

# MEDICARE COMPLIANCE

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

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## Hospital Sues HHS, FI for Recouping \$2 Million While Appeal Is Under Way

A south Florida hospital is suing HHS and a fiscal intermediary (FI) for recouping nearly \$2 million in alleged overpayments even though the hospital is in the process of appealing the claims denials. According to the lawsuit, the 2003 Medicare Prescription Drug, Improvement and Modernization Act and a CMS memorandum both forbid recoupment until the end of the second level of appeals.

In the lawsuit, filed in U.S. District Court for the Southern District of Florida, the hospital asks the court to declare that the Florida FI's "past and ongoing recoupment of alleged overpayments...violates the Medicare Prescription Drug, Improvement and Modernization Act," and to force the FI, First Coast Service Options, to stop recoupment and pay attorneys' fees. The origins of the case are a 2006 audit of certain hospital claims by the Florida recovery audit contractor (RAC), Health Data Insights (HDI). "HDI concluded that certain claims were not medically reasonable and necessary, resulting in a determination that Medicare had made in overpayment," the lawsuit states.

After learning of the overpayment determination, the hospital informed the FI that it wanted a redetermination, which triggered its appeal rights and "its right under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 to stay any recoupment until the date the decision on the reconsideration was rendered," the

*continued on p. 7*

## Inventory of CMS, IRS, Other Forms With Certifications Helps Reduce Compliance Risk

Since hospital officials sign all kinds of clinical, financial and operational forms that are submitted to government agencies every year, it's a good idea to track them down and ensure their integrity. Many of these forms contain a certification, which means the signer promises the government that all data on the forms are accurate and true and/or comply with all legal and regulatory requirements. A signed certification that's at odds with the information on the form can land a hospital in hot water, contends Cheryl Rice, corporate director of corporate responsibility at Catholic Healthcare Partners, a 30-hospital nonprofit system based in Cincinnati. Or sometimes just missing certification deadlines puts the institution at risk.

Rice is conducting an inventory of official reporting documents that have some kind of certification statement and signature lines attached to them. She was surprised to find that hospital officials may sign between 20 and 30 certifications a year.

The idea arose from a request by legal staff after the Department of Justice (DOJ) filed a false claims lawsuit against Christi Sulzbach, former Tenet Healthcare Corp. chief compliance officer and legal counsel. DOJ alleges that Sulzbach twice signed corporate integrity agreement (CIA) certifications attesting that Tenet, a for-profit hospital chain,

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complied with all legal requirements even though she allegedly knew a Tenet hospital in Florida was violating the Stark law (*RMC* 9/24/07, p. 1). The Florida hospital wound up settling the Stark case for \$22.5 million.

While CIA certifications require the signer to promise that the information complies with all laws and regulations, most CMS documents don't explicitly use this language. But hospitals are still promising the information is correct. The Medicare cost report, for example, requires the signer to certify that it has been completed based on "accurate, true and documented information."

Other Medicare documents mandating certification include a pledge that the information is accurate and true. Some examples: all claim forms, attestations that an entity is provider-based, electronic funds transfer authorization agreements and the forthcoming Disclosure of Financial Relationships Report (DFRR). The 855 enroll-

ment forms have a certification, and providers have to sign them every time they make a change — and there are penalties for failing to update the 855. For example, hospitals must update 855s when board members retire or new board members take the helm. The 855 now also requires hospitals to check whether board members have "adverse events" in their histories (e.g., criminal convictions). Hospitals have to certify the information every time it's provided, Rice says (see box, p. 3, for a list of time frames for making changes to the 855). CMS may impose penalties on hospitals for missing deadlines and providing false information. Rice says penalties include withholding Medicare payments and, at worst, revoking the Medicare provider number.

Also, the IRS's 990 reporting form for nonprofits has a certification. And states have certifications. In Ohio, for example, hospitals have to report to the state the prices of about 100 services performed and submit average charges and lengths of stay for nongovernment DRG patients, Rice says. As part of the online filing, the hospital must list its name and attest that the charges are accurate as of the date of submission. Although there is no signature line, the attestation statement on the form serves the same purpose.

There are a few compliance risks with certifications, so signers and compliance officers who might wind up reviewing certifications should consider a few things:

◆ *Hospital CEOs, chief financial officers or other executives may be dashing off their signatures*, but their staffers usually prepare the form. "Does the [signer] know what is in the document that staff is completing on their behalf?" Rice says.

◆ *When it comes to a more specific document*, a certification may reference the relevant regulation without elaborating. "[The signer] should go back into the document to determine what it is about [e.g., conditions of participation]," she says. "Because when you are filling out the certification as accurate and true, it is implicit that you are filling it out in accordance with that rule even if it's not explicitly said."

◆ *People in charge of filing certain certifications* in accordance with mandatory deadlines (e.g., the 855) may quit, retire or be downsized and take their knowledge with them. If there isn't a systematic way to track filing deadlines, the hospital may consequently miss certification deadlines, and, if it involves the 855, may face penalties.

## Identifying Certifications

So how did Rice track down all these certifications? A gathering of Catholic Healthcare Partners' lawyers and compliance officers "listed 10 right off the bat," Rice says. "And then, whatever was obvious, we figured if we dug deeper, it would provide more." For example, since there is an overall certification on the cost report, there might

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be some certifications on schedules located in the middle of the document rather than at the end where most people look first — and they were right (e.g., Schedule “Sf” for physician fees has a separate certification statement for that cost-report schedule).

Rice also found a number of forms requiring certification under “CMS Forms,” which is on the left side of the CMS home page (under “Medicare”). Unfortunately, going through this information requires a lot of legwork. Many of the 100-plus forms on that Web site are for con-

tractors, but there are forms that providers must complete as well. “I had to go through those and check which forms providers have to complete and why, whether there is a certification and the nature of the certification,” Rice says.

She also advises reading through the online *Medicare Program Integrity Manual* because it has guidance and clues on what other services or areas have potential certifications related to reporting information to official agencies and how to report to the government.

Contact Rice at [clrice@health-partners.org](mailto:clrice@health-partners.org). ✧

<b>Tracking Certifications: A Compliance Objective</b>		
<p>The 855 enrollment form is the ultimate example of the importance of ensuring that certifications are accurate and timely, says Cheryl Rice, corporate director of corporate responsibility for Catholic Healthcare Partners, a 30-hospital chain based in Ohio. Hospitals and other providers and suppliers face penalties if they don't inform CMS of certain changes in their organizations on the 855 enrollment forms and attest to the accuracy of the information provided (see story, p. 1). This table lists the kind of information that must be provided and certified. Contact Rice at <a href="mailto:clrice@health-partners.org">clrice@health-partners.org</a>.</p>		
<p><b>The Medicare Enrollment Final Rule established new timeframes for reporting changes to the 855 application on file. The new timeframes are as follows:</b></p>		
<b>Provider Action</b>	<b>Timeframe for Action</b>	<b>Impact of Delinquent Reporting/Action</b>
Missing information on first-time application to Medicare.	Submission within 60 days of CMS request.	Application rejected without appeal if no communication with CMS. If good-faith effort to resolve, timeframe may be extended.
Five-year routine revalidation of existing Medicare provider.	Submission within 60 days of CMS request including review, update, and submission of any changes and supporting documentation.	Onsite review and possible deactivation or revocation of provider's billing privileges.
Change in ownership or control.	Submission within 30 days including review, update and submission of any changes and supporting documentation.	Onsite review and possible deactivation or revocation of provider's billing privileges.
Change in billing services.	Submission within 90 days including update, and submission of changes and supporting documentation.	Onsite review and possible deactivation or revocation of provider's billing privileges.
Change in practice location.	Submission within 90 days including update, and submission of changes and supporting documentation.	Onsite review and possible deactivation or revocation of provider's billing privileges.
Change in owners, officials, directors, authorized official, delegated official or managing employee.	Submission within 90 days including update, and submission of changes and supporting documentation.	Onsite review and possible deactivation or revocation of provider's billing privileges.
Change in any other 855 fields.	Submission within 90 days including update and submission of changes and supporting documentation.	Onsite review and possible deactivation or revocation of provider's billing privileges.
Changes in durable medical equipment, prosthetics, orthotics and supplies.	Submission within 30 days including update, and submission of changes and supporting documentation.	Onsite review and possible deactivation or revocation of provider's billing privileges.
No submission of claims under existing provider number.	Consecutive 12-month period without submitted claims, beginning with first day of the first month through last day of 12th consecutive month.	Deactivation of provider number.
No National Provider Identifier reported for mandatory claims submission rules.	Mandatory by May 27, 2007, for all providers.	Any claim submitted with an inactive billing number is incomplete and unprocessable. Sanctions may be imposed under section 1848 (g) (4) of the Social Security Act for failure to file a claim required.
Adverse activity and subsequent CMS action against an individual or organization.	Thirty days from CMS initial revocation.	If a provider's billing privileges are revoked, CMS will review all other related Medicare enrollment files and associated providers and may result in revocation of other associated Medicare provider.

## Hospitalists Can Help Reduce Medically Unnecessary Admissions

The fact that hospitalists make a lot of admission decisions played a role in helping reduce the rate of medically unnecessary admissions in Michigan. Hospitalists are popular in Michigan hospitals, where the error rate for one-day stays has been reduced through a project sponsored by the Hospital Payment Monitoring Project (HPMP), CMS's vehicle to reduce inpatient payment errors.

At Borgess Medical Center in Kalamazoo, for example, hospitalists are responsible for 80% of Medicare patient admissions, says Marilyn Barnum, utilization management coordinator. So when she formed a team to address medically unnecessary Medicare one-day stays as part of the HPMP project that was run by the Medicare quality improvement organization (QIO) in Michigan (see story, p. 6), Barnum recruited both the chief clinical officer and a hospitalist.

"We decided to focus our energy for change on hospitalists since they make so many of the patient admissions," she says. "We figured we would have better success [with hospitalists] than with 200 other [private-practice] physicians around the hospital" with no particular loyalty — and who account collectively for only 20% of the Medicare admissions.

The team concentrated on reducing inappropriate one-day stays for cardiac-related problems since these are a frequent cause of unnecessary admissions. Chest pain (DRG 143), for example, is one of the 14 risk areas highlighted in Program for Evaluating Payment Patterns Electronic Report (PEPPER) submissions, which are hospital-specific data that QIOs provide to all hospitals nationally. The reports show where hospitals are above or below certain percentiles compared with all other hospitals in the state in each of the 14 risk areas so they can use their audit resources to further investigate the reason for the outlier billing.

In addition to the hospitalist, chief medical officer and Barnum, the team included the director of care management, an emergency department (ED) care manager, a care manager from the cardiac care center, an RN from patient placement area who does admission review and one staff/charge nurse from the cardiac area since the hospital was focusing on cardiac-related problems.

### Physician Orders Are Part of Care Pathways

At first, the team met weekly and then biweekly through the spring, summer and fall of 2007. The team devised and implemented ideas for reducing inappropriate one-day stays that have been quite effective, she says. The goal is to make it absolutely clear whether the physician wants the patient to be admitted to an inpatient bed or placed in observation status. Because this isn't always a meaningful distinction to the doctor — beds are beds, treatment is treatment, and only the hospital cares because the reimbursement is vastly different for inpatient versus observation — this has long proved an uphill battle. But if the patient's admission is not considered medically necessary according to Medicare (as indicated by admission screening criteria like InterQual), the hospital's out of luck. So the team brainstormed a way to ensure physicians were explicitly indicating where the patient should be placed, and that it would be medically necessary.

The most innovative idea: incorporating the physician order into clinical pathway protocols, also known as care pathways, Barnum says. These are the sets of descriptions of the patients' symptoms and treatment plans according to pre-set plans.

Until 426-bed Borgess came up with this idea, status orders (e.g., inpatient versus observation) signed by the physician would not have been on pathways, she says. There was a separate order sheet, and physicians were expected to indicate what the patient's status should be on the otherwise-blank order sheet. "But often they did not check a box, so the order status was not clear," Barnum says.

Now "we have the order on the pathways [documentation]," she says. "If physicians sign the admitting order, that's just part of it."

For example, if the patient comes in for chest pain, there are two paths to go down. Observation is usually an appropriate placement for patients following ED treatment for the chest when the patient's cardiac enzymes and EKG are negative, and chest pain has resolved (either by itself or through the administration of nitroglycerin). If that's not the case, however, inpatient admission might be warranted. If the EKG and cardiac enzymes are positive, then the patient probably should be admitted as an inpatient. But the physician has to sign the proper order.

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With the pathways method, “the order is right there from the beginning,” she says. For instance, the statement that the patient needs to be admitted as an inpatient is smack dab in the middle of the “clinical pathway protocol for percutaneous transluminal coronary angioplasty/atherectomy/stent with or standby — pre-procedure.” Now that the admission/observation order is integrated, the opportunity for error is much lower, according to Barnum. When the physician signs the clinical pathways, he or she is implicitly signing the admission or observation order, she says.

Borgess implemented other interventions to bring down the rate of one-day stays. Barnum cites the following:

◆ **Hospital administration approved extending the hours of case managers** (Borgess calls them care man-

ers) in the ED. “We went from a position of one person to where we have [the ED] covered seven days a week from 10 a.m. to 11 p.m.,” she says. “Most admissions happen between 2:30 and 11 p.m.”

Case managers help ensure admissions are medically necessary according to formal admission screening criteria. When admissions don’t meet the criteria, case managers ask physicians to reconsider.

To help get the extra case manager time approved in the ED, “we had data, and we had ED physicians’ support. We had all sorts of articles to support this, plus the chief medical officer’s support,” Barnum says. “This is seen as positive by the hospitalists’ group. Case managers can consult with the doctor — hospitalist or resident — or

### **Recovery Audit Contractors: Pilot vs. Permanent**

*The column on the left describes the CMS statement of work for recovery audit contractors (RACs) under the three-year pilot in California, New York and Florida that ends in March. The column on the right describes the CMS Statement of Work (SOW) for the permanent RACs, which will audit providers in all states starting in March (RMC 12/17/07, p. 1). This comparison was put together by Cheryl Rice, corporate director of corporate responsibility for Catholic Healthcare Partners, a 30-hospital chain based on Cincinnati. RACs are Medicare’s first contingency-fee auditors, and they are paid a percentage of all identified overpayments and underpayments. CMS made some important changes to the RACs’ marching orders, partly in response to complaints from the provider community. Contact Rice at [clrice@health-partners.org](mailto:clrice@health-partners.org).*

#### **Demonstration Project SOW**

- ◆ Focus areas left to contractor discretion and “random review.”
- ◆ Payment on contingency fee for over- and underpayments.
- ◆ Contingency fee maintained even if hospital appeal won.
- ◆ Four-year retrospective window of claims to review.
- ◆ No limit on the number of claims requested.
- ◆ No tracking of claims requested versus those already under review by other contractors.
- ◆ Tight turnaround timeframes for requests — 30 days.
- ◆ Overpayments to be made immediately.
- ◆ No medical staff oversight for medical necessity review.
- ◆ No requirement for staff to be subject matter experts.
- ◆ No penalties for abusive RAC behavior.

#### **National SOW 2008+**

- ◆ Focus areas must meet “good cause” test and “targeted review.”
- ◆ Payment of contingency fee for over- and underpayment based on principal amount collected or repaid to provider.
- ◆ Contingency fee not retained if any level of appeal is in favor of provider.
- ◆ Three-year review period starting with paid claims as of 10-1-07 forward.
- ◆ 10-case limit for “initial test cases” with record maximum limit based on provider size and time period.
- ◆ RAC data warehouse to track records under review and to avoid duplicate requests.
- ◆ Timeframes adjusted according to review stage.
- ◆ Overpayment options for providers — phased payments or reductions on current payments.
- ◆ Must employ a minimum of one full-time equivalent contractor medical director (CMD).
- ◆ Staff experience and standards.
- ◆ Required to submit State of Auditing Standards No. 70 SAS Audit to independent audit firm/CPA and CMS.

physician assistant making admission decisions and ordering as the point person for us as we review the chart.”

◆ **Borgess started physician training with staff physicians, including hospitalists.** “We got on the agenda of different staff meetings for physicians, such as cardiologists,” Barnum says. The chief medical officer did a short presentation, and she introduced the role of the case manager in the ED. Then, over the next three months, “dialogues with other staff physicians became easier,” she says, which means it wasn’t as personally challenging for case managers to ask physicians to reconsider an inpatient order, for example, that may be more appropriate as an observation placement.

The case managers look for “teachable moments” to encourage physicians to date and time their orders, says Barnum. “Some asked for InterQual criteria to brush up.”

Contact Barnum at [marilynarnum@borgess.com](mailto:marilynarnum@borgess.com). ✧

## Mich. Hospitals Focus Efforts to Improve One-Day Stay Admissions

Michigan hospitals have driven down their rate of inappropriate one-day stays through a combination of interventions, reflecting a national trend of improving fortunes on the medical-necessity front (*RMC 12/3/07, p. 1*). In Michigan, hospitals participated in a project led by Michigan’s Medicare quality improvement organization, MPRO, as part of the Hospital Payment Monitoring Program.

According to the HHS Office of Inspector General, one-day stays generally are more likely to be medically unnecessary than other hospital lengths of stay. That turned out to be true for Michigan in particular when MPRO examined data from discharges for fiscal years 2002 to 2004, MPRO officials say.

To improve the medical-necessity picture in its state, MPRO focused on 16 hospitals at higher risk of improper one-day stays (see story, p. 4). Here are some of the strategies encouraged by MPRO to help hospitals cut the incidence of one-day stays, according to Kristy Wietholter, MPRO’s director of Medicare quality review, and Ben Chen, MPRO’s senior statistical analyst:

◆ **Hold monthly educational calls with the 16 hospitals organized by MPRO.** Different speakers focused on different topics. One specialist spoke on documentation, for example, and another on compliance programs in

hospitals. In other calls, a hospital physician and fiscal intermediary physician respectively addressed inpatient admission versus observation placement.

◆ **Implement a standard quality-improvement approach called rapid-cycle “Plan, Do, Study, Act” (PDSA).** PDSA helps hospitals address errors or problems, allowing them to quickly implement interventions to solve the problem or drive down errors (depending on what’s at issue). “It’s a prescribed methodology used by the Institute of Health Improvement [and others],” Wietholter explains. “It’s been around for years.”

◆ **Educate physicians and patients about the differences in patient status.** “Physicians have to understand that they are the drivers behind determining whether a patient is admitted to inpatient or observation. But they are not incentivized to care about it. They just want to make sure the patient is getting care,” Wietholter says. The problem, of course, is that if an inpatient admission is not considered medically necessary by Medicare, the hospital may have the claim denied and lose a lot of money.

Sometimes the order is missing altogether or exists in the medical record but doesn’t specify whether the patient should be admitted as an inpatient or placed in observation. “A lot of assumptions are made by staff — that if the patient were sent to this part of the hospital, it means observation,” Wietholter says. “Sometimes that is the right assumption, and sometimes that is wrong.” So the Michigan hospitals examined their processes and applied the PDSA process to put in place a mechanism for missing orders.

“Orders are important in your billing,” Chen says. “If you bill for one or the other [patient status], and there is no documentation to support it, the claim will be denied.”

Also, patients should be informed which setting they are in — it’s hard to tell because the beds and nurses and treatments all may seem the same — and they may be angry when out-of-pocket costs are higher. It’s important to educate patients so they are not hit with unpleasant financial surprises or they have an inadequate number of qualifying inpatient days for placement in a skilled nursing facility, Wietholter says.

◆ **Install case managers in the emergency department,** where most one-day stay admissions occur. “Case managers are very helpful in going back to the physician to say, ‘You don’t have proper criteria and documentation to support this admission. Can you look at it again or consider observation?’” Wietholter says. Weekends are the classic gap that leads to pervasive one-day stay errors because some hospitals lack case manager or utilization reviewer coverage. They will review admissions retrospectively on Monday, but by then the patients have been discharged, so it’s too late under Medicare rules to change the patients’ status to observation and rebill using

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condition code 44, which would allow the hospitals to recover some reimbursement. "Providing some extra staff on weekends is cost justified when you look at denied admissions, but we know it is an environment of strained resources," Wietholter says.

Contact Wietholter at [kwiethol@mpro.org](mailto:kwiethol@mpro.org). ✧

## Hospital Sues HHS Over Recoupment

*continued from p. 1*

lawsuit contends. (Recoupment means the FI gets back overpayments by reducing a hospital's present and/or future reimbursements. Redetermination is the first level of appeal, and reconsideration is the second.)

But while the appeal was ongoing, the lawsuit alleges, the FI broke the law by recouping almost \$2 million worth of alleged overpayments. To support the hospital's assertions, the lawsuit cites the following:

(1) *The 2003 Medicare reform law stated that "the [HHS] Secretary may not take any action (or authorize any other person, including any Medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered."*

(2) *In 2006, CMS proposed a regulation implementing this provision.* The rule notes the law precludes recoupment "when an appeal is received from a provider or supplier until a decision is rendered by a Qualified Independent Contractor (QIC)." QICs are responsible for reconsiderations.

(3) *A June 3, 2004, memo from three top CMS executives* told Medicare contractors generally to stop recoupment when providers and suppliers have appealed overpayment determinations. The memo — from the directors of the financial services group and the health plan policy group and the acting director of the Medicare contractor management group — says that contractors should "cease any ongoing recoupment as a result of a demand if (a) the first recoupment action occurred after December 8, 2003 and (b) a first-level appeal has been received."

Meanwhile, the hospital's appeals of the RAC's overpayment determinations are still pending. According to a First Coast spokesperson, "We are not able to make any comments on any type of litigation, so I can't comment on the issue you asked about."

Washington, D.C., attorney Andy Ruskin, who is not involved with this case, says that the lawsuit is a no-brainer in terms of the substance. HHS and the FI "violated the law," says Ruskin, who is with the law firm Morgan, Lewis & Bockius.

But the hospital faces jurisdictional issues. Providers are not supposed to sue HHS and its proxies in civil court

until they have exhausted administrative remedies, he says. Unfortunately, in cases like these, if an FI decides to recoup during the appeals process, hospitals have to suffer the cash-flow loss while they appeal, and there's not a lot they can do about it, Ruskin says. "It's a quirk of the system."

However, the hospital argues that the federal district court has jurisdiction when it's necessary, essentially, to order an agency (e.g., HHS) "to perform a duty owed to the plaintiff" (e.g., stop the recoupment). Ruskin thinks it's a sound argument and may be accepted by the court, but it could be an uphill battle. If this lawsuit doesn't succeed, providers may just have to rely on FIs to hold off on recoupment, as they are supposed to do, and usually do.

"We all have to hope that [FIs] refrain from recouping [before appeals are resolved], and if they do, that they do it not out of a sense of *noblesse oblige* but rather because they realize they have a statute to implement," Ruskin says.

Contact Ruskin at [aruskin@morganlewis.com](mailto:aruskin@morganlewis.com). ✧

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## NEWS BRIEFS

◆ **The Department of Justice said Jan. 24 that it has intervened in whistle-blower lawsuits filed against three New Jersey hospitals, alleging they defrauded Medicare through their outlier payments.** The feds allege that the hospitals billed for “outlier” payments they didn’t deserve by inflating their Medicare charges. Medicare provides outliers, which are bonus payments for resource-intensive patients, to hospitals in cases where the cost of care is unusually high. The suits were initially filed by whistle-blowers Peter Salvatori, Sara Iveson and James Monahan. Salvatori and Iveson also filed suits against Saint Barnabas Corp. and Raritan Bay Medical Center that ended in \$265 million and \$7.5 million settlements, respectively (*RMC* 6/19/06, p. 1 and 3/26/07, p. 3). St. Barnabas was the nation’s first Medicare outlier false claims settlement. Representatives for the hospitals could not be reached for comment before the *RMC* deadline. Visit [www.usdoj.gov](http://www.usdoj.gov).

◆ **On Jan. 13, New Jersey Gov. Jon Corzine (D) signed the New Jersey False Claim Act into law.** The Deficit Reduction Act rewards states that adopt their own false claims laws with a 10% increase in the amount of federal money they can keep when a Medicaid False Claims Act case is settled, as long as the laws mirror the federal False Claims Act. Twenty states, plus the cities of New York and Chicago, now have their own false claims laws, according to Taxpayers Against Fraud. Visit [www.nj.gov](http://www.nj.gov) and [www.taf.org](http://www.taf.org).

◆ **The convictions of Robert Urciuoli and Frances Driscoll, former executives of Roger Williams Medical Center (RWMC), were overturned on Jan. 18 by the U.S. Court of Appeals for the First Circuit in Boston.** Urciuoli and Driscoll were convicted in 2006 of allegedly paying former state Sen. John Celona (D) through a consulting agreement to use his authority to benefit the political and financial interests of RWMC. Celona allegedly influenced cities to increase their ambulance transports to the facility, the feds alleged (*RMC* 10/23/06, p. 5). The appeals court’s opinion says that the district court’s instructions to the jury were too broad, and that Celona’s advocacy of the ambulance services was not necessarily illegal under laws governing “honest services” mail fraud. But a new trial is necessary because of other issues concerning negotiations with private health plans, the court says. The U.S. Attorney’s Office in Rhode Island plans to retry the case, it says in a prepared statement. An attorney for Driscoll says the court noted how “fuzzy”

the law is, but had no comment on the upcoming retrial. To read the opinion, go to [www.ca1.uscourts.gov](http://www.ca1.uscourts.gov).

◆ **CMS said in a Jan. 15 e-mail that Medicare providers should start testing claims containing their National Provider Identifier (NPI) numbers.** “After Medicare providers have submitted claims containing both NPIs and legacy identifiers and those claims have been paid, Medicare urges these providers to send a small batch of claims now with only the NPI in the primary provider fields,” CMS says. “If the results are positive, begin increasing the number of claims in the batch.” Read more at [www.cms.hhs.gov/NationalProvIdentStand](http://www.cms.hhs.gov/NationalProvIdentStand).

◆ **Lafayette General Medical Center (LGMC) has agreed to pay \$1.9 million to settle allegations that it charged federal and state health programs for medically unnecessary cardiology procedures,** the U.S. Attorney’s Office for the Western District of Louisiana said on Jan. 18. The feds allege that the hospital knowingly billed for medically unnecessary elective angiograms, angioplasties and stenting procedures. The case stems from a whistle-blower suit filed by Christopher Mallavarapu, a cardiologist who alleged that “another cardiologist was routinely endangering the health and safety of patients by subjecting them to unnecessary and inappropriate medical procedures,” the feds explain. An attorney for LGMC says the facility has diligent compliance procedures in place to ensure that all services performed are medically necessary. Visit [www.usdoj.gov/usao/law](http://www.usdoj.gov/usao/law).

◆ **Pennsylvania’s Department of Public Welfare now has a policy under which hospitals will not receive payments for “preventable serious adverse events” that affect Medicaid patients,** the Hospital and Healthsystem Assn. of Pennsylvania said on Jan. 22. The policy takes effect this month and applies to “events that occur during an inpatient stay that result in serious harm to Medical Assistance [i.e., Medicaid] patients at a general acute care hospital,” the association says. Visit [www.haponline.org](http://www.haponline.org) and [www.vermont.gov](http://www.vermont.gov).

◆ **CLARIFICATION:** “Safe harbors” apply to the anti-kickback statute and not to the Civil Monetary Penalties Law (CMPL). The biggest risk for gain-sharing arrangements is violating the CMPL. A safe harbor would have limited usefulness for gain-sharing arrangements because it would not protect them from a CMPL violation. A Jan. 21 *RMC* article may have been unclear on whether a safe harbor would solve potential issues with the CMPL.

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