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HCFA warns of further delays to Stark II regs

Top agency official outlines coming changes in mammoth final self-referral regulations

The Health Care Financing Administration (HCFA) confirmed last week that the final regulation for the Stark II self-referral law is churning its way through the agency's final clearance process, but there are still no fixed time lines. HCFA's **Joanne Sinsheimer**, a health insurance specialist who is spearheading the agency's effort, warned health care providers June 20 they can expect a massive document and said they should brace for the possibility of further delays.

"We hope and expect that we will be able to publish [the regulations] by the time summer is over," Sinsheimer told an audience at the American Health Lawyers Association's conference in Washington, DC. But even after HCFA completes its internal clearance process, the Office of Management and Budget (OMB) still has to OK the mammoth regulation before it is published.

That may not be an easy task. The end of the fiscal year is a busy time, Sinsheimer cautions. "Even though we like to think that the document has lots of clear bright lines, it is going to be a long document," she asserts. That makes it likely that it won't be the first order of business for many OMB reviewers, she adds.

The Stark II regulations are the last piece of the self-referral puzzle. Final Stark I regulations were published in August 1995. According to Sinsheimer, the final Stark II rule will respond "in great depth" to the thousands of comments the

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House committee zeroes in on hospital downcoding

The Health and Environment Subcommittee of the House Commerce Committee put Health Care Financing Administration Deputy Director **Mike Hash** on the hot seat for much of last week's four-hour hearing on the administration's mismanagement of the Medicare program. The good news for health care providers is that Congress may be gearing up to rein in an agency that ties providers in knots through its complex regulations.

Signaling a major shift in emphasis, the subcommittee was talking about underpayments to

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How to work with in-house and outside counsel

As compliance has become a burgeoning and perplexing issue for hospitals, the relationship between in-house and outside counsel has become increasingly complex.

However, **Bruce Gilbert**, general counsel for Universal Health Services, a King of Prussia, PA-based for-profit hospital company that owns more than 50 hospitals around the country, says certain ground rules can make that relationship more manageable. He offers outside counsel the following list of "do's and don'ts" to help guide their involvement with in-house counsel:

I. Do discuss the terms of the employment at the beginning of the engagement. Don't send in-house counsel a long retention letter with five pages of rules and regulations and a demand for a $25,000 retainer.

II. Do discuss strategy with in-house counsel, make recommendations, and be willing to debate the pros and cons of what is going on.

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Stark regs

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agency received on its proposed rule published in January 1998.

Here is a rundown of key changes and modifications that providers can expect:

♦ **Entity definition**. According to health care attorney **Gregg Wallander** of the Indianapolis-based firm Hall, Render, one of the most complex parts of the proposed rule concerns the term "entity." "It would seem fairly simple," he says. "But it becomes a very difficult analysis when you involve multiple entities."

Sinsheimer says HCFA was "educated" in this area through the comment process. But she says the term "entity" is still going to be a problem because it involves both ownership and compensation. "That is when it gets more complex," she asserts. "Does the entity that is providing services even know that the physician has an ownership or compensation relationship?" In the final regulation, she says HCFA tried to make that "an easier test."

♦ **Referrals**. After the question of what constitutes an entity, Wallander says the issue of what a referral is may be the most difficult and complex. For example, there is a difference between a referral and a consultation, with a referral being almost any request for any item or service, including the establishment of a plan of care.

There are also three types of "protected physicians" — radiologists, radiation oncologists and pathologists — who are excluded as long as they are engaged pursuant to a bona fide consultation. "But don't rely on one of those folks telling you that everything they do is a consultation," Wallander warns. "I have found more than once that that is not the case." He also points out that the original physician must remain engaged in order for these specialty physicians to be exempted.

The agency's definition of 11 designated health services is yet another murky area. "HCFA's interpretation is very broad and necessitates a thorough analysis of the services involved in every physician's referrals," Wallander asserts. He adds that there is some guidance from HCFA that if a designated health service is merely incidental or peripheral it will not be included. But he says the hypothetical example of bypass surgery in the proposed regulation is difficult to understand in the hospital setting. "My feeling is that the broader interpretation is the safer way to go at this point," he asserts.

"We probably should have used a different example," Sinsheimer admits, "because when you are in a hospital, everything the hospital bills for is going to be a hospital service, which is a designated health service." But she contends that HCFA now has "a better understanding," especially in the area of radiology, and says hospitals can expect to see a more lucid explanation.

She also contends that it does not always matter if the service is a designated health service. "What matters more is if we deal less intrusively with how group practices share their money," she adds. "We recognize that we were very intrusive and we are trying to do a better job."

♦ **Ownership and compensation**. According to Wallander, the compensation portion of the proposed rule has been very taxing. For example, he says there has been considerable pressure on HCFA to revise its position on compensation to eliminate incidental benefits such as free parking and meals. Sinsheimer concedes that point. "I think we did clearly make mistakes when it came to small items such as parking," she asserts. "In the final rule, we are going to take these into account."

Wallander also notes that in the proposed rule, the term "remuneration" excludes the furnishing of certain items, devices, or supplies used solely to order or communicate the results of tests or procedures for the entity. But he says hospitals frequently encounter

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problems when they attempt to link their information systems with physicians' offices.

Sinsheimer would only say HCFA has been grappling with how to handle things that hospitals do for their own benefit rather than for the benefit of physicians.

• **Outpatient hospital services**. Wallander argues that the outpatient hospital services section of Stark II would be an ideal place for HCFA to carve out "non-abusive services" such as lithotripsy. He says hospitals, especially in rural areas, frequently face situations where a physician-owned entity may be the only entity that offers a service to a particular hospital.

Sinsheimer reports that of the 12,800 comments received by the agency, the second-largest number addressed physicians who had ownership interest in lithotripsy. She says this service is similar to cardiac cath labs and vascular labs. In those cases, doctors own these entities and services are provided under arrangement to the hospital and billed as the facility portion of the services.

"What we tried to do is come up with something that is appropriate where doctors can own these items and refer to them," she reports. But she adds that a recent Health and Human Services Office of Inspector General report showed that when physicians own this service, they charge hospitals $300 to $600 more per use than if nonphysicians owned the service. ■

Outside counsel

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Don't just take the case and then start running with it on your own. "Recognize that there is a client on the other side," he asserts. "As the in-house counsel, I become that client, so you have to discuss important strategy with me."

III. Don't expect to be particularly involved in the case if you just intend to oversee someone else doing the work. "I want to deal with the lawyer who is going to actually handle the case and do the legal work," Gilbert asserts.

IV. Do staff each matter appropriately — which usually means relatively thinly. Don't expect to put together a "team" of lawyers except in extraordinary circumstances. "We want just a few people who are going to work on the case," he says.

V. Don't be afraid of a fight and the possibility of losing a case. "I have had a few lawyers who were really good and went to the best law schools, but when they had a little quirk in the case, they shy away," he asserts. "Don't start pushing us to settle because you are afraid to take on a tough case."

VI. Do communicate with in-house counsel often and at least sometimes by telephone. Don't limit your communication to letters and e-mails. "These days, it becomes very easy to become anonymous and type out an e-mail," Gilbert warns.

VII. Do recognize that every case will not end as successfully as we want, so take the setbacks with grace and help find solutions to ongoing problems. Don't be defensive about a loss or attempt to deflect blame to others. "In other words, be a stand-up guy about it," Gilbert asserts. "You can't win every time."

VIII. Do review each bill and delete unnecessary or unreasonable items before you send it to in-house counsel. Don't be a billing partner if you are not going to work on the case or are otherwise not very familiar with the case. In other words, don't just send out a bill if you didn't do the work, Gilbert concludes. ■

Relationships between lawyers 'a two-way street'

Jerry Bell, a health care attorney with Fulbright & Jaworski in Houston, warns that the relationship between in-house and outside counsel is a two-way street. Here is a list of his pet peeves that he says in-house counsel should bear in mind.

• **Don't hold sham "beauty contests."** "I have been in some 'beauty contests' where I really felt like the outcome was a predestined result," Bell asserts. "I wondered whether the whole thing was generated so the prospective client could get a lot of free ideas about how to structure a transaction or deal with a particular issue."

• **Don't unreasonably refuse to waive conflicts.** If there is no similarity between lawsuits and contracts, Bell says providers should be willing to waive potential conflicts.

♦ **Don't second guess bills needlessly.** Bell says providers should be careful not to question very minor charges unnecessarily. "When the bill is way out of line, I think that is legitimate," he says. "But just to nit-pick a bill is unreasonable."

♦ **Don't fail to collaborate.** Bell says in-house counsel sometimes fail to offer adequate background material to outside counsel. For example, a firm may be asked to prepare a medical director agreement for a facility without knowing the overall business or strategic plan. "How can we prepare even a simple medical director agreement if we don't understand the overall objectives of the client?" he asserts.

♦ **Don't play firms off against each other.** Bell says outside firms are typically not the only firm engaged by a provider. "That's fine," he asserts. "It is when we start getting played off against each other that I don't like it."

♦ **Don't think loyalty is a one-way street.** According to Bell, in-house counsel who take a hard-line position about what a conflict is but an expansive view about the firms they might use should avoid cutting a loyal law firm loose at the drop of a hat.

♦ **Don't make outside counsel the bad guy.** If there are 10 transactions and nine of them are OK, don't make outside counsel deliver the news to the CEO about the one that won't work, Bell advises. ■

Downcoding

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providers instead of overpayments. For example, **Robert Waller**, chairman of the Washington, DC-based Healthcare Leadership Council (HLC), pointed to a recent Congressional Budget Office analysis of changes in hospital billing patterns that shows hospitals have been downcoding simple pneumonia to respiratory infection at a far greater rate than ever before.

Waller also noted a recent assertion by **Gail Wilensky**, head of the Medicare Payment Advisory Commission, that hospital undercoding has become a serious problem. "You don't hear the OIG or the Department of Justice worrying about whether we are underpaying," said Wilensky.

"The environment is so hostile and the fear of being accused of fraud is so great that providers are not always seeking the appropriate level of payment and are being overly conservative," asserts HLC President **Mary Grealy**.

Michael Mangano, principal deputy inspector general of the Health and Human Services Office of Inspector General (OIG), told the subcommittee that among the OIG's continuing concerns are Medicare payments to community mental health centers for partial hospitalization services, outpatient psychiatric services, and Medicare contractors that falsify statements to improve their ratings on performance evaluations.

A spokesman for the subcommittee reports that any action stemming from the hearing is likely to be part of long-term reform rather than immediate legislation. Grealy argues the current program can't be fixed. "Our position is that you need to restructure the whole program and get away from the micro-managed fee-for service model and move to something like the cafeteria-style Federal Employees Health Benefit Program." ■

HCCB certification program now up and running

The Healthcare Compliance Certification Board (HCCB) in Philadelphia launched its certification program for compliance executives last week. The program marks the first major effort to establish baseline standards for compliance officer training and education.

The Health Care Compliance Association (HCCA) established HCCB last year to develop and manage the certification program. HCCB contracted with Applied Measurement Professionals Inc. to assist in the development, administration, scoring, and analysis of the examination.

The health care compliance exam is available five days a week during regular business hours, at various locations in all 50 states. The fee is $250 for HCCA members, and $350 for non-members.

To help candidates prepare for the exam, HCCB has developed a 15-page candidate handbook that includes an application, information on test locations and eligibility requirements, a detailed outline of the test, and a list of books and periodicals candidates can use to prepare.

To learn more, contact HCCB's Robert Rupp at (800) 980-8482 or hccb@nursecominc.com. ■