

## PHYSICIAN SUPERVISION OF HOSPITAL OUTPATIENT SERVICES: RELIEF IN SIGHT?

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The Health Care Group at Murtha Cullina is pleased to provide clients and friends with information about topics of interest.

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Remember that “clarification” CMS issued two years ago stating that many hospital outpatient therapeutic services must have “direct” physician supervision (physician present in department and immediately available)? The one that brought the “incident to” standard from physician offices to hospital outpatient departments? Since then, hospitals have tied themselves into knots trying to figure out how to staff for compliance, and CMS has received a barrage of complaints.

In the 2011 Hospital Outpatient Prospective Payment System (OPPS) proposed rule (to be published August 3 with a 60-day comment period) CMS offers up a partial solution. It has identified 16 codes called “nonsurgical extended duration therapeutic services” (NEDTS) that would require only general physician supervision. CMS says that it tried to identify lengthy procedures that commonly take place after usual business hours; that are generally supervised by nurses and ancillaries; that are non-surgical; and that are low risk. Even for the NEDTS procedures, physician supervision is necessary at the initiation of the procedure. “Initiation” continues until the physician decides the patient is stable to continue without immediate physician availability.

NEDTS procedures include *non-chemo* infusion, injection, and observation services (85x). CMS is soliciting comments on the inclusion of others, and it is likely to get many suggestions, including renewed pleas for chemotherapy and blood transfusions, about which it expressly sought comment. CMS specifically states that it omitted chemo because it views the procedure as requiring “recurrent” physician presence to evaluate the patient’s condition. Hopefully, CMS will eventually decide that the availability of an emergency

department physician would be sufficient if the patient develops a problem.

As for physician supervision of diagnostic tests, CMS proposed to allow clinical nurse midwives to provide those within their scope of practice without physician supervision. Stay tuned for the scope of the final 2011 OPPS rule, in the hope it conveys more relief to hospitals struggling to cover physician supervision of common outpatient services.

## SHOW ME THE MONEY: PPACA INCREASES COMPLIANCE DEMANDS

### Failure to Promptly Return Overpayments Creates False Claim Liability

The federal government’s aggressive drive to recover overpayments (and liberally apply False Claims Act (FCA) and other civil monetary penalties) continues to generate new enforcement risks that should have hospitals and physicians looking carefully at how the compliance staff is monitoring federal program billing.

Section 6402 of the health care reform act (fondly known as PPACA) obligates providers who “identify” an overpayment to report and refund it to the Department of Health and Human Services or the appropriate contractor by the later of (i) 60 days from the date on which the overpayment was identified (unhelpfully, this term is not defined!) or, if applicable, (ii) the date any

corresponding cost report is due. The provider must also give the reason for the overpayment.

### Failure to Have Stark-Compliant Agreements in Place Can Create an Overpayment

Overpayments are broadly defined and can include duplicates, payment for ineligible beneficiaries, payment made when other third parties were actually liable (e.g., auto insurer), and services determined by utilization review to be medically unnecessary. Even discovering that no Stark-compliant agreement exists to cover a hospital-physician financial relationship could give rise to the knowledge that the hospital received payments from the program that it should not have.

As a result of the Fraud Enforcement and Recovery Act of 2009 (FERA) amendments to the FCA, an entity may be liable for penalties if it “knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.” Under the FCA, failure to repay such “obligations” may result in monetary penalties of \$5,500 to \$11,000 per claim, plus treble damages. PPACA makes the return of overpayments an “obligation” under the FCA.

These requirements became effective on the date PPACA was enacted - March 23, 2010. Note that the repayment obligations apply to money a provider received prior to the effective date, but which are identified as overpayments after the effective date of the statute. Your compliance program should be tuned up to ensure that procedures exist to fast-track identification and repayment of overpayments. Oh, and by the way, PPACA now *requires* providers to have compliance plans as a condition of enrollment under the Medicare, Medicaid and SCHIP programs. Core elements for such plans will be developed by provider or supplier type, but it is a safe bet that these will be similar to those in the “Compliance Guidance” documents already published by the Office of the Inspector General.

### Provider Claims for Payment Made in Violation of Anti-kickback Statute are False Claims

And there’s more! After PPACA it is now clear that submitted claims that are tainted by violations of the federal health care program anti-kickback statute (AKS) are *false claims*. Claims resulting from an AKS violation cannot properly be submitted to the federal program. PPACA firmly closes off one defense against allegations of an AKS violation: PPACA establishes that “a person need not have actual knowledge of this section or specific intent to commit a violation of this section.” Courts will be able to use the long-established “one purpose” test to evaluate whether remuneration was given in an intent to induce referrals -- if even one purpose of an

arrangement was intended to induce referrals of or orders for services and supplies otherwise payable under a federal program, the intent standard will be deemed satisfied. This makes it easier to find providers guilty of violating the AKS.

If you have any questions about these or related matters, please do not hesitate to contact H. Kennedy Hudner, (860-240-6029, khudner@murthalaw.com) Paul E. Knag (203-653-5407, pknag@murthalaw.com), Heather O. Berchem (203-772-7728, hberchem@murthalaw.com) or Elizabeth M. Neuwirth (203-772-7742, eneuwirth@murthalaw.com).

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