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OIG report threatens provider-based practices

Hospitals' failure to report ownership of physician practices could lead to charges of double-billing

A new report from the Department of Health and Human Services Office of the Inspector General (OIG) could increase federal scrutiny of hospital-owned physician practices, experts say.

In the report, "Hospital Ownership of Physician Practices," the OIG claims that some hospitals are improperly classifying the physician practices they own as "provider-based" rather than "free-standing" practices, resulting in significant over-payments from Medicare.

If adopted, the OIG's recommendation that the "provider-based" designation be done away with entirely could have a serious negative impact on reimbursement both for hospitals and the practices they own.

In addition, the report could trigger a new focus for federal fraud investigators — the possibility that hospitals and their physician practices are effectively double-billing Medicare for the same services.

Based on information gathered between 1995 and 1997, the report found that about 62% of hospitals purchased or owned a physician practice. But, the report says, Medicare's Fiscal Intermediaries were aware of only about 50% of those purchasing or operating arrangements. As a result, the OIG says there may be inaccurate reporting of services by hospitals on their cost reports, leading Medicare to pay too much.

"The implication that they're making in that

*See **OIG report**, page 2*

AMA puts finishing touches on new physicians' union

Less than three months after its house of delegates voted — against the wishes of the association's hierarchy — to create a national union for employed physicians, the Chicago-based American Medical Association (AMA) has released the name and constitution of the labor organization, as well as a partial list of members of the nascent union's governing body.

According to the constitution's preamble, the union, named Physicians for Responsible Negotiation (PRN), will "advocate on behalf of our

*See **AMA union**, page 4*

Legal audit determines your Y2K liability exposure

Besides reviewing software, hardware, and other equipment for Y2K compliance, physician practices should do a legal audit of their Y2K exposure to related liability, warranty, and insurance concerns.

One problem is that many of those questions still have no answers. "The courts have not yet given guidance on the allocation of liability among health care providers, manufacturers, insurers, and others in the event of an injury or death caused by a Y2K failure of a biomedical device," notes **Jerald J. Oppel**, an attorney in Baltimore-based Ober, Kaler, Grimes & Shriver's health care practice.

A question that's easier to answer: Are your Y2K preparations sufficient to prevent your insurance company from using that as a legal argument for not paying your claim?

Oppel notes one of the major Y2K legal questions: Who is responsible for testing and certifying that biomedical equipment is Y2K-compliant?

*See **Y2K liability**, page 3*

INSIDE:

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OIG report

Continued from page 1

statement is that fiscal intermediaries know [about the arrangements] only half the time; therefore, half of what's going on out there is somehow wrong or being reimbursed incorrectly," says **Carmela Coyle**, senior vice president for policy at the Chicago-based American Hospital Association. "The problem with the report in general is that it paints with too broad a brush all hospital ownership arrangements of physician practices."

Hospitals that own physician practices may classify them in one of two ways. If they include them as part of the hospital, they must also list the operating costs of the practices on their Medicare cost report. If the practices in question meet certain criteria laid out by the Health Care Financing Administration (HCFA), the practice is classified as provider based. Alternatively, physician practices may be classified as freestanding entities, in which case the clinic wouldn't be included on the hospital's cost report and would receive Medicare payments through the physician fee schedule — Medicare Part B.

Under this second method, services — such as administrative services — provided by the hospital to the clinic would have to be accounted for via a nonreimbursable cost center in the hospital cost report, says an analyst at the Englewood, CO-based Medical Group Management Association. The hospital would have to exclude any of these services costs to the freestanding clinic from the cost report because the government considers those costs as already covered through the Part B payment.

"We do feel that the existing situation is vulnerable to fraud and abuse," says **Ben St. John**, an OIG spokesman. "Because of the limited reporting requirement, and the fact that the fiscal intermediaries and carriers would not always know whether or not the claims being submitted are appropriate, there could be duplicate billings or billings for a higher reimbursement than what is appropriate."

St. John says that without knowing the exact relationship between the hospital and the physician practice, the fiscal intermediary would have no way of knowing if it was paying duplicate reimbursement for a single service. "In terms of false claims, it would be on a case-by-case basis of whether this was knowingly done or if there was ignorance of the [reporting] requirement."

In the report, the OIG recommends that HCFA eliminate the provider-based designation, which allows hospitals to operate physician practices as though they were a part of the hospital and not a freestanding clinic. The OIG believes that some hospitals use this designation to boost reimbursement even though some clinics don't qualify for it. The OIG also recommends that HCFA require hospitals to alert fiscal intermediaries of any purchases of physician practices and seek legislation allowing it to sanction entities for failing to alert intermediaries of such an arrangement.

If the provider-based designation is scrapped, those hardest hit are likely to be physician-run clinics in inner-city or rural areas, Coyle says. "The losers would be patients who currently are able to access hospital-based clinics, who won't be able to if that higher reimbursement is not made available," she predicts. "The OIG report may move us a step backward in terms of the public policy process."

In its response to the report, HCFA agreed with the recommendations regarding tougher reporting requirements, but significantly, it shied away from endorsing OIG's recommendation to eliminate the provider-based designation. HCFA advocates level payments in all settings, so that there would

Continued on page 3

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be no advantage to classifying a clinic as free-standing or provider-based. HCFA indicated that it would be difficult to write rules that differentiate physician practices from outpatient clinics so that one is included in provider-based designations and the other is not.

It remains to be seen whether the OIG report will have a chilling effect on hospital ownership of physician practices, but Coyle notes that for many hospitals, those arrangements are already money-losers. If the OIG gets its way, there's likely to be even less incentive for hospitals to purchase physician practice. ■

Y2K liability

Continued from page 1

Should you rely on manufacturer certification?

"Currently, there is no clear-cut answer as to whether a health care provider should rely on a manufacturer's certification of Y2K compliance, or whether the health care provider also should perform independent tests to confirm Y2K compliance," he answers.

According to the General Accounting Office, some major private equipment testing and certification organizations have decided to rely on manufacturers' Y2K certifications because they have stated that manipulating the embedded software may void the manufacturers' certification to the Food and Drug Administration that the equipment is safe for patient use.

"This action, in turn, could expose the certification organization that performed tests on the equipment to legal liability should the equipment later malfunction and harm a patient," says Oppel.

Other experts say each piece of equipment should be individually tested. The reason is, microchips in individual units of the same product may have been manufactured by different suppliers or made at different times.

Some factors to take into consideration when deciding whether to independently test an item of medical or office equipment:

- Does the manufacturer certify the item as Y2K-compliant?
- What is the scope of that certification?
- What are the terms of any contract, license or maintenance agreement with each manufacturer — particularly warranty, intellectual property, and confidentiality provisions?
- What is the potential threat of harm posed by failure of the device?
- What will the cost and feasibility of replacing the device be?

Before testing any of your equipment, from telephones to medical devices, providers would be wise to first have their lawyer read the contract and guarantee terms for the equipment to ensure that testing does not place the practice at risk, Oppel advises. For instance:

- Warranties. Tampering with a biomedical device to conduct Y2K testing can invalidate a manufacturer's warranty in some instances.
- Intellectual property. If a health care facility does not own the rights to a particular software product, tampering with it may infringe on the owner's proprietary rights or may constitute a breach of the license agreement.
- Confidentiality. Allowing a third party to access software may breach confidentiality obligations contained in the license agreement. It also may expose a provider to liability for misappropriation of trade secrets.

A sales or technical representative's statement to you that his company's equipment or service is Y2K-compliant does not always mean what you think it does.

"Even when a manufacturer certifies that its equipment is Y2K-compliant, there are varying levels of assurances — from the very general and not so reassuring, to the very specific and much more reassuring," Oppel points out. For instance, a certification may:

- refer only to general indications of Y2K compliance;
- refer to the general Y2K compliance of a manufacturer's entire product line;
- indicate that certain products have been tested and are compliant;
- indicate that a particular item has been tested in a certain way and is compliant.

There are also different definitions of the term "Y2K-compliant," notes Oppel.

The Food and Drug Administration, for example, defines Y2K compliance to mean: "With respect to medical devices and scientific laboratory equipment, the product accurately processes and stores date/time data (including, but not limited to, calculating, comparing, displaying, recording, and

Continued on page 4

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sequencing operations involving date/time data) during, from, into, and between the 20th and 21st centuries and the years 1999 and 2000, including correct processing of leap year data."

Products must function as intended or expected, regardless of the date, to be Y2K-compliant. However, each manufacturer is free to respond to a customer's Y2K compliance inquiry with any definition or interpretation of what it thinks Y2K compliance is. This lack of consistency should be taken into account when evaluating each certification. ■

Y2K contingency plan can keep you functioning

Now that Y2K is only a couple of months away, you need to determine what is likely to happen if a glitch occurs, and decide how you are going to handle it.

"Contingency planning for Y2K is the same as planning for a hurricane or a snowstorm. The only difference is that you won't be surprised when it happens," says **Bruce Orgera**, executive director of Superior Consultant Co. in Southfield, MI. You should be as detailed in developing your plan as you should have been when you did your first Y2K inventory, he adds.

If you've done a proper Y2K inventory, you should already have a list that identifies every piece of equipment and every process involved with running your office that could possibly malfunction as a result of the Y2K bug.

"There are not very many things that shouldn't be on that list," Orgera points out. To develop your plan, look at each potential failure and decide what will be required to correct it. Then rank them in order of importance.

Look at every possible scenario and determine everything that can fail and what you could do in that event. For example:

If the security locks on the door to your building won't function, do you know how to get into the building?

What do you do in case of an equipment failure? Can you borrow equipment? Can you share it with another practice in your building? Will you have to direct your patients to other locations?

If a patient can't get to you, how can you get to the patient? Can your area's emergency services support a crisis?

Look at the human interaction side of your practice as part of your contingency plan. If the practice manager or office manager typically runs things, you need to designate someone else to be the leader if that person can't get into the office. You might assign the person who lives nearest the office the role of opening the office and being in charge.

After your Y2K contingency plan is laid out, have a test emergency. "Like any other emergency — such as a fire drill — if you don't practice, you may have chaos," Orgera says. ■

AMA union

Continued from page 1

members, with their employers and others, as the law allows, to create and maintain a health care system that guarantees our members a working atmosphere where they can devote the time and attention to their patients' needs." What the union will not do, however, under any circumstances, is strike or withhold essential medical services, a provision that sharply differentiates it from "almost all traditional unions," says **Todd Vande Hay**, the AMA's vice president of private sector advocacy and a member of PRN's governing committee.

"Most of the people who have been involved in organizing physicians up to this point have actively gone out and tried to convince physicians that [unionization] is an option that they should pursue," Vande Hay says. "PRN isn't going to be doing that. It's going to respond to physicians who have a desire to collectively bargain."

Currently, only two states, Washington and Texas, allow nonemployed physicians to bargain collectively, but that could change. A bill by Rep. Tom Campbell (R-CA) would amend federal antitrust laws to allow self-employed physicians to bargain collectively with managed care organizations. The bill currently has 150 co-sponsors. Vande Hay says that if the Campbell bill is passed, it could "dramatically expand the focus and potential of PRN activity."

In addition, residents may soon win the right to unionize, pending the outcome of a case in Boston in which residents argue that they are employees rather than students. "That's a huge group of people; it would also expand the PRN's focus," Vande Hay says. A ruling in that case could come by end of October. ■

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