

BB REVIEW

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Healthcare News

May 2007

MEDICARE

New Financial Incentives for Physician Quality Reporting

Widespread physician "Pay for Performance" under the Medicare Program is one step closer to a reality. On April 3, 2007, the Centers for Medicare & Medicaid Services ("CMS") released 74 detailed specifications for its Physician Quality Reporting Initiative ("PQRI"). Under this program, physicians and certain other healthcare providers (including physical therapists, physician assistants, nurse practitioners and CRNAs) can earn a bonus payment in return for complying with at least three applicable standards of good practice.

The provider may earn a bonus payment of up to 1.5% of his or her total allowed charges for covered Medicare physician fee schedule services during the six month period, subject to an overall cap to be developed by CMS in 2008. It should be noted that this bonus will only be paid with respect to traditional Medicare fee-for-service patients and not for Medicare Advantage patients. Earned bonuses will be paid out as lump sums to qualifying providers in "Mid 2008".

Individual providers are responsible for selecting the quality measures that are applicable to their practices. If an eligible professional submits data for a quality measure, then that measure is presumed to be applicable for the purposes of determining satisfactory reporting. CMS has recommended that physicians report on all quality specifications that are applicable to their patients in order to make it more likely that: (a) they will reach the 80% satisfactorily reporting requirement for the required number of standards and (b) they will not be subject to the bonus cap.

If there are three quality measures applicable to the services provided by the eligible

professional, then each measure must be reported for at least 80% of the cases in which the measure was reportable. If there are more than four quality standards applicable to the services provided by the eligible practitioner, then a minimum of three measures, selected by the eligible professional, must be reported for at least 80% of the cases in which each measure was reportable.

CMS Proposes New Requirements to Disclose Physician Ownership in Hospitals

CMS released its proposed annual update to the hospital inpatient prospective payment system (IPPS) on April 13, 2007. Among other significant changes, the proposed rule would require all hospitals to (1) disclose to patients whether they are "physician-owned" and (2) provide the names of the physician owners to patients upon request. In addition, CMS has proposed that all physician owners of a hospital who are also members of the hospital's medical staff be required to disclose their ownership interest in the hospital to all patients they refer to the hospital as a condition of medical staff membership.

The proposed rule, scheduled to be published in the Federal Register on May 3, would take effect on October 1, 2007 if adopted. CMS has specifically solicited comments regarding (1) the definition of "physician-owned hospital[s]" and (2) whether the disclosure requirements should be implemented through conditions of participation or terms of Medicare provider agreements.

The proposed rule was motivated by CMS's findings in a statutorily mandated report submitted to Congress in August 2006 regarding specialty hospitals. The disclosure requirements, however, would apply to all hospitals, and not only to specialty hospitals. Hospital industry groups generally support the disclosure requirements, and have even



BALCH & BINGHAM, LLP
HEALTHCARE CONTACT
IN ATLANTA

Richard D. Sanders

(404) 962-3578

rsanders@balch.com

30 Ivan Allen, Jr. Blvd., NW
Suite 700
Atlanta, GA 30308

HEALTH LAW PRACTICE
GROUP MEMBERS
IN ATLANTA

Chris Anulewicz

Mike Bowers

Tom Buckley

Natalie Christensen

Joe Mandarino

Dart Meadows

J. Tom Morgan

Michelle Rothenberg-

Williams

Rich Sanders

suggested that the rule should go further than the current proposal. It should also be noted that a number of states already have physician self-referral laws in place that require physicians to disclose investment interests to patients when referring patients to entities in which they are investors.

FRAUD & ABUSE

Naples Man Convicted in Cleveland Clinic Identity Theft and Medicare Fraud Case

The United States Attorney for the Southern District of Florida announced January 24, 2007 that a Fort Lauderdale jury convicted defendant Fernando Ferrer Jr., of Naples, Florida, of all eight (8) counts of an indictment, which charged him with one count of conspiring to defraud the United States, one count of computer fraud, one count of wrongful disclosure of individually identifiable health information, and five (5) counts of aggravated identity theft. He faces up to 22 years in prison.

The case involved the theft and transfer of Medicare patient information from the Cleveland Clinic in Weston, Florida. Defendant Ferrer Jr. purchased the patient information from co-defendant Isis Machado, a former Cleveland Clinic employee, who pled guilty on January 12, 2007 and testified against Ferrer at trial. The theft resulted in the submission of more than \$7 million in fraudulent Medicare claims, with approximately \$2.5 million paid to providers and suppliers. According to the Justice Department, this is the first Health Insurance Portability and Accountability Act ("HIPAA") violation case that has gone to trial in the United States.

Judge Imposes \$190 Million Civil Penalty; Medicaid HMO's Liability Now \$334 Million

On March 13, 2007, a federal judge imposed civil penalties of more than \$190 million against Amerigroup Illinois and Amerigroup Corp., raising the companies' total liability following Amerigroup's health care fraud conviction last fall to a record \$334 million (*United States ex rel. Tyson v. Amerigroup Illinois Inc.*, N.D. Ill., No. 92C6074, 3/13/07).

In October 2006, a federal jury found that the Medicaid health maintenance organization Amerigroup Corp. and its Illinois subsidiary, Amerigroup Illinois Inc., violated the False Claims Act by refusing to enroll pregnant women or sick people to keep costs down. The

jury fined the insurance company \$48 million and then tripled the penalty to \$144 million under federal guidelines.

The total damages of \$334 million are the largest ever awarded in a federal health care fraud case in the Northern District of Illinois, according to the U.S. Attorney for the Northern District of Illinois. The federal Judge based the penalties on a finding of 18,130 false claims and assessed a penalty of \$10,500 on each false claim, totaling just over \$190 million.

According to the U.S. Attorney, from 2000 to 2004, Amerigroup was paid \$243 million to set up a Medicaid managed care health plan in Illinois. Amerigroup was paid, in part, to help low-income pregnant women who had inadequate prenatal care to navigate the complicated health care system and find care, but the company ultimately spent less than half the state and federal funds it received on providing health care.

Court Denies Motion to Dismiss Indictment Charging Clinic Owner with Medicare Fraud

The U.S. District Court for the Southern District of Mississippi ordered the trial of Wilson N. Ellis to begin April 2, 2007 after denying Ellis's motion to dismiss for violation of the Speedy Trial Act. On March 5, the court denied a motion to dismiss a second indictment charging the owner of health care clinics in Mississippi with a scheme to defraud Medicare by misrepresenting the services they provided (*United States v. Ellis*, S.D. Miss., No. 3:06cr199-WHB, 3/5/07).

Prosecutors contended that, from January 1999 to December 2002, Ellis devised a scheme to defraud Medicare by misrepresenting the services of health care clinics he owned in Flowood, Miss., and Hattiesburg, Miss., that provided chelation therapy. Instead of using the appropriate code numbers for chelation therapy, which was not reimbursed by Medicare, Ellis used code numbers for intravenous infusions that were paid for by Medicare, causing the program to pay claims in excess of \$100,000.

Former Owner of Georgia Medical Facility Sentenced to Prison for Medicaid Fraud

The U.S. District Court for the Northern District of Georgia sentenced the former owner of an Atlanta medical center on March 26, 2007. He pled guilty to allegations of health care fraud and money laundering, U.S. Attorney David Nahmias said in a press release (*United States v.*



BALCH & BINGHAM LLP

BALCH & BINGHAM, LLP
HEALTHCARE CONTACTS
IN BIRMINGHAM

Colin H. Luke

(205) 226-8729

cluke@balch.com

1901 Sixth Avenue North
Suite 2600
Birmingham, Alabama
35203-4644

Cavender C. "Chris" Kimble

(205) 226-3437

ckimble@balch.com

1710 6th Avenue North
Birmingham, Alabama 35203

Jack Levy

(205) 226-8750

jlevy@balch.com

1901 Sixth Avenue North
Suite 2600
Birmingham, Alabama
35203-4644

HEALTH LAW PRACTICE
GROUP MEMBERS
IN BIRMINGHAM

Matt Aiken

Bert Amason

Bruce Barze

Hamp Boles

Andy Buck

Christie Dowling

Mike Edwards

Ed Haden

Judd Harwood

Leigh Anne Hodge

James Hughey

Chris Kimble

Jimmy King

Kristen Larremore

Alex Leath

Jack Levy

Colin Luke

Teresa Minor

Dan Murphy

Phil Nichols

Katy Ottensmeyer

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Kimberly Powell

Laura Schiele Robinson

Monica Sargent

Bill Shanks

Pam Payne Smith

Chris Terrell

Craig Williams

Lois Woodward

Chris Yeilding

Hurowitz, N.D. Ga., No. 1:05-CR-00405, 3/26/07).

Aaron M. Hurowitz, an osteopath and former owner of Midtown Medical Center, was sentenced to 27 months in federal prison, three years of supervised release, a fine of \$60,000 and restitution of \$375,000 to the Georgia Medicaid program.

The indictment accused Hurowitz of inflating "the number and amount of claims the clinic submitted to the Medicaid program" from Jan. 1, 1997 until Dec. 31, 2002. Midtown Medical Center would routinely generate multiple charge slips for a single patient on a single date of service, as well as "upcode" by submitting claims for higher levels of reimbursement than the services provided. The clinic also allegedly billed for vision screening services that were not rendered and for medically unnecessary services, such as drug screening for children.

The indictment also alleged that Hurowitz "falsified numerous medical records in an effort to conceal his fraudulent billing practices" while he was being investigated by the Georgia Department of Community Health and the State Health Care Fraud Control Unit. Finally, the indictment alleged that Hurowitz committed money laundering by transferring title on his residence to his wife to conceal the proceeds of his scheme.

Eleventh Circuit Affirms Doctor's Conviction for Submitting False Medicare DME Claims

The federal appeals court for Alabama, Georgia and Florida upheld a physician's conviction for presenting false claims for durable medical equipment to Medicare on March 29, 2007. (*United States v. Alexander*, 11th Cir., No. 06-12385, 3/29/07).

In an unpublished opinion, the U.S. Court of Appeals for the Eleventh Circuit affirmed the conviction of Dr. Zandrina Alexander of St. Petersburg, Florida. The appeals court found no evidentiary error in Dr. Alexander's trial and decided that the errors it did find did not affect the outcome of the trial.

The jury found Alexander guilty, after determining she signed a certificate of medical necessity to order a motorized wheelchair for a fictitious Medicare beneficiary.

The evidence included tape recordings that contained statements by the owner of the DME company that Alexander would sign a CMN without first treating a patient, an electronic

claim form for a wheelchair for the fictitious patient that identified Alexander as the referring physician, and a hard copy of the CMN for the patient containing Alexander's signature.

PRIVACY

CMS Clarifies Guidelines for National Provider Identifier (NPI) Deadline Implementation

The Centers for Medicare & Medicaid Services (CMS) announced April 2, 2007 that it is implementing a contingency plan for covered entities (other than small health plans) who will not meet the May 23, 2007, deadline for compliance with the National Provider Identifier (NPI) regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The final NPI rule was published in 2004 and requires all covered entities to be in compliance with its provisions by May 23, 2007, except for small health plans, which must be in compliance by May 23, 2008.

Covered entities that have been making a good faith effort to comply with the NPI provisions may, for up to 12 months, implement contingency plans that could include accepting legacy provider numbers on HIPAA transactions in order to maintain operations and cash flows, according to a CMS official.

To read more on this press release, click here or link may be accessed by internet: go to www.balch.com, select and click on tab for 'Resources and Publications'. Select 'Resources and Publications' and on the drop down menu, select 'Newsletters'. Select and click on 'Healthcare Update'. Select and click on 'May 2007 Issue'.

Loss of PHI by Vendor to Georgia Medicaid

On April 9, 2007, Affiliated Computer Services (ACS) confirmed that a CD containing the personal data of Medicaid and PeachCare members was lost. The data included personal, identifying information including addresses, birthdates, dates of eligibility, full names, Medicaid or PeachCare member identification numbers and Social Security Numbers.

On its website, The Georgia Department of Community Health (DCH) claimed it took the following actions:



BALCH & BINGHAM, LLP
HEALTHCARE CONTACT
IN GULFPORT

H. Rodger Wilder
(228) 214-0412
rwilder@balch.com
1310 Twenty Fifth Ave
Gulfport, MS 39501-1931

HEALTH LAW PRACTICE
GROUP MEMBERS
IN GULFPORT

Ann Bailey
Paul Delcambre
Rodger Wilder

BALCH & BINGHAM, LLP
HEALTHCARE CONTACT
IN HUNTSVILLE

George A. Smith, II
(256) 512-0115
gsmith@balch.com
655 Gallatin Street
Huntsville, AL
35801-4936

HEALTH LAW PRACTICE
GROUP MEMBERS
IN HUNTSVILLE

David Block
Bill Lunsford
George Smith

- DCH is requiring ACS to provide all affected members with written notification.
- DCH has requested ACS to provide all affected members assistance with information on credit watch monitoring.
- DCH has requested ACS to provide all affected members with an application to receive a free credit report.
- DCH notified the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services Office of Civil Rights, Governor's Office of Consumer Affairs and Office of the Attorney General of Georgia.

Questions or concerns about the compromise of personal information should be directed to 1-866-213-3969. To learn how to protect yourself from identity theft, visit the FTC's Web site www.ftc.gov/bcp/edu/microsites/idtheft or call 1-877-439-4338.

PROFESSIONAL LIABILITY

Georgia Hospital Cleared of RICO Charges, Claims That Negligent Podiatrist Was Agent

On February 6, 2007, the U.S. District Court for the Middle District of Georgia ruled that Middle Georgia Hospital (MGH) could not be held liable under the state Racketeer Influenced and Corrupt Organizations Act ("RICO") statute because the patient, Jay Otero, who was injured by an illegal limb-lengthening surgery performed by a podiatrist, George Vito, could not show MGH aided and abetted an aggravated assault or that he was injured by a conspiracy between MGH and Vito to violate federal mail and wire fraud statutes. (*Otero v. Vito*, M.D. Ga., No. 5:04-CV-00211, 2/6/07).

The court previously found MGH liable in the case for negligently granting Vito surgical privileges. The surgery was beyond the scope of Vito's practice.

The court rejected the agency liability theory and noted that Vito was not employed by the hospital, as well as that Otero could not show that Vito's membership on the hospital's credentialing committee or as a physician with hospital privileges rendered him an actual or apparent agent of the hospital.

The court also stated that: "[T]here is no evidence in the record to suggest that MGH ever held Dr. Vito out as its agent, and, even if such evidence existed, there is nothing to suggest that

Otero relied to his detriment on MGH's alleged holding out of Dr. Vito".

ANTITRUST

Federal Appeals Court Upholds Dismissal of Physician's Complaint Against Hospital

The U.S. Court of Appeals for the Fifth Circuit (Mississippi, Texas and Louisiana) found that an allegation that a gastroenterologist's removal from the staff of a hospital does not sufficiently allege harm to competition to state a Sherman Act claim (*Taylor v. Christus St. Joseph Health Systems*, 5th Cir., No. 06-40775, 2/6/07).

David Taylor, a gastroenterologist, joined the medical staff of Christus St. Joseph Medical Center in Paris, Texas in 1998; at that time, he also joined a private practice. He alleges that St. Joseph recruited him to compete with another local hospital, McCuistion Regional Medical Center, in the area of gastroenterology.

In 1999, McCuistion acquired St. Joseph's. After that, Dr. Taylor alleges that St. Joseph had no need to support his practice and began conspiring with his partners to drive him out of the Paris market.

During this time, two patients sued Dr. Taylor for malpractice. As a result, St. Joseph began a review of his charts. During the review, St. Joseph found that an insurer had rejected Taylor as an "approved physician." Based on that, St. Joseph disqualified Taylor from its staff and removed his hospital admission privileges.

The Fifth Circuit affirmed the trial court finding that Dr. Taylor's antitrust claim actually alleged only one fact: that he was removed from practice at St. Joseph. The court reiterated a long-standing antitrust rule: antitrust laws protect competition, not competitors.

TAX

Form 990 Compensation Questions Pose Challenges

In 2006, new questions on compensation were added to the IRS Form 990 that go beyond traditional inquiries. Many of the changes on the 2006 form involve donor-advised funds and supporting organizations.

BALCH & BINGHAM, LLP
HEALTHCARE CONTACT
IN JACKSON

David M. Thomas, II
(601) 965-8157

dthomas@balch.com
401 East Capitol Street
Suite 200
Jackson, MS 39201-2608

HEALTH LAW PRACTICE
GROUP MEMBERS
IN JACKSON

Armin Moeller
David Thomas

BALCH & BINGHAM, LLP
HEALTHCARE CONTACT
IN MONTGOMERY

J. Dorman Walker
(334) 269-3138

dwalker@balch.com
105 Tallapoosa St., Suite
200
Montgomery, AL 36104

HEALTH LAW PRACTICE
GROUP MEMBERS
IN MONTGOMERY

JoClaudia Moore
Will Sellers
Dorman Walker

The new reporting requirements for the 2006 Form 990 require tax-exempt organizations to uncover relationships between key employees.

Completing the form can be a challenging and time-consuming endeavor for tax-exempt health care organizations and sometimes raises delicate issues because the organization must ask current and former officers and board members about their private business dealings.

For example, new versions of questions 25(c), 75(b), and 75(c), requires the organization to disclose more information about the relationships between key parties at charities and relationships between exempt and taxable organizations.

In addition, part V-B now asks for compensation of former officers, directors, trustees, and key employees, although the form is not clear in defining a "former officer".

The form also includes significant changes in information requested about disqualified persons (people in a position of substantial influence over an exempt organization) for supporting organizations. Supporting organizations help support other public charities, such as hospitals, universities, museums, or fund-raisers, but the IRS continues to expand the list of disqualified persons, which includes investment advisers and the disqualified persons of the organization that it supports.

IRS Compensation Probe Finds Major Errors in Reporting by Tax-Exempt Organizations

According to a report issued by the IRS Exempt Organizations Office (Technical Guidance and Quality Assurance Group) on March 1, 2007, tax-exempt organizations had "significant reporting errors and omissions" in the areas of excess benefit transactions, transactions with disqualified persons, and loans to officers.

The IRS also said that the compliance check initiative, begun in 2004, resulted in a large number of organizations' amending their Form 990s and collection, so far, of over \$21 million in excise taxes.

Only a little over \$4 million from public charities, including nonprofit health care organizations, accounted of this total, while transactions with individuals associated with private foundations accounted for the rest.

Although the IRS noted that the report was not based on a statistical sample and that no definitive statement can yet be made concerning

the compliance level in this area, it found no evidence of widespread concerns other than reporting.

Grassley Wants GAO to Study Issues Involved in Hospitals' Tax-Exempt Status

In a letter to the Government Accountability Office on April 5, 2007, Sen. Chuck Grassley (R-Iowa), ranking member of the Committee on Finance, asked for a study of how nonprofit hospitals meet their requirement to provide community benefits in exchange for their tax-exempt status.

Grassley asked for a GAO study examining several issues:

- the community benefit standards that states have established, in addition to those from the Internal Revenue Service, and any guidelines the hospital industry uses to interpret the community benefit standard;
- the standards and policies nonprofit hospitals use to define the components of uncompensated care, charity care and bad debt, and how nonprofit hospitals interpret and report them in practice;
- how nonprofit hospitals interpret the community benefit standard for community benefits other than uncompensated care, and how nonprofit hospitals report them in practice; and
- the level of nonprofit hospital executive and board compensation, and the extent to which these executives and board members are involved with for-profit business ventures with the nonprofit hospital.

MEDICAID

Georgia Appeals Court Finds "Any Evidence" Enough to Support DCH Reimbursement Determination

The Georgia Court of Appeals held on March 19, 2007 that the Department of Community Health's ("DCH") determination regarding which cost report to use for setting a nursing facility's Medicaid reimbursement rate was supported by *some* evidence and therefore was proper.

Medicaid reimburses nursing homes according to a flat "per diem" rate that is established based upon data supplied in the facility cost report; the facility submits the cost report annually by



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Nora Yardley
205-226-3476
nyardley@balch.com

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September 30 of each year for each fiscal year ending June 30.

When a nursing facility changes ownership, DCH requires both the buyer and seller to submit separate cost reports based upon the respective periods of time that each owner operated the nursing facility.

In setting the reimbursement rate for 2004, DCH picked the lower of the per diem rates submitted by the buyer and seller.

The new owner filed a request for administrative review of the decision. The administrative law judge (ALJ) reversed the ruling, holding that the "last approved cost report" language was ambiguous and should be construed against the department as the drafter of the manual.

The Commissioner of DCH then reversed the ALJ's decision, and the new owner appealed to the superior court. The court reversed the Commissioner's decision and reinstated the ALJ's finding. DCH then appealed.

The Court of Appeals pointed to testimony given during the administrative hearing that the per diem rate is calculated based on audited cost reports, finding this interpretation was not unreasonable.

The Court of Appeals said: "if there is *any evidence* to support the final decision of the administrative agency, that decision must be affirmed."

Although the Court of Appeals granted that the evidence supporting DCH's decision is by no means overwhelming, it is sufficient under the '*any evidence*' rule to support and authorize the final decision of the department.

MANAGED CARE

U.S. Supreme Court Refuses to Review Decision That Fund Can Withhold Doctor's Payment Based on the Fund's Determination of Upcoding

The U.S. Supreme Court refused to hear a decision by the U.S. Court of Appeals for the Second Circuit, which ruled last June in an unpublished decision that a multi-employer fund did not act arbitrarily in determining that a physician had engaged in upcoding or in withholding payment to him to recoup its prior overpayments (*Sewell v. 1199 National Benefit Fund for Health and Human Services*, U.S., No. 06-1053, cert. denied 3/19/07).

Clinton Sewell is a physician who provided medical care to union members who participated in the 1199 National Benefit Fund for Health and Human Services. The Benefit Fund began investigating possible fraud and abuse of its billing system by providers in 2003. This investigation included the billing practices of "upcoding," in which providers submit claims that are more expensive than the services the patients actually received because the provider selected a higher or more expensive procedure code.

The fund identified 70 doctors (including Sewell) whose code usage fell out of normal ranges. The Benefit Fund determined that from 1999 to 2003, Sewell overbilled the fund approximately \$200,000 by upcoding. The fund recouped that amount by withholding payment on new claims submitted by the physician from approximately January 2004 through the middle of 2005.

The Court of Appeals held that, as long as the beneficiaries were not denied benefits under the plan, it was reasonable for the Benefit Fund to withhold payment to Sewell. The Court also noted that the Benefit Fund had a fiduciary duty to ensure the plan received all of the money to which it was entitled.