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Featured Story January 18, 2008

Physician Financial Relationships, Conflicts of Interest Are Expected to Top List of 2008 Enforcement Targets

Reprinted from [REPORT ON MEDICARE COMPLIANCE](#), the nation's leading source of news and strategic information on false claims, overpayments, compliance programs, billing errors and other Medicare compliance issues.

While some familiar areas are among probable 2008 targets of enforcement agencies, expect the focus to broaden, say experts. So while areas such as hospital-physician relationships will continue to garner scrutiny from the HHS Office of the Inspector General (OIG) and the Department of Justice (DOJ), whistle-blowers and health fraud investigators may also turn their attention to areas such as admission necessity, behavioral health and evaluation and management (E/M) coding.

Lawyers expect physician financial relationships to be at the top of the enforcement list. "The intense scrutiny on physician financial relationships and conflicts of interest will continue unabated in 2008," says former senior OIG attorney Howard Young. "The medical device industry may face the brightest spotlight with ongoing criminal and civil anti-kickback investigations continuing into surgeon consulting and other arrangements. And more so than in past years, this may be the year in which DOJ and OIG pursue enforcement actions against physicians who receive the alleged industry kickbacks."

In fact, hospital-physician relationships this year will probably

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be dealt an anticipated blow when CMS finalizes changes to the Stark self-referral regulation that were first proposed in the 2007 Medicare physician fee schedule regulation. One of the changes would end most under arrangements, which CMS considers abusive. Under arrangements are contractual arrangements between a hospital and another entity from which the hospital buys technical services. The patient remains a hospital patient, and the hospital bills Medicare for all services. A typical example is outpatient clinics and surgical suites. CMS would kill under arrangements by expanding the definition of designated health services.

CMS considers under arrangements bad news in part because they purportedly invite overutilization. But Washington, D.C., attorney Andy Ruskin, who is with the law firm Morgan, Lewis & Bockius LLP, says they "foster an ownership mentality," which usually "leads to higher-quality services."

'Active Stark Year' Is Expected

That's not the only way that the Stark law will crop up. "This whole year will be a very active Stark year," says South Bend, Ind., attorney Bob Wade. Any minute now, CMS is expected to finalize its Disclosure of Financial Relationships Report (DFRR), which will require 500 hospitals to reveal the details of their physician financial relationships. If CMS finds analysis of this information to be a productive Stark compliance monitoring tool, it may take the DFRR national.

One of the areas the DFRR asks about — and all hospitals must comply with — is the limit on hospital incidental gifts and benefits to physicians. Wade says he thinks this is a time bomb because he doubts most hospitals track the goodies physicians get. "Either they are not aware of this rule, or they believe there is no way the organization will exceed the [maximum]," he says, which for 2008 is \$338 per year. The problem is, different departments or subsidiaries may bestow presents on the doctor — a box of chocolates here, two tickets to the ballet there — and the threshold can be crossed if some centralized office (probably compliance) isn't tracking the total amount of the goodies. The risk: If the hospital violates Stark, all services referred by that doctor during the time period cannot be billed, says Wade, who is with the law firm Baker & Daniels.

This may be the year Congress ends physician investment in hospitals. A bill introduced by Rep. Pete Stark (D-Calif.) would bar physicians from investments in community and specialty hospitals. That would put an end to the debate over the nuances of the whole-hospital exception.

The content of false claims cases may take interesting turns and twists this year. 2008 will already be remembered for a landmark false claims settlement involving alleged medically unnecessary admissions. Saint Joseph's Hospital of Atlanta agreed to pay \$26 million to settle allegations that it submitted Medicare claims for zero-day, one-day, two-day

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and three-day hospital stays that were not medically necessary. Patients should have been treated in observation or the emergency department, according to DOJ.

And a wide range of aberrant E/M coding — rather than just conventional cases, like emergency department upcoding — may be targeted in false claims cases, says Mark Pastin, president of the Council of Ethical Organizations. He says the artificial intelligence now employed by Medicare contractors like ZPICs will enable them to detect patterns of suspicious billing at a level never seen before. Since CMS has been warning physicians about erroneous E/M coding for years, cases like these seem ripe, Pastin says.

He also contends that behavioral health will be a growing target of enforcers. Given the short staffing that he says is "endemic" to the field, "documentation is often shaky," Pastin says.

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