

The background features a faded image of a wooden gavel resting on a document. The document has some text, including 'MEMBER OF THE' and 'FEDERAL RESERVE NOTES'.

# OIG Supplemental Compliance Plan for Hospitals

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- Continuing effort to promote voluntary compliance
- *Supplements* rather than *replaces* the OIG's 1998 CPG
- Not a model compliance program
- Recognizes that the industry has made a “real” effort

- Addresses the public and private sectors' mutual goal of reducing F&A
- CPG = Good Faith Effort
- Guidelines are NOT law/create legal obligations
- Not meant as a substitute for consultation with CMS / FI
- S.O.S.O.

# Fraud & Abuse Risk Areas

- Submission of accurate claims & information
- Referral statutes
- Payments to reduce or limit services
- EMTALA
- Substandard care
- Relationships with beneficiaries
- HIPPA
- Billing in “excess” of “usual charges”

# Submission of Accurate Claims

- “Single biggest risk area”
- Common & long-standing risks
  - Incorrect coding
  - Unbundling of services
  - Medical necessity
  - Duplicate billing
  - Documentation
  - Cost Reports



# Evolving Areas

- “Evolving” risks/risks that appear to be **“under-appreciated”**
  - APC coding and billing
  - Physician referrals
  - Admissions & discharges
  - Supplemental payment considerations
  - IT

- *In case you missed it* – coding **now** matters for Outpatient Claims
  - Outpatient billing for “Inpatient ONLY” services
    - 1,695 procedures {[www.cms.gov/regulations/hopps/2004f](http://www.cms.gov/regulations/hopps/2004f)}
  - Failing to follow LCDs/LMRPs
    - Physicians “sound” judgment not really enough
    - Should be incorporated into regular billing practices
  - NCCI
    - [www.cms.hhs.gov/providers/hopps/cciedits](http://www.cms.hhs.gov/providers/hopps/cciedits)
    - Comprehensive/Component Edits

- NCCI - Mutually exclusive codes

Column 1	Column 2	Modifier 0=not allowed 1=allowed 9=not applicable
90375	90376	0
90378	90379	1
90379	J1565	9
90385	J2792	9
90389	J1670	9
90585	90586	0
90632	90633	0

## ➤ PLEASE KEEP IN MIND:

- Quarterly CCI updates used by Medicare FIs are one calendar quarter behind NCCI updates used by Medicare carriers

- Outdated chargemasters
  - Crosswalk to procedure coding
- Multiple procedure discounting rules
  - Surgical code discounting
- Improper E/M Codes
  - Hospital-specific guidelines
  - “To AHIMA or not to AHIMA”
    - Not required
    - CMS still contemplating
    - Can you be “out in front on this issue”?

## ➤ Observation

*“Although the diagnoses for “separate payment” are somewhat restrictive, payment is made for medically necessary observation services provided in the outpatient setting. **Payment for observation services not meeting the requirements for separate payment in APC 0339 is included in the payment for clinic, emergency department, or surgical procedure visit.** For all conditions other than **chest pain, asthma, and CHF**, payment for observation services is packaged into the APC in which those services were provided. Observation is not separately paid if a surgical procedure or any service that has a status indicator of “T” under the OPPS occurs on the day before or the day that the patient is admitted to observation.”*

- *“Associated Hospital Service has identified the need for further revision to the Outpatient Observation Local Coverage Determination. Therefore, the Outpatient Observation Policy Revision has been delayed and will not be updated for the **Feb 16<sup>th</sup> date** as previously stated in a prior bulletin.” (Feb 17, 2005)*

## ➤ Failure to follow the Same Day Rule

- OPPS requires all services provided on the same day to be on the same bill
- Partial Hospitalization
  - Per diem payment under OPPS
  - Reducing the range of services
  - Withholding services
  - Non-covered services
  - Not medically necessary

## A3-3194, **HO-230.7**

*Partial hospitalization programs (PHPs) are structured to provide intensive psychiatric care through active treatment that utilizes a combination of the clinically recognized items and services described in §1861(ff) of the Social Security Act (the Act). The treatment program of a PHP **closely resembles that of a highly structured, short-term hospital inpatient program. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation.** Programs providing primarily social, recreational, or diversionary activities are not considered partial hospitalization.*

*Partial hospitalization services that make up a program of **active treatment** must be **vigorous and proactive** (as evidenced in the individual treatment plan and progress notes) as opposed to passive and custodial. It is not enough that a patient qualify under the benefit category requirements §1835(a)(2)(F) unless he/she also has the need for the active treatment provided by the program of services defined in §1861(ff). **It is the need for intensive, active treatment of his/her condition to maintain a functional level and to prevent relapse or hospitalization, which qualifies the patient to receive the services identified in §1861(ff).***

*Patients admitted to a PHP **do not require 24 hour per day supervision as provided in an inpatient setting, and** must have an adequate support system to sustain/maintain themselves outside the PHP.*

# Admissions & Discharges

- Same Day Discharges & readmissions
  - Review for “prudent clinical decision-making”
- Post-acute transfers

<b>DRG</b>	<b>DRG Title</b>
12	Degenerative Nervous System Disorders
14	Intracranial Hemorrhage and Stroke with Infarction
24	Seizure and Headache Age >17 With CC
25	Seizure and Headache Age >17 Without CC
88	Chronic Obstructive Pulmonary Disease
89	Simple Pneumonia and Pleurisy Age > 17 With CC
90	Simple Pneumonia and Pleurisy Age >17 Without CC
113	Amputation for Circulatory System Disorders Except Upper Limb and Toe
121	Circulatory Disorders With AMI and Major Complication, Discharged Alive
122	Circulatory Disorders With AMI Without Major Complications Discharged Alive
127	Heart Failure & Shock
130	Peripheral Vascular Disorders With CC
131	Peripheral Vascular Disorders Without CC
209	Major Joint and Limb Reattachment Procedures of Lower Extremity
210	Hip and Femur Procedures Except Major Joint Age >17 With CC
211	Hip and Femur Procedures Except Major Joint Age >17 Without CC
236	Fractures of Hip and Pelvis
239	Pathological Fractures and Musculoskeletal and Connective Tissue Malignancy
277	Cellulitis Age >17 With CC
278	Cellulitis Age >17 Without CC
294	Diabetes Age>35
296	Nutritional and Miscellaneous Metabolic Disorders Age >17 With CC
297	Nutritional and Miscellaneous Metabolic Disorders Age >17 Without CC
320	Kidney and Urinary Tract Infections Age >17 With CC
321	Kidney and Urinary Tract Infections Age >17 Without CC
395	Red Blood Cell Disorders Age >17
429	Organic Disturbances and Mental Retardation
430	Psychoses
468	Extensive O.R. Procedure Unrelated to Principal Diagnosis
Prpsd 541	Tracheostomy with Mechanical Ventilation 96+, W/OR
Prpsd 542	Tracheostomy with Mechanical Ventilation 96+ W/out OP

- Churning of patients in co-located LTCHs
  - Only 2 such units in the Commonwealth

# Supplemental Payment Considerations

- Pass-through Items
  - New technology and drugs
- Abuse of Outliers
  - Still watching out for charge abuse
  - Changes in the RCC greater than 10% age are “suspect”
- Improper Claims for Clinical Trials
  - NCD – 9/2000
- Improper Claims for Organ Acquisition
  - Hospitals need to have adequate cost information for acquisitions
- Payment for education programs
  - Focused on dental
  - Not normally/historically operated at the hospital
  - Basic rule: Must be on hospital campus/hospital patients

## ➤ Stark Basics:

- “...prohibits hospitals from submitting – and Medicare from paying – any claim for a “designated health service” (DHS) if the referral of the DHL comes from a physician with whom the hospital has a prohibited financial relationship. This is true even if the prohibited financial relationship is the result of inadvertence or error.”
- Academic medical center exception

- **3-Part Test:**
  - Is the referral from a physician for a DHS
    - Lab, radiology, DME, etc.
  - Does the physician have a financial relationship with the entity providing the DHS
    - Including free-standing DHS providers owned by hospitals
      - Direct/indirect ownership
      - Direct/indirect compensation (cash/ on-kind)
      - Does not have to be related to the DHS

- Does the financial relationship fit an exception
  - Function over form
  - **But** form is still very important
    - Written agreements
- Fair market value
  - Process
  - Reasoning
  - Consistency
  - Accountability
- Careful monitoring of:
  - Non-monetary compensation
  - Incidental benefits (parking, etc.)
  - Professional courtesy

## ➤ Anti-Kickback

- Prohibits payments made purposefully to induce or reward the referral or generation of Federal health care program business
- Extends equally to the solicitation or acceptance of remuneration for referrals
- Extends to anyone in a position to generate Federal health care program business for a hospital

- Arrangements or practices that may present a significant potential for abuse:
  - Does the hospital have a “remunerative relationship” with anyone that could refer business?
  - With respect to the “remunerative relationship”, could ONE of the purposes of the arrangement be to reward or incent referrals?
  
- **Aggravating circumstances:**
  - Interference with clinical-decision making?
  - Result in increased costs?
  - Increase in risk of over or inappropriate utilization?
  - Result in safety or quality concerns?

- Safe Harbors: [42 CFR 1001.952]
  - Investment interests
  - Space rental
  - Equipment rental
  - Personal services/management services
  - Sale of a practice
  - Discount
  - Employee
  - GPO
  - Waiver of co-pays & deductibles
  - Practitioner recruitment (very narrow)
  - OB malpractice
  - ASC
  - Ambulance replenishing
  - Managed care risk arrangements
  
  - ***Form and Function*** matter

- Anti-kickback potential “risk” areas:
  - Joint ventures
  - Compensation arrangements
  - Relationships with other health care providers
  - Recruiting
  - Discounts
  - Credentialing
  - Malpractice insurance
  
  - *Reminder: applies to physician & other entities*

- “Risk Areas”: Joint ventures
  - Long-standing area of concern
  - Dividends, profit distributions, other economic benefit
  - Improper nexus between referral capacity & participant selection
    - Favorable investment terms for “large” referral sources
    - Active encouragement of referrals/forced divestiture
    - Tracking and distribution of referral information
    - Investment interests are non-transferable
  - Suspect structure
    - Was the participant already engaged in that business?
  - Financing & distribution of profits
    - Must be reasonable value
    - No borrowing against investment stake
    - Disproportionate returns

- Safe harbors:
  - 40% limit on ownership and revenues from referrals
  - MUA: 50% limit on ownership
  - **ASC**
- Special note: “Contractual JVs”
  - Management contract with the Hospital taking substantially no risk
- Recommended actions for Hospitals
  - Barring employed physicians from referring to the JV
  - Taking steps to ensure physicians are “not encouraged” to refer to the JV
  - Annual notification of this policy
  - Refraining from tracking the source of referrals within the JV
  - Ensuring no physician compensation is tied to referrals to the JV
  - Disclosing all financial interests to patients
  - Requiring JV partners to adopt the same positions
  - **Bottom-line: VERY LIMITED OPPORTUNITIES (outside of ASC)**

## ➤ Compensation Arrangements with Physicians

### ▪ General rules:

- Fair market value/reasonable method, uniformly applied
  - No consideration of referrals
  - Legitimate business purposes
  - Documented scope of services
  - Accountability for production of services
  - Annual review
- 
- Particular to outpatient contracts: safeguards against **private use of space**
  - Hospital-based physicians: concern is typically that the hospital will use its “referral leverage” to underpay the physicians
    - **Exclusivity has “value”** that may be able to be used to justify requiring physicians to participate in Part A services for no additional payment

❑ **Is the reverse then true???**

- Referral Arrangements with Other Providers
  - General rule:
    - Offer multiple options in discharge planning
- Recruiting
  - Significant risk area/**very limited** Safe Harbor (HPSA)
  - Guidance is abundant BUT not necessarily clear:
    - IRS: Hermann Hospital
    - IRS: Rev Ruling 97-21
    - OIG: Anti-kickback
  - General rules/area of concerns:
    - Size of recruitment benefit should be “reasonable”
      - Can consider history of being able to attract specialists
    - Payout of recruitment benefit should not exceed 3 years
    - Need is “objectively” determined
    - Not be made to “recruit” physician already practicing in service area

- Things to remember:
  - Neither joint recruitment arrangements nor recruitment activities outside of designated HPSAs are *per se* illegal
  - Must be evaluated on a case-by-case basis
  - Even when a specific area is not designated as a HPSA, that area nevertheless may be deficient with respect to a particular specialty
  
- Determining community need
  - No hard-and-fast rules for documenting community need to support physician recruitment deals
  - Rev Rul. 97-21 does not officially sanction one methodology over any other
  - Some guidance can be found in the closing agreement between the IRS and Hermann Hospital

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  1. Deficient **population-to-physician ratio** for specialty (ideal ratio set by **Graduate Medical Education National Advisory**) [*But you can use others.*]
  2. Demand for service coupled with lack of availability or **long waiting periods** (if physician being recruited to increase availability)
  3. **HPSA** designation
  4. Reluctance of physicians to relocate due to hospital's physical location (intended for hospitals in a **rural or economically disadvantaged inner-city area**)
  5. Reasonably expected reduction in physicians of that specialty in hospital's service area due to **retirement with the next 3-years**
  6. Lack of physicians **serving indigent or Medicaid patients** within hospital's service area (recruited physician commits to serving substantial number of Medicaid and charity care patients)

- Recruiting: Joint Recruiting
  - Cannot be designed to let existing physician “retire in place”
    - Intra-physician financial arrangement are important
  - High degree of scrutiny in this area
    - All arrangements should be reviewed by Hospitals
- Discounts
  - Must be arm’s length
  - Must be given/set at time of sale (rebate)
  - Must be properly disclose on Cost Report (wkst A-8)
    - Sometimes tricky – built into sale price?
  - No “swapping” of low paying Part A services for Part B referrals
- Credentialing
  - Cannot be based on procedures (except to maintain clinical quality)
  - Categorically denyig privileges to those with conflicts may be okay

- Malpractice Subsidies

- Beyond the safe harbor: OB in HPSAs
- OIG Letter, January 2003: *With respect to the proposed arrangements described in your letter, we note that, as represented, they contain a number of safeguards.*

***First**, the arrangements will be provided on an **interim basis** for a fixed period in states experiencing severe access or affordability problems, although they may be extended if, at the end of the period there is a continuing disruption in a state's malpractice insurance market – an event over which [name redacted] has no control.*

***Second**, in the states where assistance is offered, **only current active medical staff (or physicians joining the medical staff who are new to the locality or have been in practice for less than one year)** will be eligible.*

***Third**, the criteria for receiving assistance will **not be related to the volume** or value of referrals or other business generated.*

***Fourth**, each physician receiving assistance **will pay at least as much as he or she currently pays** for malpractice insurance.*

***Fifth**, participating physicians **will be required to perform services** for the Hospital and give up certain litigation rights... [of equal value to the support received]*

***Sixth**, insurance assistance **will be available regardless of the location at which the physicians provide services, including, but not limited to, other hospitals.***

- Gainsharing
  - General “hang-up”: hospitals prohibited from knowingly making payments to reduce or limit services (CMP provisions of the Act)
    - Payment need not be directly linked to diminution in care “**so long as the hospital knows that the payment may influence the physician to reduce or limit services to his or her patients**”
  - Basically – gainsharing just cannot be done . . . . .  
**UNTIL. . . . .**

## o February 7, 2005 **OIG Advisory Opinion No. 05-01**

★ **VERY narrow exception**

★ Changing practices in the OR

- ◆ Focused on supply usage/consumption
- ◆ Independent medical determination that care would not be impacted
- ◆ *“Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude: (i) the Proposed Arrangement **would constitute an improper payment to induce reduction or limitation of services pursuant** to sections 1128A(b)(1)-(2) of the Act, but that the **OIG would not impose sanctions** under sections 1128A(b)(1)-(2) on the Requestors in connection with the Proposed Arrangement; and (ii) the Proposed Arrangement **would potentially generate prohibited remuneration under the anti-kickback statute**, if the requisite intent to induce or reward referrals of Federal health care program business were present, but that **the OIG would not impose administrative sanctions on the Requestors** under sections 1128(b)(7) or 1128A(a)(7) of the Act (as those sections relate to the commission of acts described in section 1128B(b) of the Act) in connection with the Proposed Arrangement.”*

- EMTALA
  - Particularly focused on Medical Screening (NO delays – even if on “diversion”)
  - Educate on-call physicians regarding requirements
  
- Substandard Care
  - OIG can exclude entities/individuals for unnecessary or substandard care
  - Neither intent nor knowledge is required
  - Can be applied to non-Federal beneficiaries
  - Bottom line: Hospitals **MUST** monitor quality (beyond JCAHO?)
    - ◆ Cannot use “inflated” income guidelines
    - ◆ Must be rechecked over time
    - ◆ May use alternative evidence, including questionnaires

- Relationships with Beneficiaries
  - Offer or transfer of items for less than FMV to “recruit” patients
    - Including deductibles & co-insurance waivers
    - Gifts
      - \* No more than \$10/\$50 per year
        - Preventative services are expected
    - Cost sharing waivers
      - \* Can consider ability to pay but cannot be routine or advertised
      - \* “Ability to pay” must consider:
        - ◆ Local cost of living
        - ◆ Income, assets, and expenses
        - ◆ Family size
        - ◆ Scope of bills (“hardship”)

## o Relationships with Beneficiaries (continued)

### o Free transportation

- \* Can offer if “low value” (e.g. no more \$10/\$50 per year)
- \* A safe harbor may be coming
  - ◆ In the meantime, it is ok **IF**:
  - ◆ Was in existence before 8/30/2002
  - ◆ Uniformly offered to all patients
  - ◆ To and from the Hospital only
  - ◆ Within Primary Service Area
  - ◆ Costs of service are not claimed on the cost report
  - ◆ Does not include ambulance service

- Excess of “Usual Charges”
  - Long Standing Battle
  - Relies on a pure mis-equating of: Cost – gross charges – payment level
  - Discounts are to uninsured
    - o The OIG does **NOT** have the authority in this area
      - \* Never excluded nor attempted to exclude any provider for giving discounts to the *uninsured* or *underinsured*.

## \* OIG, February 2, 2004

*“The OIG is currently reviewing the public comments to the proposed regulations. Until such time as a final regulation is promulgated or the OIG indicates its intention not to promulgate a final rule, it will continue to be the OIG's enforcement policy that when calculating their "usual charges" for purposes of section 128&)(6)(A), individuals and entities **do not need to consider free or substantially reduced charges to (i) uninsured patients or (ii) underinsured patients who are self-paying patients for the items or services furnished.**”*

*.....Nothing in the OIG rules or regulations prohibits such discounts, and the OIG fully supports the hospital industry's efforts to lower health care costs for those unable to afford care. While every case must be evaluated on its own merits, it is important to note that the OIG has never brought a*

- Does the “culture” of your organization “value” compliance?
  - Is the Board involved?
  - Are the internal controls sufficient, well-structured and monitored?
  - Do you regularly self-assess your program?
- Required:
  - Code of Conduct
    - Board/senior management involvement
- Regular review of effectiveness
  - Outcomes measurement:
    - o Billing errors
    - o Overpayment
    - o Other audit results

## Next Compliance Roundtable

*A Joint Meeting with CMS, NHIC, AHS and  
Hospitals*

April 12, 2005

Dedham Hilton