

Late breaking news on
medical-legal developments
affecting physicians and
health care providers.

A publication of:

**Kern Augustine Conroy
& Schoppmann, P.C.**

"ATTORNEYS TO HEALTH PROFESSIONALS"

Email: kacs@drlaw.com

Website: www.drlaw.com

New York:

420 Lakeville Road
Lake Success, NY 11042
Tel: (516) 326-1880
Fax: (516) 326-2061

New Jersey:

1120 Route 22 East
Bridgewater, NJ 08807
Tel: (908) 704-8585
Fax: (908) 704-8899

Pennsylvania:

2000 Market Street
Suite 2803
Philadelphia, PA 19103
Tel: (800) 445-0954
Fax: (800) 941-8297

Illinois Affiliate:

Augustine, Kern & Levens, Ltd.
218 N. Jefferson Street
Chicago, IL 60661
Tel: (312) 648-1111
Fax: (312) 648-1057

**NEW LAW REQUIRES NYC NO-FAULT PROVIDERS TO ENGAGE IN
MANDATORY INCOME AND MANAGEMENT DISCLOSURE**

A recent amendment to the New York City Administrative Code imposes mandatory year-end filing and disclosure requirements upon certain high volume No-Fault providers. When at least fifty-percent of a provider's billings for a twelve-month period are attributable to No-Fault claims, a report must be filed with the NYC Department of Consumer Affairs that discloses the names, addresses and telephone numbers of the entity, identifies all of its owners and any entity performing management services for it. The amendment also prohibits health care providers, shareholders and officers of professional corporations, or management companies from paying "runners" – people who refer patients to No-Fault providers for a fee. The report must also disclose the actual percentage of the entity's billings attributable to No-Fault and contain a sworn statement that it does not use, solicit, direct, hire or employ "runners". Violations of this new law are punishable as misdemeanors and carry potential fines of \$10,000 per violation. Accuracy in reporting is crucial since the filing of a false sworn statement is punishable as a felony. Providers whose total No-Fault billings are less than fifty-percent have no reporting requirement under the new law.

OFFICE OF INSPECTOR GENERAL RELEASES 2007 WORK PLAN

Last month, the United States Department of Health and Human Services, Office of Inspector General ("OIG") released its fiscal year 2007 work plan. The document provides some insight into the OIG's investigative initiatives for the upcoming year. According to the report, The OIG will continue to focus upon hospitals, long-term care facilities and bills submitted by physicians and other health professionals. Specifically, the OIG is planning to investigate whether payments for Medicare services billed as "incident to" truly meet the standards for medical necessity and/or documentation. On the mental health front, The OIG plans to undertake substantial efforts to determine whether group therapy sessions are being improperly billed and reimbursed as individual therapy sessions. The OIG also plans to scrutinize "long-distance" physician claims associated with home health and skilled nursing facility services and will specifically focus upon services that would normally require face-to-face examination for beneficiaries who live a significant distance from the physician's office.

**OFFICE OF INSPECTOR GENERAL FINDS ESTIMATED \$20 MILLION IN
MEDICARE OVERPAYMENTS FOR RADIOLOGY SERVICES**

According to an audit conducted by the OIG, between 2001 and 2003 Medicare overpaid an estimated \$20 million by paying twice for the same radiology services--once to hospitals under the prospective payment system ("PPS") and once to radiology suppliers under Part B. According to The OIG, radiological services rendered to Medicare beneficiaries under Part B, during inpatient hospital stays, must be billed directly to the hospitals, not to the Medicare suppliers or carriers. The report further revealed that most Medicare carriers had no post-payment review procedures in place for identifying such duplicate payments and recommended that they aggressively seek recovery of these overpayments.