



Disclosure Information

A Fraud and Abuse Potpourri

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The following relationships exist related to this presentation:

NONE

Grant support (GS), consultant (C), speakers bureau (SB), stock options (SO), equity interest (EI):

NONE

Off label use of products will not be discussed in this presentation.

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My formal remarks

- Splitting CTA with radiologists: what's really possible?
- Sheehan's slides: quality and enforcement
- Payment for quality: what's new?
- Relating to hospitals around quality: a better bond within Stark and antikickback

CTA

- The spread of technology and knowledge
- The limits under the law: you can't split an interpretation
- What really is an *over-read*?
- Can the hospital pay for the over-reads?
- What happens if you hire your own radiologist?

EACH WAY TO GET PAID IN HEALTH CARE HAS UNIQUE FRAUD RISKS-AND SOME COMMON ONES

■ FEE FOR SERVICE RISKS

- Services billed but not rendered
- Medically unnecessary services
- Double-billing
- Services billed at higher level or with other inappropriate code to improperly obtain more reimbursement (upcoding, unbundling, evasion of global fees)
- Kickbacks to other providers for patient referrals
- kickbacks to patients to use more services

FEE FOR SERVICE MODEL CASES

- USA V. RUTGARD-CODING AND MEDICAL NECESSITY
- USA V. UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY-BOTH INDIVIDUAL PHYSICIANS AND UMDNJ BILLED AND PAID FOR SAME PHYSICIAN SERVICES
- USA V. GREBER-KICKBACKS TO REFERRING PHYSICIANS FOR PHYSICIAN ORDERS
- USA EX REL. LEE V. SMITHKLINE-BILLING FOR ORDERED BUT WORTHLESS TESTS
- PATH PROJECT- SERVICES PERFORMED BY RESIDENTS BILLED BY ATTENDING PHYSICIANS

WHAT IS THE QUALITY WE ARE PAYING FOR?

- 1) REDUCTION OF MEDICAL
ERRORS/ADVERSE EVENTS
- 2) IMPROVEMENT IN OUTCOMES
- 3) COMPLIANCE WITH PRACTICE
GUIDELINES OR REQUIREMENTS
- 4) REDUCTION IN COST FOR SAME
OUTCOME

CORE QUESTION: WHY (AND WHEN) FRAUD ENFORCEMENT?

- KNOWING CONDUCT BY INSTITUTION/GROSS AND SYSTEMIC LEADERSHIP FAILURES (Notice, warning, failure to act)
- INTENTIONAL ACTS BY INDIVIDUALS
- FALSE REPORTING, FAILURE TO REPORT
- APPALLING OUTCOMES
- WHAT WILL BE CONSEQUENCES OF OUR INVOLVEMENT?

QUALITY AND ENFORCEMENT

- HAS THERE BEEN A SYSTEMIC FAILURE BY MANAGEMENT AND THE BOARD TO ADDRESS QUALITY ISSUES?
- HAS THE ORGANIZATION MADE FALSE REPORTS ABOUT QUALITY, OR FAILED TO MAKE MANDATED REPORTS?
- HAS THE ORGANIZATION PROFITED FROM IGNORING POOR QUALITY, OR IGNORING PROVIDERS OF POOR QUALITY?
- HAVE PATIENTS BEEN HARMED BY POOR QUALITY , OR GIVEN FALSE INFORMATION?

Paying for Quality

- P4P: add ons to an otherwise toxic payment system
- Pay for reporting: say what?
- **PROMETHEUS PaymentTM:**
 - Provider payment Reform for Outcomes
Margins Evidence Transparency Hassle-
reduction Excellence Understandability and
Sustainability

Basic Principles

- A case rate (ECR) is constructed from an evaluation of the resources necessary to treat a patient for a condition – across all providers
- Providers come forward in whatever configurations they want and negotiate to render the part of the ECR they are comfortable with
- 10% on chronic and 20% on acute is held back in a Performance Contingency Fund which is paid
- Based on a Scorecard which measures whether you did what you said, the patient's outcomes and experience of care

Goals and Incentives

- Clinical collaboration without legal or financial integration comes from scores:
 - 70% is what you do; 30% is what everyone else does
- Paying the right amount to get what science says the patient needs including registries, NPPs
- **HASSLE REDUCTION:** no E & M bullet points, no 1-800-nurse-from-hell, no prior authorizations, no concurrent review, no post-payment audits
- Reduction in liability and fraud and abuse risk

Interventional Cardiology Is In the First ECRs

- STEMI
- Non-ischemic CHF
- Mitral Valve Regurgitation
- Participants in Clinical Working Groups:
 - Joe Messer MD, Janet Wright MD, Bonnie Weiner MD

Working with Hospitals on Quality

- Time is money
- Physicians can get paid for some things: FMV under Stark
- Doing the work on the quality initiatives
- Medical staff service may be on the list
- Gainsharing: who is helping whom?
- On-call coverage
- Avoiding LaHue-type messes

What else?

- *Get them to give you time*
 - Standing order sets: Park Nicolett
 - Templated documentation
 - Empowering nurses on the units: Hackensack
 - Standardize processes
- They can help with staffing services
 - NPs, PAs, CNSs

Get Help To Clinically Integrate

- Not exactly a “safety zone”
- Production of data is part of the point
- It is not the only reason to clinically integrate
- The five principles of UFT-A (www.uft-a.com)
 - Standardize, simplify, make clinically relevant, engage the patients, fix accountability at the locus of control
- Clinicians learning from each other and improving is also part of the point

What and How?

- Otherwise competing physicians can bargain collectively for FFS (and other forms) IF
 - They use protocols and/or CPGs to standardize delivery of care
 - They engage in internal review and profiling of participating physicians
 - They invest in infrastructure with money and time
 - They take action against poor performers
 - They provide data to payors
 - The fee bargain is ancillary to the reason to come together

The Hospital's Potential Role

- Identify CPGs
- Facilitate access to hospital infrastructure for monitoring
- Help with profiling
- Help construct rates
- Multi-provider network formation

More

- Compliance training exception under Stark
- Information technology support: the new regs under Stark and Anti-kickback
- Physician recruitment for quality

Resources

- ACR White Paper:
<http://www.gosfield.com/newissues.htm#prliab>
- “PROMETHEUS Payment: The Legal Blueprint”,
<http://www.gosfield.com/PDF/PrometheusPayment2.pdf>
- “Engaging Physicians in A Shared Quality Agenda”
<http://www.ihl.org/IHI/Results/WhitePapers/EngagingPhysiciansWhitePaper.htm>

The Clinic is Open

- Stark issues bothering you?
 - Medical directorships, compensation
- Diagnostic testing?
- Using NPPs in the practice?