if it's justified.

Documentation is the key, Mitchiner says. The decision whether to admit to observation or inpatient "is a decision that has to be made and documented by the attending physician and supported on the basis of medical evidence," he says. Suppose the patient gets sick, comes to the emergency department and then is put in observation, but the patient's medical needs intensify, requiring more than 24 hours of care. Then there has to be an order from the physician converting him to an inpatient.

"If there's no order, Medicare may pay that as an observation service even if the patient should have been an inpatient. The hospital loses a lot of money," Mitchiner says. "So you don't want to start the patient in observation if it's not clearly going to be an observation stay."

MPRO also plans to dig for other potential causes of inappropriate one-day stays. "There may be other prob-

lems we don't know about — process issues," Wietholter says. For example, when patients are admitted to observation and then upgraded to an inpatient, some hospitals will try to get Medicare reimbursement for the observation day that preceded the stay, but "that creates an error in billing," she says.

"You can switch to inpatient with a physician's order but that first day would be billed as observation. The inpatient stay starts when the order for inpatient admission is written," Wietholter adds.

Orders Must Be Very Specific

Imprecise documentation also leads to payment errors, Helderman explains. Even ostensibly specific medical records can be misleading. For example, the order may say "Admit to 2C," but 2C may treat patients in an observation as well as an inpatient status, she says.

One solution hospitals have tried with some success is standardized admission forms. Physicians just check off a box for inpatient admission or observation, Helderman says.

She also says that past experiences with hospitals show gaps in their UR processes. Inappropriate admissions tend to occur after 5 p.m. and on weekends when no UR nurse or case manager is on duty to screen patients in terms of admission criteria.

Patients come in through the emergency department, the order just says "Admit," and the assumption is made that the doctor wants an inpatient admission because there are no UR nurses or case managers there who understand the distinctions. "Then the patient is admitted when they just needed a lesser setting," Helderman says.

After the fact, when the case is reviewed, it becomes clear the documentation doesn't support the admission. "Hospitals really need to be more proactive in monitoring their short lengths of stays and looking at which DRGs they bill more often with short stays, and do more auditing and monitoring to identify trends and patterns," she says.

CMS has already identified some DRGs that are particularly prone to one-day stays. Among them: DRG 143, which is chest pain; DRG 182, which is esophagitis, gastroenteritis and miscellaneous digestive disorders age greater than 17 with complication or comorbidity (CC); and DRG 183, which is esophagitis, gastroenteritis and miscellaneous digestive disorders age greater than 17 without CC.

Contact Mitchiner at jmitchin@mpro.org, Hrehor at khrehor@txqio.sdps.org, Wietholter at kwiethol@mpro.org and Helderman at mhelderman@inqio.sdps.org. ♦

IRS Surveys Tax-Exempt Hospitals On Their Charity Care Practices

The Internal Revenue Service has sent surveys to 500 nonprofit hospitals to gauge the facilities' compliance with the rules governing their tax-exempt status, an area in which the IRS has admitted its reviews "have not been robust." The move may be a prelude to new federal charity-care requirements for nonprofit hospitals.

An increase in size and complexity of this industry, coupled with almost no change in laws governing the organizations, have created opportunities for noncompliance, says IRS Commissioner Mark Everson, who testified before the House Ways and Means Committee in May.

According to Everson's testimony, in order to qualify for tax exemption, hospitals must show that they provide benefits to "a class of persons that is broad enough to benefit the community." Such benefits could include whether the hospital conducts medical training or research activities, educates the public on health care issues, or provides health care services not otherwise available in that community.

Keeping Nonprofit Status

IRS figures from 2001 show that there are about 7,000 tax-exempt health care entities. The survey was sent to 500 hospitals and includes questions on whether it has a written policy about uncompensated care, and how much it spent on uncompensated care in the last tax period; how many notices it sends to a patient for failing to pay before it begins collection actions; and whether it charges uninsured patients higher prices for services.

Dozens of class-action lawsuits have been filed in recent years across the country by uninsured patients who accuse charity-care hospitals of charging them inflated rates and then using aggressive tactics to recover payment. The suits were filed in state and federal courts, although most of the federal cases have been dismissed. Some suits have resulted in settlements (see brief, p. 8).

"What [the IRS is] doing is an investigation with an idea toward formulating rules to codify what hospitals need to do to continue to maintain their nonprofit status," says Chicago attorney Kevin Egan. He estimates that 85% of hospitals in the U.S. have nonprofit status. "There is no hard and fast rule on what you have to do to qualify or what you have to do to keep [nonprofit status]," he adds.

Egan, who is with Foley & Lardner LLP, says that hospitals "need to have an appropriate charity care policy in place that demonstrates that they provide a benefit to the community they serve. That's all that is required right now. But the rules are changing," he says. For example, Egan says the Illinois attorney general has proposed legislation that would require nonprofits to

provide 8% of their bottom line as charity care in order to keep their real-estate and sales-tax exemptions in the state. He says federal rule changes could be similar and would be "hard and fast and clearly definable."

The IRS is "trying to collect information that will assist it in analyzing the characteristics of a tax-exempt hospital and how that sets it apart from for-profits," says Houston tax attorney Todd Greenwalt. "Hospitals need to pay attention to this process because there are going to be new elements that Congress and the IRS may add on to tax-exempt status," he tells RMC.

For example, Greenwalt points out that there is now no requirement that hospitals provide some kind of charity care. "It would not surprise me if there is some sort of initiative that comes out of this that would try to impose some kind of charity-care standard. Some states have legislation that has a minimum charity-care standard," such as Texas and possibly 20 others, he says.

Another initiative could be "standards of conduct" for hospitals for uninsured or indigent patients, says Greenwalt, who is with Vinson & Elkins LLP.

Contact Egan at kegan@foley.com and Greenwalt at tgreenwalt@velaw.com. View the survey at www.irs.gov/charities/charitable/article/0,,id=157660,00.html. Read Everson's testimony at www.irs.gov/charities/charitable/article/0,,id=139781,00.html. ♦

More HIPAA Resources From AIS

✓ *Report on Patient Privacy*, a monthly newsletter featuring innovative solutions to practical problems with the implementation of HIPAA privacy regulations.

✓ *A Guide to Auditing and Monitoring HIPAA Privacy Compliance*, a softbound book with 214 pages of how-to guidance on effective auditing and monitoring systems; includes templates on a free CD.

✓ *HIPAA Patient Privacy Compliance Guide* (updated quarterly), the industry's leading compliance looseleaf service with more than 1,000 pages of how-to chapters with extensive policies, procedures and other practical tools.

✓ *HIPAA Security Compliance Guide* (updated quarterly with news summaries), a highly practical 14-chapter looseleaf featuring summaries of the complex HIPAA security regulations, plus policies, procedures and other how-to compliance tools, written by top health care security experts.

Visit the AIS MarketPlace at
www.AISHealth.com

NEWS BRIEFS

◆ **Oklahoma physician Linda Morgan was sentenced to 10 years in prison for health care fraud and five years for a conspiracy conviction**, says the U.S. Attorney's Office for the Southern District of Texas. The sentences will be served concurrently. Morgan also must pay \$7.9 million in restitution to Medicare and Medicaid. The feds allege that Morgan, who "was unable to become licensed in Texas," received \$250 each for signing hundreds of prescriptions for motorized wheelchairs. She also signed certificates of medical necessity without evaluating the patients for whom they were signed, the feds charge. Those documents were sold to durable medical equipment (DME) companies in Texas and other states. "Dr. Morgan's fraudulent prescriptions have been linked to nearly \$8 million in Medicare and Medicaid payments to more than 60 [DME] companies around the country," the feds said in a prepared statement. An attorney representing Morgan told *RMC* he had no comment. Visit www.usdoj.gov/usao/txs.

◆ **Providence Health System's settlement in a class-action lawsuit that charged the system with unfair billing of its uninsured patients received final approval from an Oregon circuit court judge on June 23**, Providence says. As part of the settlement, Providence reviewed claims submitted by uninsured patients and found 250 claims that were entitled to refunds. The refunds total \$194,385, Providence says. In that review, Providence also found 430 unpaid bills that will receive additional adjustments and discounts, which total \$969,425. The health system will retroactively offer its current financial assistance policies and discounts to uninsured patients who have received medical care at its hospitals in Oregon since December 2001. Dozens of similar suits were filed across the country by uninsured patients who accuse the hospitals of charging them inflated rates for medical care, and then using aggressive practices to recover medical debt. The suits were filed in state and federal courts, although most of the federal cases have been dismissed. Visit www.providence.org/oregon.

◆ **Main Street Pediatrics, P.C., of Bridgeport Conn., will pay more than \$230,000 in reimbursement to Medicaid to settle allegations that it submitted false claims**, says the U.S. Attorney's

Office for the District of Connecticut. The group allegedly billed for free vaccines it received from Vaccines For Children (VFC), a joint federal and state program. Under the VFC program, physicians agree not to bill Medicaid or any other third-party payer for the cost of the vaccines, but may receive a minimal refund for the costs of inoculating the child, the feds explain. Officials say that Main Street owes an additional \$235,000 to private insurance companies. The physicians group has also entered a corporate integrity agreement. An attorney representing Main Street did not respond to phone calls seeking comment. Visit www.usdoj.gov/ussao/ct.

◆ **CMS expects to issue two more major documents in connection with its compliance effectiveness pilot, says Kimberly Brandt, CMS's director of program integrity**. The September report will unveil what could be the buried treasure: whether there is a correlation between the seven elements of a compliance program and the accuracy of provider Medicare claims submissions. The second report, slated for spring 2007 release, will be a "white paper," Brandt says. "It will be a compilation of our observations, very detailed" with a description of best practices for compliance programs.

◆ **Ali S. Makki, M.D., of Dearborn, Mich., was indicted on June 23 and charged with overbilling Medicare by more than \$500,000**, says the U.S. Attorney's Office for the Eastern District of Michigan. The feds allege that Makki billed for unnecessary medical tests, that he falsified medical records submitted in response to a Medicare audit, and that he provided false medical records to more than 500 immigrants who were "green card" applicants. The indictment also alleges that Makki billed for office visits that would have occurred while he was not in the state and for complicated surgical procedures that he never performed. An attorney for Makki said that his client is not guilty, and that they will establish that fact in court. Contact Gina Balaya at the U.S. attorney's office at (313) 226-9758.

◆ **CMS says that all of its 855 enrollment applications now are posted on the CMS Forms Internet page and can be completed online**. All of the forms can be found at www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage.

**IF YOU DON'T ALREADY SUBSCRIBE TO THE NEWSLETTER,
HERE ARE THREE EASY WAYS TO SIGN UP:**



(1) Call us at **800-521-4323**



(2) Fax the order form on page 2 to **202-331-9542**



(3) Visit **www.AISHealth.com** and click on
“Shop at the AIS MarketPlace”

**IF YOU ARE A SUBSCRIBER
AND WANT TO ROUTINELY FORWARD THIS
E-MAIL EDITION TO OTHERS IN YOUR ORGANIZATION:**

Call Customer Service at **800-521-4323** to discuss AIS's very reasonable rates for your on-site distribution of each issue. (Please don't forward these e-mail editions without prior authorization from AIS, since strict copyright restrictions apply.)