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OIG Advises on Internet Pay Per Lead Advertising

The Department of Health and Human Services Office of Inspector General (OIG) issued Advisory Opinion 08-19, on October 29, 2008, addressing an internet advertiser's proposal to extend its "pay per call" or "pay per lead" internet advertising to the chiropractic industry ("Proposed Arrangement").

Under the Proposed Arrangement, the internet advertiser maintains a service by which potential patients go to the internet advertiser's website for a listing of chiropractors in their geographic area who subscribe to the advertiser's service. The potential patient is connected by phone or email, by the internet advertiser, to the subscribing chiropractor that the potential patient chooses. The chiropractor is then charged by the internet advertiser for the call, as part of their subscription fees. This practice is known as "pay per call" or "pay per lead" internet advertising.

The OIG reviewed the Proposed Arrangement as an advertising arrangement and indicated that per-unit-of-service advertising for healthcare services can potentially implicate the anti-kickback statute and that it did not fall within the safe harbor for personal services and management contracts or for referral sources. The OIG determined that it would not impose sanctions for such an arrangement since it contained enough safeguards to minimize risk of abuse to government funded health care. The OIG acknowledged that the proposed arrangement limited such risks in following manner:

- The internet advertiser is not a healthcare provider or supplier.
- The internet service will be available to the general public and will not target federal healthcare program beneficiaries.
- The internet advertiser will provide a list of all subscribing chiropractors in the potential patient's geographic area and will not

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<http://www.kgrlaw.com>

mjc@kgrlaw.com

lmb@kgrlaw.com

steer patients to any particular provider.

- The website will include a disclaimer that the provider is paid a listed fee.
- The fee per call or email paid by each provider will represent fair market value, and will not be based on whether or not a potential patient chooses to become a patient of the subscribing chiropractor, and the prospective patients will not pay a fee for using the website, nor receive any remuneration.

The OIG continues to scrutinize provider arrangements with other parties to determine whether such arrangements could implicate the federal anti-kickback statute and whether there is a likelihood of abuse to the federal health care programs. Each health care provider arrangement should be analyzed for potential violation of federal law.

For more information please contact Linda Batten at lmb@kgrlaw.com or Mark Colucci at mjc@kgrlaw.com.

Potential for Increased HIPAA Enforcement

The Department of Health and Human Services Office of the Inspector General (“OIG”) recently issued a report criticizing the Centers for Medicare and Medicaid (“CMS”) for its “limited actions to ensure that covered entities adequately implement the HIPAA Security Rule.” The OIG stated that the actions taken by CMS did not provide effective oversight or encourage enforcement of the HIPAA Security Rule by covered entities.

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) Security Rule established national standards to protect the confidentiality and integrity of electronic protected health information (“ePHI”) while it is stored or transferred between entities. In a letter to acting CMS administrator Kerry Weems, which accompanied the report, the OIG recognized the CMS was given “(1) the authority and responsibility to interpret, implement, and enforce the HIPAA Security Rule provisions; (2) the authority to conduct compliance reviews and to investigate and resolve complaints of HIPAA Security Rule noncompliance; and (3) the authority to impose civil monetary penalties for a covered entities failure to comply with the HIPAA security rule provisions.” The OIG stated that “as of February 16, 2006, CMS had not conducted any HIPAA Security Rule compliance reviews of covered entities” and “[a]s result, CMS had no effective mechanism to ensure that covered entities were complying with the

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<http://www.kgrlaw.com>

mjc@kgrlaw.com

lmb@kgrlaw.com

HIPAA Security Rule or that ePHI was being adequately protected.”

The OIG did acknowledge that “CMS had an effective process for receiving, categorizing, tracking, and resolving complaints,” but stated that relying on voluntary complaints alone was “ineffective for identifying non-compliant covered entities.” Thus, the OIG recommended that CMS establish policies and procedures for conducting HIPAA Security Rule compliance reviews of covered entities. In a letter responding to the report, CMS stated that it disagreed with OIG’s finding that its approach was inadequate, but also stated it agreed that “compliance reviews are part of a comprehensive enforcement strategy, but [we] also feel that they are but one of several tools that can be used to promote compliance.” CMS noted that other activities, such as complaint investigation and resolution, increased outreach to the industry, and education, can be valuable in improving compliance.

The OIG report and CMS response is likely to lead to increased attention on enforcement of the HIPAA security rule. CMS maintains a comprehensive approach is the best way to promote compliance, but given the OIG’s emphasis on the lack of compliance reviews, health care providers can expect to see these types of reviews from CMS in the future.

For more information, please contact Mark Colucci at mjc@kgrlaw.com, or Linda Batten at lmb@kgrlaw.com.

CMS Issues Improper Payment Rates

In a November 17, 2008, news release, CMS announced that it saved taxpayers approximately \$400 million in improper payments in 2008. CMS reported that the projected fiscal year 2008 improper payment rate (the “Rate”) for Medicare fee-for-service (“FFS”) dropped to 3.6%, or \$10.4 billion, from 3.9% in fiscal year 2007. CMS also reported that the Medicare Advantage Rate for fiscal year 2006, the first rate reported, was 10.6%, or \$6.8 billion.

CMS emphasized that the Rate did not necessarily reflect fraud, but includes payments paid incorrectly, whether for arising from claims for medically unnecessary services or claims that were incorrectly coded. Moreover, “providers either did not submit information to support their FFS or managed care claims or did not submit additional data when requested.” Medicaid or SCHIP Rates included services provided to persons who were not eligible either for the program or

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<http://www.kgrlaw.com>

mjc@kgrlaw.com

lmb@kgrlaw.com

for the services provided.

CMS stated that it would expect the Medicare Advantage Rate to drop as has the Medicare FFS Rate. In 1996 the FFS Rate was 14.2%, compared to 3.6% in 2008. CMS advised that "error rates for Medicare Advantage, Medicaid and SCHIP [will] decline similarly through program maturation and the agency's use of tools that include statistical sampling, medical reviews and error rate reduction plans."

CMS also announced that it will conduct an in-depth evaluation of the 2008 FFS Rate to strengthen confidence in its Rates. In August 2008, the OIG was critical of CMS's claimed Rate for fiscal year 2006 for DME, prosthetics, and orthotics suppliers.

For more information please contact Linda Batten at lmb@kgrlaw.com or Mark Colucci at mjc@kgrlaw.com.